Understanding & Mitigating Compassion Fatigue for Legal Professionals

Speakers: Linda Albert, LCSW, CSAC

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. The State Bar of Wisconsin holds the largest set of research data examining 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.

Presentation Outline

I. Defining compassion fatigue. What is it? How does it play out?
II. What puts legal professionals at risk?
III. Development of compassion fatigue; the brain keeps the score.
IV. Interface between impairment and ethical violations.
V. Mitigating compassion fatigue; what is the formula for staying fit to practice.

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 30 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 WisLAP Coordinator.
Seminar Outline
Keeping Legal Minds Intact: Mitigating Compassion Fatigue Among Legal Professionals

I. DISCIPLINARY RULES

A. SCR 20:1.1. 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. SCR 20:1.3. Diligence

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

C. SCR 20:1.4 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 SCR 20:1.0(f), 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. SCR 20:1.16. 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

D. SCR 20:8.4.

It is professional misconduct for a lawyer to:

(a) violate or attempt to violate the Rules of Professional Conduct, knowingly assist or induce another to do so, or do so through the acts of another;
... 
(c) engage in conduct involving dishonesty, fraud, deceit or misrepresentation;
(d) state or imply an ability to influence improperly a government agency or official or to achieve results by means that violate the Rules of Professional Conduct or other law;
(f) violate a statute, supreme court rule, supreme court order or supreme court decision regulating the conduct of lawyers;

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

SCR 20:8.3 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.

IV. ETHICS CASES

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V. UNDERSTANDING COMPASSION FATIGUE AND MENTAL HEALTH CONDITIONS WHICH CORRELATE WITH ATTORNEY DISCIPLINE; BEST PRACTICES FOR STAYING FIT TO PRACTICE

VI. ASSISTANCE PROGRAMS

A. Wisconsin Lawyer's Assistance Program (WISLAP)

WisLAP Manager: Linda Albert lalbert@wisbar.org
(800) 444-9404 ext. 6172
WisLAP Coordinator: Mary Spranger mspranger@wisbar.org
(800) 444-9404 Ex. 6159

24 hour helpline: (800) 543-2625

B. Ethics Hotline

State Bar’s ethics counsel: Monday through Friday, 9 a.m. to 5 p.m.

Timothy Pierce tpierce@wisbar.org
(608) 250-6168 or (800) 444-9404, ext. 6168,
Aviva Kaiser akaiser@wisbar.org
(800) 444-9404 ext. 6158

C. Law Office Management Assistance Program

State Bar’s LoMAP counsel: Monday through Friday, 9 a.m. to 5 p.m.
Tison Rhine trhine@wisbar.org
(608) 250-6012 or (800)-444-9404 ext. 6012

CASE LAW

MEDICAL INCAPACITY CASES-GENERAL

In Matter Of Disciplinary Proceedings Against John Loew, 2010 WI 23 (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 Loew 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. Attorney Loew sought help from his primary physician in August 2007 and was diagnosed with anxiety and depression. He was given anti-depressant medication along with a recommendation for therapy. Attorney Loew consulted a psychiatrist in December 2007 and attended some therapy sessions beginning in early 2008. In August 2009 Dr. Gregory J. Van Rybroek, a licensed psychologist, conducted an independent psychological evaluation of Attorney Loew. Dr. Van Rybroek concluded, to a reasonable degree of professional certainty, that during the time Attorney Loew was retained in the misconduct cases he was in the throes of a major depressive episode primarily brought on by a workload he ultimately became unable to manage. Dr. Van Rybroek said it appeared the volume of Attorney Loew's workload, exacerbated by the death of a close friend, created overwhelming stress that led to serious depression. Dr. Van Rybroek opined that the situational stress led to the point where Attorney Loew became largely dysfunctional. Dr. Van Rybroek was of the opinion that Attorney Loew’s depression symptoms were situational rather than driven by a genetic predisposition toward professional certainty, that Attorney Loew’s current level of functioning was much improved. Dr.
Van Rybroek was of the opinion that Attorney Loew could return to the practice of law, subject to certain conditions, including entering into a therapy relationship to assist with better self-understanding, specifically in learning more about the internal triggers that make it difficult for him to limit his workload; remain under the care of a psychiatrist for purposes of monitoring his medication; and he should not work in the solo practice of law but rather should work in a structured legal environment where his work can be monitored. While the referee said the fact that Attorney Loew was suffering from depression in late 2006 and early 2007 was well documented in the record, his testimony at the hearing made it clear that his difficulty in running a solo law practice began well before the onset of his depression. The referee said at most Attorney Loew's depression was a contributing factor to the events outlined in the OLR's complaint, not a causal factor. The OLR had sought a six-month suspension of Attorney Loew's license. The court agreed with the referee's recommendation of a 60 day suspension and that for a period of five years following his resumption of the practice of law, the following conditions shall be imposed upon John R. Loew's practice of law: A. enter into a therapy relationship to assist with better self-understanding, specifically in learning more about the internal triggers that make it difficult for him to limit his workload; B. remain under the care of a psychiatrist, particularly for monitoring of his medication needs; C. shall engage in the practice of law under the direct supervision of a licensed attorney acceptable to and approved by the Office of Lawyer Regulation. Attorney Loew's supervising attorney shall have all the duties generally held by a supervising attorney under SCR 20:5.1(b); D. submit to the OLR, on a semi-annual basis, a report from his treating psychiatrist outlining his ongoing treatment. The reports should disclose any recurrences of the depression, and if any, whether such recurrences pose an unreasonable risk to the public if John R. Loew is permitted to continue the practice of law; E. submit to the OLR, on a semi-annual basis, a report from his supervising attorney.

In Matter Of Disciplinary Proceedings Against Nunner, 2009 WI 89, 769 N.W.2d 858 (3 year suspension for neglect and misrepresentation in multiple matters. Although Nunnery did not specifically argue mitigating factors here, the record discloses the referee's consideration of Attorney Nunnery's significant personal and physical problems during the relevant time periods, including his hospitalization, as well as the illness and death of a member of his family. The referee noted Attorney Nunnery admitted that, as a sole practitioner, he had taken on more work than he could handle effectively. Nunnery also claimed stressors of being caught in Hurricane Katrina, as well as being subjected to a $2.5 million malpractice verdict which was ultimately reversed on appeal and handling complex litigation. The court found that these factors did not excuse the misconduct but were considered in mitigation.

In Matter Of Disciplinary Proceedings Against Scott E. Hansen, 2009 WI 56, 768 N.W.2d 1 (9 month suspension for multiple counts of misconduct and conditions on reinstatement. Hansen claimed the misconduct was due to depression. The OLR indicated it considered Attorney Hansen's depression a mitigating factor, but noted that there was insufficient medical evidence submitted in this proceeding to substantiate the scope of his condition. The OLR observed that progressive discipline was warranted because of Attorney Hansen's disciplinary history. It noted that sanctions in other cases ranged from revocation to a six-month suspension for comparable misconduct. The OLR noted further that Attorney Hansen's failure to return unearned fees and his failure to cooperate with the OLR were aggravating factors not easily attributable to depression. The OLR eventually recommended a one-year suspension of Attorney Hansen's for Attorney Hansen's claim that he has suffered from depression since 1994. Attorney Hansen did file a letter from a nurse that states that he has had a "major depressive disorder" for the past "several years." Moreover, the referee stated that he failed to "see how [Attorney Hansen]'s disorder can explain Attorney Hansen's attempts to deceive not only his clients but also the Court of Appeals and the Office of Lawyer Regulation. Nor can I see how this disorder would prevent Attorney Hansen from returning fees which he agrees were unearned and which
he promised to return." The referee then recommended a six-month suspension of Attorney Hansen's license describing his depression as "a partial mitigating factor." The court imposed a 9 month suspension and the following condition upon reinstatement: Hansen "shall undergo a medical evaluation by a medical professional selected by the Office of Lawyer Regulation and a copy of that evaluation shall be provided to the Office of Lawyer Regulation as a condition for reinstatement, with the understanding that Scott E. Hansen may also submit an evaluation performed by a medical professional of his choice. If this condition is not met, the license of Scott E. Hansen to practice law in Wisconsin shall remain suspended until further order of this court."

_In the Matter of Disciplinary Proceedings Against John E Raftery_, 2007 WI 137, 306 Wis.2d 28, 742 N.W.2d 315 (6 month license suspension for multiple acts of neglect, failure to cooperate and failure to comply with rules regarding prior temporary suspension. Referee rejected assertion that all of the misconduct was the result of his longstanding chronic depression, for which he had received both inpatient and outpatient treatment. While the referee noted that Attorney Raftery's medical experts were of the opinion that Attorney Raftery had suffered from chronic depression for years, the referee said there was no evidence in the record that the medical experts related each and every count of misconduct that occurred in this case solely to the chronic depression. The referee pointed out that many of the counts of misconduct related to deliberate misrepresentations by Attorney Raftery to the OLR during its investigation of the various client grievances and to Attorney Raftery's failure to comply with supreme court rules following his temporary suspension. The referee concluded that this misconduct was not solely the result of Attorney Raftery's being "paralyzed" by depression, but rather was intentional misconduct undertaken in an effort to deceive the OLR and the public. Rather than viewing Attorney Raftery's chronic depression as an excuse for his misconduct, the referee found it to be a mitigating circumstance to be considered in recommending an appropriate discipline. Conditions imposed for a period of two years: A. law practice shall be monitored as set forth in the "Suggested plan for oversight and accountability filed by the attorney; B. shall be required to submit to OLR, on a quarterly basis, a report that he is in compliance with the "Suggested plan for oversight and accountability." The report shall disclose any patterns of neglect of client matters. Such quarterly reports shall include the written approval of the attorney; C. required to submit to OLR, on a semiannual basis, a report from his treating psychologist/psychiatrist outlining his ongoing treatment. The reports should disclose any recurrences of the depression, and if any, whether such recurrences pose an unreasonable risk to the public if he is then permitted to continue the practice of law; D. Should he, for any reason, leave the Ritger Law Office, he shall immediately inform OLR, and any continuance of his practice of law shall be subject to monitoring and a plan similar to the above.

_Disciplinary Proceedings Against Shindell_, 2002 WI 133, 258 Wis.2d 63, 654 N.W.2d 844 (1 year suspension added onto to existing suspension for various misconduct. The court noted that "the record demonstrates the existence of a number of mitigating factors, including the fact that Attorney Shindell suffered from serious personal and health problems and also had
administrative problems in her office which seemed to peak in early 1999. As the referee also noted, however, it would have been appropriate for Attorney Shindell to have obtained assistance from other attorneys in her office or brought in outside counsel during this time, and the absence of this assistance was not the fault of her clients, who were unaware of Attorney Shindell's problems.”

**Alcohol & Drug Cases – Mitigation**

*In the Matter of Disciplinary Proceedings Against Compton*

2010 WI 112 (2010)

On May 6, 2010, the OLR filed a disciplinary complaint in this matter alleging that Attorney Compton committed criminal acts that reflect adversely on his honesty, trustworthiness, or fitness as a lawyer in other respects, in violation of SCR 20:8.4(b). Aggravating factors include Attorney Compton's prior disciplinary history, the pattern of misconduct, the potential vulnerability of K.L., and the harm to K.L. Mitigating factors include the fact that Attorney Compton has been "wholly cooperative in this matter," including entering into an agreement admitting his misconduct and agreeing to the level of discipline sought by the OLR. He acknowledged the wrongfulness of his conduct and offered to turn in his law license. He voluntarily entered into a drug treatment program and has expressed remorse for his conduct. The court is advised that Attorney Compton is undergoing voluntary monitoring and as of June 11, 2010, the monitor reported Attorney Compton's continued compliance with the requirements of his monitoring program.

We approve the stipulation and adopt the stipulated facts and legal conclusions of professional misconduct. We agree that a two-year suspension is appropriate and consistent with this court's past practice. We further agree that it is appropriate to order the suspension to commence on March 16, 2010, the date Attorney Compton's law license was summarily suspended by this court. The imposition of a two-year suspension will require Attorney Compton to complete successfully the formal reinstatement process in order to regain his license to practice law in Wisconsin.

*In re Brandt*, 766 N.W.2d 194 (Wisconsin 2009)

The Office of Lawyer Regulation brought a complaint against Attorney Brandt for failure to properly supervise an employee and for multiple convictions of operating a motor vehicle while intoxicated. The Supreme Court found that the lawyer’s multiple drunk driving convictions did constitute a violation Wis. Sup. Ct. R. 20:5.3(b) because his convictions did demonstrate a serious lack of respect for the law and, therefore relate to his fitness as a lawyer. The court imposed a public reprimand. In this case, a sanction beyond a public reprimand was not necessary because they found that Attorney Brandt was the victim of his employees' embezzlement, accepted responsibility for his failure to supervise his employee, had entered pleas to the drunk driving charges and served a significant jail sentence, paid substantial fines, had taken remedial action to address his drinking problem and sought treatment.

*Disciplinary Proceedings Against Verlin Peckham*, 115 Wis.2d 494, 340 N.W.2d 198 (1983)

(The appellant argues that any suspension of his license should be stayed because his misconduct was caused by his alcoholism. He distinguishes his case from *Disciplinary
Proceedings Against Glass Schroeder, 113 Wis.2d 672 (1983), where the court denied a request for a stay of suspension and revoked the attorney's license. Unlike the appellant, Glass Schroeder misappropriated a large sum of client money over a long period of time and uttered a forged check, for both of which he was criminally convicted. Also, Glass Schroeder did not present evidence that his misconduct was causally related to his alleged drug dependency. The appellant contends that his recognition of his alcoholism and his efforts at rehabilitation render this case susceptible of a "new" discipline, one which has been recognized in other jurisdictions. He argues that the public can be adequately protected if the court conditions his continued practice on supervision by a practicing attorney, complete abstinence from alcohol, weekly attendance at Alcoholics Anonymous or Lawyers Concerned for Lawyers meetings, post treatment by his psychologist, and his maintenance of complete records concerning client funds and property coming into his possession. These conditions were imposed by the Minnesota Supreme Court in a disciplinary proceeding, Petition of Johnson, 322 N.W.2d 616 (1982), after the disciplinary agency and the attorney had stipulated to them.

The referee considered the appellant's misconduct in light of the alcoholism defense and concluded: "...His conduct does appear to have been precipitated by a drinking problem rather than an intent on his part to deceive his clients or to convert their funds. This, however, does not afford him a recognizable defense. The trust account violations which came to light as the result of a board audit and which were not denied renders his misconduct extremely serious and warrants the discipline sought by the Board based upon similar cases in the past." We agree, and we adopt the findings, conclusions and recommendation of the referee).
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:
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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,


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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, Vrklefski 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 & McAn, 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, Hemssworth, 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 & Masic, 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, Munyaner, 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 analyses. 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 (Hoyle & Smith, 1994) with AMOS software (Version 18.0.0; 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 \( \leq 2 \), RMSEA 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 (\( M = 2.40, SD = 1 \)), 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? 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.

### 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 (\( p > .18 \)). 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

<table>
<thead>
<tr>
<th>Variable</th>
<th>Time 1</th>
<th>Time 2</th>
<th>t(106)</th>
<th>LL</th>
<th>UL</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</td>
<td>1.06</td>
</tr>
<tr>
<td>Work-related exposureb</td>
<td>3.17</td>
<td>1.23</td>
<td>2.89</td>
<td>1.10</td>
<td>2.76**, 0.080</td>
<td>0.49</td>
<td>0.27</td>
</tr>
<tr>
<td><strong>PTSD</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></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</td>
<td>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>3.44***</td>
<td>0.093</td>
<td>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</td>
<td>0.10</td>
</tr>
<tr>
<td><strong>CES–D</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.54</td>
<td>10.51</td>
<td>15.67</td>
<td>9.59</td>
<td>-1.43, ns</td>
<td>-2.67</td>
<td>0.43</td>
<td>.68***</td>
</tr>
<tr>
<td><strong>SDS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.17</td>
<td>6.95</td>
<td>9.82</td>
<td>6.78</td>
<td>0.57, ns</td>
<td>-0.84</td>
<td>1.53</td>
<td>.62***</td>
</tr>
</tbody>
</table>

Note. \( N = 107 \). PTSD = posttraumatic stress disorder; IES–R = Impact of Event Scale—Revised; CES–D = Center for Epidemiological Studies Depression Scale; SDS = Sheehan Disability Scale; CI = confidence interval; LL = lower limit; UL = upper limit. 

* Cohen’s \( d \) has been corrected for dependence between means using Morris and DeShon’s (2002) Equation 5. ** 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, $\beta = .28$, $t = 3.43, p < .001, d = 0.67$, and a decreased level of hours at work, $\beta = -.18, t = -2.17, p < .03, d = 0.42$, at the subsequent time point, as evidenced by the statistically significant cross-lagged parameters. These findings indicate that exposure significantly predicted or affected attorneys’ PTSD symptomatology or hours spent at work 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 PTSD 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’ CES–D 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 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. These findings indicate that exposure significantly predicted or affected attorneys’ CES–D symptomatology and hours spent at work at Time 2, and that attorneys’ CES–D 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.
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, 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. 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.

**Figure 2.** The cross-lagged model for the prediction of depressive symptoms (Center for Epidemiological Studies Depression Scale [CES-D]). Rectangles indicate measured variables. Small circles reflect residuals (e). Bold numbers above or near endogenous variables represent the amount of variance explained ($R^2$). Bidirectional arrows depict correlations and unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. $N = 107$. * $p < .05$. ** $p < .01$. *** $p < .001$ (two-tailed). When we controlled for the effects of gender, age, years on the job, and size of local office, the significant and nonsignificant effects, as presented in this figure, were not altered. These effects were removed to simplify the figure.

**Figure 3.** The cross-lagged model for the prediction of functional impairment symptoms (Sheehan Disability Scale [SDS]). Rectangles indicate measured variables. Small circles reflect residuals (e). Bold numbers above or near endogenous variables represent the amount of variance explained ($R^2$). Bidirectional arrows depict correlations and unidirectional arrows depict hypothesized directional or “causal” links. Standardized maximum likelihood parameters are used. Bold estimates are statistically significant. $N = 107$. * $p < .05$. ** $p < .01$. *** $p < .001$ (two-tailed). When we controlled for the effects of gender, age, years on the job, and size of local office, the significant and nonsignificant effects, as presented in this figure, were not altered. These effects were removed to simplify the figure.
Furthermore, average caseload correlated with intrusion and hyper arousal 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. Boscarino, 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-lagged 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-lagged 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 Vrkilevski 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, & Jandle, 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 & Regehr, 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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Keeping Legal Minds Intact:
Mitigating Compassion Fatigue among Government Lawyers
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What is compassion fatigue?
There are several different terms often used to refer to the same phenomenon; to name a few: compassion fatique, 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 lalbert@wisbar.org.

References


Vrklevski, L., & Franklin, J., Vicarious trauma: The Impact on Solicitors of Exposure to Traumatic Material. Traumatology, 14; 106 (2008) Online version found at http://tmt.sagepub.com/cgi/content/abstract/14/1/106.
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. Attorneys participated 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 Liddell, 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. Piwowarcyzy 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; Piwowarcyzy 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 as part of a program to raise awareness about stress. Potential participants were instructed to select the closest number on a 0-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 α = 0.80, 0.82, and 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 helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep

1Baron 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).
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 (2010): 0.88, 0.81, and 0.75 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. 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 staff 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.

**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 staff 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.
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.

Mediational 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 ($\beta = 0.09, t = 1.46$, not significant [ns]) when hours at work ($z = 3.06, p < 0.01$) and exposure to trauma-exposed clients ($z = 3.003, p < 0.01$) 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

### TABLE 1. 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>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>132</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>106</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</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 with 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.
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>Group</th>
<th>Mean</th>
<th>SD</th>
<th>Mean</th>
<th>SD</th>
<th>$t$ ($df = 343$)</th>
<th>Effect Size ($d$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td></td>
<td></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>
<td>4.52**</td>
<td>0.52</td>
</tr>
<tr>
<td>IES-R avoidance</td>
<td>0.65</td>
<td>0.65</td>
<td>0.33</td>
<td>0.49</td>
<td>4.42**</td>
<td>0.51</td>
</tr>
<tr>
<td>IES-R hyperarousal</td>
<td>0.55</td>
<td>0.65</td>
<td>0.25</td>
<td>0.44</td>
<td>4.31**</td>
<td>0.50</td>
</tr>
<tr>
<td>$&lt;33$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$&gt;33$</td>
<td></td>
<td></td>
<td></td>
<td></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>
<td>4.66**</td>
<td>0.54</td>
</tr>
<tr>
<td>$&lt;16$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$&gt;16$</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SDS</td>
<td>9.80</td>
<td>6.77</td>
<td>3.61</td>
<td>4.57</td>
<td>8.58**</td>
<td>0.99</td>
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<tr>
<td>ProQOL5*-CS</td>
<td>34.92</td>
<td>6.53</td>
<td>36.62</td>
<td>6.46</td>
<td>2.24*</td>
<td>0.26</td>
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<tr>
<td>ProQOL5*-BO</td>
<td>27.36</td>
<td>6.09</td>
<td>21.57</td>
<td>5.36</td>
<td>8.47**</td>
<td>0.98</td>
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<tr>
<td>ProQOL5*-STS</td>
<td>21.20</td>
<td>5.91</td>
<td>16.82</td>
<td>4.80</td>
<td>6.73**</td>
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$^a$At the 75th percentile.

$^b$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>
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<tr>
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<th>PTSD (IES-R)</th>
<th>ProQOL5*</th>
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<tr>
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<td>Intrusion</td>
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<td>Mean SD</td>
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<table>
<thead>
<tr>
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<th>CS BO STS CES-D SDS</th>
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<tr>
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<tr>
<td></td>
<td>-0.12 0.42* 0.34* 0.24* 0.42*</td>
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<tr>
<td></td>
<td>0.07 -0.09 -0.04 -0.05</td>
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<td>0.07 -0.03 -0.05 -0.09 -0.07</td>
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<td>0.00 0.09 0.09 0.03 0.08</td>
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<tr>
<td></td>
<td>-0.02 0.04 0.02 0.01 -0.02</td>
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<tr>
<td></td>
<td>0.24 0.28* 0.27* -0.17 0.38* 0.31* 0.30* 0.37*</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.

$^a$Group is a binary-coded variable (0, administrative support staff; 1, attorney).

$^b$Sex is a binary-coded variable (0, women; 1, men).

$^*$p < 0.05 (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.
We tested whether work-related exposure (the mediators) significantly reduced (accounted for) the direct relation between groups and functional impairment symptoms (the outcome). To do this, we specified a model in which groups had a direct path to SDS 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 ($W^2(6) = 6.103, p = 0.412, W^2/df = 1.02, NNFI = 1.0, CFI = 1.0, RMSEA = 0.007 [CI, 0.000 to 0.07]$). As noted earlier, the direct path from groups to SDS symptoms was significant. However, this path became significantly weaker ($\beta = 0.25, t = 4.24, p < 0.0001$) when hours at work ($\beta = 3.83, p < 0.001$) and exposure to clients’ traumatic events ($\beta = 3.60, p < 0.001$) were included in the model. As shown in Figure 2, attorneys were significantly associated with higher hours at work ($\beta = 0.24, t = 3.866, p < 0.0001$) when hours at work ($\beta = 3.60, p < 0.001$) and exposure to clients’ traumatic events ($\beta = 3.60, p < 0.001$) were included in the model. As shown in Figure 2, attorneys were significantly associated with higher hours at work ($\beta = 0.50, t = 10.69, p < 0.0001$), which, in turn, was associated with SDS symptoms ($\beta = 0.21, t = 4.09, p < 0.0001$); moreover, attorneys were significantly associated with higher exposure to trauma-exposed clients ($\beta = 3.97, p < 0.0001$), which, in turn, was associated with SDS symptoms ($\beta = 0.19, t = 4.03, p < 0.0001$). Therefore, work-related exposure variables mediated (albeit not exclusively) the attorneys’ vulnerability to functional impairment symptoms. This model significantly explained 29% of the variance in SDS. Therefore, when work-related exposure (the mediators) was included in the model, it added a significant 9% to the explained variance in SDS.

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.

Mediatinal 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 ($\beta = 3.60, p < 0.001$) and exposure to clients’ traumatic events ($\beta = 3.60, p < 0.001$) were included in the model.
exposure to trauma-exposed clients ($z = 3.85, p < 0.001$) were included in the model. As shown in Figure 3, attorneys were significantly associated with higher hours at work ($\beta = 0.50; t = 10.70, p < 0.0001$), which, in turn, was associated with ProQOL5 symptoms ($\beta = 0.25; t = 4.38, p < 0.0001$). 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.

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 ($\beta = 0.24, t = 4.67, p < 0.0001$). 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 ($\beta = 0.08, t = 1.39, ns$) when hours at work ($z = 2.45, p < 0.05$) and exposure to trauma-exposed clients ($z = 3.20, p < 0.01$) were included in the model. As shown in Figure 4, attorneys were significantly associated with higher hours at work ($\beta = 0.50; t = 10.72, p < 0.0001$), which, in turn, was associated with CES-D symptoms ($\beta = 0.15; t = 2.51, p < 0.05$); 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 CES-D symptoms ($\beta = 0.22; t = 3.90, p < 0.0001$). 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 ($R^2$). 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). 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 ($R^2$). 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). CES-D indicates Center for Epidemiological Studies Depression Scale.
Secondary Traumatic Stress in Attorneys

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 hours and 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, 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 (1995) 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. Because 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 interaction of their level of 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.

ACKNOWLEDGMENTS

The authors thank Beth Stamm, PhD, for her input on the use and scoring of the ProQOLS as well as the overall design and Jeff Apotheker, PhD, for his critique of the original design and support of the submission to the research committee. They also thank all of the participants in this study. Finally, they thank the reviewers for their constructive suggestions and comments on an earlier draft of this paper.

DISCLOSURE

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REFERENCES


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