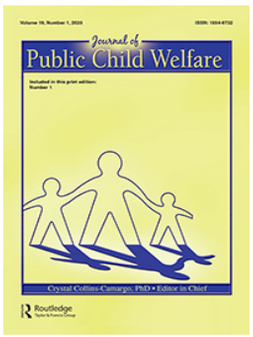

Journal of Public Child Welfare

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/wpcw20

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To cite this article: Shelby L. Clark, Brennan Miller, Becci A. Akin, Kaela Byers, Kelechi Wright, Kortney Carr & Mary Kate Hunt (2025) Exploring the relationships between self-care and well-being outcomes among child welfare professionals, Journal of Public Child Welfare, 19:1, 110-140, DOI: 10.1080/15548732.2024.2306151

To link to this article: https://doi.org/10.1080/15548732.2024.2306151

Published online: 27 Jan 2024.

JOURNAL OF PUBLIC CHILD WELFARE
2025, VOL. 19, NO. 1, 110–140
https://doi.org/10.1080/15548732.2024.2306151

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Exploring the relationships between self-care and well-being outcomes among child welfare professionals

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ABSTRACT

Child welfare workers experience increased risk of secondary traumatic stress (STS) and burnout. Despite encouragement to bolster self-care, little remains known about self-care and well-being outcomes. This study explored frequency of self-care and its relationship with STS, burnout, and compassion satisfaction by surveying 305 child welfare direct service and supervisor professionals. Participants completed the ProQol and reported frequency and types of self-care. Findings indicated frequency of self-care was associated with decreased STS and burnout, and increased compassion satisfaction. Given the prevalence of STS in child welfare, further exploration of self-care and its potential for strengthening well-being is necessary.

ARTICLE HISTORY
Received 27 June 2023
Revised 2 January 2024
Accepted 3 January 2024

KEYWORDS
Secondary traumatic stress; burnout; compassion satisfaction; self-care; child welfare workforce well-being

Work in child welfare has been extensively described as stressful and traumatizing (Bride, Jones, & MacMaster, 2007; Rienks, 2020; Sprang, Craig, & Clark, 2011). Previous scholarship has established substantial job risks impacting child welfare professionals' well-being such as experiencing significant rates of secondary traumatic stress (STS) and burnout (Baugerud, Vangbæk, & Melinder, 2018; Borjanić Bolić, 2019; Lizano & Mor Barak, 2015; Sprang, Craig, & Clark, 2011). Child welfare professionals have been found to have higher rates of STS compared to other social service professionals (Dagan, Ben-Porat, & Itzhaky, 2016; Letson et al., 2020). Some protective factors such as stronger compassion satisfaction have been associated with decreased rates of STS and burnout among child welfare professionals (Rothenberg et al., 2008; Salloum, Kondrat, Johnco, & Olson, 2015). However, little remains known about factors that may bolster compassion satisfaction.

Self-care has been suggested as a potential strategy for mitigating the risk of negative well-being outcomes such as STS and burnout among child welfare practitioners (Administration for Children's Services-New York University

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Children's Trauma Institute, 2012; National Child Traumatic Stress Network, 2011). However, scholarship establishing an evidence base supporting this claim is limited. Child welfare workforce well-being is not only important for individual professionals. Workforce well-being may also impact service delivery and outcomes for children and families engaging with child welfare services. While self-care may provide an antidote protecting and strengthening child welfare workforce well-being, more information is needed to empirically understand these relationships. Thus, the purpose of this study was to explore if self-care behaviors were associated with improved well-being outcomes among child welfare professionals.

Literature review

Self-care

Self-care has been conceptualized as any behavior an individual engages in that supports health and well-being (Lee & Miller, 2013; Newell & Nelson-Gardell, 2014). Moreover, social workers' self-care has been suggested as a phenomenon that occurs in an interconnected, dynamic process where care for self happens in both professional and personal domains. Care for self is holistic and fluid; personal self-care impacts how an individual cares for themselves professionally and vice versa (Lee & Miller, 2013). As self-care is regularly suggested to be integral in supporting child welfare workforce well-being and buffering professionals against negative consequences from emotionally demanding work, the need to measure the effects of self-care on child welfare professionals is burgeoning. However, at present the literature examining the self-care behaviors of child welfare professionals and their association with improved well-being outcomes is sparse.

Scholarship examining self-care in adjacent helping professions such as social work broadly and among therapists has found self-care to be a protective factor associated with improved well-being. In a sample of master level social workers, Bloomquist et al. (2015) found that professionals who had more positive beliefs about self-care engaged in more domains of self-care than those who held less positive beliefs about self-care. Interestingly, Bober and Regehr (2006) found that among a sample of therapists, believing that self-care and coping strategies were useful was not associated with the amount of a time a person spent caring for themselves.

Scholarship investigating self-care in child welfare contexts has begun to establish an evidence base for the self-care behaviors among this population. Despite encouragement to engage in regular self-care, most child welfare professionals report practicing self-care only sometimes (Miller, Donohue-Dioh, Niu, Grise-Owens, & Poklembova, 2019). Moreover, trauma-informed self-care has been associated with improved child welfare workforce well-being (Salloum, Kondrat, Johnco, & Olson, 2015). Importantly, repeated calls have been made for child welfare systems to prioritize workforce well-

being and support professionals in engaging in self-care (Lee, Pang, Lee, & Melby, 2017; Salloum, Kondrat, Johnco, & Olson, 2015). However, there is limited scholarship identifying organizational practices that support self-care among child welfare workers.

While individuals engage in self-care, many argue that self-care is maximized when it is supported systemically and structurally (Lee & Miller, 2013; Newell & Nelson-Gardell, 2014; Salloum, Kondrat, Johnco, & Olson, 2015). Furthering this position, some suggest positioning the responsibility for self-care as a collective responsibility is a necessary shift in the dialog and emphasis on self-care (Chamberlain, 2020; Cooke, Phillips, Eckert, & Kendrick, 2021; Pyles, 2020). Describing a shared responsibility for well-being, collective care acknowledges the structural barriers to well-being and actively works to dismantle systemic harm resulting in deleterious impacts on individual health, well-being, and thriving (Chamberlain, 2020; Cooke, Phillips, Eckert, & Kendrick, 2021; Pyles, 2020). Others explain that self-care and community care are not at opposite ends of a spectrum, but rather emphasize that communities are made up individuals and there is a reciprocal and symbiotic relationship between the well-being of both (Grise-Owens, Miller, & Brooks-Eaves, 2023). Similarly, Beauchesne (2023) explained that, "Collective care is self-care" (n.p.), explaining that community and connection are necessary to individual thriving.

Still others explain that an authentic commitment to self and collective care requires that organizations resist the encouragement of self-care as a managerial tool that places the responsibility for well-being on individuals' behavior and that organizations must disrupt the notion that professionals should engage in self-care for the sake of being more productive workers (Michaeli, 2017; Pyles, 2020). Highlighting the commodification of self-care, some describe that self-care has been both weaponized against workers who are blamed for their burnout and STS (Pyles, 2020), and also capitalized by gatekeeping well-being when self-care is accessible primarily to those with wealth (Chigudu & Chigudu, 2015). Moreover, commercialized and capitalized approaches to self-care are narrowly defined and may not be culturally inclusive. An expansive view of self-care is needed to honor the varied needs and experiences of people with diverse lived experiences (Chigudu & Chigudu, 2015; Ory, 2008; Pyles, 2020).

The emerging argument positing that communities, organizations, systems, and the individuals within them hold a shared responsibility for self and collective care is especially pertinent in child welfare settings. Despite the consistent encouragement for child welfare organizations and systems to structurally support child welfare workers in caring for themselves, evidence suggests that child welfare workers continue to struggle to access and engage in self-care practices (Miller, Donohue-Dioh, Niu, Grise-Owens, & Poklembova, 2019). This may demonstrate that child welfare scholarship, practice, and policy have struggled to prioritize self-care in ways that enable

child welfare professionals in accessing and engaging in self-care practices. Further, child welfare scholarship establishing evidence regarding the effectiveness of self-care is limited. This reveals a gap in an empirical understanding of self-care, which may limit child welfare systems and organizations in implementing effective practices and policies to support the self-care practices of professionals.

Child welfare professional well-being

The well-being of child welfare workers has been conceptualized as complex and multi-dimensional (Clark, 2022; Lizano et al., 2021). Child welfare workforce well-being has been described as including physical, social, psychological, and spiritual domains (Clark, 2022; Lizano et al., 2021). This study was interested in examining three child welfare worker well-being outcomes including STS, burnout, and compassion satisfaction.

STS and related constructs

Secondary Traumatic Stress (STS) describes the experiences of individuals such as caregivers, relatives, and service workers who have close and continued contact with other people's traumatic experiences (Bride & Figley, 2007; Figley, 1995). STS responses mirror symptoms of direct trauma exposure such as hypervigilance and disruptions to mood and sleep (Bride & Figley, 2007; Figley, 1995). Terms such as compassion fatigue and vicarious trauma similarly refer to the development of trauma responses as a result of engaging in direct work with traumatized individuals or indirect work handling traumatizing materials such as case records (Bride & Figley, 2007; Figley, 1995; McCann & Pearlman, 1990). STS, compassion fatigue, and vicarious trauma describe similar responses and have been used interchangeably in previous scholarship (Anderson, 2000; Cornille & Meyers, 1999; Kapoulitsas & Corcoran, 2015; Salloum, Kondrat, Johnco, & Olson, 2015).

Several studies have identified STS as a prevalent and significant problem among child welfare professionals (Baugerud, Vangbæk, & Melinder, 2018; Cornille & Meyers, 1999; O'Bryant, 2008; Sprang, Craig, & Clark, 2011). Approximately one-third of child welfare professionals have been found to have severe levels of STS (Rienks, 2020; Salloum, Kondrat, Johnco, & Olson, 2015). Some studies have identified demographic factors such as years of experience, age (Dagan, Ben-Porat, & Itzhaky, 2016; Rothenberg et al., 2008; Salloum, Kondrat, Johnco, & Olson, 2015), and gender (Hiles Howard et al., 2015; Rothenberg et al., 2008) predict the severity of STS among child welfare professionals. However, these findings are inconsistent as some studies have reported differing results regarding demographic predictors of STS (Baugerud, Vangbæk, & Melinder, 2018; Horwitz, 2006; Salloum, Kondrat, Johnco, & Olson, 2015).

Consistent with exploring child welfare workforce well-being from a system-driven lens, an increasing number of studies are exploring organizational factors impacting STS among child welfare professionals. STS has been associated with poor organizational outcomes such as increased turnover (Boyas & Wind, 2010; Cahalane & Sites, 2008). Work demands have also been found to be associated with STS among child welfare professionals. For example, child welfare professionals' increased time spent with clients has been associated with higher STS (Borjanić Bolić, 2019). Similarly, working more than 40 hours per week has been shown to predict higher STS (Bride, Jones, & MacMaster, 2007). Other organizational factors such as increased peer support (Bride, Jones, & MacMaster, 2007) and quality supervision (Dombo & Whiting Blome, 2016; Rienks, 2020) are reported to improve STS responses among child welfare professionals.

Burnout

Burnout has been conceptualized as a multi-faceted construct involving an individual experiencing emotional exhaustion, depersonalization, and reduced personal accomplishment that develops as a result of chronic job stress and professional overextension (Cordes & Dougherty, 1993; Maslach & Jackson, 1981). Burnout has been established as a prevalent and severe difficulty experienced by child welfare professionals (Leake, Rienks, & Obermann, 2017; Rothenberg et al., 2008; Sprang, Craig, & Clark, 2011). Moreover, studies examining burnout in child welfare settings have reported mixed results about demographic factors that are associated with burnout. Some have found a statistically significant association between burnout and age (Hamama, 2012; Salloum, Kondrat, Johnco, & Olson, 2015), tenure (Hamama, 2012; Salloum, Kondrat, Johnco, & Olson, 2015), level of education (Leake, Rienks, & Obermann, 2017) and lower levels of compassion satisfaction (Salloum, Kondrat, Johnco, & Olson, 2015). Organizational characteristics such as salary and social support from peers, supervisors, and organization leaders have been associated with decreased burnout (Font, 2012; Hamama, 2012). Further, burnout has been associated with child welfare professionals' intent to leave (Boyas & Wind, 2010; Conrad & Kellar-Guenther, 2006; Leake, Rienks, & Obermann, 2017) and increased turnover (Kim & Kao, 2014). These findings suggest that burnout among the child welfare workforce may have effects that reach far beyond individual professionals (Graeff & Hill, 2000). High workforce turnover and poor retention have been shown to predict poor child welfare outcomes such as higher probability of placement instability, increased risk of running away (Byers et al., 2023), and longer times to permanency (Flower, McDonald, & Sumski, 2005).

Compassion satisfaction

While evidence for and warnings against the negative toll of working in child welfare systems abounds, work in such settings also may have positive impacts on the workforce. Compassion satisfaction describes a phenomenon when people engaging in helping work with persons who are suffering experience this work as gratifying and fulfilling (Figley, 1995). Compassion satisfaction has been associated with improved levels of burnout and STS in child welfare workers (Conrad & Kellar-Guenther, 2006). However, protective factors such as compassion satisfaction and negative well-being outcomes may not be mutually exclusive from one another (Conrad & Kellar-Guenther, 2006). Research about the potential relationships between compassion satisfaction and other well-being constructs continues to be examined.

Study rationale

As described above, multiple gaps exist in child welfare literature regarding the relationship between well-being outcomes and self-care behaviors. To date, studies have largely focused on documenting the prevalence of well-being outcomes such as STS, burnout, and compassion satisfaction among child welfare professionals. While recognized as one potentially important strategy to promote well-being, few studies have examined the prevalence of self-care among child welfare professionals. Therefore, this study addresses gaps in the literature by investigating the relationship between well-being outcomes and self-care behaviors among child welfare professionals. Specifically, the study asked, was frequency of self-care among child welfare professionals associated with their: (1) decreased severity of STS; (2) decreased severity of burnout; and, (3) increased strength of compassion satisfaction?

Materials and method

Research design and project setting

This study was conducted as one part of a larger, 5-year, federally funded, research collaborative aimed at improving child welfare agency and court practices. This component of the larger study used a one-group longitudinal design to assess several aspects of the child welfare workforce. The current article reports on workforce well-being from the baseline survey. All study procedures were reviewed and approved by the Institutional Review Board of the University of Kansas.

The research collaborative examined the implementation and impact of several interventions, including a supervisor coaching program that comprised strategies to positively influence workforce well-being. As the guiding theory of change, coaching was posited as a key mechanism for facilitating

supervisors' skills, practices, and well-being which in turn would promote workers' skills, practices, and well-being. Connecting to longer-term outcomes, supervisor and worker well-being (e.g., lower burnout and higher compassion satisfaction) was viewed as a key component of organizational well-being (e.g., high retention rates) which linked to effective service delivery (e.g., high engagement and completion rates among families) and eventually to positive child and family outcomes. This sub-study's survey was used to assess self-care behaviors and well-being, such as STS, burnout, and compassion satisfaction.

Data collection procedures and sample

Study data were collected via an online, statewide survey conducted in November 2020. The collaborative involved the state's public child welfare agency and the full array of private providers of family preservation, foster care, and adoption – six organizations in all. Administrators of the six agencies provided researchers with comprehensive staff e-mail lists. Surveys were emailed to 1,308 individuals identified as staff working in direct service or supervisor positions in the public and private child welfare agencies in a Midwestern state. Surveys were completed in REDCap (Harris et al., 2009), which included 68 items to measure casework skills (e.g., engagement with youth and families), well-being, and self-care behaviors.

Our initial sample included 331 responses. Sixteen responses included no information about the participant and were removed. We excluded nine responses because they reported having positions other than those intended to be captured by the survey (i.e., directors, administrative, transportation, or office staff) and one participant with no position information. The final analytical sample was 305 direct service and supervisor professionals, which represents a response rate of 23.3%. This response rate is comparable to other similarly designed child welfare studies using e-mail recruitment such as Brewsaugh et al. (2022) who cold emailed participants and had a 29% response rate and Griffiths, Royse, Culver, Piescher, and Zhang (2017) who utilized strategic pre-recruitment e-mails prior to sending the online survey and had a 37.8% response rate.

Measures

Workforce well-being variables

For the purposes of this study, workforce well-being was investigated by the three constructs of STS, burnout, and compassion satisfaction. Details on how each of these constructs were measured and operationalized are described below.

Sts. STS was measured using the Professional Quality of Life (ProQol) subscale (Hudnall Stamm, 2009). The STS scale is a sum of 10 self-report items

related to frequency (1 = Never; 5 = Very Often). A sample item is "I find it difficult to separate my personal life from my life as a helper." Higher scores indicate more STS with values 22 or less being considered low, 23–41 are average, and 42 or more as high. The STS items demonstrated adequate-scale reliability (α = 0.88). We examined STS for normality with the assumption that skewness over 0.80 in absolute value (Lewis-Beck, 1995) and kurtosis > 10 (Acock, 2014) violates normality. Skewness was 0.58 and kurtosis was 3.67, which indicates the variable does not severely deviate from normality.

Burnout. Burnout was measured using the ProQol subscale (Hudnall Stamm, 2009). The burnout scale is a sum of 10 self-report items related to frequency (1 = Never; 5 = Very Often). A sample item is "I feel overwhelmed because my workload seems endless." Higher scores indicate more burnout with values 22 or less being considered low, 23–41 are average, and 42 or more as high. The burnout items showed acceptable-scale reliability (α = .71). Skewness was −0.22 and kurtosis was 3.23, which indicates the variable does not severely deviate from normality.

Compassion satisfaction. Compassion satisfaction was measured using the ProQol subscale (Hudnall Stamm, 2009). The compassion satisfaction scale is a sum of 10 self-report items related to frequency (1 = Never; 5 = Very Often). A sample item is "I get satisfaction from being able to help people." Higher scores indicate more compassion satisfaction with values 22 or less being considered low, 23–41 are average, and 42 or more as high. The compassion satisfaction items showed adequate-scale reliability (α = 0.89). Skewness was −0.41 and kurtosis was 2.62, which indicates the variable does not severely deviate from normality.

Self-care variables

Self-care was examined in two ways. These included measures of the number of types of self-care activities and the frequency of self-care. Each of these is further described below.

Number of self-care activities. In consultation with the projects' steering committee, comprised of over 40 child welfare professionals, we created an index to measure the number of activities. Consistent with other conceptualizations of child welfare workforce well-being (Clark, 2022; Lizano et al., 2021), physical, psychological, social, and spiritual domains of well-being were considered when generating the index measuring self-care activities. Participants were asked, "What types of activities do you intentionally participate in for self-care?" Participants were allowed to select as many of the eight activities as applied: spend time with friends or family, engage in a hobby, take time off from work, physical exercise, spiritual or religious practice, sleep at least 8

hours a night, eat healthy foods, and other. We summed the number of activities to calculate an index that represented the number of self-care, which could range from 0 to 8. Skewness was 0.27 and kurtosis was 2.52, which indicates the variable does not severely deviate from normality.

Frequency of self-care. Frequency of self-care was measured from one item where participants were asked, "How often do you intentionally practice self-care?" The response categories were "Never" (1), "At least 1–2 days per week" (2), "At least 3–4 days per week" (3), "At least 5–6 days per week" (4), and "At least daily" (5). Thus, frequency scores ranged from 1 to 5. Skewness was 0.78 and kurtosis was 2.46, which indicates the variable does not severely deviate from normality.

Covariates

Based on prior research examining child welfare workforce well-being, several demographic variables were included in this study as covariates. These included years of experience, education, geographic region of the Midwestern state where participants were working, agency role, licensure status, race/ethnicity, and gender. The definitions of each covariate are reported below.

Years of experience. This variable captured the number of years participants had worked in child welfare. The categories were less than 1 year, 1–3 years, 4–6 years, 7–9 years, 10 or more years. We dummy-coded each category as 1 with 1–3 years of experience as 0. We used 1–3 years of experience as a reference category because it had the largest sample size.

Education. Participants' highest level of education was originally captured in two variables. First, a degree variable was coded as 0 = no four-year degree and 1 = yes four-year degree. Second, a master's degree variable where 0 = no master's degree and 1 = yes master's degree. These variables were recoded into one variable indicating highest level of education using three categories: less than four-year degree, 4-year degree, and master's degree. We dummy-coded each category as 1 with 4-year degree as 0. For our analysis, we used 4-year degree as the reference group because it has the largest sample size.

Region. The region variable captured six geographic regions in the state defined by the state's public child welfare agency. To maintain anonymity, we have not specified region areas. Each region is dummy coded as 1 with region 4 coded as 0. We used region 4 as the reference because it had the largest sample size.

Role. This variable captured the type of agency position participants were employed in. The original variable was coded with six options that corresponded to specific job titles for public (e.g., CPS, case manager, etc.) and

private workers (adoption, kinship, etc.) including options for supervisor. The variable was recoded into 0 for direct service workers and 1 for supervisors.

License. License was a dichotomous variable that captured whether participants held a professional license (e.g., licensed master social worker, licensed professional counselor, etc.). The variable was coded as 0 for no license and 1 for license.

Race/Ethnicity. Participants provided their self-identified racial-ethnic identification. A total of 227 (74%) identified as White/European American, 28 (9%) as Black/African American/African Caribbean, 16 (5%) as Latinx/Hispanic/Spanish, 6 (2%) as American Indian/Alaska Native, Native Hawaiian, 16 (5%) as Biracial/Multiracial, 4 (1%) as other racial group, and 8 (2%) did not specify their racial identification. Due to small sample sizes, we created a dummy-coded variable for race with 0 for White/European American and 1 for People of Color (PoC). Preliminary analysis (not shown here) did not identify statistically significant differences between racial groups included in the PoC categorization. Therefore, in order to increase statistical power, we elected to use a binary coding of racial groups and use White/European American as the reference group because it had the largest sample size.

Gender. There were four response categories for gender identification: female, male, non-binary, and prefer not to answer. Participants were also allowed to not respond to the question. No participants selected non-binary or prefer not to answer. Six participants did not provide information. We used a dummy-coded variable for gender with 0 for female and 1 for male. Six respondents did not provide their gender identification.

Missing data

Data were assessed for missingness as responses were not required for survey items. Missing data ranged from 0% (i.e., years of experience, region, role) to 12.13% (i.e., burnout items) with 83% ($N = 252$) cases having complete data. Notably, missingness patterns reveal 8% ($n = 24$) of all participants did not provide responses on a single well-being variable item (i.e., secondary traumatic stress, burnout, and compassion fatigue). We utilized the user-written code mcartest (Li, 2013) to implement Little's (1988) test to assess the assumption of missing completely at random for our dependent variable items. MCAR is the ideal situation as it means missingness in the dependent variable items is not a function of itself or other variables (Allison, 2010). The test provided evidence that the missing data from well-being variable items were MCAR and we failed to reject the null hypothesis ($\chi^2 = 464.901$, $df = 435$, $p = .155$).

Therefore, since the full information maximum likelihood (FIML) approach to missing data reduces estimate and standard error biases under the assumption of MCAR (Enders & Bandalos, 2001), we used FIML when applicable. FIML uses all available information to generate parameter estimates, similar to multiple imputation (MI). However, unlike MI's random draw process of generating estimates, FIML produces the same results each time (Allison, 2010).

Analysis

Data analyses were conducted using Stata 17.0 (StataCorp, 2021). We began with univariate analyses to describe participants' demographics, number of self-care activities, frequency of self-care, STS, burnout, and compassion satisfaction. Second, we conducted simple linear regression to test the association between participants' demographics with STS, burnout, compassion satisfaction, number of self-care behaviors, and frequency of self-care. A simple linear regression allows us to test the association between our dependent and independent variables (Lewis-Beck, 1995). Finally, we conducted multivariate regression while controlling for all covariates. A multiple linear regression allows us to increase our confidence in any potential influence of our independent variables on our dependent variables by taking other variables into account (Lewis-Beck, 1995).[1] Again, to reduce estimate and standard error biases, we used the FIML approach to missing data when conducting regression analyses.

Results

Descriptive results

Table 1 presents participant characteristics. Most participants had 1–3 years of work experience (30%), identified as female (90%), and White (74%). Nearly half of participants had a 4-year degree (47%), more than half held a license (54%), and more than two-thirds were direct service staff (70%).

Descriptive results from our three well-being variables are shown in Table 2. On average, participants reported low levels of STS ($M = 22.57$, $SD = 6.01$). The average reported burnout ($M = 30.94$, $SD = 3.37$) and compassion satisfaction ($M = 40.75$, $SD = 5.50$) were in the moderate range.

Table 2 also shows the descriptive results from our self-care variables. Participants reported participating in an average of about three and a half self-care activities ($M = 3.64$, $SD = 1.49$). The most reported type of self-care was spending time with friends or family (81%, $n = 247$) and the least reported self-care activity was eating healthy foods (27.21%, $n = 83$). Figure 1 presents the frequencies for each type of self-care behavior reported. Furthermore, Figure 2 shows participants' reported frequency of self-care on a weekly basis. On average, participants reported engaging in self-care nearly 3–4 days per week

Table 1. Participant characteristics.

	n	%
Years of Experience [a]		
Less than 1 year	43	14.1
1–3 years	92	30.1
4–6 years	65	21.1
7–9 years	25	8.2
10+ years	80	26.2
Education		
Less than 4-year degree	55	18.0
4-year degree	144	47.2
Master's degree	105	34.4
Missing	1	0.4
Region [a]		
Region 1	65	21.3
Region 2	62	20.3
Region 3	57	18.7
Region 4	104	34.1
Region 5	5	1.6
Region 6	12	3.9
Role [a]		
Direct Staff	213	69.8
Supervisor	92	30.2
License [a]		
No License	139	45.6
License	166	54.4
Race/Ethnicity		
People of Color	70	23.0
White Non-Hispanic	227	74.4
Missing	8	2.6
Gender		
Female	274	89.8
Male	25	8.2
Missing	6	2.0

Notes: $N = 305$
[a]Reflects no missing values.

Table 2. Dependent and Independent variables descriptive statistics.

	n	Mean	SD	Range
Dependent Variables				
Secondary traumatic stress	274	22.57	6.01	11.0–44.0
Burnout	268	30.94	3.37	18.0–40.0
Compassion fatigue	273	40.75	5.50	25.0–50.0
Independent Variables				
Number of Self-Care Activities	283	3.64	1.49	1.0–7.0
Frequency of Self-Care	283	2.91	1.12	1.0–5.0

($M = 2.91$, $SD = 1.12$). However, the majority of participants reported practicing self-care at least 1–2 days per week (44.52%, $n = 126$). Figure 3 provides a summary of the frequency of participants' self-care.

Number and frequency of self-care and STS

To examine our first research question, we conducted a simple linear regression of STS on number of self-care activities and frequency of self-

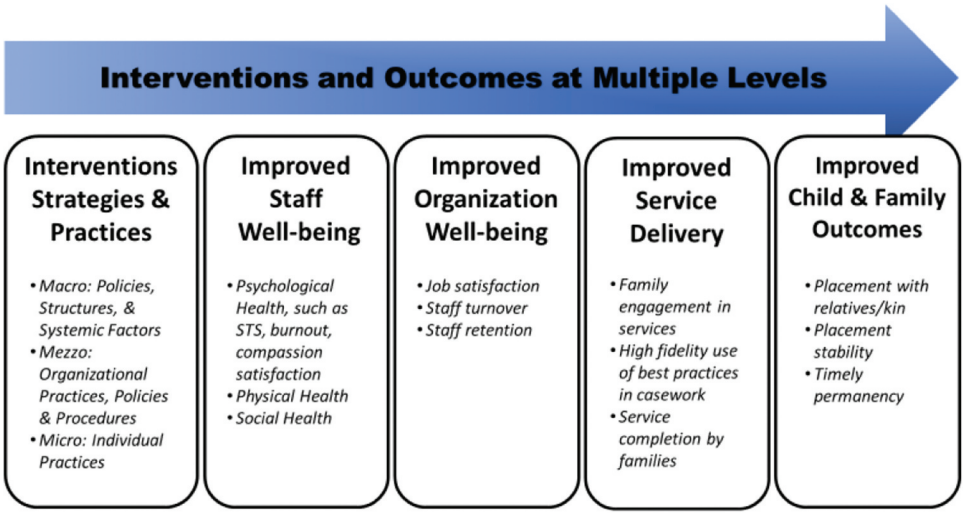

Figure 1. Theory of change for multi-level interventions and multi-level Outcomes in Child Welfare.

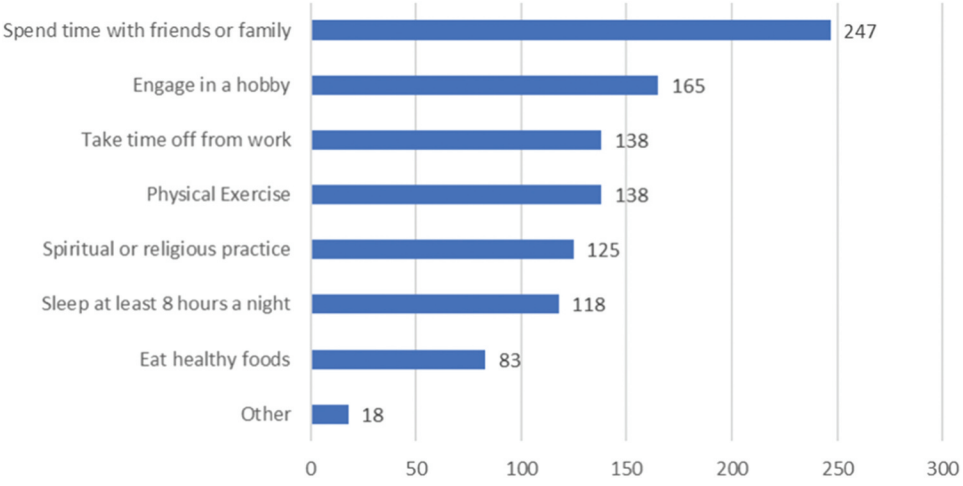

Figure 2. Types of self-care activities participants report engage In. Note. $N = 305$

care (see Table 3). We found the number of self-care activities had a negative and statistically significant relationship with STS ($\beta = -0.593$, $p = .015$, 95% *CI* [−1.069, −0.117]). The negative and statistically significant association between number of self-care activities and STS remained ($\beta = -.607$, $p = .013$, 95% *CI* [−1.089, −0.126]), even when controlling for all other covariates, which is reported in Table 4. We also report Cohen's f^2 for effect size for all multivariate models since it is the appropriate measure when the regression model has continuous predictor and outcome variables (Cohen, 1988). Guidelines for interpreting Cohen's f^2 are ≥ 0.02 as a small, ≥ 0.15 as medium effect, and ≥ 0.35 as large effect sizes (Cohen, 1988). The number

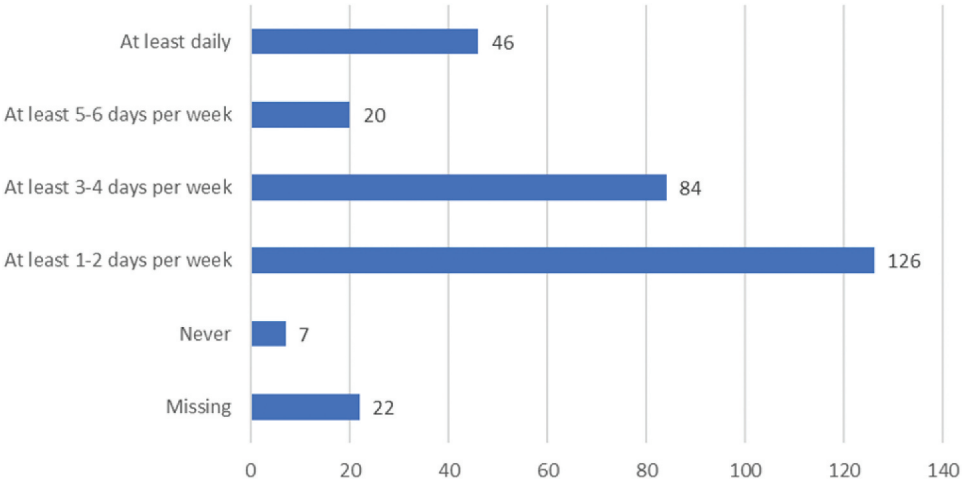

Figure 3. Participants' frequency of self-Care. Note: $N = 305$

Table 3. Simple linear regressions of number of self-care activities and frequency of self-care predicting secondary traumatic stress, burnout, and compassion satisfaction using full-maximum likelihood estimations.

				95% CI			
		β	*SE*	*LL*	*UL*	*p*	R^2
				Secondary Traumatic Stress			
Model 1	# of Self-care Activities	−0.593	0.243	−1.069	−0.117	.015	.021
Model 2	Frequency of Self-care	−1.357	0.314	−1.972	−0.741	<0.000	0.064
				Burnout			
Model 3	# of Self-care Activities	−0.102	0.139	−0.374	0.171	0.464	0.002
Model 4	Frequency of Self-care	−0.422	0.182	−0.778	−0.065	0.020	0.019
				Compassion Satisfaction			
Model 5	# of Self-care Activities	0.762	0.221	0.328	1.197	0.001	0.042
Model 6	Frequency of Self-care	0.730	0.294	0.145	1.306	0.013	0.022

Note: $N = 283$. CI = confidence intervals; LL = lower limit; UL = upper limit. Intercepts for models are not reported.

of self-care activities had a small effect on STS ($f^2 = 0.022$). See Appendix Table A1 for Cohen's f^2 effect sizes for number of self-care activities and other statistically significant covariates.

Next, we regressed STS on self-care frequency and found a negative and statistically significant relationship (β = −1.356, $p = <0.000$, 95% *CI* [−1.977, −0.736]). We also found the negative and statistically significant relationship between self-care frequency and STS (β = −1.409, $p = <0.000$, 95% *CI* [−2.024, −.793]) when controlling for covariates. Self-care frequency had a small effect on STS ($f^2 = 0.074$). See Appendix Table A2 for Cohen's f^2 effect sizes for self-care frequency and other statistically significant covariates. In sum, the more self-care activities a professional engaged in, and more frequently engaging in these self-care activities were associated with lower levels of STS.

Table 4. Multivariate regression analysis of number of self-care activities and covariates predicting secondary traumatic stress, burnout, and compassion satisfaction using full-maximum likelihood estimations.

	Secondary Traumatic Stress					Burnout					Compassion Satisfaction				
			95% CI					*95% CI*					*95% CI*		
	β	*SE*	*LL*	*UL*	*p*	β	*SE*	*LL*	*UL*	*p*	β	*SE*	*LL*	*UL*	*p*
Independent Variable															
# Self-Care Activities	−0.607	0.246	−1.089	−0.126	**0.013**	−0.067	0.133	−0.328	0.194	0.615	0.675	0.225	0.234	1.116	**0.003**
Covariates															
Years of Experience															
Less than 1 year	−1.073	1.154	−3.335	1.188	0.352	−1.302	0.628	−2.532	−0.071	**0.038**	.072	1.060	−2.006	2.149	0.946
4 to 6 years	0.626	1.069	−1.470	2.721	0.558	.462	0.590	−0.695	1.619	0.433	.244	.985	−1.687	2.174	0.804
7 to 9 years	1.262	1.428	−1.537	4.061	0.377	1.307	0.740	−0.143	2.756	0.077	1.587	1.246	−0.855	4.029	0.203
10+ years	0.152	1.046	−1.898	2.203	0.884	.827	0.573	−0.297	1.951	0.149	1.471	.950	−0.391	3.332	0.122
Education															
Less than BA	−0.301	1.062	−2.381	1.780	0.777	−.047	0.571	−1.167	1.073	0.934	.945	.961	−0.939	2.829	0.325
Master's	−0.780	0.872	−2.489	0.929	0.371	.197	0.469	−0.723	1.116	0.675	.127	.781	−1.404	1.659	0.870
Region															
Region 1	1.702	1.009	−0.277	3.680	0.092	−.751	0.549	−1.827	0.325	0.171	−.620	.921	−2.425	1.185	0.501
Region 2	0.165	1.001	−1.797	2.128	0.869	.050	0.541	−1.010	1.110	0.926	−2.257	.903	−4.027	−0.487	**0.012**
Region 3	1.758	1.036	−0.273	3.789	0.090	−.489	0.563	−1.592	0.614	0.385	−1.659	.937	−3.495	0.176	0.076
Region 5	2.935	2.971	−2.888	8.757	0.323	1.843	1.588	−1.270	4.956	0.246	1.968	2.684	−3.293	7.229	0.463
Region 6	0.969	1.858	−2.674	4.611	0.602	−.928	0.957	−2.804	0.948	0.332	−1.255	1.616	−4.423	1.913	0.438
Role (Supervisor = 1)	−1.550	0.912	−3.336	0.237	0.089	−1.443	0.493	−2.408	−0.478	**0.003**	.214	.820	−1.393	1.821	0.794
Licensed (Yes = 1)	−1.228	1.038	−3.262	0.806	0.237	−.671	0.562	−1.772	0.430	0.232	.307	.937	−1.530	2.144	0.743
Race/Ethnicity (Black/Other = 1)	−1.366	0.892	−3.114	0.381	0.125	−.919	0.496	−1.890	0.052	0.064	.294	.819	−1.312	1.900	0.720
Gender (Male = 1)	−1.910	1.269	−4.396	0.577	0.132	−3.119	0.687	−4.466	−1.772	**0.000**	−3.186	1.165	−5.470	−0.902	**0.006**
Intercept	27.704	2.036	23.714	31.695	0.000	35.511	1.101	33.354	37.668	0.000	41.586	1.847	37.965	45.206	0.000
R^2	0.092					0.169					0.111				

Note: $N = 305$. CI = confidence intervals; LL = lower limit; UL = upper limit. Reference for Years of Experience is 3 to 5 years. Reference for Education is bachelor's degree. Reference for Region is region 4. Reference for Role is frontline worker. Reference for Licensed is not licensed. Reference Race/Ethnicity is White Non-Hispanic. Reference for Gender is female.

Number and frequency of self-care and burnout

Our second research question focuses on number of self-care activities and frequency of self-care and burnout. First, we conducted a simple linear regression of burnout on number of self-care activities. Number of self-care activities did not have a statistically significant association with burnout (β = −0.102, p = .464, 95% *CI* [−0.374, 0.171]). When controlling for covariates, the number of self-care activities and burnout remained not statistically significant (β = −0.067, p = .615, 95% *CI* [−0.328, 0.194]). However, we did find professionals with less than one year of experience (β = −1.301, p = .038, 95% *CI* [−2.531, −0.071]), supervisors (β = −1.443, p = .003, 95% *CI* [−2.408, −0.477]), and men (β = −3.119, p = <0.000, 95% *CI* [−4.466, −1.772]) reported lower levels of burnout.

We also conducted a simple model with burnout regressed on frequency of self-care. We found frequency of self-care had a negative and statistically significant association with burnout (β = −0.422, p = .020, 95% *CI* [−0.778, 0.065]). The negative and statistical association held after accounting for covariates (β = −0.401, p = .020, 95% *CI* [−0.740, 0.062]). Additionally, Table 5 shows less than 1 year of experience (β = −1.226, p = .049, 95% *CI* [−2.446, −0.006]), supervisors (β = −1.271, p = .010, 95% *CI* [−2.237, −0.305]), and men (β = −3.168, p = <0.000, 95% *CI* [−4.502, −1.834]) reported lower levels of burnout. Professionals with 7–9 years of experience (β = 1.516, p = .040, 95% *CI* [0.069, 2.963]) expressed higher levels of burnout. Self-care frequency had a small effect on burnout (f^2 = 0.020). We encourage caution when interpreting results for years of experience and gender due to small sample sizes for subgroups. Overall, we did not find an association of number of self-care activities with burnout, but we found support for frequency of self-care reducing burnout.

Number and frequency of self-care and compassion satisfaction

The examination of our third and final research question began with a simple linear regression of number of self-care activities regressed on compassion satisfaction, which is presented in Table 4. The relationship between number of self-care activities and compassion satisfaction was positive and statistically significant (β = 0.762, p = .001, 95% *CI* [0.327, 1.197]). We then conducted a multivariate regression analysis that included all covariates (see Table 4). When accounting for covariates, the relationship between number of self-care activities and compassion satisfaction was positive and statistically significant (β = 0.675, p = .003, 95% *CI* [0.234, 1.115]). The number of self-care activities had a small effect on compassion satisfaction (f^2 = 0.033). Additionally, we found men, compared to women, reported lower levels of compassion satisfaction (β = −3.186, p = .006, 95% *CI* [−5.469, −0.902]). Furthermore, we used simple linear and multivariate regressions to investigate the relationship

Table 5. Multivariate Regression Analysis of Frequency of Self-care and covariates predicting secondary traumatic stress, burnout, and compassion satisfaction using full-maximum likelihood estimations.

	Secondary Traumatic Stress					Burnout					Compassion Satisfaction				
			95% CI					*95% CI*					*95% CI*		
	β	*SE*	*LL*	*UL*	*p*	β	*SE*	*LL*	*UL*	*p*	β	*SE*	*LL*	*UL*	*p*
Independent Variable															
Frequency of Self-Care	−1.409	0.314	−2.024	−0.793	**0.000**	−0.401	0.173	−0.740	−0.063	**0.020**	0.617	0.293	0.042	1.193	0.036
Covariates															
Years of Experience															
Less than 1 year	−0.616	1.128	−2.446	−0.007	.585	−1.226	0.622	−2.446	−0.007	**0.049**	−0.155	1.06	−2.250	1.940	0.885
4 to 6 years	0.603	1.042	−0.708	1.581	.563	0.436	0.584	−0.708	1.581	0.455	0.437	0.989	−1.503	2.378	0.658
7 to 9 years	1.895	1.403	0.069	2.963	.177	1.516	0.738	0.069	2.963	**0.040**	1.240	1.266	−1.243	3.723	0.328
10+ years	0.039	1.019	−0.315	1.907	.970	0.796	0.567	−0.315	1.907	0.160	1.658	0.959	−0.213	3.530	0.082
Education															
Less than BA	−0.177	1.036	−1.090	1.131	.864	0.020	0.567	−1.090	1.131	0.971	−0.054	0.792	−1.066	2.734	0.390
Master's	−0.407	0.856	−0.616	1.215	.634	0.300	0.467	−0.616	1.215	0.521	0.834	0.969	−1.607	1.498	0.945
Region															
Region 1	1.667	0.975	−1.748	0.363	.088	−0.692	0.539	−1.748	0.363	0.199	−0.291	0.971	−2.090	1.508	0.751
Region 2	−0.004	0.979	−1.080	1.025	.997	−0.028	0.537	−1.080	1.025	0.959	−2.144	0.912	−3.932	−0.357	0.019
Region 3	2.020	1.014	−1.532	0.655	**.046**	−0.438	0.558	−1.532	0.655	0.432	−1.704	0.945	−3.558	0.149	0.072
Region 5	3.886	2.911	−0.940	5.247	.182	2.153	1.578	−0.940	5.247	0.172	1.883	2.715	−3.438	7.205	0.488
Region 6	1.039	1.814	−2.786	0.931	.567	−0.927	0.948	−2.786	0.931	0.328	−1.262	1.629	−4.457	1.932	0.439
Role (Supervisor = 1)	−1.096	0.898	−2.856	0.664	.222	−1.272	0.493	−2.238	−0.306	**0.010**	0.176	0.833	−1.458	1.810	0.832
Licensed (Yes = 1)	−0.806	1.018	−2.802	1.190	.429	−0.571	0.559	−1.665	0.524	0.307	0.164	0.950	−1.699	2.027	0.863
Race/Ethnicity (Black/Other = 1)	−1.656	0.856	−3.332	0.022	.053	−0.925	0.483	−1.872	0.021	0.055	.678	0.814	−.918	2.274	0.405
Gender (Male = 1)	−1.961	1.235	−4.382	0.460	.112	−3.168	0.681	−4.502	−1.834	**0.000**	−3.210	1.176	−5.515	−0.905	0.006
Intercept	29.056	1.964	25.207	32.906	**0.000**	36.305	1.089	34.171	38.438	**0.000**	42.271	1.854	38.637	45.906	**0.000**
R^2	0.136					0.184					0.096				

Note: $N = 305$. CI = confidence intervals; LL = lower limit; UL = upper limit. Reference for Years of Experience is 3 to 5 years. Reference for Education is bachelor's degree. Reference for Region is region 4. Reference for Role is frontline worker. Reference for Licensed is not licensed. Reference Race/Ethnicity is White Non-Hispanic. Reference for Gender is female.

between frequency of self-care and compassion satisfaction. Frequency of self-care had a positive and statistically significant relationship with compassion satisfaction in the simple linear model (β = 0.730, $p = .013$, 95% *CI* [0.154, 1.306]; see Table 3) and the multivariate model (β = 0.617, $p = .036$, 95% *CI* [0.042, 1.193]; see Table 5). Self-care frequency had less than a small effect on compassion satisfaction ($f^2 = 0.017$). Notably, in the multivariate model, men reported lower levels of compassion satisfaction than women (β = −3.210, $p = .006$, 95% *CI* [−5.515, −0.905]). As mentioned before, we suggest a cautious interpretation of our gender results since we have a small sample size of men. In conclusion, the more activities a professional engaged in, and more frequent self-care was associated with higher levels of compassion satisfaction.

Discussion

This study investigated the relationship between self-care behaviors and well-being outcomes among child welfare direct service workers and supervisors employed in public and private child welfare agencies in a Midwestern state. While the prevalence and severity of well-being outcomes such as STS, burnout, and compassion satisfaction have been well established in research exploring these phenomena among child welfare professionals (Conrad & Kellar-Guenther, 2006; Baugerud, Vangbæk, & Melinder, 2018; Bride & Figley, 2007; Rienks, 2020; Sprang, Craig, & Clark, 2011; Leake et al., 2017) rare is evidence identifying whether frequency of self-care or number of distinct self-care practices may buffer the adverse effects of engaging in trauma work. Self-care has been regularly recommended as a practice that will strengthen child welfare workforce well-being (Administration for Children's Services-New York University Children's Trauma Institute, 2012; National Child Traumatic Stress Network, 2011; Salloum, Kondrat, Johnco, & Olson, 2015). However, few studies have examined self-care behaviors and their association with well-being outcomes among child welfare workforces.

This study contributes several key findings to the literature. First, participants who reported more frequent self-care and who engaged in more self-care behaviors had lower severity of STS. Second, overall, the number of self-care behaviors participants engaged in was not associated with burnout. However, participants who engaged in self-care behaviors more frequently experienced less severe burnout. Third, participants who engaged in more self-care behaviors and who practiced self-care more frequently had higher compassion satisfaction. Thus, number of self-care behaviors was associated with STS and compassion satisfaction and frequency of self-care was associated with all three of the well-being constructs – STS, burnout, and compassion satisfaction. These findings provide initial evidence about the role self-care may play in supporting child welfare workforce well-being by reducing the effects of STS

and burnout and increasing compassion satisfaction. Additional research is needed to examine if specific self-care behaviors (e.g., exercise, spending time with friends and family, etc.) are associated with improved STS, burnout, and compassion satisfaction. While these findings are preliminary and require further replication, they possibly point to self-care as one strategy that may play an important role in buffering STS and burnout and strengthening compassion satisfaction among child welfare direct service and supervisory staff. Future research determining whether these findings are consistent with other helping professionals and contexts would be beneficial.

Interestingly, the participants in this study had less severe STS and burnout and higher compassion satisfaction than what has been reported in other studies examining these constructs among child welfare workers (e.g., Baugerud, Vangbæk, & Melinder, 2018; Conrad & Kellar-Guenther, 2006; Leake, Rienks, & Obermann, 2017; Rienks, 2020). The average scores for well-being outcomes among this study's participants demonstrated their STS was low and that participants' burnout and compassion satisfaction were in the moderate range. These findings may illustrate a need for further examination of factors occurring within organizations, systems, and policies within specific states that may influence the well-being of child welfare workers. We also note that the survey occurred during the first six months of the COVID-19 pandemic. Questions remain and more investigation is needed to know whether the relatively lower scores on STS and burnout, and higher scores on compassion satisfaction, were related to the reduction in child welfare cases during this period (Jonson-Reid et al., 2020; Roy, 2020) or whether this phenomenon may be related to other factors, such as those experiencing lower well-being self-selecting out of the intervention.

Moreover, the responsibility for accessibility to self-care and well-being must continue to be positioned as shared across child welfare organizations and systems. Organizational culture may be an important factor in strengthening child welfare workforce well-being and warrants continued exploration in future research in child welfare settings. We include our voices alongside others who have suggested a trauma-informed approach to develop organizational values that are aligned with prioritizing well-being across systems of care (Conners-Burrow et al., 2013; Handran, 2015; Kramer, Sigel, Conners-Burrow, Savary, & Tempel, 2013; Tullberg & Boothe, 2019). Trauma-informed care recognizes the impact of trauma work on both service recipients and providers and normalizes trauma responses as expected when faced with violence and threats to physical and emotional safety (Tullberg & Boothe, 2019). Moreover, trauma-informed care is described as an organization and system level approach that shapes practice and policies across levels of care to establish safety, trust, empowerment, and self-determination (Bath, 2008; Bloom & Sreedhar, 2008; Hodas, 2006; Levenson, 2017). This approach to human

service work may have expansive benefits to child welfare workforce well-being. More scholarship is needed to further examine the relationship between organizational values, trauma-informed care, and workforce well-being, including self-care practices.

While the gaps in organizational support leading to increased burnout and STS are well established (Jirek, 2020), scholarship demonstrating that stronger organizational support is associated with improved workforce well-being (Brewer, Nguyen, Ziegler, Dodson, & Kurdian, 2023; Handran, 2015; Tullberg & Boothe, 2019) has highlighted the potential for organizations to positively influence the lives of professionals working within them. Specific organizational strategies such as transparency and shared power in decision-making (Killian, 2008), supervision (Griffiths, Royse, Culver, Piescher, & Zhang, 2017; Lizano, Hsiao, Mor Barak, & Casper, 2014) peer support (Griffiths, Royse, Culver, Piescher, & Zhang, 2017), and opportunities for professional development (Griffiths, Royse, Culver, Piescher, & Zhang, 2017) have been suggested as factors to improve workforce well-being. More scholarship is needed to examine organizational factors that strengthen self-care practices, and how these may influence workforce well-being.

Well documented is the fact that child welfare workers experience high expectations from multiple parties and systems (Copeland, 2021), competing workload demands such as large paperwork responsibilities (Schelbe et al., 2017), needed face-to-face time with children and families (Altman, 2008; Schelbe et al., 2017), and ongoing stress and trauma, both personally and professionally (Fraser et al., 2014). While self-care may support child welfare professionals in managing the stress accumulated from their jobs, child welfare agencies and systems should continue to advocate for and implement practices and policies that support workforce well-being. Child welfare professionals report feeling they are underpaid for the work they provide (Hill & Kalloo-Vialante, 2008; Johnco et al., 2014). Local, state, and national governments should continue to fund child welfare services and salaries that support child welfare workforce well-being.

Studies examining worker well-being have largely occurred in distinct geographical regions. This study adds a contribution of scholarship investigating STS, burnout, compassion satisfaction, and self-care in a Midwestern context specifically. However, more nationally and internationally representative scholarship is needed to better understand geographical similarities and differences of child welfare workforce's experiences of well-being and self-care.

Previous studies have found child welfare professionals practiced self-care some of the time. This study adds to the existing literature and demonstrates that the majority of child welfare professionals participating in this study were engaging in self-care on a regular basis. Similar to other studies investigating workforce well-being and self-care, this study occurred cross-sectionally. More information is needed to better understand how child welfare professionals'

well-being changes over time. Future scholarship may strengthen the evidence base for workforce well-being and self-care by investigating these constructs in longitudinal and cohort studies.

Strengths and limitations

While this study offers evidence addressing an important gap in child welfare workforce literature, results from this study should be considered in the context of several limitations. First, data were collected cross-sectionally and participants' responses regarding self-care were limited to an established set of self-care activities identified for this study. This list may not be exhaustive of the activities participants engaged in for self-care purposes. Second, this study examined child welfare professionals in only one Midwestern state with a sample that primarily identified as White and as a woman. While the child welfare workforce is primarily White and women (Salsberg et al., 2017), our sample provides limited insight into more diverse racial-ethnic and gender experiences. Next steps for researchers should be to replicate these findings and explore more diverse racial-ethnic and gender to paint a more complete picture of the child welfare workforce and their experiences of self-care and well-being in child welfare contexts. Third, this study examined only child welfare professionals working as direct service providers or supervisors. Future research is needed to replicate these results in other jurisdictions and with other agency positions (e.g., administrators). Additionally, investigations are needed to understand the full scope and trajectory of self-care practices and well-being outcomes across early, mid, and late career child welfare professionals. Fourth, though the 23.3% response rate was comparable to other child welfare studies with similar research designs (Brewsaugh et al., 2022; Griffiths, Royse, Culver, Piescher, & Zhang, 2017), the generalizability of the findings may be limited. Finally, the temporal order of the variables included in this study warrants caution in interpreting results and demonstrates a need for further investigation in the direction of the relationships between self-care behaviors and well-being outcomes among child welfare workers. That is, while this study demonstrated that increased frequency and number of self-care behaviors were associated with lower levels of burnout and STS, more research is needed to understand whether there are statistically significant relationships when the variables are tested in a different order. While self-care may buffer child welfare professionals from negative well-being outcomes, it is also possible that child welfare professionals with more severe STS or burnout are less able to engage in self-care practices. Thus, additional research is needed to further explore the direction of these associations.

Child welfare workforce well-being is often discussed as an individual experience. However, the interactions between individuals, organizations, and systems may shape the actualization of well-being (Clark, 2022; Lizano et al., 2021; Travis et al., 2016). Emerging dialogue regarding the nature of self and

community care (Chamberlain, 2020; Pyles, 2020; Travis et al., 2016) demonstrates a need for further empirical investigations examining the function, benefits, similarities, and differences between these constructs. Moreover, calls for collective care encourage organizations to acknowledge and celebrate the breadth and depth of workforce humanity by supporting a range of self-care practices (Chigudu & Chigudu, 2015). Indeed, a radical commitment to workforce well-being through self and collective care invites the deconstruction of viewing child welfare professionals' well-being primarily in the context of their work, separate from their personal lives, passions, personalities, and needs. That is, child welfare professionals' personal and professional lives are not rigidly dichotomous. Rather, personal and professional experiences are intertwined and are not separate. Therefore, child welfare professionals may need access to a wide range of self-defined self-care practices that they perceive as beneficial and impactful for their own well-being. Along these lines of countering binary thinking, strategies that advance professionals' well-being can, and likely should, co-occur at the individual (e.g., self-care), organizational (e.g., community care), and system levels (e.g., trauma-informed policies).

Findings from this study demonstrate that how often and how much self-care a child welfare professional engages in is associated with improved well-being. These results, taken with ongoing encouragement for child welfare systems and organizations to prioritize self-care, should motivate continued examination of policies, programs, and interventions that can support the self-care practices of child welfare professionals. Findings from this study provide a contribution to an emerging empirical understanding of the potential for self-care behaviors, engaged in personally but supported structurally, to actualize the well-being of child welfare workers. We suggest child welfare systems and organizations provide ample and protected time for professionals to access self-care practices. Additionally, we suggest that child welfare systems and organizations continually examine policies and practices that have direct impact on child welfare professionals' ability to engage in regular self-care such as reducing exploitative practices including overworking and underpaying workers.

Employing professionals in a system known to impact STS, burnout, and compassion satisfaction without the requisite supports to mitigate this impact may equate to worker exploitation. It is incumbent upon system leaders to proactively address well-being among the child welfare workforce. Though this study's primary purpose was to examine well-being and self-care at the individual level, more research is needed to understand organizational and system influences on well-being and self-care behaviors among child welfare professionals. Interventions addressing workforce well-being are needed beyond individuals and should expand to include organization and systems and the effect of such interventions on workforce well-being should continue to be evaluated.

Conclusion

Child welfare professionals often work with vulnerable children and families who have been marginalized and oppressed by our structures and systems. While child welfare professionals hold a responsibility to advocate for and support the well-being of the children and families they serve, their well-being may have a direct influence on how successfully they can achieve these service outcomes. Human service systems continue to highlight the importance of understanding the role of STS in workforce well-being. Child welfare scholars, practitioners, and organizations have explained the necessity of addressing workforce stress and trauma (Administration for Children's Services-New York University Children's Trauma Institute, 2012; National Child Traumatic Stress Network, 2011; Salloum, Kondrat, Johnco, & Olson, 2015). This study adds to the voices of many calling for advancing the evidence base on how to best support child welfare workforce well-being.

Note

1. We assessed for outliers for all of our multivariate regressions. Removal of outliers did not substantially alter our results and we decided to retain them in our analysis.

Acknowledgments

This study was part of the Kansas Strong for Children and Families project, which is funded by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, under grant number 90-CO-1139. The contents are solely the responsibility of the authors and do not necessarily represent the official views of the Children's Bureau. We would also like to thank those who collaborated on this study. First, we express our gratitude to the community partners including KVC Health Systems, TFI, DCCA, Cornerstones of Care, and Saint Francis Ministries for their support in conducting this study. Second, we thank the child welfare direct service workers and supervisors who participated in this study. Lastly, we thank the coaching staff who provided the intervention initiated as a part of this study.

Disclosure statement

The authors have no known conflicts of interest to report. Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, under grant number 90-CO-1139.

Funding

The work was supported by the U.S. Children's Bureau .

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Appendix

Effect Sizes for Multivariate Regression Analyses

We report effect sizes from the multivariate regression analyses in Appendix Tables A1 A2. We use Cohen's f2 since it is appropriate effect size measure when the regression model has continuous independent and dependent variables (Cohen, 1988). We only report Cohen's f2 for variables that demonstrated a coefficient that is lower than a .05-level of statistical significance.

Table A1. Cohen's f^2 effect sizes for number of self-care activities and covariates predicting secondary traumatic stress, burnout, and compassion satisfaction.

	STS	BO	CS
	f^2	f^2	f^2
Independent Variable			
# Self-Care Activities	.022	-	.033
Covariates			
Years of Experience			
Less than 1 year	-	.017	-
Region			
Region 2	-	-	.022
Role (Supervisor = 1)	-	.027	-
Gender (Male = 1)	-	.077	.028

Note: $N = 305$. Reference for Years of Experience is 3 to 5 years. Reference for Region is region 4. Reference for Role is frontline worker. Reference for Gender is female.

Table A2. Cohen's f^2 effect sizes for frequency of self-care activities and covariates predicting secondary traumatic stress, burnout, and compassion satisfaction.

	STS	BO	CS
	f^2	f^2	f^2
Independent Variable			
Frequency Self-Care	.074	.020	.017
Covariates			
Years of Experience			
Less than 1 year	-	.016	-
7 to 9 years	-	.012	-
Region			
Region 2	-	-	.020
Region 3	.016	-	-
Role (Supervisor = 1)	-	.020	-
Gender (Male = 1)	-	.080	.027

Note: $N = 305$. Reference for Years of Experience is 3 to 5 years. Reference for Region is region 4. Reference for Role is frontline worker. Reference for Gender is female.