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Vicarious Trauma: The Impact on Solicitors of Exposure to Traumatic Material

Lila Petar Vrklevski and John Franklin

This study explored vicarious trauma in the legal profession. A random sample of male and female criminal law (n = 50) and noncriminal law (n = 50) solicitors completed a research pack containing the following questionnaires: a demographic questionnaire; Vicarious Trauma Scale; Satisfaction With Work Scale; Depression, Anxiety, and Stress Scales; Impact of Event Scale–Revised; and Trauma and Attachment Belief Scale. Criminal lawyers reported significantly higher levels of subjective distress and vicarious trauma, depression, stress, and cognitive changes in relation to self-safety, other safety, and other intimacy. No significant differences were found between the two groups on measures of satisfaction with work or coping strategies in relation to work-related distress. Multiple trauma history was associated with higher scores on measures of symptomatic distress.

Keywords: vicarious trauma; solicitors; depression; anxiety; stress; cognitive changes

The term *vicarious traumatization* is attributed to McCann and Pearlman (1990b) and describes the changes that occur in trauma workers as a result of working with trauma survivors. It is a cumulative process "through which the therapist's inner experience is negatively transformed through empathic engagement with the clients' trauma material" (Pearlman & Saakvitne, 1995, p. 280).

Vicarious trauma involves "profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne, 1995, p. 152). These changes include disruptions in both self and professional identity, worldview, spirituality, abilities, and cognitive beliefs particularly in the areas of safety, trust, esteem, intimacy, and control (Saakvitne & Pearlman, 1996). Whereas posttraumatic stress disorder (PTSD) refers to the impact on primary victims of trauma, vicarious traumatization refers to the impact on secondary victims of trauma (i.e., those that work with the primary victims of trauma).

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Several other terms have also been used to describe the negative effects that result from working with trauma survivors. These include compassion fatigue or secondary traumatic stress, countertransference, and burnout (Stamm, 1997). Figley (1995) used the term *compassion fatigue* to describe secondary traumatic stress effects. He explained that "compassion is a feeling of deep sympathy or sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (p. 7). Countertransference refers to a therapist's unconscious and conscious responses to a particular client's transference. It is not specific to trauma work (Wilson & Lindy, 1994). Burnout occurs as a result of prolonged work, leading to emotional exhaustion, erosion of idealism, depersonalization, and loss of self-efficacy (Figley, 1989; Pearlman & Saakvitne, 1995; Sexton, 1999). Burnout can occur in all types of work. The distinction between these terms in the empirical literature is often not made clear, with various studies using some of the terms interchangeably. While there are similarities, overlap, and an interactional effect between the concepts of vicarious trauma, compassion fatigue, countertransference, and burnout, there are also discernible differences (Pearlman & Saakvitne, 1995; Sabin-Farrell & Turpin, 2003). The

major difference between these other terms and vicarious trauma is that the latter focuses on changes in cognitive schemas while still acknowledging symptomatic distress (McCann & Pearlman, 1990b).

McCann and Pearlman (1990b) suggest that there are unique aspects of working with survivors of sexual abuse that increase the risk of trauma workers developing vicarious trauma. Specifically, they identify empathic engagement with trauma survivors who relate narratives of overwhelming horror and pain as one of the mechanisms involved in the development of vicarious trauma. Another factor said to be involved in this process is a desire to render assistance.

They argue that vicarious trauma can lead to personal, professional, and social effects, hence it is crucial to the well-being of clients and trauma professionals to recognize and resolve vicarious trauma (Pearlman & Saakvitne, 1995). Unaddressed vicarious trauma can lead to a loss of effective treatment for the client; an inability to discharge professional, social, and personal responsibilities for the trauma worker; detachment and emotional withdrawal from family and friends; depersonalization; and disillusionment with the organization (Pearlman & Saakvitne, 1995).

Research on vicarious trauma, although predominantly focused on therapists treating survivors of sexual victimization, has also addressed other professional groups (McCann & Pearlman, 1990a). Over the past decade researchers have explored the impact of trauma work on nurses and doctors (Alexander & Atcheson, 1998; Carson, Leary, de Villiers, Fagin, & Radmall, 1995; Clark & Gioro, 1998), ambulance officers (Young & Cooper, 1999), jurors (Hafemeister, 1993), mental health staff (Zimmering, Munroe, & Gulliver, 2003), police officers (Follette, Polusny, & Milbeck, 1994), and museum workers preparing the Holocaust Memorial Museum exhibit (McCarroll, Blank, & Hill, 1995).

Criminal lawyers have been identified as a professional group particularly vulnerable to developing vicarious trauma (Saakvitne & Pearlman, 1996). Yet other than anecdotal evidence and a recent study exploring burnout and secondary traumatic stress (Levin & Greisberg, 2003), there is no research on the impact of trauma work on solicitors (Murray & Royer, 2004).

Solicitors, like doctors, nurses, police officers, and therapists, are visually and emotionally confronted by clients who have been injured and traumatized by purposeful violence. They see, hear, and feel the impact of trauma daily. Overwhelming emotions, injustice, despair, rage, self-harm, and other self-destructive behaviors are exposed and reenacted in intricate detail in the hallowed halls of justice. Solicitors experience a veritable kaleidoscope of traumatic material in the course of providing legal and other professional services to their clients (Murray & Royer, 2004).

As a professional group, solicitors are encouraged to remain emotionally detached from the cases they handle. This detachment is supposed to permit them to exercise dispassionate judgment and allow them to give independent advice to clients. However, they are not automatons. They are human beings who experience, understand, and negotiate interpersonal relationships (professional or otherwise) with the same emotions as other humans do (Murray & Royer, 2004).

Solicitors who work in criminal law deal with rape, sexual abuse of children, murder, and manslaughter on a daily basis. They are exposed to horror in graphic detail through witness testimony, court reenactments, witness conferencing, and photographic and forensic evidence. It would be erroneous to assume that professional detachment protects them from being at risk of developing vicarious trauma (Murray & Royer, 2004).

Review of the Literature

Although much has been written about the effects of vicarious trauma, the number of empirical studies in the area remains relatively small. A review of the literature suggests that a number of issues require rigorous attention: first, the difference between vicarious trauma and related concepts requires greater clarification; second, the development of a well-standardized measure that assesses both components of vicarious trauma (i.e., symptomatic distress and cognitive changes) is required; third, greater attention needs to be paid to the survey methodology to ensure more representative samples of trauma workers are recruited to studies; and fourth, the effects of mediating and moderating variables need to be better understood (Sabin-Farrell & Turpin, 2003; Salston & Figley, 2003).

The two earliest studies in the area of vicarious trauma are those of Pearlman and Mac Ian (1995) and Schauben and Frazier (1995). They have been

promoted as the main source of evidence for the development of vicarious trauma in professionals who work with trauma survivors. Briefly, both studies found that therapists with less experience had more disrupted beliefs in the areas of safety, control, intimacy, trust, and self-esteem and higher symptom levels than more experienced therapists. They also found differences between therapists who had personal trauma histories and those who did not.

Several other studies have continued to explore the impact on therapists who work with survivors (Brady, Guy, Poelstra, & Browkaw, 1999; Chrestman, 1995; Ghahramanlou & Brodbeck, 2000; Iliffe & Steed, 2000; Kassam-Adams, 1995; Steed & Downing, 1998). The majority of these studies have adopted a quantitative approach, using a variety of instruments to measure symptomatic distress and cognitive changes. Their findings have been criticized as being difficult to interpret and generalize due to (a) concerns regarding the reliability and validity of the instruments used, (b) small sample sizes, and (c) recruiting participants who had self-identified difficulties with vicarious trauma (Sabin-Farrell & Turpin, 2003).

Studies have also compared vicarious trauma in mental health professionals and police officers (Follette et al., 1994), nurses and counselors (Lyon, 1993), and professionals and volunteers (Salston & Figley, 2003) who work with survivors of sexual victimization. All these studies provide further evidence for the concept of vicarious trauma. However, the differences in the study samples (e.g., profession, work setting), variables measured, instruments used, and methodologies have led to inconsistent findings.

Studies have also explored vicarious trauma in therapists who work with sex offenders (Shelby, Stoddart, & Taylor, 2001) and therapists who work with both survivors and offenders (Way, Vandeusen, Martin, Applegate, & Jandle, 2004). The results suggest that both groups experience similar vicarious trauma effects.

Vicarious trauma effects include cognitive changes (Jenkins & Baird, 2002; Levin & Greisberg, 2003; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), intrusions (Kassam-Adams, 1995; Pearlman & Mac Ian, 1995; Steed & Downing, 1998; Way et al., 2004), avoidance (Kassam-Adams, 1995; Way et al., 2004), concerns with safety (Jankoski, 2003), hyperarousal (Jankoski, 2003; Levin & Greisberg, 2003), difficulties with trust and intimacy (Knight, 1997; Pearlman & Mac Ian, 1995; Rich, 1997), self-esteem problems (Pearlman & Mac Ian, 1995), depressed mood, and increased substance use (Rich, 1997; Zimmering et al., 2003).

Even though all trauma workers experience some degree of difficulty with the nature of the work, not all develop vicarious trauma. This suggests that certain variables may mediate or moderate the development of vicarious trauma (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

Moderating variables studied include gender (Kassam-Adams, 1995), age (Ghahramanlou & Brodbeck, 2000), amount of exposure to traumatized clients (Kassam-Adams, 1995; Schauben & Frazier, 1995), length of time providing treatment to survivors of trauma (Chrestman, 1995; Pearlman & Mac Ian, 1995; Rich, 1997), personal trauma history (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995), and personality types or characteristics (Woodward, Murrell, & Bettler, 2005). The data overall are largely inconsistent.

Mediating variables studied include access to clinical supervision (Follette et al., 1994; Pearlman & Mac Ian, 1995; Rich, 1997), training (Chrestman, 1995; Follette et al., 1994), self-care, and social support (Chrestman, 1995; Follette et al., 1994, Schauben & Frazier, 1995). Once again, evidence is sparse and inconsistent.

In summary, although the existing empirical literature is sparse and has largely focused on clinicians who treat traumatized clients, there is enough preliminary evidence to suggest that working with traumatized clients can have a negative impact on trauma workers (McCann & Pearlman, 1990).

What about the impact of trauma work on solicitors? Anecdotal evidence scattered within the case law suggests that they experience adverse effects (Murray & Royer, 2004). Additionally, Levin and Greisberg (2003) found higher levels of burnout, avoidance, intrusions, sleep difficulties, and irritability in family law and legal aid attorneys compared with mental health providers and social service workers. Unfortunately, there does not appear to be any published research exploring vicarious trauma within the legal profession.

This Study

This is an exploratory study that aimed to investigate the impact of working with traumatized clients

and their traumatic material on members of the legal profession. The study compared solicitors working with traumatized clients (criminal defense lawyers and prosecutors) with solicitors working with nontraumatized clients (conveyancers and academicians) on a number of measures. The study sought to answer the following research questions.

1. Is there a difference between solicitors working in criminal law and solicitors working in noncriminal law in terms of vicarious trauma effects?
2. What are the major coping strategies used by solicitors to deal with work-related distress and do they differ between the two groups?
3. Does personal trauma history increase vulnerability to vicarious trauma effects?
4. Is there a difference between the two groups regarding satisfaction with work?

The following hypotheses were presented.

1. Criminal lawyers would report higher scores on measures of symptomatic distress and disruptions to cognitive schemas as measured by the Vicarious Trauma Scale (VTS); Depression, Anxiety, and Stress Scales (DASS); Impact of Event Scale-Revised (IES–R); and Trauma And Attachment Belief Scale (TABS).
2. A greater number of criminal law solicitors would report using professional assistance to cope with work-related distress.
3. Personal trauma history would be associated with higher levels of vicarious trauma.
4. Criminal law solicitors would report less satisfaction with work.

Method

Participants

Participants in this study were 100 members of the legal profession. Solicitors working in criminal law (n = 50) were recruited from the Office of the Director of Public Prosecutions (ODPP), the Legal Aid Commission of New South Wales (LAC), metropolitan legal centers, and Women's Legal Services, New South Wales. The solicitors in this group were members of the Law Society, held current practicing certificates, and specialized in criminal law. Solicitors working in noncriminal law (n = 50) were recruited from the College of Law, Continuing Legal Education database, Macquarie University Law Faculty, and UTS Law Faculty. The total sample was 36% males and 64% females, with a mean age of 39.70 years (SD = 11.08). The total age range was between 24 and 64 years. Self-reported ethnicity was 73% Anglo-Saxon, 8% European, 4% Middle Eastern, and 3% Asian (14% not reporting). Educational background included bachelor's degree or less (75%) and masters or doctoral degree (25%).

Study Design and Method

Designated staff from each participating organization assisted in recruiting subjects for this study. The head of Human Resources in the ODPP and LAC, the head of Continuing Legal Education at the College of Law, the deans of Macquarie University and UTS Law Faculties, and the managers of metropolitan legal centers sent out e-mails to all staff in their organization asking for volunteers to complete a survey package investigating vicarious trauma. Interested participants collected a research pack from a designated location within the organization and returned the completed pack to the same place. E-mails continued to recruit participants until 100 research packs had been completed. The number of times e-mails were sent varied (between 4 and 15) according to the response rate from each organization. Return of the completed questionnaires signified informed consent. This method of recruitment inevitably raises questions about selection bias. However, it is not possible to know whether solicitors who participated in this study differ from those who declined (Sabin-Farrell & Turpin, 2003). It may be that those who are adversely affected by their work are more likely to volunteer and participate in research they view as meaningful and productive. Alternatively, those most affected by their work may see research as another demand on their time and therefore not participate.

Measurement

Closed-ended survey questions were developed for this study to collect demographic data.

The IES–R (Weiss & Marmar, 1997) is a standardized, self-report measure designed to parallel the *DSM-IV* criteria for PTSD. It measures subjective distress related to an identified traumatic event on three scales: avoidance, intrusions, and hyperarousal. The instrument has 22 questions rated on a

5-point Likert-type scale, ranging from 0 (*not at all*) to 4 (*extremely*). The original IES (Horowitz, Wilner, & Alvarez, 1979) was developed prior to the adoption of PTSD as a recognized diagnosis in the *DSM-III* and had two scales: intrusion and avoidance. The IES–R therefore is a more comprehensive measure of vicarious trauma effects than the IES. Scores for the IES–R factors range from 0 to 32 (avoidance and intrusions) and 0 to 24 (hyperarousal). The IES–R has adequate psychometric properties with internal consistency of between .87 and .93 (intrusions), .84 and .86 (avoidance), and .79 and .90 (hyperarousal).

Additionally, a VTS (Cronbach's α = .88) was developed to assess subjective levels of distress associated with working with traumatized clients. The scale consists of 7 items selected to assess how solicitors experience working with distressed clients (see Appendix I). The VTS items are rated on a 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Total scores range from 8 to 56, with a higher score indicating higher levels of distress. A significant correlation (.261) between the VTS and IES–R was found ($p < .01$).

The SWWS (Cronbach's α = .73) was used to measure general enjoyment and satisfaction with work (see Appendix II). The SWWS consists of five items on a 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The range is between 5 and 35, with higher scores indicating greater satisfaction with work.

Data from two other standardized instruments were also analyzed for this study. The DASS (Lovibond & Lovibond, 1995) is a 42-item self-report, paper-and-pencil questionnaire, consisting of three scales—depression, anxiety, and stress—each containing 14 items rated on a 4-point severity/frequency scale, where 0 = *did not apply to me at all* and 3 = *applied to me very much or most of the time*. The DASS has sound psychometric properties, with internal consistency of depression = .91, anxiety = .84, and stress = .90; good test–retest reliability; and demonstrated content, construct, and concurrent validity (Lovibond & Lovibond, 1995).

The TABS (Pearlman, 2003) was used to measure disruptions to cognitive schemas. The TABS is a self-report measure consisting of 10 scales and a total TABS score. The scales and internal consistency for each scale are as follows: self-safety (.83), other safety (.72), self-trust (.74), other trust (.84), self-esteem (.83), other esteem (.82), self-intimacy (.67), other intimacy (.87), self-control (.73), other control (.76), and total (.96). There are 84 items rated on a 6-point Likert-type scale ranging from 1 (*disagree strongly*) to 6 (*agree strongly*). Higher scores on the TABS indicate more cognitive disruption.

Finally, the survey asked respondents to indicate which coping strategies they used (from a list of eight) to deal with work-related distress (see Appendix III). Examples included listening to music, seeking peer support, seeking professional assistance, and so on. Responses were marked from 1 (*never*) to 4 (*very often*). They were also asked to list any other strategies they used that were not included in the list.

Statistical Analyses

Analyses were conducted using SPSS-12 (for Windows 2001). These analyses included the following: (a) *t* tests, frequencies, and Mann–Whitney nonparametric analyses to compare vicarious trauma effects, coping strategies, and satisfaction with work between the two groups and (b) 2 × 3 analysis of variance to determine the effects of trauma history. A significance level of .025 rather than the conventional .05 was used in this study as the point for a statistical finding. It is acknowledged that this may result in an inflated experiment-wise Type I error rate. However, being an exploratory study the decision to keep this rate was made so as not to make excessive Type II errors.

Results

Descriptive Findings

The respondent groups did not differ in age or ethnicity (see Table 1). Sixty-four percent of respondents were females (78% of the criminal law group and 50% of the noncriminal law group). In terms of education, 40% of the noncriminal law group had a masters or doctorate degree compared with 10% of the criminal law group. In terms of experience, 32% of the noncriminal law group still had experience (<5 years) in criminal law. In terms of a personal trauma history, 30% of respondents reported none, 15% reported one event, and 55% reported multiple events (20% sexual abuse, 23% physical abuse, 15% neglect, 36% emotional abuse). This is consistent with other studies (Schauben & Frazier, 1995). Of those who reported sexual abuse, 17 respondents were females (26%) and 3 (8.0%) were males. This

Table 1. Demographic Characteristics

Variable	Total Sample (N = 100)	Criminal Law Solicitors (n = 50 = 50%)	Noncriminal Law Solicitors (n = 50 = 50%)
Gender			
Male	36%	11 (22%)	25 (50%)
Female	64%	39 (78%)	25 (50%)
Age[a]	39.70	38.39[b]	41.40[c]
SD	11.08	10.43	11.67
Education			
Bachelors or less	75 (75%)	45 (90%)	30 (60%)
Master/doctorate	25 (25%)	5 (10%)	20 (40%)
Ethnicity[d]			
Anglo Saxon	73 (73%)	41 (82%)	32 (64%)
European	6 (6%)	5 (10%)	1 (2%)
Asian	3 (3%)	1 (2%)	2 (4%)
Middle Eastern	4 (4%)	1 (2%)	3 (6%)
Unknown	14 (28%)	2 (4%)	12 (24%)
Experience in criminal law			
Nil	31 (31%)	0 (0)	31 (62%)
Less than 5 years	37 (37%)	21 (42%)	16 (32%)
5–10 years	12 (12%)	11 (22%)	1 (1%)
10 or more years	20 (20%)	18 (36%)	2 (4%)
Experience in noncriminal law			
Nil	16 (16%)	16 (32%)	0 (0%)
Less than 5 years	30 (30%)	16 (32%)	14 (28%)
5-10 years	15 (15%)	8 (16%)	7 (14%)
10 or more years	39 (39%)	10 (20%)	29 (58%)
Trauma history			
None	30 (30%)	12 (24%)	18 (36%)
One	15 (15%)	5 (10%)	10 (20%)
Multiple forms	55 (55%)	33 (66%)	22 (44%)
Sexual abuse	20 (20%)	13 (26%)	7 (14%)
Physical abuse	23 (23%)	13 (26%)	10 (20%)
Neglect	15 (15%)	7 (14%)	8 (16%)
Emotional abuse	36 (36%)	22 (44%)	14 (28%)

a. Reported in years.
b. Data missing for one respondent.
c. Data missing for two respondents.
d. Data missing for 14 respondents.

is consistent with research that suggests that 1 of 4 women and 1 of 8 or 10 men is sexually abused as a child (Koss, 1993). Otherwise, differences between the two groups were not significant.

Trauma Findings

There were significant differences ($p < .025$) between the two groups in vicarious trauma effects, as measured by total scores on the VTS, DASS (depression and stress scales), and TABS (self-safety, other safety, and other intimacy) scales. The two groups did not differ significantly on avoidance, intrusions, and hyperarousal as measured by the IES–R (see Table 2). Mean scores for both groups across all measures and subscales were in the subclinical range. Additionally, there were significant differences between the two groups on each individual item of the VTS ($p < .025$) except for Item 4 (I find it difficult to deal with the content of my work; $p > .025$).

Coping Strategy Findings

Participants were asked to indicate which strategies they had used to cope with job-related distress (see Table 3). There were no significant differences (other than on peer support, $p < .025$) between the

Table 2. Level of Vicarious Trauma

Instrument	Total Sample (N = 100)		Criminal Law Solicitors (n = 50)		Noncriminal Law Solicitors (n = 50)		
	M	*SD*	*M*	*SD*	*M*	*SD*	*p*
Measured by Vicarious Trauma Scale (VTS)							
VTS total score	33.91	11.84	41.50	6.36	26.32	11.18	.000*
Measured by Impact of Event Scale–Revised							
Avoidance	6.32	6.06	7.50	5.74	5.14	6.20	.051
Intrusions	5.95	6.27	6.92	5.91	4.98	6.52	.122
Hyperarousal	3.24	4.36	4.04	4.75	2.44	3.83	.067
Total Score	15.50	15.62	18.44	15.05	12.56	15.77	.059
Measured by Depression Anxiety Stress Scales							
Depression	5.38	6.66	7.22	7.70	3.54	4.83	.005*
Anxiety	3.37	4.36	4.12	4.96	2.62	3.56	.085
Stress	9.60	6.95	12.04	7.85	7.14	4.87	.000*
Measured by Trauma and Attachment Belief Scale							
Self-safety	47.10	14.15	50.54	12.87	43.66	14.66	.014*
Other safety	46.32	13.47	49.42	10.48	43.22	15.41	.021*
Self-trust	51.08	13.31	52.96	10.29	49.20	15.65	.059
Other trust	47.99	13.11	50.20	13.72	45.78	12.20	.092
Self-esteem	52.69	10.79	55.00	10.68	50.38	10.50	.032
Other esteem	50.84	13.12	53.54	13.79	48.14	11.94	.039
Self-intimacy	53.51	11.02	54.80	10.99	52.22	11.01	.244
Other intimacy	51.34	13.36	55.48	13.28	47.20	12.23	.022*
Self-control	53.10	11.58	54.62	11.35	51.58	11.71	.191
Other control	50.59	10.61	51.92	10.74	49.26	10.41	.212
Tabs Total	51.83	11.43	54.32	11.19	49.34	11.22	.029

*Significant at $p < .025$ level.

two groups, with criminal lawyers more likely to seek peer support. The most frequently reported strategies were reading, seeking peer support, listening to music, and engaging in sport or exercise. It was interesting to note that the use of alcohol and prescription and nonprescription medication occurred at about the same rate in both groups, with approximately two thirds of the overall sample having used alcohol and one third of the sample having used medication to cope with distress arising from work. Notably, more criminal law solicitors (36%) compared with noncriminal law solicitors (20%) had sought professional assistance, although this finding was not statistically significant between the groups. Respondents were also asked to list any additional strategies they used to cope with job-related stress. Responses included eating, religion, and family support.

Personal Trauma History Results

The full factorial meaning and interaction between group and trauma history was tested. Findings were that in no one case was interaction between trauma history and group significant ($p< .025$). This means that any differences between the groups were consistent across trauma levels. In only two variables (depression and self-safety) did inclusion of trauma history reduce the effect of a previously significant effect of group to nonsignificance. Participants in both groups with a multiple trauma history displayed greater vicarious trauma effects (see Table 4).

Satisfaction With Work Results

No significant differences ($p < .025$) emerged between the two groups in terms of overall satisfaction with work, with mean scores being 23.34 (SD = 6.15) for the criminal law solicitors and 23.74 (SD = 6.22) for the noncriminal law solicitors.

Discussion

This study explored vicarious trauma in legal professionals, specifically solicitors engaged in criminal

Table 3. Coping Strategies

	Entire Sample (N = 100)	Criminal Law Solicitors (n = 50)	Noncriminal Law Solicitors (n = 50)	Criminal Law Solicitors (n = 50), M (SD)	Noncriminal Law Solicitors (n = 50), M (SD)
Sport/exercise	90 (90%)	47 (94%)	43 (86%)	2.92 (.82)[a]	2.60 (.91)
Reading	92 (92%)	45 (90%)	47 (94%)	2.88 (.86)	3.15 (.87)
Yoga/meditation	47 (47%)	25 (50%)	22 (44%)	1.75 (.88)	1.67 (.97)
Alcohol	63 (63%)	34 (68%)	29 (58%)	2.06 (.91)	1.79 (.88)
Prescription and nonprescription	35 (35%)	16 (32%)	19 (38%)	1.50 (.85)	1.50 (.92)
Music	90 (90%)	45 (90%)	45 (90%)	2.60 (.82)	2.71 (.87)
Supervision	51 (51%)	27 (54%)	24 (48%)	1.79 (.85)	1.60 (.80)
Peer support	91 (91%)	47 (94%)	44 (88%)	2.80 (.74)	2.31 (.72)*
Professional assistance	28 (28%)	18 (36%)	10 (20%)	1.50 (.80)	1.23 (.73)

a. Scale = 1 (*never*) to 4 (*very often*).
*$p < .025$.

Table 4. Personal Trauma History

	No Trauma History (n = 30)		Single Trauma History (n = 15)		Multiple Trauma History (n = 55)		None/ One	None/ Multiple
Trauma Type	M	SD	M	SD	M	SD	p	p
Measured by Vicarious Trauma Scale (VTS)								
VTS total score	30.97	11.77	29.80	15.17	36.63	10.27	.778	.023*
Measured by Impact of Event Scale–Revised (IES–R)								
Avoidance	3.23	3.94	4.47	4.81	8.51	6.47	.363	.000*
Intrusions	2.33	2.59	4.44	5.36	8.35	6.87	.086	.000*
Hyperarousal	1.40	2.21	2.20	2.37	4.53	5.20	.269	.002*
IES–R total score	6.97	7.98	11.07	11.20	21.36	17.31	.164	.000*
Measured by Depression Anxiety Stress Scales								
Depression	3.17	4.46	4.20	4.39	6.91	7.75	.465	.017*
Anxiety	2.53	3.54	3.13	3.14	3.90	4.98	.581	.191
Stress	7.43	5.91	9.53	6.01	10.78	7.51	.270	.038
Measured by Trauma and Attachment Relief Scale (TABS)								
Self-safety	43.53	13.14	44.27	15.07	49.82	14.10	.867	.048
Other safety	42.43	14.11	44.00	12.54	49.07	12.94	.718	.031
Self-trust	49.93	13.64	50.80	14.87	51.78	12.89	.846	.538
Other trust	47.50	14.91	45.80	14.91	48.85	13.43	.679	.670
Self-esteem	50.40	10.25	50.27	9.86	54.60	11.11	.967	.091
Other esteem	49.17	14.07	49.87	10.41	52.02	13.34	.865	.358
Self-intimacy	52.37	11.38	50.00	12.31	55.09	10.35	.525	.266
Other intimacy	47.50	11.41	51.80	13.42	53.31	14.09	.267	.056
Self-control	51.90	10.21	53.00	10.52	53.78	12.64	.737	.486
Other control	50.80	9.94	50.27	7.56	50.56	11.76	.856	.926
TABS Total	49.63	11.33	50.40	9.29	53.42	11.93	.822	.159

*Significant at $p < .025$ level.

law work. It is the first study to explore vicarious trauma within the legal profession. The study also examined variables associated with vicarious trauma such as personal trauma history, personal and professional coping strategies, and satisfaction with work.

The solicitor groups were similar in age, ethnicity, and experience in law. The criminal law group,

however, had a higher number of female respondents and a higher number of respondents with a multiple trauma history (particularly sexual abuse and emotional abuse).

The first hypothesis was supported. The level of vicarious trauma was higher in the criminal law solicitors. In particular, criminal law solicitors reported significantly higher levels of subjective distress and self-reported vicarious trauma, depression, stress, and cognitive changes in relation to safety and intimacy. Even though the differences between the two groups on scales of the IES–R were not statistically significant, the criminal law group reported higher levels of avoidance, intrusions, and hyperarousal. These results support previous findings (Levin & Greisberg, 2003).

The second hypothesis was supported with a greater number of criminal law solicitors seeking professional assistance in coping with work-related distress. Thirty-six percent of the criminal law solicitors reported having sought professional assistance compared with 20% of the noncriminal law solicitors. Overall, however, the two groups did not significantly differ in terms of the strategies adopted to cope with work-related distress. It was interesting to note that only half the respondents in both groups considered discussing work-related distress with a supervisor. They were twice as likely to look for peer support. This finding raises questions about organizational dynamics and organizational recognition of and response to employee distress. It may be that professional assistance from management is difficult to access for some of the participants or, if available, is not used because of perceived lack of confidentiality (Way et al., 2004).

The third hypothesis was supported with a multiple trauma history being associated with higher levels of vicarious trauma. Participants in both groups with a multiple trauma history had higher scores on all measures of symptomatic distress but not cognitive disturbance compared with participants that had either none or a single trauma history. However, differences between the groups were consistent across trauma levels and not significant.

The fourth hypothesis was not supported. Both groups reported similar levels of satisfaction with work. Even though working with traumatized clients and traumatic material can be distressing and difficult, there may also be an element of satisfaction in providing assistance to and advocating on behalf of these clients, and ensuring that justice is done. Schauben and Frazier (1995) and Steed and Downing (1998) also found that counselors working with trauma survivors reported several enjoyable aspects of the work, such as witnessing the strength and resilience of their clients, being part of the healing process, and feeling that the work was meaningful and worthwhile. Perhaps this type of attitude serves to reduce the risk of developing vicarious trauma and is worthy of further investigation (Sabin-Farrell & Turpin, 2003).

Although this study provided some further evidence for the concept of vicarious trauma, in relation to criminal lawyers, it is also limited in several respects. First, there is the difficulty of self-selection. It is impossible to know how representative this sample is of criminal and noncriminal lawyers. Solicitors who volunteered for this study may be inherently different from those that declined. The results may also be influenced by response biases such as minimization, lack of self-awareness and insight, denial, or concerns with confidentiality (Salston & Figley, 2003; Way et al., 2004).

Second, the assessment of vicarious trauma has been completed using a number of instruments because a single multi-item measure is still to be developed.

Third, whereas previous studies have only assessed the effects of working with sexual violence, this study has included all other types of violence. This might make the results of this study difficult to compare with others in that there was no assessment of the percentage of each type of violence in each criminal lawyer's practice.

Fourth, although multiple trauma history was found to be associated with greater vicarious trauma effects, it is not clear whether participants' responses to the questionnaires related to their own (primary) trauma or to the effect of working with traumatized clients (vicarious trauma). Despite clear instructions to respond to the questionnaires in relation to working with traumatized clients, it may be that some participants' responses reflect their own traumatic experiences. This would explain scores in the clinical range for participants in the noncriminal law group.

Fifth, there is no assessment in the study regarding period of time between last traumatic event

experienced by respondents and participation in the study. Participants with a recent history of trauma (within the past year) may have reflected this in their responses.

Finally, the study did not measure the contribution of burnout or other types of occupational stress inherent in legal work (such as the hostile court environment, conflict, heavy caseloads, and the adversarial nature of criminal law; Murray & Royer, 2004).

Despite these limitations, this study also has a number of strengths. First, it is unique in that it explores the impact of vicarious trauma on a little-studied occupational group (solicitors). Second, it provides preliminary evidence that criminal lawyers experience difficulties working with traumatized clients. Third, it highlights the implications for employers; they need to recognize the impact of trauma work on employees and put in place strategies to raise awareness, educate, and assist those employees adversely affected by trauma work. Fourth, it suggests viable coping strategies for intervention in this group (Sabin-Farrell & Turpin, 2003).

Implications and Recommendations

Recommendations include the following.

1. The use of prospective or longitudinal studies to determine the variables that moderate and mediate the development of vicarious trauma.
2. More accurate identification and implementation of coping strategies that may reduce the effects of vicarious trauma.
3. Qualitative studies to provide additional information on what aspects of criminal law work are most distressing for legal personnel.
4. Exploration of resilience in relation to trauma work because some solicitors, like some therapists, are able to repeatedly hear stories of horror and pain without experiencing deleterious effects.
5. Additional research to isolate other variables that may protect from and ameliorate the effects of vicarious trauma.
6. Greater organizational recognition of the need to put in place strategies to assist staff adversely affected by trauma work (Murray & Royer, 2004).

Appendix 1
Vicarious Trauma Scale

1. Strongly disagree
2. Disagree
3. Slightly disagree
4. Neither agree nor disagree
5. Slightly agree
6. Agree
7. Strongly agree

Please read the following statements and indicate on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*) how much you agree with them.

1. My job involves exposure to distressing material and experiences.
2. My job involves exposure to traumatized or distressed clients.
3. I find myself distressed by listening to my clients' stories and situations.
4. I find it difficult to deal with the content of my work.
5. I find myself thinking about distressing material at home.
6. Sometimes I feel helpless to assist my clients in the way I would like.
7. Sometimes I feel overwhelmed by the workload involved in my job.
8. It is hard to stay positive and optimistic given some of the things I encounter in my work.

Appendix 2
Satisfaction With Work Scale

1. Strongly disagree
2. Disagree
3. Slightly disagree
4. Neither agree nor disagree
5. Slightly agree
6. Agree
7. Strongly agree

Please read the following statements and indicate on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*) how much you agree with them.

1. In most ways my job is close to my ideal.
2. The conditions of my job are excellent.
3. I am satisfied with my job.
4. So far I have achieved the important things I want in my job.
5. If I could live my life over, I would change almost nothing.

Appendix 3
Coping Mechanisms

Coping Mechanisms:
In order to cope with your job have you ever used any of the following:

	1			4
Sport / Exercise	Never	Occasionally	Often	Very Often
Reading	Never	Occasionally	Often	Very Often
Meditation/Yoga	Never	Occasionally	Often	Very Often
Alcohol	Never	Occasionally	Often	Very Often
Prescription or Non-Prescription Medication	Never	Occasionally	Often	Very Often
Music	Never	Occasionally	Often	Very Often
Supervision	Never	Occasionally	Often	Very Often
Peer support	Never	Occasionally	Often	Very Often
Professional Assistance ie psychiatrist or psychologist	Never	Occasionally	Often	Very Often

Are there any other methods you may have used to help you cope with your job:

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References

Alexander, D. A., & Atcheson, S. F. (1998). Psychiatric aspects of trauma care: Survey of nurses and doctors. *Psychiatric Bulletin, 22*, 132-136.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology, Research and Practice, 30*, 386-393.

Carson, J., Leary, J., de Villiers, N., Fagin, L., & Radmall, J. (1995). Stress in mental health nurses: Comparison of ward and community staff. *British Journal of Nursing, 4*, 579-582.

Chrestman, K. R. (1995). Secondary exposure to trauma and self-reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for*

clinicians, researchers, and educators (pp. 29-36). Lutherville, MD: Sidran.

Clark, M. L., & Gioro, S. (1998). Nurses, indirect trauma, and prevention. *Image: Journal of Nursing Scholarship, 30*, 85-87.

Figley, C. R. (1989). *Helping traumatized families.* San Francisco: Jossey-Bass.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel.

Follette, V. M., Polusny, M. M., & Mi1beck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology, Research and Practice, 25*, 275-282.

Ghahramanlou, M., & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health*, *2,* 229-240.

Hafemeister, T. L. (1993). Juror stress. *Violence and Victims*, *8,* 177-186.

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.

Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15*, 393-412.

Jankoski, J. A. (2003) Vicarious traumatization and its impact on the Pennsylvania child welfare system. *Dissertation Abstracts International*, *63*(7-A), 2467.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress, 15*, 423-432.

Kassam-Adams, N. (1995). The risks of treating sexual trauma: stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators* (pp. 37-47). Lutherville, MD: Sidran.

Knight, C. (1997). Therapists' affective reactions to working with adult survivors of child sexual abuse: An exploratory study. *Journal of Child Sexual Abuse, 6*, 17-41.

Koss, M. (1993). Detecting the scope of rape: A review of prevalence research methods. *Journal of Interpersonal Violence, 8*, 193-222.

Levin, A. P., & Greisberg, S. (2003). Vicarious trauma in attorneys. *Pace Law Review*, *24,* 245-252.

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney, Australia: Psychology Foundation.

Lyon, E. (1993). Hospital staff reactions to accounts by survivors of childhood abuse. *American Journal of Orthopsychiatry, 63,* 410-416.

McCann, L., & Pearlman, L. A. (1990a). *Psychological trauma and the adult survivor: Theory, therapy, and transformation.* New York: Brunner/Mazel.

McCann, L., & Pearlman, L. A. (1990b). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.

McCarroll, J. E, Blank, A. S., & Hill, K. (1995). Working with traumatic material: Effects on Holocaust Memorial Museum staff. *American Journal of Orthopsychiatry, 65,* 66-75.

Murray, D. C., & Royer, J. M. (2004). Vicarious traumatization: The corrosive consequences of law practice for criminal justice and family law practitioners. *Legal Profession Assistance Conference*. Dalhousie University, Halifax, Nova Scotia, Canada.

Pearlman, L. A. (2003). *Trauma and Attachment Belief Scale (TABS)*. Los Angeles: Western Psychological Services.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology, Research and Practice, 26*, 558-565.

Pearlman, L. A., & Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. London: W. W. Norton.

Rich, K. D. (1997). Vicarious traumatization: A preliminary study. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 75-88). Brandon, VT: Safer Society Press.

Saakvitne, K. W., & Pearlman, L. A. (1996). Transforming the pain: A workbook on vicarious traumatization. London: W. W. Norton.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review*, *23,* 449-480.

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress*, *16,* 167-174.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence victims. *Psychology of Women Quarterly, 19*, 49-64.

Sexton, L (1999). Vicarious traumatization of counsellors and effects on their workplaces. *British Journal of Guidance and Counselling,* 27, 393-403.

Shelby, R. A., Stoddart, R. M., & Taylor, K. L. (2001). Factors contributing to levels of burnout among sex offender treatment providers. *Journal of Interpersonal Violence, 16*, 1205-1217.

Stamm, B. H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly,* 8, 2.

Steed, L. G., & Downing, R. (1998). A phenomenological study of vicarious traumatization amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *Australasian Journal of Disaster and Trauma Studies,* 2.

Way, I., vanDeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence, 19*, 49-71.

Weiss, D., & Marmar, C. (1997). The Impact of Event Scale-Revised. In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD*. New York: Guilford. pp. 399-411.

Wilson, J. P., & Lindy, J. D. (1994). *Countertransference in the treatment of PTSD*. New York: Guilford.

Woodward, L. E., Murrell, S. A., & Bettler, R. R. (2005). Empathy and interpersonal style. A mediational model of secondary traumatic stress symptomatology. *Journal of Aggression, Maltreatment & Trauma, 11*(4), 1-28.

Young, K. M., & Cooper, C. L. (1999). Stress in ambulance personnel. In J. Firth-Cozens & R. L. Payne (Eds.), *Stress in health professionals* (pp. 119-131). Chichester, UK: Wiley.

Zimmering, R., Munroe, J., & Gulliver, S. B. (2003). Secondary traumatization in mental health care providers. *Psychiatric Times*, *20*(4), 1-8.