Preventing Burnout in Professionals and Paraprofessionals Who Work with Child Abuse and Neglect Cases: A Cognitive Behavioral Approach to Supervision

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Professionals and paraprofessionals who treat children and families where child maltreatment has occurred are subject to many strains. This article focuses on the potential for burnout in such work. It discusses strategies in supervision to combat early manifestations of burnout and to prevent its full-blown occurrence. A cognitive-behavioral framework is used to help supervisors identify the sources of strain, the maladaptive and inflexible assumptions regarding their own capacities as professionals and their own views of families that these strains may violate, and ways to work with supervisees to reduce the impact these violations have. It also addresses supervisors' own reactions to the high level of needs such families and children present and the strain on the supervisory relationship they produce. Institutionally based and systemic issues are highlighted. © 2000 John Wiley & Sons, Inc. J Clin Psychol/In Session 56: 643–663, 2000.

Keywords: child abuse; supervision; stress; burnout

The author would like to thank her colleagues and students who commented on drafts of the paper. The comments of Beth Flanzbaum, Champika Soysa, Suzanne Gurland, Bruce Loding, and Wendy DeCoursey especially were helpful in shaping the emphases in this article. She also would like to thank the many students whom she has had the privilege to supervise and the many colleagues who have provided her with supervision and from whom she learned. She would like to acknowledge the influence of the work she did with Mark Horwitz, whose valuable insights can be seen in the foundation for parts of this manuscript. Finally, she would like to express appreciation to the editors of this special issue whose comments greatly improved the manuscript's quality.

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JCLP/In Session: Psychotherapy in Practice, Vol. 56(5), 643–663 (2000)

With the identification of the battered-child syndrome in the late 1950s, a major new area of practice emerged—working with children and adults who have encountered significant violence in their lives. This work has sparked discussion of a number of complex professional issues (e.g., biases in identification, controversies regarding recovered memories). Only recently, however, has attention been given in this dialogue to professionals and paraprofessionals' personal reactions to working with multistressed families and trauma. These reactions can produce emotional disregulation that can affect performance and lead to burnout in practitioners.

This article will give special attention to supervision strategies to identify and prevent burnout. In supervision, the exposure to trauma and the strain of multistressed families are "twice" removed, but their effects may be played out more strongly and in ways that may make them harder to identify and alleviate. Since the supervisory relationship has been seen as crucial to effectiveness in trauma cases, strengthening practice in this area seems essential. Although many models have been invoked to understand reactions to child-abuse work [e.g., traditional views of countertransferential reactions, basic stress-coping approaches, systems models, and "vicarious traumatization" (Figley, 1995; McCann & Pearlman, 1990; Miller, 1998)], an overarching cognitive-behavioral framework will be used for suggesting ways to improve supervision of those who work with these multistressed families. This includes identifying sources of strain in practitioners and the "maladaptive" assumptions that these strains violate, and then clarifying how to work preventively with them to reduce the emotional disregulation these violations produce. An attempt also will be made to address supervisors' own reactions to the overwhelming needs and risks of both supervisees and the families with whom they work, and to unrealistic agency and societal mandates.

Before proceeding, however, I want to emphasize that the majority of individuals who work with maltreating parents and their children do so with incredible effectiveness and a high level of devotion and empathy. As will be discussed later, too often the public only hears of their work when there has been a tragedy. In providing illustrative examples of the reactions practitioners exhibit in response to the strains of such work, my intent is not to contribute further to the negative images portrayed in the media. Rather, my goal is to begin to challenge the field to develop ways to produce greater resiliency in individuals who have been charged by society with an almost impossible task—protecting children and helping to make Solomon-like decisions about whether families should stay together. Although this article will focus on supervision with individual practitioners, societal and systemic change is crucial (e.g., greater financial rewards, valuing of the work done, and precautions to increase safety). It has been argued that the origins of burnout are located in a socioenvironmental context. Working with individual practitioners in supervision to prevent burnout without changing some of the realities of their work would be like arguing for the value of therapy for sexually abused children, without protecting them from the offender.

Finally, it is difficult to illustrate cognitive-behavioral strategies to help supervision "buffer" individuals against the potential for burnout using only short supervision transcripts or examples of specific phrasing. Although this is done intermittently in the text of this article, a number of caveats need to be provided as these are read. First, cognitive work involves a *slow* shifting of individuals' deeply held and cherished belief systems, expectancies, and assumptions. A useful metaphor invoked later in this article is that it is like trying to change an individual's religion. It is only through multiple "tests" by the individual over time that acceptance of more-flexible assumptions take root and a "conversion" can take place. Thus, no single interaction of a few sentences or phrases captures the slow "chipping away" at rigid and maladaptive expectancies that will be described as

required to reduce potential for burnout. Second, cognitive restructuring requires a deep level of engagement. The tone of voice with which the supervision contact takes place cannot be replicated in text form. The "affective" atmosphere of the institutional setting and the trust level of the relationship developed between the supervisor and supervisee also cannot be communicated easily. Yet, as in all human contacts, these two factors set a context for change to occur. Creating a "safe" and supportive space is essential for work with child-maltreatment cases in general and similarly, creating such a space in supervision is also crucial. Again, this is difficult to portray in a short transcript form.

Burnout and Vicarious Traumatization in Work with Multistressed Families: Symptomatology and Etiology

Stress is an inherent part of all mental-health work. In the extreme, this stress may manifest itself in a collection of negative reactions that have been labeled *burnout*. Most globally, burnout has been described as an exhaustion of a practitioner's mental and physical resources attributed to his or her prolonged and unsuccessful striving toward unrealistic expectations (internally or externally derived) (Farber, 1979, 1983; Freudenberger, 1975). Threads common to descriptions of burnout include emotional exhaustion, depersonalization, and reduced personal accomplishments (Maslach & Jackson, 1986). Signs of burnout can include: being quick to show anger and experience frustration/irritation; crying easily and finding it difficult to hold in feelings; feeling people are out to get you; engaging in heightened risk taking; substance abuse; showing excessive rigidity, stubbornness, and inflexible thinking (e.g., can't be reasoned with); becoming the "house cynic"; looking, acting, and seeming depressed and keeping to yourself more; spending greater and greater numbers of hours on tasks, but with less and less being accomplished; and living to work.

Attributions for the origins of burnout typically have included characteristics of the client, the practitioner, and the setting. Fishman and Lubetkin (1991) describe burnout as resulting from many of the factors that are inherent in mental-health work. First, it involves working with infantile, depressed, hostile, suicidal, borderline, and dependent clients—as well as others who are likely to require considerable attention, nurturance, support, compassion, and understanding. The level of demand can drain practitioners of their emotional resources. Second, progress in such work is never even, and this lack of predictability of rewards can be problematic. Finally, threats in practice today also are great (e.g., malpractice concerns, third-party payments, etc.). Caseworkers and paraprofessionals face similar threats because of fluctuations in state and federal funding.

Burnout not only occurs with many years of practice, but also can occur in young practitioners at the start of their careers. In the experienced mental-health worker, it occurs when his or her sense of fulfillment and success no longer is sufficient. This sense may be affected by the level of intellectual stimulation, financial reward, prestige, and relationships with clients and colleagues. Inexperienced practitioners may develop symptoms of burnout for different reasons, including not being constitutionally or emotionally suited for such work (Freudenberger, 1984). In such cases, they may overidentify with clients and mirror their symptoms. They also can have inflated views of their potential for success. When they encounter inevitable failures in treating clients and/or client needs that exceed their fledgling skills, they can be left with feelings of incompetence. Poor or little supervision can exacerbate these issues. Whereas these descriptions emphasize individual factors, burnout clearly is situated contextually. That is, it is more common in high-stress jobs that require caregiving and that provide inadequate support for this work.

Clinical work with children, in particular, involves factors that pose special risk for burnout. Although child work can feel more successful given children's general level of resilience, such work is undervalued in our society. For example, mothering often is not seen as a "real" job, and childcare workers are among the lowest paid in our society. Traditional techniques used with children (i.e., "play" therapy) may be seen by parents as not "real" therapy. Thus, there is less prestige involved in practice with children. Furthermore, training in child work historically has been quite limited in both psychology and social-work programs (e.g., less than one half of psychologists who do child work were trained in graduate school to do this work). Practitioners in this area, therefore, may feel that their work has less of a foundation, leaving them more vulnerable to stress and burnout. Yet another factor is that the practitioner has less control over a child's continued involvement in treatment. His or her parents have control over the work and may participate in a less-consistent way than if they were deriving direct benefit themselves. This means parents prematurely may remove a child from treatment when the most overt symptoms are gone and before more-lasting change occurs. This gives the practitioner less control over the work. As will be seen later, child-abuse cases often are court ordered into treatment and also are subject to the vagaries of mandated levels and types of services that may afford even less control.

Family therapeutic interventions are a newer area of practice with even less of an empirical foundation and, as with child work, training in such work still is very limited in most programs. Having multiple clients whose goals for individual development may conflict with the larger family system's needs can produce dilemmas for clinicians that can exacerbate an already high level of strain. No recognized diagnostic system and few valid assessment strategies have been available until recently to aid in deciding upon treatment goals and standards for delineation of "success." This makes treatment planning and judging the effectiveness of one's work difficult.

Add to these strains, exposure to direct and indirect trauma, ongoing concerns regarding violence and risk, and the multistressed nature of the typical family seen in child-maltreatment work, and the level of drain on practitioners clearly is evident. The kind of exhaustion that can result has been seen by some as a special kind of burnout, or what has been called "compassion fatigue" (Figley, 1995). McCann and Pearlman (1990) went so far as to describe the cumulative effect of empathic engagement with trauma clients as "vicarious traumatization." In this view, the core feature of all mental-health work, emotional empathy with clients, is the very factor that may increase practitioners' vulnerability (Miller, 1998). Significantly, the most effective strategies for treating trauma actually may exacerbate this vulnerability. Exposure work (i.e., guided imagery with trauma material) with survivors of trauma requires clinicians to "enter" their clients' worlds and to identify with their experience. Furthermore, during the course of therapists, caseworkers, and paraprofessionals' work with actively abusive child-protective-services (CPS) cases, new trauma may occur with which they then must cope (e.g., "Could I have done more to prevent this?"). Even intervention itself may place children and families at greater risk (e.g., domestic violence may result from a mother talking with a caseworker regarding father's drinking; children may be removed when a parent reaches out for help after losing her temper). It might be likened to doing clinical work in contexts of ongoing political repression (Comas-Diaz & Padilla, 1990).

The symptoms found in practitioners working with such cases thus even may exceed those of burnout and approach those of post-traumatic-stress disorder (PTSD). The current criteria for PTSD requires that the person have experienced, witnessed, or been confronted with an event or events that involve actual or threatened death, serious injury, or a threat to the physical integrity of self or others. This definition does not appear to

include the "indirect" trauma one may experience with clients, yet the symptoms appear similar, including re-experiencing, avoidance, or numbing symptoms, and hyperarousal. Psychologists, social workers, and paraprofessionals working with trauma report intrusive thoughts, somatic symptoms, nightmares, withdrawal, isolation, depression, anger, diminished capacity to work independently, decreased morale, and diminished job commitment (Lyon, 1993). Perhaps due to numbing, they also may fail to recognize risks they are taking (e.g., going to unsafe neighborhoods and not paying attention to cues of danger) and/or fail to recognize potential child risks when their threshold has become too high. Overidentifying with a child or a parent and losing objectivity also can occur, such as seeing oneself as the "rescuer" of a child and going beyond professional boundaries (e.g., wanting to adopt a child with whom one is working). At times, I also have encountered caseworkers who appear to feel omnipotent and who set irrational criteria for family reunification beyond mandates in statutes or agency procedures (e.g., children must each have their own bedroom). Trauma "junkies" have also been described as those who increasingly become reinforced by working with the most dramatic of cases (Miller, 1998). As in PTSD, affective disregulation and rage responses directed at clients or colleagues can occur. As I will note later, these reactions may pose the most direct difficulty for supervisors.

Vulnerability to PTSD has been linked to the intensity and chronicity of exposure, social support, personal tolerance for stress (e.g., coping style), and social/contextual variables (e.g., a parent's response to child disclosure of sexual abuse). These same factors also may be relevant in understanding reactions to working with and supervising child-abuse cases. For example, it appears that with high levels of trauma exposure, the characteristics of the individual play less of a role in the potential for PTSD, suggesting that under such conditions, all mental-health providers may be vulnerable as well. Also, females tend to be at greater risk for PTSD, and because CPS caseworkers and parent aides tend to be female, greater vulnerability to trauma may exist in these groups. Community support and other stresses also influence symptoms. Although psychologists, social workers, and parent aides tend to see clients in different settings (i.e., clinics vs in families' homes), they typically work in agencies where there is less supervision and where stress is high and rewards low. Their work is carried out within the context of legal and state mandates and within ethical guidelines (e.g., need for confidentiality). Positive outcomes are not acknowledged openly, but negative ones (e.g., the death of a child in state custody) are public and censured in the media. As will be seen, this may contribute to burnout.

Burnout and Supervision

To work effectively with child-abuse cases, it commonly is accepted that ongoing consultation is crucial. Because cases are complex, team consultation is needed to help in considering the multiple services/strategies needed and to keep the multiple risks involved in constant perspective. Unfortunately, due to limited resources and/or traditions of mental-health practice, individual or group supervision is most common. How to be an effective supervisor in work with difficult families and traumatized children, however, has not been discussed much, but may be crucial to preventing burnout in this highly stressed area of practice. This work produces unique stressors on supervisors as well, which also have not received much attention. They must balance client needs, administrative needs, supervisee needs, and, in the case of students, training needs, which can create ethical dilemmas.

Despite one's best efforts as a supervisor, the symptoms of vicarious trauma and/or stress of the work may play themselves out within supervision. Particularly troubling can

be emotional disregulation. Signs of such disregulation can include: supervisees' avoiding responsibility for a problem; flooding the supervision sessions with details or remaining unusually silent; rapidly changing the subject or prematurely complying with or repeatedly resisting a supervisor's request; overt frustration, anger, and even open verbal attacks. Claims that supervisors do not understand the problem or are pressing for solutions rather than actually trying to understand the problem also can signal difficulties in supervisory relationships.

Supervisors are subject to all the same strains as the individuals they supervise, but they may feel they are "above" reacting to them. Supervisors also may be identified by the supervisee with many of these sources of strain (e.g., they must represent the mandates of the institutional setting for matters such as doing paperwork and returning children on specified time frames to homes where there may be uncertainty as to safety). Supervisors also can come to personify the "unfeeling other" because they emphasize the need for boundaries with children and challenge the supervisee's "rescue" fantasies as they emerge. Thus, supervisors can become targets of rage because they are viewed as outsiders to the experience and not completely understanding (Manton & Talbot, 1990). The supervisor may not have been "in the trenches" for a long time and may be viewed as not really "knowing" what it is like. Also, if the supervisor's style is reflective (i.e., asking questions regarding process and affect), she or he can be seen as an elicitor of painful emotions and thus engender supervisee avoidance or withdrawal. Similarly, the supervisor can act as a reminder of events the supervisee would like to forget (e.g., an abuse incident identified late in the process), and this can add further to feeling out of control. This might be viewed as a "parallel process" (i.e., supervisees act in ways similar to their traumatized clients; supervision also can come to mirror the emotion and conflict within maltreating families). Finally, the supervisory relationship is an evaluative one, and the experience of "failure" with a client and the affective disregulation that is on "public display" in supervision may be shaming to the supervisee, such that he or she may become even more angry and/or withdraw from supervision (e.g., coming late, not sharing important risk information). Although this may occur in all supervision, "failures" in child-abuse work may mean that children are exposed to real-life risks; thus, reactions may be stronger. Indeed, such risks may be inevitable and unavoidable even with the best of intervention work!

Experiencing a supervisee's rage as one is trying to be helpful is disconcerting. Supervisors may react by attempting to provide further help, only to be rebuffed. When these efforts fail as well, the supervisor may feel ineffective or be viewed as being unhelpful, or, in the worst situation, as "out to get the supervisee," adding further tension. Supervisors also can come to take personally the anger experienced, and experience shame at not being able to "fix" matters for their supervisee. A supervisee's affective disregulation can produce realistic fear that the case is also at risk and may lead to tighter supervision (e.g., more frequent questioning of strategies employed), which can further the downward spiral of interactions.

Supervisee numbing, while not as disruptive to the supervision relationship, can produce concerns regarding the safety of cases. Since supervision in most cases in not "live," the supervisor must rely on supervisees to bring in material for discussion that will enhance their ability to problem solve around case issues. Rousing a "dissociated" practitioner to be attentive to cues being provided by the family and getting him or her to report "accurate" information may be difficult. Indeed, the very cues that may be most relevant may be affectively laden and thus, "avoided" by the supervisee. Inexperienced clinicians also may miss important opportunities to clarify risk issues as they emerge. When this fact becomes known in supervision, the supervisor is left having to wait until

the supervisee's next session with the client for clarification to occur. Such beginner errors are much more problematic than typical ones (e.g., failing to interpret something a client has said) and supervisors may react strongly either to make sure it does not happen again or out of their own fear for a child. Balancing a supervisee's training needs against client risk is more difficult here. Risk material also may come out only after most of the supervisory time is over, and thus inadequate time may be available to explore it. In this situation, the supervisor may be left with fears that "more" is out there that has not been disclosed. It can be very frustrating to learn later a piece of vital information was in the supervisee's possession and only divulged after a problem had arisen that might have been prevented had it been known earlier.

Thus, ways to modulate both the supervisor and supervisee's affect and strategies to improve supervision may be especially helpful in reducing the potential for burnout. With this goal in mind, a discussion of the potential social-cognitive origins of burnout in working with child-abuse cases follows and ways such a framework might be used to improve supervision presented.

A Cognitive-Behavioral Approach to Preventing Burnout in Child-Maltreatment Work

Key to virtually all formulations of burnout is the role of the subjective experience of the practitioner. Psychodynamic theorists see as core to the origins of burnout the therapist's own history leading to "distorted" or "underprocessing" of the emotionally laden material presented by clients (Maier & VanRybroek, 1995). Stress-coping theorists emphasize cognitive elements as determining practitioners engaging more or less effectively with work-related stressors. Even recent vicarious trauma formulations emphasize individual meaning making (Horwitz, 1998; Miller, 1998). Finally, systems-based views also argue that intervention needs to help human-service workers normalize their reactions and that supervisory structures and organizations need to provide forums for this to occur.

Each of these formulations can be incorporated into a cognitive-behavioral approach to containing the extreme reactions to child-abuse work that can lead to burnout. This approach focuses on the idea that violated expectancies lead to negative attributions (to self, others, and to one's profession), and negative affect, both of which may contribute to burnout. I have argued elsewhere that when the individuals we serve violate our expectancies regarding how they "should" behave, especially in response to our interventions, we may have strong negative emotional reactions that can lead to maladaptive interpretations and responses (blaming responses—both of our own skill and their potential negative intent) and interfere with our working collaboratively with them (Azar, 1996). This emphasis on the role of cognition provides a major bridge to understanding the reactions of practitioners to child-abuse cases, identifying their sources, and intervening through supervision to reduce their impact. Through the cumulative effect of exposure to clients with trauma or "secondary traumatization" (McCann & Pearlman, 1990), child-maltreatment cases may change our view of families. This is illustrated best by a comment by a young trainee who summarized her experience in doing sexual-abuse treatment: "I can never look at a father and daughter sitting together in the same way again. When I am out in public and come across a father with his arms around his young daughter, I no longer think 'How nice!'; I now wonder what might be going on. I am not sure I like this." We also can come to question our own efficacy and that of our profession, experiencing what Farber (1995) calls "perceptions of inconsequentiality" in our work or feeling that our input is disproportionate to perceived

output. This suggests that in formulating how to work with professionals and paraprofessionals' reactions, addressing violated role expectancies and negative misattributions needs to be considered.

It also has been argued that embracing a formal ideology may alleviate burnout by reducing the ambiguity and internal conflict inherent in human-service work (Cherniss & Krantz, 1983; Hasenfeld & English, 1974). Yet, not just any ideology may be useful. A cognitive-behavioral approach has a number of valuable aspects to recommend it. First, the assumptions underlying the behavioral approach may attenuate the intensity of practitioners' emotional reactions to indirect trauma. Since, according to this perspective, abusive parental behaviors are viewed as environmentally determined (e.g., learned), they are not viewed as something "intrinsically bad" about the parent. Thus, the attribution of intentionality that underlies anger responses is lessened. This is in contrast to the more-dispositional perspective paramount in most other theories. Adopting such a perspective in supervision similarly may lessen a more-blaming stance toward supervisees' difficulties. Furthermore, a cognitive approach allows the introduction of more helpful assumptions for supervisees with parents (as well as supervisors with supervisees), and fosters attention to hard evidence rather than to the myriad maladaptive expectations that may bombard the supervisee as he or she works on goals with cases that, in many instances, are untenable. It provides a framework to enable the supervisor to identify when role expectancies have been violated and thus, a potential source of the affective disregulation in supervision. It also provides ways to work with them once they are identified.

A cognitive-behavioral approach requires a three-staged process:

1. identifying deeply held and maladaptive or overly rigid assumptions/expectancies regarding a supervisee's role as a health-care provider (e.g., how he or she should be viewed by clients, supervisors, and the public) and the role of parents in children's lives that underlie the misattributions that are causing stress;
2. challenging these expectancies and attributions; and
3. replacing them with more-flexible and adaptive beliefs, expectancies, assumptions, and interpretations.

Below is a hypothetical example of what this process may look like in a supervisory situation involving a frustrated supervisee:

SUPERVISEE: She wasn't there again today . . . I don't know what to do . . . [assumption: I *should* know what to do] (*Really exasperated and fuming.*) I don't get it. Doesn't she realize she could lose her kids if she doesn't make our appointments. I'm beginning to feel like she doesn't care at all. [makes a negative attribution about the parent] Maybe we should think about not returning them.

SUPERVISOR: It's hard when it feels like they are not trying. Why do you think this is happening?

SUPERVISEE: [a bit frustrated with the question] I think she really doesn't care.

SUPERVISOR: Doesn't care?

SUPERVISEE: Yes, I think she wants us to take them permanently.

SUPERVISOR: What's the most frustrating part of this?

SUPERVISEE: Uh, I guess it's the fact that she lies to me . . . [violates the idea that clients want our help, resulting in a negative attribution to the client]

SUPERVISOR: Lies to you?

SUPERVISEE: She makes the appointment with me and seems engaged in wanting to talk to me but . . . when I get to the house—she is either not there . . . or says she is on her way out and can I come back tomorrow! I don't know what I am doing wrong. [negative self-attribution]

SUPERVISOR: Maybe you are doing nothing wrong . . . These are tough cases. Remember our average cancellation rate is pretty high. [a more-flexible expectation]

SUPERVISEE: Yeah, but this is happening with most of my cases right now . . . [making a global self-attribution, increasing potential for loss of meaning]

SUPERVISOR: It is the holidays . . . for many of the families—this is a hard time of year . . . [helping the home visitor make an external attribution]

SUPERVISEE: That's all well and good, but how do I explain the small number of visits I have completed this month. [fears of institution-based consequences]

SUPERVISOR: Well, I review the numbers with the area director and I can explain what has been happening . . . Let's get back to what you might be able to do . . .

SUPERVISEE: I have tried everything *you've* suggested . . . nothing works!! (*getting frustrated*)

SUPERVISOR: I guess I haven't got any magic for you. [modeling it's o.k. to not have answers] In some cases, even I fail.

SUPERVISEE: It's not that what you suggest fails . . . well,—the mother is just stressed out . . . I am not sure she feels we are serious in trying to get her kids back to her. [with this statement the case is focused back on the parent and her needs and there is a "safer" space in which to work]

SUPERVISOR: She's feeling helpless . . . mmmm . . . I wonder how you would like her to behave?

SUPERVISEE: Well, I'd like her to see I am trying to help her—that I am trying to be on her side. I have been working with her for six months now . . . and I suppose I expect that by now she should be at home when we are supposed to meet.

SUPERVISOR: I wonder, is this is realistic? Lots of our clients miss their appointments—and it may have nothing to do with whether they see us as "on their side" or not. They just may feel generally that people aren't very trustworthy. [attempting to normalize] I'm not sure you can measure your success by this. Sounds like both of you are feeling helpless. What would make her feel less helpless? Can you problem solve with her about what would make you both feel less helpless?

Essentially, the goal in supervision is to provide the professional and paraprofessional with a "revised" worldview that is more flexible and consonant with the realities of the work and that allows him or her to maintain meaning in the face of many obstacles to feeling successful. This does not preclude the need for systems-based change, but, given that such change is slow, it provides a framework within which to operate while this is taking place. This revised worldview needs to include revisions of the way in which supervision is handled. For example, an assumption may need to be created that one *does* talk in supervision about one's emotional reactions to clients, rather than perceiving this as problematic or evidence of a disturbance within supervisees. Similarly, an assumption on the part of supervisors also might be created that, at times, supervisees will appear affectively disregulated in response to cases and that this is normative. Supervisors also may need to keep in mind that, as they balance the myriad of competing interests (e.g., client risks and needs, supervisee risk and training needs, administrative demands, etc.), they may become, on occasion, affectively disregulated, especially if they experience supervisees as "numbing" in the face of difficulties of their cases. Finally, supervisors need to see themselves as advocates for supervisees and for administrative change when

expectations for cases are unrealistic (e.g., reduction of level of severity in a supervisees' caseloads; need for rotation in supervisees' work functions; establishing crisis-debriefing teams).

Based on cognitive theory, the assumptions with which one views social roles, such as therapist, helping professional, and competent parent, constitute templates or *role schemas* that act as filters in the formation of our impressions of events and others and our responses to them, as well as our views of ourselves. Because role schema are influenced by life experiences, there is often variation in the way members of any given society construct them. These schemas can operate in an almost automatized fashion and, depending upon their complexity, they can either broaden our intake of information or limit it (i.e., determine our search for cues and their interpretation). Once established, they are highly resistant to disconfirming information. This can lead to misinterpretations, premature judgments, and maladaptive responses in our interactions with others. In work with mothers who abuse children, for example, my colleagues and I have found that their schema regarding children—what they believe children are capable of, how they believe children think, and how they expect children to relate to parents—are overly rigid and infuse children with adultlike capabilities and motivation (Azar, 1989a; Azar & Rohrbeck, 1986). These schemas prime parents to assign blame too readily to children, even when cues do not indicate it is warranted (i.e., they indicate situational causes; Azar, 1989b) and to react with negative affect (e.g., frustration, anger), coercive parenting, and, ultimately, to abuse. They also result in less-adaptive socialization responses (e.g., calm parenting responses such as use of explanation) and poorer overall parent–child transactions. Despite their resistance to disconfirming information, under certain circumstances, these mothers' schemas are subject to change through *cognitive restructuring*, whereby cognitive distortions are identified, challenged, and replaced with more-adaptive assumptions (Azar, 1989a).

As with these mothers, professionals' difficulties in working with child-maltreatment cases may be rooted in overly rigid and inflexible schema. In this case, the schemas are about "ideal" therapy or casework and "ideal" clients and families. For supervisors, too, difficulties may be rooted in these same idealized models, as well as the models we hold of "ideal" supervisees. Such models can result in insurmountable roadblocks to collaboration. In laying the groundwork for cognitive restructuring with supervisees, it is important first to identify the sources of strain within child-abuse work and the ways in which these strains violate the models that practitioners hold regarding their role and that of families, the ways in which families should relate to them as helpers, and how their agencies and society should see them. As will be seen, while much of clinical work violates our cherished assumptions, child-abuse cases violate these in an *extreme* way and thus subject practitioners to similarly extreme reactions. For example, many problems involve underestimating the stressfulness of our work and the high potential for failure (i.e., high recidivism rates). Strategies to cope with these reactions are needed.

Working with Multistressed Families and Violations of Our Deeply Held Expectancies

Professionals and paraprofessionals hold deeply a number of basic assumptions or expectancies that are challenged in child-maltreatment work. When strong reactions are observed in practitioners, these assumptions in part may be at fault and might constitute the focus of supervisory interventions. A sample of these include:

- Family problems are always manageable and we have the tools to be helpful.
- I *know exactly* what my role is in relation to the families and children I serve.

- Parents and children want my help and will view my efforts positively.
- Because of my role as a helper, I will be safe (e.g., I should be able to tolerate client verbal abuse and visiting unsafe neighborhoods).
- I will not do harm.
- As a mental-health practitioner, I *should* always be empathic with any client.
- I am engaged in activities that are valued by others.
- I always will receive the support of my colleagues.
- I approach my work with a clear idea of my biases and have ways to keep them out of my judgments and reactions.

The strains of working with child-abusing parents and their children can violate these expectations. These strains include the extent and nature of the problems, role strain and agenda conflicts, direct and indirect physical risk, practical problems (training level, pay scale), the lack of an adequate treatment technology, unrealistic societal expectations and criticism, practitioners' own trauma history, and personal biases and expectancies.

The Extent of the Problem

Early views of child abuse argued that it was infrequent and that parents who would do such terrible acts must be crazy and "not like the rest of us." These views quickly were proven wrong. Almost three million children are reported as maltreated each year and many encounter more than one form of abuse (National Center on Child Abuse and Neglect, 1999). Overlap with other forms of family violence also has been found [i.e., half of wife-battering men also abuse their children, and interestingly, slightly more than a third of battered woman also report doing so (Saunders, 1994)]. Rather than having a major psychiatric disorder (e.g., psychosis), most abusing parents are not diagnosable, or, if they are, they suffer from personality disorders or are limited cognitively (both of which are less amenable to brief parenting interventions). Substance abuse, homelessness, antisocial behavior, and poverty all characterize typical cases. CPS caseloads are high and levels of support services are inadequate. Clearly, these families' problems have few easy solutions. Nonetheless, the perceived task is to "solve" them. Holding this belief too strongly can be onerous and keep indicators of moderate efficacy out of practitioners' reach. Helping supervisees reframe problems as ones that are more "solvable" is essential (e.g., overuse of physical means of discipline, social isolation).

Supervisees also must become comfortable with the fact that, rather than embracing practitioners' help, many families are resistant to it. First, families often have competing priorities that have little to do with psychological processing of issues (the major tool of our work). Parents have limited resources and struggle daily with survival issues (e.g., financial strain, limited social networks, lower educational attainment, and perhaps intellectual limitations). It is difficult to work on being more consistent with your children and using more positive strategies when you are unsure as to how you will feed them or whether you will have a place to live. Second, based on their own family and marital histories, parents' belief in a "relationship" being helpful also may be limited. Finally, the nature of the therapeutic relationship is often involuntary, moderated by the legal system. All these factors make the basics of clinical practice difficult. Attending appointments, consistently applying strategies to improve their life circumstances and psychological health, and engaging, even at minimal levels, in a therapeutic relationship may all be difficult goals to achieve. Clients often are highly resistant to contact, and slow to make progress, if at all. High attrition (87% in one study) and recidivism rates (20–70%) are common.

As a starting point, therefore, definitions of "success" in some cases need to be reframed as involving improvements in motivation and relationship skills (e.g., attendance at sessions; making eye contact in meetings; asking for help around concrete issues) to allow for more attainable initial goals. Recognizing client accomplishments, no matter how small, and linking them to supervisee efforts, and providing specific, positive, and genuine feedback regarding the supervisee's accomplishments are essential (National Center on Child Abuse and Neglect, 1994).

Role Strain and Agenda Conflict

Individuals who decide to work in child abuse typically have done so because they want to be helpful, especially to children. They assume that people want to be helped and will reach out to them as practitioners, valuing what they do. Clients who resist appointments, who continue to hurt their children after you have "invested" in them, and continue to engage in behavior destructive to their family life, and in the face of children's vulnerability violate these assumptions. Add to this clients who may be belligerent and threatening and who often lack basic social skills, one easily can see the role strain involved. Even the most basic of courtesies may not occur. For example, I have had parents in group treatment who have spent the sessions doing crossword puzzles or looking out windows. Thus, while therapeutic relationships are typically nonreciprocal, the imbalance here may be even extreme. This can be especially problematic for inexperienced clinicians, who may see such behavior as evidence of disrespect for their skills.

Denial of problems is a common stance in maltreating parents. Young clinicians react with confusion, shock, and disbelief as clients tell them clear mistruths regarding information that they know the client knows they have. Parents rarely acknowledge their abuse and the young clinician is put in the position of hearing conflicting stories regarding what led to families' involvement with CPS. Time and energy may be spent in hearing both sides of the story and still not being able to proceed with an agreed-upon foundation for the work. If parents' stories, which typically hold them blameless, are accepted to any great extent by the clinician, it is jarring when another abuse incident occurs and he or she sees visible evidence of being misled. As with addictions, viewing families as in various stages of the change process may be helpful. The initial task of the supervisee, therefore, may not be necessarily to make them "better" parents, but to move them to a more workable level of potential for change. Ultimately, the final goal also must be reframed as helping parents be "adequate" parents, rather than ideal ones.

Referral of an abusive family by social-service agencies or the courts often can result in different kinds of role strain for supervisees. Two conflicting intervention goals present themselves—keeping the family together versus physical protection of the child. When child risk occurs (i.e., consideration of the need to report abuse), a situation can emerge that is analogous to sexual-abuse victims' dilemma in making a disclosure. Telling will potentially produce negative changes in the family; not telling means continued exposure to risk. Our knowledge base on risk assessment still is limited, and training in this area often is lacking. This can produce ambiguity in decision making in some cases. Moreover, actions taken to accomplish protection for the child may be perceived as negatively affecting the family's chance of success in treatment (e.g., fears that an already tenuous relationship with the therapist may fall apart). Federal panels have called for improvements in training in such issues (National Research Council, 1993), but there are no easy solutions to this conflict. Individual practitioners and their supervisors must sit with the tensions here.

Other areas of role strain occur around client confidentiality (e.g., mandated reporting and providing information to courts), the involuntary nature of the therapeutic relationship (e.g., court-ordered treatment), and disparities among parents', children's social-service agents', and therapists' goals for families. Parents may enter treatment with the attitude of: "I want to get protective services off my back, so I'll come to sessions, but don't expect me to do anything." The agency may want to demonstrate that they have tried every alternative for reuniting the family before terminating parental rights, while the intervention agent is working on the assumption that he or she must work to reunite the family. Conversely, the social-service agency may have a reunification goal, while the therapist sees this as unrealistic or too risky for the child and may be unable to stop reunification. Agenda conflicts can be particularly stressful in child work. Children may want to return to their parents even as we are asked to help them adjust to permanent removal. Children also may be bonded to foster parents and we are told to help them adjust to a return home.

These conflicting agendas can lead to feelings of being placed in an adversarial position and/or, at the very least, like one is working on an ever-shifting ground. "Parallel process" again can occur whereby the interaction between the clinician and the family parallels relationships within the family or between the family and CPS. Similar processes may occur in supervision.

The supervisor can reduce role strain by helping supervisees negotiate clear expectations with all parties at the outset and as the work progresses. Clear expectancies produce a sense of "safety" that is crucial to trauma work. An example of this around mandated reporting might be: " We both have a problem—you don't like the idea of being in treatment and I don't like the idea of a client who does not want to be here. How should we handle this?" Written contracts with families around expectancies also may be useful. In supervision, reframes can work. For example, reporting can be reframed as a therapeutic act (e.g., it confronts the family with "how bad things have gotten"; it may produce heightened levels of support services). Actions such as having supervisees offer to the client the opportunity to make the report him- or herself, or with the therapist's assistance, also can lessen the strain. This step may reduce some of the parent's anger at being "betrayed" and, in making a self-referral, the client is making a public statement of having a problem that may motivate change. Follow-up with the client in dealing with CPS also can act to substantiate the reframe by enhancing the relationship (i.e., the first time such a report was made, clients had to go through the process alone; now they have the therapist to help them). These strategies help to differentiate therapists' role from that of the "authorities" and model openness that often is lacking in families who "keep secrets" like abuse.

Full exploration of supervisee feelings is crucial. Self-disclosure by supervisors also may alleviate the sense of isolation in engaging in behaviors that seem so inconsistent with basic ethics. The more experienced supervisor may "forget" how it feels to deal with each of these issues. Supervisors may need to carry a caseload of at least one family to keep the experiences fresh and commensurate with the current clinical realities (e.g., recent rise in drug involvement of families).

Indirect and Direct Exposure to Violence

Working with child-abusing families involves direct and indirect risks. Indirect exposure to violence is high. For example, in a treatment-outcome study with 59 families conducted by the author (Azar, 1989a), there were two murders. Clinicians' reactions may

depend upon the depth of the relationship. As suggested earlier, the supervisor, who is distanced from the case, may be less visibly affected by these incidents and thus may be viewed by a supervisee as "not caring," which may create tension. Both supervisors and supervisees also may second-guess the work done. A blaming process can go on where each blames the other for the "failure." The negative reactions of others can add strain. Colleagues may want to distance themselves from the incident to avoid confronting their own fears (e.g., "Will this happen in one of my cases?"). Crisis-debriefing teams can be useful to help staff deal with extreme workplace trauma (Mitchell & Everly, 1996). Such teams review events in the case with staff and allow for validation of feelings. However, such interventions typically create "temporary" open cultures and do not speak to what Horwitz (1998) calls the "daily landscape" of CPS work, which typically involves chronic exposure to lower levels of incidents of physical and sexual abuse of children. He argues that the same openness needs to be woven into day-to-day transactions within agencies where trauma is common. Unfortunately, while CPS agencies institutionally may have mandated internal responses to help workers deal with the aftermath of a death, outside the agency clinicians and parent aides who may have worked with the case may not be included and thus may have only a supervisor with whom to process the loss.

The sight of a severely abused or neglected child is very moving, and to encounter this on a regular basis can feel similar to being in a war zone. Also, since low levels of abuse/neglect often do not result in removal of children, the knowledge that one is helpless in protecting a child from harsh treatment or inadequate care can be overwhelming. The resulting chronic level of strain and guilt may play itself out in supervision with a less-experienced clinician who may displace anger over this situation onto the supervisor for "not helping this child." The experienced clinician, however, is not immune from a similar response when it comes to particular children. For example, I have encountered cases where a child came into an agency's care at holiday time, or a particular child had an especially waiflike quality or a severe and malicious injury that set off a chain reaction in staff that led to maladaptive actions that ultimately did not serve the child's best interest. This can lead to divisiveness and high tension among staff, outside agency clinicians, and lawyers.

Supervisors are not immune from blaming supervisees as well, as they too experience a sense of helplessness (e.g., "If they had carried out the work as I told them, then this would not have happened."). Indirect cues that supervisees may be at fault for risk increases can be subtly or not so subtly communicated. It is here that consultation with another supervisor may be crucial and, where possible, appropriate processing of one's own feelings of helplessness and vulnerability may be useful. Unfortunately, in some agency settings, there may be climates that work against such processing, and liability issues may come into play, making open discussions more risky.

As noted above, there is much overlap between child abuse and domestic violence. Thus, it is inevitable that supervisees will encounter incidents of battering. Like the sight of a battered child, arriving at a home and finding a mother with a black eye or bruises can be jarring. Such moments require crisis management, derailing any planned work. Because most home visitors and CPS workers are female, identification with such women can be stronger. Also, given that domestic violence is so common, there is a greater likelihood that the worker herself may have experienced a similar event in her own life. This can lead to heightened, and perhaps inappropriate, emotional responses (e.g., anger at the woman for not leaving her partner as the worker did herself). After this incident, it also may be difficult for a supervisee to report such a mother for maltreatment of her child because "she has been through so much already." Supervisors need to be sensitive to this possibility.

Professionals and paraprofessionals encounter direct violence as well in this work (e.g., tires being slashed, threats of violence, or actual assaults). In one cross-national study, for instance, 48.8% of the social workers studied reported at least one victimization experience from clients over the previous year [verbal abuse (44.8%), physical threats (17.9%), and physical assaults (3.2%); Guterman, Jayaratne, & Bargal (1996)]. (Experienced caseworkers reported less victimization than did less experienced ones, which may reflect a greater capacity to control their caseloads rather than a better ability to reduce such threats.) Such experiences produce negative mood states, distraction, and fear. Although safety cannot be assured, and CPS cases require a tolerance for a certain amount of danger to complete the tasks assigned, it is in supervision that the level of danger needs to be constantly monitored, and where situations that are too dangerous to pursue must be identified. Actions to protect supervisees may be needed (e.g., assigning a second practitioner to go on home visits, providing staff with cellular phones, or requiring clients to come to the agency for sessions as opposed to doing home visits, or even deeming a case as untreatable because of risks to staff).

Confidentiality mandates preclude practitioners from sharing the details of these violence experiences with their families. Moreover, if they do, their partner's or other family members' reactions may be protective ones, urging them to quit their jobs. As one home visitor said who had been caught on the stairs between two individuals in a gun battle, "If I go home and tell my husband, he will not let me come back to work. I love my work—I can't talk to him about this." Thus, supervision may be the only place where the experience can be processed fully.

Supervisors play a crucial role in communicating the "normativeness" of the feelings clients produce. They can provide opportunities for them to be discussed and encourage supervisees to engage in preventive self-care: taking time off, physical exercise, enforcing guidelines for overtime and caseload sizes, and when the supervisee's emotional disregulation is outside of normative bounds, seeking outside consultation and making referrals for services for supervisees (e.g., therapy, change in workload or positions). (See Saakvitne & Pearlman [1996] for a self-help training workbook.) Critical-incidence debriefing teams (designed for extreme incidents) can be used to build in prevention efforts regarding violence (e.g., develop policies and advocate for agency change to protect staff).

Training of Child-Protective Workers and Parent Aides

As noted earlier, having a strong foundation for one's work can buffer against burnout. The limitations of the training in child-protection work recently has received much attention (e.g., some reports suggested that many caseworkers did not even have training in social-work practice [Williams, 1983]). Parent aides who are often selected for their "natural" caregiving skills may not have many of the skills required to handle the emotional and risk issues involved in such cases. Advanced training for psychologists in child abuse and the issues involved in identification, risk assessment, and treating such families has not been a common practice. Recent calls have been made for better training and staff-development programs in CPS, as well as lower caseloads and greater availability for consultation services for providers. In addition, more research around the training practices in various professionals including physicians, teachers, and childcare workers is warranted (Carroll, 1980; National Research Council, 1993). Although it is typically a supervisor's role to make sure supervisees have the necessary knowledge, skills, and resources to do their jobs, systemic problems at the agency/state-funding level make this

task more difficult. Thus, supervisors need advocacy skills to affect agency changes in training and hiring practices and at the same time hold realistic expectations about their power to affect such changes. They also need to keep their supervisees' level of training in mind in making judgements regarding performance and case assignments. The potential for dilemmas is obvious here and a major source of supervisor strain.

It also is noteworthy that in all areas of professional practice it is not uncommon for supervisors to have no training in supervision. They assume the role by virtue of their experience level or other serendipitous circumstances (e.g., higher educational attainment). Training in the basics of supervision and ongoing attendance at workshops to refine skills are important. Furthermore, more than other practice areas, supervision of one's supervision should be sought out to deal with ongoing issues. Indeed, team rather than solely dyadic (single supervisor with supervisee[s]) work has been advocated. Skills in analyzing performance problems are important. When a performance discrepancy is seen, the specific source needs to be identified. For example, if the practitioner has trouble accurately assessing a mother's ability to protect her child (i.e., conclusions regarding risk appear to be based on speculation rather than on information garnered from the mother and other relevant sources), it may signal a different need for training than if the practitioner is able to provide information for a risk assessment for physical abuse, but not neglectful parental behavior. As noted earlier, training in dealing with supervisee resistance and emotional disregulation may be especially important when supervising child-abuse cases.

Trauma History

It is not atypical for individuals who choose to work in child abuse to themselves have histories laced with trauma, maladaptive parenting, and stressful life situations. Although this may make them especially well suited to engage with clients and understand their experiences, it also may contribute to strain (Pearlman & MacIan, 1995). For example, a lament in supervision might be, "My mom made do with what she got from welfare. I can't understand why this mom can't!" Such "percolating" negative emotions need to be dealt with in supervision rather than being expressed through more internal processes less within the supervisee's awareness. Otherwise, they may erupt into "acting out" responses.

The State of Our Treatment Technology

Treatment-outcome work has indicated that our current techniques for dealing with child abuse have limited success. The general conclusions of national evaluations point to traditional therapy and casework as being ineffective in combating this problem. Social-learning-theory-based treatments and lay self-help groups have shown the most effectiveness. This may be due to the fact that these two approaches address specific skill deficits and the social isolation found in abusive parents. Yet, even these interventions have been shown to have high attrition rates and to be less effective with the most multiproblemed families. Large-scale outcome studies validating their efficacy also have not been done as of yet. Thus, work in this area does not have the empirical foundation that is present in other problem areas. This makes provision of strategies to supervisees more difficult. Acknowledgement of the limitations of our approaches needs to be highlighted in supervision. This makes successes all the more meaningful.

Institutional Mandates and Pay Scales

Accountability has increased in public institutions. Staff within child-protective settings and in agencies who do contracted work with their clientele, often are buried under a pile of paperwork and procedural reviews (e.g., written service plans, case reviews, etc.). Although this is necessary to ensure proper monitoring of cases, this added burden can feel oppressive, irrelevant, and even harmful in the face of the level of strain placed on workers by the clients. There also is great pressure to reach a disposition on cases within legislated time periods to keep children from languishing unnecessarily in foster care (i.e., either to decide that terminating parental rights is the right course of action or conversely, that a child be returned home). With high caseloads, low-risk cases, where progress may be more likely, are a lower priority and thus may be closed earlier than the worker might like. Conversely, a child may be returned home because a parent has met some legally specified criteria (complied with a service plan) without making "clinically significant" progress. Thus, judgments can be made based on procedural guidelines rather than a clinician's views or the need for more fine-tuned work. At the same time, caseworkers and therapists may be held "accountable" (and feel responsible) if the decision is in error (e.g., a child dies once returned to a parent). Fortunately, this does not occur very often given the risks involved, but happens enough in agencies for the threat to be there. Indeed, such losses continue to be processed by agency staff a decade later, "as if it happened yesterday." Thus, the loss of control produced by institutional mandates can contribute to strain and, ultimately, burnout.

Pay scales for CPS workers and parent aides are notoriously low. Other professions that deal with violence (e.g., police) receive reasonably high levels of remuneration for this risk. This disparity is not lost on caseworkers. Furthermore, when they experience personal economic strain, entitlement programs provided to impoverished parents may be viewed with some level of jealousy. For example, one worker complained about a mother who called her regarding having run out of money for diapers, and lamented having trouble paying for her own child's diapers, "Where does she get off expecting me to feel for her!" Over time, such feelings may ferment into full-blown burnout.

Isolation

The work of CPS workers and parent aides often takes place in the home setting. Social workers and psychologists working within the family-preservation approach also do such home visits. Making "house calls" has begun to be viewed as having many benefits (Markowitz, 1992). Indeed, some contract work with CPS and HMOs requires that a portion of the work take place in the home. Although the benefits are many, it may mean entering dangerous neighborhoods and homes. In the author's own work, she was been on home visits where police arrived to arrest parents and she had to explain who she was and why she was there. Occasionally, one arrives at an apartment door after climbing a flight of stairs where there is no lighting and finds strangers answering the door who look belligerent and appear to be intoxicated or on drugs. Home visitors have tires slashed and their cars broken into. Viewing drug deals or being at risk of drive-by shootings are not unheard of. Work with rural parents requires being in isolated, remote places doing home visits. While some home visitors describe "getting used to the feel of" places, and stopping "generalizing that everyone hanging out on the street is a menace," others report being "too naive" at first to be fearful and only later realizing the danger. Stepping on animal feces, having cockroaches crawl on your clothes, and experiencing other indignities face home visitors. Home visits challenge

the boundaries of the client–therapist relationship, producing further role strain. Markowitz (1992) gives an example where a family was so angry at the state-mandated intrusion that they never invited the therapist to sit. In work with another family, a therapist spent his time talking to them through the screen door. While this is part of the "process" of engagement, it still may feel "devaluing." This too needs to be acknowledged in supervision.

Unrealistic Expectations of Society

Much of what I already have written speaks to the unrealistic attitude society has toward interventions with CPS cases. Although practitioners may get some respect for being willing to work with "those people," we also find that others are usually on the verge of criticism and disparagement. The lay public generally believes that it is "easy" to take children from parents who harm them, and it is only because state-agency staff do not "try hard enough" that children die. They also believe we can predict the violence despite our low capacity to do so. We know that expectations of mindreading can lead to conflict and destructive responses (Eidelson & Epstein, 1982). Indeed, a strong backlash occurs when an agency "loses" a child (e.g., it makes front-page news and the inadequacies of our professional group are highlighted). The typical questions are: "How could you [the collective you] let this happen?" or " How could you have missed this?"

At the same time, there are *exposes* regarding the intrusiveness of child-protective agencies and the "mistakes" they make "going after" parents who have not done anything wrong. Both supervisors and supervisees need to continue to work in the face of these views.

Our Own Personal Biases

Just because one is a professional, it is not automatic that we leave all our own personal biases "at the door' (Azar, 1996). In the media, the disadvantaged mother is portrayed perpetually as the root of societal problems. If she would just be more responsible, stronger, care for her children better, love them more, and choose better partners, then there would be no problems. Such a view is laced with the fundamental attribution bias (i.e., the tendency to assign causality for negative events to person-based as opposed to situation-based factors). Clearly, abusing parents also have acted in ways counter to our views of what "good" parents "should" be like.

A clash of values based on ethnic or racial variation also can occur. Clinicians must be careful not to generalize their own personal views on parenting to the families they are asked to treat (Azar, 1996). A culturally relativistic point of view has been advocated, which defines treatment goals in relation to cultural, community, and personal expectations and capabilities (Azar & Benjet, 1994).

Across each of these areas, the helpful metaphor to give supervisees is that we are in the business of changing "religion," and that they and the parent have different beliefs. Throughout history, people have demonstrated a willingness to die rather than relinquish such beliefs. This immediately explains client resistance. Thus, child-abusing parents may be willing to engage in self-defeating behavior in order to preserve their views on how they should conduct family life. Their strong reactions to our opposing this can be seen as healthy resistance. Recent solution-focused views have articulated this idea well. According to de Shazer (1984), when clients do not follow directives, it is their way of

"cooperating" by teaching us the best way to help them. This positive reframe allows clinicians more space in which to work. Intervention is approached with the humbleness of a stranger. One is a learner rather than "all knowing." As with all beginners, failures are thus inevitable and not to be seen as shameful.

Summary

In identifying these sources of strain, a cognitive framework has been advocated around four areas of practice: (1) dealing with emotional disregulation, (2) helping to counteract feelings of inconsequentiality, (3) reframing supervisee and client disparities of goals/expectations in terms that are workable, and (4) providing clear strategies to deal with risk issues. These parallel the needs of trauma victims—the need to get safe, get upset, and then get it together. As when supervisees feel like they have failed clients, so do supervisors feel like they "fail" supervisees if they cannot negotiate these difficulties. Four targets for cognitive work suggested include: role strain, unrealistic expectancies, values conflicts, and indirect trauma symptoms that may be directed at supervisors. Holding more flexible and realistic assumptions regarding both parents and supervisees is crucial in this work. Such expectancies might include (adapted from Azar, 1996):

- Parents/supervisees do the best they can;
- Parents/supervisees need to feel a sense of mastery in their role;
- Parents/supervisees have difficulty being easy on themselves;
- Seeking help is dangerous;
- Parents/supervisees are ambivalent about wanting help;
- Parents/supervisees expect you to tell them "you're doing a bad job";
- There is no one right way to parent/do parent work; and
- Change is dangerous; change is slow.

Systems change also is needed (e.g., better training and pay scales, greater societal valuing of the work). This requires advocacy from supervisors, which is the last suggested strategy to reduce burnout and increase resiliency. Supervisors need to take a broader view of their intervention "territory." Through advocacy, agencies have begun to respond to the strains outlined above (e.g., crisis-debriefing teams; special staff meetings to cope with staff reactions to threats). In addition, state agencies have begun to offer training on dealing with trauma and burnout. State commissions have called for changes in working conditions (e.g., decreased caseloads and lower densities of the highest risk cases; clearer decision-making strategies for removing children permanently from high-risk homes; reducing unnecessary paperwork) (National Center on Child Abuse and Neglect, 1994).

Work at the societal level has not been addressed sufficiently and consideration needs to be given to efforts at this level. With client permission, for example, greater publicizing of "success" stories might go far to improving the demoralization that can occur when tragedies occur.

Child-maltreatment cases result in huge challenges to practitioners. Efforts at all levels are needed to reduce the strains involved. I have focused on practitioner-based efforts within the supervisory relationship, as well as the need for institutional and societal changes. Cognitive work may short circuit negative chain reactions that occur in work with child-abuse cases and increase practitioners' resilience in the face of the very difficult task society has asked them to accomplish.

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