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Mental health and quality of life among Norwegian child welfare service workers

Mental helse og livskvalitet hos norske barnevernsarbeidere

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ABSTRACT

Social workers in child welfare services play an important role in preventing crises and identifying the need for and implementing relevant measures among children and families of different ages and circumstances, often with little recognition. The main aim of this study was to examine mental health and overall- and professional quality of life of 978 Norwegian child welfare (CW) service workers. The design was cross-sectional and quantitative analyses showed that several demographic and job-related factors were associated with poorer mental health and quality of life. Approximately half of the respondents showed levels of psychological distress that warranted professional support and moderate or high levels of burnout and secondary stress (professional quality of life). Professional quality of life explained most of the variance in psychological distress and overall quality of life, respectively, after controlling for demographic and job-related variables. The findings of this study can lay the foundation for preventing mental health and quality of life issues among CW workers, as it indicates the focus areas for schools of social work in terms of the mental health of students and future CW workers.

SAMMENDRAG

Ansatte i barnevernet spiller en viktig rolle i å forebygge kriser og identifisere behov for gjennomføring av relevante tiltak blant barn og familier i ulike aldre og omstendigheter, ofte med liten annerkjennelse. Hovedmålet i denne studien var å undersøke den mentale helsen, overordnet, – og profesjonell livskvalitet hos ansatte i barnevernet i Norge. 978 ansatte responderte positivt til å delta i studien. Kvantitative analyser i tverrsnittstudien viste at flere demografiske og jobbrelaterte faktorer var assosiert med dårlig mental helse og livskvalitet. Ca halvparten av respondentene rapporterte psykisk stress tilsvarende mulig behov for profesjonell støtte, samt moderate eller høye nivåer av utbrenthet og sekundært stress (profesjonell livskvalitet). Profesjonell livskvalitet forklarte mesteparten av variansen i psykisk stress og overordnet livskvalitet etter å ha kontrollert for demografiske og jobbrelaterte variabler. Funnene i studien kan legge grunnlag for bevissthet med hensyn til å forebygge psykisk uhelse og lav livskvalitet

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hos ansatte i barnevernet samt at den indikerer viktige fokusområder i undervisning når det gjelder forebygging av studenters og fremtidige barnevernsarbeideres mentale helse.

Introduction

Social workers in child welfare (CW) services play an important role in preventing crises and identifying the need for and implementing relevant measures among children and families of different ages and circumstances, often with little recognition (Pecora et al., 2018; Pryce et al., 2007). Although they are regularly faced with criticism from individuals, groups, society, and the media, CW workers have few, if any, opportunities to explain or defend their actions due to the duty of confidentiality and professional ethical guidelines. Furthermore, if the skills of a CW worker are limited or inadequate, this can have implications for their psychological well-being (Baugerud et al., 2018; Wooten et al., 2011).

Research has shown that social workers across cultures and nationality in general are thought to be more vulnerable and have higher levels of stress and distress compared to other professionals (Geirdal et al., 2022; Griffiths et al., 2018; Harvey et al., 2014; Johnson et al., 2005; Tufte, 2013). Based on research among 600 American social workers working as CW's Pryce et al. (2007) described how clients' crises and trauma can have an impact on social workers' own mental health and quality of life (QoL). Also, Figley (1995; Figley & Beder, 2012; Figley & Ludick, 2017) have underscored that human workers like CW workers may encounter personal difficulties when they meet clients with large personal burdens. Based on occupational literature, one plausible argument for this could be the gap experienced between expectations regarding social workers' knowledge and skills and the reality of their work. This often includes a heavy workload and high demands when meeting individuals in crisis (Wooten et al., 2011), the amount of work, challenging routines and experiences (Adams et al., 2006; Barak et al., 2001; Boyas & Wind, 2010; Dagan et al., 2016; LeBlanc et al., 2012; Schelbe et al., 2017), their place of work (Kim, 2011), supervision and support from leaders (Barak et al., 2009; Chan et al., 2010; Knight, 2017; Lizano & Barak, 2012; Olkowska et al., 2020). For example, compared to those working in private childcare, CW workers in public care have reported higher workloads, more role conflicts, higher levels of depersonalisation, poorer levels of achievement, and higher levels of psychological distress (Kim, 2011), and CW workers who experience threats of violence or actual violence in their work situation have reported poorer mental health than the general population (King, 2021). Individual factors like age (Boyas et al., 2015; Lizano & Barak, 2012), education (Geirdal et al., 2022), and work–family conflict and coping mechanisms (Baugerud et al., 2018; McFadden et al., 2015) are factors associated with the mental health and QoL among CW workers across cultures and contexts, as well.

Compassion fatigue (CF), burnout (BO), and secondary traumatic stress (STS) refer to a person's empathetic attitude towards others, long-term feelings of hopelessness and exhaustion that impact a person's potential to carry out their work efficiently and can occur in several professions, but especially among human workers. In a Finnish study by Baldschun et al. (2019), CW workers reported higher levels of burnout and secondary traumatic stress compared to social workers without CW-related work, which points to both individual and organisational factors. This result is in line with the findings of McFadden et al. (2015; 2018) and Baugerud et al. (2018), who both noted the importance of demographic characteristics, the nature of work, and coping mechanisms, as factors that can predict burnout and secondary traumatic stress. Despite the high burnout rate among CW workers, the study by McFadden et al. (2015) emphasized the high level of resilience among these workers.

Quality of life might mean different things to different people according to area of application. The World Health Organization (WHO) defines QoL as 'Individuals' perceptions of their position in life in the context of the culture and values in which they live and in relation to their goals,

expectations, standards and concerns' The broad concept of QoL encompasses overall, generic, and disease-specific domains, including physical, emotional, cognitive and role functioning, general health, and overall experience (Karimi & Brazier, 2016). Overall QoL is defined as overall well-being comprising objective descriptors, subjective evaluations, and emotional well-being added together with personal development and purposeful activities (Felce & Perry, 1995) while the professional quality of life (ProQoL) is the quality one feels about work (Stamm, 2010).

In the Norwegian context, Andreassen (2014)and Vangbæk (2014) found that workload and a lack of resources were factors that primarily affected burnout among CW workers. Furthermore, Baugerud et al. (2018) determined that the strongest predictors of burnout were a low level of compassion fatigue (CF) in addition to a high workload, and a recent study enlightened that social workers working as CW have poorer mental health than other social workers (Geirdal et al., 2022). Aside from these studies, the mental health and QoL of CW workers in Norway have not been examined. Accordingly, knowledge about the mental health, QoL, and psychological distress of CW workers in Norway remains limited.

Based on national and international research and knowledge from the field, this study aimed to fill the knowledge gap regarding Norwegian CW workers' mental health, QoL, and levels of psychological distress. Further, we aimed to examine the association between overall QoL, psychological distress and, demographic and job-related variables and, professional QoL (including CS, BO, and STS). The following research questions were formulated: (1) How do Norwegian CW workers report their mental health status? (2) To what extent is the reported mental health status associated with demographic- and work-related factors? (3) Does professional QoL have higher significance in terms of psychological distress and overall QoL than demographic and job-related factors?

Materials and methods

The data in this cross-sectional survey were collected in November 2020. Information about, and invitations to participate in, the study were distributed through the Trade Union and Professional Association for Social Workers (FO) in Norway to their members who were working as CW workers. The FO sent two reminders to those who did not respond the first time.

Survey

The survey consisted of questions on demographic, educational, and work-related variables, mental health, and QoL. In addition to age, gender, and education level, the questions included the time that had passed since education, experience as a CW worker, type of place of work, and type of work. Further, we asked whether the respondents worked in municipal, state, or private CW, in first- or second-line services, in a rural or urban area, how many cases they handled per month, whether their work was supervised, the kind of supervision and their experiences of threats of violence or actual violence at work (see Table 1 in Supplementary Material for more information).

Mental health and QoL questionnaires

To examine mental health and QoL, we used three well-known self-report instruments: the General Health Questionnaire 12 (GHQ-12) about psychological stress (Goodwin et al., 2013; Malt et al., 1989), Cantrils Ladder (CL) measuring the overall QoL (Cantril, 1965) and the Professional Quality of Life Scale (ProQoL-5) about professional QoL measuring compassion satisfaction (CF) and compassion fatigue (CF). CF consists of two subscales, namely, burnout (BO) and secondary traumatic stress (STS) (Stamm, 2010). All together 43 questions.

Several studies have supported the validity of the GHQ-12 (Firth, 1986; Goodwin et al., 2013; Nerdrum et al., 2006) and its translations, including translations into Norwegian (Hystad &

Johnsen, 2020; Malt et al., 1989). All the GHQ-12 questions have a four-point response scale ranging from 0 = 'not at all', 1 = 'same as usual', 2 = 'rather more than usual', and 3 = 'much more than usual', with possible scores ranging from 0 to 36. Higher scores indicate more psychological distress. The GHQ-12 case score, on the other hand, is based on the clinical theory that one can identify a clinically meaningful threshold in the dimension of distress measured by the GHQ-12. This threshold constitutes the cut-off point at which a clinically significant disorder (case) is reflected in the participant's score. When using the GHQ-12 as a screening instrument with categorical scoring (i.e. 0 = 'not at all', 0 = 'same as usual', 1 = 'more than usual', 1 = 'much more than usual'), the results are scored in the range 0–12. A level of distress where professional help may be useful is indicated if the answers are 'more than usual' or 'much more than usual' for four or more questions (Goldberg et al., 1998). In this paper, we applied both scoring systems, with a Cronbach's alpha of 0.88.

CL measures overall QoL with one item, 'How is your life?' which is rooted in the respondent's present experience (Cantril, 1965). The response alternatives are between 0 to 10, with the best possible of quality life being 10 (Cantril, 1965). A score of 6 or more is labelled as high life satisfaction (Cantril, 1965). CL has been reported as having good validity and stability across different populations dal.

The ProQoL-5 (Stamm, 2010) includes 30 items that measure CF and CS rated on a five-point scale between 1 and 5. Both compassion fatigue, burnout, and secondary traumatic stress are divided according to cut-off scores that indicate loads, where 0–22 = low, 23–41 = moderate, and 42–50 = high (Stamm, 2010).

Even studies have raised some validity issues regarding ProQoL (Hemsworth et al., 2018; Samson et al., 2016), other studies have supported the validity and reliability of ProQoL-5 in different populations (Baugerud et al., 2018; Geoffrion et al., 2019; Lauvrud et al., 2009; Søndenaa et al., 2013), which confirms its relevance for use in this study. The Cronbach's alphas were 0.88, 0.79, and 0.79 for CS, BO, and STS, respectively, in this study.

Statistical analyses

Descriptive analyses were used to compare the subgroups of the GHQ-12, CL, and ProQoL-5 using an independent *t*-test (mean/SD) and ANOVA with Bonferroni (posthoc multiple comparisons) (see Table 1 in Supplementary Material).

The categorical variables were analysed using the chi-square test (x^2), *bivariate correlations* were undertaken using Pearson's *r* between the variables, and internal consistency was examined via Cronbach's alpha (α).

Hierarchical multiple linear regression was used to examine the associations between the demographic and work-related variables and CS, BO, and STS as the independent variables and GHQ-12 and CL as the dependent variables. In addition, Hierarchical multiple linear regression was used to examine the contribution of the independent variables to the variance in GHQ-12 and CL when controlling for the other variables. Only the variables that significantly correlated with GHQ-12 and CL were included in the Hierarchical multiple linear regression. The demographic variables were included in step 1, job-related variables in step 2, and professional quality of life; compassion satisfaction, burnout and secondary traumatic stress in step 3. The statistical significance was set to <0.05.

Collinearity analysis between overall QoL (CL) and ProQoL was performed. Tests to see if the data met the assumption of collinearity indicated that multicollinearity was not a concern (Compassion Fatigue Scores, Tolerance = 0.89, VIF = 1.11; Compassion Satisfaction, Tolerance = 0.89, VIF = 1.11).

Moderation analyses were also performed to investigate whether the demographic and work-related variables moderated the relationships between professional QoL and the GHQ-12 and between professional QoL and overall QoL. To avoid possible multicollinearity, the included variables were standardised before being used in the regression analysis. The interaction effect (intercept) was then determined by calculating the product between the independent variables, in this case, BO, CF, and STS, and the moderator (i.e. demographic and work-related) variables. Each intercept variable

was given a name to target the variable. In the linear regression analysis, the GHQ-12 and CL were added as dependent variables, while BO, CF and STS, together with the intercepts, were added as independent variables one pair at a time. The demographic and work-related variables were considered to have a moderating effect between burnout, compassion fatigue, and secondary stress and psychological distress (GHQ-12) and overall QoL (CL), respectively, if the *p*-value was <0.05 in the coefficients table.

Ethical considerations

The survey was distributed via email, and the respondents answered online using PCs, Macs, tablets or mobile phones. All the data were stored and analysed in Service for Sensitive Data (TSD 2.0), the University of Oslo, which is a platform for collecting, storing, analysing, and sharing sensitive data in compliance with Norwegian privacy regulations. Only the project leader had access to the data in TSD.

To participate in the survey and provide answers using the online form, each respondent was required to log in with their personal ID, which was either a one-time code for a bank or mobile ID. Consent was presupposed by their active participation (i.e. by answering 'yes' to the question about participation in the online form before being allowed to continue with the survey). Necessary approval was collected (Norwegian Agency for Shared Services in Education and Research (NSD) ref. 649746), and a risk and vulnerability analysis (ROS) was developed according to the current rules.

Results

Participants

About 5000 CW workers were invited to participate in the study. Of these, 978 (19.5%) accepted the invitation, of which 884 (90.4%) were women. The response rate was low, however, when compared to statistics on social workers in general and CW workers in Norway from Statistics Norway (SSB, 2021) the respondents were representative in terms of demographic variables and education. Additionally, compared to other studies in the field, the number of participants in this study was high.

Descriptive analyses

Demographic variables

In Norway, there are two streams in social work education: bachelor's and master's degrees in social work with a broad focus on all types of clients and bachelor's and master's degree in child welfare, which is primarily focused on children and families with relevant social work and child welfare theories, respectively.

Among the respondents, 548 (56%) had a bachelor's degree in CW, and 365 (37.3%) had a bachelor's degree in social work. While 445 (45.5%) had a bachelor's degree only, 462 (48.2%) had undertaken continuing education, and 71 (7.3%) had a master's degree. The age range was 22–66 years (Table 1 in Supplementary Material).

Work-related variables

Time since education and work experience varied between 1 and 45 years. The majority, 541 (55.3%) of the respondents were working as case managers, 793 (81%) in municipal child protection, 782 (79.9%) in first-line services, and 687 (70%) in cities. Furthermore, 442 (45.5%) reported a caseload of between 10 and 20 cases per month. While 669 (69%) reported threats of violence, 212 (21.6%) had experienced violence at work. Among the respondents, 369 (38%) worked alone on cases, 333 (34%) seldom or never had supervision, and of those who were supervised, 342 (41%) received individual supervision (for more information, see Table 1 in Supplementary Material).

Psychological distress and overall QoL

Of the respondents, 484 (49.5%) and 238 (24.3%) reported scores equal to caseness for psychological distress and overall QoL, respectively. This indicates that they needed help to cope with mental health issues while working as CW workers. Lower age, lower educational level, fewer years since relevant education, and limited work experience were all significantly associated with higher levels of psychological distress and reduced overall QoL. Those employed as case managers, in municipal CW, or first-line services reported significantly higher levels of psychological distress and poorer overall QoL than those working in other places in CW services, those who were leaders, and those working in second-line services. A high number of cases per month was also significantly associated with more psychological distress and a poorer overall QoL, while threats of violence and actual violence were of significant importance for overall QoL. Those respondents who received supervision regarding particular cases indicated significantly higher levels of psychological distress than those who reported being supervised on their own reactions and feelings and a significantly reduced overall QoL. The same significant pattern was found between those who had individual supervision compared to those who were supervised in groups (Table 1 in Supplementary Material).

Professional QoL

Except for secondary stress, where women reported a significantly higher level than men, no significant differences were observed between genders in terms of professional QoL. Age played a significant role in professional QoL, with younger CW workers experiencing significantly less satisfaction in their work (CS) and higher levels of burnout and secondary traumatic stress (STS). Having less time since education and less experience was associated with reduced compassion satisfaction and increased levels of burnout and STS.

The level of education displayed a significant association with increased compassion satisfaction and decreased burnout and STS, regardless of the type of bachelor's or master's degree or continuing education. Working as a case manager, in municipal childcare or first-line services, as well as the number of cases were significantly linked to poorer professional QoL across all three dimensions of professional QoL.

Threats of, and actual violence in the workplace were significantly associated with burnout and STS. Those who received individual supervision had lower compassion satisfaction and higher levels of burnout and STS compared to the participants who were supervised in groups. Additionally, respondents who were supervised with a focus on their reactions showed lower levels of burnout and STS and a higher level of compassion satisfaction compared to those whose supervision was focused on their cases. Those who worked in cities showed the significant highest level of STS (Table 1 in Supplementary Material).

Bivariate correlations

Associations between GHQ-12 and CL caseness and professional QoL levels

Table 1 shows the significant associations between GHQ-12 and CL caseness as determined by the GHQ-12 and CL, and the different levels of CS, BO, and STS, as measured using Pearson's chi-square.

Hierarchical multiple regression analyses

The results of the hierarchical multiple regression analyses are presented in Table 2. The demographic and work-related variables and compassion satisfaction, burnout and secondary stress were significantly associated with psychological distress and explained 5.6%, 4.3%, and 46.5%, respectively, of the variance (R^2 change) in GHQ-12. Among these, burnout and secondary stress showed the strongest unique contributions ($\beta = 0.506$, $p < 0.001$ and $\beta = 0.147$, $p < 0.001$, respectively). The *F*-values of the ANOVA test of significance in the final regression model confirmed that the combination of the independent variables significantly predicted psychological distress, as measured using the GHQ-12.

Table 1. Crosstab between psychological distress case (GHQ) and overall QoL case (CL) and compassion satisfaction (CS), burnout (BO) and secondary stress (STS). Significance measured with Chi^2.

				Total	GHQ Psychological distress			CL Overall Quality of Life		
					No case	Case		No case	Case	
				N (%)	N (%)	N (%)		N (%)	N (%)	
			Levels	978	494 (50.6)	484 (49.4)	*p*	740 (75.6)	238 (24.4)	*p*
ProQoL-5		CS	Low	21 (2.1)	2 (0.4)	19 (3.9)	<0.001	4 (0.5)	17 (7.1)	<0.001
Professional Quality of Life			Moderate	820 (83.6)	389 (78.7)	431 (89.1)		609 (82.3)	211 (88.9)	
			High	137 (14.0)	108 (20.9)	34 (7.0)		127 (17.2)	0	
	CF	BO	Low	235 (24)	195 (39.5)	40 (8.3)	<0.001	227 (30.7)	8 (3.4)	<0.001
			Moderate	743 (76)	299 (60.5)	444 (91.7)		513 (69.3)	230 (96.6)	
			High	0	0	0		0	0	
		STS	Low	447 (45.7)	299 (60.5)	148 (30.6)	<0.001	390 (52.7)	57 (23.9)	<0.001
			Moderate	530 (54.2)	195 (39.5)	335 (69.2)		350 (47.3)	180 (75.6)	
			High	1 (0.1)	0	1 (0. 2)		0	1 (0.4)	

Note: Case GHQ: score > 4 (score 0–12); CL case score < 6 (score 0 −10); CS, BO and STS score 0–22 = low, 23–41 = moderate and 42–50 = high (score 0–50).

Table 2. Multiple hierarchical regression analysis.

	Independent variables	Beta	*p*	R^2	R^2-change	*P*	F
Psychological distress (GHQ)							
Demographics	Step 1						
	Age	−0.06	0.87				
	Educational level (Bachelor/master/continuing education)	−0.046	0.09				
	Years since education	−0.009	0.83	0.056	0.056	<0.001	16.05
Job related factors	Step 2						
	Years of experience in CW	−0.63	0.14				
	Number of cases per month (0–10/11–20/>21)	−0.019	0.51				
	First versus second line CW's	−0.015	0.67				
	Working place	−0.009	0.78				
	Municipal versus state and private CW	0.001	0.98				
	Supervision (on cases versus feelings)	−0.025	0.36				
	Supervision (individual versus in groups)	−0.027	0.32	0.099	0.043	<0.001	8.92
Professional QoL	Step 3						
	Compassion satisfaction (CS)	−0.060	0.12				
	Burnout (BO)	0.506	<0.001				
	Secondary stress (STS)	0.147	<0.001	0.465	0.365	<0.001	53.23
Overall QoL (CL)							
Demographics	Step 1 Demography						
	Age	−0.006	0.88				
	Educational level (Bachelor/master/continuing education)	0.009	0.73				
	Years since education	0.051	0.22	0.045	0.045	<0.001	12.77
Job related factors	Step 2 Job related factors						
	Experience in CW	0.008	0.84				
	Number of cases per month (0–10/11–20/>21)	0.039	0.18				
	First versus second line CW	0.034	0.034				
	Workplace	−0.015	0.67				
	Municipal versus state and private CW	0.006	0.88				
	Supervision (on cases versus own feelings)	0.047	0.08				
	Supervision (individual versus in groups)	−0.016	0.55				
	Threats in CW	−0.017	0.52	0.091	0.045	<0.001	7.25
Professional QoL	Step 3						
	Compassion satisfaction (CS)	0.138	<0.001				
	Burnout (BO)	−0.505	<0.001				
	Secondary stress (STS)	−0.091	<0.01	0.473	0.383	<0.001	51.11

Note: GHQ and CL are dependent variables.

Both the demographic and work-related variables and the professional QoL subscales were significantly associated with overall QoL and together explained 47.3% of the variance in overall QoL measured via CL. CS, BO, and STS made statistically significant and unique contributions: $\beta = 0.138$, $p < 0.001$; $\beta = -0.505$, $p < 0.001$; $\beta = 0.091$, $p < 0.01$, respectively (Table 2).

Moderation analyses

Only age was observed to have a significant moderator effect on the relationship between burnout and psychological distress (GHQ-12). No other demographic or work-related variables had a moderating effect on the relationship between any of the independent and outcome variables (data not shown).

Discussion

The main findings of this study shed light on the considerable distress experienced by CW workers and revealed that nearly half the respondents reported psychological distress at a level that may

require professional help and various demographic and work-related variables, including professional QoL.

Working in the Child Welfare Service was found to be a significant source of psychological stress. These findings are in line with previous research, which has highlighted the stressors that social workers, in general, face. This stress is often attributed to the complexity of their work, the challenges posed by organisational structures, workplace culture, and working environment. In our study, this was associated with job-related factors like workload and place of work. In line with Kim (2011), we found that those working in public care were associated with higher levels of psychological distress, as well as higher workloads are of importance for psychological distress. CW workers are further tasked with the dual role of prevention and assessments of interventions at individual, group, and societal levels as also underscored by Wooten et al. (2011), tasks that involve addressing comprehensive work demands and interacting with individuals in crises (Fantus et al., 2017; Kim, 2011; McFadden et al., 2015; Pryce et al., 2007; Wooten et al., 2011).

Notably, the study found that age, and level of education, including the possession of a master's degree and/or continuing education, had a significant association with the respondents' mental health, overall QoL, and professional QoL. These findings are consistent with prior research, such as Lizano and Barak (2012) and Boyas et al. (2012; 2015), which identified age as a significant factor associated with burnout and mental health among CW workers across cultures and contexts.

The study revealed that a substantial proportion of the respondents (49.5%) reported psychological distress at a level that corresponds to the possible need for professional help, as described by Goldberg et al. (1998). On a particular concern, approximately 65% of the CW workers younger than 40 years of age, scored equivalent to GHQ-12 caseness, indicating significant psychological distress. This stands in stark contrast to data from the Norwegian Institute of Public Health (NIPH) (2018), which reported a significant share (16%–22%) of the general adult population meeting the criteria for a mental disorder in a given. These high distress levels among young CW workers may, in part, be attributable to limited professional experience and a shorter period since their education. These findings are partly in line with Schelbe et al. (2017), who highlighted the importance of job demands, work-related challenges, and work experience for mental health among young CW workers.

One noteworthy discovery was the positive importance of supervision with a focus on the CW workers' reactions and emotions. This form of supervision significantly improved mental health and QoL compared to those who received supervision centred on individual cases the employee was working on. Furthermore, group supervision was found to enhance both mental health and QoL. This may be related to a sense of safety and mutual support in group settings, which helps to encourage individuals to share their feelings and challenges, in line with Knight (2017), thereby contributing to self-confidence and self-awareness, and better mental health, as well. From a qualitative perspective, good supervision can facilitate positive meetings between helpers and clients, and strengthen the social work performance. A reason supervision in groups contributes to reduced psychological distress among CW workers can be related to the experience of being 'in the same boat'. This results in recognition of the challenges a worker may be facing, and opportunities for the mutual exchange of experiences and experiences that include support and understanding is in line with theories about group work (Heap, 2005; McDermott, 2020; Shulman et al., 2009). Previous research has also shown that adequate supervision is a buffer against the negative effects of working in CW (Barak et al., 2001, 2009). Resources that provide supervision related to personal resonance, one's own emotions and emotional regulation are important in light of how demanding it is to work in CW, which is a field characterised by power, control, and complex matters, and because CW staff may have physical and emotional reactions that 'settle in the body' (Olkowska et al., 2020).

Despite the significant demands of the job and given previous research, it was surprising to find that a substantial percentage of the respondents reported symptoms of burnout and secondary traumatic stress, with 76% and 54% respectively. Among the respondents who reported psychological distress above the GHQ-12 threshold, a significant majority reported symptoms of both burnout

and secondary traumatic stress. These findings were notably higher than those reported in previous studies, such as that of Conrad and Kellar-Guenthers (2006) among American CW workers, and an earlier Norwegian study (Baugerud et al., 2018). One plausible explanation for these heightened distress levels could be that our data were collected during the COVID-19 pandemic, especially considering that 85% of the respondents indicated that the pandemic had impacted their work. However, we cannot rule out that the reported high levels of psychological distress and reduced QoL were related to the pandemic. It is important to acknowledge the potential influence of other factors, and age, work experience, and level of education seem to be crucial factors that may act as resources for coping, particularly from a resilience perspective.

Norwegian social workers specifically educated as CW workers have reported a significantly higher level of psychological distress compared to other social workers six years following graduation (Geirdal et al., 2022). An intriguing observation was therefore the lack of significant differences between CW workers who had bachelor and master degrees in CW, who at an overall level focus on children and families with relevant theories and interventions, and those with a bachelor and master degree in social work with educational focus based in different social work theories and social work interventions and covers all types of clients. These findings could be related to the fact that previous studies, for example, Geirdal et al. (2022) did not focus on CW work in particular but rather the entire breadth of the field of social work. Being CW workers seems in general to be a primary determinant of psychological distress and QoL, independent of the kind of social work education. Instead, the level of education emerged as a potential buffer against psychological distress and reduced QoL. This findings align with the results of a study on the general population (Rognerud et al., 2002), highlighting the protective role of education.

A noteworthy aspect was the importance of compassion fatigue (CF), which encompasses both burnout and secondary traumatic stress, and compassion satisfaction (CS) in explaining the total variance of mental health (GHQ-12) and overall QoL (CL). The influence of CF and CS appeared to surpass that of demographic and work-related variables. This underscores the independent contributions of CF and CS to psychological distress, which is in agreement with the findings of Adams et al. (2006) for social workers in general. It also highlights professional QoL as a key unique feature of the workplace environment and not a merely designation.

In the context of moderating variables, age emerged as a key variable influencing the relationship between burnout and psychological distress. Accordingly, it is important that employers should be particularly vigilant and conscious when monitoring and supporting newly hired and young employees in terms of the risks they may be exposed to in their work as CW workers. In an interesting study among Norwegian employees, Tufte (2013) found that employees in CW services had a 6.7 times relative risk of becoming disabled compared to engineers. In comparison, nurses had a 3.9 relative risk of disability, further emphasizing the importance of targeted and adequate supervision, support, and follow-up for those working in CW, especially the youngest employees.

While prior research has addressed the challenges and stressors faced by CW workers, including studies conducted in Norway (Andreassen, 2014; Baugerud et al., 2018; Geirdal et al., 2022; Vangbæk, 2014), to the best of our knowledge, this is the first study who have examined the relationship between psychological distress, overall QoL and professional QoL, and the study is distinct in its focus. While the study's primary focus was on Norwegian CW workers, it offers insight that can be of importance and relevance to CW workers in Europe and across the globe.

Strengths and limitations

The main finding of our study was that both demographic and work-related variables were associated with mental health and overall QoL among CW workers. When the demographic and work-related variables were controlled for, professional QoL was found to be most important for mental health and overall QoL. While age was the only variable found to have a moderating effect on the relationship between burnout and psychological distress, we noted that work characteristics and roles in CW

were important when it came to the workers' mental health status on overall QoL. Notwithstanding, personal family burdens, which may vary, as well as levels of education, work experience, and age, may have an impact on overall QoL, and these should be explored in future research.

The relatively high number of respondents may have led to varying statistics. On the other hand, we invited approximately 5000 CW workers to participate in our study, and among them, 978 (approximately 20%) accepted our invitation. Because our invitations were sent out by the FO, we were not able to conduct a dropout analysis to identify those who did not respond. Accordingly, we were not able to determine the age, gender education types, or levels of the workers who were non-responsive, nor whether the respondents' answers may have been skewed in terms of their mental health status and QoL. However, statistics from SSB regarding social workers in CW show demographic characteristics and educational levels that are similar to those of the respondents in our study, which emphasises the generalisability of our findings. Nevertheless, even though the number of respondents in this study was high compared to several comparative studies, both national and international, the fact that relatively few CW workers responded to our invitation is a limitation of this study, and it is therefore, difficult to generalise our findings to all workers in Norway.

Conclusion

In summary, a considerable number of Norwegian CW workers had high levels of psychological distress, reduced overall QoL, and moderate or high levels of burnout and secondary stress (professional QoL). Age, little experience in CW service, and a short time since completing the education were found to be important indicators for the outcome measures, as were the level of education, workload in terms of the number of cases and supervision. Symptoms of burnout and secondary traumatic stress were found to be most important concerning psychological distress and overall QoL. Age was identified as a moderating factor between burnout and psychological distress. Our findings warrant a greater focus on the workloads of CW workers, a lower number of cases handled per month, and supervision in groups with a focus on workers' emotions. Not least, this should apply to the youngest employees.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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