Secondary trauma in the legal professions, a clinical perspective

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Abstract
This article describes the importance of being aware of secondary trauma in lawyers, interpreters, judges, police, forensic physicians and other professionals that work with traumatized clients. In addition, it presents a psycho-educational model developed by the author to address secondary trauma among those associated with the legal and clinical professions.

Introduction

The Institute for Study of Psychosocial Trauma (ISPT) is a non-profit organization based in California, providing psychological treatment to refugees affected by war trauma and the aftermath of torture since the early 1980's. ISPT has trained clinicians and other health personnel throughout the U.S., South and Central America, staff in an International Court, and international human rights lawyers and field workers. Also, we provide training and consultation on secondary trauma to graduate students at the Law Schools of the University of Santa Clara, Stanford University and the University of California at Berkeley.

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We work with human-induced trauma caused by experiencing or witnessing acts of war, genocide, religious, political or ethnic persecution, domestic abuse, incest, rape, genital mutilation, and human trafficking. Our main emphasis, however, has been serving survivors of war and physical, psychological and sexual torture.

Our initial work with secondary trauma was focused exclusively on primary responders and clinicians. In the past eight years, it has expanded to include interpreters and members of the legal profession, including lawyers.

It is now well established that interpreters are among those vulnerable to experiencing secondary trauma, just as associates of trauma survivors, primary responders, disaster workers, victim assistance specialists, nurses, physicians, psychotherapists, and others.

Psychological trauma

Psychological trauma may originate from natural disasters such as earthquakes, wildfires, tornadoes, floods and hurricanes. The aftermath of natural disasters can include death, destruction, loss, infectious diseases, homelessness and psychological distress. Trauma may also be caused by experiencing or witnessing human violence, such as acts

of war, genocide, religious, political or ethnic persecution, torture, domestic abuse, incest, rape, genital mutilation, and human trafficking. Most clinicians believe that it is harder to recover from a human-induced trauma, since it implies intentionality.

Psychological trauma refers to an experience that is emotionally painful, distressful, or shocking. It creates a psychological wound that may lead to substantial negative impact to a person's physiological, psychosocial and family systems. According to the Diagnostic Manual published by the American Psychiatric Association, Posttraumatic Stress Disorder (PTSD) may occur when "a person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others; and the person's response involved intense fear, helplessness or horror".[1]

The consequences of trauma and PTSD vary widely according to diverse variables, such as the victim's age, the pretrauma psychosocial context, the nature and severity of the trauma, and the support received following the trauma. Some common symptoms of trauma and PTSD include fear, helplessness, horror, anger, rage, sleep disturbances, alterations in memory, irritability, difficulty concentrating, re-experiencing traumatic events, avoidance or numbing to avoid thoughts and feelings connected with the traumatic events, detachment, and estrangement from others.

Psychological trauma creates an emotional wound that may harm a person's physiological and psychological systems. Severe traumatic events involve extreme stress that overwhelms the ability to cope, and shatters habitual categories of perception and understanding. Trauma may entail different losses, such as those of sense of self, meaning and hope. This experience of loss often varies according to ethnic, cultural and religious differences and the national or sociopolitical context in which it occurs. These losses usually lead to feelings of depression. If interviewed superficially, a traumatized person may be diagnosed with a major depressive disorder, and the trauma symptoms may be overlooked.

Secondary trauma

Many of the experiences and symptoms described above, are also commonly reported by caregivers and other providers that interact with traumatized patients or clients. Therefore, Figley,[2,3] and others introduced the concept of secondary trauma, also known as vicarious traumatization,[4] event countertransference,[5] and compassion fatigue.[6]

Secondary trauma refers to the psychological signs and symptoms that result from ongoing involvement with traumatized clients. Professionals that engage with empathy and care with people that have endured severe trauma may experience psychological difficulties produced by the survivors' account of their traumatic experience and the professional's reactions to such accounts. By becoming a witness to these atrocities, these may become part of the providers' consciousness, leading to a potential incorporation of their clients' traumatic experiences.

Therefore, professionals may experience, to a lesser degree, some of the same symptoms as those impacted by primary trauma. As stated above, these may include fear, helplessness, horror, anger, rage, sleep disturbances, alterations in memory, irritability, difficulty concentrating, avoidance or numbing to avoid thoughts and feelings connected with traumatic events, detachment, and estrangement from others.

In addition, they may undergo intense emotional reactions, ranging from denial

to over-identification. The delineation of a model to address secondary trauma (see below) will allow for a more detailed description of symptoms, behaviors, feelings and concerns associated with secondary trauma.

Smith et al[7] evaluated results of their studies on the effect of secondary trauma on psychotherapists, and concluded that experience with particularly severely traumatized clients, combined with frequent confrontations may influence therapists' in-session reactions. They oppose the view that long-term trauma therapy experience exerts prolonged negative influences on therapist's well-being or in-therapy behaviour. They add, however, that given the exploratory nature of their studies thus far, these results need to be tested in a controlled quantitative design.

A significant part of the clinical literature shows that "wounded healers" are less effective in helping traumatized clients.[6] At the same time, they may show particular strengths in working with survivors. A wounded healer may attain a deeper understanding of the dynamics of a specific trauma as a direct result of having endured a comparable traumatic experience.

Clinicians dealing with human-induced trauma have long understood the usefulness of psychotherapy with victims of primary trauma. More recently, they have recognized their own vulnerability to secondary trauma while working with traumatized individuals, including victims and witnesses at war crimes tribunals. Conversely, the secondary trauma of the legal professional has hardly been addressed. Those working in war crime tribunals, or with political asylum applicants that are victims of war, torture, trafficking, domestic violence, etc. are clearly vulnerable to secondary trauma. Being exposed daily to detailed traumatic narratives is extremely demanding and adds an important emotional dimension to legal work.

However, lawyers are not traditionally trained to address work-related emotions or acknowledge the potentially traumatic impact that their work may have on them and, by extension, on their clients. In some instances, they may feel overwhelmed by unidentified emotions. Legal professionals may experience symptoms such as those described above, and may also undergo intense emotional reactions, ranging from denial to over-identification.

These feelings are particularly conflicting when they are neither labeled nor voiced and may lead them, for example, to unknowingly detach. In such cases they distance themselves from their clients, withdrawing empathy and a supportive stance. Continued distress may even lead them to abandon work with victims, thus depriving from legal representation an already underserved population.

There are very few published articles about secondary trauma in the legal profession, and we hope that this article may stimulate further interest in the subject.

Secondary trauma: examples

The following examples included in this section might be helpful to readers unfamiliar with the actual experience of secondary trauma.

Literal statements from interpreters in group processes which I developed and co-led include: "How do I get out of the feeling that I didn't help the client?"; "How can I cope when I feel overwhelmed by the narrative that I have to translate?; "Can you give me tools to deal with my sadness?"

When interpreters have themselves been victims of primary trauma, their risk of re-traumatization is very high.[8] Interpreters still affected by primary trauma have reported stomach aches, "heartache", feeling exhausted after a session translating for a hu-

man rights attorney, inability to stop thinking about the reported trauma several hours or even days after interpreting, increased intake of alcohol or "junk food" following a work session. Statements recorded include: "I feel flooded by memories of what went on in my country"; "I get scared of what information will come up next and what I will have to deal with in the following session".

Our experience addressing the secondary trauma of attorneys and field workers that document situations of genocide and human rights violations in conflict areas and refugee camps, of immigration attorneys that deal frequently with extremely traumatized refugees, and those assigned to interview war prisoners in detention camps, indicates that the potential for secondary trauma in that professional population deserves serious attention. In individual psychotherapy work with legal professionals, we have frequently encountered feelings of anger, rage, fear, guilt, identification with the client, and internalization of their clients' pain.

In group work with legal advocates, common statements include: "I never suspected that documenting these human rights violations would affect me so deeply"; "I have had so many nightmares since interviewing a client that was brutally tortured, that now I am afraid of going to sleep".

Concern about retraumatizing the client appears with increased frequency among legal professionals that are starting to learn about retraumatization. In the past year I have been addressing the subject through frequent phone consultations with attorneys throughout the United States, as well as in training events for law students.

Levin and Greisberg[9] conducted a study to evaluate secondary trauma in attorneys, and stated that "The major finding of our study was that attorneys working with traumatized clients experience significant symptoms of secondary trauma and burnout". They further point to the need for identifying effective interventions to reduce secondary trauma among legal professionals in order to enhance the delivery of legal services to victims of trauma.

Parker[10] argues that law students working with traumatized clients must be trained to identify trauma issues that may affect the client-law student relationship, and states that some students identify with the client and internalize their pain, while others close off and block out emotions.

A psycho-educational model to address secondary trauma

Williams & Sommer,[11] Pearlman[12] and others have used specific approaches to address secondary trauma. Most share some basic principles such as the importance of self care, the need to develop awareness of signs of excessive stress, and the need to identify personal triggers for secondary trauma. Some clinicians also propose debriefing following particularly painful trauma-related interviews, to facilitate the provider's release of thoughts and feelings that might not otherwise be expressed.

Understanding that education and accurate information are important elements in the prevention of secondary trauma, I developed a psycho-educational model for prevention and early intervention for legal professionals, primary responders, psychotherapists, and others that may be vulnerable to secondary trauma.

When working with providers who live and work in societies where war, terrorism or human rights violations are occurring, we need to be aware that they commonly share an experience of primary trauma with their clients. It is important to understand that this creates unique difficulties in the provision of services. For example, in situations

such as those of primary responders, human rights lawyers or psychotherapists, they might be facing their own primary trauma, while also incorporating their clients' traumatic experiences. This creates problems such as blurring of boundaries, potential exacerbation of emotional responses and issues of personal safety. Such problems may hinder the lawyer or clinicians' ability to set limits in their work, take care of their own physical and emotional health, and even allow themselves to be mindful of their personal reactions to trauma. It is therefore crucial to focus on the physical and mental well-being of providers, explore creative means for self-care and the release of emotions and personal feelings, and provide supervision to help minimize the blurring of boundaries. Group training or supervision may also function as a support system.

What follows is an attempt to present a step-by-step description of the topics addressed in lectures, discussions or process sessions and small groups. These are introduced below in the order in which they take place.

1. The training starts with lectures and interactive sessions to teach the concepts of trauma, retraumatization and secondary trauma; this is followed by a discussion of individual, family, and community effects of traumatic events and how these interact with the work of providers.

2. The next step is a lecture and open discussion of the process through which caretakers develop symptoms that parallel those of their clients and of the way in which their behavior is impacted by such symptoms; consideration of emotional changes and their impact on their outlook on life; attention to behavioral changes following secondary traumatization, including disruption in relations with spouses or partners, children, co-workers, supervisors, and friends. The exact number of hours devoted to each topic varies according to the number of days prearranged for each program.

3. The previous topics are followed by a discussion of common secondary trauma symptoms such as irritability, hypervigilance and numbing as well as of the potential for dangerous behaviors such as reckless driving, alcohol or drug abuse. All the information discussed is based on an understanding of the cultural meaning of trauma and healing within the group with which we work, and awareness of culturally appropriate ways to develop and foster resilience whenever that is possible. Although our team is not completely multicultural, we actively try to educate ourselves within possibilities on the meaning ascribed to trauma in different cultures. In addition, our experience in individual psychotherapy with traumatized individuals from many different cultures has taught us to request their help to explain to us the meaning of concepts such as trauma and healing in their specific culture.

4. Following the examination of the impact of secondary traumatization on the individual caregiver we lead a discussion about the ethical responsibility of traumatized professionals to address personal healing needs. This is necessary to avoid distortion of the interview, interpretation or treatment process when a professional is unable to act according to each profession's convention of "do no harm". Awareness of potential counterproductive responses ranging all the way from excessive distancing to over-identifying with their clients[13] contribute to a better understanding of how secondary trauma may affect a provider's decision-making process, lead to inhibited listening, ameliorate the

ability to maintain appropriate boundaries and to render effective services.

5. Subsequent to such analysis, we offer education to facilitate early identification of symptoms of secondary traumatization, and approaches to prevent further traumatization. Examples that lead to a "mentality of prevention" include suggestions such as:

"Learn to identify changes in your mood. Are you feeling angry very frequently? Do you often feel that you are about to cry? Given the work you are currently doing, these may be signs of secondary trauma; do not ignore them. Try to make some time for activities that distract you from your everyday routine, such as spending time outdoors, playing with friends, children or pets, engaging in some artistic pursuit, etc. Also, practice observing your mood changes. The more you observe these changes, the more control you will eventually acquire over your moods."

"Learn to identify changes in your behavior. Do you get frustrated very frequently? Are you becoming impatient with your family, friends, co-workers? Have you increased your alcohol intake? Are you fighting a lot with your spouse or significant other? Do you have a desire to attack them physically or feel that you cannot control your temper when you are around them? In your present circumstances, these also might be signs of secondary trauma. They may indicate that you need to take time out, get support from friends, or talk to a psychotherapist."

6. This is followed by a lecture on diverse approaches to self-care which contribute to both prevent secondary traumatization and attempt to reverse its effects as needed. Some of these approaches emphasize the importance of incorporating balanced nutrition, physical exercise and a short, interesting, inspiring, or relaxing activity into everyday life. Also, we highlight the importance of obtaining supervision from someone that understands the dynamics of work with traumatized clients, as well as ongoing discussion groups with peers whenever possible. The support of professional peers provides nonjudgmental listening, objective feedback, and additional professional perspectives.

A central aspect of our presentation on the topic of self-care involves organizing small process groups to recapitulate the reasons that lead each professional to trauma work. This is followed by questioning whether such reasons are still valid, in order to evaluate potential occupations in a related field that does not necessarily involve trauma. For those who decide to continue their employment in the field of trauma, we strongly recommend to limit direct involvement with survivors of trauma and to attempt to combine it with other lines of work. Ideally, this recommendation should apply to everybody in this field, in order to prevent burnout and secondary traumatization.

If the original motivation to choose this line of professional work remains in place, participants are invited to reflect on the two sides of trauma work. On the one hand, it deals with the "dark side of life". On the other, it grants us the privilege to bring light into darkness, challenge those in power who adhere to a worldview that creates horror and despair, fight injustice, or to try to fulfill an inner commitment of healing the world. It also allows us to appreciate the courage and resilience of those who have endured harrowing experiences.

7. At this stage the amount of exposure to the subject usually allows us to safely move into small process groups to consider individual variables that may increase the vulner-

ability to secondary trauma. These include personal trauma history, degree of integration of traumatic experiences, and lack of necessary support from the social and family milieu. A respectful and concerned discussion of personal trauma history sometimes leads to an appropriate referral for individual or group psychotherapy.

When there is acknowledgement of lack of social or family support, we try to decrease feelings of frustration and loneliness by clarifying that it is not realistic to expect immediate support or understanding from family and friends. It may take them some time to acknowledge the pain involved in trauma work, and people who are not familiar with trauma need help to gradually understand and develop the ability to process the information that is shared with them. (Confidentiality regarding identification and specific circumstances of clients is always emphasized).

In addition, we attempt to normalize expected reactions such as anger, outrage and hopelessness that result from continued exposure to the helplessness of traumatized victims. When these emotions emerge, we put forward the option of joining local organizations that focus on preventing the specific crimes that cause major negative impact in each provider. This offers a positive channel to express anger and helps counteract feelings of hopelessness.

8. In the following meeting we bring up the possibility of considering spiritual support to provide holding and thus complement the encouragement given by colleagues, family and friends. Through my experience lecturing on the spiritual dimensions of trauma I have learned that a significant percentage of professionals interacting with trauma are open to exploring a mind-body-spirit paradigm. For many, trauma work demands new frames of meaning, since traditional intellectual constructs cannot easily incorporate the traumatic wounds with which we are confronted. The need to find additional ways of relating to these traumatic wounds sometimes leads providers into exploring a spiritual path. For some, spirituality suggests therapeutic avenues that encourage the transformation of traumatic experiences.

As stated earlier, this psycho educational program takes place in the form of lectures, small group discussions, process sessions and individual meetings as needed. These different formats are designed to promote personal and professional connections and peer support, which contribute to counteract isolation, a common element of secondary trauma. Group interactions emphasize safety, thus allowing for discussion of fears, frustrations, and feelings of anxiety and inadequacy due to the difficulties involved in work with a severely traumatized population. In addition, safe groups encourage examination of the desire to distance oneself from the trauma, associated with feelings of guilt for wanting to abandon the client; and of issues of mistrust and betrayal, which parallel the client's experience.

Peer groups also provide a helpful forum to address ethical dilemmas generated by coming face to face with the hate and violence in the world. For many providers, witnessing the unspeakable may seriously challenge belief systems. These challenges often lead to questions of purpose and meaning that affect victims as well as those who work with them. It is valuable for providers to discuss these questions, as well as dilemmas regarding faith or religion if they seem important. Even if there are no universal answers to these questions, it helps to have an opportunity to reflect on, and access the spiritual, ethical or moral resources congruent with each individual's belief systems.

Providers that struggle with these questions without giving them a voice make themselves more vulnerable to isolation and existential loneliness.

Conclusions

Even though secondary trauma is not a universal phenomenon that impacts all professionals interacting with trauma, the problem is frequent enough to merit serious attention. Secondary trauma may affect a provider's decision-making process, lead to inhibited listening, decrease the ability to maintain appropriate boundaries and to render effective services. Also, many professionals burdened by secondary trauma abandon their work with trauma survivors in order to avoid serious emotional distress.

It is important to keep in mind that particularly vulnerable individuals, such as those with a history of unresolved primary trauma, may need individual or group psychotherapy in addition to education and self care.

Prevention and education appear as a very cost-effective approach to avoid the negative consequences of secondary trauma affecting providers, and by extension, service users. Education is also a simple way to remind legal and clinical professionals about the risks of retraumatization, and to bring into focus the dangers involved in retraumatizing clients through inadequate, untimely or insensitive questions.

Our emphasis on group work provides a safe forum to discuss important practical issues as well as existential dilemmas that may intensify symptoms of secondary trauma.

The psycho-educational model described above has proved to be a valuable method to identify, prevent or diminish the effects of secondary trauma. A central focus of this model is the clarification of personal motivations leading professionals to trauma work and its connection to purpose, meaning, worldview and the spiritual dimensions of trauma.[14] It also allows us to remind providers that while we cannot undo what happened to those we serve, we can attempt to heal and restore.

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Recommended readings

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