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Vicarious Traumatization: The Corrosive Consequences of Law Practise for Criminal Justice and Family Law Practitioners

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Introduction

Criminal defence lawyers were identified as a professional group at risk of vicarious traumatization in a 1996 book, *Transforming the Pain*, by Karen Saakvitne and Laurie Anne Pearlman [1]. It is likely that few criminal defence lawyers were aware of this then, and few have become aware of it since. Saakvitne and Pearlman's point in identifying criminal defence lawyers as a population at risk - along with prosecutors, "family law" lawyers, and judges - was that any professional group working with clients who have been traumatized will be at risk of vicarious traumatization themselves.

What is vicarious traumatization? It appears to be best understood as an *effect*. The *effect* is a disruption of an ordinary level of the psychological and emotional functioning of a helping professional. The disruption has a negative effect on the professional's competence in performing professional tasks. This disruption seems to be caused by a professionally obligated involvement with traumatic events, or a professionally obligated close contact with persons who have been involved in traumatic events. If left unmanaged, vicarious traumatization reduces the helping value that the professional relationship is supposed to have for the client. The kind of traumatic event required would appear to be an event that resulted in physical or psychological distress to a person, and which is outside ordinary human and community experience.

[1] Saakvitne, Karen W. and Pearlman, Laurie Anne; *Transforming the Pain: A Workbook on Vicarious Traumatization*; W.W.Norton & Company Inc. (1996); at p. 20. Saakvitne and Pearlman weren't necessarily the first to identify lawyers in this way. References to lawyers suffering vicarious traumatization were made by Dutton, Mary Ann and Rubinstein, Francine L. in "Working with People with PTSD: Research Implications"; Chapter 4 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; at pp.89 - 91.

This is not an idle idea. In *R. v. Murray* [2], Justice Gravely of the Ontario Superior Court of Justice presided over the trial of an alleged obstruction of justice. Videotapes of two young girls being unlawfully confined, sexually abused, and otherwise physically and emotionally degraded were the emotional and evidentiary centrepiece of the trial. Both girls were subsequently murdered. Justice Gravely commented about the tapes and their impact on the lawyers appearing before him both as counsel and as witnesses:

> [20] Everyone exposed to the videotapes has been deeply affected by the experience.
> [21] Doyle had to review the tapes by way of trial preparation for Rosen. In giving her evidence she broke down at the recollection and said that she saw the tapes nine times, but "a million times in my head".
> [22] Rosen, a veteran criminal defence counsel, was obliged to hesitate part way through his evidence as he recollected the images on the tapes. He described viewing the tapes on September 13, 1994 with MacDonald and Clayton Ruby. MacDonald wept beside him as the tapes were shown and Rosen said he himself was extremely upset. Murray described the tapes as "caustic", "corrosive" and "shocking". Even defence counsel, Mr. Cooper, who must in his career have been exposed to almost everything terrible the court system has to offer, was obliged to request a brief adjournment in the course of reading in some of this evidence.

While the depth of depravity depicted in those particular videotapes may rarely be equaled, the obligation of criminal justice counsel to confront bile-inducing allegations and instances of inhumanity within our society is part of the daily fare of their professional experience.

[2] [2000] O.J. No. 2182; 48 O.R. (2d) 544 (Ont. S.C.J.)

So too are the lawyers occupied with child protection, spousal violence, and custody issues obligated daily to manage the extraordinary and extreme effects of damaging interpersonal behaviour. By way of a random example only, the typical diet for these counsel was described in *Durham Childen's Aid Society v. C.L.* [3], as follows:

> 29 There are numerous other examples in the evidence and reports that confirm the physical and emotional underdevelopment of these three children. I fully agree with the conclusion of J.B. (author of the s. 54 Assessment dated February xx, xxxx) where she states that "the lack of stimulation and care in the home environment was clearly evident." I would go further and state that, short of starvation, these children were so grossly neglected by their parents that they now have so many special needs they may never overcome them. The depravation to which these children were subjected was indefensible in any context. I appreciate that the parents lead an itinerant lifestyle and had financial difficulties and that they are low functioning intellectually. The fact is that they were completely unable to understand even the most rudimentary needs of their children. They grossly neglected to parent them in any meaningful way. It is indeed unfortunate that this was not discovered earlier.

Or, in another random example from *Family Youth and Child Services of Muskoka v. L.R* [4]:

> 89 Moving from the theoretical to the personal, it is obvious that the maternal grandparents and uncle are distraught that their connection with M.J.D. might be permanently broken.
>
> 90 Notwithstanding empathy for the terrible loss to the biological family through no act of their own, and a pity for the birth mother who now regrets having made the decision she did, there can be no doubt that the best interests of the child demand that he remain in the K. family, and that all impediments to adoption be removed. Although there has seldom been a sadder decision, never has there been one so compellingly imperative.

[3] [2001] O.J. No. 5131 (Ont. S.C.J.)
[4] [1998] O.J. No. 2446 (Ont. C.J., Gen.Div.)

Legal professionals, like doctors and nurses and social workers, are visually and emotionally confronted by clients whose bodies have been injured by purposeful violence. Legal professionals, like child protection workers, record the minutiae of abusive histories in client interviews. Legal professionals, like social workers and police, may witness families being torn apart by destructive behaviours - whether criminal or not. Legal professionals, like therapists, encounter a broad variety of traumatic material as wide as human experience in the course of providing empathic counseling to and advocacy for their clients.

Psychologists and counselors have begun to explore how clients and client experiences can have a disrupting and disabling effect on the lives and practices of the service professionals obligated to assist these clients. This has been found to be particularly evident in client relationships where the clients' lives and presenting issues are traumatic and dysfunctional. To date, the academic studies have mainly focused on physicians, nurses, social workers, and other first responders to crises like firemen and ambulance attendants.

The experience of lawyers working in the areas of family and criminal law may be similar to that of the previously studied groups. This paper reviews some of the existing literature and juxtaposes that literature with some of the experiences common in practising criminal and family law. The purpose of this review is to explore whether the hypothesis of vicarious trauma assists us in understanding the disrupting and disabling effects of certain kinds of professional legal practise on lawyers.

Dutton and Rubinstein have already articulated the point this way:

> Trauma workers are persons who work directly with or have direct exposure to trauma victims, and include mental health professionals, lawyers, victim advocates, caseworkers, judges, physicians, and applied researchers, among others. . . .
> . . . this chapter focuses specifically on the impact on trauma workers of their contact with traumatic events and their sequelae through their work with persons directly involved with traumatic experiences. [5]

It is the conclusion of the authors that vicarious trauma is indeed an occupational hazard of some kinds and methods of lawyering. Our review of the literature suggests that vicarious trauma has the potential to adversely affect the functioning of lawyers in many different ways - both because of its symptoms, and its consequences if unsuccessfully managed. The value of the services that affected lawyers are able to offer to clients will show the most immediate effects. The effects may, however, extend to infect the quality of justice in the courts where these lawyers appear. Inadequately managed, the effects will certainly manifest themselves in the personal and family lives of these lawyers as well.

Vicarious traumatization is a better explanation for certain kinds of service failures than "burnout". It is a legitimate alternative to the occasional (and rather pejorative) conclusion that a lawyer who has fallen into trouble is "unsuited" to a particular kind of practise. Understanding the psychological and service symptoms as manifestations of vicarious traumatization also provides a better avenue into treatment than other diagnoses. That may permit quicker amelioration of the effects of traumatization on legal service, and on legal service professionals.

[5] Dutton and Rubinstein, at p.83

Some effects of exposure to traumatic material are recognized as inevitable. It is the failure to recognize or manage even minor degrees of these effects that has troubling implications for clients, bar associations, law firms, and the individual lawyers themselves. When the effects are left unrecognized and unattended, vicarious trauma may cause lawyers to leave practise unnecessarily, and may create opportunities for lawyers to unintentionally disserve or damage the interests of their clients. These concerns may not be limited to lawyers working in the field of criminal and family law. Dealing appropriately with the risks of vicarious traumatization is important for any lawyer who wants to maintain a role as an effective service provider in whatever area of the law he or she chooses to work.

The overarching and consistent concern for clients, bar associations, firms, and lawyers personally, is this durability of lawyers as active, effective professional practitioners. Individual lawyers - whether practising alone or within a firm - should use elements of this article as a prod to begin to assess their own susceptibility and level of successful coping with the hazards of dealing with traumatic material. If for no reason other than a lawyer's own self-interest in maintaining his ability to practise, lawyers at risk should be able to motivate themselves for private, self-assessment of these issues.

Definition of Concepts

What is "vicarious trauma"? The purpose of a definition is to understand something that is observable. Definitions provide us with a reference point, a gauge against which to measure what we can see and describe. Definitions also alert us to what we might expect to see, criteria of what we should look for in order to draw a reasonable conclusion that we have indeed observed something of significance.

Definitions allow clinicians to be consistent in identifying treatment populations, and consistent in measuring outcomes with individual sufferers within those populations.

In her *Guidebook on Vicarious Trauma* [6], Jan I. Richardson wrote:

> Providing a definition of vicarious trauma is the first step in identifying and accepting the deep changes that occur in counsellors and advocates as a result of working with abused women and children. Definitions that describe the profound effect on therapists resulting from exposure to the trauma experiences of their clients are offered by those in the vanguard of this emerging field of study. . . .
>
> Compassion fatigue, vicarious traumatization, secondary traumatization, secondary stress disorder, insidious trauma and vicarious trauma are all terms that are used in an attempt to label and define what happens, why it happens, and how to live healthily with the experiences. . . . .

Research work is still in its infancy. However, there already appear to be some potentially significant differences in the types of issues comprehended by the different terms listed by Richardson in the preceding passage. While we await consensus as to the most appropriate terms to define particular constellations of issues in professional behaviour, some outlines of a conceptual framework are emerging in this area.

[6] Richardson, Jan I.; *Guidebook on Vicarious Trauma*, National Clearinghouse on Family Violence; © Her Majesty the Queen in Right of Canada, 2001 Cat. H72-21/178-2000E; ISBN 0-662-29517-X; http://www.hcsc.gc.ca/hppb/familyviolence/html/Vicarious%20Trauma%20HTML/english/

Vicarious Trauma: A Consequence of Professional Engagement with Traumatic Content

The pioneer in this field, Charles R. Figley [7], described vicarious trauma occurring in the therapeutic relationship as follows:

> We can define STS [secondary traumatic stress] as the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized or suffering person
> . . .
>
> The STS phenomenon has been called different names over the years. We suggest that compassion stress and compassion fatigue are appropriate substitutes. Most often those names are associated with the "cost of caring" (Figley, 1982) for others in emotional pain.

This definition is echoed by treatment innovators Saakvitne and Pearlman [8]:

> [T]hrough exposure to the realities of people's intentional cruelty to one another, and through the inevitable participation in traumatic reenactments in the therapy relationship, the therapist is vulnerable through his or her empathic openness to the emotional and spiritual effects of vicarious traumatization. Their effects are cumulative and permanent, and evident in both a therapist's professional and personal life

[7] Figley, Charles R.,"Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview"; Chapter 1 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; Brunner/Mazel Inc. (1995: New York); at pp.7, 9.
[8] Saakvitne, Karen W. and Pearlman, Laurie Anne; "Treating Therapists with Vicarious Traumatization and Secondary Traumatic Stress Disorders"; Chapter 8 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; at p. 151. More recently, some have suggested that vicarious trauma is capable of arising from contact by the professional with contagious, emotionally arresting material alone. Under this more recent view, an actual therapeutic relationship between the primary victim and the professional is not necessary. The primary victim of trauma may only be a particularly compelling vehicle through which the traumatic material is communicated to the helping professional: *e.g.*, Carol Hartman, "The Nurse-Patient Relationship and Victims of Violence"; *Scholarly Inquiry for Nursing Practice: An International Journal*; 1995: 9(2): 175 - 192at p.176.

Richardson's *Guidebook on Vicarious Trauma* contains this comprehensive, itself emotionally laden, derivative definition of "vicarious trauma", again giving primacy to the concept of professional engagement with traumatic material:

> Vicarious trauma is the experience of bearing witness to the atrocities committed against another. It is the result of absorbing the sight, smell, sound, touch and feel of the stories told in detail by victims searching for a way to release their own pain. It is the instant physical reaction that occurs when a particularly horrific story is told or an event is uncovered. It is the insidious way that the experiences slip under the door, finding ways to permeate the counsellor's life, accumulating in different ways, creating changes that are both subtle and pronounced. Vicarious trauma is the energy that comes from being in the presence of trauma and it is how our bodies and psyche react to the profound despair, rage and pain. Personal balance can be lost for a moment or for a long time. The invasive and intrusive horrors infiltrate and make their mark. The waves of agony and pain bombard the spirit and seep in, draining strength, confidence, desire, friendship, calmness, laughter and good health. Confusion, apathy, isolation, anxiety, sadness and illness are often the result. [9]

An important element of each of these definitions appears to be the requirement of traumatic content *and re-enactment or re-experience in a therapeutic or caring relationship*. Talk therapy about the effects of a remembered event would not justify the same level of professional concern as therapies where an actual re-experience of the violence exists. The definitional approach of these authors, requiring a re-experiencing of another's trauma, probably flowed from their background in professional therapeutic counseling, and the apparent similarities that seemed to exist between post-traumatic stress disorders and vicarious trauma.

[9] Richardson, loc. cit.

This sense of professional "participation" in traumatic events through the professional's personal reactions to traumatic material is less evident in other definitions of vicarious trauma in the literature. Closer study of the work done by Saakvitne and Pearlman shows that it is the professional *interaction* with the client that is the vehicle of potential harm [10]. The harm comes from the professional having to receive and help manage traumatic material for (or with) a client - not merely listening to it, and not just sharing the emotional experience of the client.

This is important in the legal representation context because a legal professional may be required to manage and work through traumatic material without direct interaction with the "victim". For example, criminal defence lawyers and family law counsel may be obligated to manage the impact of traumatic material on behalf of an admitted or alleged perpetrator, on behalf of a third-party witness to trauma, or on behalf of a victim (broadly defined) of the physically or psychologically distressing act. It doesn't matter that the criminal defence lawyer never speaks to or cross-examines the victim of a murder - the horrific events leading to a death still have the capacity to upset and destabilize the lawyer's emotional equilibrium.

This concept of a professional "managing" traumatic material is consistent with the idea of vicarious trauma manifesting itself as a problem in the professional's interaction with a client. For example, in their workbook *Transforming the Pain*, Saakvitne and Pearlman describe vicarious trauma as:

> . . . the cumulative transformative effect on the helper working with the survivors of traumatic life events.[11]

[10] Saakvitne and Pearlman (1996); *e.g.*, at pp. 46ff
[11] Ibid.; at p. 17

Or, later in the same workbook:

> . . . A transformation of the helper's inner experience, resulting from empathic engagement with clients' trauma material. [12]

A similar concept was developed by Cerney:

> This particular traumatization comes from being exposed to a reality that is beyond ordinary comprehension and seems unbelievable to the uninitiated. As therapists begin to accept the credibility of what they are hearing, their own moorings in reality may be shaken, if not shattered. Their internal schemata . . . are altered or destroyed, and they, too, become traumatized as they seek to construct a new reality for themselves. [13]

Blair and Ramones also focused on the professional experiencing of psychological consequences because of the professional's status as a helper, suggesting that professional empathy is the entry point for contagious, traumatic material that in turn prompts a psychological reaction in the professional:

> In recent years, vicarious traumatization has been identified as the experience of disruptive, disturbing, or painful psychological consequences experienced by professionals who treat victims of traumatic experiences . . . .
> . . . vicarious traumatization goes far beyond the emotional and psychological effects of simple empathy. Rather, vicarious traumatization is a contagious, malignant process that can have severe consequences for professionals.
> . . . Vicarious traumatization has been identified as a unique phenomenon . . . used to explain the psychological reactions that occur to the treaters of victims of abuse and trauma. . . . . [14]

[12] Saakvitne and Pearlman (1996); at p. 40
[13] Cerney, Mary S., "Treating the 'Heroic Treaters'"; Chapter 7 in Figley, ed., *Compassion Fatigue*; at p.145
[14] Blair, D. Thomas, and Ramones, Valerie A.; "Understanding Vicarious Traumatization"; *Journal of Psychosocial Nursing*; 1996: 34(11): 24 - 30, at p.25

This definitional approach really flows from the same kind of thinking espoused by Figley, already referred to above. Figley described "compassion stress":

> . . . as the natural behaviors and emotions that arise from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized person. [15]

The core value of each of these definitions of vicarious trauma is that each expresses how the professional dealing with traumatic material does not remain emotionally or psychologically independent and insulated from the client or the relevant traumatic event. The idea that vicarious traumatization arises as something new *because of* the professional relationship indicates that something more than empathy and a desire to help is involved. After all, any committed family member may manifest empathy towards an afflicted family member and have a desire to help that person. The writers cited thus far appear to be suggesting that vicarious traumatization is something that blossoms from within and because of the helping professional's *relationship* with the client.

What professional relationship is required with a victim or relevant traumatic event before a professional is at risk of suffering "vicarious trauma"? What is it that is significant about the relationship itself? The answer suggested by the writers seems to be rooted in this obligation to help manage the traumatic material toward some result.

If we unbundle the elements of the professional relationship that therapists and social workers and nurses have with their clients we would observe that:

[15] Figley (1995), at p.xiv

a) the professional exercises empathy;

b) the relationship has as its object or purpose the giving of help to the client sufferer; and

c) there is an element of professional obligation in maintaining the relationship.

This third element would appear to have potential significance in several respects. A professional obligation in a caring relationship will generally involve a commitment on the part of the professional to pursue treatment strategies that will help rather than harm; a commitment on the part of the professional to manage the client's problem in a way that is personally helpful to the client; and a concurrent commitment to help according to certain standards and ideals of professional practise.

In short, professional obligation to a client involves commitment by the professional to the provision of competent, effective and ethical services. Further, the maintenance burdens for these relationships rest on the shoulders of the professional rather than the client. More narrowly in the care-giving context, this kind of professional relationship by definition involves an undertaking by the professional to *do something* about the client's problem. The professional is expected to assume a level of responsibility for both the client and the client's problem.

Lawyers in criminal matters are usually seen as advocates for a client (Defence counsel), or as advocates for a point of view about certain historical facts (Prosecuting counsel). Each of these lawyers is also expected to exercise professional detachment and reserve from their client, or from the facts. Both may have to deal with traumatized individuals - either as clients or as witnesses or as

victims. However, as either prosecuting or defence counsel, the professional becomes engaged in helping a traumatized individual *do something* about the traumatic material. Rather than simply being horrified or saddened by hearing about a traumatic event, the legal professional has to shoulder responsibility for alleviating the injury of the traumatic event - whether that be to a victim or to an accused. The same may be repeated for all counsel involved in child protection proceedings.

Social workers, doctors, nurses, firemen, and other crisis responders are also all required to *do something* about different kinds of impacts on those touched by traumatic events. What is common among lawyers working in the criminal justice or family law systems, and being in a therapeutic or care-giving relationship, is this obligation *do something* about the client's problem involving the traumatic material. A prosecutor may be seen as having an obligation to validate and legitimize the criminality of a victim's injury. Defence counsel has a corresponding obligation to avoid punitive injury to the innocent, and limit the harm done by society to those who are properly accused. These jobs are performed for someone. These jobs require the legal professional to get involved with whatever traumatic material is legally significant. These roles can only be performed properly where the relationships between the client and the professional manifest the essential elements of competent, effective, and ethical professional engagement. Finally, the burden of responsibility for maintaining the relationships fall on the shoulders of the lawyer.

The kind of *professional* engagement being described requires an investment of effort, empathy, and commitment by the service provider. The investment or commitment is directed to an outcome on behalf of another person. In this respect, lawyers are not any different from medical or social work professionals. If that is correct, vicarious trauma becomes understandable as a condition that arises from

within a professional relationship as a *reaction* to the traumatic material. Whether the relevant traumatic material comes to the professional by direct contact with a victim, or is an experience that the professional participates in because a client relives it, or is something that the professional simply hears or reads about, the traumatization is fundamentally the professional's *reaction* to the material. This is faithful to the original conception proposed by Figley, and is consistent with the more modern definitions of vicarious traumatization promoted by other writers. [16]

Therefore, for the purposes of this article, it is proposed that a working definition of vicarious traumatization for lawyers working in the criminal justice and family law sectors would include three essential elements. These would be:

a) an emotional and psychological disruption suffered by the professional;

b) the disruption would be caused as a consequence of fulfilling professional obligations to manage the traumatic material, to achieve or pursue some helping objective for another; and,

c) the professional obligations would involve engagement with a person (a client, a witness, or a victim) who has experienced a legally significant traumatic event.

[16] See again Dutton and Rubinstein, at note 5. Some have already suggested that this would also explain the complaints by judges and jurors of symptoms consistent with vicarious trauma, even though judges and jurors are not usually seen as having a "professional relationship" with victims of traumatic events, or traumatic material. Judges and jurors do have an obligation to *do something* about traumatic material that is communicated to them. Judges and jurors do have certain standards of behaviour to which they must adhere, procedurally and ethically, in performing their roles. Thus, they may be seen as having a *process* relationship with persons affected by traumatic events. A deeper analysis of vicarious traumatization in relation to the judiciary is beyond the scope of this paper, and, indeed, is believed to be already underway. The authors are aware of work that has been done by Dr. Peter Jaffe and an ongoing interest by the American Judges Association in the area of vicarious trauma.]

This working definition allows us to make a fair assessment of whether vicarious traumatization affects lawyers who work in criminal justice and family law for the purpose of this article. If the vicarious traumatization as defined is found, the definition should also serve as a means to recognize or diagnose vicarious traumatization in criminal justice and family law lawyers.

Alternative Terminology

The definition of vicarious traumatization set out above is consistent with other phraseology that has been used by some counsellors. The phrase "indirect trauma" - the choice of the International Society for Traumatic Stress Studies (ISTSS) [17], and of Clark and Gioro - describes an impact that happens to caregivers:

> Numbed feelings, fearfulness, withdrawal, and nightmares are common among people who have been victimized and may develop in those caring for victims. Despite nurses' knowledge and experience in working with survivors, some . . . are likely to exhibit symptoms similar to those of their clients.
> . . .
> . . . Survivors can tell their story with such emotions that nurses absorb the intensity of feeling, shut down to avoid feelings, or stop a client from sharing. Nurses then become unwitting partners in the survivor's unconscious reenactment of the victim-perpetrator experience of the original trauma. This partnership can continue to the detriment of both patient and nurse until someone or something intervenes.
> . . .
> The insidious nature of indirect trauma can disrupt nurses' mental and emotional well-being to such an extent that troubling changes begin to insinuate themselves into their personal lives. . . . . [18]

[17] http://www.istss.org/indirect.htm
[18] Clark, Marcia L., and Gioro, Sandra; "Nurses, Indirect Trauma, and Prevention"; *Image: Journal of Nursing Scholarship*; 1998: 30(1), 85 - 87

The Clark and Gioro definition is of interest because they, and the ISTSS, describe the problem as not only manifesting itself in personal impacts on the care provider, but also in having a distinct impact on the value of the therapeutic relationship with and for the client. We are of the view that the impact on the professional relationship is not only a consequence, but part of what defines "vicarious trauma".

Figley promoted the term "compassion fatigue" rather than "vicarious trauma" in *COMPASSION FATIGUE: Coping with Secondary Traumatic Stress in those who treat the traumatized* - the 1995 collection of articles he edited for the Brunner/Mazel Psychological Stress Series. He explained:

> Thus although STS [Secondary traumatic stress] and STSD [Secondary traumatic stress disorder] are the latest and most exact descriptions of what has been observed and labeled over hundreds of years, the most friendly term for this phenomenon, and one that will be used here, is compassion fatigue (Joinson, 1992). Webster's Encyclopedic Unabridged Dictionary of the English Language (1989) defines compassion as 'a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (p.299). Its antonyms include "mercilessness" and "indifference". My very informal research leads to the finding that the terms compassion stress and compassion fatigue are favored by nurses (Joinson first used the term in print, in 1992, in discussing burnout among nurses), emergency workers, and other professionals who experience STS and STSD. Such discomfort might arise from a concern that such labels are derogatory. Feeling the stress, and even the fatigue, of compassion in the line of duty as a nurse or therapist better describes the causes and manifestations of the duty-related experience. [19]

Since then, Susan D. Moeller's influential 1999 book *Compassion Fatigue: How the Media Sell Disease, Famine, War and Death* (Routledge; ISBN 0415920981) has overtaken Figley's intentions for the phrase. Richardson has commented:

[19] Figley (1995), at pp.14 - 15

> In this guidebook, the term "vicarious trauma" will be used. Feedback from groups and individuals during this project, as well as consideration of the use of terms available in the literature, determined that "vicarious trauma" comes closest to identifying the specific experiences of anti-violence workers. "Compassion fatigue" is another term often applied to this field; however, it is increasingly used to describe exhaustion and desensitization to violent and traumatic events portrayed, in particular, by the media. [20]

Still, Figley had good reason to choose the "compassion fatigue" wording when he did. The point was to capture the idea that the problem to be addressed consisted of a mix of traumatic material, empathic engagement with that material, and a professional obligation and desire to engage with that material. We feel that Richardson's explanation for choosing the "vicarious traumatization" terminology is persuasive.

What Vicarious Trauma Is Not

Definitions, if they are to be precise, should also exclude certain things. That must be done here as well. If we are intent on identifying a condition to be known as vicarious traumatization, we have to know how is it different from other known conditions such as burnout, secondary victimization, secondary traumatization, or true incapacity to cope. This issue is of considerable practical importance.

For example, in 1991, a lawyer in Toronto was caught with two accomplices robbing a bank while armed with firearms. He was just two years out of law school and through bar admission. The disbarment ruling by the Law Society of Upper Canada attached a description of the lawyer's involvement in this misadventure as follows:

[20] Richardson, loc. cit.

> He at the time of this offence had recently been fired from a firm here in Toronto; he told me his professional life was in shambles. He was under an immense amount of stress, he was suffering he felt, although I take it it wasn't officially clinically diagnosed, but he was suffering from depression. He worked for five years without a holiday, worked very hard and felt that he was being abused by the people he worked for. He took therefore to alcohol to escape the pressures of work.
>
> He as I say comes from a good family, he has sisters out west in Alberta, both of them one being a teacher and one being a nurse. When I asked him why someone of his obvious intelligence would get involved in a thing like this, he told me that he was having difficulty handling the pressures of the job and started to crack up and drink like a fish. He had an idea to go in and demand a holiday from these people, and I guess he also had another idea which was to cut his expenses and slow down a bit, perhaps take a sabbatical, and in the result he gave up the apartment he was living in and he rented this house on O'Connor Drive and put down the first and last month's rent, he thought he would live really cheap there and invite all his friends to live with him and have them pay the rent along with him but it got out of hand, the reason it got out of hand is because it became a bit of a crash pad, a flop house, people were in and out all the time and he had very little control over collecting rent from these people, phone bills got run up, there was drinking and drugs, it turned into a real party house and his work suffered with all this, he told me that bills got out of control in January and he found himself deep in debt and he ended up getting fired from the firm about a week before the robbery. [21]

Is this a lawyer who had burned out, was simply overworked, or was he vicariously traumatized by the work he had been doing? Vicarious traumatization is suggested by phrases such as "worked very hard and felt he was being abused by the people he worked for", the fact that he was apparently feeling depressed about his work, and that he had adopted avoidance strategies such as the repetitive overconsumption of alcohol.

[21] L.S.U.C. v. Kay, [1992] L.S.D.D. No.42.

If professional counselors are to be in a position to make a diagnosis, and then to design a treatment, for afflicted lawyers, they have to be able to distinguish what is seen in cases of vicarious trauma from what is seen in cases of overwork or burnout. As lawyers, we should be aware that vicarious traumatization is at least a diagnostic alternative to the traditional diagnoses made when lawyers and their practises come apart.

Secondary traumatization or secondary victimization are phrases used to describe a prolonged exposure to persons suffering from chronic post-traumatic stress disorder [22]. Secondary traumatization or victimization is therefore a psychological change that occurs as a result of simple exposure to a traumatized individual, regularly and over time. There is no necessary care giving relationship involved with the person who suffered the direct traumatization. There is no obligation to work with the direct sufferer to reach some outcome. There is no responsibility assumed for another's problem. Others use the term "secondary traumatic stress" to include the care giving component, and thus attempt to explain the phrase as indistinguishable from "vicarious trauma" as described above [23]. The purpose of doing so seems to be based on a desire to use a term that folds neatly into the diagnosis of a condition comprehended by the phrase *secondary traumatic stress disorder*. However, not all those who are affected by managing traumatic material for others develop the full panoply of symptoms that qualify as a traumatic stress disorder. It is evident from the literature examining vicarious traumatization in other professional groups that negative psychological effects that require treatment can exist without ever developing to the extreme of a traumatic stress disorder.

[22] Blair, D. Thomas, and Ramones, Valerie A.; "Understanding Vicarious Traumatization"; *Journal of Psychosocial Nursing*; 1996: 34(11): 24 - 30, at p.25

[23]: *e.g.*, Stamm, B. Hudnall; *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*; 2nd ed.; 1999, Sidran Institute and Press; Cornille, Thomas A., and Meyers, Tracy W.; "Secondary Traumatic Stress Among Child Protective Service Workers: Prevalence, Severity and Predictive Factors"; *Traumatology*: 1999: 5(1), Article 2

The term "secondary traumatization" is also used by some to describe the process of revictimization which is said to occur, for example, when a sexual assault victim is compelled to endure a demeaning physical examination or litigation process. Since use of the word "secondary" as an adjective provides such little clarity, there is a valid question as to the value in using it at all.

Burnout is a phrase - perhaps overused and incorrectly applied as a pejorative label - which began to be used as a shorthand about 20 years ago to describe professional depression. Blair and Ramones adequately summarize the current understanding of burnout as follows:

> . . .[B]urnout . . . was originally defined as a complex of psychological responses to the particular stresses of constant interaction with other persons in need . . . .
> . . . Burnout also can be understood in terms of learning theory, and has been identified as a progressive loss of idealism or the professional's unrealistically high expectations concerning professional work given the clinical, social, or organizational environment, and usually are not amenable to adjustment. . . .
> Burnout also has been closely associated with clinical work involving difficult or complex patient populations . . . Burnout has been examined in relation to work in special clinic areas such as corrections where treaters come in frequent close contact with both victims and perpetrators . . . and encounter continual exposure to central themes of violence and abuse . . . .[24]

While those authors feel that burnout shares many features of vicarious traumatization, they also feel that the observed symptoms in vicarious trauma are not fully accounted for by burnout. In particular, the experiencing of symptoms similar to those of the client, as if living through the original traumatic experience, are not explained by the concept of "burnout".

[24] Blair and Ramones, at p.25

Also, burnout is said to be caused by generalized occupational stress rather than the stress of having taken on the obligation of managing the client's trauma, or having to interact with the client's traumatic material to an objective. In fact, burnout doesn't require the professional's involvement with any traumatic material at all. As Pearlman and Saakvitne point out:

> Burnout has been applied to trauma therapists, as well as to many other individuals in social service or helping jobs identified as high stress with low rewards, or in situations in which the workers' minimal goals (Rotter,1954), the minimum necessary for work-related satisfaction, are unachievable. Burnout is related to the situation, but does not incorporate the interaction of the situation with the individual that is essential in vicarious traumatization. [25]

Conclusions About Definitions of Vicarious Trauma

It is our conclusion that vicarious traumatization is the most useful label to use when describing the emotional and psychological disruption suffered by a professional as a result of professional engagement with traumatic material. When the nature of a helping professional relationship is fully appreciated as involving a commitment to the competent, effective, and ethical improvement of the condition of a client involved in traumatic events, a real parallel can be seen between lawyers working in criminal justice and family law, and professionals who work in the fields of physical and mental health. The definition proposed earlier also is sufficiently precise that it excludes conditions such as burnout, secondary traumatization, and post traumatic stress disorders. It is a definition that will allow recognition of the condition - where it exists.

[25] Saakvitne, Karen W. and Pearlman, Laurie Anne; "Treating Therapists with Vicarious Traumatization and Secondary Traumatic Stress Disorders"; Chapter 8 in Figley, Charles R., ed., *Compassion Fatigue*; pp. 150 - 177, at p.153

Recognition of Causes

In *L.S.U.C. v. Gardiner*, [26], a disciplinary panel observed:

> It appears that Mr. Gardiner, between December 1991 and December 1992, came to an emotional and psychological nadir. His practice was overwhelming him so that he was in a state of, "confusion, personal financial pressures added heavily to his psychological load. He lost his home, and his income from the legal practice dried up. His life had become a day-to-day existence of surviving moment by moment." He had to turn to his parents for help. Eventually, their resources were depleted and he finally ended up "a failure".

The lawyer's psychiatrist also observed that:

> He is a person, who, in the past, was quite vulnerable to being overwhelmed. Thereafter would begin a downward spiral of anxiety, depression, disorganization and disarray. In the end, he would become emotionally exhausted, immobilized and unable to function - both in his life and in his profession.

While the personality traits which proved to be Mr Gardiner's undoing may have pre-existed the stresses of law practise, or have been accentuated by the stresses of law practise, we don't know why this particular individual and this particular practise fell apart. The minimal point that can be gained from this casualty report is that the psychological distress, feelings of lack of competence, or deskilling, could have arisen from many different causes. It is because of the multiple *potential* sources of the symptoms that it is important to be able to uncover their roots. If that can be done, treatment and management should be able to be more effective and certainly more focused on the real, underlying problem.

[26] [1996] L.S.D.D. No. 73,

Work in the field of vicarious traumatization with other professional groups has identified specific causes of symptoms that in turn signify the existence of vicarious trauma in a helping professional. Particular types of material or particular types of client obligations apparently do create an elevated risk of vicarious traumatization. Once again, this requires an appreciation of the kinds of material that become vicarious in their impact, and the kind of "helping" and assumption of responsibility for maintaining client relationships that open the professional to risk of vicarious traumatization

The Relationship

Many of the leaders in this field agree that vicarious trauma is inevitable in certain kinds of relationships. Figley's view is that:

> The professional work centered on the relief of the emotional suffering of clients automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering as well. [27]

The question then becomes how to assess the level of risk exposure to stressors in the professional relationship under study. However, for the purposes of this review, it is important to understand more fundamentally why the helping professional is at risk at all. Why is it that emotional or psychological distress shows up in the helping professional at all?

Figley describes the process of absorbing suffering as "empathic induction" [28]. His own studies have led him to the following views as to cause:

[27] Figley(1995), at p.2

[28] Figley(1995), at p.4

> . . . trauma workers are always surrounded by the extreme intensity of trauma-inducing factors. As a result, no matter how hard they try to resist it, trauma workers are drawn into this intensity. Beyond this natural by-product of therapeutic engagement, there appear to be four additional reasons why trauma workers are especially vulnerable to compassion fatigue:
> 1. **Empathy is a major resource for trauma workers to help the traumatized.** . . . .empathy is a key factor in the induction of traumatic material from the primary to the secondary victim. Thus the process of empathizing with a traumatized person helps us understand the person's experience of being traumatized, but, in the process, we may be traumatized as well.
> 2. **Most trauma workers have experienced some traumatic event in their lives**. . . .
> 3. **Unresolved trauma** of the worker will be activated by reports of similar trauma in clients . . . .
> 4. **Children's trauma** is also provocative for therapists. . . . .[29]
> [Emphasis in original]

Thus, Figley identifies the nature of the professional relationship, the *therapeutic engagement*, as the primary cause of vicarious trauma effects in the professional care givers. He concisely summarized his views as follows:

> Compassion stress is defined as the stress connected with exposure to a sufferer. Empathic ability is defined as the ability to notice the pain of others. It is frequently the characteristic that leads people to choose the role of helper, especially as a social worker, counselor, or other type of professional helper. This ability is, in turn, linked to one's susceptibility to emotional contagion, defined as experiencing the feelings of the sufferer as a function of exposure to the sufferer. This is similar to the feeling of being "swept up" in the emotion of the victim(s), and is the very essence of the feeling of compassion for another. Much of this is associated, in turn, with identifying with the victim(s) . . . .

[29] Figley(1995), at pp.15 - 16

> Empathic ability is also linked to empathic concern, the motivation to act. Without the motivation to respond to the victim, the helper does nothing - irrespective of the helper's ability to respond and the extent to which the helper is exposed to the suffering of the victim. Both empathic ability and emotional contagion account for the extent to which the person makes an effort to reduce the suffering of the sufferer. The effort is the empathic response. . . . The extent to which the helper is satisfied with his or her efforts (sense of achievement), and the extent to which the helper can distance himself or herself from the ongoing misery of the victim(s), accounts for how much the helper experiences compassion stress. [30]

The case of Stephen Chernoff [31] provides a compelling example of these kinds of disposing factors first driving a practitioner away from certain practise areas, and into sole practise, and eventually into massive misappropriations of trust funds to accommodate client needs rather than personal needs. The lawyer's psychiatrist described the development of the lawyer's occupational history - *and occupational collapse* - as follows:

> After graduating from law school Mr. Chernoff worked for one year at the firm at which he Articled but was laid off. He subsequently opened a practice with his brother-in-law and they practised together for seven years. He states that the practice was unequal in terms of workload and financial contribution and because restructuring the partnership had implications for his relationship with his wife and her family, he abandoned efforts to change the arrangements. After the breakup of the marriage, Mr. Chernoff relocated his practice and split up the partnership. He focused on real estate, in part because he was unable to tolerate any interpersonal confrontations that might be expected in other branches of legal practice. Mr. Chernoff 's real estate practice "boomed" and his office expanded up to six employees.
>
> Apparently, Mr. Chernoff 's professional problems began when the real estate market changed. He states that, "I felt that I was constantly being put in the position of having to bail (clients) out, even if there was no

[30] Figley(1995), at pp. 252 - 253
[31] *L.S.U.C. v. Chernoff*, [1991] L.S.D.D. No. 110.

> solution to a problem. It seemed as though half my clientele were mortgagees who were not being paid and the other half were mortgagors who could not pay". Several clients began to "hound" Mr. Chernoff for money and he, "did not have the courage" to tell these people there was nothing he could do. He stated that he could not bear confrontations with clients and at this time he began to use his personal funds or trust fund money in order to cover shortfalls in mortgages. Concurrent with the dramatically increased stress at work, he finally broke up with his girlfriend, his nephew died and his mother was having increasing problems coping with his father's deteriorating state. At a time when problems became particularly acute, he was unable to function efficiently at work and fell further and further behind the legal work required.

The psychiatrist concluded:

> Mr. Chernoff was suffering from a major depressive episode following a series of severe stressors including the collapse of his law practice, the breakup of an important relationship, the death of his nephew and the inexorable decline in his father's condition due to Alzheimer's disease. Mr. Chernoff's personality is characterized by low self-esteem. He devalues his own achievements and is overly dismayed by personal shortcomings. He often adopts a passive stance in conflictual relationships and has difficulty expressing anger. He has difficulty being assertive during confrontations and finds himself taking responsibility for the problems of others.
>
> Mr. Chernoff has no previous history of alcohol abuse. The episode of alcohol abuse was directly linked to the depressive episode and has resolved completely. At this point Mr. Chernoff's depressive symptoms have completely resolved. The aspects of his personality that predisposed him to depression and represent part of the context for his inappropriate professional conduct are the focus of the psychotherapy. He has agreed to continue to receive psychotherapeutic treatment.

Unfortunately, by the time the problem had been identified, over $800,000 of client funds had been misappropriated and the lawyer's career as a lawyer was over. However, the case shows classic symptoms of vicarious trauma - a lawyer on his own trying to solve client problems that are not within his power to solve, but preferring to jeopardize his own professional status rather than candidly informing the clients of difficult truths. There is avoidance with clients, with family, and the accompanying devaluing of self that accompanies such avoidance. There is intermingling of personal and professional life, and a common disinclination to deal with interpersonal conflicts in either forum. There is an insistence by the lawyer on attempting to manage client problems while being confronted with his own unmanageable personal problems. If this is not vicarious trauma because the *current* practise content is simply real property mortgages, it may be a case of direct trauma from family and personality issues disrupting an already destabilized practise. In the view of the authors, the psychological consequences for the lawyer in the *Chernoff* case certainly seem to mirror what Figley has described.

The engagement process described by Figley means that the professional helper and the client are in a relationship with each other. There is an obligation of care undertaken by the professional to the person needing care. That obligation of care requires some empathic commitment by the helping professional to the client. The consequence is that in order to make a successful empathic commitment to, and connection with, a client, a professional helper exposes his/her emotional and psychological self to the disturbing and disruptive experiences of the client. That creates the avenue for a successful professional engagement, but it also creates the opportunity for professional infection and harm. As Valent has observed:

> Empathizing with and being devoted to victims opens the helper to feeling all the maladaptive SSs [survival strategies] and traumatic responses of victims. Hence, the initially adaptive identification and understanding of victims may lapse into the helper's becoming a fellow victim. [32]

Associated with this idea that Figley's "empathic induction" is a contributing cause of vicarious traumatization, is the recognition that helping professionals bring their own issues to the helper-client relationship. The measure of how traumatizing a relationship is will depend in part on what personal stress management capacities the professional uses or needs, and how the professional responds to the particular stressors in the therapeutic relationship. To use an obvious example, a professional with a personal sexual abuse history may be required to more actively manage his/her handling of a sexual abuse client than a professional without such a personal history. [33]

[32] Valent, Paul; "Survival Strategies: A Framework for Understanding Secondary Traumatic Stress and Coping in Helpers"; Chapter 2 in Figley, Charles R., ed., *Compassion Fatigue*; pp.21 - 50, at p. 45

[33] This also raises the issue of countertransference, a distinct problematic condition in any therapeutic relationship. In countertransference situations, the professional is seeking to meet his or her own personal needs through the client, rather than the other way around. For example, Blair and Ramones (1995) explain countertransference at p.26 as "the activation of unresolved conflict or unconscious concerns within the therapist. Therapeutic interaction with patients may reactivate early conflicts, socializations, experiences, and memories. . . . ". Hartman sees countertransference as a reaction style adopted by therapists - the one characterized by avoidance of the client's issues, the other by over-identification with the client's issues: Hartman, Carol R.; "The Nurse-Patient Relationship and Victims of Violence"; *Scholarly Inquiry for Nursing Practice: An International Journal*; 1995: 9(2): 175 - 192. It is those things, perhaps better summarized by Figley (1995)'s reference at pp.9 - 10 to Corey (1991) and Singer and Luborsky (1977):

> . . . the process of seeing oneself in the client, or overidentifying with the client, or of meeting needs through the client.
>
> . . . all of a therapist's conscious and unconscious feelings about or attitudes toward a client, ...

The distinction between countertransference and vicarious trauma was expressed most clearly by Saakvitne and Pearlman (1995), at 156:

> Quite broadly, countertransference can be understood as the therapist's responses to a particular client and all that client represents to the therapist (including the client's material, presentation, and transference to the therapist, and the therapist's transference to the client), whereas vicarious traumatization refers to the cumulative impact of trauma work on the therapist across clients.

Pearlman and Saakvitne have given considerable thought to the causes of vicarious trauma common to helping professionals working with traumatized clients. They also identify causes of vicarious trauma as inherent in the therapeutic relationship, such as the following:

> Traumatic events can happen to any one of us or our loved ones at any time; it is almost intolerable, however, to accept the fact that our lives can be permanently changed in a moment. . . . The presence of a survivor client in our office is an inescapable reminder of our own personal vulnerability to traumatic loss.
> . . .
> . . . clients who have been profoundly hurt and betrayed in early trusting relationships bring to the therapy relationship powerful emotional needs and a highly developed sense of mistrust. They present enormous pain and distress and yet are often unable to be soothed, given their despair and vigilance. These clients are often compelled unconsciously to reenact both within and outside the therapy relationship earlier painful, abusive, and denigrating relationships.
> . . .
> In addition, in our role as trauma therapists, we must also be, in effect, bystanders and helpless (although not silent) witnesses to damaging and often cruel past events. This helplessness to change what happened in the past transforms us, challenges our helper identities, and can lead us defensively to devalue survivor clients. . . .
> . . .
> In summary, all of these challenges to our sense of ourselves and our beliefs about the world and the people in it present unique demands for us, as trauma therapists, and make us susceptible to vicarious traumatization. [34]

[34] Pearlman and Saakvitne (1995), at pp. 154 - 155.

Figley, Pearlman and Saakvitne each suggest that the aspect of the caring relationship that renders a helping professional susceptible to vicarious trauma is the obligation to be empathically open to the client. In order for the relationship to succeed, the client must repose some trust and reliance in the professional to care for them. The professional must be sufficiently engaged with the client's emotions and in rapport with the client's world view to be able to effect positive change in the client's presenting problem. The helping professional needs to commit personal, human energy to the relationship in order to determine and then to establish a treatment or problem-solving strategy, and thus to achieve treatment objectives. An increase in the risk of vicarious traumatization will therefore appear to correspond with any increase in the level of emotional investment and commitment required of the professional to achieve treatment objectives.

As was mentioned in passing earlier, lawyers are generally expected to remain emotionally detached from the cases they handle. It is this detachment that is supposed to permit them to exercise dispassionate judgment and to give independent advice to clients. However, lawyers are not automatons. They are human beings who experience and understand the world with the same toolbox of emotions as other humans do. Yet, the lawyer's emotional reaction to traumatic material has generally been seen as irrelevant to resolving the legal problem that needs to be solved through the lawyer-client relationship - except by the client. The client is very sensitive, particularly in family and criminal law matters, about having a lawyer who is, if not a cheerleader, at least emotionally committed to the achieving success in the litigation.

It is our view that the traditional conception of lawyering as a detached and emotionless exercise does not suit legal practises that deal in the consequences of human suffering. The world of child protection and custody proceedings is not

sterile and antiseptic. Counsel are expected to appreciate and serve the emotional needs of children, and to seek results that foster the physical, emotion, and nurturing security of those children. That cannot be effectively done without the lawyer committing personal, human energy to engage the client or the child in a trusting relationship working toward a common objective.

As Defence counsel in criminal matters, lawyers are required to engage with their clients to an extent that the client feels able to trust the lawyer with the client's most private knowledge, thoughts, and experiences. The lawyer must maintain that commitment of trust and confidence with the client, while developing a strategy to achieve the client's objectives for any legal process. The lawyer must then advocate on behalf of the client with others. The client's cause is expressed by the lawyer, often instead of by the client. A prosecutor too must be able to empathically engage with victims of offences in order to fully appreciate the significance of a particular criminal act, and then endeavour to express the true depth of human or social harm through entirely dispassionate advocacy.

The point is that lawyers are not immune from vicarious traumatization because of any obligation of professional detachment. To repeat what was said by Figley:

> Both empathic ability and emotional contagion account for the extent to which the person makes an effort to reduce the suffering of the sufferer. The effort is the empathic response. . . . The extent to which the helper is satisfied with his or her efforts (sense of achievement), and the extent to which the helper can distance himself or herself from the ongoing misery of the victim(s), accounts for how much the helper experiences compassion stress. [35]

[35] Figley (1995), at p. 253

The relationship with a client who has been traumatized, or whose problem involves traumatic material (as we discuss below), is an indicator of a risk of vicarious traumatization. The fact that there is a relationship does not mean that there will be an *unmanageable* impact or effect. Professional detachment may be a useful skill by which to inhibit or manage the negative effects of a legal care giving relationship with a traumatized client. The point here is that the *relationship of empathy* is a major risk factor for vicarious traumatization because of what it requires from the lawyer who wants to be both helpful to his client and effective within the legal system in achieving results for his client.

The Content

The *content* of the harm to be "helped" is also recognized as a cause of vicarious trauma. The content not only places stress on the helping professional and the client as people, but also on their relationship. Beaton and Murphy identified three "operational components" to their concept of vicarious trauma:

> (1) having witnessed or been confronted by actual or threatened death or injury, or by a threat to the physical integrity of oneself or others; (2) provocation by the stressor of responses of fear, horror, and helplessness; and (3) direct or indirect exposure to an exceptional mental or physical stressor, either brief or prolonged. [36]

The first component adopts the phrasing and concept of a traumatic stressor contained in the DSM IV.

[36] Beaton, Randal D., and Murphy, Shirley A.; "Working with People in Crisis: Research Implications"; Chapter 3 in Figley, ed., *Compassion Fatigue*; pp.51 - 81, at p.53

Other writers have included stressors such as "exposure to the grotesque; hearing of the violent or sudden loss of a loved one; witnessing or learning of the violence to a loved one; learning of one's exposure or that of a loved one to a noxious agent; and causing death or severe harm to another." [37]

Dutton and Rubinstein specifically include:

> . . . criminal victimization (e.g., sexual battery, domestic violence, homicide of a family member); the suicide of a family member or friend; the Holocaust; a natural disaster (e.g., earthquake, hurricane); accidents (e.g., nuclear plant explosion, plane crash, serious car accident); combat; kidnapping or being held hostage (e.g., being held prisoner of war or hostage by terrorists, child snatching); and social violence (e.g., riots, political terrorism). [38]

Cerney prefers a general definition of the necessary content:

> Because each person's experience of trauma is so different, there is much discussion about what may or may not constitute trauma . . . Nevertheless, authors generally agree that a "traumatic event is one in which the person is flooded with intense stimulation that he or she cannot control" . . . .[citations omitted]. [39]

Yet another conception of what constitutes "traumatic material" may be drawn from the work of Munroe:

[37] Green, B.; "Defining trauma: Terminology and generic stressor dimensions"; *Journal of Applied Social Psychology*, 20(20), 1632 - 1642 (1990)
[38] Dutton and Rubinstein, at pp. 82 - 83
[39] Cerney (1995), at p.131

> Traumatic events that shatter trust can be seen in key concepts related to trauma, such as shattered assumptions (Janoff-Bulman, 1992), disrupted schemas (McCann & Pearlman, 1991), a lost sense of invulnerability (Lifton, 1979), and loss of community (Erikson, 1976; Lifton, 1979).
>
> An event can be defined as traumatic to the degree to which it violates the sense of basic trust. Behavior is then altered to be functional in a world that is based on an expectation of exploitation rather than a sense of basic trust . . . . [40]

Any of these definitions of "traumatic material" is sufficient to identify the kind of content that is capable of causing vicarious traumatization.

Traumatic material is material that is outside of normal experience, and that is overwhelming to both the primary sufferer and the engaged professional's sense of physical and psychological security. It is something that requires special or extraordinary coping measures. It is something that is outside of anyone's ability to control - particularly if it has occurred in the past. There is no capacity to prevent or undo a harm. Normally, it is something that has involved a threat of harm or actual harm to the physical health or bodily integrity of the client. While the specific kind of event may be familiar to the professional in his or her professional work, the traumatic event would likely be outside the professional's personal life experience during off-duty hours. That is why the professional's sense of security would be tested in dealing with the traumatic material.

[40] Munroe, James F.; "Ethical Issues Associated With Secondary Trauma in Therapists", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.211 - 229 (1995), at p.211

Whichever of the descriptions of traumatic material is preferred, the traumatic content capable of causing vicarious traumatization is handled daily by the family courts, the criminal justice system, and the legal professionals who work within those institutions. Defence and prosecuting counsel are expected to review the minutiae of homicidal, and occasionally suicidal, violence - counting knife wounds, tracing the shape and location of blood stains, assessing the significance of gunshot entry wounds and the existence or not of powder burn residues at the entry site. Family lawyers too may engage in documenting bruises for size, and aging them according to colour. On many of these occasions the lawyer has to come, photographically, face to face with a victim of fatal violence, whether that be a child of 15 months, or a homeless alcoholic of 85. Where the violence has fallen short of being fatal, the lawyer will likely confront living proof of the scars, injuries, and emotional devastation in a breathing, speaking witness.

There can be little doubt that the family court system and the criminal justice system deal with traumatic material that is capable of traumatizing those who must deal with it after the fact. The same vile material that must be managed by the lawyer must also be processed by the accused or the applicant for custody. The lawyer may be called upon to familiarize a client, for the first time, with material about which the client was unaware at the time of the actual events. The content of a criminal lawyer's work and the family law lawyer's work does qualify as having traumatic job content, just like those who work in emergency rooms and other crisis response occupations.

The Duration of Contact with Traumatic Material

In addition to the relationship in which exposure to traumatic material occurs, and the content of the exposure, Dutton and Rubinstein identify another unique feature of what causes vicarious traumatization in helping professionals:

> Unlike crisis workers (e.g., emergency room workers, fire rescue and disaster teams, crisis hotline workers), whose response is to the immediate effects of a catastrophic event on the survivor, trauma workers are faced with the prolonged, and often compounded, aftermath of the trauma. Thus the trauma worker's exposure to trauma has far more complex ramifications than does exposure to the traumatic event itself.
> Working with the aftermath of trauma involves more than just exposure to the traumatic event (e.g., through the recounting of the event by the client and others, the client's in vivo re-experiencing of the event or re-vivification in the trauma worker's presence, and examining photographs of the physical injuries that followed a traumatic event). It also involves exposure to the survivor's reaction to the traumatic event (e.g., intense emotional pain, fear, rage, despair, hopelessness). In addition, there is exposure to the institutional and other social responses to the traumatized individual that revictimize her or him and over which the trauma worker may have little control (e.g., incarceration of a battered woman and separation from her children following a police call to her home in response to a complaint of domestic violence against her, unfounded sexual abuse allegations that result in returning a child to his or her alleged abuser, disregard by guards of sexual battery of refugee women held in detention while awaiting deportation).
> . . . Through exposure to the concept of "trauma," therapists not only become aware of their clients' pain, but also come to the realization that a particular traumatic event can occur, has occurred, perhaps repeatedly; and may recur. It is for these reasons that it is possible for a therapist, attorney, or other trauma worker exposed to the graphic details of a traumatic event, even if only once, to become traumatized.[41]

[41] Dutton and Rubinstein, at pp. 91 - 92

While professional contact with a particular item of traumatic material may be long or short, it will probably always be intense. A prosecutor or defence counsel may need to sift through traumatic material repetitively for periods of time up to several years. Counsel involved in a child protection proceeding will often be flooded with pages and pages of progress notes from an Agency involvement with a family that must be painstakingly read, considered and dissected. While duration may extend opportunity for traumatization, and while repeated exposure may enhance the opportunity for infection, it is not a requirement of traumatization.

Conclusion about the Recognition of Causes

What the Cerney formulation lacks is a recognition that the flooding, intense stimulation associated with vicarious trauma is invariably negative and destabilizing - a point specifically addressed in the Munroe analysis. Therefore, it is suggested that an event should be regarded as traumatic and capable of contributing to vicarious traumatization when it creates *an unanticipated or uncontrolled negative stimulus to the recipient of the experience*. In the criminal justice or child protection context, this is probably going to involve an event of violence or threat of violence to an individual.

Earlier we defined "vicarious trauma" as including three essential elements:

> (1) an emotional and psychological disruption suffered by the professional;
>
> (2) the disruption would be caused as a consequence of fulfilling professional obligations to manage the traumatic material, to achieve or pursue some helping objective for another; and,

> (3) the professional obligations would involve engagement with a person (a client, a witness adverse in interest, or a victim) who has experienced a legally significant traumatic event.

We may now adjust the third essential element in this definition of "vicarious trauma" so that it reads as follows:

> (3) the professional obligations would involve engagement with a person who has experienced a legally significant event in which the recipient of the experience suffered an unanticipated or uncontrolled negative stimulus.

The nature of the professional relationship, the nature of the content to be managed, and the duration of the contact with the negative material are all recognized as contributors to vicarious traumatization among health care professionals. These would also appear to be features of the relationships that criminal justice counsel, as well as lawyers involved in child protection or contested child custody litigation, must maintain in order to do their work.

Defence counsel, prosecutors, and the lawyers who litigate about the proper care of children, are all obligated to address negative, traumatic events because of a professional relationship with a client, victim, or witness. The content of the traumatic material will be legally significant in that counsel will have to address issues of the client or witness' participation in those traumatic events, their reactions to those events, as well as the immediate and life consequences of those events for the client, the witness, or some third party. If the relevant event was violent, it will likely be visually repelling as well as emotionally traumatic. This contact with the traumatic events will often persist over the several months or years that the case is in the system. The traumatic events will often be outside of the ordinary experience of

the professional's own daily life. If not, the events may resonate with a traumatizing event from the professional's own past.

Thus, the roles and tasks of family law counsel and criminal justice counsel share the same types of underlying causes of vicarious traumatization as exist for health care professionals who have been studied up until now. Lawyers do not have any inherent human or professional immunities. It appears obvious that the analysis of vicarious traumatization that fits other helping professions does have something to contribute to our understanding of how lawyers function, and how sometimes they fail to function, effectively. When it comes to vicarious traumatization, the symptoms should be caused the same way in lawyers as they are in nurses, social workers, and therapists.

Symptoms and Effects

The constellation of symptoms described in relation to professionals said to be suffering from the effects of vicarious trauma is large. The symptoms reported are sometimes descriptive but are generally non-specific and non-diagnostic. At our current stage of knowledge, the list of symptoms is not considered to be closed, nor are there any definitive criteria for diagnosis or exclusion. Instead, diagnosis appears to be based on a body of symptoms in the care provider, coupled with the existence of a care-giving relationship involving a traumatized individual, and a lack of confidence that the symptoms can be better explained by some other diagnosis.

Hartman identified specific biological reactions to traumatic material in nurses. These reactions resulted in certain identifiable and predictable behaviours on the part of the nurses studied - such as overinvolvement or withdrawal, behaviours that, in short, "adversely affect the empathic connection necessary for therapeutic

outcome of the nurse-patient relationship". [42] Hartman's study is somewhat unique in its approach of measuring or identifying a biological reaction that corresponds with certain behavioural responses between a care giving professional and a client. Some studies have also established correlations between disposing factors and symptoms that are suggestive of causes [43].

A close connection is maintained with the research in the field of post-traumatic stress disorders - out of which our current appreciation of vicarious trauma grew. The symptoms of post-traumatic stress disorder, and their causes, may show up somewhat differently in the context of delivering professional services. It has been supposed that post-traumatic stress disorder is a limbic disorder involving the amygdala. Daniel Goleman discussed this idea in his book, *Emotional Intelligence*, in language that quite precisely fits the difficulty that traumatized care-providers experience:

> Endorphin changes add a new dimension to the neural mix triggered by reexposure to trauma: a *numbing* of certain feelings. This appears to explain a set of "negative" psychological symptoms long noted in PTSD: anhedonia (the inability to feel pleasure) and a general emotional numbness, a sense of being cut off from life or from concern about others' feelings. Those close to such people may experience this indifference as a lack of empathy. . . . .[emphasis in the original] [44]

[42] Hartman (1995), at p.176
[43] Kassam-Adams, Nancy; "The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychotherapists", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.37 - 48.
[44] Goleman, Daniel; *Emotional Intelligence*; Bantam Books (1995), at p.206. See also: Glover, Hillel; "Emotional Numbing: A Possible Endorphin-Mediated Phenomenon Associated with Post-Traumatic Stress Disorders and Other Allied Psychopathologic States", *Journal of Traumatic Stress* 5, 4(1992).

Unfortunately, most studies only make observations about emotional and psychological reactions that appear to correspond with findings of vicarious trauma. Observations about emotional and psychological reactions do have value. They just do not lend themselves as easily to consistent measurement as other kinds of observations. Care must be taken in associating the emotion observed with the illness so that the treatment is appropriate.

Hartman's work is additionally useful to the issues in this paper because it speaks directly to the manifestation of symptoms in the care giver/patient relationship instead of effects simply on the personality and personal functioning of the care giver. Hartman saw that the emotional engagement, created by the communication of traumatic material from the patient to the nurse, necessarily led to a certain array of reactions on the part of the nurse. The array of reactions includes alterations in the care giver's ability to soothe the self, ability to demonstrate self-consistency, self-cohesion, self-monitoring, ability to exercise sustaining self-esteem, and maintaining a sense of oneself as part of a community. In our experience, lawyers in the criminal justice and family law sphere face these same problems:

> There is *increased physiological and physical reaction*. The symptoms associated with autonomic arousal are rapid heart rate at resting, somatic reactions, sleep disturbances (particularly REM abnormalities), agitation, inattention, drowsiness, and uncontrolled and unintended emotional displays. These reactions occur with patients and are carried over into the private life of the caregiver. *Emotional reactions* include irritability, annoyance or disdain; anxiety and fear reactions; depression and sadness; anger, rage and hostility; detachment, denial, and avoidance; sadistic/masochistic reactions; voyeuristic and sexualized reactions; and confusion, psychic overload, overwhelmed reactions, and guilt. These reactions are often responded to with shame and embarrassment as they are manifested in interactions with patients, coworkers, and families. The reactions underscore the

> emotional dysregulation. *Psychological reactions* are detachment, overuse of intellectualization, rationalization, isolation, denial, minimization, and fantasy. Another complex response is overidentification with the patient with increased use of psychological defenses such as projection, introjection, and denial.
>
> A last grouping of signs of vicarious traumatization and resultant countertransference includes behavioral symptoms that may or may not be in the conscious awareness of the provider, i.e., forgetting appointments, lapse of attention, parapraxes (distorted perceptions of the patient), loss of empathy, hostility, and anger toward patient, relief when the patient misses an appointment or a wish that the patient not show up for appointments, denial of feelings, denial of need for supervision and consultation regarding the patient, a self-centered belief that one has a special "gift" for working with a certain population of victims of violence, overconcern and/or identification with the patient, psychic numbing or emotional constriction, self-medication or numbing (increased use of drugs and alcohol); loss of professional boundaries during work with patient and reactions where the professional takes on a more or less positive vantage point of the patient's plight (such as that of the protector or rescuer); or the professional takes on a complementary vantage point of the patient, where the professional can be the punisher, the abusive parent. These increased patterns of involvement are also associated with intense preoccupation with the patient (can't stop thinking about the patient), dreams and disturbed sleep, being easily reminded of the patient when not intending to think about him or her. [45]

The consequence of these kinds of behaviours and reactions in the relationship between professionals and their patients is that the therapeutic relationship suffers either from the professional being remote, avoiding, and uninvolved, or conversely, being overinvolved and dominating of the patient with the professional's own issues. In either case, the professional relationship is not governed by the needs, and outcome needs, of the client. This can come fairly close to what therapists describe as "countertransferrance", discussed earlier. [46]

[45] Hartman, at pp.179 - 180
[46] See note 33

The most useful point from that passage in Hartman's work for this review is that a true diagnosis of vicarious trauma is not just a ticking off of symptoms manifested by the professional. Diagnosis of vicarious trauma will include symptoms manifested by disturbances in the professional-client relationship. The extent or depth of the psychological problems suffered by the professional alone may really be diagnostic of the degree of traumatization rather than its existence in the professional's relationships with his clients.

Yassen prepared a concise table of impacts of "secondary traumatic stress" on professional functioning which it is useful to present as a whole [47]:

Performance of Job Tasks	**Morale**	**Interpersonal**	**Behavioural**
Decrease in quality	Decrease in Confidence	Withdrawal from Colleagues	Absenteeism
Decrease in quantity	Loss of Interest	Impatience	Exhaustion
Low motivation	Dissatisfaction	Decrease in quality of relationship	Faulty judgment
Avoidance of job tasks	Negative attitude	Poor communication	Irritability
Increase in mistakes	Apathy	Subsume own needs	Tardiness
Setting perfectionist standards	Demoralization	Staff conflicts	Irresponsibility
Obsession about detail	Lack of appreciation		Overwork
	Detachment		Frequent job changes
	Feelings of incompleteness		

Richardson adoption of Yassen's work, in her *Guidebook on Vicarious Trauma*, is an example of the wide practise of circular citation among articles in this area of inquiry [48]. Blair and Ramones [49], and Clark and Gioro [50], also appear to rely heavily on the conclusions of other writers.

[47] Yassen, J.; "Preventing secondary traumatic stress disorder", Chapter 9 in in Figley, Charles R., ed., *Compassion Fatigue*; pp.178 - 208, at p.191
[48] Richardson, loc. cit.
[49] Blair and Ramones, at pp.24 - 25
[50] Clark and Gioro, at pp.85 - 86

Crothers reports at least an anecdotal basis for her listing of symptoms [51]. Organized according to Yassen's categories, which do seem helpful, these are:

Performance of Job Tasks	*Morale*	*Interpersonal*	*Behavioural*
Lack of attention	Anger	Intolerance	Sleeplessness
Client Overinvolvement	Sadness	Compassion	Nightmares
Annoyance with patient care	Guilt	Sensitivity	Irritability
Frustration with patient care	Grief	Denial	Hypervigilence
Disgust with client material	Despair	Caution	Lack of energy
Fascination with client material	Fear	Irreverance	Tearfulness
	Depression	Distrust	Nausea
	Terror	Paranoia	Respiratory stress
	Helplessness		Chills
	Feeling deskilled		Mental Exhaustion

Saakvitne and Pearlman write from clinical and workshop tested experience, if not from empirical study of defined populations. When drawn into identifying symptoms, their list is long, and may be successfully organized according to Yassen's categories [52]. Their unique contribution in this area however, in our view, is the recognition that vicarious traumatization is not a static condition, but rather a process:

> Vicarious traumatization is a process, not an event. It includes our strong feelings and our defences against those feelings. Thus vicarious traumatization is our strong reactions of grief, rage, and outrage, which grow as we repeatedly hear about and see people's pain and loss and are forced to recognize human potential for cruelty and indifference, *and* it is our numbing, our protective shell, and our wish not to know, which follows these reactions. These two alternating states of numbness and overwhelming feelings parallel the experience of PTSD. [53]

[51] Crothers, Delphine; "Vicarious Traumatization in the Work With Survivors of Childhood Trauma"; *Journal of Psychosocial Nursing*; 1995: 33(4): 9 - 13, at p.9

[52] Saakvitne and Pearlman (1995), at pp.159 - 165
[53] Saakvitne and Pearlman (1996), at p.41

There is some comfort that can be taken from the repetition of observed symptoms from one article to another, and among writers and researchers, but repetition can not be accepted as a basis to conclude that the identified symptom is indeed relevant and diagnostic. The science is not yet there.

The authors share the general approach in the literature to accept that symptoms may be observed over four specific areas: Performance of job tasks, Morale, Interpersonal, and Behavioural. We expect that vicarious trauma should be a potential diagnosis from symptoms that detract from the value to the client of the helping professional relationship. The diagnosis would then be made if those symptoms could be associated with the three elements of vicarious trauma discussed earlier, and that are not clearly the result of some other illness or condition.

Our view is based both on professional practise experience, and anecdotal comments in the literature relating to other professional groups. For example, in addressing the ethical issues that arise with respect to vicarious trauma and therapists, Munroe discussed the kind of relationship disruptions that may result from a care-giver who is suffering from vicarious trauma. The comments are as apt for dysfunctional criminal justice and family law counsel as they are for the therapists being discussed:

> A therapist who is overwhelmed by the traumatic impact of numerous clients may be in a state of avoidance when a particular client comes in. It is possible that when this client needs to talk about trauma, the therapist will discourage discussion to protect himself or herself. Alternately, the therapist who is in an intrusive phase may insist on getting at the details of a client's trauma when the client is not ready. If the therapist is suffering from disturbed sleep or nightmares he or she may not be attentive to the needs of the client. The therapist's

> irritability from overexposure may result in the client's being silenced during a session. Overexposed therapists may also be trying to rescue clients who do not need to be rescued, or going on a mission to route out traumatic perpetrators when this is not in the client's best interests. Therapists might also become suspicious of other professionals whom they think do not "understand" the needs of trauma clients, and thereby impede the client from accessing necessary services. Therapists may begin to avoid their trauma clients and misdiagnose them, or they may avoid meetings and supervision. [54]

Professional discipline decisions are replete with examples of lawyers who exhibit, or claim, some level of depression. These depressions are associated with disrupted decision-making such as "paralysis with respect to deadlines", overzealousness with respect to client issues, and substance abuse: *e.g.*, *L.S.U.C. v. Rayner*, [1994] L.S.D.D. No. 20; *L.S.B.C. v. McNabb*, [1999] L.S.D.D. No. 54; *L.S.B.C. v. Peters*, [2000] L.S.D.D. No. 10. Symptoms of depression are certainly seen in young, as well as senior, family law practitioners: *e.g.*, *L.S.B.C. v. McNabb*, *supra*; *L.S.U.C. v. Riley*, [1997] L.S.D.D. No. 44. Whether these are symptoms of vicarious trauma is impossible to determine based on the record provided by the written decisions in those cases. That is one of the reasons why a more focused analysis of the issue is being proposed in this paper.

For example, the following comments were made of a lawyer practising primarily real estate law, and likely not suffering from anything vicariously traumatic at all, in *L.S.U.C. v. Wong*, [55]:

> Miss Wong's underlying personality (sic) is that of a compulsive nature, meaning that she is meticulous, precise and dedicated to perfectionism.
> . . .

[54] Munroe, James F.; Shay, Jonathan; Fisher, Lisa; Makary, Christine; Rapperport, Kathryn; Zimering, Rose; "Preventing Compassion Fatigue: A Team Treatment Model"; Chapter 10 in Figley, Charles R., ed., *Compassion Fatigue*; pp. 209 - 231, at pp.217 - 218

[55] *L.S.U.C. v. Wong*, [1991] L.S.D.D. No. 104

> As she migrated more towards her occupational responsibilities she was confronted by a rising fear of losing control of her personal life, meaning issues relating to her family and marriage. As there was little compromise available, the frustration led to a type of obsessional neurosis which ultimately culminated in a picture of clinical depression. As typical in these instances, there is no subjective perception of depression which manifests (sic) itself cognitively as a loss of concentration, attention and intellectual capacity as well as physically which reports (sic) in fatigue, loss of sleep and ultimately exhaustion. At these times even simple decisions seem overwhelming.

Vicarious traumatization would not appear to arise from these symptoms such as sleeplessness and being overwhelmed by even simple decisions because there is no apparent engagement with traumatic material, and there is a legitimate, alternative psychiatric diagnosis.

Stamm encapsulated the symptomatology issues in concise terms:

> Susceptibility to Secondary Traumatic Stress stems from two basic, and related, areas: (a) lack of control and (b) questions of competency. Questions of competency, at least in part, arise from the professional's feelings of lack of control of traumatic material. Therefore, controlling the trauma is a necessary component of competency. When people feel as if they are prepared, or at least have the ability to act positively during an event (that is, to exert some control during the event), there is a better outcome. When people feel as if they have no control the prognosis is quite poor. [citations omitted] [56]

If our analysis is correct, then the core symptoms of vicarious trauma would appear to include the following:

[56] Stamm. B. Hudnall; "Creating Virtual Community: Telehealth and Self-Care Updated" (1999); in Stamm, B. Hudnall; *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*; pp.179 - 208, at pp.180 - 181.

1. A reduction in the professional's sense of confidence

2. The reduction in professional confidence is in relation to his/her own competence to provide helping services to the client

3. The reduction in confidence manifests itself in the professional either

   (a) avoiding care giving opportunities which would reinforce this sense of a lack of competence, or,

   (b) submersing him or herself in care giving opportunities in search of a successful, and perfect, outcome which is reasonably unachievable

   and in either case the professional isolates him or herself from peers and family

4. The avoidance or submersion both demonstrate a failure by the professional to appropriately manage the demands of the client and the client's traumatic material to an achievable outcome; and

5. The professional manifests an aversion response to the client's traumatic material by either avoiding it or demeaning the significance of it.

Managing the demands of the client and client's traumatic material to an achievable outcome is the purpose of any professional engagement - whether the professional is a nurse, a social worker, or a lawyer. The particular sources of failure in vicarious traumatization would seem to arise from the professional's dissatisfaction with client relationships on the basis that those relationships are not meeting the professional's expectations for the relationship. This is therefore the professional's problem rather than a client problem, though client service is certainly a casualty when the professional care-giver loses his way with appropriately managing the relationship.

The professional problem in this context would then seem to be that the requirement of dealing with a client's traumatic material as one's own through empathy can easily

distract the professional from the task of helping the traumatized individual. The more overwhelming the traumatic material, the less attention the professional will have for the client themselves. This thought was put sharply by Pearlmann and Saakvitne:

> . . .the therapist with unacknowledged vicarious traumatization can retraumatize clients and otherwise harm them in both overt and subtle ways. When a therapist's emotional and psychological needs are not addressed in appropriate ways outside his or her work, they can become more focal in the therapy relationship than the client's needs . . . . This imbalance can result in violations of therapeutic frame and boundaries, such as forgotten appointments, unreturned phone calls, or inappropriate contact with clients between sessions, as well as the more serious violations of abandonment, professional mistreatment, and sexual or emotional abuse of clients. . . . . [57]

This disconnection between the purpose of the professional relationship and what is actually happening between the professional and the clients is an additional source of stress for both clients and the professional service provider. Therefore, the symptoms seen are symptoms often associated with stress disorders. What makes these symptoms diagnostic of vicarious trauma, instead of post-traumatic stress disorder or burnout, are these: the nature of the material whose effects must be "fixed", the continuing intellectual commitment to the need for "fixing" to be done, but with a simultaneous sense of helplessness of actually securing the desired result. This sense of helplessness is what undermines the professional's whole sense of his own value in the professional relationship. It may also make treatment, cure or repair more difficult and more prolonged.

[57] Pearlmann and Saakvitne (1995), at p.157

A good example of this kind of breakdown in the professional relationship, with delay and avoidance of a fairly straightforward problem affecting a very traumatized client, is the case of *L.S.U.C. v. Ward*, [58]. The solicitor was a busy criminal practitioner, with a special talent for serving the needs of the mentally ill. A practise opportunity arose to broaden his practise, and locate it closer to his home. In the course of that upheaval, a client arrived on the lawyer's doorstep who had just lost his wife in a car accident that appeared to be entirely the other driver's fault. This was not an area of practise where the lawyer was skilled, and he provided service that was later described as "awful". In the course of mismanaging his client's claim, there was a pattern of non-communication, deceptive communication, misleading communication, and - according to the Discipline Committee - fraudulent misrepresentation. This all became magnified by temporarily successful deception of the Law Society about the case as well. Ultimately, the Discipline Committee seemed mystified by the solicitor's behaviour:

> The reports of Dr. Kunjukrishnan are of little assistance to the Committee in assessing the reason why the solicitor would create fraudulent documents for Mr. Lee's signature. It would appear that Mr. Ward does not suffer from any major psychiatric problem. He has shown some anxiety and depression and shows a tendency to procrastinate. Further, he requires ongoing professional help and marriage counselling.
>
> However, a tendency to procrastinate does not explain a wilful act of fraudulent misrepresentation to a client - particularly a client who, as Mr. Lee was, vulnerable and grieving.
>
> Much of the evidence led by Mr. Ward related to his difficulties between 1985 and 1987 and the Committee is mindful that the Bernard Lee matter arose in 1984. The Committee also notes that the problem relating to Mr. Ward's wife did not arise until 1989, and therefore, the Committee puts little weight, if any, in the testimony of Mrs. Ward with respect to her problem with her eating disorder as it may have impacted upon her husband. By 1989, the solicitor was dealing exclusively in Carleton Place and his Ottawa practise had been closed

[58] *L.S.U.C. v. Ward*, [1995] L.S.D.D. No. 6

> down. The Committee notes that the final releases were executed by Mr. Lee on May 28, 1988, and new releases were executed on March 31, 1989. The misleading of the Law Society occurred on April 29, 1991. Thus, the Committee finds it difficult, if not impossible, to put any weight on the solicitor's description of the stressful years, 1985 to 1987. Those years may account for his inactivity on the Lee file, but they do not account for the relevant dates upon which the solicitor has been found guilty of professional misconduct.

However, if a vicarious trauma analysis had been applied to the solicitor's history, particularly with two previous disciplinary penalties for failing to serve clients in a conscientious, diligent and efficient manner, and failing to reply to his Society, one would note that these symptoms of avoidance and delay based on lack of confidence and a reduced sense of competence are not unexpected in a solicitor who had been practising for about 7 years when the problems began. The solicitor described his practise as follows:

> Mr. Ward testified that he was extremely busy with his Ottawa practise until the end of 1987. He told the Committee that he had completed approximately three thousand criminal cases since his call to the bar, much of it comprised of duty counsel work. He described the difficulty of practising in Carleton Place and having to commute to Ottawa to do criminal defence cases and to Smith Falls for Provincial Court cases and to Perth for cases in the General Division. Moreover, when he purchased the Carleton Place practise, he found it to be heavily weighted towards real estate, requiring his attendances at two registry offices in Almonte and Perth. He told the Committee that he is the second busiest practitioner in his area and has active criminal files numbering at any given time from fifty to a hundred.

The diagnosis of vicarious traumatization would not have excused the lawyer's mishandling of the civil litigation file that became his undoing. However, if the diagnosis had been made or its potential identified, the lawyer could have adopted

strategies to overcome the risks that vicarious traumatization posed to his client relationships.

In a passage already quoted above, "compassion" is:

> a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause [59]

and compassion fatigue, or vicarious trauma, renders the professional less able or even unable to fulfil that desire to alleviate the client's pain. Even though the past and its harms cannot be undone, uncontrolled compassion can make a lawyer or other helping professional become overwhelmed by the desire to do just that: achieve the unachievable. That can only lead to failure, and doubting of competence. Symptoms which speak to those issues of helplessness, a sense of being de-skilled, a sense of lack of competence, are therefore the kind of symptoms one looks for to find vicarious trauma. Certainly, legal professionals who display these kinds of symptoms in their work, or who demonstrate these qualities in their relationships with clients, need to assess their functioning critically. This would be so whether these professional care givers wish to describe the cause of the symptoms "vicarious traumatization", or not. These are the symptoms that form the foundation for the repeatable self-tests appended to this paper, and which will be described under the heading of "Diagnosis" below.

[59] Figley, at pp.14 - 15; see note 19

Identification of Susceptible Populations

Immigration law has been referred to by some writers as another high risk professional service area for vicarious trauma. Mr Lennon was a lawyer whose practise gradually came to be comprised almost entirely of refugee immigration work [60]. Mr Lennon was busy. He was, according to the evidence, compassionately committed to his clients. His efforts on behalf of his clients left him little time or inclination to direct careful attention to the administrative requirements of his law practise. Ultimately he was caught having engaged in reckless billing practices over a lengthy period of time, and suspended from practise with conditions. The evidence before the Committee included the following:

> "He admitted to having been very depressed in mood for an extended period of time....He said that he had experienced feelings of anxiety, and a growing sense of hopelessness and helplessness that clearly arose from the situation he was in, but was pervasive enough to affect all aspects of his life. He had found himself completely preoccupied with the accusations and filled with feelings of shame and dread....He allowed his law practice to languish. He let his secretary and bookkeeper go and did not take on any new work, so he began to run into financial difficulties and had to inject personal money into his practice in order to keep his office open. He had been suicidal during much of this period and spent a lot of his time planning how to close out his practice completely and in an orderly fashion so as not to leave any clients in the lurch and not leave his family with the added burden of having to settle his affairs. On several occasions, he made serious plans to take his own life but did not go through with these because of concern for his wife and two children. When we met, he was still struggling with all these feelings and could not honestly say that he had dropped his suicidal intent. He said that his life had become an excruciating ordeal...."
> . . .

[60] *L.S.U.C. v. Lennon*, [1998] L.S.D.D. No. 87

> At an emotional level, he felt shocked and humiliated by the whole event, due to the inevitable loss of credibility that would ensue. He found this devastating because he had always prided himself upon being an honest lawyer who dedicated himself to the best interests of his clients and felt he was regarded by the community as a person of integrity. It seemed very ironic that his behaviour, motivated as it was by a professional ethic of doing his utmost for his clients, rather than by a selfish interest in his own gain, could make him appear to be the kind of self-serving lawyer that he himself had always disdained."

Although the depression was recognized at the time of the investigation of his billing practices, and attributed to that investigation, the evidence as a whole appears to suggest a lawyer who had worked extremely hard to live up to an ideal he had of himself and yet continued to fall short of that ideal. The billing problem was more symptomatic of an undue concentration on client needs, rather than a demonstration of simple greed - as a superficial consideration of the facts might suggest. The reckless billing not only harmed the public interest, but the lawyer's own financial interests as well. Everything demonstrated by this lawyer, including the time during which the inappropriate behaviour persisted, is consistent with his emotional response to the content of his practise. It was perhaps eloquently expressed by a character reference cited by the Committee dealing with Mr Lennon. The reference described Lennon's client-relationship style:

> . . .the letter of support . . . states that he is a person who is thought of highly in his community and who has garnered a reputation for working with socially disadvantaged people and displaying:
>
> > "particular compassion and sensitivity to their plight."
> > "I have seen him take the time to listen to them in circumstances where I doubt that others might have been so generous."

Lennon's case appears to meet the major criteria for symptoms of vicarious traumatization. His case is an example of why we should recognize that lawyers do not suffer symptoms of vicarious traumatization because of the category of law that

they practise: criminal, family, or real estate. They are affected by vicarious traumatization because of the content of the material that they must manage, and the relationship which they must develop with their clients in order to do their work effectively.

Saakvitne and Pearlman approach the question of susceptible populations most broadly. They state:

> This workbook is written for any professional, paraprofessional, or volunteer who is working with clients who have been traumatized. If you serve or help those who have suffered trauma, you are at risk for vicarious traumatization. [61]

After identifying police, criminal defence lawyers, prosecutors, judges, victim advocates, and others, Saakvitne and Pearlman continue:

> Vicarious traumatization is also relevant for . . . anyone who is repeatedly exposed to and empathically engaged with the stories of trauma survivors . . . . [61]

Earlier, we referred to Dutton and Rubinstein's definition of who "trauma workers" are:

> Trauma workers are persons who work directly with or have direct exposure to trauma victims, and include mental health professionals, lawyers, victim advocates, caseworkers, judges, physicians, and applied researchers, among others. . . . [62]

[61] Saakvitne and Pearlman (1996), at pp.19 - 20.

[62] Dutton and Rubinstein, at p. 83

The important issue in assessing susceptibiliity is always the *functional* role of the professional, not a particular job title or career identifier. There are likely many lawyers who never empathically engage with their clients, nor with the material that becomes legally significant. The risk of vicarious traumatization would appear to fall on those professionals who (1) do empathically engage with (2) traumatic material, and who (3) are professionally obligated (4) to deal with that material in some way. This is the point we made earlier in this paper.

The lawyer who does not engage with a client's trauma material, and whose services have no necessary relationship with the trauma material, may maintain a professional service relationship without engaging in any "fixing" of the trauma-related problem. For example, a client may engage a lawyer to provide real estate services, such as the purchase or sale of a home. The real estate services may be provided fully without ever addressing the emotional distress (from a child's sexual abuse or murder to mere callous adultery) that created the breakdown of the marriage and led to the need for the property transaction. The source of the client's distress would simply not be legally significant to that legal service. The problem that we are dealing with here is a professional having to "fix" something directly related to the traumatic material.

Quantification of Incidence/ Assessment

Some of the writing about vicarious trauma supposes that its effects on care givers are an "inevitable" consequence of providing therapeutic services to traumatized clients. If that were so, then it would be easy to conclude that there are as many care givers affected by vicarious trauma as there are care givers providing services to client victims. The quantity of impact would be exponential beyond each traumatized individual.

This "inevitable" consequence has not yet been established in the literature or by empirical research. It is a theory compellingly argued by Figley, and others [63]. At the same time, there are hints in the research that may point the other way [64]. It may be premature to be attempting to quantify the incidence of vicarious traumatization in different professional groups. The development of tools to measure by degrees the extent of vicarious traumatization affecting professionals is even further off. All that can safely be said is that measurement is a challenge. Beaton and Murphy described the problem as follows [65]:

> Three assumptions related to assessment and diagnosis are that classification systems, as well as trained personnel, are available, and that those with symptoms can report them, and will do so. However, this is not the case. . . .
>
> Undoubtedly, a major, if not the primary, barrier to identifying secondary stress in crisis workers is the "John Wayne syndrome" . . . . The macho, male cultural characteristic of most crisis workers does not permit them easily to assume "patient roles". Professional crisis workers perceive role conflict when they themselves must seek help. They feel out of control by admitting weakness and vulnerability and fear that their "manhood" may be questioned. Furthermore, most crisis workers consciously and unconsciously use psychic protective mechanisms such as denial, repression, and suppression, thereby deceiving themselves, as well as others.
>
> A second barrier is that co-workers, and even family members, may not be able to detect secondary post-trauma symptoms as most post-trauma symptoms are subjective in nature. . . .
> . . .

[63] Figley, at p.2; see also note 27
[64] Roe-Berning, Shelley, and Straker, Gill; "The Association Between Illusions of Invulnerability and Exposure to Trauma"; *Journal of Traumatic Stress*; 1997: 10(2); 319 - 327.
[65] Beaton, Randal D., and Murphy, Shirley A.; "Working with People in Crisis: Research Implications"; Chapter 3 in Figley, ed., *Compassion Fatigue*; pp.51 - 81,at p. 75

> Finally, traumatized crisis workers are subjected to more stigma than are most victims. Their traumatization is troubling to their supervisors and co-workers since it reminds them that it could also happen to them . . . . If there is a heavy reliance upon teamwork, identified co-worker trauma victims are watched carefully and with some suspicion, because crisis workers need to operate effectively and efficiently under suboptimal, and even chaotic, conditions. . . .

There seems to be a whole sub-industry developing with respect to assessment tools or devices to identify sufferers, or to measure the acuteness of traumatization. Saakvitne and Pearlman devote a large chapter of their workbook to a body of instruments designed to assess vicarious traumatization [66]. These instruments can generally be used by individuals on their own, in collaboration with others, or in groups. The instruments have been designed so that they may be used repetitively over time in order to monitor changes in the professional's own health. The responses required of the person being assessed will be qualitative in nature, rather than simply of the yes/no variety.

The primary Saakvitne and Pearlman tool reflects their concept of what vicarious traumatization actually is. Responses are looked for from the subject in the areas of the nature of the professional's work, the nature of the clientele, the nature of the workplace, the helper's own self-assessment of various work-related issues, and the nature of the social and cultural context for the work being done.

Other measures used by Saakvitne and Pearlman are a simple "Distress Level" test focusing almost entirely on the inner experience of the test subject, and the "Signs of VT" test, which asks only for a report from the subject about *changes* in various areas of the professional's personal and employment life.

[66] Saakvitne and Pearlman (1996), at pp.57 - 59

Specific beliefs and experiences can also be measured to help identify signs of vicarious traumatization, and any vulnerabilities needing care. There are, of course, further measures designed to assess the effectiveness or value of care strategies which are undertaken to treat the vicarious traumatization. None of these tests specifically assess the impairment of the professional relationship with the professional's client.

Figley designed a compassion fatigue self-test for psychotherapists that deals with professionally relevant situations [67]. The test questions are framed as statements of subjective feelings or attitude. The questions seek a range of agreement or disagreement with these statements. The statements themselves are suggestive of avoidance of emotional stimulation, estrangement and isolation from professional associates, loss of behaviour controls (e.g., sleeplessness, emotional outbursting), predisposing personal history, identification with and distancing from clients and their issues, work obsession, helplessness, and negative ideation about work context. Client relationship issues are addressed more directly in this instrument.

Yassen endorses the view that assessment of vicarious traumatization be grounded in the professional's own self-assessment. The process of self-assessment is itself a healing and protective tool for professionals at risk of vicarious traumatization:

> Self-awareness denotes a nonjudgmental and compassionate attitude toward oneself, an understanding of one's current life circumstances, and a level of maturity that enables one to accept oneself. It involves a willingness [to] adduce personal meaning from traumatic experiences, and to incorporate these lessons into a self view. It also means accepting the small ways in which one can take control in the face of powerlessness . . . .
> Finally, self-awareness means knowing when outside help is needed. [68]

[67] Figley, at pp.13 - 14
[68] Yassen, at p.187, 188

Munroe views evaluation by others through observation as an effective method of assessment [69]. This may work in team treatment groups, where clinical relationships can be observed in a meaningful way. However, even in the health care context, the usual concerns about client confidentiality would probably prevent this kind of observation of solo therapist or other health care practitioners.

Catherall takes Munroe's thinking a step further with the view that treatment teams are necessary to successfully manage the vicarious traumatization of its members. He explains:

> The experience of the trauma survivor, who feels alienated and misunderstood, is likely to be enacted in the dynamics of the group unless this phenomenon is specifically anticipated and steps taken to prevent it. This untoward event is usually made manifest by a distancing reaction; the traumatized member is viewed as not functioning well because there is something wrong *with* him or her, rather than because something happened *to* him or her. Viewing the secondary traumatization as indicative of something wrong with the individual allows other members to disown their own vulnerability to traumatic stress and protects them from identifying with the traumatized member's disturbing affect, a mechanism that has long been recognized in group processes.
> . . .
> From the perspective of group dynamics, the affected member is carrying the vulnerable feelings for the entire group when the other members disown their common link with him or her (Yalom, 1970). If he or she can be pushed out of the group, either physically or psychologically, then the other members of the group can maintain the illusion that they are free from the threat of traumatization. [70]

[69] Munroe *in Figley*, at p.212
[70] Catherall, Don R.; "Preventing Institutional Secondary Traumatic Stress Disorder"; Chapter 11 in Figley, ed., *Compassion Fatigue*; pp. 232 - 247, at pp.239 - 240

Munroe shares this view:

> Although therapists may belong to communities outside their workplaces, the most effective place for a preventive community is the work site where secondary traumatization takes place. The greater the exposure to trauma clients, the greater will be the need for a treatment team. The program described here illustrates the functioning of such a team.
>
> . . . We hold three tenets regarding the team's functioning and secondary trauma.
>
> The first tenet is the acceptance of the reality of secondary trauma, including an understanding and expectation that each team member will be affected by the work we do with traumatized veterans on an ongoing basis. This is not an issue that is ever resolved, and no team member is assumed to have any immunity or special status with regard to being affected. It is assumed that on any given day or with any given case, each team member will vary in the degree to which he or she is affected.
>
> The second tenet is that these therapist responses be regarded as a natural and valuable process rather than as a deficiency on the part of team members. Such responses of team members to any given client or situation are assumed to be significant clinical information. . . . .It is also assumed that therapist responses such as vague feelings or dreams are personally valid and clinically relevant.
>
> The third tenet of team functioning is the assumption that each team member can be an accurate observer of how other team members are personally responding to secondary trauma, and how such responses influence treatment interventions. . . .Team members must learn to trust and listen to one another. [71]

[71] Munroe *in Figley*, at pp.212, 214:

Implicit in this care approach is the validation of each professional's response to trauma, and the maintenance of the professional as a fully active member of the treatment team while resolving and managing the effects of any vicarious traumatization.

In the legal profession, team assessment and professional care can be problematic - particularly for those working as Defence counsel in small practices. However, where a lawyer does practise as part of a larger firm, the same concerns exist as in larger health care practises: a professional who admits to suffering some impact may be regarded as admitting to professional weakness; a professional who acknowledges some impact may lose status within his professional group, and may see professional opportunities and income opportunities shrink. While the large practise does provide an accessible network of peers who may share the professional experience of managing traumatized clients and their problems, employing this group successfully as a tool for caring and managing professional trauma requires special effort - *even if everyone were to truly adopt the idea that impaired functioning from vicarious traumatization was an inevitable affliction of all, just being variable in its degrees in anyone at any particular time*.

The reality of legal practise is that many lawyers practise alone. In Canada, there are approximately 66,247 lawyers, 16,454 of whom are sole practitioners [72].

[72] *2000 Law Societies Statistics*; Federation of Law Societies of Canada. These are the most recent available statistics. The number of sole practitioners has been estimated because the Quebec Barreau does not supply that information. The estimate therefore is the product of the sum of sole practitioners from all provinces and territories other than Quebec (11,742), plus 25% of the insured and exempted members of the Quebec Barreau (being 4,712 of 18,848). Notaries practising on their own in Quebec are included in the 11,742 because they do supply that information to the Federation of Law Societies. The 25% figure has been selected because it is comparable to the proportion of sole practitioners of Bar membership in Ontario (6,357 of 22,711).]

Even within large firms, there may be little supervision of lawyer functioning, and little trust that warning signs of vicarious traumatization can be shared. Therefore, it is probably safe at this point to conclude that even in team law practices, primary responsibility for assessment of vicarious traumatization of lawyers will have to be achieved through self-assessment. Although recreational and casual social association with other lawyers engaged in similar practices may be comforting to the small firm practitioner, such interactions would be of limited value in examining particular case circumstances because of confidentiality obligations.

An additional difficulty experienced by sole practitioners and small firm practitioners is that troubled individuals are poor monitors of their own compliance and competence in managing mental health issues. In addition, the symptoms that may be associated with vicarious trauamatization are also associated with a number of other conditions. For example, in *L.S.U.C. v. Tassy*, [73], the Law Society was dealing with a solicitor who had a "dysthymic disorder . . . characterized by low grade chronic depression", and demonstrated symptomatology inconsistent with positive self-monitoring and healthy self-management:

> Mr. Tassy has tended to cope with this depressive illness by working 7 days a week and filling his off hours with as much structured physical activity as possible. This also appears to be a method for Mr. Tassy to cope with the irritability associated with the dysthymic disorder and also work related stress.
>
> Personality disorder of mixed type. Mr. Tassy's longitudinal history is consistent with a personality disorder or mixed type, in that he demonstrates recurrent difficulties in initiating and maintaining relationships, impulsivity and conflict resolution. Mr. Tassy shows a mixture of schizoid obsessional, antisocial and narcissistic traits. The schizoid traits refer to his lack of interest in human contact and his

[73] *L.S.U.C. v. Tassy*, [1997] L.S.D.D. No. 46

> tendency to prefer social isolation. The obsessionality is evident in his efforts to control as much of his environment as possible and not to deviate from a task, even if some unforeseen events should arise as in the case of the recent offense. The antisocial traits are evident in Mr. Tassy's history of impulsivity and aggressive behaviour towards others.

Whether vicarious traumatization had anything at all to do with Mr Tassy's difficulties, the point is that merely putting the means to identify a problem in the hands of individual lawyers is an insufficient strategy for identifying, measuring, and managing lawyer stress. An assessment instrument may not be used, it may be misused, or it may be relied on to mis-identify a problem as burnout or vicarious traumatization. Diagnosis is really the task of the professional psychologist or psychiatrist. All that a self-assessment instrument should do is work to alert the lawyer as to whether he ought to seek outside assistance in assessing his functioning. Unless this is a habit for the firm, or for the sole practitioner, an "outside" assessment of the lawyer's functioning may not happen until the Courts order detention for assessment as they did for Mr Tassy - when he had been charged with his *third* offence of violence in three years.

Several modified versions of the Figley and Pearlmann-Saakvitne assessment tools exist. Richardson, for example, has proposed a self-assessment tool for use by transition house workers who work with victims of sexual and domestic violence [74]. It draws heavily on the work of Yassen, but follows the format and concept developed by Figley. We have developed a similar instrument for lawyers based on the Figley tool, and it is appended to this paper. It is essential to remember that the value of this self-assessment tool would not be in the results obtained on any particular test occasion. The value is instead the cumulative trend of results obtained by repeating the test at regular intervals, and noting the degree or trend of change.

[74] Richardson, loc. cit.

A further caution about the appended assessment tool is warranted. The weighting of particular issues in the assessment tool is not yet scientific. It may be that future studies among lawyers would suggest that self-esteem issues, for example, deserve a heavier weighting than they would with a population of emergency medical team members, or 911 despatchers. This would be because challenges to self-esteem issues are potentially more destabilizing to lawyer functions than 911 functions.

Distinctions in Management / Treatment Needs

Once vicarious traumatization has infected a professional and that professional's relationships with clients to some degree, what treatment must be undertaken to restore the professional to optimum functioning? What strategies should be undertaken by the professional to inhibit the effects of vicarious traumatization in his or her practise, and in his or her life?

Saakvitne and Pearlman are of the view that treatment for vicarious traumatization must address two main issues - the care giver's stress, and the care giver's demoralization [75]. In other words, treatment must address both stress and despair. The stress and despair each have personal and professional implications, which may call for different management strategies.

To address the stress, Saakvitne and Pearlman suggest that a treatment strategy should include self-care, nurturing activities, and escape. What this means is that the care giver will include better life balance, limits, healthy habits, and connection with others as cornerstones of a wellness strategy.

[75] Saakvitne and Pearlman (1996), at pp.57 - 59

Nurture follows improved balance by providing a focus on pleasure, comfort, relaxation and play for the care giver. Escape permits opportunity to forget about work or to engage in fantasy as a means of getting away from painful feelings. Sports, games, and culturally satisfying work which is clearly distinct from the professional occupation are examples of escapes that are effective in nurturing the downtrodden spirit of a professional suffering from vicarious traumatization.

In Saakvitne and Pearlman's view, vicarious traumatization carries meaning, and therefore successful treatment will also require transformation of that meaning into something positive. This will require the care giver to identify a meaning or purpose, to infuse an activity with that meaning, and to challenge negative beliefs or assumptions which threaten that sense of meaning. This is because the traumatic material is believed to have disrupted the professional's personal appreciation of the world. Successful treatment may also be achieved, at least in part, by participation in community building activities outside of the self. What is important is to engage the professional in an activity that restores or reinforces the professional's personal sense of personal value.

Each of these strategies is supposed to be in service of the objectives of "awareness, balance, and connection", and expressing those in the professional, organizational, and personal realms of the subject's life. Saakvitne and Pearlman wrote:

> Awareness reflects our attunement to our own needs, limits, emotions and resources. This awareness of one's own inner state and disequilibrium sets the stage for responsiveness and self-care. . . .
> A trauma worker must have balance, both among life activities and within him- or herself. Balance provides stability to help you keep your footing and keep your priorities straight. . . .

> Maintaining connection to others, to ourselves, and to something larger than ourselves provides an antidote to the isolation that is a hallmark of vicarious traumatization. Inner connection allows us greater awareness of our needs, experience, and perception. Connection to others, personally and professionally, is critical for trauma workers; we cannot afford to do this work alone. . . . [76]

There is a significant variety of exercises designed for personal or group work in pursuit of these treatment strategies - just as described a variety in the assessment tools which could be used. Exercises may usually be analyzed as efforts to make participants more aware of the issues, more aware of imbalances in the care-giver's life, and more aware of the need for others.

Peer consultation - particularly with respect to how this works against isolation and detached-ness - is often a proposed course of management of the effects of vicarious traumatization. Indeed, it is often identified as the core method of on-going treatment and a mechanism of prevention of vicarious traumatization [77]. Vicarious traumatization is not a condition that lends itself to successful treatment solely from within an individual. External connections with co-workers, friends and family, are required to avoid the depths of the condition while remaining as a functional and effective professional.

Saakvitne and Pearlman described the purpose and importance of supervision and peer connection in vicarious traumatization management as follows:

> Supervision must afford a place in which to discuss cases and one's responses to the work without shame. It is enormously helpful to have a safe place where one can acknowledge, express, and work through

[76] Saakvitne and Pearlman (1996), at p.75
[77] *e.g.*, Munroe *in Figley*, at pp.215 - 216

> clients' painful material with a trusted colleague. Supervision should include a discussion of therapeutic successes, large and small. Not only can we learn from our successes, but we restore our sense of value and our hope when we observe the efficacy of our work . . . .[78]

Elsewhere, Pearlman wrote:

> Five need areas have been identified as particularly susceptible to the effects of psychological trauma. . . . Safety, trust, esteem, intimacy, and control are areas of vulnerability for trauma therapists as well as for survivors. These needs, and our beliefs within each area, shape our relationships with others, so our own vulnerabilities here have a major impact upon both our personal and professional relationships. Self-care strategies aimed at restoring our sense of connection with others help to counter the isolation that can mark vicarious traumatization. Moreover, they provide a testing ground for schemas that have been disrupted through our work. The importance of professional and personal connection is illustrated by the trauma therapist sample: over two-thirds found it helpful to attend workshops, talk with colleagues between sessions, and discuss cases informally, and in the personal realm, to socialize and spend time with family.
>
> Group supervision can also promote connection. Trusted colleagues can help us examine our distortions. In addition, reflecting upon one's cynicism, fears, mistrust of others, need for control, lack of intimacy with others, or misanthropy can illuminate and possibly reverse the disrupted cognitive schemas that can develop through trauma work and then become overgeneralized without awareness. Perhaps most important, as we learn from and support one another in this work, we remember that we are not alone, which can help mitigate the sense of isolation that can come from working under the highly demanding constraints of confidentiality. [79]

Rosenblum, Pratt and Pearlman expanded on this point:

[78] Saakvitne and Pearlman (1995), at p.16
[79] Pearlman, Laurie Anne; "Self-Care for Trauma Therapists: Ameliorating Vicarious Traumatization", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; (1995), at pp.60 - 61

> It is essential for every clinician to receive supervision, regardless of licensure status. This includes individual supervision, small group supervision, biweekly case conferences, biweekly seminars, and informal consultation whenever needed. Not only is it important to ensure that supervision is available, but, less tangibly, that supervision fosters an atmosphere of respect, safety and control for the therapist who will be exploring the difficult issues evoked by trauma therapy. Respect can allow for maintenance of self-esteem and a sense of safety while a therapist examines mistakes and powerful countertransference issues. Open examination of boundaries of the supervisory relationship can allow the therapist to maintain control of the situation and regulate the level of intimacy. [80]

This is not a level of supervision that would be familiar - or likely even welcome - within the accepted culture of independent barristers and solicitors. Outside of team practises, among the many sole practitioners and the other practitioners who practise very much alone even though physically in association with others, this idea of team supervision is certainly problematic. A different care strategy might be mandated for lawyers.

Beaton and Murphy identified the following elements of a preventive and treatment response to the risks of occupational vicarious traumatization: *recognition* of the existence of stress and employee responses to stress, *education* about the effects of stress, *acceptance* of the stress reactions of others through empathy, *permission* to those suffering stress to express feelings openly, *exploration* of resources to assist in resolving the stress, and *referral* for further support as required [81]. These may be the keys to a management strategy for vicarious traumatization in the legal profession.

[80] Rosenblum, Dena J., Pratt, Anne C., Pearlman, Laurie Anne; "Helpers' Responses to Trauma Work: Understanding and Intervening in an Organization", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.65 - 79, at pp.76 - 77
[81] Beaton, Randal D., and Murphy, Shirley A.; "Working with People in Crisis: Research Implications"; Chapter 3 in Figley, ed., *Compassion Fatigue*; pp.51 - 81, at p.76

Dutton and Rubinstein were tentative in their conclusions about what might actually work to resolve traumatic stress reactions. They wrote:

> Trauma workers' coping responses may be considered in two categories: personal and professional. Personal strategies might include taking time for play in addition to work, developing a network of emotionally supportive personal relationships, taking time for self-exploration and attending to personal needs, and using personal therapy as a means of coping with the effects of working with trauma. Professional strategies refer to using peer supervision and consultation, working in a professional setting with others rather than in isolation, and diversifying one's professional practice. Empirical evidence is required to test the effectiveness of these coping strategies singly and in combination. [82]

The authors expanded upon the concept of supervision and consultation with peers:

> Another work-related strategy is the availability of supervision consultation and/or peer support that allows for the emotional safety necessary for trauma workers to talk about their STS reactions in an environment that provides support and comfort. Supportive supervision has been found to correlate with relieving stress in mental health professionals. [83]

The concept of critical incident debriefing has become standard for crisis workers who respond to emergencies for sharp, but relatively short, periods of time. It is of interest that the critical incident debrief begins as a *group* intervention [84]. This implicitly sends the message that the debrief is for everyone because everyone is affected by the critical incident. The treatment is not just for the "weaker links".

[82] Dutton and Rubinstein; at pp. 94 - 95
[83] Ibid., at p. 97
[84] Harris, Chrys J.; "Sensory-Based Therapy for Crisis Counselors"; Chapter 5 in Figley, Charles R., ed., *Compassion Fatigue*; pp.82 - 100; at p.108

This is the same understanding that McCammon and Allison bring to their views about treating and managing traumatic stress in crisis workers. They described it as follows:

> Foreman (1990) discussed the use of "decompression". This is accomplished in one-to-one discussions, or by talking in small work groups, during breaks and immediately following rotation off-site. It involves normalizing and validating the workers' reactions, and allowing them to ventilate frustrations and intense emotions. Attempts are made to defuse survivor guilt, self-doubt, and conflicts by helping the worker reframe emotional reactions. [85]

McCammon and Allison considered a number of different management models and concluded:

> Although the various models were developed to address the needs of different populations, all the models involve structuring opportunities for participants to review the events of the traumatic situation and ventilate feelings; learn skills for intergrating and mastering the event; and learn to identify, enlist, and accept help from their support systems. [86]

In other words, when dealing with vicarious traumatization, care and repair is not a solitary exercise, any more than assessment of susceptibility or affect is. Lawyers are going to need other people involved in order to successfully manage the impacts of vicarious traumatization, and at least some of these other people really ought to be peers. People who do not serve the same clientele from the same professional position will simply be less able to appreciate the burdens that vicarious traumatization brings to professional practise, and the task of maintaining a professional relationship with demanding client issues.

[85] McCammon, Susan L., and Allison, E. Jackson, Jr.; "Debriefing and Treating Emergency Workers"; Chapter 6 in Figley, Charles R., ed., *Compassion Fatigue*; pp. 115 - 130, at pp.120 - 121
[86] Ibid., at p.123

Peers can be "empathically attuned" to other professionals in a way that professionals in some other discipline (or spouses, or golf and bridge partners) may not [87].

Cerney endorses this view as well:

> What appears to be most helpful to therapists who work with trauma victims is for them to acknowledge that they cannot treat every patient. They must also be connected with their peers in support groups and supervision groups. They must not isolate themselves. To maintain some opportunity to express their feelings of pain, guilt, and responsibility, they need to discuss their cases regularly with their colleagues and supervisors. In an accepting atmosphere, these traumatized therapists can gain support and assistance in rebuilding their view of the world - albeit a different view.
>
> In addition, therapists should limit their practice and take time to refresh themselves in their private lives through leisure and relaxation. . . . . [88]

As important as the peer group is, the actual healing occurs within individuals. It is the individual who has to reacquire or maintain his or her own sense of competence to manage traumatic material. It is the individual who needs to rebuild self-esteem. It is the individual who has to return to managing professional and helping relationships with clients. Harris explains:

[87] Catherall, Don R.; "Coping with Secondary Traumatic Stress: The Importance of the Therapist's Professional Peer Group"; in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.80 - 92, at p.84; and Rowe, C. E., MacIsaac, D. S.; *Empathic attunement: The "technique" of psychoanalytic self-psychology*; Jason Aronson (Northvale, N.J.: 1989).
[88] Cerney, at p.145

> . . . the trauma worker will need to identify a healing theory that is ecologically sound for the self - in other words, a healing theory that can be stated in the positive, that is under the control of the trauma worker, and that is testable or measurable as far as achieving results is concerned. The healing theory is the key for the trauma worker to feel secure when going back to the job and to the world. [89]

Prevention is, of course, a significant stress management strategy in its own right. Yassen points out that the strategies in prevention should be specifically directed toward the deleterious symptoms that are the wounds of vicarious traumatization. Thus, an effective prevention strategy will include:

> 1. **Balance** - actively creating it, not only between work and play, but between work with traumatic material and work on other issues;
> 2. **Setting boundaries** - which not only protects the professional, but also models appropriate behaviour to the client. Boundaries exist in relation to overwork, therapeutic boundaries with the patient, personal boundaries in relation to how much of oneself to devote to the work, and knowing one's limits;
> 3. **Getting help and support** - from peers, supervisors, and role models or mentors;
> 4. **Creating a Self-care Program** - which identifies and then nurtures the personal coping strategies of the professional, so that these will exist when called upon;
> 5. **Evaluation** of Personal Healing;
> 6. **Professional training** and job commitment; and
> 7.**Replenishment**. [90]

Yassen echoes the general refrain about supervision and peer contact for prevention purposes as well:

[89] Harris, at p.113
[90] Yassen, at pp.190 - 200

> No matter how experienced we are, it is important to build in supervision or consultation on a regular basis. It is crucial to get an outside perspective from someone trusted or to receive guidance in facing a new challenge. Supervision provides the opportunity to have someone listen solely to us, as we have had to do with our clients. If this is not available at work, outside arrangements should be made.
>
> . . . Coping strategies should also include contact with colleagues on a regular basis. Again, this breaks the isolation and sets up a climate in which workers are encouraged and expected to exercise self-care. . . [91]

Munroe endorsed the team treatment concept as a treatment method as well as a prevention tool:

> Like direct trauma, then, secondary trauma violates trust, severs connections to community, and destroys meaning. Thus a treatment team can serve as a community to prevent secondary trauma in therapists. The primary function of the team is to identify and alter trauma engagement patterns. The therapist who is engaged is often not aware that he or she is being engaged. But even the therapist who is aware of being engaged may find it extremely difficult to find a way out. . . . The treatment team that expect secondary trauma on a regular basis is in a unique position to recognize emotional and behavioral responses of therapists that signal engagement. The team can support or confront the engaged therapist as necessary. [92]

The idea of the team, and how those who are afflicted with the costs of traumatic material remain part of the team, creates an environment of community rather than of isolation. The professional's sense of competence, self-esteem, and sense of inclusion is maintained. As the authors expressed it:

[91] Yassen, at pp.194, 195 - 196
[92] Munroe *in Figley*, at p.212

> The community that validates the survivor and continues to include him or her as a valued member provides roles and relationship patterns that are not repetitions of the trauma. . . . The team provides a complementary function that enables the therapist to maintain the valued role of a healer. [93]

This is also the view espoused by Stamm, who wrote:

> Trauma work reminds me of my individual limits; I come face to face with the fact that the world is full of death, hate, violence, and evil.
> . . .
> So where is the hope amid this much suffering? I believe it is in the nurturance of the individual within the sustenance of community. My experiences have shown me how communities, when well cared for, sustain their members during these times of failed self-sufficiency. The deepening community that results can bring about healing and positive individual transformations for all of its members. . . . Interdependency is the process. Interdependency does not substitute the group for the individual but weaves the individual with the group in such a way as to increase the individual's and the group's tolerance for the task of living. [94]

And again:

> The astute reader will notice that there is a chorus of important points that emerge from the collective voice of the authors - primarily (a) do not do this work alone and (b) monitor your responses to the work through your own careful attendance to your process and through supervision by your trusted colleagues. [95]

Catherall makes a further useful point about using group connections as a prevention strategy against vicarious traumatization:

[93] Munroe *in Figley*, at p.215
[94] Stamm, B. Hudnall; *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*; 2nd ed.; 1999, Sidran Institute and Press, at pp.xvi - xvii
[95] Ibid, at p.xxxv

> The intense primitive emotions precipitated by traumatization and experienced empathically in secondary traumatization can be very disruptive in groups. Such intense emotional states influence the group dynamics and can polarize group members. . . . This untoward event is usually made manifest by a distancing reaction; the traumatized member is viewed as not functioning well because there is something wrong *with* him or her, rather than because something happened *to* him or her. Viewing the secondary traumatization as indicative of something wrong with the individual allows other members to disown their own vulnerability to traumatic stress and protects them from identifying with the traumatized member's disturbed affect . . . . [Emphasis in original] [96]

Chrestman added the following observation in a brief study of things that appear to lessen the impact or incidence of stress symptoms in some clinicians:

> These data also suggest that certain periodic participation in training activities may perform an important mediating function for trauma therapists. While acquisition of skills and knowledge is the obvious benefit of participation, increased social/professional support and identification of a referral network may help to decrease feelings of isolation and overwhelming responsibility. These activities do not necessarily require a trauma focus. In this sample, the number of non-trauma specific CEU [continuing education unit] credits was associated with decreased anxiety symptoms. [97]

This recognition that vicarious trauma is most effectively dealt with and overcome by the self within a community that continues to be supportive of the person's ability to function competently shows how different vicarious traumatization is from burnout. In burnout, the sufferer's exhaustion may demand at least a temporary removal from the work that caused the exhaustion.

[96] Catherall, Don R.; "Preventing Institutional Secondary Traumatic Stress Disorder"; Chapter 11 in Figley, ed., *Compassion Fatigue*; pp. 232 - 247, at p. 239
[97] Chrestman, Kelly R.; "Secondary Exposure to Trauma and Self-Reported Distress Among Therapists"; in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.29 - 36, at p. 34

On the other hand, the exhaustion of vicarious traumatization cannot be relieved except by maintaining the professional's involvement in helping work. This itself affirms the professional's sense of personal competence in being still able to provide value to the clients that he or she continues to see.

When each of the treatment approaches described above is boiled down to their basic strategies, it appears that what is common to them is this:

1. Maintain the professional's role as a helping professional, and

2. Foster the professional's self-esteem or self-confidence that he / she can provide value to others despite the traumatization involved in the work.

How is this done? As the various writers cited above have suggested, associates of the professional should play the primary role in drawing out the cure from the inner resources of the affected professional. These associates may be part of the same treatment team or firm, or they may be more in the nature of confidantes and coaches to a sole practitioner. Whatever form it takes, professional peers should provide a support system to the affected professional that includes emotional support, information, social companionship, and instrumental support. "Instrumental support" is tangible, practical aid such as assistance with paperwork and telephone tasks.

A particularly effective method for restoring damaged self-confidence is apparently to encourage the affected professional to demonstrate to himself that he can do things that are beautiful or creative or pleasurable - something the professional can recognize as uniquely human emanating from himself and that can be made apparent to others. This seems to permit the professional to recall that his whole

value as a professional and as a human being is not bound up in perfectly solving the problem presented by the next client. Dance, painting, singing, and sporting activity is capable of providing this kind of external demonstration of the person's ability to create something outside of his own body or mind, something that others can visualize and appreciate, that is worth something to the professional. It has also been suggested that it is the adrenalin high that comes from physical activity that is the effective restorative [98].

Conclusion

Susan McCammon observed:

> I recalled talking with an attorney who was prosecuting a child sexual abuse case. I asked him about the emotional effect of listening to children's accounts of abuse. It is part of his professionalism that these things do not cause emotional effect, he told me. But later in the conversation he recounted a dream he has had - he is standing by his boat dock and sees children's clothes washing up (a boat was involved in the abuse account) and is horrified when he recognizes his child's shoes among those floating in the water. I felt compassion for his experience of the grim nightmare, but was almost amused at his idea that his professionalism was protecting him from being emotionally affected. [99]

The reality is that work with or on behalf of people who have been caught up in traumatic situations affects those who do the work. The issue is not whether helpers are immune or not, but rather whether the helpers have appropriate and sufficient strategies in place to manage the impact of that traumatic material. If they do, their relationship with the client will have greater value for the client.

[98] Williams, Mary Beth, Sommer, John F. Jr.; "Self-Care and the Vulnerable Therapist" (1995); in Stamm, B. Hudnall; *Secondary Traumatic Stress;* pp.230 - 246, at p. 243

[99] McCammon, Susan L.; "Painful Pedagogy: Teaching About Trauma in Academic and Training Settings"; in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.105 - 120, at pp.105 - 106.

This article has endeavoured to apply the theory and understanding of vicarious traumatization to the lawyering experience. As has been seen, the hypothesis makes sense, and does allow a better understanding of how lawyers become affected by the work that they do. The paper suggests some strategies for how lawyers may manage the stresses that vicarious traumatization will impose upon them. Still, many specific questions in relation to the depths of the emotional fatigue that can be created, and when that fatigue might be described as a personal disorder, are not yet answerable. What we do know is that even a temporary experience of the common symptoms would significantly degrade the value of the client's experience of the lawyer client relationship. And that is reason enough to take vicarious traumatization seriously.

A Self - Assessment Tool

This tool is based on an original assessment tool developed by Stamm and Figley (Stamm, at pp.18 - 19; Figley, at pp.13 -14), and offered by them for use with mental health caregivers. The viability of using this modified tool to assess vicarious trauma with lawyers is still under assessment. It is recommended that this tool only be used as a self-assessment guide for lawyers who wish to consider their personal susceptibility to vicarious trauma. No mental health diagnosis should be made on the basis of this tool. If a lawyer has a mental health concern as a result of considering the elements of this self-assessment tool, the lawyer should consult further with a qualified mental health practitioner.

Charles Figley has said that caring deeply about others makes us emotionally vulnerable to the catastrophes that affect them. Compassion has both positive and negative aspects that may manifest themselves in your personal functioning, your work, and in your relationships with others through your work - including clients, co-workers, and adversaries. This self-test assists you in assessing your own level of stress from vicarious trauma. Try to use this tool at least monthly, as well as at the conclusion of any major piece of litigation in volving death or alleged violence. Retain past tests to permit you to compare total scores as well as specific answers from test to test.

Name:

Date of Assessment:

Assign a number between 1 and 5 that comes closest to your existing feeling about yourself and your work, with 1 being rarely/never, to 5 being very often/always

Personal Satisfaction

1._____ I am happy.
2._____ I am satisfied with my life.
3._____ I have beliefs that sustain me and endorse the value of the work I am doing.
4._____ I learn new things from my clients.
5._____ I feel connected to others
6._____ I have a good balance between work, personal relationships, and free time
7._____ I enjoy the company of some of the people I help.
8._____ I enjoy my work.
9._____ I feel that I have the tools and resources to the do the job I have to do for my clients.
10._____ I feel that I have good peer support when I need to work through a problem or issue in my practise
11._____ I feel invigorated by helping a client
12._____ I feel joy as a result of helping a client
13._____ I have thoughts that I am a success as a helper of my clients
14._____ I enjoy my peers and co-workers

15._____ I feel that I can rely on my peers and co-workers for support and understanding
16._____ I have confidence in the skills of my co-workers
17._____ I trust my co-workers
18._____ I feel that I am able to keep up with new developments in the law for the benefit of my clients
19._____ I feel that I am able to keep up with new methods for better serving clients
20._____ I feel that my co-workers have confidence in me as a person
21._____ I feel that my co-workers have confidence in my skills as a lawyer
22._____ I plan to do this kind of work for a long time to come.

Over 95: extremely high potential for work satisfaction; 85 - 95: high potential for work satisfaction; 75 - 85: good potential for work satisfaction; 55 - 75: some potential for work satisfaction; Below 55: Irregular and inconsistent potential for work satisfaction

How you feel about how you do your Work

23._____ I am a sensitive person
24._____ I have thought that I need more close friends (people that know me and are supportive of me)
25._____ I have thought that there is no one to talk to about my highly stressful experiences whom I can trust and who will understand the kind of stress that I will be talking about.
26._____ I work too hard for my own good
27._____ I have felt on edge about professional matters, and have attributed this to work with one or two specific clients
28._____ I wish I could avoid working with some clients
29._____ I have felt that my clients dislike me personally and that I need to change that
30._____ I have felt weak, tired, and run down as a result of my work
31._____ I have felt depressed as a result of my work
32._____ I am unsuccessful in separating work from personal life
33._____ I feel little compassion for or confidence in the skills of my co-workers
34._____ I feel I am working more for the money than for personal fulfillment
35._____ I have thoughts that I am a failure in my work
36._____ I have a sense of worthlessness, disillusionment, or resentment associated with my work
37._____ I feel that I am distracted by bureaucratic and unimportant tasks of practice and that my skills and work would be better applied to direct client care.

38._____ I feel that I am not on the path to achieving my life goals
39._____ I plan to do this kind of work but in different practise circumstances

Risk of Burnout scale: 34 or less: low risk for burnout; 35 - 51: moderate risk for burnout; 52 - 68: high risk for burnout; Over 68: extremely high risk for burnout

How you feel about yourself and your work because of your clients

40._____ I force myself to avoid certain thoughts or feelings or ideas that remind me of a disturbing experience
41._____ I find myself avoiding certain activity or situations because they remind me of a disturbing experience
42._____ I have gaps in my memory about disturbing events
43._____ I feel estranged from others (clients, co-workers, family, family equivalents)
44._____ I have difficulty falling or staying asleep
45._____ I have outbursts of anger or frustration, and experience irritability, with little provocation
46._____ I startle easily
47._____ While working with a client I thought (even momentarily) about violence as a solution to his/her interpersonal difficulty
48._____ I have had flashbacks and other intrusive recollections connected to my clients
49._____ I have had first-hand experience with traumatic events in my adult life
50._____ I have had first-hand experience with traumatic events in my childhood
51._____ I have had to "work through" an event in my life that I believed to be traumatic
52._____ I am disturbed by something a client has said or done to me, and wonder whether it will be repeated by other clients
53._____ I experience dreams or intrusive thoughts that are similar to those of a client
54._____ I have experienced intrusive thoughts of a session with a particularly difficult or troubling client
55._____ I have involuntarily recalled traumatic personal experiences while assisting a client
56._____ I am preoccupied with more than one client
57._____ I am losing sleep over a client's traumatic experiences
58._____ I have been concerned that I might have been infected by the traumatic stress or experiences of my clients
59._____ I remind myself to be less concerned about the well-being of my clients

60._____ I have felt trapped in my work with these clients
61._____ I have felt a sense of hopelessness about my professional work when working with my client
62._____ I have put myself or others in danger for the purpose of working with a client
63._____ I have thoughts that I need to demonstrate and prove my skills to others
64._____ I have thoughts that I have no control over the results of my work
65._____ I am planning to leave this kind of work.

Risk of vicarious traumatization manifesting itself in a disorder.

Any level of risk may manifest itself in a relationship upset or distraction with the client:

- Under 26: low risk of vicarious traumatization;
- 26 - 52: moderate risk of vicarious traumatization;
- Over 52: likely risk of vicarious traumatization manifesting itself in reduced client service and high risk of developing into a disorder if uncorrected.

The Legal Profession Assistance Conference has website and hard copy materials on other mental health issues as well as many strategies for avoiding personal, professional, emotional and related issues. You can access these materials at www.LPAC.ca or, you can contact LPAC's Executive Director at:

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References

Beaton, Randal D., and Murphy, Shirley A.; "Working with People in Crisis: Research Implications"; Chapter 3 in Figley, ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp.51 - 81.

Blair, D. Thomas, and Ramones, Valerie A.; "Understanding Vicarious Traumatization"; *Journal of Psychosocial Nursing*; 1996: 34(11): 24 - 30.

Catherall, Don R.; "Coping with Secondary Traumatic Stress: The Importance of the Therapist's Professional Peer Group"; in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.80 - 92.

Catherall, Don R.; "Preventing Institutional Secondary Traumatic Stress Disorder"; Chapter 11 in Figley, ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp. 232 - 247.

Cerney, Mary S., "Treating the 'Heroic Treaters'"; Chapter 7 in Figley, ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp. 131 - 149.

Chrestman, Kelly R.; "Secondary Exposure to Trauma and Self-Reported Distress Among Therapists"; in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.29 - 36

Clark, Marcia L., and Gioro, Sandra; "Nurses, Indirect Trauma, and Prevention"; *Image: Journal of Nursing Scholarship*; 1998: 30(1), 85 - 87.

Corey, G.F.; *Theory and practice of counseling and psychotherapy*; Brooks Cole (1991: Belmont, Calif.)

Cornille, Thomas A., and Meyers, Tracy W.; "Secondary Traumatic Stress Among Child Protective Service Workers: Prevalence, Severity and Predictive Factors"; *Traumatology*: 1999: 5(1), Article 2.

Crothers, Delphine; "Vicarious Traumatization in the Work With Survivors of Childhood Trauma"; *Journal of Psychosocial Nursing*; 1995: 33(4): 9 - 13.

Dutton, Mary Ann and Rubinstein, Francine L.; "Working with People with PTSD: Research Implications"; Chapter 4 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp.82 - 100.

Federation of Law Societies of Canada; *2000 Law Societies Statistics*.

Figley, Charles R.,"Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview"; Chapter 1 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; Brunner/Mazel Inc. (1995: New York); pp.1 - 20.

Glover, Hillel; "Emotional Numbing: A Possible Endorphin-Mediated Phenomenon Associated with Post-Traumatic Stress Disorders and Other Allied Psychopathologic States", *Journal of Traumatic Stress* 5, 4(1992)

Goleman, Daniel; *Emotional Intelligence*; Bantam Books (1995),352 pages

Green, B.; "Defining trauma: Terminology and generic stressor dimensions"; *Journal of Applied Social Psychology*, 20(20), 1632 - 1642 (1990).

Harris, Chrys J.; "Sensory-Based Therapy for Crisis Counselors"; Chapter 5 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp.82 - 100

Hartman, Carol R.; "The Nurse-Patient Relationship and Victims of Violence"; *Scholarly Inquiry for Nursing Practice: An International Journal*; 1995: 9(2): 175 - 192.

International Society for Traumatic Stress Studies: http://www.istss.org/indirect.htm

Kassam-Adams, Nancy; "The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychotherapists", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.37 - 48.

McCammon, Susan L.; "Painful Pedagogy: Teaching About Trauma in Academic and Training Settings"; in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.105 - 120.

McCammon, Susan L., and Allison, E. Jackson, Jr.; "Debriefing and Treating Emergency Workers"; Chapter 6 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp. 115 - 130.

Munroe, James F.; "Ethical Issues Associated With Secondary Trauma in Therapists", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.211 - 229.

Munroe, James F.; Shay, Jonathan; Fisher, Lisa; Makary, Christine; Rapperport, Kathryn; Zimering, Rose; "Preventing Compassion Fatigue: A Team Treatment Model"; Chapter 10 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp. 209 - 231.

Pearlman, Laurie Anne; "Self-Care for Trauma Therapists: Ameliorating Vicarious Traumatization", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.51 - 64.

Richardson, Jan I.; *Guidebook on Vicarious Trauma*, An online resource book.; National Clearinghouse on Family Violence; © Her Majesty the Queen in Right of Canada, 2001 Cat. H72-21/178-2000E; ISBN 0-662-29517-X; http://www.hcsc.gc.ca/hppb/familyviolence/html/Vicarious%20Trauma%20HTML/english/

Roe-Berning, Shelley, and Straker, Gill; "The Association Between Illusions of Invulnerability and Exposure to Trauma"; *Journal of Traumatic Stress*; 1997: 10(2); 319 - 327.

Rowe, C. E., MacIsaac, D. S.; *Empathic attunement: The "technique" of psychoanalytic self-psychology*; Jason Aronson (Northvale, N.J.: 1989)

Rosenblum, Dena J., Pratt, Anne C., Pearlman, Laurie Anne; "Helpers' Responses to Trauma Work: Understanding and Intervening in an Organization", in Stamm, B. Hudnall, *Secondary Traumatic Stress*; pp.65 - 79.

Saakvitne, Karen W. and Pearlman, Laurie Anne; *Transforming the Pain: A Workbook on Vicarious Traumatization*; W.W.Norton & Company Inc. (1996); 159 pages

Saakvitne, Karen W. and Pearlman, Laurie Anne; "Treating Therapists with Vicarious Traumatization and Secondary Traumatic Stress Disorders"; Chapter 8 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp. 150 - 177.

Stamm. B. Hudnall; "Creating Virtual Community: Telehealth and Self-Care Updated" (1999); in Stamm, B. Hudnall; *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*; at pp.179 - 208.

Stamm, B. Hudnall; *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*; 2nd ed.; 1999, Sidran Institute and Press

Valent, Paul; "Survival Strategies: A Framework for Understanding Secondary Traumatic Stress and Coping in Helpers"; Chapter 2 in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp. 21 - 50.

Williams, Mary Beth, Sommer, John F. Jr.; "Self-Care and the Vulnerable Therapist" (1995); in Stamm, B. Hudnall; *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*; at pp.230 - 246.

Yassen, J.; "Preventing secondary traumatic stress disorder", Chapter 9 in in Figley, Charles R., ed., *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the traumatized*; pp. 178 - 208.