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Vicarious Trauma in Attorneys

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Abstract

Although secondary trauma and burnout have been the subject of investigation in emergency workers and mental health professionals, no systematic studies have evaluated these responses in attorneys. Growing out of our collaboration with the Pace Women's Justice Center, we designed a survey to assess the presence of secondary trauma responses and symptoms of burnout in attorneys working with victims of domestic violence and criminal defendants. Compared with mental health providers and social services workers, attorney's surveyed demonstrated significantly higher levels of secondary traumatic stress and burnout. This difference appeared related to the attorneys' higher caseloads and lack of supervision around trauma and its effects. These findings create a starting point for further study into attorney responses and methods of ameliorating the stress of work with traumatized clients.

Introduction

Over the last generation and particularly following the inclusion of Posttraumatic Stress Disorder (PTSD) in the 1980 *Diagnostic and Statistical Manual of Mental Disorders—Third Edition (DSM-III)*,¹ the mental health field has witnessed an explosion of interest in trauma and its effects. A decade after *DSM-III* the mental health community began to recognize the effects of work with the trauma victim on the helping profes-

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1. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 236-38 (3d ed. 1980).

sionals themselves.² These phenomena have been labeled "Compassion Fatigue,"³ "Secondary Traumatic Stress (STS),"⁴ and "Vicarious Traumatization (VT)."⁵

Figley summarized the STS formulation as the "cost of caring," manifested by symptoms similar to those of PTSD including re-experiencing the event witnessed, avoidance of recollections of the event, numbing in affect and function, and persistent arousal.⁶ In contrast, "Vicarious Traumatization," as conceptualized by McCann and Pearlman, develops as a consequence of the relationship with the traumatized client during long-term individual psychotherapy.⁷ In addition to internalizing accounts of the patient's victimization with resultant effects on memory and internal imagery, the trauma therapist experiences a disruption in central schemas including assumptions about the world, trust and dependency, safety, power, independence, esteem, and intimacy.⁸ Both STS and VT degrade the professional's ability to perform her task and affect functioning in daily life beyond the job.

Quantitative research efforts on the secondary effects of trauma have focused predominantly on workers who have brief contact with the victim, e.g., disaster workers,⁹ firefighters,¹⁰ and relief workers,¹¹ and to a lesser extent on professionals with prolonged contact with victims, e.g., therapists.¹² These studies

2. See IL McCann & Laurie Anne Pearlman, *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims*, 3 J. TRAUMATIC STRESS 131 (1990); see also Charles R. Figley, *Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview*, in COMPASSION FATIGUE: SECONDARY TRAUMATIC STRESS DISORDERS IN THOSE WHO TREAT THE TRAUMATIZED 1 (Charles R. Figley ed., 1995).

3. See Figley, *supra* note 2.

4. *Id.*

5. See McCann & Pearlman, *supra* note 2.

6. See Figley, *supra* note 2.

7. See McCann & Pearlman, *supra* note 2.

8. *Id.*

9. Robert J. Ursano et al., *Posttraumatic Stress Disorder and Identification in Disaster Workers*, 156 AM. J. PSYCHIATRY 353 (1999).

10. Dieter Wagner et al., *Prevalence of Symptoms of Posttraumatic Stress Disorder in German Professional Firefighters*, 155 AM. J. PSYCHIATRY 1727 (1998).

11. Cynthia B. Eriksson et al., *Trauma Exposure and PTSD Symptoms in International Relief and Development Personnel*, 14 J. TRAUMATIC STRESS 205 (2001).

12. Joan Laidig Brady et al., *Vicarious Traumatization, Spirituality, and the Treatment of Sexual Abuse Survivors: A National Survey of Women Therapists*, 30 PROF. PSYCHOL.: RES. & PRAC. 586 (1999); Laurie Anne Pearlman & Paul S. Mac

have identified risk factors for developing STS and VT related to the nature of the trauma exposure as well as trait factors in the professional.¹³ Among emergency workers event-related risks for development of STS symptoms included identification with the dead after a disaster,¹⁴ degree of exposure and diminished social supports,¹⁵ number of distressing missions and length of service in firefighters,¹⁶ and work with child victims.¹⁷ In addition to the effects of caseload on mental health professionals,¹⁸ a prior personal history of trauma,¹⁹ and prior treatment for a psychological disorder²⁰ increased the risk of secondary trauma symptoms. Therapists with less experience were also more vulnerable to VT, with lack of supervision creating additional risk.²¹

A small number of studies have focused on professionals in the legal arena.²² Follette et al., found that police officers surveyed reported significantly greater symptoms of psychological distress (anxiety, depression, dissociation, sleep problems) and PTSD symptoms than mental health professionals.²³ Although

Ian, *Vicarious Traumatization: An Empirical Study of the Effects of Trauma Work on Trauma Therapists*, 26 PROF. PSYCHOL.: RES. & PRAC. 558 (1995); L.J. Schauben & P.A. Frazier, *Vicarious Trauma: The Effects on Female Counselors of Working with Sexual Violence Survivors*, 19 PSYCHOL. WOMEN Q. 49 (1995); Tracy Woodard Meyers & Thomas A. Cornille, *The Trauma of Working with Traumatized Children*, in TREATING COMPASSION FATIGUE 39 (Charles R. Figley ed., 2002); D.F. Wee & D. Myers, *Stress Response of Mental Health Workers Following Disaster: The Oklahoma City Bombing*, in TREATING COMPASSION FATIGUE 57 (Charles R. Figley ed., 2002).

13. See sources cited *supra* notes 9-12.

14. Ursano et al., *supra* note 9, at 358.

15. Eriksson et al., *supra* note 11, at 210-11.

16. Wagner et al., *supra* note 10, at 1731.

17. Figley, *supra* note 2, at 16.

18. See Brady et al., *supra* note 12; see also Pearlman & Mac Ian, *supra* note 12.

19. Brady et al., *supra* note 12, at 387.

20. Figley, *supra* note 2, at 15-16.

21. Pearlman & Mac Ian, *supra* note 12, at 561-64.

22. See Victoria M. Follette et al., *Mental Health and Law Enforcement Professionals: Trauma History, Psychological Symptoms, and Impact of Providing Services to Child Sexual Abuse Survivors*, 25 PROF. PSYCHOL.: RES. & PRAC. 275 (1994); see also D. Brooke, *Impairment in Medical and Legal Professionals*, 43 J. PSYCHOSOM. RES. 27 (1997); Len Klingen, *The Mentally Ill Attorney*, 27 NOVA L. REV. 157 (2002).

23. Follette et al., *supra* note 22, at 279-81.

studies have characterized substance abuse²⁴ and mental illness²⁵ among attorneys under stress, there are no studies addressing secondary trauma symptoms or the effects of work with traumatized clients.

Despite the lack of empirical work on secondary trauma responses among attorneys, the "clinical" law literature has raised issues regarding the responses of attorneys to work with difficult and traumatized clients, particularly counter-transference and identification with the victim.²⁶ Allegretti calls for increased training of attorneys in managing the "face-to-face, long-term, and intensely personal relationship" that develops between client and attorney.²⁷ An understanding of this principle has recently entered into "clinical" curricula for law students. For example, at Pace Law School the clinical coursework has included readings such as Groves' article "Taking Care of the Hateful Patient,"²⁸ and "The Difficult Legal Client," co-authored by a psychiatrist.²⁹

In addition to symptoms of secondary trauma, helping professionals have long been known to experience "burnout."³⁰ Burnout develops gradually due to the accumulation of stress and the erosion of idealism resulting from intensive contact with clients.³¹ The syndrome is characterized by physical symptoms such as fatigue, poor sleep and headaches, emotional changes including anxiety, irritability, depression and hopelessness, and behavioral manifestations including aggression, cynicism, and substance abuse,³² leading to poor job performance, deterioration in interpersonal relationships, and significant at-

24. Brooke, *supra* note 22.

25. Klingen, *supra* note 22.

26. See Joan S. Meier, *Notes from the Underground: Integrating Psychological and Legal Perspectives on Domestic Violence in Theory and Practice*, 21 HOFSTRA L. REV. 1295 (1993).

27. Joseph Allegretti, *Shooting Elephants, Serving Clients: An Essay on George Orwell and the Lawyer-Client Relationship*, 27 CREIGHTON L. REV. 1, 8 (1993).

28. J.E. Groves, *Taking Care of the Hateful Patient*, 298 NEW ENG. J. MED. 883 (1978).

29. J. Barrette & N. Kaye, *The Difficult Legal Client*, 94 CASE & COMMENT 1 (1989).

30. B.A. Farber & L.J. Heifetz, *The Process and Dimensions of Burnout in Psychotherapists*, 13 PROF. PSYCHOL. 293 (1982).

31. *Id.* at 298.

32. Figley, *supra* note 2, at 12-13.

trition among professionals working with traumatized populations.³³

In collaborating with domestic violence and criminal attorneys the author (APL) informally uncovered varying degrees of secondary trauma and burnout symptoms. To explore these phenomena further, we undertook a preliminary questionnaire survey to determine the presence of these symptoms among attorneys working with traumatized clients, compare those responses to other professionals, and identify possible risk factors.

Overview of the Study

Participants were drawn from a variety of legal and mental health agencies. Attorneys were recruited from agencies specializing in domestic violence and family law as well as legal aid criminal services. The mental health professionals, recruited from community agencies, fell into two groups: mental health professionals providing treatment and social services workers providing concrete and case management services to the mentally ill.

Participants completed a survey that combined the Secondary Trauma Questionnaire (STQ) developed by Motta, et al.,³⁴ and items assessing burnout adapted from Figley.³⁵ Secondary trauma questions assessed three domains: 1) re-experiencing the trauma of the person who had been traumatized in imagery, flashbacks, and nightmares; 2) avoidance of reminders of those traumas; and 3) symptoms of increased arousal including disturbed sleep, increased startle, and irritability. The burnout items included low energy, depressed mood, a feeling that work with the traumatized clients was taking over too much of life, feedback from friends that the subject had lost interest in pleasurable activities, and negative perceptions of self and work function. The survey also recorded personal and work data including number of trauma clients encountered within the last year, personal history of trauma, and history of prior treatment.

33. *Id.*

34. R.W. Motta et al., *Initial Evaluation of the Secondary Trauma Questionnaire*, 85 PSYCHOL. REP. 997 (1999).

35. Figley, *supra* note 2, at 13-14.

Summary of Study Outcomes

The three groups—attorneys, mental health providers, and social service workers—were of similar age and experience, and were predominantly female. The groups also did not differ in history of childhood trauma or prior history of treatment for emotional problems but the attorneys showed a higher rate of adult trauma. Caseload of traumatized clients during the prior twelve months was significantly higher for attorneys compared to both mental health providers and the social services workers. More than half the attorneys surveyed encountered twenty-one or greater trauma clients during the prior year whereas almost 70% of the other professionals averaged twenty or fewer clients in the same time period.

Survey results demonstrated that attorneys experienced more symptoms of secondary trauma and burnout compared with both comparison groups. In addition, the attorneys were consistently higher on each of the subscales of secondary trauma. Translating these scores into symptoms, the attorneys demonstrated higher levels of intrusive recollection of trauma material, avoidance of reminders of the material and diminished pleasure and interest in activities, and difficulties with sleep, irritability, and concentration.

Subjects in all three groups with a history of mental health treatment had significantly higher scores for secondary trauma and burnout. Prior childhood and adult trauma history were not predictive for any of the subjects studied. For all subjects (including the attorneys) increased client load predicted higher scores on secondary trauma and burnout.

During the course of planning and completion of the study the author (APL) heard informally from attorneys regarding their experiences. One attorney at a legal aid office representing victims of domestic violence wrote:

It actually feels good to hear that I am not the only one who feels depressed and helpless and that these issues are worth studying. Fortunately, the stress has decreased with experience and time for me, but I still have vivid memories of quite traumatic experiences representing victims of domestic violence who were so be-

trayed that it was difficult to continue to have faith in humankind.³⁶

Attorneys working with victims frequently reported that they had become over-extended with their clients including contacts after hours and becoming mired in assisting them in securing housing, benefits, etc. Another common theme was the frustration in representing women who appeared passive and unable to utilize the resources provided. Attorneys drew on the paradigm of "Battered Women Syndrome"³⁷ to assist in understanding these behavioral patterns. Overall they attributed their secondary trauma responses to lack of preparation in understanding the clients and lack of a regular forum to discuss and ventilate regarding their own feelings. Several noted that frustrations encountered with the legal and governmental systems required to assist these clients were a significant contributor to their distress, e.g., high caseloads, hostile courts and law enforcement personnel, indifferent administration and supervisors.

Discussion and Future Directions

The major finding of our study was that attorneys working with traumatized clients experience significant symptoms of secondary trauma and burnout. Second, the attorney group demonstrated higher symptom scores in all areas of secondary trauma (intrusion, avoidance, and arousal) and burnout compared to mental health providers and social services workers. Number of clients was moderately positively correlated with symptoms. This is consistent with other findings that the intensity of exposure is a risk factor for secondary trauma.³⁸

In contrast, adult and child trauma were not related to intensity of response among the professionals in our study. Previous studies have not been inconsistent, identifying prior trauma as a risk factors in some samples³⁹ but not others.⁴⁰ On the

36. Anonymous survey response (on file with author).

37. LENORE E. WALKER, *THE BATTERED WOMAN SYNDROME*.

38. See Wagner et al., *supra* note 10; see also Eriksson et al., *supra* note 11; Pearlman & Mac Ian, *supra* note 12.

39. See Brady et al., *supra* note 12; see also J.R.T. Davidson. & J.A. Fairbank, *The Epidemiology of Posttraumatic Stress Disorder*, in *POSTTRAUMATIC STRESS DISORDER: DSM-IV AND BEYOND* (J.R.T. Davidson & E.B. Foa eds., 1993).

other hand, attorneys, mental health providers, and social services workers with a prior history of mental health treatment all scored consistently higher on secondary trauma and burnout.

As to the origin of the increased secondary trauma and burnout responses among the attorneys, higher case loads alone may explain the difference. The preliminary nature of our study requires a follow-up to indicate if other factors play a role in the difference. Attorneys responding at the "Think Tank" felt that in addition to their high case loads the lack of systematic education regarding the effects of trauma on their clients and themselves and the paucity of forums for regular ventilation were significant contributors to development of secondary trauma and burnout. Even among mental health professionals with advantages of education and supervision secondary trauma responses are common.⁴¹

Both the data and the informal responses from attorneys point toward the necessity, as stressed by Silver, of developing educational programming for law students and attorneys regarding the effects of trauma on their clients and themselves.⁴² Future research should focus on clarifying the extent of and risk factors for secondary trauma in attorneys, judges, and allied professions. This work should form the basis for identifying the most effective interventions for reducing secondary trauma among legal professionals in order to enhance the delivery of legal services to victims of trauma.

40. See Schauben & Frazier, *supra* note 12; see also Follette et al., *supra* note 23.

41. Figley, *supra* note 2, at 15; Schauben & Frazier, *supra* note 12, at 61-64; Meyers, *supra* note 12, at 39-53; Wee & Meyers, *supra* note 12, at 57-83.

42. Marjorie A. Silver, *Love, Hate, and Other Emotional Interference in the Lawyer/Client Relationship*, 6 CLINICAL L. REV. 259, 305-13 (1999).