KEEPING LEGAL MINDS INTACT: MITIGATING COMPASSION FATIGUE AMONG LEGAL PROFESSIONALS

Presented by the
American Bar Association
Commission on Lawyer Assistance Programs,
Section of Tort Trial and Insurance Practice,
Solo, Small Firm and General Practice Division,
Commission on Law and Aging,
Standing Committee on Legal Aid and Indigent Defendants and
Center for Professional Development
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This publication accompanies the audio program entitled “Keeping Legal Minds Intact: Mitigating Compassion Fatigue Among Legal Professionals” broadcast on October 22, 2014 (event code: CE1410KLM).
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Keeping Legal Minds Intact: 
Mitigating Compassion Fatigue Among Legal Professionals

Wednesday, October 22, 2014 | 1:00 – 2:30 PM Eastern
Sponsored by the ABA Commission on Lawyer Assistance Programs, Tort Trial and Insurance Practice Section, Commission on Law and Aging, Standing Committee Legal on Legal Aid and Indigent Defendants, Solo, Small Firm and General Practice Division and the ABA Center for Professional Development

Presenters:
Linda Albert, LCSW, CSAC
Deborah Smith, J.D.
Gregory Van Rybroek PhD, J.D.

Seminar Objectives

• Gain an understanding of what compassion fatigue is
• Understand the signs and symptoms; contributing factors & research on CF
• Ethical violations what’s the connection?
• Understand best practices for prevention and mitigation of compassion fatigue

Linda Albert, LCSW, CSAC
Fill In the Blanks

• The world is a _______place.
• Life is _______.
• I am _______ as a human being.
• I want to change _______ about my job.
• I want to change _______ about myself.
• Most often I feel ____________.
Compassion Fatigue Defined

• The cumulative physical/emotional/psychological effects of continual exposure to traumatic or distressing stories/events
• When working in a helping capacity
• Where demands outweigh resources

DOING…

• Too much
• For too long
• With too few resources
• And working with the big uglies in life
Compassion Fatigue Advisory...

• Any person regardless of race, gender, ethnicity, age, occupation… can develop this condition
• Doesn’t imply weakness, just “human-ness”
• Is more about “dis-ease” than disease,

Disabled Top of your game

WHAT’S ON YOUR PLATE?
Work Load: Look Feel Familiar?

Statistically significant correlation with CF

Individual Vulnerabilities

- History of or current trauma
- Health problems
- Alcohol or Drug use/troubles
- Poor job performance
- Depression or Anxiety
- Life problems-spouse/partner, children, parents
Client Expectations/Stressors

- Unrealistic
- Want it now
- Unhappy, sad, mad, frustrated
- Stress from the pressure
- Stress from the difficult material being reviewed and the workload yet expected to appear and be completely unaffected by it

Adversarial nature of law....
It’s a Balancing Act For All Lawyers

Zero Sum Game
Pessimism works in the professional world but not in the interpersonal world
High pressure but low-decision latitude

How Does CF Develop?

- Neurobiological changes-Mirror neurons-empathy
- Cognitive changes: Shattering of Primary Assumptions
Empathy

- Experience the experiences of someone else (Shane, 2008)
- Enduring those same experiences and emotions (Lydialyle Gibson)
- Empathy is involuntary: a shared emotion—this is hardwired into the brain (L. Gibson)
- Human beings who spend time with other human beings who are empathetic tend to feel better

The Role of Mirror Neurons in Empathy

- Monkey see Monkey Do
- Human brains mirror neurons: learning language; imitating motions; understanding others’ intentions and mental states.
- Mirror neurons allow us to empathize

Source: Shane, Simone; found at http://serendip.brynmawr.edu/exchange
Functional brain imaging shows that some of the same regions of the brain are activated by personal pain, at left, and by empathy over the pain of a loved one, at right. But other areas are not activated by empathy.

How Listening Impacts Us

Verbal

Imagery

Affect

Body

Interpersonal
Impact on Primary Assumptions
Pre-trauma exposure

• The World is Benevolent
• The World is Meaningful
• The Self is Worthy

Source: Janoff-Bulman, Shattered Assumptions

Impact of Continual Exposure to

• Shattered assumptions about basic beliefs in our world for safety, security, trust, justice
• The world is not a good place, there is no meaning; pessimism, depression, irritability, sickness
• Heightened awareness of vulnerability and the fragility of life-increased anxiety/anger/…

Source: Bulman, Shattered Assumptions
One attorney says…..

• “I think this happens to everyone whether they admit or not or show it or not. It is inevitable with that kind of caseload that one will at least at times go bonkers. This wears on all of us and on some of us more than others. We see colleagues severely affected all the time. I think the practice leaves scars. Some make it better than others, obviously, but everyone suffers…”

--criminal lawyer

Source: WisLAP Program permission granted

Impact upon Practitioners

• Powerlessness
  • Indecisive/Anxious/Irritable
  • Alienate from others
Fill In the Blanks

• The world is a _________ place.
• Life is ________.
• I am ________ as a human being.
• I want to change __________ about my job.
• I want to change ______ about myself.
• Most often I feel ____________.

Symptoms Reported

• Intrusive thoughts
• Anger/anxiety/fear/
• Irritability
• Sleep disturbance
• Fatigue
• Loss of Appetite
• Loss of empathy
• Loss of faith in humanity
• Sense of isolation from others
• Physical complaints

Source: Vrklevski et al. (2008) and Levin et al. (2003) and Jaffe et al. (2006) Levin, Albert et al. (2011)
Depressed/Overwhelmed Lawyers Don’t Communicate Well

- **RULE 1.4 Communication**
  
  (a) A lawyer shall:

  (1) Promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in rule 1.0(e), is required by these rules;

  (2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

  (3) keep the client reasonably informed about the status of the matter;

  (4) promptly comply with reasonable requests by the client for information; and

  (5) consult with the client about any relevant limitation on the lawyer’s conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

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Georgetown Journal of Legal Ethics 2001 cited depression as a significant factor in lawyer discipline.
Disciplinary Case: Neglect

- 60 day suspension for multiple counts of neglect. Attorney stated that after starting his own firm his practice mushroomed. Although he was offered assistance with office staff, he said he was too overwhelmed to take the time to train these individuals.
- Due to his inability to turn down new clients, Attorney XYZ began working virtually around the clock, leading to a deterioration of his physical and mental health.
- He then began to practice from his home and began experiencing the onset of severe depression resulting in problems with communication and diligence.

Doing too much for too long with too little can impact competent representation and diligence

- **Rule 1.1. Competence**
  - A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

- **Rule 1.3 Diligence**
  - A lawyer shall act with reasonable diligence and promptness in representing a client.
Matter of Attorney S- The petition alleges professional misconduct by respondent during 1993 and 1994, a very stressful period in his life. In addition to the failure of his law practice and deterioration of his personal finances, both his mother-in-law and father died of cancer. The stresses also affected his own physical and psychological well-being. While these circumstances mitigate his misconduct, we reiterate that attorneys must attend to their clients' interests punctually and with vigor despite distracting and stressful intrusions from personal and family problems or advise their clients of their option to obtain other counsel . . . Likewise, such intrusions do not excuse an attorney's obligation to promptly and fully cooperate with petitioner. (Six-month suspension upheld).
Mitigating Compassion Fatigue for Lawyers/Judges

- Individual
- Professional
- Societal

- Awareness, Balance and Connection (Jaffe, et al. Levin, Albert et al.)

Insuring fitness to practice…..Life/Job Satisfaction…..

The things that cause the things that cause the things…..
Organizational Contributions to Compassion Fatigue

- Heavy caseloads-Long Hours
- Inefficient administration
- Excessive paperwork
- Inadequate resources to meet the demands
- Lack of supportive supervision

Source: Levin et al. (2003), Osofsky et al. (2008)

Professional Strategies/Organizational

- Awareness: Implementing education-become trauma informed
- Debriefing via Connection: Forum for legal and/or other professionals

Source: Jaffe et al.
Talking and Connections
Help the Brain

What Individuals Can Do

Research-based suggestions for improving mood, increasing life satisfaction and mitigating CF

- Recognize the **risks** for your self
- Find a way to **debrief** distressing material
- Work on **self awareness** every day
- Take an **inventory** of how balanced your life is—be intentional about balancing it out
- **Evaluate** your tension reducing behaviors
- Be **intentional** about **protecting** yourself
Let's form a collaboration and study it...

Compassion Fatigue: An Organizational Response

Deborah Smith, J.D.
It Started With Information

- In 2009, Linda Albert made a presentation to a group of agency managers and non-manager leaders about compassion fatigue.
- She presented the results of studies done with other professionals and with lawyers.
- We were familiar with the symptoms, but had never known it had a name.
- It was an AHA! moment for many in attendance.

We Needed To Know More

- The State Bar of Wisconsin's WisLAP program, Dr. Andrew Levin of Westchester Jewish Community Services and the Wisconsin State Public Defender agreed to collaborate on a study.
- A study of lawyer and non-lawyer staff of the WSPD would give the agency specific information about the breadth and depth of the problem.
- The results would provide a basis upon which to propose responses designed to help affected staff and mitigate impairment.
Why us?

- The Wisconsin State Public Defender is a state agency with offices in 38 locations.
- The WSPD has over 250 lawyers handling heavy caseloads with little support.
- Nearly all the senior executive staff and all regional managers had been staff attorneys and knew the stresses from personal experience.
- The WSPD has been a leader in innovative practices in the criminal justice system and in state government.

Why Should We?

Besides how such potential harm might fall under state or federal laws for workplace health and safety:

**Competence: 1.1**

A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

An impaired lawyer, regardless of the nature of the impairment, may not be able to provide competent representation.

Our standards are higher than mere competence.
Why Should We?

- Besides our responsibility to colleagues as human beings:

  - Responsibilities of partners, managers, and supervisory lawyers 5.1
    - (b) A lawyer having direct supervisory authority over another lawyer shall make reasonable efforts to ensure that the other lawyer conform to the Rules of Professional Conduct
    - (c) (2) the lawyer is a partner or has a comparable managerial authority in the law firm in which the other lawyer practices, or has direct supervisory authority over the other lawyer, and knows of the conduct at the time when its consequences can be avoided or mitigated but fails to take reasonable remedial action.

Developing The Study

- The study was designed using strict academic standards, validated survey instruments and was submitted for approval to the Westchester Jewish Community Services Research Committee for Institutional Review Board approval.
- Staff concerns about confidentiality were addressed and no survey responses were made available to the Wisconsin State Public Defender.
- We looked at how to introduce the subject to staff and encourage participation.
- Linda went out to a number of local offices to give an introduction to the subject of compassion fatigue and talk about our involvement in the study.
You Want Us To Do What?

- How do you ask an overworked staff to do one more thing?
- Leadership at the executive level
- Leadership at the regional and local level
- Endorsement by respected peers
- Explain and repeat….and repeat….and repeat

Getting Out The Message

- Introductory email from senior managers in administration
- Follow up email from regional managers
- Follow up discussions by local office managers
- Follow up emails from the attorneys’ union president
- Announcement email of survey date
- Reminder emails as the survey date approached
- Additional reminder emails during survey period
The Study

- Attorney and non-attorney staff were surveyed using four validated instruments:
  1. Center for Epidemiological Studies Depression Scale (CES-D measures symptoms of depression)
  2. Impact of Event Scale-Revised (measures symptoms of PTSD)
  3. Sheehan Disability Scale (measures levels of functional impairment)
  4. Professional Quality Of Life Scale Version 5 (measures symptoms of secondary stress, burnout and compassion satisfaction)

The Study

- Regional Training

- After the survey went out: Linda presented day-long training on compassion fatigue and ways to mitigate the potential negative impact of their work at ten regional locations
- Staff participation was encourage, but not mandatory
- Responses to the training varied, but were generally positive
The Study

Linda also collected the thoughts and feelings of staff from around the state about how working with clients and working in the criminal justice system affects them.

Although, not part of the study this information was useful to agency managers

Linda provided weekly email tips and reminders about keeping themselves balanced and healthy

The Study

- Initial survey sent- 74% response rate
- Staff were surveyed every three months
- Surveys continued for one year
- A total of 4 rounds of surveys were done
# The Results

## Depression

<table>
<thead>
<tr>
<th></th>
<th>General population</th>
<th>Administrative support staff</th>
<th>Attorneys</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of respondents scoring in the clinically significant range on the depression inventory</td>
<td>10%</td>
<td>19.3%</td>
<td>39.5%</td>
</tr>
</tbody>
</table>

## PTSD

<table>
<thead>
<tr>
<th></th>
<th>General population</th>
<th>Administrative support staff</th>
<th>Attorneys</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of respondents scoring in the clinically significant range of PTSD</td>
<td>7%</td>
<td>1%</td>
<td>11%</td>
</tr>
</tbody>
</table>

## Secondary Traumatic Stress:

<table>
<thead>
<tr>
<th></th>
<th>Administrative support staff</th>
<th>Attorneys</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of respondent scoring in the clinically significant range of secondary traumatic stress</td>
<td>10.1%</td>
<td>34%</td>
</tr>
</tbody>
</table>

## Burnout:

<table>
<thead>
<tr>
<th></th>
<th>Administrative support staff</th>
<th>Attorneys</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of respondents scoring in the clinically significant range of burnout</td>
<td>8.3%</td>
<td>37.4%</td>
</tr>
</tbody>
</table>

## Functional Impairment: Impact on home, leisure time and work:

<table>
<thead>
<tr>
<th></th>
<th>Administrative support staff</th>
<th>Attorneys</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of respondents scoring in the clinically significant range for functional impairment</td>
<td>27.5%</td>
<td>74.8%</td>
</tr>
</tbody>
</table>
The Results

The study also showed how people are choosing to cope with the stress of work.

A=attorneys
SS= Support staff
I=investigators
C=Client

Talk with peers
97.3%  79.8%  90%  87.5%

Talk with supervisors
56.9%  47.8%  37%  60%

Increase alcohol/drug
19.6%  8.4%  11.1%  0%

Use prescription med
15%  9.6%  0%  6.7%

Exercise
75%  56.2%  75.9%  33.3%

Music
66.7%  64.4%  57.1%  68.8%

Meditation/Yoga
28.4%  21.4%  26.6%  26.7%

Seek family support
55.2%  49.5%  33.3%  50%

What Should We Do?

Participants were also asked what things would make a difference in the levels of stress in the workplace. The answers from the sessions and the answers from the evaluations were again compiled, grouped, and ranked by number of responses. They said:

- Reduce caseloads (#1 in evaluation comments)
- Improve technology (#1 at the training sessions)
- Have more sessions to reflect & process these issues in a safe environment (#2 at the training sessions)
- Increase staff and resources (tied for #2 at the training sessions)
- Management needs to be nicer, more encouraging and helpful
- Flexibility with schedules
- Have more fun in the workplace, lighten up
- Training for new employees on the risks of the work

Short take: More autonomy, more control and more interconnectedness. Plays out in the research on lawyers and well being.
Why Do We Do It?

Responses to the question “Why do you do the work?” were:

- Like to help
- Providing comfort during chaos
- Variety is interesting and fun
- Making a difference
- Paycheck, retirement, job security
- Co-workers
- Work is consistent with values
- Being the underdog
- Get to fight the government
- Feeling needed, purpose
- Humor
- Creativity
- Problem solving

Important factors for well being:
- INTERNAL MOTIVATION
- SENSE OF PURPOSE
- WORK IS INTERESTING
- FITS WITH VALUES

What Do We Need To Do?

Provide information to new staff about compassion fatigue and the importance of self-care in our work environment.

Additional training for managers to find ways to eliminate unnecessary stress and to be more effective in their support for staff.

Explore why some people handle the stress well and why some people handle stress less well.

Implement a REAL employee assistance program.
What Do We Need To Keep in Mind?

While we will go the extra mile to help our clients, we don’t always put that same effort into taking care of ourselves and our colleagues.

While we understand the fear, frustration and anger of our clients as they work their way through life and the criminal justice system, we are not always as understanding with ourselves and our colleagues.

While we resent the unfair judgments of some prosecutors and judges about our clients, some of us make unfair judgments about colleagues who find themselves overwhelmed, depressed or stressed out.

What do legal professionals need to pay attention to? How to get/be well and stay that way:
Krieger & Sheldon, 2014 on Lawyer Happiness

Key Findings:

• HAVING A SENSE OF CONTROL OVER ONE’S CHOICES (.66)
• INVOLVED WITH THEIR PEERS (.65)
• JOB COMPETENCY (.63)
• FIND MEANINGFUL WORK (.55)
• FEEL SUPPORTED AT WORK (.46)
• INTRINSIC VALUES – FIND PERSONAL GROWTH, HELP OTHERS ETC. (.30)

Tough Topic—Soon It Melts Away
Happy Pills?

3 to 4 Million Years of Human Evolution
Natural Rewards Elevate Dopamine Levels

No “Happiness” Lobe

Brains and Happiness

- Our brains are not trying to make us happy. They are trying to regulate us to help us survive.
- Biologically we are driven to survive, not to become happy.
- Once we feel safe in terms of survival, issues like desires, pleasures and happiness, become more prominent.
The Prefrontal Cortex

Brain is Where the Action Is

Brain Chemicals Such as Dopamine
Listening to music improves mood and feeling of happiness by stimulating the release of dopamine, a neurotransmitter with an important role in affecting the expectations of pleasure.

*Nature Neuroscience, 2011*
Our Brain on Exercise

If you start exercising, your brain recognizes this as a moment of stress. As your heart pressure increases, the brain thinks you are either fighting the enemy or fleeing from it. To protect yourself and your brain from stress, you release a protein called BDNF (Brain-Derived Neurotrophic Factor). This BDNF has a protective and also reparative element to your memory neurons and acts as a reset switch. That's why we often feel so at ease and like things are clear after exercising. At the same time, endorphins, another chemical to fight stress, are released in your brain. The endorphins tend to minimize the discomfort of exercise, block the feeling of pain, and are even associated with a feeling of euphoria. Buffer, 2012
**Genetic Predisposition**

- Neuroscientists pinpoint brain regions:
  - left prefrontal cortex corresponds to positive frame of mind
  - right prefrontal cortex coincides with negative emotional state
  - dopamine relays information to left prefrontal cortex
  - people with more sensitive dopamine receptors are cheerful.

- Predisposition to happiness clearly observed in infants.
  - some babies have naturally higher activity in left prefrontal cortex

**Brain Plasticity in Adulthood**

- Studies of Buddhist monks
  - credited with 10,000–50,000 hours of meditation experience
  - left prefrontal brain activity vastly higher than ever seen before.
Watson (2000) discovered that positive emotion rises over the early part of most days and dissipates during the day's last several hours. Studying people’s reports of day-to-day moods confirms that stressful events -- an argument, a sick child, a car problem—trigger bad moods. But by the next day, the gloom nearly always lifts.
Mood and Day of the Week

*Gallup-Healthways Daily Happiness-Stress Index*

By day of the week

- % With a lot of enjoyment/happiness without a lot of stress/worry
- % With a lot of stress/worry without a lot of enjoyment/happiness


Marriage

Clark, Diener, Georgellis, Lucas, 2008
Divorce
Clark, Diener, Georgellis, Lucas, 2008

Widowhood
Clark, Diener, Georgellis, Lucas, 2008
Birth of Child

Clark, Diener, Georgellis, Lucas, 2008

Unemployment

Clark, Diener, Georgellis, Lucas, 2008
Income Goes Up – Happiness Does Not

Happiness Tracking: A Wandering Mind is an Unhappy Mind – Work on the Present
"Life is being on the wire, everything else is just waiting."

Karl Wallenda
3 TYPES OF HAPPINESS

Higher Purpose
Being part of something bigger than yourself

Passion
FLOW and ENGAGEMENT
Time flies

Pleasure
ROCK STAR
Chasing the next high

Is this the Happiness we Long for?
Maslow's hierarchy of needs

- Survival
- The Lucky Camp
- Self Actualization

Slow Motion
You Wanna Change Things?
Do Better? Get Happier?

12 Happiness Activities:
Lyubomirsky (2007)

• Expressing Gratitude
• Cultivating Optimism
• Avoiding Overthinking and Social Comparison
• Practicing Acts of Kindness
• Nurturing Social Relationships
• Developing Strategies for Coping
• Learning to Forgive
• Increasing “Flow” Experiences
• Savoring Life’s Joys
• Committing to your Goals
• Practicing Religion and Spirituality
• Taking Care of your Body (Meditation/ Acting Happy)
Science Supports Practical Approaches

• Improve attitude – optimists 50% less chance of heart disease, heart attack, stroke
• Work, but do less of it – balance equals happier
• Reduce material things – Increase Experiences
• Make friends – If no Close Friend → unhappy
• Help Other People – Volunteer – Kindness → happiness
• Start Laughing – It kicks in good brain chemicals, it helps the heart
• Ordinary Experiences better than Extraordinary
✓ CHOOSE – No One Can Do It For You

Am I a Contributor to my Unhappiness?

[Images of a thinking person with a finger pointing and a person deep in thought]
What we wish for:
To Control Everything

The Battle for Control
Reduce False Personal Positions

False Positions
Hostility = Unhappiness

CHANGE - Brutal Honesty

Personal Change only happens:

IF WE WANT IT TO HAPPEN REAL BAD, OTHERWISE IT WON’T HAPPEN BECAUSE IT IS TOO HARD

Be Honest: How bad do you want it? If you don’t want it bad enough then let it go. To hold it (mentally) causes unnecessary self-destructive stress and unhappiness.
Mind Wandering

Because Mentally We Are:

Worrying.
Regretting.
Complaining.
Perseverating.
Comparing.
Life is what happens to you while you're busy making other plans.

“Beautiful Boy” (Darling Boy)
John Lennon
*Double Fantasy* (1980)

Recognizing Death Helps Realize Happiness
Life Satisfaction Improves with Age, So Smile

**AVERAGE LIFE SATISFACTION**

Score on a 1-7 scale

- **Average life satisfaction**
- **Female**
- **Male**

SOURCE: British Household Panel Survey

- **41-50**
Keeping Legal Minds Intact: Mitigating Compassion Fatigue Among Legal Professionals

Speakers: Linda Albert, LCSW, CSAC
Deborah Smith, JD
Gregory Van Rybroek, PhD, JD

Presentation Outline

I. Ethical Rules of Conduct Impacted by Attorney Impairment.
II. Defining compassion fatigue. What is it? How does it play out?
III. Interface between impairment and ethical violations.
IV. Review of the Research on Attorneys and Compassion Fatigue.
V. Mitigating compassion fatigue; what is the formula for staying fit to practice.

People often go to law school hoping to make the world a better place. Many lawyers pursue that goal – representing victims of domestic violence, defending those facing homelessness because of foreclosure, those accused of crime who also suffer from addiction or mental illness or assisting immigrants facing deportation, for example. Yet over time, this work can lead to compassion fatigue. Compassion fatigue is defined as the cumulative physical, emotional and psychological effects of being continually exposed to traumatic stories or events when working in a helping capacity. It has been studied extensively in social workers, nurses, doctors and therapists who work with victims of trauma. Recently researchers have begun to examine the impact upon legal professionals. This seminar will look at which legal professionals are most at risk, the development of compassion fatigue, the interface between attorney impairment and discipline and what individual and organizational measures can prevent and mitigate compassion fatigue.

LINDA ALBERT is a Licensed Clinical Social Worker and a Certified Alcohol and Drug Counselor. She received her Master’s Degree from UW-Madison in Social Work. She has professional assessment/treatment/referral competencies in the areas of addictions, eating disorders, depression, anxiety, trauma and illness impacted by stress. Linda has worked over the past 31 years as an administrator, consultant, trainer and psychotherapist in a variety of settings including providing services to impaired professionals. Linda has co-facilitated a research project on compassion fatigue and legal professionals resulting in two recent publications. She has done multiple presentations for conferences at the local, state and national level. Currently Linda is employed by the State Bar of Wisconsin as the Wisconsin Lawyers Assistance Program Manager.

DEBORAH M. SMITH received her bachelor’s degree from the University of Wisconsin - Milwaukee and her J.D. from UW-Madison. Ms. Smith attended the Program for Senior Executives in State and Local Government at Harvard’s JFK School of Government. She has
taught both substantive criminal law and criminal procedure at the University of Wisconsin Law School. Ms. Smith began work with the Wisconsin State Public Defender in 1980. She is now retired and has recently begun writing fiction.

Ms. Smith has been active with the State Bar of Wisconsin. She served two terms on the State Bar’s Board of Governors. She is currently serving on the Wisconsin Lawyer Assistance Program committee and the Wisconsin Lawyers Fund for Client Protection. Ms. Smith served an integral part in facilitating a research project on compassion fatigue and legal professionals.

DR. GREGORY VAN RYBROEK is currently Director of the Mendota Mental Health Institute in Madison and the Mendota Juvenile Treatment Center. In addition, he is an active member of the State Bar. Dr. Van Rybroek received his Ph.D. in Psychology from the UW-Madison and his J.D. degree from the UW-Madison Law School. He is an Adjunct Professor at the UW Law School, Adjunct Associate Professor in the UW-Madison Department of Psychology, and Adjunct Clinical Professor in Psychology in the UW-Madison Department of Psychiatry, and Clinical Professor of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin in Milwaukee, specializing in psycho-legal issues. Dr. Van Rybroek has authored multiple articles on clinical-legal topic areas, and frequently presents at state and national conferences. In his capacity as a licensed psychologist, he carries out private forensic assessments for the courts and attorneys. Dr. Van Rybroek serves on the Wisconsin Lawyers Assistance Program Committee.
Seminar Outline
Keeping Legal Minds Intact: Mitigating Compassion Fatigue Among Legal Professionals

I. DISCIPLINARY RULES

A. Rule 1.1. Competence

A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

B. Rule 1.3. Diligence

A lawyer shall act with reasonable diligence and promptness in representing a client.

C. Rule 1.4 Communication

(a) A lawyer shall:

(1) Promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in rule 1.0(e), is required by these rules;

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of the matter;

(4) promptly comply with reasonable requests by the client for information; and

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

C. Rule 1.16. Declining or terminating representation

(a) Except as stated in par. (c), a lawyer shall not represent a client or, where representation has commenced, shall withdraw from the representation of a client if:

(1) the representation will result in violation of the Rules of Professional Conduct or other law;

(2) the lawyer's physical or mental condition materially impairs the lawyer's ability to represent the client; or

(3) the lawyer is discharged

(b) Except as stated in paragraph (c), a lawyer may withdraw from representing a client if:

(1) withdrawal can be accomplished without material adverse effect on the interests of the client;

(2) the client persists in a course of action involving the lawyer's services that the lawyer reasonably believes is criminal or fraudulent;

(3) the client has used the lawyer's services to perpetrate a crime or fraud;
(4) the client insists upon taking action that the lawyer considers repugnant or with which the lawyer has a fundamental disagreement;

(5) the client fails substantially to fulfill an obligation to the lawyer regarding the lawyer's services and has been given reasonable warning that the lawyer will withdraw unless the obligation is fulfilled;

(6) the representation will result in an unreasonable financial burden on the lawyer or has been rendered unreasonably difficult by the client; or

(7) other good cause for withdrawal exists.

(c) A lawyer must comply with applicable law requiring notice to or permission of a tribunal when terminating a representation. When ordered to do so by a tribunal, a lawyer shall continue representation notwithstanding good cause for terminating the representation.

(d) Upon termination of representation, a lawyer shall take steps to the extent reasonably practicable to protect a client's interests, such as giving reasonable notice to the client, allowing time for employment of other counsel, surrendering papers and property to which the client is entitled and refunding any advance payment of fee or expense that has not been earned or incurred. The lawyer may retain papers relating to the client to the extent permitted by other law..

II. MEDICAL INCAPACITY

SCR 21.17. Medical incapacity suspension, conditions

The license of an attorney to practice law may be suspended indefinitely or conditions may be imposed on the attorney's practice of law with the attorney's consent or upon a finding that the attorney has a medical incapacity, pursuant to the procedure set forth in SCR chapter 22.

III. REPORTING

Rule 8.3 Reporting Professional Misconduct

(a) A lawyer having knowledge that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate professional authority.

(b) A lawyer having knowledge that a judge has committed a violation of applicable rules of judicial conduct that raises a substantial question as to the judge's fitness for office shall inform the appropriate authority.

(c) This rule does not require disclosure of any of the following:

(1) Information otherwise protected by Rule 1.6.

(2) Information acquired by one of the following:

(i) A member of any committee or organization approved by any bar association to assist ill or disabled lawyers where such information is acquired in the course of assisting an ill or disabled lawyer.

(ii) Any person selected by a court or any bar association to mediate or arbitrate disputes between lawyers arising out of a professional or economic dispute.
involving law firm dissolutions, termination or departure of one or more lawyers from a law firm where such information is acquired in the course of mediating or arbitrating the dispute between lawyers.

(a) A lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate professional authority.

(b) A lawyer who knows that a judge has committed a violation of applicable rules of judicial conduct that raises a substantial question as to the judge's fitness for office shall inform the appropriate authority.

(c) This Rule does not require disclosure of information otherwise protected by Rule 1.6 or information gained by a lawyer or judge while participating in an approved lawyers assistance program.

V. UNDERSTANDING COMPASSION FATIGUE AND MENTAL HEALTH CONDITIONS WHICH CORRELATE WITH ATTORNEY DISCIPLINE

A) Development of compassion fatigue
B) Interface with ethical violations and attorney impairment

VI. ATTORNEY RESEARCH SPECIFIC TO COMPASSION FATIGUE

A) Overview of the Wisconsin Study
B) Applications to organizations and practitioners

VII. BEST PRACTICES FOR STAYING FIT TO PRACTICE

A) Research on Attorneys health and well being
B) Prevention of ethical violations through prevention of impairment

APPLICABLE CASE LAW

1. Alcohol Cases

In re Disciplinary Action Against Glasser, 831 N.W.2d 644 (2013)

Glasser pled guilty to, and was convicted of, two counts of misdemeanor theft by swindle. Glasser had allegedly made $31,000 in unauthorized charges on her deceased father’s credit card account. The Director of the Office of Lawyers Professional Responsibility petitioned for disciplinary action alleging that Glasser committed a criminal act that reflected adversely on her honesty, trustworthiness, or fitness as a lawyer in other respects. Glasser presented evidence of her severe and chronic alcohol dependency at her disciplinary hearing. She called a clinical psychologist who testified regarding the extent of Glasser’s alcohol dependency and that Glasser was in full recovery. The psychologist stated that Glasser’s alcohol dependency played a role in her misconduct because “alcoholism impairs money management.” The psychologist further stated that Glasser would habitually black out and, as a result, neglect her disabled child. The psychologist opined that Glasser was in full remission and, therefore, presented low risk of future misconduct. At the hearing, witnesses
testified to the fact that Glasser was serious about her sobriety and participated in Alcoholics Anonymous (“AA”) and Lawyers Concerned for Lawyers. However, the Court found that Glasser’s alcoholism did not cause her misconduct and therefore failed the test to be an independent mitigating factor. Nonetheless, the Court looked at the extreme stress in Glasser’s life as a mitigating factor which encompassed her alcoholism as it related to causing her stress and financial instability. Under a totality of circumstances relating to extreme personal stress, including alcoholism, the Court found Glasser entitled to mitigation. The Court sanctioned Glasser to a thirty (30) day suspension to be followed by five (5) years of supervised probation if Glasser is reinstated. Glasser was ordered to maintain total abstinence from alcohol and mood altering drugs except as prescribed by a physician, attend AA or another approved support program, provide proof of attendance to the Director and submit to periodic urinalysis drug screening.

In re Disciplinary Action Against Nipper, 825 N.W.2d 119 (2013)

The Director of the Office of Lawyers Professional Responsibility filed a petition alleging professional misconduct against Nipper after he pled guilty to six criminal offenses, including disorderly conduct, violating his probation and a no-contact order, and DWI. Additionally, the petition alleged that Nipper neglected a client matter, failed to communicate with a client, and failed to return a client’s property. Nipper unconditionally admitted the allegations in the petition. Nipper was suspended for a minimum of ninety (90) days with conditional reinstatement. The reinstatement conditions included establishing an ongoing relationship with a treating physician and compliance with any recommend care, regularly attend and verify his attendance at Alcoholics Anonymous or an equivalent group, and comply with any recommended psychological and/or chemical dependency treatment or care. Additionally, if Nipper was reinstated, he would be subject to four (4) years’ probation with strict conditions relating to his sobriety, treatment and care, and cooperation with the Director.

Iowa Supreme Court Attorney Disciplinary Bd. V. Cannon, 821 N.W.2d 873 (2012)

The underlying actions for Cannon’s misconduct occurred over a three year period. Cannon was convicted of possession of cocaine in 2009, of operating a motor vehicle while intoxicated (“OWI”) in 2010, and convicted of operating a boat while intoxicated in 2011. Cannon was charged with misconduct by committing a criminal act(s) that reflected adversely on his honesty, trustworthiness, or fitness as a lawyer in other respects. Cannon claimed that his alcoholism and depression were factors in his offending conduct. The Court accepted that both depression and alcoholism were factors in Cannon’s criminal conduct. Cannon had two operating while intoxicated offenses (motor vehicle and boat) and his conviction of cocaine possession appears to have been the result of a search incident to an arrested for public intoxication where the officers found a bag of cocaine on his person. Cannon sought and complied with treatment through a variety of sources, including two (2) years of addiction counseling, participation in Alcoholics Anonymous, assistance from a lawyer’s assistance program, and a holistic Catholic-based substance abuse problem. Cannon’s acceptance of reasonability and demonstrations of remorse were accepted by the Court as mitigating factors. The Court suspended Cannon’s license to practice law for thirty (30) days.

In re Reinstatement of Sanger, 288 P.3d 935 (2012)

The Court held that Sanger carried his burden of showing that he was deserving of reinstatement. Sanger had previously resigned from the bar pending a disciplinary proceeding and the Court accepted his resignation. Sanger was investigated for multiple grievances resulting from his chronic alcoholism and failure to properly attend to his client’s affairs. Sager allegedly furnished an alcoholic beverage to a person under the age of twenty-one (21), was charged with a felony count of driving under the influence of alcohol, transported a firearm while under the influence of alcohol, forged his AA signatures, had an inappropriate relationship with a client, as well as other actions amounting to misconduct. Sanger entered and successfully completed a ninety (90) day inpatient alcohol treatment program. Further, he had maintained uninterrupted and total sobriety since 2007. Sanger maintained work as a law clerk pending his reinstatement, participated in Alcoholics Anonymous (“AA”), and the Lawyers Helping Lawyers program. Sager conceded he was an
alcoholic and was open and cooperative. Further, at the time of the opinion, Sager was in full recovery and involved with the Lawyer’s Helping Lawyers program. The Court determined that he was fit for reinstatement to the bar.

In re Vondersaar, 974 N.E.2d 1018 (2012)

Under the terms of a consent agreement with the State Board of Law Examiners, Vondersaar was conditionally admitted to the Indiana bar. Vondersaar’s conditional admission included a requirement that he refrain from the use of alcohol, have no arrests for any criminal offense, and have no alcohol related incidents for a period of three (3) years starting on the date of his admission. Approximately five months from the date of his admission, Vondersaar was arrested for and later pled to operating a vehicle while intoxicated (OWI). At the time of his arrest, Vondersaar’s blood alcohol level was .31. In addressing his OWI, the Court suspended Vondersaar for ninety (90) days for violating the consent agreement. Upon the termination of the ninety (90) days suspension, Vondersaar would have been reinstated to his conditional admission status. However, during his suspension period Vondersaar continued to practice law. The Commission petitioned the Court and Vondersaar’s license was revoked. Vondersaar was barred from submitting a new application to the Bar of Indiana for a period of eighteen (18) months.

Wright v. Kentucky Bar Association, 390 S.W.3d 797 (2013)

Wright petitioned the Court to impose a thirty (30) day suspension probated for three (3) years conditioned on participation in the Kentucky Lawyers Assistance Program (KYLAP”) and the program’s monitoring agreement as a sanction for his various ethical violations. Wright negotiated the proposed discipline with the Kentucky Bar Association (KBA) and the KBA did not object his motion. Wright failed to competently represent a client, engaged in conduct intended to disrupt a tribunal, and committed a criminal act that reflected adversely on his honesty, trustworthiness, and fitness as a lawyer. The violations stem from a series of alcohol related offenses: (1) Wright was found in contempt of court for making an appearance in circuit court while intoxicated, (2) Wright was arrested and charged with alcohol intoxication while on his way to meet with a client, and (3) Wright was charged with one count of driving under the influence (Wright pled guilty to an amended charge). The Court accepted the proposed sanction as appropriate; however, the Court noted Wright’s “troubling pattern of alcohol-related behavior” warranted compliance with KYLAP.

Stark City Bar Assn. V. Zimmer, 135 Ohio St.3d 462 (2013)

Zimmer’s misconduct stemmed from a multitude of violations relating to operating a vehicle and repeated failures to make required appearances in a personal capacity. In 2011, Zimmer crashed his car into a parked vehicle and a building and fled the scene. Zimmer was later arrested and, while in custody, it was discovered that he had an outstanding bench warrant related to a failure to appear in open court in 2008. Additionally, Zimmer had been arrested in 2006 for operating a motor vehicle while intoxicated. Zimmer failed to appear at his hearing and a bench warrant was issued. In 2012, after roughly six years, Zimmer pled guilty and was sentenced to home arrest. Two months later, Zimmer failed to check-in with his supervisor and a bench warrant was issued for his arrest. Zimmer and the Board suggested to the Court that “Zimmer’s ‘sporadic interaction’ with the Ohio Lawyers Assistance Program (“OLAP”) may be relevant to mitigation.” However, the Court stated that there was no documentation, formal diagnosis, or other evidence that Zimmer was enrolled in a treatment program. The Court determined that Zimmer’s contacts with the OLAP were not a mitigating factor. However, the Court stated that Zimmer’s record of alcohol-related traffic offenses suggested that he had untreated substance abuse issues. The Court indefinitely suspended Zimmer and conditioned his reinstatement upon proof of compliance with an established substance abuse program due to the strong likelihood that he suffered from substance abuse and/or a mental disorder.

2. Drug Cases
In re Disciplinary Proceedings Against Compton, 347 Wis.2d 290 (2013)

In 2009, Compton was convicted of two felonies including felony possession of narcotic drugs (heroin) and had a misdemeanor criminal possession of cocaine dismissed but read-in. Compton stipulated to, and received, a two year suspension retroactive to his previous summary suspension. In 2012, Compton applied for reinstatement and the Office of Lawyer Regulation ("OLR") did not oppose it. The Court stated that Compton had met all of the standards required for reinstatement. The manager of the Wisconsin Lawyers Assistance Program ("WisLAP") worked with Compton during his first year of voluntary monitoring. The WisLAP manager noted that Compton had done an exemplary job in fulfilling his obligations under his monitoring contract and had a low risk of relapsing given his extended period of sobriety. Compton successfully complied with his treatment plans and passed his drug and alcohol tests. Further, according to the WisLAP manager, Compton extended his voluntary monitoring for an additional four years (for a total of five years) with a termination date in 2014. The Court agreed with the referee and reinstated Compton. However, the Court conditioned Compton’s reinstatement on his continued participation in a WisLAP monitoring program for a two (2) year period from the date of reinstatement.

In re Meek, 295 Kan. 1160 (2012)

In 2009, Meek was indicted and charged in federal court with knowingly and intentionally aiding and abetting the manufacture of marijuana, knowingly and intentionally maintaining a place for the purpose of manufacturing marijuana, and knowingly and unlawfully possessing Hydrocodone. Meek eventually pled guilty to knowingly and unlawfully possessing Hydrocodone. In his plea agreement, Meek provided that he purchased hydrocodone tablets from a client. Meek committed misconduct for having a conflict of interest with a current client and for committing a criminal act that reflected adversely on his honesty, trustworthiness or fitness as a lawyer in other respects. In 2011, Meek entered into a five (5) year Substance Abuse Monitoring Contract with the Kansas Lawyers Assistance Program (KALAP). Thereafter, Meek was sentenced in his criminal case to two (2) years of federal probation subject to certain conditions. In the ethics matter, Meek was suspended for forty (40) months. After completing twelve 12 months of supervision, the remaining twenty-eight (28) months were to be stayed with Meeks to be placed on probation for twenty-eight (28) months subject to conditions which included abstinence, aftercare, alcohol and drug evaluation, drug screenings and monitoring.

In re Alderman, 110 So.3d 545 (2013)

In 1994, Alderman began to experience severe neck and chest pain due to nerve damage suffered during a surgical procedure. Alderman took pain medications and eventually became addicted to Oxycontin. He eventually sought treatment. However, in 2009, Alderman was charged with possession with intent to deliver and misdemeanor possession of cocaine. He pled guilty to the possession charge and participated in a rehabilitation program. Around the same time, Alderman voluntarily ceased the practice of law. He underwent treatment for drug addiction but was charged with possession of a controlled substance and obstructing an officer soon thereafter. Alderman voluntarily admitted himself to a ninety (90) day drug addiction program and upon completion remained in an outpatient program. At the mitigation hearing, Alderman had multiple witnesses including a drug abuse counselor and a police officer testify to the fact that Alderman had been drug free and was an asset to others with addiction issues. The Court accepted the recommendations of the Board and sanctioned Alderman by suspending him from the practice of law for two (2) years. The Court mandated daily attendance at a twelve-step program evidenced in writing, enrolling in regular counseling sessions for two (2) years, thirty (30) hours of service to the Lawyers Assistance Committee over two (2) years, and random drug screening on two-hour notice for two years. The suspension of his license was split with one (1) year served retroactively based on his voluntary withdrawal from practice and one (1) year to be held in abeyance pending two (2) years of supervised practice.
In re Muse, 980 N.E.2d 838 (2013)

The Indiana Supreme Court Disciplinary Commission (“Commission”) sought an interim suspension of Muse’s license because she was found guilty of a felony. Muse entered a guilty plea to one felony count of possession of marijuana. Muse violated the Indiana Profession Conduct Code when she committed a criminal act that reflected adversely on her trustworthiness or fitness as a lawyer. The parties cited that Muse executed a monitoring agreement with the Indiana Judges and Lawyers Assistance Program (“JLAP”) as a mitigating factor. The Court suspended Muse for one hundred and eighty (180) days with thirty (30) days to be actively served and the remainder stayed for two (2) years of probation with conditions.

In re Macedonio, 103 A.D.3d 154 (2013)

Macedonio engaged in illegal conduct that reflected adversely on his honesty, trustworthiness, or fitness as a lawyer. In 2008, Macedonio entered a plea of guilty to one (1) felony count of criminal possession of a controlled substance. In 2012, Macedonio was permitted to withdraw his plea of guilty and entered a plea of guilty to one (1) misdemeanor count of criminal possession of a controlled substance. Macedonio completed intensive rehabilitation and maintained his abstinence. The Court suspended him for a period of two years. The effective date of the suspension was the date of his plea in 2008. However, the Court actually reinstated Macedonio based on the passage of time and the evidence in the record.

3. Mental Health Cases

Cincinnati Bar Assn. v. Britt, 133 Ohio St.3d 217 (2012)

Britt stipulated to a variety of violations of the Rules of Professional Responsibility and the Board recommended an indefinite suspension and an order to make full restitution to affected clients. The Cincinnati Bar Association (“Bar”) objected to the Board’s recommendation citing a need for stricter punishment due to the nature and extent of the misconduct. Britt’s misconduct was based on him having deposited unearned client fees into his operating account, treating flat fees as earned upfront, failing to deliver or pursue certain agreed work, charging excessive fees, and aiding in the unauthorized practice of law. The Bar sought permanent disbarment as an appropriate sanction. The Court accepted the Board’s recommendation and added to the sanction that Britt would have to complete twelve credits of CLE relating to law-office and trust-account management prior to seeking reinstatement. Additionally, the Court required one (1) year of monitoring upon his reinstatement. Britt presented his diagnosis of depression as a mitigating factor. However, the evaluating psychiatrist opined that Britt’s depression was not so severe as to substantially impair his ability to practice law. The Court stated that Britt failed to demonstrate that his depression was a mitigating factor.

Cleveland Metro. Bar Assn. v. Pryatel, 135 Ohio St.3d 410 (2013)

The Cleveland Metropolitan Bar Association charged Pryatel with a variety of counts of misconduct. Pryatel initially cooperated with the investigation and received a certified notice of the complaint. However, Pryatel failed to answer the complaint. The Board recommended permanent disbarment as the appropriate sanction for Pryatel’s misconduct. Pryatel filed motions to remand for a hearing and to supplement the record while the Board’s final report was pending. Pryatel argued that a previously “undiagnosed psychological issues interfered with his capacity to defend himself against the disciplinary charges.” The Court remanded the case to the Board and limited its review to the consideration of Pryatel’s mitigation evidence and to supplement the record. Based on the new mitigating evidence, the Board reduced its recommendation to an indefinite suspension. The Board previously found Pryatel’s failure to cooperate with the investigation to be an aggravating factor. Pryatel cited undiagnosed general anxiety disorder and major depressive disorder as the reason for his failure to answer the complaint. His diagnosing psychiatrist concluded that his depression was in remission and that he was capable of returning to the ethical and competent practice of law as
long as he continued to receive treatment for his condition. Pryatel entered into a three (3) year contract with the Ohio Lawyers Assistance Program (“OLAP”). His OLAP program required group therapy, individual counseling, and contact with OLAP at least three (3) times a week. However, the Court found that Pryatel’s mental health issues were not a mitigating factor. The Court noted that Pryatel’s psychiatrist concluded that his mental disorders contributed to his failure to answer the complaint, not that the disorders contributed to his professional misconduct. The Court agreed with the Board and imposed indefinite suspension as the sanction for the misconduct. The Court further conditioned Pryatel’s reinstatement on his compliance with his OLAP contract, obtaining mental health treatment for his mental health issues, and fulfilling treatment and reporting conditions of OLAP and his treating psychiatrist.

**Disciplinary Counsel v. Bogdanski, 135 Ohio St. 3d 235 (2013)**

In 2011, Bogdanski was charged with multiple ethical violations. Bogdanski twice forged and notarized a client’s signature, showed a propensity for dishonesty when she repeatedly made excuses to her clients explaining her failure to communicate with them, failed to diligently pursue her clients’ matters, and failed to competently represent her clients. Although it does not appear that Bogdanski submitted evidence to the panel or the Board relating to any mitigating factors, disciplinary counsel testified that Bogdanski informed him that she suffered from mental health issues and had issues regarding prior drug use. The Court indefinitely suspended Bogdanski with conditions on her reinstatement. The Court conditioned Bogdanski’s reinstatement on entering into a contract with Ohio Lawyers Assistance Program (“OLAP”) or a health-care professional appointed by the relator. Additionally, Bogdanski would have to complete a substance abuse and mental health evaluation as well as comply with the recommendations of OLAP or the treating health care professional.

**Disciplinary Counsel v. Hilburn, 135 Ohio St. 3d 1 (2012)**

Hilburn was charged with multiple violations of the Rules of Professional Conduct including neglecting client matters, lack of responsiveness to client requests for information and documents, conduct prejudicial to the administration of justice and failure to cooperate with a disciplinary investigation. The parties stipulated to the facts, certain violations (with other dismissed), aggravating and mitigating factors, and the documents related thereto. The Court adopted the panel’s findings and adopted the stipulated sanction.

In the second count against Hilburn, a lower court judge found Hilburn in contempt and indicated that he would forward the transcript of the hearing to the disciplinary counsel’s office. Hilburn responded by stating that she was already in contact with the Ohio Lawyers Assistance Program (“OLAP”) and, therefore, the judge need not contact disciplinary counsel. However, Hilburn had not requested assistance from OLAP prior to her statement.

Of the parties stipulated aggravating and mitigating factors, Hilburn’s documented mental disability was discussed in the most detail. Hilburn’s OLAP contract was presented as well as testimony from an OLAP employee. Hilburn’s treating health-care profession was a nurse practitioner. The nurse practitioner, in her professional opinion, stated that with a reasonable degree of certainty Hilburn’s depression rendered her unable to function on a professional level and contributed to the actions underlying her misconduct. The panel questioned whether or not the opinions of a certified nurse practitioner can support a finding of mental health as a mitigating factor.

The Court agreed that the nurse practitioner had the competency and experience in making diagnoses of depression to give a professional opinion in support of finding mental disability as a mitigating factor. The Court stated Hilburn’s mental health disability was a mitigating factor. The Court adopted the stipulated sanction of eighteen (18) month suspension with twelve (12) months stayed on conditions. The conditions included Hilburn remaining in compliance with her OLAP contract and treatment recommendations of her mental health-professionals. Further, Hilburn’s reinstatement was
conditioned on a certification that she is able to return to competent, ethical and profession practice of law by a qualified psychiatrist.


Weisel was asked by a client to commence a civil action. However, Weisel did not file the action and in an attempt to cover his tracks produced a fraudulent stipulation of settlement to his client. Weisel used a fictional index number, caption, and settlement amount. Further, Weisel forged another attorney's name at the bottom of the stipulation. Weisel then filed a valid complaint in Small Claims Court before his client discovered the stipulations were fraudulent. The other attorney learned of Weisel's dishonesty. Weisel then wrote letters to his client and the other attorney and claimed that he “suffered from an ‘addiction [to] lying’ that he analogized to an addiction to drugs or alcohol.” The Court ordered a nine (9) month suspension and that Weisel take and pass the New York State bar exam ethics section prior to seeking readmission. Additionally, the Court ordered Weisel to appropriately address his pathological behavior.

**Disciplinary Counsel v. Leksan, 136 Ohio St.3d 85 (2013)**

Leksan was charged with twenty-two (22) violations of the Rules of Professional Conduct based on various improprieties related to his handling of his client trust account. At a hearing before a panel of the Board Leksan testified to his long-term depression and gambling addiction. The full Board adopted the panel's findings and recommended sanction. The Court adopted the Board's findings of fact and indefinitely suspended Leksan and placed conditions on his reinstatement. Among other things, Leksan failed to maintain the proper accounting of his client’s funds, deposited personal funds in the trust account, used trust funds for personal and business expenses, used individual client funds to pay other clients, and used trust account funds to make loans of more than $30,000 to friends. Leksan was a recovering gambling addict and struggled with an alcohol addiction. He had engaged in treatment for those and other issues for over ten (10) years. The record contained a letter from a psychiatrist who stated that he treated Leksan for depression and low self-esteem for more than ten years. The psychiatrist further stated that Leksan desired to be “associated with people in a higher socio-economic class and spending beyond his means, led to his mismanagement of his personal and professional accounts.” The psychiatrist also stated that Leksan used gambling as a distraction and believed that his gambling was a way to resolve his debts. Further, the psychiatrist stated that Leksan joined Gamblers Anonymous, Alcoholics Anonymous, and the Ohio Lawyer Assistance Program (“OLAP”) to address his gambling and alcohol additions in 2009. The psychiatrist believed that Leksan could successfully and responsibly practice law in the future based on his progress, new skills, new support system, and a continued commitment to treatment. The Court accepted Leksan’s depression, alcohol addiction, and gambling addictions as mitigating factors. The Court sanctioned Leksan to an indefinite suspension with his reinstatement conditioned upon, among other things, proof that he complied with his OLAP contract and recommendations of his treating professionals.
The Toll of TRAUMA

by Dianne Molvig

A groundbreaking study of Wisconsin State Public Defender attorneys examines the effects of “compassion fatigue” – the cumulative physical, emotional, and psychological effects resulting from continual exposure to others’ traumatic experiences. This article discusses factors contributing to the risk any lawyer may face of experiencing its symptoms, and what can be done to mitigate it.

Ben Gonring spends his days representing 10 to 17 year olds who are in trouble with the law. After 15 years in the juvenile unit of the Wisconsin State Public Defender (SPD) Office in Madison, he says the best part of his job is getting to know his young clients well, so he can be an effective advocate for them in court. But gaining that knowledge also has a dark side.

“When you dig into these kids’ stories,” he says, “you realize what sort of life they’re living and the trauma they see every single day. On the one hand, you marvel at their ability to survive. On the other hand, it makes you so sad. You learn about a lot of bad stuff, and you have to try to process that every day. It’s hard. Really hard.”

Judy Schwaemle retired from the Dane
Taking a break from her work as a public defender in Milwaukee, Yvonne Vegas says awareness is the first thing lawyers need to mitigate the effects of clients’ trauma in their personal lives. “Lawyers need to know that what they’re feeling is real and that it’s something they can discuss – that they don’t have to feel embarrassed or ashamed for feeling this way. That’s a step in the right direction.”
Key Study Findings

The study found that SPD attorneys reported significantly higher levels of compassion fatigue than administrative support staff and the general population, when data for the latter were available for comparison. The study’s findings break down by specific symptoms of compassion fatigue as follows.

“A major finding of our study,” Dr. Andrew Levin reports, “is that the extent of caseload and lawyers’ exposure to other people’s trauma were clearly related to symptoms of compassion fatigue.” Interestingly, factors such as years on the job, age, office size, gender, and personal history of trauma made no significant differences in compassion fatigue levels.

Depression
Depressed mood, loss of interest or pleasure, disturbed sleep, loss of appetite, low energy, poor concentration, feelings of guilt or low self-worth
• General population: 10 percent
• SPD administrative support staff: 19.3 percent
• SPD attorneys: 39.5 percent

Post-traumatic Stress Disorder
PTSD, triggered by a terrifying event; symptoms include flashbacks, nightmares, severe anxiety, uncontrollable thoughts
• General population: 7 percent
• SPD support staff: 1 percent
• SPD attorneys: 11 percent

Functional Impairment
The extent to which exposure to traumatic material interferes with functioning in work, social/leisure life, and family/home life
• SPD support staff: 27.5 percent
• SPD attorneys: 74.8 percent

Secondary Traumatic Stress
The “cost of caring” about another person who has experienced trauma; symptoms are similar to those of PTSD
• SPD support staff: 10.1 percent
• SPD attorneys: 34 percent

What the Numbers Mean

Are we to conclude from the key findings that SPD attorneys are impaired on the job? Absolutely not, says Dr. Andrew Levin, medical director at the Westchester Jewish Community Center in Hartsdale, N.Y., and cofacilitator of the study. Bear in mind, he emphasizes, these results come from self-reporting instruments, which indicate trends, not diagnoses of conditions.

Take, for instance, the depression statistic. “It shows that almost 40 percent of attorneys are over the threshold number on the depression inventory,” Levin explains. “That does not mean they have a clinical diagnosis of depression. All it means is that they have a likelihood for being at risk for depression.”

Likewise, the functional impairment measure doesn’t mean SPD lawyers are failing to function well on the job. “It may mean, for example, that you had a tough day at work,” Levin explains, “and when you got home you weren’t able to pay as much attention to your family as you would have liked, or you were irritable. Your job is interfering with your home life.”

If anything, the data show just how resilient the study participants are, Albert points out. “Despite the fact that they endure ongoing exposure to trauma and have these high caseloads, they continue to meet the requirements of their employment,” she says. “It’s amazing that they do. They are handling the demands of the job, but not easily and not without it having an impact on their lives.”
County District Attorney’s Office last year after 27 years. Many times in her career, she saw horrifying evidence of what one human did to another. Those disturbing images often lingered and intruded into her thoughts away from work. Even now that she’s retired, memories remain.

“To this day,” she says, “when I go past a place where a homicide occurred that I prosecuted, I think about it, every time. I drive past and think, that’s where Sarah was killed.”

Experiences such as these can take a toll on lawyers. Recently, the State Bar of Wisconsin undertook a study to learn just how significant that toll is and what can be done to mitigate it.

The study examined the prevalence of what’s known as “compassion fatigue” — that is, the cumulative physical, emotional, and psychological effects of continual exposure to traumatic stories or events when working in a helping capacity.

On a late fall day, State Public Defender lawyers Ben Gonring and Deb Smith talk about how the nature of their jobs may contribute to compassion fatigue. “When you dig into kids’ stories, you realize what sort of life they’re living and the trauma they see every single day. … You learn about a lot of bad stuff, and you have to try to process that every day,” says Gonring, who represents juveniles.

“It’s hard. Really hard.”

Smith, SPD director of assigned counsel, agrees. “Many of us who have been around for a while know there can be a cost, emotionally and psychologically, to doing this kind of work. Even for lawyers who know how to maintain an appropriate professional demeanor and distance, this stuff seeps in. It changes your perspective on the world.”
In psychological language, exposure to another person’s trauma is referred to as secondary trauma. “There’s research on the impact of secondary trauma on human beings, but it’s never been looked at extensively with lawyers. We’re on the forefront of this,” says Linda Albert, coordinator of the State Bar’s Wisconsin Lawyers Assistance Program (WisLAP) and cofacilitator of the compassion fatigue study.

Research exists on the effects of stress on attorneys, and some researchers have used some of the language related to compassion fatigue. “But no one has studied it systematically,” says Dr. Andrew Levin, medical director at the Westchester Jewish Community Center in Hartsdale, N.Y., who facilitated the study with Albert. “So this was an effort to say, ‘People have made these observations. They seem to have some validity. Can we establish that more rigorously?’”

Roots of the Study
As WisLAP coordinator, Albert has given presentations about compassion fatigue to many groups of legal professionals in recent years. She’s seen the topic hit home again and again with various audiences.

“I’ve done this with bankruptcy lawyers, guardians ad litem, public defenders, prosecutors, judges, court commissioners. … Every time it’s resonated,” she says.

Levin and Albert learned of their mutual interest in the topic of compassion fatigue and decided to do a formal study of its effects on Wisconsin attorneys. They decided to focus on one specific group: state public defenders.

“Compassion fatigue is an important issue,” says Deb Smith, director of assigned counsel for the SPD and the agency’s point person for the study. “Many of us who have been around for a while know there can be a cost, emotionally and psychologically, to doing this kind of work. We deal with a lot of unpleasantness. Even for lawyers who know how to maintain an appropriate professional demeanor and distance, this stuff seeps in. It changes your perspective on the world.”

To learn more about such effects, study questionnaires went out to a total of 474 SPD attorneys and administrative support staff. Response rates for completed surveys were remarkable: 78 percent of attorneys and 65 percent of support staff.

While the study’s target group was public defenders, Smith believes it will have value for the profession as a whole. “There’s a large community of lawyers who deal with trauma-exposed clients and who need to be aware of compassion fatigue,” she says. “These lawyers need to make sure they’re taking care of themselves. This isn’t just a public defender issue; it’s a lawyer issue.”

Count judges among those affected by compassion fatigue, as well. Neal Nielsen, an eight-year veteran on the circuit court bench in Vilas County, says judges’ exposure to trauma differs from lawyers’. “Attorneys are much more closely related to the facts of the case for a much longer period of time than are judges,” he notes.

Still, judges sit on the bench hearing, day in and day out, about a procession of incidents of trauma inflicted or endured by people in their courtrooms. “And I can sit here now and call up in my mind with great accuracy all the autopsy photos I’ve ever seen,” Nielsen says.

In the Trenches
Dana Smetana sees a key message her fellow SPD attorneys ought to take away from the study results: “There’s nothing wrong with you. I think sometimes lawyers think they’re going crazy,” says Smetana of the SPD Eau Claire office, where her duties include trying cases as well as being a regional supervisor. She’s been with the SPD for 27 years. “If lawyers are feeling this
To this day, when I go past a place where a homicide occurred that I prosecuted, I think about it, every time. I drive past and think, that’s where Sarah was killed.

– Judy Schwaemle, Dane County assistant district attorney, retired

way, it’s the symptoms of what’s going on with this job. It’s nothing negative about you as a person. Awareness of that is a huge factor.”

As a supervisor, she knows young SPD lawyers must learn to put up protective boundaries, to keep their emotions in check. “The older attorneys get good at that,” she observes, “but then when they go home, they have trouble lifting those boundaries” with families and friends.

Not letting the effects of exposure to trauma spill over into one’s personal life is one of the most difficult aspects for lawyers, agrees Yvonne Vegas, a 22-year SPD veteran who’s now in the Milwaukee office. “Our clients have a lot of trauma in their lives: poverty, lack of education, homelessness, joblessness, mental health issues, substance abuse issues,” she says. “Their issues become ours. You absorb that on a day-to-day basis, and you take it home with you. It can make you irritable and short-fused with your family.”

Like Smetana, Vegas believes awareness of these dynamics is critical for lawyers exposed to clients’ trauma. “Lawyers need to know that what they’re feeling is real,” she says, “and that it’s something they can discuss – that they don’t have to feel embarrassed or ashamed for feeling this way. That’s a step in the right direction.”

Some observers, of course, might point out that public defenders and prosecutors know what they’re in for when they decide to pursue this type of law practice. True, says former district attorney Schwaemle. “You knew this would be coming,” she says. “But there’s knowing, and then there’s knowing.”

The effects can cut deeper than some might have imagined. Take, for instance, prosecuting a sexual assault case. “When you prepare for the trial,” Schwaemle says, “you put yourself in the place of the victim. You have to ask yourself why the victim behaved a certain way because you have to explain that to the jury. You relive the victim’s experience and put yourself in her shoes.”

Robert Kaiser also has seen “inexplicably, indescribably horrible evidence” in his 34 years as a district attorney, the last 24 of those in Dane

Coping with Compassion Fatigue

Exposure to clients’ trauma isn’t going to stop. But you can mitigate the effects this exposure has on you. Here are a few strategies:

• Debrief. Talk with another lawyer who understands what you’re going through and can offer support. Debriefing can become a part of the office culture. Remember, this is a discussion about how the case is affecting you as a person, not a rehashing of legal strategies.

• Take care of yourself. Eat healthy foods. Exercise regularly. Get enough sleep. Learn relaxation techniques so you can let go of stress and disturbing, repetitive thoughts. Know what truly brings you joy in life and make time for it.

• Strive for balance and interconnection. Give up the urge to be all things to all people, including clients. Allow time to connect with friends and family to counterbalance the stresses you feel at work and put everything back in perspective.

• Come up with a plan. When compassion fatigue is weighing on you, it can be difficult to get off the treadmill and set a new course. Stop long enough to notice how you’re feeling, reacting, and behaving at work and at home. Develop a plan of action for yourself. What needs to change? Where can you start?

• Seek help. If you think compassion fatigue is interfering with your work or personal life, reach out for help. A good place to start is WisLAP. Call the 24-hour helpline, at (800) 543-2625, or coordinator Linda Albert at (800) 444-9404, ext. 6172. All inquiries are confidential.
“We have to acknowledge what people in criminal justice, not just public defenders, go through. We need to recognize how difficult it is to see people in crisis every single day. And we have to be able to talk about it.”

– Kelli Thompson, State Public Defender

County and the remainder in Chicago. He never wanted to be anything but a district attorney, and he knew exposure to trauma would be part of the job.

“What you don’t expect,” Kaiser says, “is that as you’re trying to keep people safe – whether it’s keeping an individual safe from an abuser, or keeping society in general safe from a psychopath who will victimize anybody he can get his hands on – you won’t get the support you need to do your job.”

The combination of burgeoning caseloads and shrinking budgets makes it increasingly difficult for district attorneys to fulfill their duty to protect the public, Kaiser notes. In his eyes, lack of support sends a message that crime victims and the district attorneys’ work don’t matter.

“We’re saddened by our work,” he says. “We’re certainly affected by it. But when you live it and then people act as though what you do is not important, that’s trauma.”

Public defenders, too, are hurt by budget cuts. And they’re targets of public scorn for simply doing their job: defending people’s constitutional rights.

Thus, heavy caseload and exposure to trauma aren’t the only factors fueling compassion fatigue in attorneys. In the State Bar’s study, SPD participants wrote in comments about additional contributing factors. The top three were lack of respect, lack of control in one’s work life, and lack of enough time to process issues and give or get support.

“When you have those factors,” observes WisLAP’s Albert, “on top of exposure to trauma and heavy caseloads, that’s where I see the perfect storm.”

Next Steps
The State Bar’s study puts compassion fatigue on the legal profession’s radar. “We have to acknowledge what people in criminal justice, not just public defenders, go through,” says State Public Defender Kelli Thompson. “We need to recognize how difficult it is to see people in crisis every single day. And we have to be able to talk about it.”

Going forward, she says, the SPD will provide more staff training to educate people about compassion fatigue and to learn coping skills. Open day-to-day communication in the office is also critical, she says. “Our lawyers need to know it’s okay to take a breath,” she says. “You can’t live with a terrible case for a year, close it, and then just say, ‘On to the next one.’”

The results of the study, the first of its kind, appear in the December issue of the *Journal of Nervous and Mental Disease* and will draw wider attention to the topic of attorneys’ compassion fatigue. Albert already has spoken about it at a Canadian conference and for the national conference of the American Bar Association’s Commission on Lawyer Assistance Programs. In addition, Albert is working with the SPD to develop strategies that both individual attorneys and the agency can use to minimize work-related stress. She anticipates adapting these strategies for use by lawyers in other practice areas.

“I think these findings will be unsettling for the legal profession,” Albert says. “The implications of this study definitely will go way beyond Wisconsin.”

The State Bar is one of several bar associations participating in a second study that seeks information on factors, personal and professional, that contribute to life and career satisfaction or dissatisfaction. The study, to be conducted in May 2012, is headed by Dr. Kennon Sheldon, University of Missouri, Department of Psychology, and Prof. Lawrence Krieger, Florida State University College of Law. “WisLAP will use the data to develop ways to prevent and mitigate professionalism, ethics, and mental health and substance abuse problems within the profession,” Albert says.
Keeping Legal Minds Intact: Mitigating Compassion Fatigue among Government Lawyers

By Linda Albert*, LCSW, CSAC
WisLAP Coordinator

What is compassion fatigue?
There are several different terms often used to refer to the same phenomenon; to name a few: compassion fatigue, vicarious trauma, secondary traumatic stress, second hand shock and secondary stress reaction. Compassion fatigue is defined as the cumulative physical, emotional and psychological effects of being continually exposed to traumatic stories or events when working in a helping capacity. It has been studied extensively in social workers, nurses, doctors and therapists who work with victims of trauma. Recently researchers have begun to examine the impact upon legal professionals including lawyers doing criminal law or family law and judges. Compassion fatigue involves a cluster of symptoms such as, but not limited to, sleep disturbance, anxiety, intrusive thoughts, a sense of futility or pessimism about people, lethargy, isolation and irritability. The development of compassion fatigue involves neurophysiology and is best addressed from both the neurobiological and the social psychological research and perspectives.

Who is most at risk?
Levin et al (2003) found that attorneys and judges who work in the field of criminal or family law are considered at higher risk of developing compassion fatigue compared to those who work in other areas of the law. These legal professionals listen day after day to stories of human induced violence. They read and re-read detailed documentation of the traumatic material within cases. Attorneys are often times in long term relationships with their clients thereby witnessing the impact of the trauma upon their client or their clients’ victim. They observe domestic violence victims re-entering into risky environments without regard for safety and throughout their work with victims, offenders and the system are expected to perform at the top of their game without being impacted by the traumatic material. After all, lawyers are taught not to show weakness, to deny, defend and deflect vulnerability, while staying emotionally detached at all times.

The reality is that government lawyers are human beings. Any person regardless of professional competence can develop compassion fatigue. The struggle for government lawyers is the assumption (both their own and that of others) that they will not be impacted by the work that they do. The reality can be quite different. Lawyers that are exposed to traumatic stories and events may have physiological reactions

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such as increased heart rate, breathing rate and muscle tension. They can have emotional responses such as sadness, anger or fear. They may also experience changes in their assumptions about life, other people and issues of safety. Often lawyers will be unaware of these reactions or ignore or dismiss them as unimportant. These reactions are indicative of the physiological and psychological changes occurring within the mind/body due to the processes of empathy or identification, reactions of the autonomic nervous system and patterns of thinking. If left unchecked and unattended to these reactions wear on the mind and the body resulting in the above mentioned cluster of symptoms known as compassion fatigue. The results can be varying degrees of impairment for the attorney.

What places government lawyers at increased risk?
Levin et al. (2003) found that compared to mental health providers and social service workers attorneys who worked with domestic violence and criminal defendants had “significantly higher levels of secondary traumatic stress and burnout”. Researchers went on to state that this is likely due to higher case loads, lack of supervision or support and lack of education in regards to the impact of ongoing exposure to traumatic material and events. Osofsky et al. (2008) also identified similar organizational and job issues which contribute to the development of compassion fatigue. Factors included high caseloads, minimal support from supervisors, lack of peer support, excessive paperwork, inadequate resources to meet demands and limited job recognition. These researchers also reported the impact of compassion fatigue upon the work environment listing such issues as increased absenteeism, impaired judgment, low motivation, lower productivity and high staff turnover.

These factors coupled with the culture of practicing law may discourage government lawyers from recognizing the signs of distress, disclosing if they are struggling or prevent them from seeking assistance. In contrast social service and mental health workers are educated about the potential impact of the work upon their mental and physical health and are encouraged to talk about it and address how the work affects them in order to lessen the impact. This is often done in a safe, confidential and supportive environment. Government lawyers and their office managers universally state they do not have this provision built in to their work environment, that they are bound by confidentiality and would lack the resources, time or energy to create this environment for themselves. However, some recognize the need for it.

Those working as public defenders or prosecutors may identify with some of the above. For example, prosecutors or public defenders involved in a long, arduous trial are seldom afforded the time to replenish and restore themselves following the trial. Instead they are likely to go forward the next day into another formidable case without the ability to take pause and reflect upon how the work is impacting them physically, emotionally or mentally. One lawyer stated, “I am expected to operate like a machine, often getting notices to be at four places at the same time and go from trial to trial with no regard for what I can reasonable do or what the impact might be on myself as a professional or a person”. Another lawyer expressed, “I am supposed to take it all in and not be affected by it; it’s like mental battering”.

What can legal organizations do?
A review of the literature suggests that organizations that employ government lawyers first and foremost need to recognize and acknowledge that compassion fatigue exists and identify how it impacts the lawyer and the organization. Prevention strategies include reducing caseloads due to the correlation between high caseloads and the prevalence of compassion fatigue and educating government lawyers about what compassion fatigue is and how a person may be impacted while working with traumatic stories and events. Supervisors and managers would be astute to address this issue, educate their legal staff and encourage staff to debrief their high trauma cases on a regular basis in a supportive atmosphere. With the current culture of
budget deficits, limited space and resources and increasing caseloads it is imperative (albeit difficult) for managers and organizations to adopt a strategy of how offices can address and mitigate this versus why they cannot.

What can legal professionals do?
Whether an attorney, judge, doctor or a mental health professional the recommendations to mitigate or treat compassion fatigue are similar.

**Awareness.** It is important for government lawyers to understand what compassion fatigue is, be assessing for it through utilizing a survey, checklist or other instrument on a regular basis.

**Debriefing.** Talking on a regular basis with another government lawyer who understands and is supportive is seen as helpful. This involves talking about the traumatic material, how one thinks and feels about it, acknowledging how one is personally affected by it and putting a plan in place for balance.

**Balance.** Working on balance in all areas of one’s life is emphasized throughout the research on mitigating compassion fatigue. Because of the physiological changes that occur a holistic approach is best. Yes, this means establishing a healthy diet, sleep and exercise program (argh) which we all talk about but few of us actually attend to. Exercise and relaxation work can be beneficial in counteracting the impact on the autonomic nervous system. Working on healthy interpersonal relationships is also a good idea (even if we have been married or divorced a zillion years and live with small children, adolescents or have aging parents giving us the excuse to say “balance is impossible”). Most of us give up on finding balance as work and personal life just keeps pouring it on but the truth is there are probably steps we can take to simplify, to do less of, to ask for help or just plain stop trying to be all things to all people, including our clients. Sound familiar? Start thinking about how you can work on balance versus why you cannot.

**Be intentional.** If your life is out of whack, you have compassion fatigue, depression, anxiety, substance abuse problems or are just plain overwhelmed, put a plan in place for change. Work with your thoughts. Recognize and acknowledge that the skills you possess which contribute to your success as an attorney (motivated, perfectionist, achievement oriented, driven, fixer,) and the environment in which you work in may contribute to an imbalance in your life. Seeking balance encompasses a change in lifestyle which requires hard work addressing thoughts, emotions and behaviors. Intentionally seek assistance to help yourself implement change and redirect the thoughts that tell you, “I should be able to do this by myself”. Your new mantra can become, “I don’t have to do it all by myself”.

**The good news: WisLAP can be a resource specifically for you.**
If you want to consult with a mental health professional or work with a trained attorney consider calling the Wisconsin Lawyers Assistance Program (WisLAP). WisLAP specializes in understanding and addressing the issues which face today’s legal professionals. The program offers free in house educational sessions or one on one consultation or assistance for problems like compassion fatigue, depression, anxiety, addictions or other challenges.

**What is WisLAP?**
WisLAP is a member service of the State Bar of Wisconsin. The program utilizes trained Wisconsin judges and attorneys who provide confidential assistance to judges, lawyers, law students and their families. Each request for help is treated with the same confidentiality as the lawyer-client relationship. WisLAP is exempt
from reporting professional misconduct to the Office of Lawyer Regulation (OLR) or to the Judicial Commission. WisLAP does not ask callers to disclose their identity and does not keep case records. The program is designed to help members build on their strengths and provide support through the enhancement of physical, mental and emotional health. Confidential support is available 24/7 by calling 800-543-2625. Or contact Linda Albert, WisLAP Coordinator directly at 800-444-9404 ext 6172 or email jalbert@wisbar.org.

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Secondary Traumatic Stress in Attorneys and Their Administrative Support Staff Working With Trauma-Exposed Clients

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Abstract: Although secondary trauma has been assessed in various groups of mental health professionals, few studies, to date, have examined secondary trauma among attorneys exposed to clients’ traumatic experiences. This study examined indicators of secondary trauma among attorneys (N = 238) and their administrative support staff (N = 109) in the Wisconsin State Public Defender Office. Attorney participants demonstrated significantly higher levels of post-traumatic stress disorder symptoms, depression, secondary traumatic stress, burnout, and functional impairment compared with the administrative support staff. This difference was mediated by attorneys’ longer work hours and greater contact with clients who had experienced or had been directly involved with trauma. Sex, age, years on the job, office size, and personal history of trauma did not predict symptoms. These findings suggest a need to support attorneys experiencing these symptoms and to address high workloads as well as the intensity of contact with trauma-exposed clients.

Key Words: Attorneys, secondary traumatic stress, PTSD, depression, functional impairment, burnout.

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The phenomenon of Secondary Traumatic Stress (STS; Figley, 1995) or Vicarious Traumatization (VT; McCann and Pearlman, 1990) have been described since the mid-1980s, roughly coinciding with the growth in treatments focused on clients who were victims of trauma. Originally described in therapists, secondary trauma occurs when the professional develops intrusive thoughts, avoidance and withdrawal, and symptoms of tension and disturbed sleep related to exposure to traumatic material presented by the client (Figley, 1995). In addition, the professional may develop alterations in “basic assumptions” about themselves, people, society, and safety (McCann and Pearlman, 1990). In addition to STS and VT, professionals working intensely with clients develop Burnout (BO), an accumulation of stress and the erosion of idealism characterized by fatigue, poor sleep, headaches, anxiety, irritability, depression, hopelessness, aggression, cynicism, and substance abuse (Farber and Heifetz, 1982). In this study, we examined the impact of work with clients who have experienced or have been directly involved in trauma on attorneys and their administrative support staff in the Wisconsin State Public Defender Office.

Available research among mental health and social service providers has identified several risk factors for the development of STS and VT including female sex (Kassam-Adams, 1999), intensity of the exposure (Creamer and Liddle, 2005; Erikson et al., 2001; Kassam-Adams, 1999), history of previous trauma (Brady et al., 1999; Bride et al., 2007; Kassam-Adams, 1999), and less experience on the job (Pearlman and Mac Ian, 1995). Subsequent studies have suggested the primary importance of organizational and work-related factors compared with exposure (Baird and Jenkins, 2003; Devilly et al., 2009; Regehr et al., 2004) and have found no relationship with personal trauma history (Boscarino et al., 2004; Ortlepp and Friedman, 2002; Schnaube and Frazier, 1995). Risk factors for BO include female sex, overwork, the slow and erratic pace of the work, lack of success, and the tendency of the work to raise personal issues (Jenkins and Baird, 2002; Maslach et al., 2001).

Drawing on the concepts of STS and VT, the “clinical” (practice-related) law literature was the first to address the impact of lawyer-client relationship on the attorney (Meier, 1993; Silver, 1999) and the need for increased training of attorneys in managing the “face-to-face, long-term, and intensely personal relationship” that develops between client and attorney (Allegretti, 1993, p. 7). Early quantitative studies of attorneys focused on rates of depression, identifying a 20% rate of clinically significant depression in the attorneys who were surveyed (Benjamin et al., 1990; Eaton et al., 1990).

Only a handful of studies have attempted to characterize and quantify secondary trauma and BO symptoms experienced by attorneys and delineate their relationship to risk factors. Using semistructured interviews of 23 Canadian prosecutors working with “sensitive cases” involving domestic violence and incest, Gomme and Hall (1995) found symptoms of demoralization, anxiety, helplessness, exhaustion, and social withdrawal that were qualitatively linked to high caseloads and long work hours. Lynch (1997) reported that public defenders ranked work overload, the unpredictability of trials, the frequent lack of a defense, harsh sentences, arguing with prosecutors, and interactions with angry clients and families as the most frequent and intense sources of job stress but did not relate these to any symptom measures. More recently, Levin and Greisberg (2003) compared 55 attorneys working in family and criminal court with 87 mental health professionals and 25 social service workers. Their results indicated that compared with the other groups, attorneys demonstrated higher levels of secondary trauma and BO that were correlated with caseload. Comparing 50 attorneys working in criminal courts with 50 working in the civil arena, Vrlevski and Franklin (2008) found more depressive symptoms, subjective stress, and changes in sense of safety and intimacy among the criminal attorneys. A personal history of multiple traumas predicted higher scores on measures of vicarious trauma, post-traumatic stress, and depression. Piwowarczyk et al. (2009) reported that among 57 attorneys specializing in asylum cases, the hours per week devoted to those cases correlated with trauma score. All three of these studies of distress in attorneys suggest a relationship between exposure to trauma and distress but suffer from small sample size, selection bias involving convenience samples, and relatively low percentage responses from the pool of possible subjects (Levin and Greisberg, 2003; Piwowarczyk et al., 2009; Vrlevski and Franklin, 2008).

The current study sought to address those limitations in a relatively larger study, assessing the relationships between exposure to...
clients’ traumatic experiences and a range of outcomes including posttraumatic stress disorder (PTSD) symptoms, depression, functional impairment, and STS and BO symptoms in attorneys and administrative support staff working at the Wisconsin State Public Defender Office. In light of previous studies, we hypothesized that a) the average number of hours working and the caseload of trauma-exposed clients would predict higher symptom load and b) attorneys would experience greater symptoms than would administrative support staff because of their greater client involvement. Moreover, we conceptualized attorneys’ work-related exposure (hours per week working and number of trauma-exposed clients) as mediating variables based on our interpretation of the literature on both exposure and STS. As such and consistent with the literature on exposure, our primary hypothesis was that c) work-related exposure would serve as a vehicle through which being directly versus indirectly exposed to clients who had experienced or had been directly involved in trauma is associated with psychological symptoms. Specifically, attorneys, in comparison with administrative support staff, were expected to report high levels of exposure, which, in turn, would be associated with their significantly higher levels of PTSD symptoms, depression, functional impairment, STS, and BO symptoms. Lastly, the study explores the relationship between personal characteristics such as age, sex, years on the job, office size, and personal trauma history and the outcome variables. Given that the findings have varied for these factors in previous studies, we did not predict specific effects for these independent variables.

METHODS

Participants and Procedures

We sampled participants for this study from the Wisconsin State Public Defender Office. At the time of the study (in early 2010) there were a total of 474 potential participants, including 307 attorneys and 167 administrative support staff, in the 38 offices across the state. The attorneys routinely interact closely with defendants in local jails, prisons, courthouses, and in their own offices. Cases run the gamut from mild violence or substance abuse to homicide and sexual offenses such as rape or child abuse. In addition to hearing first-hand accounts, the attorneys review reports and photographs and have contact with physical evidence such as bloody clothing. Administrative support staff typically performs brief financial eligibility evaluations in their offices and at times, at the jail. On occasion, defendants spontaneously relate details of their offense to the support staff, who also have contact with reports and photographs.

Potential participants received encouragement to participate in the study from the Wisconsin State Public Defender Office and the State Bar of Wisconsin as part of a program to raise awareness about stress. Survey materials were made available online by the survey office of the State Bar of Wisconsin. Potential participants received an email providing the necessary link to the questionnaires and were encouraged to complete the survey from personal computers on the job site. All subjects were provided with informed consent in the form of a cover letter at the start of the online survey packet. Proceeding to the questionnaire indicated consent. Participation was voluntary and anonymous. The research proposal was reviewed and approved by the Wisconsin State Public Defenders Office and the Wisconsin Bar also reviewed and approved the study. The final sample contains 347 participants (an overall response rate of 73.20%) including 238 attorneys (response rate of 77.52%) and 109 administrative support staff (response rate of 65.27%).

Measures

Background and Trauma Exposure Assessments

Demographic and personal information included age, sex, job description (attorney versus administrative support staff), number of years on the job, average number of hours worked per week (for the previous 3 months), and size of local office (total staff) specified on a 1-to-4 scale: less than 10 (1), 10 to 20 (2), 21 to 40 (3), and greater than 40 (4). Because participants expressed a strong need to protect their anonymity, information regarding the specific office where the participant worked as well as ethnic origin was omitted.

Personal history of trauma was gathered by asking, “Have you been a victim of any of the following types of trauma? Please estimate numbers of incidents from childhood/adolescence (up to age 15).” Types of trauma were divided into six groups: a) physical assault or abuse, b) sexual assault or abuse, c) witness to violence, d) other crime victim, e) fire, and f) natural disaster. The question was repeated for age 16 years and older. Sum scores were generated for each of the age periods for the a) total number of physical and sexual assault or abuse incidents and b) total number of nonphysical/nonsexual trauma incidents.

Exposure to client trauma was assessed by asking, “How many clients have you worked with, within the last three months who had experienced or been directly involved with trauma such as death, physical assault or abuse, domestic violence, rape, violence or fire?” Participants were instructed to select the closest number on a 1-to-5 scale: none (0), 1 to 20 (1), 21 to 40 (2), 41 to 60 (3), 61 to 80 (4), and 81 or more (5).

Outcome Variables

PTSD symptoms

The Impact of Events Scale–Revised (IES-R; Weiss and Marmar, 1997) was used to assess the symptoms of PTSD. This instrument is composed of 22 items derived from the PTSD criteria according to the DSM-IV (American Psychiatric Association, 1994). Respondents were asked to rate each item on a scale of 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit), and 4 (extremely), according to how distressed they had been by symptoms of intrusion, hyperarousal, and avoidance over the past 7 days. All participants were asked to specifically link the symptoms to traumatic material related to a case or cases they had encountered as part of their work. No time frame was specified regarding when the material was encountered. The IES-R has good psychometric properties (Creamer et al., 2003) and has good convergent validity with other measures of PTSD (Ljubotina and Muslic, 2003). In the present study, we obtained internal consistency Cronbach’s alpha reliability coefficients of $\alpha = 0.80, 0.82, 0.87$, for avoidance, hyperarousal, and intrusion, respectively. The maximum score for the scale is 88; a cutoff of 1.5 (equivalent to a total score of 33) was found to provide the best diagnostic accuracy (Creamer et al., 2003).

Depressive symptoms

The Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) is a 20-item scale designed to measure the severity of current depression in the general population. The items, each of which is assessed on a scale from 0 to 3, measure depressed mood, feelings of guilt and worthlessness, feelings of hopelessness and helplessness, psychomotor retardation, loss of appetite, and sleep

$^1$Baron and Kenny (1986) characterize mediation as a case in which a variable, such as exposure, functions as a “generative mechanism through which a focal independent variable [such as attorney vs. support staff] is able to influence the dependent variable of interest” (p. 1173; see also Frazier et al., 2004). Mediation occurs when an external variable such as exposure better explains a relationship between a predictor, such as being directly (attorneys) versus indirectly (administrative support staff) exposed to trauma-exposed clients, and an outcome, such as various symptoms (Frazier et al., 2004).

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disturbances (Radloff, 1977). All participants were asked to report symptoms they had felt in the past week. The CES-D is in wide use and has acceptable levels of internal consistency (Radloff, 1977). Extensive evidence from a variety of samples attests to the reliability and validity of the CES-D (Eaton et al., 2004). In the present sample, the estimate of internal consistency Cronbach’s alpha reliability coefficient was 0.90. A score of 16 or higher (of a possible maximum of 60) has been used as the cutoff point for high likelihood of clinically significant depression (Radloff, 1977).

**Functional impairment levels**

The Sheehan Disability Scale (SDS; Sheehan et al., 1996) was used to assess the extent to which exposure to clients’ traumatic material interfered with functioning in three spheres. Participants rated the following question (in three forms): “My feelings about the clients and cases at work have disrupted my (work, social life/leisure, or family life/home responsibilities)” on a 0-to-10 visual analogue scale with the following descriptions: none (0), mild (1 to 3), moderate (4 to 6), severe (7 to 9), and very severe (10). In the present sample, the estimate of internal consistency Cronbach’s alpha reliability coefficient was 0.92. According to the scale’s authors, a score of 5 or higher for any of the three questions is associated with significant functional impairment (Sheehan et al., 1996).

**Levels of STS and BO**

The Professional Quality Of Life Scale Version 5 (ProQOL5; Stamm, 2010) is a 30-item questionnaire broken into three 10-item groups measuring Compassion Satisfaction (CS), STS, and BO. The CS dimension (CS) “is about the pleasure you derive from being able to do your work well” (Stamm, 2010, p. 12), with higher scores indicating greater work satisfaction. STS items measure fear, sleep difficulties, intrusive images, or avoiding reminders of the person’s traumatic experiences. BO items measure feelings of hopelessness and difficulties in dealing with work. Higher scores on these dimensions indicate more distress. Participants were instructed to answer questions with respect to their reactions and symptoms in the previous 30 days as related to work at the Wisconsin State Public Defender Office. Responses were scored on a 1-to-5 visual analogue scale, with never (1), rarely (2), sometimes (3), often (4), and very often (5). In the present sample, the estimates of internal consistency Cronbach’s alpha reliability coefficients were 0.90, 0.85, and 0.83 for CS, STS, and BO, respectively. These are similar to alpha coefficients reported by Stamm (2010): 0.88, 0.81, and 0.75 for CS, STS, and BO, respectively. Analysis of the scale produces Z scores that are then converted to T-scores, with a mean of (SD) of 50 (10). A T-score greater than 57 for CS or greater than 56 for STS and BO are above the 75th percentile in samples used in the development of the scale (Stamm, 2010).

**Data Analysis**

Descriptive statistics were first calculated for demographics, trauma history, and work and exposure variables and compared between groups using Z-tests. Groups were compared regarding sex differences using chi-square analyses. Mean scores for the IES-R, CES-D, SDS, and the three subscales of the ProQOL5 were calculated and compared between groups using t-tests. In addition, the cutoff scores for each of the measures for the two groups were compared using chi-square analyses. We then performed a bivariate analysis correlating demographics, work variables, exposure and trauma history with the symptoms scales.

After these initial tests, we tested our hypotheses regarding the mediating role of work-related exposure for the outcome variables using multivariate analyses with an structural equation modeling (SEM; Hoyle and Smith, 1994) strategy that assessed measurement errors for the dependent and independent variables using AMOS software (Version 18.0.0; Arbuckle, 2009) and the maximum likelihood method. A nonsignificant chi-square value has traditionally been used as a criterion for not rejecting an SEM model; a nonsignificant chi-square value indicates that the discrepancy of the matrix of the parameters estimated based on the model being evaluated is not different from the one based on empirical data. Because of the restrictiveness of the chi-square approach for assessing model fit (Bentler and Bonnet, 1980; Jöreskog and Sörbom, 1993; Kenny and McCoach, 2003; Landry et al., 2000), we also used alternate criteria that reflect the real-world conditions of clinical research, in addition to the overall chi-square test of exact fit to evaluate the proposed models: a) the chi-square/df ratio, b) the root mean square error of approximation (RMSEA), c) the comparative fit index (CFI), and d) the nonnormed fit index (NNFI). A model in which the chi-square/df was 2 or less, CFI and NNFI were greater than 0.95, and the RMSEA index was between 0.00 and 0.06 with confidence intervals between 0.00 and 0.08 (Hu and Bentler, 1999) was deemed acceptable. These moderately stringent acceptance criteria clearly reject inadequate or poorly specified models while accepting for consideration models that meet real-world criteria for reasonable fit and representation of the data (Kelloway, 1998).

**RESULTS**

**Group Differences**

We first compared the attorneys and the administrative support staff groups on background and work characteristics (Table 1), work-related exposure and personal history of previous trauma (Table 1), and the study outcome variables (Table 2). No significant differences were found with regard to age and size of local office. However, as shown in Table 1, the administrative support staff group has significantly fewer men than the attorneys group, and participants in the attorneys’ group reported significantly more years on the job and of hours per week working compared with the administrative support staff group. No significant differences were found for childhood or adulthood-related exposure variables. However, as shown in Table 1, participants in the attorneys group reported working with significantly more clients who experienced or were directly involved in trauma compared with the administrative support staff group.

Comparing attorneys and support staff on outcome variables (Table 2), attorneys had significantly higher mean scores on all measures except CS, the latter being lower among attorneys than among administrative support staff. Furthermore, significantly more participants in the attorney group met screening criteria for PTSD (11% vs. 1%), depression (39.5% vs. 19.3%), functional impairment (74.8% vs. 27.5%), BO (37.4% vs. 8.3%), and STS (34% vs. 10.1%) compared with the administrative support group. Only a minority of attorneys (19.3%) and administrative supports staff (25.7%) reported CS above the 75th percentile level (the groups did not differ) compared with norms for the ProQOL5 CS.

**Bivariate Associations**

Table 3 provides a summary of the zero-order correlations for all of the study variables. Sex, age, years on the job, size of local office, and a personal history of childhood or adult trauma did not significantly correlate with any of the outcome variables. Group membership (attorneys vs. administrative support staff) was significantly associated with all outcomes, except with the ProQOL5 CS scale, with attorneys reporting higher scores for symptoms and impairment. In addition, work-related exposure as measured by the average number of hours working and the number of clients worked with in the last 3 months who experienced or were directly involved with trauma were both significantly and positively correlated with symptom measures, again with the exception of the ProQOL5 CS scale. For each of the three variables with significant correlations to outcome variables, the strongest correlations were consistently seen with BO and functional impairment.
Background and Trauma Exposure Variables Among Attorneys and Administrative Support Staff

<table>
<thead>
<tr>
<th>Background Variables</th>
<th>Attorney (N = 238)</th>
<th>Administrative Support Staff (N = 109)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>132</td>
<td>11.00</td>
<td>94</td>
</tr>
<tr>
<td>Male</td>
<td>106</td>
<td>9.08</td>
<td>13</td>
</tr>
<tr>
<td>Age</td>
<td>45.72</td>
<td>11.00</td>
<td>45.07</td>
</tr>
<tr>
<td>Years on the job</td>
<td>15.22</td>
<td>10.26</td>
<td>12.11</td>
</tr>
<tr>
<td>Average number of hours working</td>
<td>46.43</td>
<td>9.08</td>
<td>34.73</td>
</tr>
<tr>
<td>Size of local office</td>
<td>2.39</td>
<td>1.02</td>
<td>2.53</td>
</tr>
<tr>
<td>Trauma exposure variables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical and sexual abuse</td>
<td>3.16</td>
<td>15.37</td>
<td>3.27</td>
</tr>
<tr>
<td>Not physical and sexual abuse</td>
<td>4.02</td>
<td>16.37</td>
<td>1.50</td>
</tr>
<tr>
<td>Adulthood trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical and sexual abuse</td>
<td>4.90</td>
<td>15.43</td>
<td>3.96</td>
</tr>
<tr>
<td>Not physical and sexual abuse</td>
<td>3.59</td>
<td>13.79</td>
<td>1.78</td>
</tr>
<tr>
<td>Work-related trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of clients working in the last 3 mos who experienced or were directly involved with trauma</td>
<td>3.20</td>
<td>1.299</td>
<td>1.98</td>
</tr>
</tbody>
</table>

*p < 0.01 (two-tailed).

**p < 0.001 (two-tailed).

ns indicates not significant.

Multivariable Analyses

The Mediating Models

In testing our primary hypothesis that work-related exposure variables mediate the relationships between groups and PTSD symptoms (IES-R), depressive symptoms (CES-D), functional impairment (SDS), and levels of STS and BO (ProQOL5), we followed Baron and Kenny’s (1986) criteria for mediation, according to which, a) there must be a significant association between the predictor and criterion variables; b) in an equation including both the mediator and the criterion variable, there must be a significant association between the predictor and the mediator, and the mediator must be a significant predictor of the criterion variable; and c) there must be a decrease in the direct relationship between the independent and the dependent variables (Baron and Kenny, 1986; Kenny et al., 1998). If the significant direct relationship between the predictor and the criterion variables decreases when both the mediator and the predictor variable are included in the equation, then the obtained pattern is consistent with the mediation hypothesis. If the direct association approaches zero, the mediator fully (although not necessarily exclusively) accounts for the relation between the predictor and the criterion (Baron and Kenny, 1986). As a further test of mediation, MacKinnon et al.’s (2002) z’ test was used to examine the significance of the indirect relationship between the independent variable and the dependent variable via the hypothesized mediator.

Models for the Prediction of PTSD symptoms (IES-R)

Direct association model

We first confirmed the existence of a significant direct relation between groups and PTSD symptoms. We defined the latent PTSD construct (factor) using participants’ intrusion, avoidance, and hyperarousal scores as its indicators. This model fit the observed data well (\( \chi^2[2] = 2.081, p = 0.35, \chi^2/df = 1.04, NNFI = 1.0, CFI = 1.00, RMSEA = 0.01 \) [confidence interval (CI), 0.000 to 0.08]). As predicted, attorneys were significantly associated with high levels of PTSD symptoms (\( \beta = 0.26, t = 4.833, p < 0.0001 \)). This model significantly explained 7% of the variance in PTSD symptoms.

Mediation association model

We tested whether work-related exposure (the mediators) significantly reduced (accounted for) the direct relation between groups and PTSD symptoms (the outcome). To do this, we specified a model in which groups had a direct path to PTSD symptoms, as well as an indirect path through work-related exposure variables (controlling for the shared variance among mediators). The mediational model fit the observed data well (\( \chi^2[6] = 6.346, p = 0.386, \chi^2/df = 1.06, NNFI = 1.0, CFI = 1.0, RMSEA = 0.01 \) [CI, 0.000 to 0.07]). As noted earlier, the direct path from groups to PTSD symptoms was significant. However, this path became significantly weaker (\( p = 0.09, t = 1.46 \), not significant [ns]) when hours at work (\( z = 3.06, p < 0.01 \)) and exposure to trauma-exposed clients (\( z = 3.03, p < 0.01 \)) were included in the model. As shown in Figure 1, attorneys were significantly associated with higher hours at work (\( \beta = 0.50, t = 10.71, p < 0.0001 \)), which, in turn, was associated with PTSD symptoms (\( \beta = 0.20, t = 3.18, p < 0.001 \)); moreover, attorneys were significantly associated with higher exposure to trauma-exposed clients (\( \beta = 0.39; t = 7.76, p < 0.0001 \)), which, in turn, was associated with PTSD symptoms (\( \beta = 0.19; t = 3.23, p < 0.001 \)). Therefore, the work-related exposure variables mediated (albeit not exclusively) the attorneys’ vulnerability to PTSD symptoms. This model significantly explained 14% of the variance in PTSD symptoms. Therefore, when work-related exposure (the mediators) was included in the model, it added a significant 7% to the explained variance in PTSD symptoms.

Models for the Prediction of Functional Impairment Levels (SDS)

Direct association model

We first confirmed the existence of a significant direct relation between groups and functional impairment. We defined the latent SDS construct (factor) using the participants’ SDS scales scores as its indicators.
indicators. This model fit the observed data well ($\chi^2 = 0.70, p = 0.71, \chi^2/df = 0.35$, NNFI = 1.0, CFI = 1.00, RMSEA = 0.000 [CI, 0.000 to 0.07]). As predicted, attorneys were significantly associated with high levels of functional impairment symptoms ($\beta = 0.44$, $t = 8.370, p < 0.0001$). This model significantly explained 20% of the variance in SDS.

### TABLE 2. Means, SDs, and Prevalence of Cutoff Scores for Outcome Variables

<table>
<thead>
<tr>
<th></th>
<th>Attorney (N = 238; 69%)</th>
<th>Administrative Support Staff (N = 109; 31%)</th>
<th>t (df = 343)</th>
<th>Effect Size (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IES-R intrusion</td>
<td>0.73</td>
<td>0.58</td>
<td>0.46</td>
<td>0.34</td>
</tr>
<tr>
<td>IES-R avoidance</td>
<td>0.65</td>
<td>0.65</td>
<td>0.33</td>
<td>0.49</td>
</tr>
<tr>
<td>IES-R hyperarousal</td>
<td>0.55</td>
<td>0.65</td>
<td>0.25</td>
<td>0.44</td>
</tr>
<tr>
<td>&lt;33</td>
<td>212</td>
<td>108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;33</td>
<td>26 (11%)</td>
<td>1 (0.92%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CES-D</td>
<td>14.08</td>
<td>10.27</td>
<td>8.91</td>
<td>7.68</td>
</tr>
<tr>
<td>&lt;16</td>
<td>144</td>
<td>88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;16</td>
<td>94 (39.5%)</td>
<td>21 (19.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDS</td>
<td>9.80</td>
<td>6.77</td>
<td>3.61</td>
<td>4.57</td>
</tr>
<tr>
<td>&lt;5</td>
<td>60</td>
<td>79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;5</td>
<td>178 (74.8%)</td>
<td>30 (27.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ProQOL5*-CS</td>
<td>34.92</td>
<td>6.53</td>
<td>36.62</td>
<td>6.46</td>
</tr>
<tr>
<td>&lt;57</td>
<td>192</td>
<td>81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;57</td>
<td>46 (19.3%)</td>
<td>28 (25.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ProQOL5*-BO</td>
<td>27.36</td>
<td>6.09</td>
<td>21.57</td>
<td>5.36</td>
</tr>
<tr>
<td>&lt;56</td>
<td>149</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;56</td>
<td>89 (37.4%)</td>
<td>9 (8.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ProQOL5*-STS</td>
<td>21.20</td>
<td>5.91</td>
<td>16.82</td>
<td>4.80</td>
</tr>
<tr>
<td>&lt;56</td>
<td>157</td>
<td>98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;56</td>
<td>81 (34%)</td>
<td>11 (10.1%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

aAt the 75th percentile.  
*p < 0.05 (two-tailed).  
**p < 0.001 (two-tailed).  
PTSD indicates posttraumatic stress disorder; IES-R, Impact of Events Scale–Revised; CES-D, Center for Epidemiological Studies Depression Scale; SDS, Sheehan Disability Scale; ProQOL5, Professional Quality of Life Scale version 5; CS, Compassion Satisfaction; BO, Burnout; STS, Secondary Traumatic Stress; ns, not significant.

### TABLE 3. Correlations Between Predictors and Outcome Variables

<table>
<thead>
<tr>
<th></th>
<th>PTSD (IES-R)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intrusion</td>
<td>Avoidance</td>
<td>Hyper-Arousal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groupa</td>
<td>0.24*</td>
<td>0.24*</td>
<td>0.23*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexb</td>
<td>-0.00</td>
<td>-0.07</td>
<td>-0.04</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.01</td>
<td>-0.06</td>
<td>-0.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years on the job</td>
<td>0.10</td>
<td>0.04</td>
<td>0.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number of hours working</td>
<td>0.29*</td>
<td>0.26*</td>
<td>0.25*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Size of local office</td>
<td>0.12</td>
<td>0.01</td>
<td>0.10</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Childhood physical and sexual abuse</td>
<td>0.12</td>
<td>0.11</td>
<td>0.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood not physical and sexual abuse</td>
<td>-0.01</td>
<td>-0.01</td>
<td>0.06</td>
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<tr>
<td>Adulthood physical and sexual abuse</td>
<td>0.02</td>
<td>-0.02</td>
<td>0.04</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Adulthood not physical and sexual abuse</td>
<td>-0.00</td>
<td>-0.04</td>
<td>0.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work-related exposure</td>
<td>0.24*</td>
<td>0.28*</td>
<td>0.27*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 3. Correlations Between Predictors and Outcome Variables

<table>
<thead>
<tr>
<th></th>
<th>PTSD (IES-R)</th>
<th>ProQOL5</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CS</td>
<td>BO</td>
<td>STS</td>
<td>CES-D</td>
<td>SDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusion</td>
<td>-0.12</td>
<td>0.12</td>
<td>0.34*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.07</td>
<td>0.02</td>
<td>-0.09</td>
<td>-0.04</td>
<td>-0.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyper-Arousal</td>
<td>0.07</td>
<td>-0.03</td>
<td>-0.05</td>
<td>-0.09</td>
<td>-0.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ProQOL5*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrusion</td>
<td>-0.05</td>
<td>0.38*</td>
<td>0.37*</td>
<td>0.26*</td>
<td>0.40*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyper-Arousal</td>
<td>0.10</td>
<td>-0.02</td>
<td>-0.00</td>
<td>0.04</td>
<td>0.04</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To ensure that the overall chance of a type I error remained less than 0.05; we applied a full Bonferroni correction.

This table shows...

---

*Group is a binary-coded variable (0, administrative support staff; 1, attorney).  
*Sex is a binary-coded variable (0, women; 1, men).  
*p < 0.05 (two-tailed).  
**p < 0.001 (two-tailed).  
PTSD indicates posttraumatic stress disorder; IES-R, Impact of Events Scale–Revised; CES-D, Center for Epidemiological Studies Depression Scale; SDS, Sheehan Disability Scale; ProQOL5, Professional Quality of Life Scale version 5; CS, Compassion Satisfaction; BO, Burnout; STS, Secondary Traumatic Stress.
Models for the Prediction of Levels of STS and BO (ProQOL5)

Direct association model

We first confirmed the existence of a significant direct relation between groups and ProQOL5 STS and BO. We defined the latent ProQOL5 construct (factor) using participants’ STS and BO scales scores as its indicators. This model has zero degrees of freedom; thus, fit indices could not be estimated. As predicted, attorneys were significantly associated with high levels of STS and BO symptoms ($\beta = 0.45, t = 6.74, p < 0.0001$). This model significantly explained 20% of the variance in ProQOL5 STS and BO.

Mediation association model

We tested whether work-related exposure (the mediators) significantly reduced (accounted for) the direct relation between groups and STS and BO symptoms (the outcome). To do this, we specified a model in which groups had a direct path to ProQOL5 symptoms, as well as an indirect path through work-related exposure variables (controlling for the shared variance among mediators). The mediational model fit the observed data well ($\chi^2(2) = 2.939, p = 0.23, \chi^2/df = 1.47$, NNFI = 1.0, CFI = 1.0, RMSEA = 0.004 [CI, 0.000 to 0.08]). As noted earlier, the direct path from groups to ProQOL5 symptoms was significant. However, this path became significantly weaker ($\beta = 0.24, t = 3.866, p < 0.0001$) when hours at work ($z' = 3.60, p < 0.001$) and

![FIGURE 1. Mediational model for PTSD symptom levels (IES-R). Rectangles indicate measured variables and large circles represent latent constructs. Small circles reflect residuals (e) or disturbances (d); bold numbers above or near endogenous variables represent the amount of variance explained ($R^2$). Unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. GROUPS is a binary-coded variable (0, administrative support staff; 1, attorney). IES-R indicates Impact of Events Scale–Revised.](image1)

![FIGURE 2. Mediational model for functional impairment levels (SDS). Rectangles indicate measured variables and large circles represent latent constructs. Small circles reflect residuals (e) or disturbances (d); bold numbers above or near endogenous variables represent the amount of variance explained ($R^2$). Unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. GROUPS is a binary-coded variable (0, administrative support staff; 1, attorney). SDS indicates Sheehan Disability Scale.](image2)
exposure to trauma-exposed clients \( \left( z' = 3.85, p < 0.001 \right) \) were included in the model. As shown in Figure 3, attorneys were significantly associated with higher hours at work \( \left( \beta = 0.50; t = 10.70, p < 0.0001 \right) \), which, in turn, was associated with ProQOL5 symptoms \( \left( \beta = 0.23; t = 3.81, p < 0.0001 \right) \); moreover, attorneys were significantly associated with higher exposure to trauma-exposed clients \( \left( \beta = 0.39; t = 7.80, p < 0.0001 \right) \), which, in turn, was associated with ProQOL5 symptoms \( \left( \beta = 0.25; t = 4.38, p < 0.0001 \right) \). Therefore, work-related exposure variables mediated (albeit not exclusively) the attorneys’ vulnerability to STS and BO symptoms. This model significantly explained 32% of the variance in ProQOL5 STS and BO. Therefore, when work-related exposure exposure to trauma-exposed clients \( \left( z' = 3.85, p < 0.001 \right) \) were included in the model. As shown in Figure 3, attorneys were significantly associated with higher hours at work \( \left( \beta = 0.50; t = 10.72, p < 0.0001 \right) \), which, in turn, was associated with CES-D symptoms \( \left( \beta = 0.15; t = 2.51, p < 0.05 \right) \); moreover, attorneys were significantly associated with higher exposure to trauma-exposed clients \( \left( \beta = 0.39; t = 7.76, p < 0.0001 \right) \), which, in turn, was associated with CES-D symptoms \( \left( \beta = 0.22; t = 3.90, p < 0.0001 \right) \). Therefore, work-related exposure variables mediated (albeit not exclusively) the attorneys’ vulnerability to depressive symptoms. This model significantly explained 12% of the variance in CES-D symptoms. Therefore, when work-related exposure

FIGURE 3. Mediational model for secondary traumatic stress and burnout levels (ProQOL5). Rectangles indicate measured variables and large circles represent latent constructs. Small circles reflect residuals (e) or disturbances (d); bold numbers above or near endogenous variables represent the amount of variance explained \( \left( R^2 \right) \). Unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. GROUPS is a binary-coded variable \( \left( 0, \text{administrative support staff}; 1, \text{attorney} \right) \). ProQOL5 indicates Professional Quality of Life Scale version 5.

FIGURE 4. Mediational Model for Depressive Symptoms Levels (CES-D). Rectangles indicate measured variables and large circles represent latent constructs. Small circles reflect residuals (e) or disturbances (d); bold numbers above or near endogenous variables represent the amount of variance explained \( \left( R^2 \right) \). Unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. GROUPS is a binary-coded variable \( \left( 0, \text{administrative support staff}; 1, \text{attorney} \right) \). CES-D indicates Center for Epidemiological Studies Depression Scale.

Models for the Prediction of Depressive Symptoms (CES-D)

Direct association model

We first confirmed the existence of a significant direct relation between groups and depressive symptoms. We defined the observed variable CES-D scores. This model has zero degrees of freedom; thus, fit indices could not be estimated. As predicted, attorneys were significantly associated with high levels of depressive symptoms \( \left( \beta = 0.24, t = 4.67, p < 0.0001 \right) \). This model significantly explained 6% of the variance in CES-D symptoms.

Mediational association model

We tested whether work-related exposure (the mediators) significantly reduced (accounted for) the direct relation between groups and depressive symptoms (the outcome). To do this, we specified a model in which groups had a direct path to CES-D symptoms, as well as an indirect path through work-related exposure variables (controlling for the shared variance among mediators). This model (Fig. 4) has zero degrees of freedom; thus, fit indices could not be estimated. As noted earlier, the direct path from groups to CES-D symptoms was significant. However, this path became significantly weaker \( \left( \beta = 0.08, t = 1.39, \text{ns} \right) \) when hours at work \( \left( z' = 2.45, p < 0.05 \right) \) and exposure to trauma-exposed clients \( \left( z' = 3.20, p < 0.01 \right) \) were included in the model. As shown in Figure 4, attorneys were significantly associated with higher hours at work \( \left( \beta = 0.50; t = 10.72, p < 0.0001 \right) \), which, in turn, was associated with CES-D symptoms \( \left( \beta = 0.15; t = 2.51, p < 0.05 \right) \); moreover, attorneys were significantly associated with higher exposure to trauma-exposed clients \( \left( \beta = 0.39; t = 7.76, p < 0.0001 \right) \), which, in turn, was associated with CES-D symptoms \( \left( \beta = 0.22; t = 3.90, p < 0.0001 \right) \). Therefore, work-related exposure variables mediated (albeit not exclusively) the attorneys’ vulnerability to depressive symptoms. This model significantly explained 12% of the variance in CES-D symptoms. Therefore, when work-related exposure
(the mediators) was included in the model, it added a significant 6% to the explained variance in CES-D symptoms.

**DISCUSSION**

To our knowledge, this is the largest study of attorneys’ emotional responses to work with clients who have experienced or have been directly involved with trauma. Our data, collected from 238 attorneys and 109 administrative support staff of the Wisconsin State Public Defender Office, indicated a significant level of distress among the attorneys compared with administrative support staff. Measures of PTSD symptoms, depression, functional impairment, BO, and STS were consistently higher among attorneys compared with administrative support staff, which was predicted given the longer work hours and higher level of exposure to clients with a history of trauma among the attorneys. Bivariate analysis demonstrated that these measures of distress were, in fact, significantly correlated with hours worked per week and the number of trauma-exposed clients. Subsequent SEM modeling illustrated that work-related exposure variables (hours at work and number of trauma-exposed clients) were significant, albeit not exclusive, mediators of the differences of group membership on symptoms. Therefore, although both attorneys and administrative support staff were exposed to trauma-exposed clients, the attorneys’ longer work hours and greater direct contact with these clients associated with their vulnerability to PTSD symptoms, depression, functional impairment, STS, and BO compared with the administrative support staff’s indirect exposure to these trauma-exposed clients.

The findings of this study confirmed the results of earlier small studies (Levin and Greisberg, 2003; Vrlevski and Franklin, 2008) and also demonstrated a significant relationship between work exposure variables and depression and functional impairment. Specifically, we found significant impairment in the attorney group, with 74.8% scoring above threshold on the SDS, 39.5% demonstrating significant symptoms of depression (compared with the earlier findings of a 20% rate of depression in attorneys [Benjamin et al., 1990; Eaton et al., 1990]), more than a third scoring above the 75th percentile on STS and BO, and 11% with clinically significant PTSD symptoms. In a recent review of secondary trauma literature, Elwood et al. (2011) pointed out that the secondary trauma literature has largely failed to characterize impairment in professionals experiencing secondary trauma. It appears that at least for attorneys working in the public defender setting, PTSD, secondary trauma, and BO symptoms are accompanied by significant impairment and rates of depression (Kessler et al., 1994) and PTSD (Kessler et al., 1995) greater than those reported in community samples.

In addition, the attorneys reported less compassion satisfaction on the ProQOL5 compared with administrative support staff, and only a minority in both groups reported high levels of satisfaction with their work. Linley and Joseph (2007), also using the ProQOL, found the therapeutic bond was the best predictor of compassion satisfaction in a sample of therapists. This suggests a need to better characterize the relationship between public defenders and their clients and its impact on work satisfaction, particularly given Lynch’s (1997) finding that public defenders felt stressed by encountering angry clients and families.

Our SEM analysis raises a question concerning the relative contribution of general workload as measured in hours per week compared with that of exposure to traumatized clients, given that each made nearly equal contributions to the outcome measures. Although Figley (1985) proposed that secondary trauma is “the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 7), Regehr et al. (2004) found that work load stressors such as documentation and lack of resources, as well as public scrutiny and organizational issues, played a stronger role in mediating STS and depression compared with client exposure. The stress of the work setting itself, particularly a public legal setting where attorneys have high caseloads, are often not valued by clients, the justice system, or society and generally lack sufficient resources appears to make at least an equal contribution to overall distress (see also Lynch, 1997). Future studies are needed to better characterize the relationships between these stressors and attorneys’ symptoms and functioning.

In contrast with the previous study by Vrlevski and Franklin (2008), no relationships were found between personal trauma and distress variables. Given that the literature for mental health providers is inconsistent (Brady et al., 1999 versus Boscarino et al., 2004), our finding is expectable. The disparate findings across studies may be related to the challenges of accurately measuring past trauma, that is, the subjects’ hesitancy to record this information and their widely varying interpretations of this type of question. The two other findings were the lack of impact of sex or years on the job. Before previous literature studying therapists has found female sex predictive of STS (Kassam-Adams, 1999) our finding raises questions about differences between attorneys and their administrative support staff and mental health professionals. Regarding years on the job, available results are contradictory, at times indicating greater risk of symptoms of STS and BO with increasing years on the job (e.g., Jaffe et al., 2003) versus a protective effect of greater experience (Maslach et al., 2001; Pearlman and Mac Ian, 1995), suggesting that this variable is multidimensional and that its effects vary in different settings.

What emerges is that similar to mental health professionals, attorneys working as public defenders with clients who have experienced or have been directly involved in trauma are at high risk of developing clinically significant symptoms of secondary trauma and BO as well as depression and functional impairment. Our study adds a potential mechanism by which this high vulnerability is a result of the intensity of their exposure and the length of work hours. These findings point to the need to support attorneys in identifying the development of these symptoms and to implement interventions to reduce them. The current trend is to encourage professionals with STS and BO to seek peer and supervisory support, increase leisure and physical activity, seek counseling and psychiatric treatment as needed, and develop a variety of resiliency skills (e.g., Gentry et al., 2002). However, Bober and Regher (2006) found that these individual approaches did not reduce traumatic stress scores. Instead, they recommended institutional interventions. Our findings reinforce this more nuanced picture and suggest that emphasis must be placed on reducing long work hours as well as on the extent of client exposure such as the rotation of attorneys between different types of services. Given that public defender services are underfunded and overloaded, these types of institutional changes remain a significant challenge.

There are several limitations to this study. Our study’s cross-sectional nature limits any assignment of causality; our model cannot provide a definitive answer to the question of the direction of the observed effects. One might argue that mediation variables may have been affected by the outcome variables, that is, attorneys with more symptoms and impairment may have worked longer hours because of low efficiency or may have been attracted to work with clients who had experienced trauma. Second, the administrative support staff may not have represented the best comparison group. Although this group did provide a good comparator because of differences in work and exposure variables, another group of attorneys working with clients with no trauma exposure (e.g., corporate attorneys) may have been a better comparison, particularly given that attorneys and support staff differ in education and responsibilities. The administrative support staff group also had significantly fewer men than the attorney group, although the absence of a relationship between sex and outcomes suggests that this difference did not affect the study’s findings.

Despite these limitations, our naturalistic study investigated a unique phenomenon that may well have significant ecological validity. To the best of our knowledge, the present study represents the first attempt to apply SEM analysis to the association between indicators
of STS symptoms and to examine the mediating role of work-related exposure in attorneys and administrative support staff. Our findings highlight the importance of theoretical models that include job-related description (direct versus indirect exposure to clients’ traumatic events) and related job exposure (intensity and amount of exposure) and their role in the development of symptoms and impairment.

CONCLUSIONS

Attorneys working in the Wisconsin State Public Defender Office demonstrated significantly higher levels of PTSD symptoms, depression, STS, BO, and functional impairment compared with administrative support staff. This difference was mediated by attorneys’ longer work hours and greater contact with clients who had experienced trauma. These findings suggest a need to support attorneys and administrative support staff experiencing these symptoms and to address high workloads as well as the intensity of contact with trauma-exposed clients.

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DISCLOSURE

This study was supported by the State Bar of Wisconsin and the Wisconsin State Public Defender Office. The authors have nothing to disclose.

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The Effect of Attorneys' Work With Trauma-Exposed Clients on PTSD Symptoms, Depression, and Functional Impairment: A Cross-Lagged Longitudinal Study

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The Effect of Attorneys’ Work With Trauma-Exposed Clients on PTSD Symptoms, Depression, and Functional Impairment: A Cross-Lagged Longitudinal Study

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To date, few studies have examined mental health consequences among attorneys exposed to clients’ traumatic experiences. A longitudinal, 2-wave, cross-lagged study was used in a cohort of attorneys (N = 107) from the Wisconsin State Public Defender’s Office. We assessed changes in posttraumatic stress disorder (PTSD), depression, and functional impairment over a 10-month period and tested the effects of intensity of contact with trauma-exposed clients on symptom levels over time. Attorneys demonstrated strong and significant symptom stability over time in PTSD, depression, functional impairment, and levels of exposure. Analyses involving cross-lagged panel correlation structural equation modeling path models revealed that attorneys’ levels of exposure to trauma-exposed clients had significant positive effects, over time, on PTSD, depression, and functional impairment. Gender, age, years on the job, and office size did not predict any of the outcomes. Level of exposure to trauma-exposed clients predicted reduction of weekly working hours over time, but there was no reciprocal relationship between PTSD, depression, and functional impairment and level of exposure over time. These findings underscore the central role of exposure to trauma-exposed clients in predicting mental health outcomes and emphasize the need to support attorneys by managing the intensity of exposure as well as addressing emerging symptoms.

Keywords: attorneys, psychological trauma, posttraumatic stress disorder, depression, functional impairment

To date, few studies have examined the mental health consequences among attorneys exposed to clients who have experienced or been directly involved in traumatic events (trauma-exposed clients). In addition, available quantitative studies of distress in attorneys have only been cross-sectional in nature. Focusing on depression, Benjamin, Darling, and Sales (1990) and Eaton, Anthony, Mandel, and Garrison (1990) and Eaton, Anthony, Mandel, and Garrison (1990) identified a 20% rate of clinically significant depression in the attorneys surveyed, but these findings were not related to work experiences. In a study of 23 Canadian prosecutors using semistructured interviews, Gomme and Hall (1995) reported symptoms of demoralization, anxiety, helplessness, exhaustion, and social withdrawal. They linked these symptoms to high caseloads of “sensitive cases” such as domestic violence and incest as well as long work hours. Lynch (1997) reported that public defenders ranked work overload, the unpredictability of trials, the frequent lack of a defense, harsh sentences,
arguing with prosecutors, and dealing with angry clients and families as the most frequent and intense sources of stress, but the study did not measure specific symptoms of stress. A pilot study by Levin and Greisberg (2003) found that attorneys working in family and criminal courts demonstrated higher levels of secondary trauma and burnout compared with mental health professionals and social service workers, and these measures of distress correlated with caseload. Comparing 50 attorneys working in criminal courts with 50 working in the civil arena, Vrklevski and Franklin (2008) found more depressive symptoms, subjective stress, and changes in sense of safety and intimacy among the criminal attorneys. A personal history of multiple traumas predicted higher scores on measures of vicarious trauma, posttraumatic stress, and depression. In another study comparing criminal and civil attorneys, Hasnain, Naz, and Bano (2010) also found that criminal attorneys reported higher levels of stress than civil attorneys. This difference was seen among attorneys with more than 10 years' experience but was not observed in attorneys in training. Piwowarczyk et al. (2009) reported that among 57 attorneys specializing in asylum cases, hours per week devoted to those cases correlated with trauma score. All of these studies of attorneys suggest a relationship between exposure to trauma and attorneys' symptoms but suffer from small sample size and, given their cross-sectional design, do not elucidate the course of the symptoms or the direction of effects between exposure and symptomatology.

Studies of other human service professionals working with trauma-exposed clients such as social workers (Kassam-Adams, 1999), law enforcement officers (Follette, Polusny, & Milbeck, 1994), and psychotherapists (Pearlman & Maclan, 1995) are also limited by cross-sectional design. Some of these studies have linked intensity of work-related exposure (Creamer & Liddle, 2005; Eriksson, Kemp, Gorsuch, Hoke, & Foy, 2001; Kassam-Adams, 1999) to secondary trauma symptoms, although other findings have suggested the primary importance of organizational and work-related factors (Baird & Jenkins, 2003; Devilly, Wright, & Varker, 2009; Regehr, Hemsworth, Leslie, Howe, & Chau, 2004) compared with exposure.

Recently, in a large cross-sectional study, our group examined indicators of secondary trauma among attorneys (n = 238) and their administrative support staff (n = 109) and found that the attorneys demonstrated significantly higher levels of posttraumatic stress disorder (PTSD) symptoms, depression, secondary traumatic stress, burnout, and functional impairment compared with administrative support staff (Levin et al., 2011). In addition, we found that the difference in symptoms was mediated by attorneys' longer work hours and greater exposure to trauma-exposed clients and was not related to other variables such as gender, years on the job, office size, or personal history of trauma. The present study used a longitudinal design in a subsample of attorneys from our previously reported cohort of the Wisconsin State Public Defender’s Office (Levin et al., 2011) to assess changes in symptoms of PTSD, depression, and functional impairment over a 10-month period. In addition, our design sought to measure the relative contributions of caseload of trauma-exposed clients and hours worked to symptom and functional impairment levels over time and the direction of effects between caseload of trauma-exposed clients, hours worked, and symptoms and functional impairment.

Method

Participants and Procedure

We conducted a longitudinal follow-up study on a sample of attorneys working in the 38 offices of the Wisconsin State Public Defender’s Office (Levin et al., 2011). In that study, we collected data in March 2010 via the Wisconsin State Public Defender’s Office intranet to 307 attorneys, with an initial response of 238 attorneys (78%). The data for the current study were based on a follow-up survey that was distributed in December 2010 to all attorneys working in the office. This resulted in 142 responses, of which 107 were attorneys who had also completed the original survey, representing 45% of the 238 who initially responded. The 107 attorneys (51 men and 56 women) were in their mid-40s (M = 45.72 years, SD = 11.0), with almost 16 years' experience on the job (M = 15.89, SD = 11.03), working on average in local offices (total staff) of more than 10–20 people (M = 2.40, SD = 1.0). Preliminary analyses indicated that the means for hours worked, t(236) = 0.81, ns, caseload of trauma-exposed clients, t(236) = 0.20, ns, size of local office, t(236) = 0.09, ns, and background variables of gender (χ² = 0.59 ns), age, t(236) = 0.11, ns, years on the job, t(236) = 0.55, ns, as well as the outcome variables of intrusion, t(236) = 0.44, ns, avoidance, t(236) = 1.42, ns, hyperarousal, t(236) = 0.79, ns, depression, t(236) = 0.22, ns, and functional impairment, t(236) = 0.47, ns, did not differ at the initial survey in March 2010 between the subset that followed up (n = 107) and the remaining 131 participants.

Survey materials were made available online by the survey office of the State Bar of Wisconsin. Potential participants received an e-mail providing the necessary link to the questionnaires and were encouraged to complete the survey from personal computers on the job site. All participants received information regarding the study in the form of an informed consent cover letter at the start of the online survey packet. Proceeding to the questionnaire indicated consent. Participation was voluntary and anonymous and there was no remuneration for participation. The research proposal was reviewed and approved by the Westchester Jewish Community Services Research Committee as well as its board of directors and chief executive officers. Leadership at both the Wisconsin Public Defender’s Office and the Wisconsin Bar also reviewed and approved the study.

Measures

Background and trauma exposure assessments. Demographic and personal information included age, gender, number of years on the job, average number of hours worked per week (for the prior 3 months), and size of local office (total staff) specified on a 1–4 scale, ranging from 1 (fewer than 10), 2 (10–20), 3 (21–40), and 4 (more than 40). Because participants expressed a strong need to protect their anonymity, information regarding the specific office where the participant worked as well as ethnic origin were omitted.

The attorneys routinely interact closely with defendants in local jails, prisons, courthouses, and in their own offices. Cases run the gamut from mild violence or substance abuse to homicide and sexual offenses such as rape or child abuse allegedly perpetrated by the attorneys’ clients. In addition to hearing first-hand accounts,
the attorneys review reports and photographs and have contact with physical evidence (e.g., bloody clothing). Exposure to client trauma was assessed at baseline (Time 1) and 10 months later (Time 2) by asking, “How many clients have you worked with within the last three months who had experienced or been directly involved with trauma such as death, physical assault or abuse, domestic violence, rape, violence or fire?” Participants were instructed to select the closest number on a 0–5 scale: 0 (none), 1 (1–20), 2 (21–40), 3 (41–60), 4 (61–80), and 5 (81 or more). We elected to use six categories rather than a precise number because our pilot study indicated that attorneys were not able to report an exact number based on their recollection of the prior 3 months. However, it is important to note that five response categories are believed to represent an interval level of measurement. The use of the six categories in our study does not violate the axiom of transitivity for the ordinal scale: the intervals between the scale points (number of clients represented by each category) correspond to empirical observations in our pilot study (see, e.g., Dawes, 2008).

Outcome variables.

PTSD symptoms. The Impact of Event Scale—Revised (IES–R; Weiss & Marmar, 1997) was used to assess symptoms of PTSD at Time 1 and Time 2. This instrument comprises 22 items derived from the PTSD criteria of the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM–IV; American Psychiatric Association, 1994); Respondents were asked to rate each item on a scale of 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit), and 4 (extremely), according to how distressed they had been by symptoms of intrusion, hyperarousal, and avoidance over the past 7 days. All participants were asked to specifically link the symptoms to traumatic material related to a case or cases they had encountered as part of their work. No timeframe was specified regarding when the material was encountered. The IES–R has good psychometric properties (Creamer, Bell, & Failla, 2003) and has good convergent validity with other measures of PTSD (Ljubotina & Muslic, 2003). In the present study, we obtained internal consistency Cronbach’s reliability coefficients of $\alpha = .79$, $.80$, and $.85$, and $\alpha = .80$, $.78$, and $.86$, for avoidance, hyperarousal, and intrusion subscales, at Time 1 and Time 2, respectively.

Depressive symptoms. The Center for Epidemiological Studies Depression Scale (CES–D; Radloff, 1977) is a 20-item scale designed to measure severity of current depression in the general population and was used at Time 1 and Time 2. The items, each of which is assessed on a scale from 0 to 3, measure depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbances (Radloff, 1977). All participants were asked to report symptoms they had experienced in the past week. The CES–D is in wide use and has acceptable levels of internal consistency (Radloff, 1977). Extensive evidence from a variety of samples attests to the reliability and validity of the CES–D (Eaton, Munro, Smith, Tien, & Ybarra, 2004). In the present sample, the estimates of internal consistency Cronbach’s reliability coefficients were $\alpha = .91$ and $\alpha = .93$ at Time 1 and Time 2, respectively.

Functional impairment. The Sheehan Disability Scale (SDS; Sheehan, Harnett-Sheehan, & Raj, 1996) was used to assess the extent to which exposure to clients’ traumatic material interfered with functioning in three spheres at Time 1 and Time 2. Participants rated the following question (in three forms): “My feelings about the clients and cases at work have disrupted my (work, social life/leisure, or family life/home responsibilities)” on a visual analogue scale ranging from 0 (none), 1–3 (mild), 4–6 (moderate), 7–9 (severe), to 10 (very severe). In the present sample, the estimates of internal consistency Cronbach’s reliability coefficients were $\alpha = .91$ and $\alpha = .90$ at Time 1 and Time 2, respectively.

Data Analysis

Mean scores for exposure to traumatic clients and hours at work as well as for IES–R, CES–D, and SDS scores were calculated and compared between times (repeated measure) using $t$ tests and stability of symptoms was assessed using Pearson correlation among same assessments over time. We then performed a bivariate analysis correlating demographics, work variables, and exposure with the symptoms scales at each time point.

Following these initial tests, we tested our hypotheses regarding the role of work-related exposure (exposure to client trauma and hours at work) for the outcome variables using multivariate analysis. We used cross-lagged panel correlation path models to explore the causal sequence between exposure to traumatic clients and work hours at Time 1 and symptomatology at Time 2 (PTSD or CES–D or SDS), using structural equation modeling (SEM) that assessed measurement errors for the dependent and independent variables (Hoye & Smith, 1994) with AMOS software (Version 18.0; Arbuckle, 2009) and the maximum likelihood method. Several components of these models are noteworthy. First, they include two time points, and the effects of exposure and hours at work on PTSD, depression, and functional impairment are estimated. These aspects of the models are referred to as cross-lagged effects. Second, the model also includes the influence of exposure and hours at work at the first time point on exposure and hours at work at the later time point. The same is true for PTSD, depression, and functional impairment. These aspects of the model, called autoregressive effects, can be thought of as indicators of the temporal stability of the measures. Estimations of these parameters in the model control for the stability of the variables. Thus, any cross-lagged effects can be considered effects that add predictive power over and above that which can be simply obtained from the stability of the measures. Finally, note that exposure, hours at work, PTSD, depression, and functional impairment are each allowed to intercorrelate within each time point. These aspects of the model are called synchronous correlations. Estimating these errors in the model allows for correlations between variances in PTSD or depression or functional impairment and exposure and hours at work that are not already explained by the influences of the variables from earlier time points.

A nonsignificant chi-square has traditionally been used as a criterion for not rejecting an SEM; a nonsignificant chi-square indicates that the discrepancy of the matrix of the parameters estimated based on the model being evaluated is not different from the one based on the empirical data. Given the restrictiveness of the chi-square approach for assessing model fit (Jöreskog & Sörbom, 1993; Kenny & McCoach, 2003; Landry, Smith, Swank, & Miller-Loncar, 2000), we also used alternative criteria that reflect the real-world conditions of clinical research in addition to the
overall chi-square test of exact fit to evaluate the proposed models: (a) the \( \chi^2/df \) ratio, (b) the root mean square error of approximation (RMSEA), (c) the comparative fit index (CFI), and (d) the non-normed fit index (NNFI). A model in which \( \chi^2/df \) was \( \leq 2 \), CFI and NNFI were greater than 0.95, and the RMSEA index was between 0.00 and 0.08 (Hu & Bentler, 1999) was deemed acceptable. These moderately stringent acceptance criteria clearly reject inadequate or poorly specified models, but accept for consideration models that meet real-world criteria for reasonable fit and representation of the data (Kelloway, 1998). Effect sizes were computed using Cohen’s \( d \) (Cohen, 1992).

**Results**

**Descriptive Statistics**

On average, participants had almost 16 years on the job (\( M = 15.89 \) years, \( SD = 11.03 \)), were working more than 46 hr/week (\( M = 46.07, SD = 6.61 \)), were from offices of (total staff) more than 10–20 people (\( M = 2.40, SD = 1.0 \)), and were exposed to 41–60 clients within the past 3 months who had experienced or been directly involved with trauma such as death, physical assault or abuse, domestic violence, rape, violence, or fire (\( M = 3.16, SD = 1.23 \)).

**Baseline to Follow-up Differences in PTSD, Depression, and Functional Impairment**

As shown in Table 1, no significant changes were found in mean scores of baseline and follow-up for average number of hours worked per week, depression, functional impairment, and hyperarousal symptoms. However, participants reported significantly lower mean scores of work-related exposure, intrusion, and avoidance at Time 2. As can also be seen from Table 1, correlations indicate that all symptom scores reported at Time 1 were significantly and strongly associated with the corresponding symptom scores reported at Time 2, indicating strong and significant stability. Moreover, significant strong stability was also demonstrated for average number of hours worked as well as for level of exposure to trauma-exposed clients.

Fifteen percent and 9% of the sample met screening criteria for PTSD at Time 1 and Time 2, respectively (\( p > .01 \)). A cutoff of 1.5 (equivalent to a total score of 33) was found to provide the highest levels of sensitivity/specificity when comparing the IES–R with the PTSD Checklist (Creamer et al., 2003) and was used as a cutoff for preliminary diagnosis of PTSD (see, e.g., Weiss, 2007). Forty-three percent and 40.2% of the sample met screening criteria for depression at Time 1 and Time 2, respectively. A score of \( \geq 16 \) has been used as the cutoff point for high likelihood of clinically significant depression (Radloff, 1977). Finally, 74.8% and 73.8% of the sample met screening criteria for functional impairment at Time 1 and Time 2, respectively. A score of \( \geq 5 \) for any of the three questions is associated with significant functional impairment (Sheehan et al., 1996).

**Bivariate Associations**

Table 2 provides a summary of the zero-order correlations for the study variables. Gender, age, years on the job, and size of local office did not significantly correlate with any of the outcome variables at either time point. Work-related exposure was significantly correlated with depression (\( r = .24, d = .49 \), and \( r = .22, d = .45 \)) and impairment (\( r = .27, d = .56 \), and \( r = .33, d = .70 \)) at both time points and at Time 2 with intrusion (\( r = .24, d = .49 \)) and hyperarousal (\( r = .27, d = .56 \)) symptoms. Average number of hours worked per week correlated with depression (\( r = .27, d = .56 \)), functional impairment (\( r = .31, d = .65 \)), intrusion (\( r = .34, d = .72 \)), and hyperarousal (\( r = .30, d = .63 \)) at Time 1 but not with any of the outcome variables at Time 2.

**Multivariable Analyses: Cross-Lagged Models**

**Prediction of PTSD symptoms (IES–R).** At each time point, we defined the latent PTSD construct (factor) using participants’ intrusion, avoidance, and hyperarousal scores as its indicators.

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**Table 1**

**Number of Working Hours, Caseload of Trauma-Exposed Clients, and Outcome Variables at Time 1 and Time 2**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Time 1</th>
<th>Time 2</th>
<th>t(106)</th>
<th>95% CI</th>
<th>Cohen’s ( d )</th>
<th>( r ) (Time 1 and 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of hours working</td>
<td>46.06</td>
<td>6.61</td>
<td>46.01</td>
<td>6.97</td>
<td>-0.22, ns</td>
<td>-1.33, 1.06</td>
</tr>
<tr>
<td>Work-related exposure(^b)</td>
<td>3.17</td>
<td>1.23</td>
<td>2.89</td>
<td>1.10</td>
<td>2.76(^**)</td>
<td>0.080, 0.49</td>
</tr>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.27, 0.59</td>
</tr>
<tr>
<td>IES–R Intrusion</td>
<td>0.76</td>
<td>0.59</td>
<td>0.43</td>
<td>0.55</td>
<td>6.30(^**)</td>
<td>0.23, 0.43</td>
</tr>
<tr>
<td>IES–R Avoidance</td>
<td>0.76</td>
<td>0.70</td>
<td>0.55</td>
<td>0.57</td>
<td>3.47(^**)</td>
<td>0.093, 0.34</td>
</tr>
<tr>
<td>IES–R Hyperarousal</td>
<td>0.61</td>
<td>0.65</td>
<td>0.61</td>
<td>0.61</td>
<td>-0.06, ns</td>
<td>-0.11, 0.10</td>
</tr>
<tr>
<td>CES–D</td>
<td>14.54</td>
<td>10.51</td>
<td>15.67</td>
<td>9.59</td>
<td>-1.43, ns</td>
<td>-2.67, 0.43</td>
</tr>
<tr>
<td>SDS</td>
<td>10.17</td>
<td>6.95</td>
<td>9.82</td>
<td>6.78</td>
<td>0.57, ns</td>
<td>-0.84, 1.53</td>
</tr>
</tbody>
</table>

\(^a\) Cohen’s \( d \) has been corrected for dependence between means using Morris and DeShon’s (2002) Equation 8. \(^b\) How many clients have you worked with, within the last three months, who had experienced or been directly involved with trauma such as death, physical assault or abuse, domestic violence, rape, violence or fire? Participants were instructed to select the closest number on a 0–5 scale, where 0 = none, 1 = 1–20, 2 = 21–40, 3 = 41–60, 4 = 61–80, and 5 = 81 or more.

\( ** p < .01 \), \( *** p < .001 \) (two-tailed).
while controlling for the autocorrelations among same measures errors (within-subject repeated measures). This cross-lagged SEM (see Figure 1) fit the observed data well, $\chi^2(21) = 14.90$, $p = .83$, $\chi^2/df = 0.71$; NNFI = 1.0; CFI = 1.0; RMSEA = 0.0001, 95% CI [0.000, 0.05]. This model showed a nonsignificant effect of Time 1 PTSD symptoms on Time 2 exposure or hours at work, $\beta = -.06$, $t = -0.65$, $ns$, and $\beta = -.06$, $t = -1.39$, $ns$, respectively, as well as nonsignificant effects of Time 1 hours at work on Time 2 exposure or PTSD symptoms, $\beta = .07$, $t = 0.82$, $ns$, and $\beta = -.04$, $t = -0.46$, $ns$, respectively. In contrast, Time 1 exposure had a noteworthy and statistically significant follow-up effect on PTSD symptoms, exposure, and hours at work, such that higher levels of exposure at one time point were related to an increased level of PTSD symptoms, $\beta = .20$, $t = 2.70$, $p < .01$, $d = 0.53$, and a decreased level of hours at work, $\beta = -.19$, $t = -2.26$, $p < .02$, $d = 0.44$, at the subsequent time point, as evidenced by the statistically significant cross-lagged parameters. These findings indicate that exposure significantly predicted or affected attorneys’ CES–D symptomatology and hours spent at work at Time 2, and that attorneys’ PTSD symptomatology or hours spent at work at Time 1 did not predict or affect levels of exposure at Time 2. Moreover, hours at work at Time 1 affected exposure and CES–D symptoms at Time 2 indirectly through its association with exposure at Time 1. These associations were not altered when we controlled for gender, age, years on the job, and size of local office and their associations with predictors and outcomes.

Prediction of depressive symptoms (CES–D). At each time point, we defined the observed variable overall CES–D scores. This cross-lagged path model had zero degrees of freedom; thus, fit indices could not be estimated (see Figure 2). This model showed a nonsignificant effect of Time 1 CES–D symptoms on Time 2 exposure or hours at work, $\beta = -.07$, $t = -0.82$, $ns$, and $\beta = .03$, $t = 0.36$, $ns$, respectively, as well as nonsignificant effects of Time 1 hours at work on Time 2 exposure or CES–D symptoms, $\beta = .07$, $t = 0.76$, $ns$, and $\beta = .10$, $t = 1.37$, $ns$, respectively. In contrast, Time 1 exposure had a noteworthy and statistically significant follow-up effect on CES–D symptoms, exposure, and hours at work, such that higher levels of exposure at one time point were related to an increased level of PTSD symptoms, $\beta = .20$, $t = 2.70$, $p < .01$, $d = 0.53$, and a decreased level of hours at work, $\beta = -.19$, $t = -2.26$, $p < .02$, $d = 0.44$, at the subsequent time point, as evidenced by the statistically significant cross-lagged parameters. These findings indicate that exposure significantly predicted or affected attorneys’ CES–D symptomatology and hours spent at work at Time 2, and that attorneys’ PTSD symptomatology or hours spent at work at Time 1 did not predict or affect levels of exposure at Time 2. Moreover, hours at work at Time 1 affected exposure and CES–D symptoms at Time 2 indirectly through its association with exposure at Time 1. These associations were not altered when we controlled for gender, age, years on the job, and size of local office and their associations with predictors and outcomes.

To obtain the most parsimonious model and allow the evaluation of the overall goodness of fit of the path model, we calculated the final model in which we removed the nonsignificant paths found in the full model (i.e., of Time 1 hours at work on Time 2 CES–D and exposure and of Time 1 CES–D on Time 2 exposure and hours at work). This model fit the observed data well, $\chi^2(4) = 3.14$, $p = .54$, $\chi^2/df = 0.79$; NNFI = 1.0; CFI = 1.0; RMSEA = 0.0001, 95% CI [0.000, 0.08].

Prediction of functional impairment (SDS). At each time point, we defined the observed variable overall SDS scores. This cross-lagged path model had zero degrees of freedom; thus, fit indices could not be estimated (see Figure 3). This model showed a nonsignificant effect of Time 1 SDS symptoms on Time 2 exposure or hours at work, $\beta = -.09$, $t = -1.08$, $ns$, and $\beta = -.04$, $t = -0.53$, $ns$, respectively, as well as nonsignificant effects of Time 1 hours at work on Time 2 exposure or CES–D symptoms, $\beta = .07$, $t = 0.76$, $ns$, and $\beta = .10$, $t = 1.37$, $ns$, respectively. In contrast, Time 1 exposure had a noteworthy and statistically significant follow-up effect on CES–D symptoms, exposure, and hours at work, such that higher levels of exposure at one time point were related to an increased level of PTSD symptoms, $\beta = .20$, $t = 2.70$, $p < .01$, $d = 0.53$, and a decreased level of hours at work, $\beta = -.19$, $t = -2.26$, $p < .02$, $d = 0.44$, at the subsequent time point, as evidenced by the statistically significant cross-lagged parameters.

Table 2

Correlations Between Predictors and Outcome Variables at Time 1 and Time 2

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Intrusion</th>
<th>Avoidance</th>
<th>Hyperarousal</th>
<th>CES–D</th>
<th>SDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender*</td>
<td>-.14</td>
<td>-.26</td>
<td>-.19</td>
<td>-.23</td>
<td>-.23</td>
</tr>
<tr>
<td>Age</td>
<td>.05</td>
<td>-.06</td>
<td>-.00</td>
<td>-.03</td>
<td>.05</td>
</tr>
<tr>
<td>Years on the job</td>
<td>.00</td>
<td>-.03</td>
<td>-.04</td>
<td>-.07</td>
<td>.00</td>
</tr>
<tr>
<td>Size of local office</td>
<td>.16</td>
<td>-.03</td>
<td>.19</td>
<td>-.03</td>
<td>.06</td>
</tr>
<tr>
<td>Average number of hours working</td>
<td>.34***</td>
<td>.16</td>
<td>.30***</td>
<td>.27***</td>
<td>.31***</td>
</tr>
<tr>
<td>Work-related exposure</td>
<td>.13</td>
<td>.07</td>
<td>.20</td>
<td>.24***</td>
<td>.27***</td>
</tr>
<tr>
<td>Time 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender*</td>
<td>-.15</td>
<td>-.07</td>
<td>-.17</td>
<td>-.11</td>
<td>-.21</td>
</tr>
<tr>
<td>Age</td>
<td>.08</td>
<td>.12</td>
<td>.05</td>
<td>.11</td>
<td>.00</td>
</tr>
<tr>
<td>Years on the job</td>
<td>.00</td>
<td>.08</td>
<td>-.00</td>
<td>.07</td>
<td>-.08</td>
</tr>
<tr>
<td>Size of local office</td>
<td>.03</td>
<td>.10</td>
<td>-.12</td>
<td>-.00</td>
<td>-.03</td>
</tr>
<tr>
<td>Average number of hours working</td>
<td>.05</td>
<td>.11</td>
<td>.07</td>
<td>.18</td>
<td>.18</td>
</tr>
<tr>
<td>Work-related exposure</td>
<td>.24**</td>
<td>.16</td>
<td>.27**</td>
<td>.22*</td>
<td>.33***</td>
</tr>
</tbody>
</table>


* Gender is a binary-coded variable (0 = women, 1 = men).

To ensure that the overall chance of a Type I error remained less than .05, we applied a full Bonferroni correction.

*** p < .01 (two-tailed).
Time 1 hours at work on Time 2 exposure or SDS symptoms, $\beta = .07$, $t = 0.83$, ns, and $\beta = .05$, $t = .54$, ns, respectively. In contrast, Time 1 exposure had a noteworthy and statistically significant follow-up effect on SDS symptoms, exposure, and hours at work, such that higher levels of exposure at one time point were related to an increased level of SDS symptoms, $\beta = .20$, $t = 2.39$, $p < .01$, $d = 0.47$, and a decreased level of hours at work, $\beta = -.18$, $t = -2.15$, $p < .03$, $d = 0.42$, at the subsequent time point, as evidenced by the statistically significant cross-lagged parameters. These findings indicate that exposure significantly predicted or affected attorneys’ SDS symptomatology and hours spent at work at Time 2, and that attorneys’ SDS symptomatology or hours spent at work at Time 1 did not predict or affect levels of exposure at Time 2. Moreover, hours at work at Time 1 affected exposure and SDS symptoms at Time 2 indirectly through its association with exposure at Time 1. These associations were not altered when we controlled for gender, age, years on the job, and size of local office and their associations with predictors and outcomes.

To obtain the most parsimonious model and allow the evaluation of the overall goodness of fit of the path model, we calculated the final model in which we removed the nonsignificant paths found in the full model (i.e., of Time 1 hours at work on Time 2 SDS and exposure and of Time 1 SDS on Time 2 exposure and hours at work). This model fit the observed data well, $\chi^2(4) = 1.67$, $p = .80$, $\chi^2/df = 0.42$; NNFI = 1.0; CFI = 1.0; RMSEA = 0.0001, 95% CI [0.000, 0.09].

**Discussion**

To our knowledge, this study reports one of the first investigations in attorneys (or any helping professionals) examining longitudinal changes in mental health outcome measures including PTSD, depression, and functional impairment and the relationship of these symptoms to work with trauma-exposed clients. The participants, 107 attorneys working in the Wisconsin State Public Defender’s Office, experienced continued stress over a 10-month period as demonstrated by similar levels of depression, functional impairment, and PTSD hyperarousal at both time points. Furthermore, the percentage of attorneys who exceeded clinical thresholds for depression and functional impairment was unchanged over the period of the study. Although there was a modest but significant decrease in the PTSD symptoms of intrusion and avoidance over the 10-month period, there was no significant change in the number of attorneys who scored above the threshold of clinically significant PTSD symptoms.
significant PTSD. Total hours worked per week were unchanged, but caseload of trauma-exposed clients did show a small but significant decrease. These decreases in the PTSD symptoms and caseload of trauma-exposed clients may suggest that the attorneys who participated in the follow-up survey were initially in less distress, but there were no statistical differences found on any of the symptom measures at baseline between the participants who followed up with those who did not. Overall, these findings indicate significant stability in levels of symptomatology over a 10-month period.

Bivariate analysis revealed that average caseload of trauma-exposed clients significantly correlated with depression and functional impairment measures at both time points, whereas hours worked per week only correlated with these measures at baseline.
Furthermore, average caseload correlated with intrusion and hyperarousal at follow-up but not at baseline. These inconsistent correlations between outcome variables and exposure measured by hours worked and trauma-exposed client caseload mirror the equivocal findings in the general secondary trauma literature (e.g., Kassam-Adams, 1999, and Creamer & Liddle, 2005, vs. Boscario, Figley, & Adams, 2004) and contrast with our earlier report (Levin et al., 2011) in which both factors correlated with symptoms in the larger sample surveyed at the initial time point. Piwowarczyk et al. (2009), in a small sample, also found a relationship between caseload of trauma-exposed clients and increased symptoms in asylum attorneys. Gender, age, years on the job, and size of office were not correlated with any of the outcome measures at either time point.

Consistent with our previous findings (Levin et al., 2011), these results on balance show that attorneys were more likely to exhibit increased levels of symptomatology when working with trauma-exposed clients. However, the current study’s follow-up findings indicate cross-legged effects in which exposure had a significant effect over time on both hours worked and symptomatology such that higher levels of exposure at Time 1 were related to increased symptoms and decreased hours worked 10 months later. Stated differently, the cross-legged findings indicate that over and above the continued levels PTSD, depression, and functional impairment, there was an additional unique effect of exposure on these outcome measures over time. Furthermore, no reciprocal effects were found, that is, whereas higher levels of exposure predicted increased levels of symptoms and decreased hours at work 10 months later, PTSD, depression, and functional impairment did not have any effects on exposure over time.

Our findings suggest several possible conclusions. First, they provide strong evidence that exposure to trauma-exposed clients may be a vulnerability factor, given that higher levels of exposure resulted in increased severity of symptoms and reduced time spent at work 10 months later. Furthermore, the lack of reciprocal effects suggests that the attorneys surveyed may have ignored their symptoms of distress in making decisions about working hours and caseload. We might speculate that attorneys decreased their work hours over the 10-month period in response to study participation and the accompanying increased awareness of the phenomenon of secondary trauma and not because of how they felt. At the same time, they did not (or were unable to) decrease their caseloads of trauma-exposed cases. In this regard, a number of participants of the study stated (sometimes quite emphatically) in a comments field at the end of the survey that they felt “powerless” to manage their caseloads. Thus, alternatively, we might speculate that continued high caseloads of trauma-exposed clients were unavoidable.

Our results and the results of other studies of professionals working with perpetrators suggest a need to expand Figley’s (1995) formulation that secondary trauma is “the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 7). The present study, as well as our earlier study (Levin et al., 2011), and the studies of Gomme and Hall (1995) with prosecutors and Vrkleveksi and Franklin (2008) with criminal defense attorneys, illustrate that work with perpetrators precipitates secondary traumatic stress responses. Likewise, studies of sexual offender therapists document secondary traumatic responses similar to those seen in therapists treating victims (see review by Moulden & Firestone, 2007). The only study comparing these two groups of therapists reported similar levels of symptoms in both groups (Way, VanDeusen, Martin, Applegate, & Jandl, 2004). Moulden and Firestone (2007) concluded that work with perpetrators precipitates symptoms in therapists via the same mechanisms (e.g., constructivist self-development theory) thought to cause symptoms in any professional exposed to traumatic material. In light of these findings, it appears that exposure to traumatic material, regardless of the relationship with the client, precipitates symptoms. It should be noted that our questionnaire asked the attorneys to quantify the number of clients who “had experienced or been directly involved with trauma.” Given that criminal defendants are themselves often victims of trauma, the clients were most likely to be both perpetrators and victims. The attorneys in our study commented that they frequently experienced negative feelings toward the people they were assigned to defend. Future research should attempt to tease out the effects of sympathy versus revulsion toward the client as well as the effects of perpetrator versus victim status on the development of symptoms.

Although our prior report (Levin et al., 2011) identified the need to support attorneys by addressing their work hours and their caseloads, this study suggests that given limited resources to effect change, the focus should be on the attorneys with the largest caseloads of trauma-exposed clients. In addition to developing strategies to decrease the size of these caseloads, perhaps by rotation of attorneys who receive these cases, the present study suggests that resources such as counseling and education should be concentrated on supporting these attorneys. Although the efficacy of traditional approaches for assisting professionals who experience secondary trauma exposure (e.g., Gentry, Baranowsky, & Dunning, 2002) including education about trauma and development of personal resilience have been challenged (Bober & Regel, 2006), the current findings again tilt toward more specific emphasis on the work with the trauma-exposed clients rather than simply addressing general working conditions. Longitudinal studies of primary victims of trauma suggest that social support (Galea et al., 2002; Neria, Besser, Kiper, & Westphal, 2010) and coping strategies (Mayou, Ehlers, & Bryant, 2002) affect long-term outcome in victims beyond the intensity of exposure, highlighting the need to examine these factors in future studies of outcomes in helping professionals working with trauma-exposed populations.

The present study has several limitations. First, the study used a sample confined to attorneys who work as public defenders who were demographically homogeneous, thus limiting generalizability to other attorneys and other helping professionals. Second, although this is the only study we are aware of that has surveyed attorneys longitudinally, the sample of attorneys who repeated the survey (N = 107) was relatively small. One factor contributing to the follow-up rate of 45% may have been the lack of remuneration. The validity of our findings in this limited sample is bolstered by the lack of difference on any variables between the participants and the attorneys who did not repeat the study. A future study should examine responses in a larger, more diverse sample across a range of attorney types, that is, defense, prosecution, civil, and even corporate, and if possible, compare them with other professionals with different levels of exposure. A further limitation is the lack of a precise characterization of the specific types and frequencies of trauma (assault, homicide, rape, fire, etc.) encountered by the public defenders. This is a general limitation in the legal field; for example, Gomme and Hall (1995) characterized the impact of
work with domestic violence and incest on prosecutors, but they did not quantify this caseload nor did they have a comparison with prosecutors working, for instance, in homicide. This is another rich area for future exploration.

Despite these limitations, our study investigated a unique phenomenon, focusing on longitudinal exposure and symptoms that may well have significant ecological validity. The study focused on participants who reported on their experiences as they were occurring over a 10-month period. Moreover, to our knowledge, the present study represents the first attempt toward understanding the relationships between attorneys’ exposure to trauma-exposed clients and symptomatology, over time, through the use of a cross-lagged design. An important next step will be to use longitudinal designs to explore the underlying mechanisms of attorneys’ exposure-related symptoms. For example, one possible direction would be to examine the longitudinal role of various affect regulation strategies, coping mechanisms, and social support as potential mediators and/or moderators of the effects of exposure over time. Taken as a whole, the present study points to the central role of attorneys’ individual differences in exposure to trauma-exposed clients in the development of symptoms of PTSD, depression, and functional impairment.

References


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