00:00:08 **Pryce** – Welcome to the Florida Institute for Child Welfare Podcast. This series is Child Protection Caseworker Support. I am Jessica Pryce, your host, on each episode we will explore topics that are relevant to child welfare professionals, we will directly from people who work every day to make a difference in the lives of children and families. It is our goal that this podcast is accessible, informative, and supportive. So, if you know someone who works in child welfare, be sure to share this podcast with them.

Today on the Florida Institute for Child Welfare Podcast we are discussing vicarious trauma, burnout, and compassion fatigue. On this episode we will discuss the differences between these three terms which are routinely used interchangeably. As a child welfare professional, it is important to know and identify when you are experiencing each of these so they can be properly addressed. Our Guest today is April Lott, who is the president and CEO of Directions for Living. Here and her team specialize in wrap-around services, including addressing homelessness, child welfare needs, and behavioral health with the overall goal of ending the cycle of trauma. Let’s get started.

00:01:27 **How are you April?**

**Lott** – I’m good, thank you.

**Pryce** – Could you tell us a little bit about the work you do and what brought you into child welfare?

00:01:36 **Lott** – Well as you said, I’m the president and CEO at Directions for Living, which is a community mental health, substance abuse, and child welfare agency. So we, have been in our community of Pinellas County, serving Pinellas County, Hillsborough County, and Pasco County for the past 38 years. We started as a certified community mental health center, primarily serving individuals who were diagnosed with a severe persistent mental illness and didn’t have access to mental health services, primarily due to a lack of funding, lack of insurance, that kind of thing. And then over the years we’ve grown and developed to address all of the social determinants of health within our community. So we, work in housing and homelessness and case management, and when provided the opportunity, when the State of Florida privatized into child welfare, we had the opportunity to bring our expertise to the table of child welfare. Believing that the nexus between the abuse and neglect of children and the mental health substance abuse needs of those families that were perpetrating abuse that it, you know, that this very cyclical nature that that we often hear about kind of this generational abuse begets abuse kind of thing. And we believed as a community mental health provider who truly understood, not only the impact of trauma, but the diagnosis of mental illness and or addiction, that bringing that expertise to the table could really do a lot to serve and protect children. I came to this work - it’s a very long story so I won’t go into it, but really it was around the age of fourteen that I really felt like I was called to to do this work. I didn’t know that it was really going to be
necessarily in the field of child protection, I just knew that it was going to be with children. Initially I thought that that meant the role of a teacher and quickly kind of through a series of opportunities discovered, the role of child protective investigator and you know, then very quickly out of college in fact, it was my very first job out of college was as a child protective investigator. So, I spent several years in that role and then moved from there to working with individuals who had been convicted of sex crimes against children, but in any case; so, ultimately you know, I went back to school, FSU go Noles! And, got you know, my master’s degree in social work and then became licensed in all the while working towards the role that I’m ultimately in as the CEO.

00:04:41 Pryce – And I think that is a great segue into what we’re going to be chatting about today. I am interested April, in how you got into the vicarious trauma kind of sector. You do various workshops and speak on secondary trauma and vicarious trauma. And, could you give us a definition and kind of what got you involved in that?

Lott – Well, when I was working as a protective investigator, in my early days as a protective investigator, I had a particularly, horrendous death, child death case. And early in my career, I questioned whether or not I could actually serve in the role of protective investigator. And I went to my supervisor, who I can see as clearly as I can see you as I tell you this story. In any case, one of the things that she said to me, she said a lot of inappropriate things to me which I won’t go into, but one of the things that she said to me is that she introduced me to this term burnout. And she literally said to me, ‘you know, you’re burned out.’ Now mind you, I had been out of training and in position for probably four months, and she’s already talking to me about burnout, that I was burned out. And as she went on to say, what she no doubt thought was helpful, I became very intrigued about this term, burnout. And so, when I went back to school for my graduate, for my master’s degree, I began to study compassion fatigue. I began to look at burnout actually, which led me to compassion fatigue. And you know all the work that’s been done at FSU relative to this topic and this subject, I mean they really are the leaders. In any case, it was at FSU that I’m trying to figure out what this term burnout means, only to learn that it’s a very negative connotation. And it actually didn’t describe what happened to me at all. Because by definition, burnout means that you do not like what you do and that you do not want to do what you do, and that it not what happened to me. I loved what I did, and I wanted to continue to do what I was doing. And so, by definition, it was compassion fatigue. And compassion fatigue and burnout look very similar to each other with that very distinct difference. Which is that if you are burned out, you really don’t want to do it. You really do want to do something different, you wanna go work in a different industry, you want to stop doing the work that you’re doing. With compassion fatigue, you want to do this work. In fact, if you were to relocate to another part of the state or another part of the country, you probably would do this work regardless of where you end up. And that, in fact, was me. It had nothing to do
with, the county that I was working in, or the agency that I was working for. In fact, it had to do with my repeated exposure to the trauma histories of, in this case, the children that I was serving to protect. And so, by definition, compassion fatigue and or vicarious trauma, which are two different things. So, there’s burnout, there’s compassion fatigue, and then there’s vicarious trauma. All three are different; but vicarious trauma by definition really is where you experience somebody else’s trauma through them.

Pryce – I appreciate the distinction between those three things because even myself, I’ve used burnout, I’ve used compassion fatigue, and I’ve used vicarious trauma. And I think sometimes I’ve used them interchangeably. So, I really appreciate you drawing a distinction between those three things.

Lott – I would say that, you know, I get particularly interested in correcting people who are using the terms burnout interchangeably with compassion fatigue because of the distinction I’ve just made and because we have incorrectly suggested to our young child welfare professionals that perhaps this isn’t the job for them. When that is, nothing could be further from the truth. And when my supervisor suggested that to me very early in my career, now thirty-five or more years ago, if I had taken her recommendation, right, where would I be today? And, the fact of the matter is that we have hundreds of child welfare professionals who like what they do and want to do what they do, but are nonetheless being negatively impacted by this repeated exposure to somebody else’s trauma. And so, our solution just needs to be different. It is not - we can’t afford to lose anyone of our child welfare professionals who are willing and able to do this work. We can’t afford to lose one. In fact, we need each of them to bring ten more to the table. Right, so we have to be very very intentional in how we speak about these issues so that we don’t mislead and or suggest to our young or even our advanced child welfare professionals that it’s time to do something different.

Pryce – So April, I’m sitting here thinking about my own experiences as well, and I know you mentioned that you had that horrific case. And I remember when I was in the field, I had cases that really impacted me, and it really wasn’t talked about a lot. And I’m curious if supervisors and leadership, are they being trained on how to identify vicarious trauma? I know you had a supervisor that, as you said, didn’t say the most appropriate things. From your lay of the land, are supervisors and leadership being trained to better assess that with their staff?

Lott – I don’t think so, I really don’t if I’m being - if I’m being candid. I believe that we now have a better grasp on the impact of trauma primarily due to the heavily dispersed research on adverse childhood experiences. And, there has been a plethora of trainings at frontline staff levels on ACEs and on the impact of trauma. But I don’t think that we’re doing as good of a job specifically training supervisors on how to prevent compassion fatigue and vicarious trauma, how to address it
when they see it, how to assist their staff with healing and or treating those dynamics I don’t think that we’re doing as good a job as we as we could.

**Pryce** – And, I also wanted to talk about, like I mentioned, a case that I had as a PI, and it was a three-year-old. And he was lying on the floor watching television, and the TV was mounted. And I was called because the TV fell on top of him and he had a traumatic brain injury. And after I did that case, I called basically everyone in my family asking them if their TV’s are mounted correctly. So, I started to obsess over ‘is your TV mounted correctly?’ I asked my sister don’t let your- my don’t my nieces to watc*...

| 00:11:43 | Pryce – And, I also wanted to talk about, like I mentioned, a case that I had as a PI, and it was a three-year-old. And he was lying on the floor watching television, and the TV was mounted. And I was called because the TV fell on top of him and he had a traumatic brain injury. And after I did that case, I called basically everyone in my family asking them if their TV’s are mounted correctly. So, I started to obsess over ‘is your TV mounted correctly?’ I asked my sister don’t let your- my don’t my nieces to watch TV on the floor. So, even then I didn’t put a name to it, but there was obviously some type of traumatic response. And so, I wanted to ask you, what advice do you have to the caseworkers and the case managers that are listening. When you do have these responses, and you don’t really know what to do with it, how do you approach your supervisor? Like what do you do with that, what are the indications that they are experiencing something adverse? |
| 00:13:46 | **Lott** – You know, I honestly believe that, first and foremost, that supervisors should dur-during regular supervision, should be having those conversations. In other words, it’s already planned. The fact of the matter is that every single case manager and every single child protective investigator has currently had a hard, difficult case that has in fact, probably impacted them similarly to what you’ve described. So, we should just on a routine regular basis, we should be saying to our staff in supervision, ‘talk to me about you know, the worst case that you have right now. Talk to me about what’s happening, you know, how your how your thinking how you’re feeling, all that kind of stuff.’ You know, if it becomes obsessive, right then, you know we might want to have a different a different conversation; but certainly we want supervisors, in my opinion, to be sharing with staff that this is likely to happen. “And when it does, I want you to tell me because it doesn’t mean that there’s something wrong with you, it means that now’s your time and we need to address it.” |

| 00:13:46 | **Pryce** – No, that makes sense, it’s it’s almost normalizing. |
| 00:13:46 | **Lott** – Yes. |

**Pryce** – These things that are going to occur. And if it goes across the threshold of this is a normal response, but now let’s talk about it if like you said, it becomes obsessive or you can’t; it’s almost making your work dysfunctional in some ways, then we can chat about that. And I love that you said when I said what a case manager can do when they’re experiencing it, but then you said there should already be ongoing dialogue in your supervisory meetings, even in your team meetings this should be a part of your conversation. So, I’m hoping that if you’re listening that is already a part of your relationship with your supervisor so that there isn’t any fear of how to talk about this. It’s a normalized way to discuss it, so I appreciate you saying that.
So, I know this might be leading into my next question because I wanted to ask you what is a trauma informed workplace, and does that included, like you just said, this constant kind of feedback loop from your supervisors?

00:14:42 Lott – You know a trauma informed workplace, interestingly enough, when we talk about trauma informed agencies or trauma informed workplace, it’s usually through the lens of the client, the client facing experience. We don’t typically talk about a trauma-informed workplace through the lens of a staff member. And so, I think that shift is a shift that needs - is the next phase, is the next step that we need to be focusing on as an industry. So, trauma-informed workplace currently is you know, workplaces that are sensitive to and knowledgeable about the impact of trauma on the clients that they serve. You know, on the, certainly I would say on the staff that the facility has been set-up that it’s not retraumatizing. It’s not a frustrating place to navigate, that policies and procedures are sensitive to trauma. But usually, like I said, it’s the lens that a trauma-informed workplace is looking through. It is about the client as opposed to about the staff. Does that make sense? Yeah so, you know I think the next phase, the next step we need to take as an industry is how do we create environments that are trauma informed and trauma sensitive to our staff. That we begin to recognize and appreciate that our staff come to us with their own adverse childhood experiences. Sometimes they come to us with an excessive amount of adverse childhood experiences and then which then makes them far more susceptible. Even if you’re ACE (Adverse Childhood Experiences) score is a zero, right? You’ve had no childhood adversity, you are still at risk of compassion fatigue, vicarious trauma, and burnout. But if your score is a one, a two, an eight, a ten; the higher your score, the more susceptible you are to compassion fatigue, vicarious trauma, and burnout. So, it really is I think, important for us to begin to understand that the way we, the way we train our staff, the way we ensure their success. Like the amount of training that we allow them to do, the amount of practice we allow them to do, the amount of time we allow them to error, and still be in a safe environment. In other words, every error doesn’t result in some kind of disciplinary action or termination. All of those things will need to be included, in my opinion, in a trauma-informed or trauma-sensitive workplace.

00:17:27 Pryce – No, that’s really fascinating and I’m glad you made a distinction between what a trauma-informed workplace is. Is it the lens of a client, or is it the lens of the caseworker, or frontline staff? So, when you talked about the they’re more susceptible to certain things, that that’s kind of fascinating to me because it’s almost as if we need to transform our workplaces into trauma informed because a lot of our caseworkers are coming from that experience. So, I’m glad you brought that up, and I hope that organizations will start moving toward that. It could be this concurrent type of lens we’re not only going to be mindful of the trauma our clients are facing, but also the trauma that might be right in front of us in our units, in our cubicles, in our offices.
Lott – I think what ACE taught us, what ACE certainly taught me is that there isn’t an ‘us and them,’ right? What ACE has taught us, if we really understand ACE, what it’s taught us is that it is all of us. It is all of us who have experienced childhood or been exposed to childhood adversity. And, in fact, the ACE study you know, says, revealed that 70 percent of us have at least one ACE in our childhood. And that 80 percent of those have at least two, right? And then it goes from there. And so I think if we begin to look at our workforce through that same lens of, and I don’t mean to say that we want to ‘therapatize’ all of our staff, but to begin to understand that it is all of us, right? To assume that the people we are caring for are somehow different than us begins to do this ‘us and them’ thing. And you know, I think that’s where we lose sight of how we best take care of staff. I always want to say that the opposite or the antidote to vicarious trauma, the antidote to compassion fatigue is, in fact, staff satisfaction. So, the more we can focus on staff satisfaction, the less likely our workforce will turnover, the less likely our workforce will be impacted by burnout, compassion fatigue, or vicarious trauma.

Pryce – Interesting, and this might be, you might have just answered the question I was going to ask because- so, my question for you is vicarious trauma preventable? I know you just mentioned the staff satisfaction. Can you talk a little bit about is this something I know you said earlier it’s going to happen, but how can we in some ways prevent it or get ahead of it?

Lott – I think getting ahead of it is probable, as likely as we could do, I don’t know that we could prevent quite frankly. I think that some level of vicarious trauma is likely to happen to every professional who has a repeated exposure to somebody else’s trauma. So, if we could limit that, which by definition, right that’s what these case managers and protective investigators are doing. So, by definition, we can’t we can’t limit or eliminate that. So, I think some level of vicarious trauma is to happen at some point during someone’s career, and it might even happen at a at a low level throughout their entire career. But I do think that we can stop it from growing and stop it from becoming that leads to or contributes to the poor performance of a case manager or the turnover of case manager and it really is all the things that we’ve already talked about. Probably the only thing that I haven’t said yet is that there really is a personal professional responsibility to this topic. So, not everything can be done from the agency, form the supervisor, from the whatever. You know, there is a personal professional responsibility of all of the staff to develop a self-care plan, to make sure they’re you know, doing what they can in spite of, or despite their work to take care of themselves. You know, that they’re- you know like you have a bottle of water in front of you, right? That people are hydrating, that they are eating healthy to the extent that they can, that they’re limiting the amount of sugar and or you know, carbohydrates that they’re that they’re eating, that they are you know, they have an exercise plan, that they have a plan for good healthy relationships, they have a plan for fun, you
know that they plan for their day off, I mean some of the things that just seem so obvious are not routinely being done.

00:22:27 Pryce – No, that makes a lot of sense; and I recall again when I was in the field, I had a colleague that she would take a day off bi-weekly. She would say ‘I’m taking the day off.’ And I would talk to a close colleague of mine and say-

Lott – Can you believe that?

Pryce – ‘why don’t we do that? I mean look at-’ or I could say, or I would say ‘why don’t we do that?’ Like we’re killing ourselves trying to be here every single day. But, that was her self-care, she was saying bi-weekly I’m taking a day off, I mean if you have PTO (Paid Time Off) why not? So it’s those types of things. So, I know her still today and I tell her you were such an example of how to say this job is going to be tough, but I’m going to choose me one day every two weeks. So it, that’s an option for people if they have the support from their leadership. But I think what you said makes a lot of sense, we can’t put the onus completely on the organization; we should take some of that responsibility as well.

Am I correct in saying that cause I used to say that I burnout, but now that you’ve talked about this, I do want to give the listeners another way to kind of frame it and make it more accurate. So, is it fair to say you could experience vicarious trauma and then that leads into compassion fatigue, and if it’s not managed well you could end up burned-out?

Lott – Mmhm Yes.

Pryce – Is that is that basically accurate?

Lott – Yup, that would be the trajectory I would say.

Pryce – Okay.

Lott – You know that, exactly the way you said it.

00:23:54 Pryce – Cause burnout is when you’re essentially done with the work, you don’t want to do it anymore.

Lott – Yeah, you don’t want to do it anymore. You don’t like it; you would rather do anything but what you’re doing. Most people, most child welfare professionals if you talk to them, my experience has literally been across the country. When I ask the question ‘how many of you like what you do?’ 99 percent raise their hand. When I ask them ‘how many of you do what you want to do?’ 99 percent of them raise their hand. I mean literally they’re in most of these training place you know there’s hundreds of people, one or two people are like ‘I’m done,’ right? Ninety-nine percent of them are like ‘this is what I want to do, but it’s hurting me,’ right? ‘It has impacted me.’ And so it is the ‘it’s hurting me, it’s impacted me’ piece that we want to focus on and work on while continuing to say ‘we can’t lose even one of you who is willing to do this work, our children need every one of us.’
Pryce – Thank you April, and thank you all for listening in, I really appreciate this conversation. Is there anything else you kind of want to add as we sum up April to the listeners?

Lott – I think just you know thank you for doing this work, and for hanging in there and you know, keeping the faith that we are changing lives and making a difference in in families.

Pryce – Thank you again to our guest. Such a great discussion about better understanding the trauma that we all face and how manage compassion fatigue and burnout. If you are a child welfare professional, I end every podcast with a heartfelt thank you, we appreciate your commitment to this work, and we hope the podcast was helpful. To learn more about the Florida Institute for Child Welfare and to read more about our guest, visit WWW.FICW.FSU.EDU. I want to acknowledge Aaron Kudja, our podcast engineer, and Marianna Tutwiler, the producer of this series. Until next time, I am Jessica Pryce, and we are strengthening child protection by providing caseworker support.