When the Lawyer Becomes Traumatized: A Scoping Review

Marie-Jeanne Léonard1, Daniel Saumier2, and Alain Brunet2,3

Abstract

Lawyers can be exposed to cases involving traumatic elements of crimes. Such exposure may result in symptoms of posttraumatic stress disorder (PTSD) and have adverse effects on the lawyers’ capacities to work. A scoping review was conducted to summarize original investigations of work-related PTSD among lawyers in terms of (a) trauma exposure conceptualization and operationalization, (b) symptom severity, (c) prevalence, and (d) risk factors. The scoping review also aimed to highlight potential directions for future studies and clinical implications. Literature searches were conducted in PsycINFO, Embase, Pubmed, MEDLINE, PILOTS, and Google Scholar. Of 341 initial publications, 9 were included. A majority conceptualized the impact of work-related trauma exposure as secondary traumatic stress and operationalized work-related trauma exposure as the number of cases or clients involving traumatic material. Levels of PTSD symptoms reported by lawyers were positively related to levels of work-related trauma exposure.

Keywords

lawyer, posttraumatic stress disorder, secondary traumatic stress, vicarious trauma, scoping review

While many consider the legal profession as prestigious and noble, is it possible that being a lawyer has detrimental effects on one’s mental health? Significant rates of depression, anxiety, and substance use (e.g., alcohol, opioids, cocaine) have been identified among lawyers (e.g., Krill et al., 2016). Lawyers are responsible for advising and defending their clients with competence and diligence. This implies not only a rigorous interpretation of the law, but also an understanding of clients’ issues. Yet, some lawyers can be exposed to horrific details of events of a traumatic nature, such as videos of physical aggressions, gruesome depictions of legal evidence, and emotional testimonies that can translate, for some, into symptoms of posttraumatic stress disorder (PTSD). Considering their professional duties and their position of power over their clients, lawyers need to be in control of their mental health and cognitive capacities. It is therefore important to understand how and to what extent PTSD may impact their mental health, so as to advance academic research and inform clinical programs adequately.

Trauma Conceptualization

PTSD was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (American Psychiatric Association [APA]). The introduction of this new diagnosis stimulated vigorous research and led to a number of conceptual ramifications. One of them is the conceptualization of work-related trauma that emerged in the 1990s, with vicarious trauma and secondary traumatic stress being considered as the predominant notions (Jenkins & Baird, 2002). Vicarious trauma had a circumscribed definition and referred to the negative alteration of a (mental health) professional’s cognitive schema as a result of working with traumatized individuals, and the experience of intrusive memories stemming from this work (Jenkins & Baird, 2002). Secondary traumatic stress described the development of symptoms akin to those of PTSD, including re-experiencing, avoidance, and hyperarousal symptoms without being directly exposed to a traumatic event (Figley, 1995; Jenkins & Baird, 2002).

In 2013, the 5th edition of the DSM defined PTSD as a condition that could stem from “experiencing repeated or extreme indirect exposure to aversive details” of traumatic events throughout the course of professional duties (APA, 2013). PTSD is characterized by a set of 20 symptoms grouped into four clusters: (a) re-experiencing symptoms (i.e., intrusive memories, distressing dreams, flashbacks, and

1Université du Québec à Montréal, Montreal, Quebec, Canada
2Douglas Mental Health University Institute, Montreal, Quebec, Canada
3McGill University, Montreal, Quebec, Canada

Corresponding Author:
Marie-Jeanne Léonard, Department of Psychology, Université du Québec à Montréal, Pavillon Adrien-Pinard, Montreal, Quebec H2X 3P2, Canada.
Email: leonard.marie-jeanne@courrier.uqam.ca

Creative Commons CC BY: This article is distributed under the terms of the Creative Commons Attribution 4.0 License (https://creativecommons.org/licenses/by/4.0/) which permits any use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).
distress or other intense reactions due to trauma reminders); (b) avoidance of trauma-related stimuli (i.e., avoidance of internal stimuli, such as memories and thoughts, or external stimuli, such as places); (c) negative alterations of mood or cognition (i.e., dissociative amnesia, exaggerated negative beliefs about oneself or the world, altered cognitions of the cause/consequence of the traumatic event, exaggerated negative emotions, decreased interests, social withdrawal, and incapacity to feel positive emotions); and (d) alterations in arousal and reactivity (i.e., irritability, anger, hypervigilance, recklessness, easily startled, decreased concentration capacities, and sleep disturbances). By definition, the DSM-5’s conceptualization of PTSD encompassed vicarious trauma and secondary traumatic stress, providing a comprehensive conceptual framework.

**Trauma-Related Symptoms Among Professionals**

Trauma exposure among many lawyers is similar to that of other professionals, including journalists, social workers, and law enforcement agents. Such professionals have indeed been identified as being at risk of developing trauma-related symptoms, although PTSD prevalence rates varied between 4% and 32%, depending on the study and on the profession (Asmundson & Stapleton, 2008; Bride, 2007; Pearlman and Saakvitne, 1995; Pyevich et al., 2003). Among social workers working with a traumatized clientele, Bride (2007) identified that a large portion reported intrusion (45%), avoidance (25%), and arousal symptoms (25%). Similarly, Jaffe et al. (2003), reported that 63% of a sample of judges experienced at least one symptom of vicarious trauma including sleep disturbances, feeling isolated, cognitive difficulties (e.g., issues with concentration), and interpersonal problems. Considering the apparent effects that indirect trauma exposure has on public safety personnel (Carleton et al., 2018), it is not unreasonable to suspect that many lawyers could also be at-risk of developing trauma-related symptoms.

Knowing that many lawyers handle cases involving a traumatized clientele, such as refugees, child abuse victims, and sexually assaulted individuals, it is important to understand how these cases may impact their mental health. The aim of the current study was to conduct a scoping review to further our understanding of how the association between traumatic material exposure and PTSD symptoms was conceptualized and operationalized in previous studies. The study also sought to summarize and disseminate patterns in current research findings regarding how and which PTSD symptoms lawyers tend to develop based on the four symptom clusters of the DSM-5, as well as, the prevalence and risk factors associated with PTSD symptoms. Examining the association between work-related trauma exposure and PTSD symptoms among lawyers can identify the knowledge gaps to highlight areas for future studies and clinical implications. Based on those patterns, a framework for reporting such findings is proposed.

**Method**

**Procedure**

This scoping review collated information from existing peer-reviewed studies based on the stages of Arksey and O’Malley (2005): (a) identify the research question, (b) identify relevant studies, (c) select the studies, (d) chart the data, and (e) collate, summarize, and report the results, the 6th stage “expert consultation” being optional. Two independent reviewers conducted the retrieval, selection, and analysis of the studies. Next, they compared their results. All (minor) discrepancies were resolved by consensus. The research question of this scoping review was: How have studies previously conceptualized the effects of work-related trauma exposure among lawyers and what types of PTSD-related symptoms do lawyers report?

**Database Search**

Relevant studies published up to May 2019 were searched through PsyCINFO, Embase, Pubmed, MEDLINE, PILOTS, and Google Scholar search engines. No search restrictions (except language) were used so as to ensure the retrieval of as many relevant investigations as possible. The following search terms were used across all search engines: “Secondary traum*,” “Vicarious traum*,” “Compassion fatigue,” “Posttraumatic stress,” “Posttraumatic stress disorder,” “PTSD,” “Attorney*,” “Lawyer*” in either the title, abstract, subject heading word, or keyword heading of the studies (“*” indicates that the word was truncated to search for all possible words containing the characters prior to it). See Appendix 1 for an example of the search expressions used.

**Screening**

Manuscript inclusion (including dissertations) was based on four criteria: the study (a) was an original piece of work, (b) reported findings from a sample composed of practicing lawyers, (c) assessed PTSD symptom severity, and (d) was written in the English language. Manuscripts relating to (a) clinical law, (b) personal stories, or (c) described solely as PowerPoint presentations were excluded. Because the scoping review specifically targeted lawyers as a professional population, studies reporting global findings from a combination of lawyers and other professionals were excluded if they did not provide specific results for lawyers. Titles and abstracts of the retrieved studies were screened based on the study criteria. The full texts of the apparently eligible publications were retrieved and reviewed based on the same criteria. The references of the reviewed papers were scanned using the snowball technique to find additional papers which may have been missed otherwise (Sayers, 2007). Data from the included studies were extracted from the manuscripts: authors and year of publication, country, participants’ profession, sample size, study design, data collection method, measures used, and key findings.
Results

The search yielded 341 publications (see Figure 1). After eliminating duplicates, 219 titles and abstracts were screened, and 202 of those were excluded as they did not investigate PTSD symptoms, or were not original studies. The 17 eligible publications were reviewed based on the same criteria. The manuscript of one study (thesis) was not available online. Although the corresponding author of the study was contacted to obtain the manuscript, this person did not reply to the inquiry. The academic institution of the author was therefore contacted to obtain a copy of the manuscript. Due to a 2-year embargo placed on the manuscript, the institution could not provide it. The study was therefore excluded. The snowball technique did not yield additional papers. Of 16 remaining studies, 7 were excluded since (a) they did not involve an original research (i.e., descriptive paper on secondary trauma among professionals) or relate to the theme of the current review (n = 2), (b) the sample assessed was not exclusively composed of lawyers and no specific results for lawyers were provided (n = 4), or (c) the manuscript was not written in English (n = 1). A total of nine studies were therefore retained for analyses (Table 1). Seven were empirical studies and two were dissertations. One study had a longitudinal design (Levin et al., 2012) and five had a control group (Leclerc et al., 2019; Levin et al., 2011; Levin & Greisberg, 2003; Maguire & Byrne, 2017; Vrklevski & Franklin, 2008), and PTSD (see Leclerc et al., 2019; Levin et al., 2012). One study adopted both secondary traumatic stress and PTSD as conceptualizations of work-related trauma exposure (Levin et al., 2011). All studies that adopted the conceptualization of secondary traumatic stress considered that it involved symptoms of intrusive memories, avoidance, and hyperarousal. Goldman (2006) and Piwowarczyk et al. (2009) added that secondary traumatic stress could also result in cognitive schema disruption. Goldman (2006), Sokol (2014), as well as Levin and Greisberg (2003), identified secondary traumatic stress as a concept similar to PTSD. However, they noted that the two concepts differ based on the trauma exposure-type; while secondary traumatic stress involves indirect exposure, PTSD arises from direct exposure, which is not entirely consistent with the DSM-5 criteria for PTSD. Vicarious trauma was defined by Vrklevski and Franklin (2008) and Maguire and Byrne (2017) as the alteration of cognitive schemas regarding the self and the world due to engagement with traumatic material. Maguire and Byrne (2017) conceptualized vicarious trauma as similar to PTSD, with the exception that it did not involve enough symptoms to be considered as such. Finally, Leclerc et al. (2019), Levin et al. (2012), and Levin et al. (2011) applied the DSM-5 trauma exposure criterion (the so-called Criterion A) when assessing their lawyer participants. Consistent with the DSM-5 diagnostic criteria, they defined PTSD as involving four types of symptoms: intrusive, avoidance, and hyperarousal symptoms, as well as changes in cognitive schemas. Goldman (2006), Leclerc et al. (2019), and Levin et al. (2011) all agreed that there was a conceptual overlap between secondary traumatic stress and vicarious trauma, and that these concepts could be used interchangeably. Sokol (2014) and Vrklevski and Franklin (2008) also noted a conceptual overlap between these conceptualizations of trauma, but, along with Piwowarczyk et al. (2009), they considered them to describe distinct conditions.

Trauma Conceptualization

Among the retained studies, three different trauma conceptualizations were used: (a) secondary traumatic stress, (b) vicarious trauma, and (c) PTSD as defined by the DSM-IV or the DSM-5. The most frequently used trauma conceptualization was secondary traumatic stress (see Goldman, 2006; Levin & Greisberg, 2003; Piwowarczyk et al., 2009; Sokol, 2014), followed by vicarious trauma (see Maguire & Byrne, 2017; Vrklevski & Franklin, 2008), and PTSD (see Leclerc et al., 2019; Levin et al., 2012). One study adopted both secondary traumatic stress and PTSD as conceptualizations of work-related trauma exposure (Levin et al., 2011). All studies that adopted the conceptualization of secondary traumatic stress considered that it involved symptoms of intrusive memories, avoidance, and hyperarousal. Goldman (2006) and Piwowarczyk et al. (2009) added that secondary traumatic stress could also result in cognitive schema disruption. Goldman (2006), Sokol (2014), as well as Levin and Greisberg (2003), identified secondary traumatic stress as a concept similar to PTSD. However, they noted that the two concepts differ based on the trauma exposure-type; while secondary traumatic stress involves indirect exposure, PTSD arises from direct exposure, which is not entirely consistent with the DSM-5 criteria for PTSD. Vicarious trauma was defined by Vrklevski and Franklin (2008) and Maguire and Byrne (2017) as the alteration of cognitive schemas regarding the self and the world due to engagement with traumatic material. Maguire and Byrne (2017) conceptualized vicarious trauma as similar to PTSD, with the exception that it did not involve enough symptoms to be considered as such. Finally, Leclerc et al. (2019), Levin et al. (2012), and Levin et al. (2011) applied the DSM-5 trauma exposure criterion (the so-called Criterion A) when assessing their lawyer participants. Consistent with the DSM-5 diagnostic criteria, they defined PTSD as involving four types of symptoms: intrusive, avoidance, and hyperarousal symptoms, as well as changes in cognitive schemas. Goldman (2006), Leclerc et al. (2019), and Levin et al. (2011) all agreed that there was a conceptual overlap between secondary traumatic stress and vicarious trauma, and that these concepts could be used interchangeably. Sokol (2014) and Vrklevski and Franklin (2008) also noted a conceptual overlap between these conceptualizations of trauma, but, along with Piwowarczyk et al. (2009), they considered them to describe distinct conditions.
| Study                                             | Participants (N), country                      | Study design | Measures for PTSD                                                                 | Key findings                                                                                                                                 |
|--------------------------------------------------|------------------------------------------------|--------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| Levin & Greisberg (2003)                         | (1) Lawyers in criminal and family law (55); (2) Mental health professionals (87), USA | CS STQ       | Higher levels of PTSD symptoms among lawyers than controls.                      | Lawyers reported emotional disturbances, sleep disturbances, and negative alterations of their mood/cognitions.                               |
| Goldman (2006)                                   | (1) Law guardians (lawyers who represent children in court proceedings; 125), USA       | CS Traumatic Events Checklist, IES-R, STS, and TABS | STS: 10.4% reported moderate levels, 7.2% reported high levels.                  | IES-R: little to no symptoms of intrusion and avoidance, no hyperarousal symptoms. Highest scores were moderately severe ($M = 29.37$, $SD = 8.65$). |
| Vrklevski & Franklin (2008)                      | (1) Lawyers in criminal law (50); (2) Non-criminal law solicitors (conveyancers and academicians; 50), Australia | CS VTS, IES-R, and TABS | STS: 9% of sample reported moderate to severe levels of symptoms (score $> 38$) and 0% reported severely high levels of symptoms. | VTS: higher levels among lawyers than control group. Lawyers reported cognitive changes. IES-R: higher levels among lawyers ($M = 18.44$, $SD = 15.05$) than control group ($M = 12.56$, $SD = 15.77$), but non-significant difference. |
| Piwowarzcyk et al. (2009)                        | (1) Lawyers representing asylum seekers pro bono (57), USA                              | CS STS and Life Events Checklist | STS: mean score of intrusion, avoidance, and hyperarousal symptoms significantly lower at Time 2. 15% of lawyers at Time 1 and 9% of lawyers at Time 2 could receive a diagnosis of PTSD. Strong and stable symptoms over time. Symptoms increased when working with traumatic elements. |
| Levin et al. (2011)                              | Wisconsin State Public Defender Office: (1) Lawyers (238); (2) Administrative support staff (109), USA | CS IES-R and ProQOL5 (section STS) | IES-R: no correlation with exposure to disturbing media.                          | Lawyers as a group reported moderate levels of STS ($M = 36.08$). 37% reported moderate levels and 15% reported high levels of STS. No correlation with exposure to disturbing media. |
| Levin et al. (2012)                              | Wisconsin State Public Defender’s Office (107), USA                                     | L (10-month IES-R period) | Moderate exposure group was 5.01 points higher on PCL-5 than no exposure group. High exposure group was 10.03 points higher on PCL-5 than no exposure group. High exposure group was 5.03 points higher on PCL-5 than moderate exposure group. 9% of lawyers met screening criteria for PTSD based on DSM-5 criteria. |
| Sokol (2014)                                     | Military Judge Advocate General’s Corps lawyers (27), USA                               | CS Exposure to disturbing media and STSS | VTS: scores were significantly higher for lawyers ($M = 39.86$, $SD = 7.81$) than for mental health professionals ($M = 33.13$, $SD = 6.96$). Emotional stability: negative correlation with VTS scores and with IES-R scores.   | VTS: scores were significantly higher for lawyers ($M = 39.86$, $SD = 7.81$) than for mental health professionals ($M = 33.13$, $SD = 6.96$). Emotional stability: negative correlation with VTS scores and with IES-R scores. |
| Maguire & Byrne (2017)                           | (1) Lawyers (36); (2) Mental health professionals (30), Australia                     | CS VTS and IES-R | VTS: scores were significantly higher for lawyers ($M = 39.86$, $SD = 7.81$) than for mental health professionals ($M = 33.13$, $SD = 6.96$). Emotional stability: negative correlation with VTS scores and with IES-R scores. | VTS: scores were significantly higher for lawyers ($M = 39.86$, $SD = 7.81$) than for mental health professionals ($M = 33.13$, $SD = 6.96$). Emotional stability: negative correlation with VTS scores and with IES-R scores. |
| Leclerc et al. (2019)                            | (1) Lawyers (478). Classification: no trauma exposure (0% caseload = traumatic), moderate (1%–50% caseload = traumatic), high (51%–100% caseload = traumatic), Canada | CS Life Event Checklist for DSM-5 and PCL-5 | Moderate exposure group was 5.01 points higher on PCL-5 than no exposure group. High exposure group was 10.03 points higher on PCL-5 than no exposure group. High exposure group was 5.03 points higher on PCL-5 than moderate exposure group. 9% of lawyers met screening criteria for PTSD based on DSM-5 criteria. |

Note. CS = cross-sectional; L = longitudinal in the section “Study design”. STQ = Secondary Trauma Questionnaire; IES-R = Impact of Events Scale—Revised; STS = Secondary Trauma Scale; TABS = Trauma and Attachment Belief Scale; VTS = Vicarious Trauma Scale, STSS = Secondary Traumatic Stress Scale, and PCL-5 = PTSD Checklist for DSM-5 in the section “Measures for PTSD.”
Operationalization of Exposure to Traumatic Material

The level of exposure to traumatic material among lawyers was operationalized differently across the studies. Most studies considered that the client-load or the number of cases involving traumatic material among lawyers were reliable measures of exposure. Some specified a specific time period in their assessment of client-load or number of cases (Levin et al., 2011, 2012; Levin & Greisberg, 2003), but Goldman (2006) and Sokol (2014) did not. Levin and Greisberg (2003) considered the number of traumatized clients worked with over a period of 1 year, while Levin et al. (2011) and Levin et al. (2012) restricted the number of traumatized clients over a period of 3 months. In addition to the number of clients, Levin et al. (2011) assessed the impact of the number of hours worked weekly on symptomatology. Sokol (2014) examined exposure to traumatic material based on three additional aspects: the percentage of cases involving traumatic material and the time since the first and the last exposure to traumatic material. Vrklevski and Franklin (2008) and Maguire and Byrne (2017) operationalized exposure to traumatic material based on whether the lawyers had been practicing criminal law and family law, but did not consider the level of exposure. Leclerc et al. (2019) measured the level of trauma-related exposure as a tripartite variable. Lawyers were categorized as having none (0%), up to half (1%–50%), or more than half (51%–100%) of their cases involving traumatic material in the past year. Piwowarczyk et al. (2009) recruited lawyers who had worked pro-bono for asylum seekers. They operationalized the level of exposure to traumatic material based on the number of pro-bono hours worked per week. They considered it to be a proxy for the number of hours exposed to traumatic material, although they did not account for the number of regular hours worked. As can be seen, the operationalization of trauma exposure varied greatly across studies.

Do Lawyers Report PTSD Symptoms from a Specific Cluster?

Intrusive symptoms. Although Levin and Greisberg (2003) did not report conducting any statistical test, the authors stated to have found a higher level of intrusive symptoms related to traumatic material for lawyers compared to mental health professionals. Using the Impact of Event Scale—Revised (IES-R), this tendency was observed by Levin et al. (2011) when they compared lawyers ($M = 0.73, SD = 0.58$) to their administrative support staff ($M = 0.46, SD = 0.34$). However, using the IES-R, Vrklevski and Franklin (2008) did not find that lawyers ($M = 0.31, SD = 0.27$) differed from a control group of non-criminal law practicing solicitors ($M = 0.23, SD = 0.30$). The levels of symptoms reported in both Levin et al.’s and Vrklevski and Franklin’s studies were in the subclinical range. Investigating a group of law guardians, Goldman (2006) found that the severity of intrusive symptoms varied between no symptoms (0) and moderately to quite severe symptoms (2.63), with a sample mean of 0.53 ($SD = 0.59$) on the IES-R. Levin et al.’s (2012) longitudinal study revealed a significant decrease of intrusive symptoms after a 10-month period (baseline: $M = 0.76, SD = 0.59$; follow-up: $M = 0.43, SD = 0.55$ on the IES-R). They also reported a significant, but weak correlation at the follow-up between the level of exposure to traumatic material and intrusive symptoms ($r = .24$).

Avoidance symptoms. Lawyers had higher levels of avoidance symptoms related to exposure to traumatic material compared to their administrative support staff (Levin et al., 2011), but not compared to non-criminal law practicing solicitors (Vrklevski & Franklin, 2008). Low levels of avoidance symptoms were noted on the IES-R by Levin et al. (2011) for lawyers ($M = 0.65, SD = 0.65$) and their support staff ($M = 0.33, SD = 0.49$), as well as, by Vrklevski and Franklin (2008) for lawyers ($M = 0.34, SD = 0.26$) and non-criminal law practicing solicitors ($M = 0.23, SD = 0.28$). Levin and Greisberg (2003) reported that lawyers also had higher levels of avoidance symptoms than mental health professionals, but they did not report the statistical results, hindering the interpretation of the results. Goldman (2006) also found subclinical levels of avoidance symptoms among lawyers ($M = 0.45, SD = 0.55$ on the IES-R), although symptom severity ranged between no symptoms (0) and moderately to quite severe symptoms (2.38). Levin et al. (2012) identified a significant decrease of avoidance symptoms over time using the IES-R (baseline: $M = 0.76, SD = 0.70$; follow-up: $M = 0.55, SD = 0.57$).

Hyperarousal symptoms. Levin and Greisberg (2003) found that lawyers reported more hyperarousal symptoms, including concentration, sleep, and irritability symptoms, than mental health professionals (although no data was provided). In 2011, Levin et al. noted a significantly higher severity of hyperarousal symptoms among lawyers ($M = 0.55, SD = 0.65$) compared to their administrative support staff ($M = 0.25, SD = 0.44$) on the IES-R. This result was not supported by Vrklevski and Franklin (2008) who compared lawyers ($M = 0.18, SD = 0.22$) to non-criminal law practicing solicitors ($M = 0.11, SD = 0.17$). Goldman (2006) found that lawyers demonstrated on average low hyperarousal symptoms ($M = 0.26, SD = 0.33$), but symptom severity varied between no symptoms (0) and little to moderate symptoms (1.50) on the IES-R. Levin et al. (2012) reported that hyperarousal symptoms were stable over a 10-month period (baseline: $M = 0.61, SD = 0.65$; follow-up: $M = 0.61, SD = 0.61$ on the IES-R). The authors also found significant but weak to moderate correlations at baseline between the number of hours worked weekly and hyperarousal symptoms ($r = .30$), as well as, at the 10-month follow-up between the level of exposure to traumatic material and hyperarousal symptoms ($r = .27$).
Cognitive alterations symptoms. Levin and Greisberg (2003) found that lawyers reported more symptoms related to loss in “pleasure and interest in activities” than mental health professionals (although they did not report any data). In addition, Vrklevski and Franklin (2008) found that lawyers had significantly higher levels of cognitive disruptions than non-criminal law solicitors on the Trauma and Attachment Belief Scale and on the Vicarious Trauma Scale. Maguire and Byrne (2017) noted that although both lawyers ($M = 39.86, SD = 7.81$) and mental health professionals ($M = 33.13, SD = 6.96$) had moderate symptoms on the Vicarious Trauma Scale, lawyers had significantly higher levels of cognitive alterations. The authors also reported that emotional stability negatively correlated with symptom severity. Overall, Goldman (2006) identified that 17% of lawyers had severe disruptions in their beliefs related to self and other-safety, self and other-trust, self and other-esteem, self and other-intimacy, as well as self, and other-control.

Secondary traumatic stress, vicarious trauma, and PTSD. The studies reviewed also included results related to the overall syndromes (secondary traumatic stress and vicarious trauma) and disorders (PTSD). Goldman (2006) found that although the average secondary traumatic stress severity among lawyers was minimal (i.e., the average score on the Secondary Trauma Scale was inferior to the clinical threshold of 38), 10.4% of the sample reported moderate levels of secondary traumatic stress (i.e., score between 38 and 44 on the Secondary Trauma Scale) and 7.2% reported severe levels of secondary traumatic stress (i.e., score between 45 and 62 on the Secondary Trauma Scale). Still, Goldman (2006) concluded that the study “provided little evidence for secondary traumatization” when lawyers were considered as a group. Goldman (2006) noted that “in essence, law guardians as a group reported that they only rarely or occasionally experience adverse emotional reactions to their work.” Contrary to Goldman (2006), Piwowarczyk et al. (2009) concluded that lawyers working with traumatic material were at risk for secondary traumatic stress. They found that 87% of their sample reported two or more symptoms and that 9% reported moderate levels of secondary traumatic stress on the Secondary Trauma Scale, although none reported levels that were of clinical concern (i.e., score of 45 or higher). Sokol (2014) identified that 37% of the sample scored moderately for secondary traumatic stress (i.e., score between 38 and 48 on the Secondary Traumatic Stress Scale) and that 15% obtained scores translating in high levels of secondary traumatic stress (i.e., score above 49 on the Secondary Traumatic Stress Scale). The study revealed that the symptoms did not correlate with the levels of exposure to traumatic material. The authors nonetheless concluded that lawyers were at higher risk of secondary traumatic stress than other professionals. Levin et al. (2011) found that more lawyers (11%) than their administrative support staff (1%) had probable PTSD. The same tendency was observed for secondary traumatic stress, with 34% of lawyers compared to 10% of their administrative support staff reporting clinically severe levels of symptoms (i.e., score above 56 on the Professional Quality of Life Scale Version 5, secondary traumatic stress subscale). The authors reported that lawyers were more vulnerable for developing trauma-related symptoms than their administrative support staff, but that this relationship was mediated by the number of hours worked weekly and the number of clients dealt with. This model explained a modest 14% of PTSD symptom variance. It was also significant for secondary traumatic stress symptoms. Leclerc et al. (2019) reported that 9% of lawyers had PTSD symptoms that met or exceeded the DSM-5 diagnostic criteria for PTSD. Furthermore, they reported that lawyers moderately exposed to traumatic material (1%–50% of their caseload) had significantly higher levels of PTSD symptoms than those unexposed (0%) to traumatic material. Lawyers highly exposed to traumatic material (51%–100% of their caseload) also had higher levels of PTSD symptoms than those moderately exposed and unexposed to traumatic material. Levin et al. (2012) found lawyers to have significant levels of symptoms over time, with 15% at baseline and 9% at follow-up who screened positive for probable PTSD.

Risk Factors for PTSD Symptoms

The risk factors associated with PTSD symptoms in the reviewed studies were inconsistent. A higher caseload involving traumatic material or working with more trauma-related clients were related to higher symptom severity by Levin and Greisberg (2003), Goldman (2006), Levin et al. (2011), and Leclerc et al. (2019), but not by Sokol (2014). A history of prior trauma exposure in the personal life of the lawyers was also associated with the development of PTSD symptoms by Goldman (2006), Vrklevski and Franklin (2008), Maguire and Byrne (2017), and Leclerc et al. (2019), but not by Piwowarczyk et al. (2009) reported no association. Longer hours worked weekly was identified as influencing the increase of PTSD symptoms by Goldman (2006), Piwowarczyk et al. (2009), Levin et al. (2011), and Leclerc et al. (2019). While Piwowarczyk et al. (2009) and Levin et al. (2012) reported no association between years of experience and symptom severity, Goldman (2006) reported statistically significant results. Indeed, Goldman (2006) found that fewer years of work experience as a lawyer was related to an increase in symptom severity, but that more years of experience was specifically related to higher hyperarousal symptoms. Goldman (2006) was the only one to report younger age as a factor associated with symptom severity. Levin et al. (2012) reported such association with age. Female gender was associated with more symptoms by Levin and Greisberg (2003) and Leclerc et al. (2019), but Goldman (2006), Piwowarczyk et al. (2009), Levin et al. (2012), and Maguire and Byrne (2017) reported no such results. Levin and Greisberg (2003) found that prior treatment for mental health issues was associated with greater...
symptom severity. Furthermore, the profession of lawyers was considered a risk factor for PTSD symptoms by Maguire and Byrne (2017). Sokol (2014) reported that time since the first and the last exposure to a case involving traumatic material was a risk factor. Piwowarzycy et al. (2009) and Levin et al. (2012) reported no association between symptom severity and firm size.

Levin et al. (2012) computed cross-lagged panel correlation path models using structural equation modeling to investigate the relationship between the levels of PTSD symptoms at follow-up and exposure to traumatic material and hours worked weekly at baseline. The study revealed a significant positive relationship over time between PTSD symptoms and the lawyer’s quantity of work, including exposure to traumatized clients. Interestingly, the number of hours worked weekly at baseline was related to the levels of exposure and PTSD symptoms at follow-up through its association with the level of exposure at baseline. Levin et al. (2012) suggested that exposure to traumatic material may be a vulnerability factor for the development of PTSD symptoms in lawyers.

Discussion

The present review of the scientific literature exposed the confusion surrounding the conceptualization of trauma among lawyers. Researchers have either conceptualized lawyers’ trauma symptomatology as secondary traumatic stress, vicarious trauma, or the DSM-IV or DSM-5 PTSD. In both the case of secondary traumatic stress and vicarious trauma, the criteria for diagnosis were not clear and rigorous. While these syndromes were meant to depict differing consequences of work-related trauma, they were used interchangeably and considered as reflecting the same syndrome (Baird & Kracen, 2006). However, the trauma-related symptoms covered by these conceptualizations differ. Three clusters of symptoms are involved in secondary traumatic stress (intrusive memories, avoidance, and hyperarousal), while PTSD involves four types of symptoms, the fourth being cognitive disruptions, and vicarious trauma specifically reflects emotional distress and cognitive alterations associated with trauma exposure at work. Adopting the conceptualization of PTSD is more rigorous as it involves meeting a number of diagnostic criteria, while the conceptualizations of secondary traumatic stress or vicarious trauma simply involve meeting a scale threshold to be considered as having severe symptoms. Overall, secondary traumatic stress seemed to still be the preferred conceptualization in a majority of studies investigating lawyers (Goldman, 2006; Levin & Greisberg, 2003; Piwowarzycy et al., 2009; Sokol, 2014).

Severity levels of work-related trauma exposure among lawyers were operationalized in various ways, such as the number of trauma-related legal clients that were associated with trauma-laden material, the type of law practiced, or the percentage of cases involving traumatic material. All studies recruited convenience samples and only one recruited a control group of lawyers not exposed to cases involving traumatic material (Leclerc et al., 2019). The majority of the studies retained in this scoping review employed a cross-sectional design and all relied solely on self-report measures.

Overall, intrusive, avoidance, and hyperarousal symptoms were generally low when considering lawyers as a group, while cognitive symptoms were on average moderately severe. Mean intrusion levels ranged between .31 and .76 on the IES-R, mean avoidance levels ranged between .34 and .76 on the IES-R, and mean hyperarousal levels ranged between .18 and .61 on the IES-R when considering lawyers as a group (Goldman, 2006; Levin et al., 2012; Levin et al., 2011; Vrklevski & Franklin, 2008). These results are below the proposed clinical cut-off of 1.5 on the IES-R (Levin et al., 2011). Mean cognitive symptom scores ranged between 39.86 and 41.50 on the Vicarious Trauma Scale (i.e., moderate score; Maguire & Byrne, 2017; Vrklevski & Franklin, 2008) and between 47.91 and 54.32 on the Trauma and Attachment Belief Scale (i.e., average score; Goldman, 2006; Vrklevski & Franklin, 2008) when considering lawyers as a group. The proportions of lawyers reporting high or severe secondary traumatic stress in the past week or month varied between 15% and 34%, while the past week or month PTSD prevalence rate varied between 9% and 15%. Although as a group lawyers tended to report low levels of PTSD symptoms, subgroups of lawyers exposed to traumatic material developed moderate to high levels of symptoms. Therefore, lawyers who deal with trauma-related cases are at risk to develop PTSD symptoms, but results are not consistent as to whether lawyers have higher levels of symptoms than control groups. The risk factors identified across the studies included work-related trauma exposure levels, longer hours worked, female gender, and past traumatic events experienced in the personal life. The inconsistencies across the studies regarding symptom severity, prevalence rates, and risk factors could be due to heterogeneous conceptualizations of trauma, divergent operationalizations of work-related trauma exposure, various study designs, and differing populations of lawyers recruited (e.g., law guardians, criminal lawyers, etc.). Consequently, the results might be over or under-representations of the true prevalence rates and they are not generalizable.

Implications

Research implications. Although imperfect, the studies reviewed above suggest that a sizable proportion of lawyers practicing certain types of law report significant levels of PTSD symptoms, and that more investigations under improved methodological conditions are warranted to further investigate this problem. Ideally, future studies investigating PTSD symptoms among lawyers would use epidemiologic analyses to reveal the adequate levels of PTSD symptoms and risk factors associated with it. Epidemiologic analyses entail that researchers employ probability sampling methods to decrease recruitment biases. Using
studies should investigate productivity at work and how PTSD symptoms impact lawyers' capacities to work. Future work duties, it would be important to better understand how lawyers are not necessarily exposed to traumatic material. Cases. In addition, within a law practice, such as criminal law, traumatic material could spend less than 50 hr working on these cases, while a lawyer dealing with 10 cases involving traumatic material could spend more than 70 hr working with traumatic material from this case, while a lawyer dealing with 10 cases involving traumatic material could spend more than 70 hr working on these cases. In addition, within a law practice, such as criminal law, lawyers are not necessarily exposed to traumatic material.

The use of diverse conceptualizations of work-related trauma exposure might explain the inconsistent findings reported in the reviewed studies. Consensus regarding this conceptualization is needed to produce conclusions that are comparable over time. We recommend future studies to assess for PTSD based on the DSM-5 criteria instead of secondary traumatic stress or vicarious trauma to generate up-to-date results. Secondary traumatic stress and vicarious trauma are non-DSM syndromes without standardized criteria that were employed before the DSM-5. Researchers should use longitudinal designs and assess the variations of severity in PTSD symptoms over time (incidence, remission, and persistence of symptoms).

Researchers should assess trauma exposure levels based on the time spent working with traumatic material instead of the number of clients worked with or the percentage of legal cases dealt with that involve traumatic material. It is important to keep in mind that lawyers do not spend an equal amount of time on all cases and that not all lawyers work the same number of hours weekly (some can work less than 35 hr per week, while others can work more than 70 hr per week). Therefore, a lawyer working on one specific case can spend 50 hr per week working with traumatic material from this case, while a lawyer dealing with 10 cases involving traumatic material could spend less than 50 hr working on these cases. In addition, within a law practice, such as criminal law, lawyers are not necessarily exposed to traumatic material.

Since lawyers cannot avoid traumatic material during their work duties, it would be important to better understand how PTSD symptoms impact lawyers' capacities to work. Future studies should investigate productivity at work and how PTSD symptoms affect lawyers behaviorally and cognitively. There is a need to understand if and what kind of avoidance symptoms lawyers develop toward the traumatic material, how those symptoms manifest themselves at the job, and how they impact the quality of the services they dispense. Lonergan et al. (2016) conducted a review of the literature on trauma-related symptoms in jurors and concluded that "graphic evidence," "trial complexity," and "deliberations" were factors regularly associated with PTSD symptoms. There is a need to understand how various types of trauma exposure impact symptom levels among lawyers. Future studies should also seek to determine the economic impact associated with the presence of PTSD symptoms among lawyers (e.g., costs associated with loss of productivity at work, turnover rates, health care services used, etc.). Such results might "speak" louder to law firms and associations, encouraging the implementation of preventive and intervention measures for PTSD among lawyers at risk.

Clinical implications. The present scoping review findings suggest that lawyers are at risk of developing PTSD symptoms due to their exposure to traumatic material, although only a portion of them developed clinically significant symptoms (as is always the case in the field of PTSD). Psychologists, physicians, and other mental health professionals should be aware of these results to adequately assess lawyers consulting them for possible posttraumatic stress symptoms. PTSD is often misdiagnosed for depression or “burnout” due to symptom overlap and stigma (Brady et al., 2000). Levin and Greisberg (2003) and Maguire and Byrne (2017) identified two aspects on which lawyers differ from mental health professionals and that may contribute to the development of PTSD symptoms: (a) lawyers are not specifically trained to handle clients who were involved in a traumatic event or to handle the effects of this exposure and (b) they do not have access to a space to vent their feelings and to turn to peer support. The few studies conducted so far have encouraged law professionals and academics to raise awareness regarding this issue. Still, the largest body of literature directed at lawyers is meant to understand PTSD when clients developed it and how to use it in court. This illustrates how PTSD among clients of lawyers is prevalent and how the law objectifies PTSD. Moreover, it is not possible to know if concerned lawyers consult the documents raising awareness on PTSD symptoms in their profession. Law Schools could benefit from implementing a course on this issue in their curriculum. Such a course has the potential to make lawyers better aware of the symptoms, which could reduce stigma and encourage them to consult with mental health professionals. Although more research is necessary to deepen our understanding of this question, lawyers should have access to literature and treatments tailored to their needs.

Limitations

Studies investigating PTSD symptoms among lawyers published in a language other than English were not included in
this scoping review. Furthermore, some studies might not have been included as “lawyer” is a heteronymous title across countries. Our search included the titles “Lawyer*” and “Attorney*,” but more studies might have been published under other legal professional titles. The principal limitation of this scoping review was the small number of studies that could be included and analyzed. This scoping review was further limited due to the lack of quality of these few studies’ methodology (e.g., none except one employed a longitudinal design, all samples recruited were not representative). The comparison of the results of the retained studies was also limited in the present scoping review because of the conceptual confusion surrounding trauma symptomatology, the different operationalizations of work-related trauma exposure, the varied methodologies, and the samples used. Data pooling of the reviewed studies was not possible due to the small amount (or even lack) of statistical results reported in certain studies (Levin & Greisberg, 2003; Piwowarczyk et al., 2009).

Appendix

Search Strategy Employed on MEDLINE.

| #   | Searches                                                                 | Results |
|-----|--------------------------------------------------------------------------|---------|
| 1   | Secondary traum*.mp. [mp=ti, ab, hw, kw]                                  | 2,518   |
| 2   | Vicarious traum*.mp. [mp=ti, ab, hw, kw]                                  | 1,264   |
| 3   | Compassion fatigue.mp. [mp=ti, ab, hw, kw]                               | 2,664   |
| 4   | Posttraumatic stress.mp. [mp=ti, ab, hw, kw]                             | 111,770 |
| 5   | Posttraumatic stress disorder.mp. [mp=ti, ab, hw, kw]                    | 107,205 |
| 6   | PTSD.mp. [mp=ti, ab, hw, kw]                                             | 84,402  |
| 7   | Attorney*.mp. [mp=ti, ab, hw, kw]                                        | 10,412  |
| 8   | Lawyer*.mp. [mp=ti, ab, hw, kw]                                          | 11,437  |
| 9   | 1 or 2 or 3 or 4 or 5 or 6                                               | 131,632 |
| 10  | 7 or 8                                                                    | 19,645  |
| 11  | 9 and 10                                                                  | 186     |

Acknowledgments

We would like to extend our appreciation to our colleagues, Ram Sapkota, Michelle Lonergan, Samantha Maltezos, Sereena Pigeon, and Emmanuelle Brien-Robidoux for their feedback on this manuscript.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Marie-Jeanne Léonard  https://orcid.org/0000-0003-0755-5431

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).

Arksey, H., & O’Malley, L. (2005). Scoping studies: Towards a methodological framework. International Journal of Social Research Methodology, 8(1), 19–32. https://doi.org/10.1080/136455703200019616

Asmundson, G. J. G., & Stapleton, J. A. (2008). Associations between dimensions of anxiety sensitivity and PTSD symptom clusters in active-duty police officers. Cognitive Behaviour Therapy, 37(2), 66–75. https://doi.org/10.1080/16506070801969005

Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. Counselling Psychology Quarterly, 19(2), 181–188. https://doi.org/10.1080/09515070600811899

Brady, K. T., Killeen, T. K., Brewerton, T., & Lucerini, S. (2000). Comorbidity of psychiatric disorders and posttraumatic stress disorder. Journal of Clinical Psychiatry, 61(7), 22–32.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. Social Work, 52(1), 63–70.

Carleton, R. N., Afifi, T. O., Turner, S., Taillieu, T., Duranceau, S., LeBouthillier, D. M., & Asmundson, G. J. G. (2018). Mental disorder symptoms among public safety personnel in Canada. Canadian Journal of Psychiatry, 63(1), 54–64. https://doi.org/10.1177/0706743717723825

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

Goldman, S. (2006). Secondary traumatization in law guardians representing traumatized youth. Dissertation Abstracts International: Section B: Sciences and Engineering, 66(11-B), 6271.

Jaffe, P. G., Crooks, C. V., Dunford-Jackson, B. L., & Town, M. (2003). Vicarious trauma in judges: The personal challenge of dispensing justice. Juvenile and Family Court Journal, 54(1), 1–9.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. Journal of Traumatic Stress, 15(5), 423–432.

Krill, P. R., Johnson, R., & Albert, L. (2016). The prevalence of substance use and other mental health concerns among American attorneys. Journal of Addiction Medicine, 10(1), 46–52.

Leclerc, M.-E., Wemmers, J.-A., & Brunet, A. (2019). The unseen cost of justice: Post-traumatic stress symptoms in Canadian lawyers. Psychology, Crime and Law, 26, 1–21. https://doi.org/10.1080/1068316X.2019.1611830

Levin, A. P., Albert, L., Besser, A., Smith, D., Zelenski, A., Rosenkranz, S., & Neria, Y. (2011). Secondary traumatic stress in attorneys and their administrative support staff working with trauma-exposed clients. Journal of Nervous and Mental Disease, 199(12), 946–955. https://doi.org/10.1097/NMD.0b013e3182392c26

Levin, A. P., Besser, A., Albert, L., Smith, D., & Neria, Y. (2012). The effect of attorneys’ work with trauma-exposed clients on PTSD symptoms, depression, and functional impairment: A cross-lagged longitudinal study. Law and Human Behaviour, 36(6), 538–547. https://doi.org/10.1037/h0093993
Levin, A. P., & Greisberg, S. (2003). Vicarious trauma in attorneys. *Pace Law Review, 24*(1), 245–257.

Lonergan, M., Leclerc, M.-E., Descamps, M., Pigeon, S., & Brunet, A. (2016). Prevalence and severity of trauma- and stressor-related symptoms among jurors: A review. *Journal of Criminal Justice, 47*, 51–61. https://doi.org/10.1016/j.jcrimjus.2016.07.003

Maguire, G., & Byrne, M. K. (2017). The law is not as blind as it seems: Relative rates of vicarious trauma among lawyers and mental health professionals. *Psychiatry, Psychology and Law, 24*(2), 233–243. https://doi.org/10.1080/13218719.2016.1220037

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

Piwowarczyk, L., Ignatius, S., Crosby, S., Grodin, M., Heeren, T., & Sharma, A. (2009). Secondary trauma in asylum lawyer. *Bender’s Immigration Bulletin, 14*(5). https://immigrantjustice.org/sites/immigrantjustice.org/files/Secondary%20Trauma%20in%20Asylum%20Lawyers.pdf

Pyevich, C. M., Newman, E., & Daleiden, E. (2003). The relationship among cognitive schemas, job-related traumatic exposure, and posttraumatic stress disorder in journalists. *Journal of Traumatic Stress, 16*(4), 325–328. https://doi.org/10.1023/A:1024405716529

Sayers, A. (2007). Tips and tricks in performing a systematic review. *British Journal of General Practice, 57*(542), 759.

Sokol, N. L. (2014). *Dirty work: The effects of viewing disturbing media on military attorneys* (Master’s thesis). Minnesota State University.

Statistics Canada. (2017, October 23). Probability sampling. https://www150.statcan.gc.ca/n1/edu/power-pouvoir/ch13/prob/5214899-eng.htm

Vrklevski, L. P., & Franklin, J. (2008). Vicarious trauma: The impact on solicitors of exposure to traumatic material. *Traumatology, 14*(1), 106–118. https://doi.org/10.1177/1534765607309961