UNDERSTANDING THE IMPACT OF SECONDARY TRAUMA ON LAWYERS WORKING WITH CHILDREN AND FAMILIES

Presented by the
American Bar Association
Center on Children and the Law,
Standing Committee on Legal Aid & Indigent Defendants,
Division for Public Services,
Commission on Disability Rights,
Health Law Section,
Commission on Youth at Risk and
Center for Professional Development

ABA
Defending Liberty
Pursuing Justice
The materials contained herein represent the opinions of the authors and editors and should not be construed to be the action of the American Bar Association Center on Children and the Law, Standing Committee on Legal Aid & Indigent Defendants, Division for Public Services, Commission on Disability Rights, Health Law Section, Commission on Youth at Risk or Center for Professional Development unless adopted pursuant to the bylaws of the Association.

Nothing contained in this book is to be considered as the rendering of legal advice for specific cases, and readers are responsible for obtaining such advice from their own legal counsel. This book and any forms and agreements herein are intended for educational and informational purposes only.

© 2016 American Bar Association. All rights reserved.

This publication accompanies the audio program entitled “Understanding the Impact of Secondary Trauma on Lawyers Working with Children and Families” broadcast on May 4, 2016 (event code: CE1605CAL).
TABLE OF CONTENTS

1. Presentation Slides

   Christina Rainville

3. Secondary Trauma and Burnout in Attorneys: Effects of Work with Clients Who are Victims of Domestic Violence and Abuse
   Andrew P. Levin

4. Professional Quality of Life Scale (ProQOL): Compassion Satisfaction and Compassion Fatigue
Introductions

Carly Baetz is a psychologist and postdoctoral fellow at Mount Sinai Health System, Center for Child Trauma and Resilience in New York, NY. In her current role, Dr. Baetz is helping to implement trauma-informed practices and treatment in the New York City juvenile justice system, with an emphasis on addressing secondary traumatic stress (STS) among juvenile justice professionals. Dr. Baetz has more than five years of experience providing mental health services to individuals with histories of trauma, including youth involved in the juvenile justice and child welfare systems. Prior to becoming a psychologist, Dr. Baetz represented youth in child protective and juvenile delinquency cases as a staff attorney at the Legal Aid Society, Juvenile Rights Practice in New York, NY.

Introduction to the Audience

In what capacity are you working with children and families?

A. Representing youth in child protection cases
B. Representing youth in juvenile delinquency cases
C. Representing youth in another capacity
D. Representing caregivers in child protection cases
E. Representing caregivers in another capacity
F. Representing/working at a child/family agency
G. Other
Agenda

• Overview of trauma and Secondary Traumatic Stress (STS)
• Impact of STS on attorneys working with children and families
• Strategies for preventing and addressing STS
• Resources
• Q&A

POLLING QUESTION

How would you describe your degree of knowledge about Secondary Traumatic Stress?

A. No knowledge
B. A little knowledge
C. Some knowledge
D. Extensive knowledge - I could do this webinar!
Trauma and its Impact

- Actual or threatened death, serious injury, or sexual violence
- Includes physical abuse, sexual abuse, community violence, loss of loved one
- Significant impact on brain and body
- Changes view and response to stress, others and the world

POLLING QUESTION

Think about the children and families that you work with and/or represent. What percentage of those clients and families have histories of trauma?

A. None
B. Less than 25%
C. 25-50%
D. 50-75%
E. 75-100%
Trauma and Juvenile Court

• 70-90% of youth in the juvenile justice system have histories of trauma
  – Average number of traumas experienced > 6
  – 30-50% develop PTSD

• 90% of caregivers in child protective cases have histories of trauma

Trauma and Juvenile Court

• Legal system is difficult to navigate, even more so for individuals with histories of trauma

• Trauma triggers everywhere!
  – Loss of control
  – Intrusive questions
  – Perception of not being safe or not being heard
How does this Relate to Attorneys?

• Working extensively with clients who are struggling with their own histories of trauma and trauma-related symptoms can have an emotional impact on us

• Emotional distress is expected and understandable - this work is tough and attorneys are human!

Secondary Traumatic Stress (STS)

• Behavioral and emotional response resulting from indirect exposure to trauma

• In DSM-5, criteria for PTSD can be met through indirect exposure to trauma in professional capacity

• STS is also known as vicarious trauma or compassion fatigue

• But differs from burnout
**STS and Child/Family Attorneys**

- STS can result from any aspect of attorney’s job that involves indirect exposure to trauma
  - Listening to client’s trauma stories
  - Preparing cases and reading trauma stories
  - Hearing testimony and other evidence in court

- Zealous advocacy and ethical responsibility to the client, but often forget to take care of ourselves

- Direct exposure to trauma in the workplace

---

**Research on STS and Attorneys**

- Empirical research is still growing, but existing research suggests high rates of STS
  - In one study, rates of STS for family and criminal court attorneys were higher than for mental health professionals (Levin & Greisberg, 2003)
  - Study of public defenders found that 34% met criteria for STS and 75% met criteria for functional impairment (i.e., disruption in personal life, family life, etc.) (Levin et al., 2011)
Symptoms of STS

- Difficulty concentrating and focusing
- Depression/hopelessness
- Avoidance
- Hypervigilance
- Intrusive images
- Nightmares
- Headaches, stomachaches
- Difficulty sleeping
- Difficulty concentrating and focusing

Impact of STS Symptoms

- STS symptoms can have a significant impact on work life, personal life, and mental health and well-being
- But what does this actually look like for attorneys working with children and families?
# STS Symptoms in the Workplace

- **Avoidance**
  - Avoiding certain clients, not returning phone calls
  - Avoiding certain questions in interviews with clients
  - Lateness to work, missing meetings, calling in sick
- **Decreased empathy toward clients**
- **Hypervigilance**
  - Feeling on edge
  - Intense focus or worry about safety or welfare of all clients
  - Easily startled or upset

---

# STS Symptoms in the Workplace

- **Irritability**
  - More easily agitated, argumentative or impatient with co-workers, supervisors, judges, clients
  - Difficulty concentrating, focusing, remembering things
- **Impact on client advocacy**
- **Feeling hopeless about the work**
- **Trouble remembering the purpose**
- **Dreading work**
POLLING QUESTION

Do any of these signs or symptoms show up in your workplace?

A. Yes
B. No
C. I don’t know

STS Symptoms in Personal Life

• Difficulty sleeping
• Nightmares
• Stomachaches, headaches
• Extreme fatigue/feeling tired all of the time
• Strained interpersonal relationships
  • Withdrawal from social interactions or relationships
• Compromised parenting
STS Symptoms in Personal Life

- Irritability or aggressive behavior
- Extreme physical reactions to trauma reminders
- Numbing, withdrawing, shutting down (may include use of alcohol or drugs)
- Change in view of the world and others
  - “World is an unsafe place”

Vulnerability to STS

- **Everyone** who works with individuals with a history of trauma is vulnerable to developing STS
- STS is a *normal* and *understandable* response to this work
- Certain factors can make us more vulnerable:
  - Prior history of trauma (mixed findings)
  - Lack of support, particularly social support and organizational support
  - High caseloads
POLLING QUESTION

What are some of the things that work for you when trying to combat work stress?

A. Exercise
B. Taking walks
C. Talking to friends and/or family
D. Taking vacations
E. Other
F. No strategies

Addressing STS

• Pain and emotional distress are a part of life for everyone, especially in this work
• It is ok to acknowledge this and seek help when it feels overwhelming – you don’t have to go it alone!
Individual Strategies for Addressing STS

• Regular vacations (work-free!)
• Exercise, healthy eating, and sleep
• Breaks during the day
• Setting clear work boundaries (if possible)
• Activities and hobbies outside of work
• Connecting with friends, family, community

Individual Strategies for Addressing STS

• Talk about it! Talk to friends, family, supervisors or other colleagues who understand
• Seek counseling
  • EAP or outside therapy – does not have to be long-term
  • Ideal if therapist has experience treating individuals with trauma – not all of them do!
Individual Strategies for Addressing STS

- Mindfulness practice
- Meditation
- Yoga practice

Think about why you do this work
- Consider discussing with colleagues
- Consider writing this down so you can be easily reminded when things are difficult
Individual Assessment of STS

• **ProQOL** (Stamm, 2009)
  - [http://www.proqol.org/uploads/ProQOL_5_English_Self-Score_3-2012.pdf](http://www.proqol.org/uploads/ProQOL_5_English_Self-Score_3-2012.pdf) (includes scoring)
  - Over past 30 days, “my work makes me feel satisfied,” “I can’t recall important parts of my work with trauma victims”

• **Secondary Traumatic Stress Scale** (Bride et al., 2004)
  - In the last 7 days, “I had trouble concentrating,” “I wanted to avoid working with certain clients”

**POLLING QUESTION**

Does your organization have anything in place to prevent and address STS?

A. Yes
B. No
C. I don’t know
### Organizational Strategies to Address STS

**Organizational culture is key!**

- Foster a safe and supportive environment
  - Address physical and psychological safety
  - Build conversations about STS into meetings, supervision, case discussions
  - Create wellness or STS committees
  - Encourage staff get-togethers (off-site)
  - Increase access to EAP or other supports

### Organizational Strategies to Address STS

- Encourage frequent breaks, leaving work on time, vacations, and support for staff who are feeling overwhelmed
- Consider implementing strategies for helping staff with high caseloads
- Consider developing and implementing a de-briefing protocol for responding to workplace trauma
Organizational Strategies to Address STS

- Consider routine, anonymous surveys of staff to gauge STS and well-being
- Regular staff trainings on:
  - Understanding trauma
  - Understanding the impact of trauma on clients and staff
  - Skills for working with trauma survivors and managing personal “alarms”

  Keep the conversation going!

Supporting Colleagues

- Be alert for signs and symptoms (often subtle)
- Check in with colleagues on a regular basis
- Consider instituting peer support groups
- Normalize STS by talking about it
- Offer resources
- Think about how you would want to be supported
Additional Resources

- NCTSN Learning Center: http://learn.nctsn.org/
- ABA publications on trauma and legal practice

Q&A
Thank you all for listening!

References

One day recently, Tammy Loveland—a well-regarded victim’s advocate who works in a prosecutor’s office—did something out of character. A defense lawyer was taking a position that was upsetting a victim. Of course, defense lawyers often need to take positions that upset a victim—there is nothing unusual about that.

On this day, Loveland stormed into a young prosecutor’s office and started screaming at the prosecutor about the defense lawyer’s demands and telling the prosecutor she was not doing enough to protect the victim. After yelling and using colorful language for several minutes, Loveland burst into tears and fled to her office.

For 18 years, Loveland has worked with countless children (and adults) who have been sexually abused, physically abused, neglected or who have witnessed heinous crimes like murder. She has done it all with endless compassion and grace and never appears fazed by it. Her conduct on this day, however, was the kind that could result in job loss or disciplinary action.

None of this made sense. Loveland was a dedicated employee who was universally respected in the office and the community. Defense lawyers upset victims every day, and Loveland was highly experienced in dealing with those issues. Concerns started running through the office. Was Loveland having marital problems? Maybe someone in her family was not well? No, the problem was more complex. Her sudden outburst was a classic sign of secondary traumatic stress.

Secondary Traumatic Stress
Secondary traumatic stress, also known as vicarious trauma or compassion fatigue, is a condition that mimics post-traumatic stress disorder. It is caused by being indirectly exposed to someone else’s trauma. Much has been written about secondary trauma for social workers and therapists who work directly with children and adults who have experienced trauma. Indeed, many social workers and therapists learn about secondary trauma in their coursework and some have regular trainings on secondary trauma once

What’s Inside:
130 CASE LAW UPDATE
137 POLICY UPDATE
ABA Supports Empowering Indian Tribes in Juvenile Justice Cases
ABA Report Urges Alternatives to Detention for Immigrant Families
138 CUTTING EDGE
Strengthening Families in Baltimore City
140 RESEARCH IN BRIEF
What Courts Should Consider When Determining Children’s Best Interests
144 LEGISLATIVE UPDATE
New Child Welfare Bill Focuses on Keeping Families Together

Internet: http://www.childlawpractice.org
they start working.

Many lawyers, judges, and others who work in the juvenile court system, however, are unaware that secondary trauma might be affecting them or their colleagues. You do not have to work directly with a traumatized child to develop secondary traumatic stress: anyone who works in a courtroom and listens to testimony about traumatic events can be at risk.

Erika Tullberg, an expert on secondary trauma and the resulting secondary traumatic stress, is an assistant professor at New York University’s Child Study Center and the director of a federally-funded effort to implement trauma-informed child welfare practice in New York. Tullberg describes secondary trauma as “a behavioral toxin.” Not only can one develop secondary traumatic stress from listening to others describe traumatic events, one can also be impacted merely by working in an office where others are suffering from secondary trauma. Tullberg says anyone who has experienced a personal trauma, especially in childhood, can be more vulnerable to developing secondary traumatic stress—especially if the individual is working with clients who have suffered a similar kind of trauma.

Any organization that works with individuals who have suffered trauma should focus on secondary trauma, says Tullberg. Secondary trauma can affect an employee’s longevity on the job, as well as the employee’s effectiveness.

If you work in the juvenile court system in any capacity, it is important to know the signs, so you can get help if you have symptoms, and support your colleagues when they need help.

Signs of Secondary Traumatic Stress

Workplace symptoms

The symptoms of secondary traumatic stress that are most typically seen in the workplace are:

- avoidance (e.g., arriving late, leaving early, missing meetings, avoiding clients, skipping certain questions during interviews),
- hypervigilance (e.g., feeling on edge, perceiving colleagues and clients as threatening, feeling like all clients are in danger),
- seeing things as “black or white” rather than tolerating ambiguity,
- becoming argumentative, and
- shutting down or numbing out (alcohol and drug use are common coping mechanisms).

Secondary trauma can affect an employee’s longevity on the job, as well as the employee’s effectiveness.

Tullberg says that organizations often view employees with these symptoms as poor performing workers rather than focusing on the impact that the work has on the employee. Tullberg explains that an organization should not address these symptoms as a disciplinary matter, but rather, organizations should work to do a better job of preparing and sustaining staff through their difficult work.

Personal life symptoms

Secondary traumatic stress can also impact people’s personal lives. Common symptoms can include:

- sleep disturbance and nightmares,
- headaches,
- stomach pain,
- PTSD symptoms such as intrusive thoughts and memories; severe emotional distress or physical reactions to something that reminds the person of the traumatic event; avoidance of people, places or things that remind the person of the event; irritability, angry outbursts or aggressive behavior; inability to focus; being easily started; hypervigilance,
- extreme fatigue/always tired,
- negative thinking and a tendency to become upset about everything,
- strained relationships with family and friends,
- compromised parenting, and
- doubts about whether the world is a safe place.

Tullberg believes training about secondary trauma is key. She notes that organizations provide training on the nuts and bolts of doing the job, but often do not provide training on the emotional impact of the work.

Sources of Secondary Traumatic Stress

Loveland’s situation is a good example of how secondary traumatic stress develops. Her outburst with the prosecutor involved a victim who had recently attempted suicide. The victim’s only adult “family” was the abuser, so when the victim showed up in the emergency room after attempting suicide, the police called Loveland looking for a family contact. There was no one, so Loveland went to the hospital herself to support the victim. She sat with the victim and worked with her in the hospital to help her get the professional help she needed. Now, months later, this frail victim simply could not handle the defense lawyer’s demand, and Loveland was terrified it would send the victim over the edge.

Past client traumas

Working with individuals suffering from suicidal thoughts or behaviors is part of working in the juvenile and criminal court systems. Loveland had previously worked closely with a victim who committed suicide, and that changed her forever. She found, years later, that it was not something she could ever get over.

The victim who committed suicide had had lifelong mental health issues stemming from horrific sexual abuse as a child. She had spent her life in and out of mental health hospitals. She was hospitalized multiple times during the case. She had been raped by a
serial rapist who preyed on vulnerable women with mental health issues and other disabilities. Everyone wanted him prosecuted; the only question was whether the stress of the pending case was too much for the victim. She seemed to be handling it okay. She said she was okay. Her therapist gave the go-ahead at every step of the proceeding. After the defendant pled guilty, she came to the sentencing and seemed happy with the result. Loveland took her out to lunch the day after the verdict, and she seemed fine. Two days later she was gone.

To Loveland, her personal second-guessing was unending. Was the victim unhappy with the sentence? Was the pressure of the case too much for her? Had the case triggered the trauma of her youth? Were signs somehow missed that she was in danger?

Loveland explains that after that suicide, she became hypervigilant. She obsessed about whether every person she works with might be thinking about suicide. She asked victims questions to assess their mental health that she never would have asked before; and she thought about it—constantly.

Given Loveland’s prior trauma of having a victim commit suicide, her behavior with the prosecutor in the second case made sense. Someone who has been through the trauma of losing one victim to suicide would be emotional and “over the top” when another victim, who had previously attempted suicide, was being pushed to the edge.

Loveland later explained that she was embarrassed that she got so out of control. In the moment, she could not remember that the prosecutor was not her enemy, but instead was on her side. There was no way to reason with Loveland. She knew that she was being irrational, but she could not control it.

Personal influences
Loveland also thinks her issues with secondary traumatic stress began before the suicide. After having a child, it became difficult to sit through meetings about child sexual abuse.

She says she started squirming and could not stop thinking about whether she was doing enough to protect her child from the abuse she was hearing about during the workday. It became difficult to listen to details without feeling physically uncomfortable and wanting to leave the room. Loveland, the ultimate professional, never let her colleagues know the work conversations were keeping her up at night. She suffered in silence and never complained, but 18 years of working with trauma victims had an effect.

Addressing Secondary Trauma

People who work in trauma-related fields need defined breaks and should not be checking their emails and texts every few minutes, all night, and on weekends.

Self-Help
Take care of general health and well-being. Tullberg recommends a number of self-help measures, some of which she describes as “general health” recommendations: take regular vacations; exercise regularly; get enough sleep; eat well, etc. In addition, Tullberg recommends leaving the office at a reasonable hour each day, not working outside office hours except in an emergency, and having an agreement with your colleagues not to contact each other off-hours unless it is truly an emergency. People who work in trauma-related fields need defined breaks and should not be checking their emails and texts every few minutes, all night, and on weekends. Put it away, but have some mechanism for people to reach you if there is a true emergency.

It is also important to focus on things you like to do, whether it be art, writing, being connected to your community or friends.

Seek counseling or other supports.
In Tullberg’s experience, people who work with trauma victims work hard at getting the victims to engage in therapy, but are not good at getting themselves to go. Breaking down that barrier and engaging in therapy or other supports to address secondary trauma symptoms is critical, she says. Loveland recommends having a trusted therapist “on call” to talk to every once in a while when the secondary traumatic stress symptoms become overwhelming.

Perform self-assessments. It is important for employees to do regular “self-assessments” or “check-ins.” Free online surveys can help employees gauge where things stand and whether a problem is developing. Two tools to consider:

- Proqol.org has a self-assessment tool to help employees gauge where they stand on the “compassion fatigue/burnout” scale. It also looks at “compassion satisfaction,” or the positive aspects of one’s work.

These kinds of self-assessments can be helpful, as it is easy to lose perspective when one is in the thick of things.

Focus on positive job aspects. Tullberg recommends taking time to focus on positive job aspects and the things that go well, rather than focusing on the trauma. Taking time to do this with colleagues, rather than alone, can help combat the negativity that can develop within a group that is impacted by secondary trauma.

Take vacations. Loveland finds it helpful to take long vacations as often as possible. She recommends taking
two-week vacations because she finds that it takes a few days from work just to begin to unwind.

Organizational Help
While self-help can play an important role in recovery, organizational-level interventions are key. Some organizations look to the employees to “cure” themselves, but that is not a reasonable expectation. Other organizations look to a “quick fix” of running one training session. Tullberg says the most effective programs involve an organization’s long-term commitment to actively addressing the impact of trauma on employees. The most important component of mitigating the impact from secondary trauma (and the best way to limit employees from developing it in the first place) is through organizational changes.

Talk about secondary trauma.
People need to be trained to know what it is, and how to recognize it among themselves and their staff. Some organizations use surveys for the employees to fill out so they can get a personal “weather report” on how they are doing every few months. These surveys can help the employee recognize a developing problem before it gets out of control. These surveys also can be done anonymously but collected by the agency so that the organizational leadership gets an accurate reflection of how the staff is doing on an ongoing basis.

Focus on changing the workplace and organizational culture.
Is this an office where everyone works until 8 p.m. and it is a badge of honor to work long hours? Is everyone expected to respond to emails within five minutes, 24/7, including on the weekend and while on vacation? If so, the culture at the organization will need to change. People who are working around trauma need regular, defined breaks in their schedule.

Create a supportive atmosphere.
Do supervisors take time to support employees? Or do people get reactive and bounce their reactivity off each other, such that, when one person is over-reacting to a situation, or unable to accept ambiguity (for example, perhaps that parent did not mean to hurt the child?), others join in and escalate the response? Is this the kind of office where everyone “one-ups” each other in gruesome details about the cases they are working on? Or do people support each other when discussing trauma and only share limited information on a need-to-know basis or when an employee needs support from a colleague?

Be sensitive when discussing cases.
Loveland recommends greater sensitivity when discussing case details. Even though employees may seem “numb” to the trauma, she points out that topics being discussed can be sensitive for people in the room who do not want to let on that they are suffering. She recommends toning down the discussions and not going into detail unless it is essential for the group to hear.

“Normalize” conversation around secondary traumatic stress.
Organizations should spread the message that secondary trauma symptoms are not a sign of weakness or failure. Organizations also need to train employees so they understand the symptoms and can talk openly about it.

An organization’s culture can affect everyone—including leadership and support staff that may not have much direct client contact. Tullberg explains that an organization’s culture can feed—or even foster—secondary traumatic stress rather than mitigate it. Strategies to address its impact should not be limited to staff who work most closely with clients, but should address the overall culture and functioning of the organization.

How to Help a Colleague
Many people who work in the juvenile court system might recognize the signs of secondary traumatic stress in a colleague, but not know how to help. Approaching colleagues can be difficult, unless the organization’s culture normalizes secondary traumatic stress so everyone feels comfortable having that conversation. Some steps to take:

- Talk about your own struggles with the work as a way to start the conversation.
- Forward helpful resources. The National Child Traumatic Stress Network (http://www.nctsn.org/resources/topics/secondary-traumatic-stress) has a number of helpful resources on secondary trauma.
- Raise the topic at a staff meeting.
- Host a broader training in your office.

Conclusion
Secondary traumatic stress is a normal consequence of the work we do, but we can all work to limit its prevalence and its symptoms.

Christina Rainville JD, is the Chief Deputy State’s Attorney for Bennington County, Vermont, where she heads the Special Investigations Unit. She is also a former recipient of the American Bar Association’s Pro Bono Publico Award.

This article was produced under grant number 2012-VF-GX-K012 from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this article those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice or ABA.
Secondary Trauma and Burnout in Attorneys: Effects of Work with Clients Who are Victims of Domestic Violence and Abuse

Andrew P. Levin, MD

Dr. Levin is Assistant Clinical Professor of Psychiatry at Columbia University College of Physicians and Surgeons, Medical Director of Westchester Jewish Community Services, and site supervisor for the Forensic Fellowship at the Albert Einstein College of Medicine. Dr. Levin practices and teaches in the area of psychological trauma and provides consultation in civil and criminal matters. Please direct inquiries to Andrew P. Levin, MD, Medical Director, Westchester Jewish Community Services, 141 North Central Avenue, Hartsdale, NY 10530 or by email at alevin@wjcs.com.

Over the last generation and particularly following the inclusion of Posttraumatic Stress Disorder (“PTSD”) in the 1980 Diagnostic and Statistical Manual of Mental Disorders, Third Edition (“DSM-III”), the mental health field has witnessed an explosion of interest in trauma and its effects. A decade after the publication of DSM-III, the mental health community began to recognize the effects of working with trauma victims on helping professionals themselves. The phenomenon of “Secondary Traumatic Stress” (“STS”), also labeled “Compassion Fatigue,” has been defined as the “natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person.” STS, as defined by Figley, involves symptoms analogous to those seen in PTSD, i.e., re-experiencing images of the traumas of the person receiving aid, avoidance of reminders of this material, numbing in affect and function, and persistent arousal.

“Vicarious Traumatization” (“VT”), a related concept developed to describe the reactions of therapists working in long-term psychotherapy with victims of domestic violence and child abuse, involves the disruption of deeply held “schema.” Therapists working with these individuals come to doubt deeply held beliefs about safety, the inherent kindness of others, and intimacy. Available research on therapists and counselors working with victims of trauma has consistently established the presence of STS and VT responses. Research in this area has also revealed a correlation between STS and VT and general psychological distress, and there is a consensus that STS and VT degrade the professional’s ability to perform his or her task and function in daily life beyond the job.

In addition to STS and VT, the psychological literature has recognized the syndrome of “burnout.” Burnout develops gradually due to the accumulation of stress and the erosion of idealism resulting from intensive contact with clients. It is characterized by fatigue, poor sleep, headaches, anxiety, irritability, depression, hopelessness, aggression, cynicism, and substance abuse. Although this mixture of symptoms has led some to criticize burnout as an imprecise construct, Jenkins and Baird observe that burnout is supported by multiple statistical analyses and, in fact, has been more rigorously studied than secondary trauma. Risk factors for burnout include female gender, overwork, the slow and erratic pace of the work, lack of success, and the tendency of the work to raise personal issues.
Secondary Trauma Among Legal Professionals

The major thrust in quantitative research on secondary trauma exposure has focused on those who have brief but direct contact with the victim (and may themselves be exposed to danger) such as disaster workers,\textsuperscript{12} firefighters,\textsuperscript{13} and relief workers.\textsuperscript{14} The intensity of exposure in these groups would suggest that it is difficult to analogize their responses to those of therapists and other helpers significantly removed from the trauma itself. However, in spite of the apparent differences between emergency workers and therapists or other helpers, risk factors for the development of STS in therapists parallel those for the development of PTSD in emergency workers, including a prior history of trauma,\textsuperscript{15} prior treatment for a psychological disorder,\textsuperscript{16} and percentage of trauma survivors in therapists’ caseloads\textsuperscript{17} (analogous to the degree of exposure in firefighters\textsuperscript{18} and relief personnel\textsuperscript{19}). A further risk factor for therapists is lack of experience and supervision.\textsuperscript{20}

A small number of studies have focused on psychological responses in legal and law enforcement professionals who work with trauma victims. Follette \textit{et al.} found that police officers experience significantly greater symptoms of psychological distress (anxiety, depression, dissociation, sleep problems) and PTSD than mental health professionals.\textsuperscript{21} A study of 23 Canadian prosecutors working with “sensitive cases” involving domestic violence and incest revealed symptoms of demoralization, anxiety, helplessness, exhaustion, social withdrawal.\textsuperscript{22} A major factor was the high caseloads—the 23 prosecutors worked in 51 different courts and regularly put in as many as 10-40 hours per week overtime.

Jaffe, \textit{et al.} surveyed 105 judges in criminal, family and juvenile courts.\textsuperscript{23} They reported that 63% experienced symptoms of vicarious trauma. Female judges and those who had been on the bench more than six years were at greatest risk. Additional symptoms included sleep disturbances, intolerance of others, physical complaints, and depression. Judges identified the increased number of specialty courts with a “steady diet of highly emotional cases” as particularly stressful aspects of the work. Further, their efforts to be impartial coupled with a sense of isolation from other judges and an inability to discuss cases with others created additional stress.

With an eye to secondary trauma, the clinical law literature has raised issues regarding the lawyer-client relationship and resultant identification and counter-transference in attorneys representing domestic violence victims.\textsuperscript{24} Separate and apart from the issues of vicarious trauma, an earlier literature has described substance abuse and mental illness among attorneys, conceptualizing these disorders as sequela of legal work, but not specifically as the effects of work with traumatized clients.\textsuperscript{25} The possible connection between secondary trauma and these problems deserves further exploration.

Allegretti calls for increased training of attorneys in managing the “face-to-face, long-term, and intensely personal relationship” that develops between client and attorney.\textsuperscript{26} In a joint presentation by the Center for Constitutional Rights and the Bellevue/NYU
Program for Survivors of Torture at the 2007 conference of the International Society for Traumatic Stress Studies, professionals described the development of vicarious trauma in attorneys representing prisoners at Guantanamo. To support the attorneys, the psychologists of the NYU program educated the attorneys about PTSD, techniques for interviewing clients who have suffered torture, and methods of self-care to combat secondary trauma.

In recognition of the complexities of representing individuals with a variety of psychological symptoms and patterns, law school curricula have integrated materials such as Groves' article “Taking Care of the Hateful Patient,” and “The Difficult Legal Client,” co-authored by a psychiatrist. At the Santa Clara University School of Law, students working at the Katharine and George Alexander Community Law Center representing victims of torture seeking asylum participated in course work to learn about the impact of trauma on their clients. In addition, the faculty, in collaboration with psychologists, imparted techniques to facilitate interviewing of these complex clients and to address the impact of work with this difficult material on the students themselves.

The Pace Study of DV Attorneys

In collaborating with domestic violence and criminal attorneys over a several year period, I found varying degrees of psychological distress congruent with the syndromes of STS, VT, and burnout. Supervisors at the Pace Women's Justice Center, a service for indigent women seeking legal remedies to domestic violence, identified a pattern of fear and revulsion in attorneys developing after initial contact with traumatic material, followed by over-involvement with clients, diminished performance, and high rates of turnover. Attorneys working in the homicide arena complained of frustration, fatigue, and demoralization that interfered with performance and family life.

In order to characterize the effects of work with trauma victims on attorneys, we undertook a preliminary questionnaire survey to determine the presence of these symptoms among attorneys working with traumatized clients and to compare them with mental health professionals and social services workers serving similar populations. Full details of the study have been described by Levin and Greisberg. The study recruited 55 attorneys from agencies specializing in domestic violence and family law as well as public defender criminal services. The 87 mental health professionals who participated included therapists such as social workers and psychologists, psychiatrists, and social service workers at a county agency investigating child abuse. Participants completed a two page questionnaire assessing secondary trauma and burnout as well as demographics, professional discipline, years on the job, work hours per week, number of clients in the last year who had traumatic material, personal trauma history, and a history of treatment for “emotional problems” and “substance use.”

Compared with mental health professionals and social service workers, attorneys were consistently higher on both secondary trauma and burnout scales. Across both attorneys and mental health professionals, women had significantly higher scores than men. Mental health treatment history also predicted a higher score on the questionnaire.
for both attorneys and mental health professionals. Prior childhood and adult trauma history were not predictive of higher scores on any of the measures, although they have been in other studies of secondary trauma. Correlation analysis for all subjects revealed a significant positive relationship between number of clients and total score. Hours per week were weakly correlated with burnout score. Caseloads of traumatized clients during the prior year were significantly greater for the attorneys compared to both mental health professionals and social services workers. Fifty-two percent of attorneys saw more than 21 cases in the prior 12 months compared with only 25% and 28% of the mental health and social services professionals, respectively. The small sample size precluded a definitive demonstration that the higher caseloads of attorneys were responsible for their higher questionnaire scores, but the data trended in that direction.

During the course of the study, I had occasion to hear informally from attorneys regarding their experiences. One attorney at a legal aid office representing victims of domestic violence wrote:

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

The themes identified by this attorney include both the direct symptomatic presentation of secondary trauma as well as the long-term effects on worldview identified by McCann and Pearlman. For this attorney it also appears that effects of the work have persisted, albeit at a lower intensity, over an extended time frame. Another common theme was the frustration in representing women who appeared passive and unable to utilize the resources provided. Attorneys drew on the paradigms of “Battered Women Syndrome” and “learned helplessness” to assist in understanding these behavioral patterns.

Study of Law Students

As a follow-up to the study of practicing attorneys we turned to law students working with victims of trauma. The participants were 43 second and third year law students enrolled in a semester long practicum at the Pace Women’s Justice Center working under the direct supervision of faculty interviewing women seeking orders of protection and court intervention, preparing motions, and arguing before the court. The students completed questionnaires at the start and end of the semester measuring secondary trauma, burnout, professional satisfaction, and responses to traumatic material. The students registered only a mild increase in symptoms of burnout and scored significantly lower on secondary trauma and burnout than the practicing attorneys studied earlier. Measures of satisfaction fell in the normal range indicating that the students enjoyed their work and felt they had a positive impact on the lives of their clients. On the
measure of response to “the most upsetting client trauma,” scores measuring intrusive memories and avoidance of the material were comparable to the responses of medical students encountering cadavers and were approximately half of those seen in a clinical population with PTSD. Three students registered responses in the clinical range, indicating a significant impact caused by learning about a client’s trauma. Overall, the study demonstrated that the majority of students working in a family court setting with traumatized clients will not be seriously affected but a small minority may have significant responses. Law school faculty need to be alert to these individuals to provide support and even possible referral to counseling if needed.

**Future Directions**

In light of the studies described, the observations in the clinical law literature, and the two small studies done by our group, it is clear that work with traumatized clients, especially when attorneys grapple with high caseloads and a frustrating system, creates a significant risk of secondary trauma and burnout. Attorneys discussing their experience of secondary trauma at a “Think Tank” on domestic violence felt that in addition to their high case loads, the lack of systematic education regarding the effects of trauma on their clients and themselves—as well as the paucity of forums for regular discussion of these issues—were significant contributors to development of STS and burnout. Even among mental health professionals with advantages of education and supervision, secondary trauma responses are common. Further risk factors for attorneys in the family court include work with cases involving children, a risk factor previously established for secondary trauma, and identification with battered women, as demonstrated by the higher scores among female attorneys and therapists in our study.

In response to the risks of STS, Silver has advocated for educational programming for law students and attorneys regarding the effects of trauma on their clients and themselves. These recommendations build on the strategies advocated by Pearlman and Saakvitne, including education, support, supervision, maintenance of proper boundaries, and self care. They also emphasize the importance of the institutional environment, often described by attorneys in our study as either “hostile” or, at best, “indifferent” to their personal needs. Similarly, in a recent review, Salston and Figley noted, “We must do all that we can to insure that those who work with traumatized people—including but not limited to those exposed to crime victimization—are prepared. […] A place to start is to incorporate stress, burnout, and compassion fatigue into our curriculum, and especially our supervision.”

Consulting mental health professionals can assist legal professionals in high risk areas (family court or criminal settings) in identifying STS, burnout, and vicarious trauma, as well as collaborating in the development of consistent approaches to monitoring and managing its effects. In addition to consultation, mental health professionals, as utilized at Santa Clara University School of Law, can play an important role in the development of law school curricula and continuing legal education programs. Future research should focus on clarifying the nature and extent of secondary traumatic responses,
understanding their relationship to PTSD, and delineating the risk factors for their development in attorneys, judges, and allied professions. This work would then form the basis for identifying the most effective interventions for reducing secondary trauma among legal professionals in order to enhance the delivery of legal services to victims of trauma.

4 Id.
10 Id.
33 See Figley, supra note 2; McCann & Pearlman, supra note 2.
39 McCann & Pearlman, supra note 2; Figley, supra note 2; Brady, Guy, Poelstra & Brokaw, supra note 10; Pearlman & Maclan, supra note 10; Schauben & Frazier, supra note 10.
40 Meyers & Cornille, supra note 2.
41 Figley, supra note 2.
42 Silver, supra note 23.
43 Laurie Anne Pearlman & K.W. Saakvitne, Trauma and the Therapist (1995).
45 Parker, supra note 28.
When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

<table>
<thead>
<tr>
<th>Question</th>
<th>1=Never</th>
<th>2=Rarely</th>
<th>3=Sometimes</th>
<th>4=Often</th>
<th>5=Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am happy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am preoccupied with more than one person I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I get satisfaction from being able to [help] people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel connected to others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I jump or am startled by unexpected sounds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I feel invigorated after working with those I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I find it difficult to separate my personal life from my life as a [helper].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I think that I might have been affected by the traumatic stress of those I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I feel trapped by my job as a [helper].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Because of my [helping], I have felt &quot;on edge&quot; about various things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I like my work as a [helper].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I feel depressed because of the traumatic experiences of the people I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I feel as though I am experiencing the trauma of someone I have [helped].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I have beliefs that sustain me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I am pleased with how I am able to keep up with [helping] techniques and protocols.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I am the person I always wanted to be.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. My work makes me feel satisfied.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. I feel worn out because of my work as a [helper].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. I have happy thoughts and feelings about those I [help] and how I could help them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. I believe I can make a difference through my work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I am proud of what I can do to [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. As a result of my [helping], I have intrusive, frightening thoughts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. I feel &quot;bogged down&quot; by the system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. I have thoughts that I am a &quot;success&quot; as a [helper].</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. I can't recall important parts of my work with trauma victims.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. I am a very caring person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. I am happy that I chose to do this work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other’s trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.
WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

### Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The sum of my Compassion Satisfaction questions is</strong></td>
<td><strong>So My Score Equals</strong></td>
<td><strong>And my Compassion Satisfaction level is</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 or less</td>
<td>43 or less</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Around 50</td>
<td>Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are “reverse scored.” If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. “I am happy” tells us more about the effects of helping when you are not happy so you reverse the score.

<table>
<thead>
<tr>
<th>You Wrote</th>
<th>Change to</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The sum of my Burnout Questions is</strong></td>
<td><strong>So my score equals</strong></td>
<td><strong>And my Burnout level is</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 or less</td>
<td>43 or less</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Around 50</td>
<td>Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The sum of my Secondary Trauma questions is</strong></td>
<td><strong>So My Score Equals</strong></td>
<td><strong>And my Secondary Traumatic Stress level is</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 or less</td>
<td>43 or less</td>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Around 50</td>
<td>Average</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© B. Hudnall Stamm, 2009-2012. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold. Those interested in using the test should visit www.proqol.org to verify that the copy they are using is the most current version of the test.