



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.

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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

within Grotberg's domains are also more likely to exhibit resilience. Within the inner strengths domain, they found that identity traits such as having managed optimism, or a balance of idealism and realism within their professional identity, as well as self-efficacy were important to resilience. Regarding external supports and resources, or workplace assets in this case, they found that resilience was associated with having flexible and individualized support, a culture of trust within the team and wider organization, and effective role models. Regarding social strengths, they found that reflexivity is important for resilience. In defining reflexivity, Kearns and McArdle (2011) combined descriptions from Payne (2002) and Etherington (2004) to describe it as learning and insight through returning to previous thoughts and experiences, thereby assessing choices and actions based on their value in the future, within the context of personal, social, cultural, and institutional domains. Also, organizational factors that have shown to promote either resilience or burnout can mediate the effect of stress and improve job satisfaction (McFadden, Campbell, & Taylor, 2014).

Of the people who are exposed to a single traumatic event, large numbers manage this temporary upheaval with no discernable disruption to their daily lives, or exhibit transient symptoms that typically diminish over time (Bonanno, 2008; Yehuda, Bryant, Marmar, & Zohar, 2005). However, those in professions where exposure to trauma occurs repeatedly, in the process of performing their vocational duties, it can be difficult to experience any type of sustained reprieve from trauma exposure, which would allow time to return to their level of functioning and performance before future exposure to trauma. Because of this ongoing exposure, it is important for organizations to be proactive in addressing reactions and symptoms, regardless of how mild they may seem (Tehrani, 2011). Trauma symptoms can be divided into four clusters (a) intrusion—persistently re-experiencing the traumatic event (e.g., recurrent, involuntary, intrusive memories; nightmares; dissociative reactions; intense or prolonged distress; marked physiological reactivity), (b) avoidance—persistent effortful avoidance of distressing trauma-related stimuli, (c) negative alterations in cognitions and mood (e.g., dissociative amnesia, negative beliefs about oneself or the world, distorted blame of self or others for the traumatic events or its consequences, negative trauma-related emotions, markedly diminished interest in pre-traumatic activities, feeling of alienation from others, constricted affect), and (d), alterations in arousal and reactivity (e.g., irritable or aggressive behavior, self-destructive or reckless behavior, hypervigilance, exaggerated startle response, concentration or sleep difficulties; American Psychiatric Association, 2013). Any of these trauma symptoms can impact the daily functioning and productivity of the individual experiencing them. Some tools that have shown efficacy for alleviating the effects of trauma include self-directed techniques that workers can follow to engage in mental exercises that produce a feeling of safety, relaxation techniques, and guidelines for creating a healthy lifestyle. However, while these tools can be helpful, in instances when trauma symptoms prove too overwhelming, individuals should seek the support of a trained trauma therapist (Tehrani, 2011).

1.5. Goals

The current study had three goals. First, the researchers sought to examine individual themes within a sample of child welfare professionals, specifically childhood experiences and resilience. Second, we wished to examine professional themes within this sample, specifically professional social climate and professional quality of life. Finally, the researchers wanted to examine the relationships between individual themes and professional social climate with professional quality of life in a sample of child welfare providers.

2. Methods

This study was approved by the Texas Christian University Institutional Review Board for Human Subjects Research.

2.1. Participants

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 United States of America. Consistent with other studies of similar populations (e.g., Myers, Mobley, & Booth, 2003), most participants were female (83.9%) and their primary cultural background was Caucasian (72.4%). A minority were African American (16.0%), Asian/Pacific Islander (1.5%), and Hispanic (10.1%). Age of participants ranged from 24 to 71 ($M = 37.59$, $SD = 9.82$). Participants were either married (59.3%) or single (28.4%) with only a small number of divorced individuals (12.3%). Over half of the participants (60.9%) had children. Most participants provided indirect services (58.9%). The most common indirect service job titles were child advocate, clinical supervisor, educator, foster care supervisor, program director, and trainer. The most common direct service job titles were behavioral intervention specialist, case manager, psychologist, social worker, therapist, and therapeutic childcare specialist. All participants had earned at least a Bachelor's degree and most (66.1%) had a Masters or Doctorate degree.

2.2. Measures

2.2.1. ACEs

ACEs (Felitti et al., 1998) is a 10-item questionnaire about childhood maltreatment and family dysfunction. Participants indicate whether they experienced each item (ex. Were your parents ever divorced or separated?). Higher scores indicate increased adverse childhood experiences. The current sample yielded the following internal consistency coefficients of .74.

2.2.2. Resilience Questionnaire

The Resilience Questionnaire (Rains & McClinn, 2013) is a 14-item self-report measure of resilience (ex. When I felt really bad, I could almost always find someone I trusted to talk to). Participants rate themselves on each of the 14 statements on a five-point Likert scale (1 = definitely not true to 5 = definitely true). Any items rated as a 4 or higher are identified as a protective factor. Number of protective factors is summed leading to a score ranging from 0 to 14 with higher scores indicating higher levels of resilience. The current sample yielded the following internal consistency coefficients of .82. Most organizations in the current study were already using the Resilience Questionnaire as part of their regular evaluation process. For the sake of continuity, we adopted it for the current research study. Although it has strong face validity, little psychometric information was available for the Resilience Questionnaire.

2.2.3. Group Environment Scale (GES)

The GES (Moos, 2002) is specifically designed to assess the organizational culture within groups. It consists of 90 true/false questions that represent the three dimensions (Relationship, Goal-Oriented, and System Maintenance), which are further divided into 10 subscales. The Relationship dimension included the subscales of Cohesion, Expressiveness, and Leader Support. The Goal Oriented dimension included the subscales of Independence, Task Orientation, Self-Discovery, and Anger and Aggression. The System Maintenance subscales included Order and Organization, Leader Control and Innovation. Subscale totals range from 0 to 10, where higher scores indicate a greater presence of the dimension within the environment. Raw scores were converted into standardized scores (Moos, 2002). The current sample yielded the following internal consistency coefficients: Cohesion (.83), Expressiveness (.67), Leader Support (.85), Independence (.58), Task Orientation (.71), Self-Discovery (.76), Anger and Aggression (.76), Order and Organization (.81), Leader Control (.63) and Innovation (.61). Data for the current study was examined at the level of the subscales.

2.2.4. Professional Quality of Life Scale (ProQOL)

The ProQOL (Stamm, 2010) is a 30-item self-report measure of the positive and negative aspects of helping professions. Professionals rate themselves on each of the 30 statements on a five-point Likert scale (1 = never to 5 = very often). The measure yields subscale scores for Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. The Compassion Satisfaction subscale measures the extent to which an individual is able to derive pleasure from doing his or her work well or helping others (ex. I am happy that I chose to do this work). Higher scores on the Compassion Satisfaction scale indicate higher level of functioning. The Burnout subscales measure a professional's feelings of hopelessness and difficulties in dealing with doing his or her job effectively (ex. I feel trapped by my job as a helper). Higher scores on the Burnout scale indicate higher level of burnout. The Secondary Traumatic Stress subscale measures work-related, secondary exposure to people who have experienced trauma (ex. I find it difficult to separate my personal life from my job as a helper). Higher scores on the Secondary Traumatic Stress scale indicate higher level of secondary trauma. The current sample yielded the following internal consistency coefficients: Compassion Satisfaction (.86), Burnout (.76), and Compassion Fatigue (.81).

2.3. Procedures

Data was collected during a trauma-informed intervention workshop for child welfare professionals in a large metropolitan area in the southern United States of America. Participants who wished to participate completed an informed consent and all questionnaires during the morning on the first day of training. Of the 258 participants at the training, 192 completed all questions. Completion rate was 74.4%.

3. Results

The results section is organized in three parts, each corresponding to the major goals of the study. Part one will examine themes related to individual characteristics, providing a basic description of the sample's characteristics on the ACEs and Resilience Questionnaire, as well as comparing the current sample of child welfare professionals to normative sample data for the general population when available. Part two will examine professional themes within this sample as measured by the GES and ProQOL and will compare the current sample to normative samples for the general population on these professional themes. Part three will examine the relationships between individual themes and professional social climate with professional quality of life. Specifically this section will investigate which descriptive variables, individual themes, and GES subscales are the most predictive of the ProQOL subscales.

3.1. Individual themes

3.1.1. ACEs

Frequency and percentages for total ACE scores in the current sample and percentages in the normative sample for the general population can be found in Table 1. Results reveal a high prevalence of ACEs among child welfare providers serving children in foster care

Table 1
Frequencies and percentages for total ACE score.

Number of ACEs	Current sample (n = 192)		Norm
	n	%	%
None	48	25.0	36.1
One	47	24.5	26.0
Two	30	15.6	15.9
Three	19	9.9	9.5
Four or more	48	25.1	12.5

($M = 2.18, SD = 2.13$). Three-fourths of participants (75.0%) reported at least one of the ACE categories, half (50.6%) reported two or more ACE categories, and over a quarter (25.1%) reported four or more ACE categories. Chi Square test revealed that participants in the current sample were significantly more likely to report four or more ACE categories (25.1%) than the normative sample for the general population (12.5%), $\chi^2 = 17.30, p < .001$.

Frequency and percentages for prevalence of individual categories of ACEs can be found in Table 2. The current study found that parental loss through divorce or abandonment was the most frequently reported category (41.1%), followed closely by a family member experiencing depression or mental illness (35.9%). A series of analyses were conducted to examine the relationships between demographic variables (age, sex, marital status, children, educational level, and level of care) and total ACE categories. Correlational analysis revealed that total number of ACE categories was significantly related to age ($r = .15, p < .05$), such that older participants had more ACE categories than younger participants. Independent Sample t test revealed that participants with a graduate education reported fewer ACE categories ($M = 1.95, SD = 2.00$) than participants who did not have a graduate education ($M = 2.62, SD = 2.32$), $t = -2.84, p < .01$. No significant differences were found for the remaining variables.

3.1.2. Resilience Questionnaire

Scores on the Resilience Questionnaire ranged from 3 to 14 ($M = 12.14, SD = 2.24$). Overall the current sample reported a high level of supportive factors and resilience. Normative data for the general population on the Resilience Questionnaire was not available. A series of analyses were conducted to examine the relationships between demographic variables (age, sex, marital status, children, educational level, and level of care) and resilience. No significant relationships were found.

3.2. Professional themes

3.2.1. Group Environment Scale (GES)

Means and standard deviations for the GES scales for the current sample and the normative sample for the general population (Moos, 2002) can be found in Table 3. Independent Sample t test significantly differed from the normative sample for the general population on all GES subscales except Leader Support. Participants in the current sample reported lower scores on Cohesion, Expressiveness, Independence, Task Orientation, and Order and Organization subscales than the normative sample for the general population. However, participants reported higher scores than the normative sample on Self-Discovery, Anger and Aggression, Leader Control, and Innovation.

A series of analyses were conducted to examine the relationships between demographic variables (age, sex, marital status, children, educational level, and level of care) and GES subscales. Correlational analysis revealed that Task Orientation was significantly related to age

Table 2
Frequencies and percentages prevalence of individual categories of ACEs (n = 192).

ACEs	Current sample (n = 192)		Norm
	n	%	%
Parental loss through divorce or abandonment	79	41.1	23.0
Depressed/mentally ill household member	69	35.9	17.0
Psychological abuse	58	30.2	11.0
Substance abuse by household member	54	28.1	27.0
Emotional neglect	46	24.0	15.0
Sexual abuse	39	20.3	21.0
Physical abuse	37	19.3	28.0
Domestic violence	31	16.1	13.0
Physical neglect	20	10.4	10.0
Incarceration	10	5.2	6.0

Table 3
Means and standard deviations for GES subscales.

Scale	Current sample (n = 192)		Norm group		t	d
	M	SD	M	SD		
Cohesion	4.95	.71	6.61	2.21	10.36**	1.01
Expressiveness	4.76	.78	6.69	2.14	12.43**	1.19
Leader Support	5.29	.70	5.51	2.16	1.41	ns
Independence	4.68	.87	6.48	1.76	14.04**	1.30
Task Orientation	4.41	.69	6.51	1.98	14.62**	1.42
Self-Discovery	5.78	.78	5.05	2.36	4.27**	.41
Anger and Aggression	5.65	.66	3.54	2.68	10.88**	1.08
Order and Organization	5.39	.75	5.74	2.26	2.14*	.21
Leader Control	5.80	.89	4.86	2.17	5.96**	.57
Innovation	6.44	.83	4.38	2.16	13.14**	1.26

* $p < .01$.** $p < .001$.

($r = .15, p < .05$), such that older participants had more Task Orientation than younger participants. Independent Sample t test revealed that participants with a graduate education reported lower scores on the Anger and Aggression subscale ($M = 50.21, SD = 5.65$) than participants who did not have a graduate education ($M = 52.08, SD = 6.36$), $t = -2.07, p < .05$. No significant differences were found for the remaining variables.

3.2.2. Professional Quality of Life (ProQOL)

Means and standard deviations for the ProQOL scales for the current sample and the normative data for the general population (Stamm, 2010) can be found in Table 4. Independent Sample t -tests significantly differed from the normative sample on all ProQOL subscales. Participants in the current study report higher levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress than the normative sample.

A series of analyses were conducted to examine the relationships between demographic variables (age, sex, marital status, children, educational level, and level of care) and ProQOL scales. Correlational analysis revealed that Compassion Satisfaction was significantly related to age ($r = .18, p < .01$), such that older participants had more Compassion Satisfaction than younger participants. Further, results showed that Burnout was significantly related to age ($r = -.20, p < .01$), such that younger participants reported higher scores on the Burnout Scale than older participants. Independent Sample t test revealed that females reported higher levels of Secondary Traumatic Stress ($M = 24.58, SD = 5.36$) than males ($M = 21.65, SD = 4.67$), $t = -2.84, p < .01$. Results also suggested significant difference for participants with children on Compassion Satisfaction ($t = -3.09, p < .01$), Burnout ($t = 3.00, p < .01$), and Secondary Traumatic Stress ($t = 2.01, p < .05$). Participants who did not have children reported significantly lower levels of Compassion Satisfaction ($M = 38.09, SD = 5.20$), than participants with children ($M = 40.30, SD = 4.57$). Participants with children reported lower levels of Burnout ($M = 23.00, SD = 4.72$) than participants who did not have children ($M = 25.24, SD = 5.53$). Furthermore, participants with children reported lower levels of Secondary Traumatic Stress ($M = 23.46, SD = 4.87$) than participants who did not have

Table 4
Means and standard deviations for ProQOL subscales.

Scale	Current sample (n = 192)		Norm group		t	d
	M	SD	M	SD		
Compassion Satisfaction	39.44	4.93	37.00	7.30	4.43**	.39
Burnout	23.88	5.16	22.00	6.80	3.63**	.311
Secondary Traumatic Stress	24.10	5.35	13.00	6.30	22.83**	1.90

** $p < .001$.

children ($M = 25.11, SD = 5.92$). No significant differences were found for the remaining variables.

3.3. Predicting ProQOL subscales

The authors were interested in the extent to which descriptive variables, ACEs, Resilience, and GES predicted ProQOL subscales. A series of regression analyses were conducted predicting Compassion Satisfaction, Burnout, and Secondary Traumatic Stress from all significant descriptive variables (type of caregiving, age, sex, ethnicity, marital status, presence or absence of children, education level, presence or absence of spiritual beliefs), ACEs score, Resilience Questionnaire scores, and all GES subscale scores. All categorical variables were recoded into dichotomous variables (direct caregiver, female, Caucasian, married, children, graduate education, spiritual beliefs) for analysis. Mediator and moderator effects for all major predictors were explored, but were nonsignificant on all three professional quality of life scales.

3.3.1. Compassion satisfaction

As shown in Table 5, Compassion Satisfaction was significantly predicted by total number of ACEs, the Resilience Questionnaire, and reported levels of Leader Control. Participants with more ACEs reported more Compassion Satisfaction than individuals with fewer ACEs. Individuals with higher scores on the Resilience Questionnaire reported more Compassion Satisfaction than participants with lower scores on the Resilience Questionnaire. Moreover, individuals who reported higher levels of Leader Control within their organization reported less Compassion Satisfaction than participants who reported lower levels of Leader Control.

3.3.2. Burnout

As shown in Table 6, Burnout was significantly predicted by total number of ACEs, the Resilience Questionnaire, reported levels of Leader Control, and type of caregiving provided. Participants with more ACEs reported less Burnout than individuals with fewer ACEs. Individuals with higher scores on the Resilience Questionnaire reported less Burnout than participants with lower scores on the Resilience Questionnaire. Moreover, individuals who reported higher levels of Leader Control

Table 5
Predicting compassion satisfaction from descriptive variables, ACEs, resiliency, and GES subscales (n = 192), standardized coefficient (β).

Predictors	B	SE B	β
ACEs	.65	.20	.28**
Resiliency	.40	.18	.18*
Cohesion	-.02	.07	-.03
Leader Support	-.01	.06	-.02
Expressiveness	.02	.06	.02
Independence	-.01	.05	-.02
Task Orientation	.11	.07	.14
Self-Discovery	-.03	.06	-.05
Anger and Aggression	.08	.07	.10
Order and Organization	.06	.06	.08
Leader Control	-.11	.05	-.17*
Innovation	-.05	.06	-.08
Direct Care	.83	.74	.08
Age	.05	.04	.10
Female	-.30	.96	-.02
Caucasian	-.66	.48	-.10
Married	.29	.79	.03
Children	1.14	.89	.11
Graduate Education	.95	.78	.09
Spiritual Beliefs	1.26	.70	.13
Adj. R ²			
F			

* $p < .05$.** $p < .01$.

Table 6
Predicting burnout descriptive variables, ACES, resiliency, and GES subscales (n = 192), standardized coefficient (β).

Predictors	B	SE B	β
ACES	-.57	.20	-.23**
Resiliency	-.76	.19	-.33**
Cohesion	.02	.07	.02
Leader Support	-.09	.07	-.12
Expressiveness	-.01	.06	-.01
Independence	.03	.05	.05
Task Orientation	-.04	.07	-.05
Self-Discovery	.05	.06	.07
Anger and Aggression	-.03	.07	-.04
Order and Organization	-.05	.06	-.07
Leader Control	.12	.05	.18*
Innovation	.04	.06	.06
Direct Care	-1.56	.77	-.15*
Age	-.07	.04	-.14
Female	1.04	.99	.07
Caucasian	.15	.50	.02
Married	.21	.81	.02
Children	-1.03	.92	-.10
Graduate Education	-1.11	.80	-.10
Spiritual Beliefs	-.16	.72	-.02
Adj. R ²	-.57	.20	-.23
F	-.76	.19	-.33

* $p < .05$.

** $p < .01$.

within their organization reported more Burnout than participants who reported lower levels of Leader Control. Further, participants categorized as direct care providers reported more Burnout than indirect care providers.

3.3.3. Secondary Traumatic Stress

As shown in Table 7, Secondary Traumatic Stress was significantly predicted by the Resilience Questionnaire and gender. Individuals with higher scores on the Resilience Questionnaire reported less Secondary Traumatic Stress than participants with lower scores on the Resilience Questionnaire. Furthermore, males reported less Secondary Traumatic Stress than females.

Table 7
Predicting Secondary Traumatic Stress from descriptive variables, ACES, resiliency, and GES subscales (n = 192), standardized coefficient (β).

Predictors	B	SE B	β
ACES	-.15	.22	-.06
Resiliency	-.57	.20	-.24**
Cohesion	.03	.08	.04
Leader Support	-.05	.07	-.07
Expressiveness	-.01	.07	-.01
Independence	-.05	.06	-.07
Task Orientation	-.01	.07	-.02
Self-Discovery	.05	.07	.07
Anger and Aggression	.03	.08	.03
Order and Organization	.01	.07	.01
Leader Control	.09	.05	.14
Innovation	-.01	.06	-.01
Direct Care	-1.17	.82	-.11
Age	-.04	.05	-.06
Female	2.76	1.06	.19**
Caucasian	-.11	.53	-.02
Married	-.20	.87	-.02
Children	-.89	.98	-.08
Graduate Education	-1.53	.86	-.14
Spiritual Beliefs	-.36	.77	-.03
Adj. R ²	-.15	.22	-.06
F	-.57	.20	-.24

** $p < .01$.

4. Discussion

Regarding the individual themes, this study found a high prevalence of ACEs among child welfare professionals serving children in foster care. This finding is consistent with previous research that ACEs are more prevalent among human service workers (Esaki & Larkin, 2013) than the normative for the general population (Dong et al., 2004; Felitti & Anda, 2010). While we can find no studies that provide definitive correlations as to why individuals with ACEs may be more likely to choose helping professions, we propose some thoughts for consideration. First, traumatic events induce feelings of helplessness and lack of control (Beck, Jacobs-Lentz, Jones, Olsen, & Clapp, 2014). By entering into a helping profession, individuals can begin to perceive themselves as having some form of authority or control over situations very similar to the ones they experienced in their own childhood. Thus, such professions offer them an opportunity to face these situations from a position of strength, which may be alluring to populations with ACEs that is not present for other populations. In addition, because of their own experiences, social workers with a history of ACEs may have a higher level of empathy and concern for the children and families they will serve due to their ability to identify with these populations. Knowing from firsthand experience the frustrations and feelings experienced by their clients, they may feel a desire to help those who are going through similar circumstances that they themselves experienced. In addition, those with ACEs may have been more likely to have had positive experiences and received some form of assistance from those in social welfare professions, and thus, due to their early exposure to these occupations, are more likely to explore these paths as career options. However, while these may seem to be plausible factors for the higher rate of ACEs found in social workers, research is needed to help us more confidently explain this phenomenon.

In looking at overall individual demographic patterns, only age, level of education, gender, and parental status showed to have significant mediating effects on the outcome measures. Regarding age, we found that older participants tended to have more ACEs, more task orientation, more compassion satisfaction, and lower burnout scores than younger participants. Also, professionals with graduate degrees tended to have fewer ACEs and lower levels of anger and aggression (as reported on the GES). Females reported higher levels of secondary traumatic stress, which has also been found in other studies as discussed in the introduction to this study. Participants with children reported significantly higher levels of compassion satisfaction, lower rates of burnout, and lower levels of STS. It seems that as individuals grow older, and build families of their own, workplace stress that might otherwise lead to burnout, seems to have less influence on their lives. Thus, it may be important for agencies to take steps to ensure that younger and single employees are provided with training and coping tools early in their career when they may need it most.

Regarding the professional themes, results of the Professional Quality of Life survey (ProQOL) found that participants generally reported higher levels of compassion satisfaction, burnout, and secondary trauma stress than the normative sample for the general population. Results of the Group Environment Scale (GES) showed that participants had lower scores than the norm for (a) cohesion (one's involvement in and commitment to their professional group including concern and friendship shown to one another), (b) expressiveness (the level of freedom of action and expression of feelings that are encouraged in the group), (c) task orientation (the emphasis placed on completing concrete, practical tasks, and on decision-making and training), and (d) order and organization (the formality and structure of the group and the explicitness of rules and sanctions). Higher scores on the GES were reported for (a) self-discovery (how much the group encourages members' discussions of personal problems), (b) anger and aggression (the extent to which there is open expression of anger and disagreement in the group), (c) leader control (the extent to which the leader directs the group, makes decisions, and enforces rules), and (d) innovation

(how much the group promotes diversity and change in its own functions and activities).

Finally, we were interested in the extent to which the demographic variables, ACEs, resilience, and GES predicted ProQOL subscales. We found that those with (a) higher levels of leader control reported less compassion satisfaction and more burnout, (b) those with more ACEs and higher levels of resilience reported more compassion satisfaction and less burnout, (c) those with higher levels of resilience reported less secondary traumatic stress, and (d) those categorized as direct care providers reported more burnout than indirect care providers. Thus, while having a controlling leader led to increased worker burnout, those who reported high levels of resilience were least likely to succumb to worker burnout and STS.

Our findings were consistent with Lawson and Myers (2011) findings that mental health professionals who were female and younger were more likely to experience burnout and compassion fatigue. However, inconsistent with our study, Lawson and Myers found those with higher educational degrees also had higher rates of burnout and compassion fatigue. They also found that those with less clinical experience and those who had a higher percentage of clients with PTSD had higher levels of burnout and compassion fatigue.

In addition, while our participants showed a higher rate of ACEs, the presence of ACEs did not adversely effect their ProQOL subscales, and even seemed to improve compassion satisfaction and protect against burnout. These findings were consistent with the findings of Marcus and Dubi (2006) who found that prior experiences of trauma in mental health professionals are not significantly correlated with compassion fatigue, burnout, anxiety, or depression. Thus, the mere presence or absence of ACEs in social workers may not predict whether or not that individual will experience success or difficulty at higher or lower rates than other individuals. Regarding our finding that direct care providers reported more burnout than indirect care providers, Eunju et al. (2013) determined that creating a sense empowerment can particularly help direct care providers manage the psychological stress associated with providing services directly to traumatized populations.

Also, our findings that having a controlling leader can lead to higher rates of burnout are consistent with Eunju et al. (2013), discussed in our review of literature for this study, which found having a sense of power and agency over one's work can reduce the likelihood of burnout. Eunju et al. (2013) determined that making improvements in organizational climate can help create the conditions to provide employees with an increased sense of control. In addition, studies have found that social workers were less likely to leave their jobs when they viewed their supervisors as those who were supportive and provided more guidance (see McFadden et al., 2014). Thus, it seems that the type of relationship provided by a supervisor can play a pivotal role in perceived stress, job satisfaction, burnout, and turnover. Thus, we postulate that supervisors who are authoritative, rather than authoritarian, may be the most effective at providing the type of support that will produce the best outcomes for their employees. The concept of authoritative leadership stems from the term "authoritative parenting" which is used to describe parenting that maintains control and high expectations, yet is simultaneously warm, rational, and receptive to their child's communication. Authoritative parents maintained high control while providing positive encouragement of the child's autonomous and independent strivings. Children of authoritative parents tend to be more self-reliant, controlled, explorative, and content with themselves.

In contrast, authoritarian parenting is described as detached and controlling, and less warm than other parents. They tend to have children who are more discontent, withdrawn, and distrustful (Baumrind, 1971). Thus, supervisors with an authoritative approach would be supportive and yet allow workers to develop a sense of agency and control over their work.

Supervisors with an authoritarian approach may be more akin to those reported as having high levels of leader control in our study, resulting in less compassion satisfaction and more burnout for our

participants. Many studies have determined that authoritative parenting produces better emotional outcomes for children, than does the authoritarian approach (Baumrind, 1971; Gregory et al., 2010; Steinberg, Blatt-Eisengart, & Cauffman, 2006). Popper and Maysless (2003) have examined the similarities between leaders and parents. In a review of literature, they found that good or "transformational" leaders and good parents, shared similar qualities, a few of which include (a) attentiveness and responsiveness, (b) communicates openly and with expression/emotion, (c) sets realistic goals and inspires faith in one's ability to accomplish them, (d) promotes autonomy, (e) instills sense of worth, (f) generates a sense of trust in him/herself, and (g) develops other transformational leaders that can replace him/her. While they do not use the term "authoritative" in their article, the description of what Popper and Maysless call "transformational" leadership and "good" parenting, seem very closely aligned to descriptions of authoritative parenting. Further investigation into the similarity between the different types of parenting styles and the different types of leadership styles described may provide helpful parallels to consider when investigating stress, burnout, and other possible effects on social workers.

4.1. Limitations

Several limitations exist in the current study. Though the Resilience measure has excellent face validity and was widely used among the organizations in the current sample, little psychometric information is available. Future research should evaluate the psychometric properties on this questionnaire. Also, because we had three hypotheses, providing a thorough investigation of all aspects of each of these was prohibitive. Future research should investigate each of these topics separately in order to explore each one in more depth. Another limitation is that most of the participants (58.9%) provided indirect services to children, thus future studies should provide separate analyses, for those with indirect vs. direct contact with children, to determine if there are differences between these two groups. In addition, participants varied across many organizations, levels of management, and levels of experience. Future research should compare experiences of individuals based on these variations.

In addition, our results showed high scores for both "leader control" and "innovation" on the Group Environment Scale. The GES describes leader control as the extent to which a leader directs the group, makes decisions, and enforces rules. Innovation is described as the extent to which the group promotes diversity and change in its own functions and activities. It seems contradictory to have high scores for both categories. That is, would it be likely that a highly innovative group would have a highly controlling leader? Future research should explore this finding more thoroughly.

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