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BURNOUT IN THE FIELD OF FORENSIC PSYCHOLOGY AND INTERVENTION TECHNIQUES

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CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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has been approved by the
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Abstract

Forensic psychologists are at a heightened risk for encountering vicarious trauma, compassion fatigue, and burnout, all of which influence quality and continuity of care (Sansbury et al., 2015). The current literature review aims to discuss how burnout relates specifically to the field of forensic psychology. For the purposes of this discussion, clinical psychologists who perform forensic duties, as well as board certified forensic psychologists are considered. Research questions that are addressed in this discussion include what the existing research states regarding vicarious trauma in forensic settings, likely gender differences in burnout and vicarious trauma, and documented interventions that appear most useful in addressing burnout in forensic psychology. How burnout is influenced by vicarious traumatization and compassion fatigue are discussed, in addition to how vicarious resiliency may aid in diminishing he effects of burnout. The term vicarious is utilized throughout this literature review as a differentiation for trauma or resiliency that is experienced via the client's shared experiences, rather than a personal experience. A proposed burnout group specific for forensic psychologists is offered as well.

BURNOUT AMONG THE FIELD OF FORENSIC PSYCHOLOGY AND INTERVENTION TECHNIQUES

DEDICATION

First, I would like to thank my committee members, Dr. Bates, and Dr. Brown. Your guidance and support throughout my academic journey have been invaluable. Dr Bates and Dr Brown, you both had an instrumental role in the professional I am today. The path to get here has been long and not always easy, but your unwavering support and guidance encouraged me to push forward.

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We made it!!

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CHAPTER I: INTRODUCTION

It is estimated that close to one-fifth of emergency management, law enforcement, and criminal justice personnel will develop or are at a high risk of developing occupational stress or burnout (Kelty & Gordon, 2015). Forensic psychologists are at a heightened risk for encountering vicarious trauma, compassion fatigue, and burnout, all of which influence quality and continuity of care. Forensic psychologists are continually exposed to perpetrators, traumatic experiences, high-risk clients, and organizational demands that differ greatly from clinicians practicing general clinical psychology (Sansbury et al., 2015). Furthermore, female forensic psychologists are regarded as having specified risk factors due to de-feminization and factors impacting empathizing with perpetrators. Currently, additional risk factors in the field of forensic psychology include the variations in COVID-19 precautions in state or county jails or prisons, which directly impacts the clinician's safety and well-being and potentially negatively influences the clinician's cognitive and emotional resources, leaving them less resilient to burnout.

Definition of Burnout

Burnout has been conceptualized as a construct comprised of three dimensions: emotional exhaustion, "defined as the emotional manifestation of chronic fatigue or stress" (Gallavan & Newman, 2013, p. 1).; depersonalization, which refers to "callousness or lack of concern regarding clients or patients" (Gallavan & Newman, 2013, p. 1).; and a decrease in the perception of personal accomplishment, which is generally defined as the "perception of enthusiasm and effectiveness that comes from working with people" (Gallavan & Newman, 2013,p. 1). Professional burnout as a syndrome is described as a process of gradual loss of emotional, cognitive, and physical energy, which is manifested in the symptoms of mental exhaustion, emotional exhaustion, personal detachment, and reduction of satisfaction by

professional activities (Kulakova, 2015). Burnout is a gradual and progressive process that occurs when work-related stress results in emotional exhaustion (Gallavan & Newman, 2013). Emotional exhaustion is related to the clinicians' ability to separate themselves from their client's experiences and an ability to depersonalize client experiences (Gallavan & Newman, 2013). Emotional exhaustion may also occur when the professional's sense of achievement decreases, likely occurring more frequently when the complexity of the professional's case load increases with little balance (Gallavan & Newman, 2013). Some experts have described burnout as a change in the part of the individual's personality, which may deprive the expert from being fully realized in the profession, thus contributing to negative trends within the workday, which gradually become an integral part of the self (Kulakova, 2015). Kulakova (2015) described negative trends within the workday as acts that cause the clinician to cut corners within their administrative work or time with their clients. Additionally, Kulakova explains that the personality as a construct is known to have many pieces or fragments that make it complex. Given the impact burnout may have on certain aspects of a professional's personality, burnout has the capability of altering these fragments and essentially depriving the professional of fully integrating into their chosen profession. The expert likely becomes complacent and engages in work related activities that may be viewed as negative, which the professional may have not engaged in if not experiencing burnout. An example of such behavior would be engaging in a pattern of delayed documentation following sessions or neglecting certain details of a clinical interview (Kulakova, 2015).

Burnout experienced within helping professionals has undergone various reformations of its definition. Previously, helping professional burnout was considered an exclusive reaction on the part of the caregiver to seeing challenging, struggling, suffering patients day after day

(Eckleburg-Hunt et al., 2018). However, relevant, and current research suggests that helping professional burnout is also highly correlated to excessive technology and clerical work associated with patient care (Eckleberry-Hunt et al., 2018). In a related study, Linzer et al. (2017) examined the relationship between patient care and workplace demands placed on the physicians to examine the relationship between workplace stress and implementation of organizational resources. The study utilized 34 primary care clinics in New York City. The physicians were randomly assigned to either the control or treatment group. The treatment group received quality improvement projects to improve communication and documentation, as well as workflow designs and case management assistance for chronic patients, strategies which have been found useful for strategies in institutional settings. The control group did not receive the resources as the treatment group did. A multilevel regression analysis was utilized to assess the impact of work changes on outcomes at 6 and 12 months. The multilevel regression was utilized to assess the impact of work condition changes on outcomes (Linzer et al., 2017). Results indicated overall improvement in the treatment group compared to the control group when institutional strategies were implemented. A conceptual model evidenced a "trend toward reduced error rate in providers with lower burnout" (Linzer et al., 2017). Limitations of this study included a short timeframe and few participants. However, the outcomes of this study evidenced generalizability and a platform of which to expand the definition of burnout.

Definition of Vicarious Trauma

Vicarious trauma (VT) is related to the phenomenon generally associated with the "cost of caring" for others (Figley, 1982). Pearlman and Saakvitne defined it as "the profound shift in world view that occurs in helping professionals when they work with individuals who have experienced trauma: helpers notice that their fundamental beliefs about the world are altered and

possibly damaged by being repeatedly exposed to traumatic material" (Pearlman & Saakvitne, 1995, p. 3). Although VT differs in acuity and onset from burnout, VT contributes to burnout by limiting the professional's emotional resources, making it difficult to cope with work and daily life demands (Pearlman & Saakvitne, 1995). Limited emotional resources may lead to emotional exhaustion, which impacts the professional in a multifaceted manner. The trauma-related stress response of emotional exhaustion is "globally affiliated with prolonged strain at work, not simply contact with clients who have experienced trauma" (Sansbury et al., 2015, p. 7). Burnout can emerge after extreme cases of either vicarious traumatization or compassion fatigue, which is related to gradual and steady exposure to trauma related symptoms via the client which drains the clinician's emotional resources (Sansbury et al., 2015).

Contributing Factors to Burnout and Vicarious Trauma in Clinical Psychology

Psychologists are subject to emotional demands that increase the risk of burnout (Simpson et al., 2019). Psychologists are continually exposed vicariously to content related to traumas, losses, deaths, injuries, physical abuse, emotional abuse, and sexual abuse that clients disclose. Secondary exposure to trauma often results in professionals experiencing symptoms of trauma exposure themselves, which refers to vicarious traumatization (Culver et al., 2011). Factors such repeated exposure to traumatic details of events and the need for the clinician to manage their own emotional responses have been recognized in the literature as emotionally taxing (Culver et al., 2011) and can disrupt work continuity and quality if not recognized and efficiently managed (Culver et al., 2011).

Burnout arises from organizational and personal factors in conjunction with maintaining client standards and ethically navigating client care. Greater organizational demands, such as extensive electronic documentation, less autonomy in treatment protocols, and additional policies

and procedures are placed on psychologists working in community settings, hospitals, state facilities, and government facilities, making it difficult for psychologists to maintain a balance of workload due to higher client volume and case acuity, as opposed to a private practice setting. (Simpson et al., 2019). Additionally, psychologists' personal beliefs, biases, or traditional coping strategies often clash with expectations and demands placed on them by either their organization or ethical standards (Robinson-Wood, 2017). Psychology is considered a fluid, dynamic, and highly regulated entity regarding requirements for ethics, curriculum, practice hours, accreditation, and licensure (Robinson-Wood, 2017). The elements of accountability and self-introspection are highly regarded in order to maintain ethical and moral standards. In the field of psychology, continual self-assessment is necessary, which can be a drain on a professional's emotional and mental resources (Simpson et al., 2019). Psychologists are expected to be accountable and transparent during the process of internal/personal as well as external/organizational reviews. The process of proper reviewing requires the psychologist to introspect and observe their own personal attributes, which may be difficult while encountering burnout (Robinson-Wood, 2017).

Furthermore, clinical psychologists are expected to have unrelenting standards and self-sacrifice for their clients' greater good (Kaeding et al., 2017). Often, psychologists must maintain empathy for clients regardless of their presenting problem, which may sometimes include behaviors, worldviews, or actions that may seem unjust or even immoral (Kaeding et al., 2017). Psychologists must sacrifice their own comfort at times to provide a space where a therapeutic alliance can be built, which is unique to the field of mental health. The therapist's ability to be empathically accurate is particularly important concerning clients' emotions because being correctly attuned to changes in clients' fluctuating emotions underlies many therapeutic

interventions (Kaeding et al., 2017). Awareness and empathetic understanding of the client's current and past affective experiences may be emotionally taxing when faced with strong or misplaced affective stimuli from the client (Atzil-Slonim et al., 2019). Psychologists are uniquely trained to explore, identify, and address their own personal biases and worldview to empathically connect with clients while maintaining a therapeutic awareness of their emotional responses to the client's presentation. Acquired skills such as these are referred to as countertransference (Atzil-Slonim et al., 2019). According to Abargil and Tishby (2021) the changing emotions of the clinician may reflect the patient's diagnosis and can be used to better understand the patients' inner worlds and core themes of interpersonal conflict and tendencies (Abargil & Tishby, 2021). Providing an equilibrium of emotions in a therapeutic setting can contribute to burnout by decreasing the clinician's "sense of self-assertiveness and integrity to their views if not mitigated by self-care and proper training" (Abargil & Tishby, 2021, p. 4).

Burnout Specific to Other Forensic Occupations

Correctional facilities' employees are potentially exposed to a greater number of on-the-job risk factors because they house a population against their will with the mission of contributing to public safety by "actively encouraging and assisting offenders to become law-abiding citizens while exercising reasonable, safe, secure, and human control" (Finney et al., 2013, p. 6). Job risk factors are considered a concern for their personal physical safety as well as promoting feelings of exhaustion, cynicism, detachment, ineffectiveness, and lack of personal accomplishment (Finney et al., 2013). In 2015, 20% of police officers reported heightened work stress compared to a normative population (Kelty & Gordon, 2015). On average, correctional officers were discovered to experience moderately higher levels of burnout and distress when compared to law enforcement officers not working within the prison setting (Xanthakis, 2009).

Although police officers have a heightened safety risk due to being front-line first responders, forensic interviewers within a correctional facility are exposed to emotionally disturbing details and circumstances similar to those of professionals working in the mental health field. Within a correctional facility, specified as a state prison or county jail, moderate levels of burnout and mild levels of secondary trauma among forensic interviewers have been discovered compared to other personnel such as correctional nurses or guards who did not evidence a steady increase in burnout related symptoms (Perron & Hiltz, 2006).

How Demands and Environment Could Contribute to Burnout in Forensic Psychology

Because deinstitutionalization policies of the 1950s required the closure of state mental institutions and the release of mentally ill individuals, there are now more individuals with mental illness in jails or prisons than in the remaining state mental hospitals (Fagan & Augustin, 2011. In fact, prisons are now called the "New Asylums" (Fagan & Augustin, 2011) based on the number of mentally ill inmates within their walls, and correctional mental health professionals are charged with attending to the psychological needs of those and other inmates. In addition to deinstitutionalization, other social policy initiatives, such as the "War on Drugs" and the "get tough on crime" mentality have led to an increase of the number of prisoners in the United States (Fagan & Augustin, 2011). As a result, the workload for correctional professionals has increased (Gallavan & Newman, 2013).

The field of clinical psychology has stringent ethics codes that must be held with the utmost regard to ensure client safety and confidentiality. The ethical decisions faced by forensic psychologists differ from the dilemmas typically experienced in general clinical psychology, and forensic psychologists likely have additional ethical dilemmas and demands placed on them (Allan, 2013). Forensic psychologists' assessments and tasks often challenge what is ethical and

what is not (Allan, 2013). For example, correctional and forensic psychologists provide services to people whose legal rights are restricted, which places forensic psychologists in a unique situation given that the APA code of conduct ensures psychologist maintain the human rights and dignity of others (Allan, 2013). Forensic psychologists often have their personal ethics and morals challenged. For example, forensic psychologists may be hired to perform death row evaluations, which can be a highly controversial sentencing (Day, 2014). Regardless of the psychologist's personal ideation and morality regarding the death row penalty, they must remain objective and perform their duties, which can become extremely emotional taxing. Maintaining objectivity can be difficult and requires emotional intelligence and insight, which wears on resources (Day, 2014).

The code of conduct for forensic psychologists differs from non-forensic psychologists in three main areas of consideration: integrity, knowledge of the legal system, and harm. Although the definition of integrity remains the same, applicability differs for Forensic Psychologist. In clinical psychology's ethical code, integrity is viewed as a key principle, while integrity for a forensic psychologist is largely formulated by the Board of Forensic Psychology as an 'advisement' on how to practice, leaving a larger than traditional grey area for clinical judgement (Allan, 2013). Secondly, clinical psychologists are expected to maintain awareness of state and local laws, while forensic psychologists are responsible to have a larger understanding of legal and professional standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients (EPPCC Standard 2.01; American Psychological Association, 2017). In terms of harm, both clinical and forensic psychologists are required to do no intentional harm to clients. However, the steps necessary to avoid harm to clients and to maintain confidentiality vary for forensic psychologists. For

example, a forensic psychologist may not be required to protect personal information of the defendant they are performing an evaluation on due to the nature of the evaluation, whereas the court would be the technical client (Allan, 2013). Additionally, ethical, and legal guidelines are often vague, leaving the forensic psychologist to utilize their clinical judgment without clear guidelines at times, which increases stress and anxiety, both of which are associated with burnout (Allan, 2013).

Documentation is extensive compared to other areas of psychology, including extensive record review typically consisting of arrest record review, witness statements, and medical records at times (Simpson et al., 2019). Forensic psychologists are also required to perform court ordered evaluations, which have more stringent guidelines for report writing format and are scrutinized more compared to general psychological assessment reports. It is known that excessive documentation is correlated with burnout for psychologists (Simpson et al., 2019). Forensic psychologists' caseloads frequently have limited variety, causing feelings of stagnation and complacency. In addition, psychologists who work in correctional settings or with forensic clients are often given less room for autonomy in the decision-making process of assessment and treatment modalities (Carrola et al., 2016). Systemic policy often provides less control or choice over theoretical orientation and treatment approaches, which may diminish the sense of independence in the job setting. Further treatment limitations may occur because of time limits with clients, a client's level of willingness to process their previous experiences due to distrust within the legal system, and difficulty implementing certain orientations that require emotional availability while the client is in a state of hypervigilance due to their environment or because of the client's innate aversion to affective processing (Carrola et al., 2016).

Forensic clients often have a secondary gain that motivates them to malinger or feign psychiatric or behavioral dysfunctions (Rupert & Morgan, 2005). Continually maintaining a skepticism of clients and their intentions has the potential to callous the psychologist and thus reduce motivation or job satisfaction within the work setting. Furthermore, clients in the forensic population often have not chosen to see a psychologist and may engage in negative client behaviors, such as disrespectfulness, aggression, and dismissing manners toward the clinician Last, forensic psychologists may work longer hours than other clinical psychologists, given the demand for testifying and more collection of collateral information during the assessment process (Rupert & Morgan, 2005).

Statement of Problem

Burnout has been researched extensively in numerous settings and fields, such as within general mental health professions, clinical psychology, and correctional settings (Rupert & Morgan, 2005). Research has indicated warning signs, symptoms, and answers to aid in alleviating the issue of burnout in the forensic workforce but has not specifically addressed how to do this for forensic psychologists (Rupert & Morgan, 2005).

In summary, the field of forensic psychology is a unique subset of clinical psychology as it requires extensive documentation, higher probability of exposure to vicarious trauma, a higher incidence of disregard for services by the client, and an increased threat from environmental dangers, such as COVID-19. In addition to limited research regarding what burnout looks like for the forensic psychology population, there are limited interventions to aid in alleviating burnout symptoms that are tailored to this unique entity of psychology.

Purpose of Clinical Research Project Literature Review

The purpose of this literature review is to bridge the gap between research examining general burnout in the field of mental health, burnout specific to forensic settings, and burnout specific to forensic psychologists. After the gap in research is examined and the high potential for burnout in this professional field is highlighted, ways to safeguard against burnout and vicarious trauma are discussed. Techniques that may be useful in preventing and processing burnout are reviewed and the differences between vicarious trauma and burnout are addressed. Potential gender differences in burnout and vicarious trauma for female forensic psychologists are also be examined. As such, assessment strategies for screening for burnout, combating burnout symptoms, and company/organizational strategies that may be implemented are reviewed. This review addressed the following research questions:

RQ1: What does the literature tell us about burnout and vicarious trauma in forensic settings, and how might that apply to forensic psychology?

RQ2: Are there likely gender differences in burnout and vicarious trauma in the field of forensic psychology?

RQ3: What interventions appear to be most useful in addressing burnout in forensic psychology?

Research Procedure

Various databases, such as Google Scholar, EBSCOhost, and American Psychological Association PsycArticles were utilized to locate peer-reviewed psychological and scientific journals and articles that address general burnout, burnout in clinical psychology, burnout when working with forensic and correctional clients, vicarious trauma, risk factors for forensic psychologists, and the gap in research. In addition, scholarly books and dissertations will be

utilized for foundational and background data and to link proposed research questions to existing peer-reviewed data.

CHAPTER II: BURNOUT IN FORENSIC PSYCHOLOGY RELATED TO VICARIOUS TRAUMA, FEMALE DIFFERENCES, AND TO COVID-19

Burnout Related to Vicarious Trauma

Empathy and Vicarious Experience

Vicarious trauma is a contributor to the field of forensic psychology as clinicians are exposed daily to risk factors for vicarious trauma, such as the expectation for empathy and a phenomenon specific to humans – vicarious experience. Vicarious trauma can contribute to rates of burnout as it diminishes emotional and mental resources, leaving the clinician vulnerable to work related fatigue, diminished self-care, and diminished personal fulfilment from work. Further contributing factors of vicarious trauma, such as specific gender vulnerabilities and heightened risk factors of COVID-19, are discussed in this chapter as well.

Empathy, the ability to vicariously experience and to understand the effect of other people, is fundamental for successful social-cognitive ability and behavior (Lockwood, 2016). Empathy is thought to be a critical facilitator of prosocial behavior and is regarded as a core component of a therapeutic experience (Lockwood, 2016). Prosocial behaviors are those that allow clinicians to feel for others and show empathy for what that specific person is experiencing (Wondra & Ellsworth, 2015). Although empathy does not mean clinicians know without a doubt exactly how another is feeling, it has arguably been deemed the single most important element to development of a therapeutic relationship as well as a fundamental component of psychological and forensic assessments. Empathy, feeling what others feel, is regarded as a special phenomenon separate from other emotional experiences. Current empathy theories focus on how clinicians feel emotions for others who feel the same thing, but not how they feel emotions for others who do not feel the same emotion or feel an expected emotion, such as feeling angry for

someone who is sad or feeling embarrassed for someone who is self-assured (Wondra & Ellsworth, 2015). Empathy theory is a particularly fascinating phenomenon due to how clinical psychologists are to feel empathy for all clients, despite the information or emotions presented to them. Empathy may be particularly challenging for forensic psychologists' who work with perpetrators of all crimes. For example, some perpetrators may present as sad, in which case the clinician must remain objective and not feel an alternate emotion, such as anger for the victim (Wondra & Ellsworth, 2015). According to Hoffman (2020), empathy is a moral development compromised of five mechanisms: mimicry, classical conditioning, direct association, mediated association, and role-taking.

Empathy through mimicry involves a two-stage process. First, the observer automatically imitates the target's emotional, facial, postural, or vocal expressions (Hoffman, 2020). Second, afferent feedback, which is feedback that occurs from an inward response, imitates the expression that causes the associated emotional state in the observer (Wondra & Ellsworth, 2015). Classical conditioning is learned through the psychologist's developmental years and relates to emotional cues, which alert the professional to affective experiences. After the clinician experiences a cue, the direct association takes place, in which the observer sees the target's emotional expression or situation. It reminds the observer of their own past emotional experiences. Then the observer feels the emotions that they felt during the original experiences (Wondra & Ellsworth, 2015). It is during this stage specifically mental health professionals, specifically forensic psychologists, must draw upon their training and resources to not revert to the conditioned response, as this may skew their objectivity, which leads to assuming what one is experiencing, rather than observing their own experience. During the mediated association process, observers learn about targets' emotional experiences through words. Then observers

imagine the target's emotional expressions and mimic them, remember their own past experiences, and feel the emotions from the memories or both. Mediated association is similar to mimicry or direct association, but the observer does not perceive the target's experience directly (Wondra & Ellsworth, 2015). Last, the observer begins role-taking, which occurs when observers either imagine themselves in the target's situation or imagine how the target feels. As with mediated association, observers might mimic imagined emotional expressions or might feel emotions by using their own emotional memories to imagine the target's situation. Nevertheless, role-taking is more effortful than mediated association. Role-taking involves active attempts to understand a target by bringing emotional memories or imagined emotional expressions (Wondra & Ellsworth, 2015).

The typical and unconscious empathetic experience described in detail is something humans experience in all capacities (Hoffman, 2020). However, this empathetic process differs slightly for psychologists as they are expected to empathize with the client's experience and not assume an emotion through their own direct association (Hoffman, 2020). Assumptions or associations to one's own experiences presumes a role of knowing what the client or patient is processing through, which hinders the therapeutic relationship and has the capability of skewing a psychological assessment (Lockwood, 2016). Unlike empathy or sympathy that people feel for one another, psychologists are expected to vicariously experience the patient's emotional or behavioral state to accurately interpret and empathize with their specific experience (Hoffman, 2020). Taking one's perspective and empathetically relating positively contributes to the therapeutic relationship and provides clinically significant information relevant to a diagnostic impression, professional opinion, or recommendations (Lockwood, 2016). Specifically, if a client, patient, or defendant presents with a non-typical affect or behavioral disposition for the

experience they are reporting, this discrepancy reflects clinically significant dysfunction, which may be attributed to an affective disorder, psychiatric disorder, personality dysfunction, or malingering (Lockwood, 2016). Although traditional empathy and vicarious experience are closely related, they differ in nuances of emotional and cognitive experiences (Lockwood, 2016).

According to Lockwood (2016) an important distinction within the structure of empathy is often made between emotional/affective and cognitive aspects. Affective empathy is commonly understood as an affective state (e.g., the experience of emotion, pain, or reward) caused by sharing the state of another person through observation or imagination of their experience. Although an observer's emotional state is comparable with that of another person, the observer is aware that someone else is the source of that state. In other words, the observer is aware that the emotion they are experiencing is a result of the client's or defendant's emotional state, and not their own. Cognitive aspects of empathy are commonly referred to as perspective-taking, mentalizing, or theory of mind. The cognitive aspects are conscious and can be developed through training. Combined, these processes enable an observer to understand another person's beliefs, desires, and emotions through a vicarious experience (Lockwood, 2016).

A vicarious experience or perspective-taking is a physiological reaction that is unique to humans, who have the ability of higher-order thinking (Singer et al., 2004). Numerous studies have explored the neural responses to vicarious experiences such as Singer et al. (2004) who conducted one of the most influential experiments in terms of how physiologically experience a vicarious experience. The examiners expressed particular interest in comparing pain-related brain activity in the context of "self" and "other." Examiners recruited 16 heterosexual couples to assess one's ability to feel pain for another. The female participant's brain activity using Functional Magnetic Resonance Imaging (fMRI) was assessed while a painful stimulation was

applied to her partner's right hand and the male's brain activity was assessed while painful stimulations were given to their partner's left hand. On a large screen situated behind the board, cues were presented in random order indicating whether the female participant or her partner would receive a no pain condition or high pain condition stimulation. Following the stimulation, questionnaires developed by the examiners were administered after fMRI scanning, which served to validate measurements of individual pain threshold made before the fMRI, to obtain subjective evidence for empathic experience during scanning, and to assess stable individual differences in empathy to determine whether individual scores would predict the amplitude of empathy-related brain activity. As expected, the painful stimuli elicited empathic involvement of the participants, while non-painful stimuli were regarded as significantly more pleasant. Singer et al. found that the anterior insula and anterior cingulate cortex responded both when the participants themselves received the painful stimulus and when they viewed a cue indicating that their partner received a painful stimulus. In contrast, response in the secondary somatosensory cortex and primary somatosensory cortex was associated with greater response to the pain participants received themselves, compared to pain received by their partners. These results indicate that while empathy can be a conscious process, empathy occurs at a physiological level first. For example, animal models have suggested there are central divisions between the anterior cingulate gyrus and anterior cingulate sulcus that may be crucial for understanding social behavior at a physiological level (Singer et al., 2004). These findings are especially important because they provide researchers with physiological evidence that empathizing with others is a biological process that cannot always be controlled. This information is also pertinent to a vicarious experience because it is the mechanism that allows clinicians to experience the emotions and

experiences of others as if they have personally been subjected to the experience (Lockwood, 2016).

For clinical psychologists, experiencing one's emotional distress and experiences on both an emotional and cognitive level requires a substantial number of cognitive resources, emotional resources, and the ability to self-introspect to maintain objectivity (Lockwood, 2016). Mental health professionals may experience robust empathy that can lead to emotional over involvement and a negative vicarious experience. For forensic psychologists or psychologists performing forensic evaluations, the number of resources and amount of self-awareness is heightened due to the nature of the clients, their attitudes, and their possible motivation for secondary gains. Furthermore, forensic psychologists are expected to maintain a level of empathetic understanding for all clients, regardless of their attitudes, actions, and/or crimes. Forensic psychological assessments often are performed for perpetrators of crimes that may be morally difficult to process or conceivably understand. Exploring the individual's past to discover possible mitigating factors that can be utilized to harvest empathy is likely emotionally tiresome, sometimes feeling merely unfeasible, and contributes to heightened rates of burnout (Lockwood, 2016).

A study conducted by Gallaven and Newman (2013) examined the relationship between burnout and empathy in correctional mental health professions. The examiners conceptualized burnout into three dimensions for the purpose of the study: emotional exhaustion; depersonalization, which they regarded as a diminished lack of concern for others; and a decrease in one's perception of their achievements. For the purpose of this study, self-selected correctional mental health providers included 45 men and 55 women from the Department of Corrections in Oklahoma, Arkansas, Alabama, Missouri, Wyoming, and Pennsylvania.

Demographic of the participants were not explicitly shared; however, researchers notated the mean of participants as 46-yars-old. Professionals who participated in this study were either mailed or emailed a packet containing the Maslach Burnout Inventory–Human Services Survey (MBI-HSS; Maslach & Jackson, 1981), the Professional Quality of Life survey (ProQOL; Stamm, 2010), the Life Orientation Test–Revised (LOT–R; Scheir & Carver, 1985), the Work–Family Conflict Scale (WFC; Netemeyer, 1996), and the Attitude Toward Prisoners Scale (ATP; Melvin et al., 1985). The practitioners were instructed to complete each self-report measure and return it to the examiners. The examiners scored and compared results utilizing the principal components analysis (PCA) and multiple regression analyses. Results and demographic variables collected at the onset of the study revealed a significant number of professionals who reported that they experience depressive symptoms, which would be a confounding variable regarding the effect of their work environment contributing to burnout. However, negative work experiences, separate from depressive symptoms, were a significant contributing factor to burnout *(r* = .62). Feelings associated with negative work experiences were described as less control over their work environment, lower optimism, and emotional exhaustion. Furthermore, higher optimism was found to have a negative relationship with burnout (*r* = .68). Although implications of this study are pertinent, limitations are present. The current study utilized a small sample size with different employment classifications, which is a limitation given that extraneous variables such as job position are less controlled for, and generalizability is minimal. Furthermore, administration was self-report, completed on site as well as remotely, which makes controlling for environmental factors difficult. Self-report instruments without validity scales also increase the potential for respondents to overreport or underreport experiences. However, findings such as these are important for correctional mental health staff due to the suggestion that implementation

of coping skills, seen in those who reported higher optimism, are likely integral for alleviating or combating burnout (Gallaven & Newman, 2013).

Research Related to Vicarious Trauma

Vicarious trauma differs from direct trauma, as direct trauma is one that a person is directly impacted by. Posttraumatic stress disorder (PTSD) is most diagnosed from direct trauma exposure. PTSD is classified as a trauma and stressor-related disorder in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) and has eight criteria that must be met to receive a diagnosis of PTSD. Each category for PTSD has several sub-criteria that help delineate a diagnosis. The following are the diagnostic categories for PTSD:

(a) exposure to actual or threatened death, serious injury, or sexual violence in one or more of the specific criteria; (b) presence of one (or more) of the following intrusion symptoms associated with traumatic event(s) occurring after the traumatic event has occurred; (c) persistence avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidence by one or both of the following subcriteria; (d) negative alterations in cognitions and mood associated with the traumatic event(s) beginning or worsening after the traumatic event(s) occurred, as evidence by two of more of the subcriteria; (e) marked alternation in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two or more of the subcriteria; (f) duration of the disturbance (criteria b, c, d, and e) is more than one month; (g) disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and (h) the disturbance is not attributable to the physiological effects of a substance or another medical condition. (p. 271)

It is rather apparent that the DMS-5 diagnostic criteria for post-traumatic stress is exclusive and does not include additional complexities seen in trauma, such as vicariousness.

Vicarious traumatization has been defined as the transformation that occurs within the therapist (or another trauma worker) due to empathic engagement with clients' traumatic experiences and the toll those experiences take (Sansbury et al., 2015). The transformation occurs when managing trauma among clients results in altered memory systems and cognitive schemas for the therapist. Memory systems are associated with the clinician's memory retention of specific scenarios, while cognitive schemas are associated with how the world and events that occur are perceived. Both concepts are associated with five need areas: "safety, dependency or trust, power, esteem, and intimacy" (Sansbury et al., 2015, p. 6). When these alterations occur, clinicians demonstrate increased awareness of how fragile life can be and can become suspicious or distrusting of others due to their perceptions of safety or trust being disrupted and/or altered. These experiences can prompt unexplainable and unwarranted changes in affect, such as anger or sadness, which can complicate how an individual interacts with colleagues and clients in the work environment, as well as impact interactions within their personal lives. The incidence and severity of clinician symptomology depends on the degree to which the clinician identifies and applies aspects of their own life and experiences to the experiences of their clients. However, more recent studies have broadened the concept of vicarious traumatization to include countertransference, empathy, and emotional turmoil (Sansbury et al., 2015). Related to countertransference, clinicians who fail to contain reactions to client emotion are susceptible to changes in their own belief systems, reduced awareness, and increased defensiveness. Related to empathy, the ability to connect with client suffering helps the clients and increases vicarious trauma if clinicians cannot "manage" the empathic process. Finally, emotional contagion

involves unconsciously reliving a client's trauma beyond simply attempting to understand it with empathy (Sansbury et al., 2015).

Professionals who routinely interface with trauma and violence, such as those working in corrections, the legal system, and mental health, can develop symptoms related to what is referred to as vicarious trauma, compassion fatigue, or burnout (Pirelli et al., 2020). However, compassion fatigue, which is similar to vicarious trauma, does not require exposure to a traumatic event or awareness of a traumatic event. Compassion fatigue "develops via the process of empathizing with clients' emotional pain and suffering without the presence of direct or indirect trauma exposure" (Pirelli et al., 2020, p. 1). Symptoms of compassion fatigue may develop either gradually or rapidly and can include the experience of intrusion symptoms, negative emotional arousal (e.g., experiencing higher levels of anger, hate, frustration), difficulty separating work and home life, lower levels of distress tolerance, emotional outbursts, decreased work satisfaction, negative self-soothing behaviors (e.g., drinking, social isolation), and decreased general functioning and productivity at work and home (Pirelli et al., 2020).

A study conducted by Meadors et al. (2010) aimed to examine the differences between secondary trauma, also known as vicarious trauma, and burnout, as well as the impact secondary trauma may have on the professional. Prior to beginning their research, they examined a study that evidenced nearly 7% of professionals who work with traumatized individuals exhibit emotional responses similar to those of a traumatic stress reaction (Thomas & Wilson, 2004). The examiners recruited pediatric nurses who worked on the pediatric intensive care unit (PICU), neonatal intensive care unit (NICU), and the pediatric floor (PEDS). Participant demographics were primarily women, which is considered a limitation of the study. Examiners assessed the likelihood the participants were in contact with traumatized individuals by frequency of trauma

patients being admitted to their floors and then administered the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004), The Professional Quality of Life Scale (ProQOL; Stamm, 2010), and the Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1996). A correlational design was chosen to represent the relationships between the constructs associated with secondary traumatization. In addition, a hierarchical linear regression analysis was chosen to provide insight on the predictive nature of secondary traumatic stress (STS), also referred to as vicarious trauma, and post-traumatic stress disorder (PTSD) variables with compassion fatigue. Pearson's correlation was used primarily to examine the relationship between secondary traumatic stress, compassion fatigue, and burnout by comparing the constructs of STS and PTSD with the results of the STSS, ProQOL, and JES-R. Results indicated burnout was correlated with compassion fatigue $r(142) = .56$, $p = .01$), while compassion fatigue was correlated with secondary trauma responses $r(142) = .72$, $p = .01$). Authors concluded that results suggest both constructs of secondary trauma responses and compassion fatigue have a positive relationship with burnout within helping professionals (Meadors et al., 2010) despite not presenting a clear statistical link between secondary trauma response and burnout.

Hatcher and Noakes (2010) examined the impact of working with sex offenders on treatment providers. Participants of this study were clinicians in Australia who were actively treating convicted sex offenders. The clinicians were asked to complete self-report questionnaires, such as a demographic questionnaire, The Professional Quality Life Scale (ProQOL; Stamm, 2010) and The Impact of Events Scale (IES; Weiss & Marmar, 1996). They were also asked to complete three qualitative questions, which included: "In what ways do you feel your work with sex offenders has impacted upon your life; What coping strategies do you use to deal with this impact; How do colleagues help you deal with the impact of your work with

sex offenders" (Hatcher and Noakes, 2010, p. 4). Descriptive statistics evidenced that this population was at a low risk for burnout and compassion fatigue. However, the treating providers who evidenced the lowest threat of compassion fatigue and burnout endorsed taking numerous mental health days, having control over their work environments and community, and having access to supervision and colleague support. Results suggest that although the clinicians who participated in this study endorsed being subjected to traumatic events and emotionally fatiguing details, organizational supports allowing proper self-care aided in their work fulfillment and potentially in the prevention of burnout and compassion fatigue (Hatcher and Noakes, 2010). The current study is pertinent to the field of forensic psychology as it highlights how compassion fatigue can be mitigated from developing or becoming severe (Hatcher &Noakes, 2010), which is important for clinicians who are regularly required to be emotionally present and objective with their clients.

Though evidence has found that risk for traumatization can be mitigated by supervision, clinicians who work with offenders and have limited opportunities for supervision have reported higher levels of distress and burnout than those who have supervision readily available (Ellerby, 1998). Research has focused on clinicians who work with victims of sexual abuse. However, those who work with perpetrators are also at risk for vicarious traumatization and/or compassion fatigue, which can result in changes in worldview, identity, issues surrounding safety and trust, and intrusive visual images and painful affect (Ellerby, 1998). Farrenkopf (1992) found that 25% of professionals who worked with sexual offenders reported high levels of stress, exhaustion, depression, and burnout. Furthermore, in his research, 33% of these professionals experienced symptoms of vicarious traumatization, including hypervigilance, suspiciousness, and fear for the safety of loved ones (Farrenkopf, 1992).

The mental health field is unique in that providers are tasked with regulating their own behavior and emotional well-being in the context of their professional competence. For example, as stated in the American Psychological Association's (2017) Ethical Principles of Psychologists and Code of Conduct, Standard 2.06:

Personal Problems and Conflicts: (a) psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from competently performing their work-related activities; (b) when psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties." Although the importance of practitioners recognizing and maintaining their own psychological health is vital, practitioners frequently fail to effectively intervene personally or professionally prior to the point at which impairment leads to deterioration in self-care, self-awareness, and professional accuracy. This issue is particularly relevant for forensic health providers and examiners for are frequently exposed to the possibility of vicarious traumatization. (p. 14)

Moreover, as Varela and Conroy (2012) outlined in their publication on forensic competencies, there are both general and specialized competencies relevant to those who engage in forensic mental health assessment (FMHA), intervention, consultation, research, supervision training, and management administration (Varela & Conroy, 2012). Forensic psychologists perform criminal, civil, and administrative evaluations, all of which have their own potentials for vicarious trauma or compassion fatigue due to their unique requirements (Pirelli et al., 2020). For criminal evaluations, forensic practitioners conduct a range of evaluations in various types of

criminal matters, such as those related to pretrial and sentencing risk/mitigation, criminal competencies, and mental health defenses (e.g., insanity, diminished capacity). According to Pirelli et al. (2020), it is not the type of evaluation that is likely to be the particularly bothersome aspect of the case, but rather the nature of the offense in question and the characteristics of the defendant and victim involved.

Civil evaluations are not commonly considered to be as disturbing compared to criminal evaluations. However, civil cases are, in fact, often associated with acts inflicting injuries on oneself or others (Pirelli et al., 2020, p. 8). For example, civil commitment matters, by definition, involve "those who have either engaged in violent or suicidal behavior or who at least pose an elevated risk to themselves, others, or property" (Pirelli et al., 2020). Nearly half of the states in the country also have sexually violent predator laws, which allow for the extended civil commitment of those who have committed particularly serious sex offenses and who pose a heightened recidivism risk. Forensic practitioners also conduct evaluations of violent crime victims in civil matters, such as assessing for the presence of psychological injuries in personal injury cases (Pirelli et al., 2020).

Lastly, administrative evaluations may not include violent or lewd behaviors, but still pertain to laws and fall under the umbrella of forensic psychology (Pirelli et al., 2020). The main distinction is that a lawsuit or formal legal complaint has yet to be filed on administrative cases. Although evaluations in these contexts may not technically meet the formal definition of FMHAs, they are forensic in nature in many respects. Examples include preemployment and fitness-for-duty evaluations in a range of employment contexts including law enforcement candidates and officers; mental health expungements; evaluations for gun permit applicants; and violence, sexual, and fire-setting risk assessments for youths, such as those needed for treatment

planning, residential placement, and suitability to return to school (Pirelli et al., 2020). Although the nature of these evaluations may not be considered a risk of vicarious traumatization or compassion fatigue, they have the potential to influence a provider who has a personal history similar to an evaluation they are conducting. Additionally, administrative evaluations more often include lengthy record reviews, lengthy reports, and stringent templates regarding how the report should be written for submission. As noted previously, excessive documentation is a contributing factor related to burnout (Pirelli et al., 2020).

Female Specific Factors Contributing to Burnout in Forensic Psychology

Female forensic psychologists face gender discrimination and sexism in the field (Shelley et al., 2011). This diminishes the respect for the position and makes delivering quality assessments difficult (Shelley et al., 2011). Female forensic psychologists are discriminately regarded as having less ability to objectively empathize with difficult clients due to heightened emotional states, which can be seen as a liability in a correctional setting. A vast majority of abuse and violence cases are against women, which can create countertransference and make it difficult to maintain objectivity when engaging in therapy with a client who has perpetrated and/or experienced these assaults (Shelley et al., 2011).

Furthermore, the way women dress in the workforce, interact with others, and carry themselves is important to consider when working with this population (Ermshar & Meier, 2014). How code-switching (i.e., how they carry and portray themselves in the workplace versus their true authentic personality and demeanor) influences them is potentially significant regarding burnout and work dissatisfaction (Ermshar & Meier, 2014). Gender stereotypes and biases impact how women are perceived in the field of forensic psychology (Lea et al., 1999). According to stereotypical gender scripts, women are expected to empathize with victims, who

are often children or women. However, a female clinician hired by the defense counsel representing an individual charged with a violent sexual offense may face stigmatization from the community, who may believe the clinician is supporting the alleged sexual offense, as opposed to aligning with the stereotyped gender script society has implemented (Lea et al., 1999).

Moreover, when cases pertain to child molestation, clinicians who work with or represent the alleged perpetrator can be perceived as unsympathetic to children who have been abused (Lea et al., 1999). Similarly, clinicians who advocate for treatment or emphasize the capacity for sex offenders to reintegrate into society with therapy and training may be perceived as endorsing sexual offending behaviors (Lea et al., 1999). This societal response can be difficult for women to manage, as the clinician's intent is to uphold the defendant's constitutional rights and present objective psychological data about the defendant (Ermshar & Meier, 2014). Stigmatization such as this needs to be processed in supervision, consultation, or personal therapy, as it is highly correlated with burnout. Furthermore, stigmatization, such as what is described above, is also identified in other areas of forensic psychology, such as family court. Research has discovered that women are not only preferred but retained for expert testimonies in family cases due to the stigmatization that they are nurturing and caring (Ermshar & Meier, 2014).

Unfortunately, female forensic psychologists need to be diligent regarding their appearance and how it may provoke or influence a client (Dean & Barrett, 2011). Both male and female psychologists, in all realms of psychology, are expected to, at the minimum, adhere to business causal or modest attire. However, for female forensic psychologists, heightened vigilance is required to the point of de-feminization. This high level of vigilance is due to the objectification of women, negative connotations associated with women among offenders, which

the prevalence of paraphilia among offenders that can be easily triggered by visual stimuli (Dean & Barrett, 2011). Female clinicians report needing to "de-feminize" themselves to avoid potential advances or inappropriate behaviors from offenders and to ensure that the focus remains on the clinical work. Thought is given to the type of shoes worn (i.e., no heels or open-toed shoes), perfume, jewelry, or any clothing that might remind the offender that the clinician herself is a sexual being (e.g., cleavage, displaying legs or toes). Since female clothing is often more form-fitting, it is common practice to purposely wear loose clothing to de-accentuate feminine traits (Dean & Barrett, 2011) and avoid attracting attention or focusing on a particular body part (Ermshar & Meier, 2014). Male attire is traditionally looser, making this a unique difficulty and caution for women. De-feminization is not only associate with levels of burnout due to the work environment but also due to self-concept in a professional setting as well as in personal life (Ermshar & Meier, 2014). If a female forensic psychologist is expected to de-feminize herself, that change can quickly become internalized as a flaw within her (Dean & Barrett, 2011). The ego then becomes fractured, and women can feel lost within themselves and their work, uninspired in all facets of life, less powerful and in control of themselves, and less confident in their work and general abilities. A decline in work continuity and happiness is likely the first area that would be impacted by losing one's sense of self. However, quickly to follow may be a broader loss of self-perception, influencing their relationships and relational roles in life, such as the role of a spouse and/or mother. Being stripped of femininity is a potentially debilitating and harmful expectation that is recommended to be processed and monitored by the clinician to ensure a balance is obtained and the self is not lost (Dean & Barrett, 2011).

Research indicates that compared to men, women interpret inappropriate behaviors by the clients as personal (Dean & Barrett, 2011). For example, if a client makes a sexual gesture or

comment toward a female clinician, the female clinician may think they did not maintain clinical boundaries diligently enough or may feel as though they were too friendly with the client (Dean & Barrett, 2011). This mindset can be detrimental to the sense of self, and female clinicians may become emotionally calloused as a means of self-protection, and thus less empathetic toward their clients (Ermshar & Meier, 2014). Women are encouraged to discuss inappropriate client behavior in supervision or consultation with other clinicians to avoid the potential for internalization of the client's actions. Discussing inappropriate client behaviors has been established as a crucial aspect of supervision (Ermshar & Meier, 2014).

A survey study conducted by Morgan and Porter (1999) examined the work-related experiences of female mental health trainees. A structured questionnaire was administered to 100 psychiatric trainees. Results indicated that 86% of the participants had experienced unwanted sexual contact while working. Researchers elaborated that 47% of the reported cases involved deliberate touching, cornering, or leaning over counters, while 18% of the participants endorsed receiving telephone calls, letters, or materials of a sexual nature. However, researchers in this study discovered that less than two-thirds of female clinicians actually discussed negative client behaviors with their supervisor due to the nature of the comments, gestures, or behaviors, which were often sexual or inappropriate in nature and elicited feelings or shame or embarrassment. Information such as this is pertinent to women within the field of forensic psychology as they are often exposed to inappropriate conduct. Women in forensic psychology should be encouraged to share these experiences as a means to protect themselves from burnout (Morgan & Porter, 1999). Other research has found that supervisees are hesitant to raise certain issues with their supervisors for fear that they will be deemed "irrelevant" or "unimportant" (Hartl et al., 2007). Ladany et al. (1996) suggested that female trainees fear they may be unsupported, "laughed off,"

or that they will jeopardize their training evaluation and/or future career if they bring up these concerns. Furthermore, trainees may worry that their supervisor will frame inappropriate behaviors as a lack of skill/competence or poor personal boundaries, rather than exploring the emotional impact the client's behavior had on the clinician (Ermshar & Meier, 2014).

Forensic psychologists are regularly exposed to deviant sexual behaviors through their client's history, which is often pertinent to the evaluation and needs to be assessed thoroughly in conjunction with the remainder of their psychosocial background (Ermshar & Meier, 2014). Clinicians working with sex offenders are expected to delve into the depths of the client's sexual history to better understand and treat deviant sexual behaviors, as well as to assess the possibility of future risk. In this role, the clinician is exposed to vivid images of the sexual offenses and/or sexually deviant fantasies and behaviors, which can impact the clinician's own psychological and sexual functioning (Ermshar & Meier, 2014). Offenders have been possibly charged with or committed illegal acts, including murder, rape, or child molestation, and it is a natural human response to experience some fear and/or distain while hearing these types of details of past actions, especially in a one-to-one therapeutic relationship or while gathering a detailed psychological history (Ermshar & Meier, 2014). Depending on the gruesomeness of the sexual content, exposure to deviant sexual content and inappropriate behavior can lead to changes in sexual intimacy in the clinician's personal life. Clinicians working with this population have reported avoiding sexual contact altogether and becoming distracted during sex and/or ending sexual contact prematurely within their own personal lives. This impact on sexual intimacy is often not addressed or acknowledged by clinicians in the field. However, supervisors should educate trainees on this potential influence on their sexual intimacy to empower them to seek resources to manage this sensitive topic (Ermshar & Meier, 2014).

Women who work with offenders face unique challenges regarding countertransference, especially when clients have committed sexual abuse or violence (Ermshar & Meier, 2014). Often, working with these populations increases the female clinician's awareness of the potential for victimization or trauma in her own life (Ermshar & Meier, 2014). Furthermore, female forensic psychologists must remain objective when evaluating sexual perpetrators against children, which may be particularly difficult and potentially unfeasible for those who have children of a similar age or for those who recently had a child or are pregnant (Ermshar & Meier, 2014).

Maintaining professional boundaries and competency is a way to abide burnout (Ermshar & Meier, 2014). For a female psychologist, declining a client or referring a client to a different provider due to her own countertransference helps maintain professional and personal boundaries. However, the stigma surrounding female forensic psychologists regarding the difficulty of remaining objective due experienced emotions, makes recognizing one's boundaries difficult. Therefore, consultation with a trusted colleague or seeking supervision through a supervisor or trusted mentor is monumental when working with the forensic population (Ermshar & Meier, 2014).

Research has examined vicarious trauma in males and women but has rarely directly assessed gender differences. Farrenkopf (1992) found that 25% of female professionals who worked with sexual offenders reported high levels of stress, exhaustion, depression, and burnout. Furthermore, in his research, 33% of these professionals experienced symptoms of vicarious traumatization, including hypervigilance, suspiciousness, and fear for the safety of loved ones (Farrenkopf, 1992). In 2009, a female mental health professional provided her own account of her insidious onset of burnout from working with sex offenders (Ermshar & Meier, 2014). She

stated she began to have difficulty sleeping as she would ruminate or dream about vivid details shared with her via her clients. She discussed how seeking supervision was crucial in her treatment of burnout symptoms. Women in supervisory roles are often placed at an even higher risk for developing symptoms associated with burnout due to being in a role of hearing the offenses secondhand with no connection to the client. As a female supervisor, it may be more difficult to think of the victim and/or the offender as whole persons when there is no working relationship with either, given that the relationship would typically aid in empathy building and objectivity. As such, it will be important for supervisors within this context to seek their own consultation and support for these difficulties (Ermshar & Meier, 2014).

Preparing female clinicians for the emotional and psychological demands of forensic work with violent or sexual offenders is imperative. As noted previously, stereotypical gender scripts, in which women are expected to empathize with victims, can result in stigmatization of those working with offenders because it is seen as evidence for supporting or excusing their behaviors. Considering this example, the attitude and atmosphere toward women in forensic psychology can serve as a self-fulfilling prophecy, setting women up for increased difficulties in the field, as they strive to prove that they indeed can handle their job without seeking support or help for their own individual burnout levels. Preparing female forensic psychologists for counter-transferential issues, de-feminization, and the potential for vicarious traumatization would serve to help female clinicians continue to thrive in the field of forensic evaluation and treatment, thereby benefiting the offender's treatment and the field in general (Ermshar & Meier, 2014).

Burnout Related to COVID-19 For Forensic Psychology

COVID-19, also referred to as coronavirus disease, reached the level of a pandemic in 2020, affecting countries across the world (Rajkumar, 2020). Widespread outbreaks of infectious

diseases, such as COVID-19, are associated with an increase in psychological distress and symptoms of mental illness. Mental health clinicians worldwide should be aware of these manifestations, their correlates, and strategies to manage and treat symptoms of a pandemic. Heightened levels of stress, anxiety, worry, depression, and rumination have been found within the general mental health field following the COVID-19 pandemic. However, research has discovered populations who are more susceptible to contracting COVID-19. One of these specialized population includes individuals who are mentally ill, homeless, and of an ethnic minority background, some, or all of which apply to a large majority of forensic clients (Rajkumar, 2020).

Prisons, meat-packing plants, nursing homes, and rural health systems have all been identified as structural vulnerabilities within U.S. Public Health, but research understanding of the role of prisons in COVID-19 spread is limited (Rajkumar, 2020). As of November 30, 2020, at least 252,000 incarcerated individuals (incarcerated persons and detainees) and employees in U.S. prisons and jails tested positive for the coronavirus, and 1450 had died. Furthermore, Sims et al, (2021) reported incarcerated individuals are a highly vulnerable population whose barriers to timely health care include requiring incarcerated individuals to pay copays for health care, a practice that is legal in 35 states (Sims et al., 2021).

Forensic psychologists are at special risk for contracting COVID-19 due to working primarily with individuals who are incarcerated currently or recently were (Sims et al., 2021). Prisons and jails are limited in feasible resources to implement social distancing and proper personal protection for inmates, accelerating the spread of COVID-19 throughout those facilities (Hawks et al., 2020). Additional risk factors for those incarcerated are preexisting conditions and age, which weaken the immune system and increase the likelihood of contacting COVID-19. As

a result of longer sentences (mostly for non-violent offenses), the average age of the prison population has increased. In 2013, state prisons housed 131,500 persons older than 55 years, a 400% increase since 1993 and a known risk factor for an increase in severity in COVID-19 symptoms. Many incarcerated persons older than 55 years have chronic conditions, such as heart and lung diseases, also increasing the risk of severe symptoms (Hawks et al., 2020).

A study conducted by Nowotny et al. (2021) examined the incidence of COVID-19 in prison staff versus the general population. The examiners utilized national data and compared prison staff to the national data utilizing STATA 15. Examiners obtained data specific to prison staff from the Covid Prison Project (CPP), which released its data in January of 2021. The Federal Bureau of Prisons, Puerto Rico, and 45 state prison systems were included in this analysis. The baseline for staff who reported symptoms to the CPP was approximately 400, 889 staff members. The examiners calculated risk-ratios and state-level case rates but had to exclude the Federal Bureau of Prisons because there is not a direct jurisdictional comparison. Throughout the study period, prison staff reported higher rates of contracting COVID-19 compared to the general population. For example, the daily average for prison staff reporting a positive COVID-19 test were 9.95 per 1000, while the general population was averaging 2.85 per 1000 reported cases. Results imply prison and correctional staff have been at heightened risk for contracting COVID-19 (Nowotny, et al., 2021).

Additionally, incarcerated individuals and employees of prisons are at heightened risk for COVID-19 from “crowded dormitories, shared lavatories, limited medical and isolation resources, daily entry and exit of staff members and visitors, continual introduction of newly incarcerated or detained persons, and transport of incarcerated or detained persons in multi-person vehicles (Sims et al., 2021, p. 2). Furthermore, proper disinfectants that have been proven

to eliminate the COVID-19 virus are limited within correctional settings, making sanitization less than adequate. Incarcerated individuals also traditionally have poor hygiene, which exacerbates the spread of COVID-19 throughout the prison and jail communities (Sims et al., 2021).

A study conducted by Sims et al. (2021) examined the correlation between the size of the incarcerated population related to COVID-19 cases and deaths. They analyzed the presence of state and federal prisons as a correlate of COVID-19 spread by matching data on prison locations and capacities, reported cases and deaths, county-level demographics, and weather controls. The timeline utilized corresponds with the first wave of COVID-19 and does not include variants with dates ranging between January 2020 to July 2020. The examiners then used an ordinary least squares design to aid in eliminating county wide variables that could account for COVID-19 rises. This design aided in the strength of the control group as they accounted for extraneous variables. The examiners used prison as a binary term to identify both state and federal penitentiaries. Furthermore, the examiners utilized a duration equalized sample, which allowed them to sample data 30 days after the initial onset of the first documented case and re-sample every 30 days. Data pertaining to COVID-19 cases was collected via two methods, one being a county wide data base, and the second being a daily tracker of case counts available via the New York Times. Prison capacities and locations were derived from the Department of Homeland Security data base, which included 5,808 facilities, 2,100 being state and federal bureaus. The examiners found that COVID-19 cases were 9% higher in counties with a prison and that they increased in proportion to incarcerated population and total capacity (measured in 1000-person increments). An additional 1000-person capacity was correlated with a 4.96% increase in cases. Evidence demonstrated that the capacity of the prison was positively corelated with the number

of cases as well. Additionally, the correlation was stronger for state or federal prisons, rather than county jails, likely due to the traditionally larger population of incarcerated individuals. Despite rather robust findings, limitations of the study were apparent. For example, COVID-19 testing is highly susceptible to inconsistent reporting given guidelines changing through state lines, as well as shortages of testing materials and asymptomatic carriers. Furthermore, the study found correlational evidence, rather than causal evidence, indicating the potential for extraneous variables to have influenced the findings (Sims et al., 2021).

Forensic psychologists or clinical psychologists who work with forensic clients regularly are considered front-line workers, thus increasing susceptibility when working with the jail and prison population. Forensic psychologists are limited in telehealth options, both due to prison policy and technology limiting the scope of the assessment. Therefore, forensic psychologists are forced to engage in an environment that is potentially dangerous for them, as well as their loved ones. Forensic psychologists may experience increased hypervigilance and skepticism, limiting their cognitive and emotional resources that would traditionally be devoted to a comprehensive evaluation. With diminished resources, the potential for vicarious trauma and burnout exponentially rises (Sims et al., 2021).

CHAPTER III: ORGANIZATIONAL, GROUP, DIDACTIC, AND PERSONAL INTERVENTIONS TO COMBAT AND DECREASE BURNOUT IN THE FIELD OF FORENSIC PSYCHOLOGY

Vicarious Resiliency in the Field of Forensic Psychology

Vicarious resilience has been defined as the positive impact on and personal growth of therapists resulting from exposure to their client's resilience (Hernandez-Wolfe, 2018). Vicarious resiliency is something that may be drawn upon as an aid to deter the symptoms of burnout and compassion fatigue (Hernandez-Wolfe, 2018). Traditionally, resiliency is thought to be a construct that the client, patient, or defendant builds through a therapeutic process or corrective emotional experience. However, vicarious resilience is built by the mental health provider through their personal exploration and experiences. Vicarious resiliency is embedded in resilience theory as the vicarious learning process, which allows for integration of the impact of clients whose positive adaptation stems from their ability to cope with adversity (Hernandez-Wolfe, 2018). According to Walsh (2016), "resilience is the ability to withstand and rebound from disruptive life challenges: it involves dynamic processes that foster a positive adaptation in the context of a significant adversity" (Walsh, 2016, p. 5) Beyond coping and adaptation, these strengths and resources enable the victim to recover and positively grow. Masten and Coatsworth (1998) viewed resilience as a dynamic process in which individuals display positive adaptation despite experiences of adversity in the past or in the present.

> Hernandez-Wolfe (2018) proposed seven dimensions of vicarious resiliency:
>
> changes in life goals and perspectives; client-inspired hope; increased recognition of the clients' spirituality as a therapeutic resource; increased self-awareness and self-care practices; increased consciousness about power relative to social location; increased capacity for resourcefulness; and an increased capacity for attentiveness to the patients'

> narratives of trauma. Changes in life goals and perspectives occur following posttraumatic growth. Qualitative research on vicarious resilience has shown that helping professionals who are empathetic toward trauma survivors and their accounts, experience vicarious posttraumatic growth, which causes changes in their philosophy of life, goals, and perspectives. (p. 3)

Additionally, clients are capable of inspiring their clinicians through their hope. A mutual affirmation is important in vicarious resilience as it points to the positive, reciprocal influence of the therapy. Next, the clinician is advised to make meaning through suffering, which can be done through spirituality or cognitive restructuring with clients (Hernandez-Wolfe, 2018).

Furthermore, clinicians must maintain an increased self-awareness and increase in self-care practices (Hernandez-Wolfe, 2018). Studies of vicarious trauma, compassion fatigue, and burnout have confirmed the vital role of self-care in the well-being of therapists. This body of research points to the need to balance a healthy mind and body to prevent irritability, insufficient or unsatisfactory sleep, doubts about one's own therapeutic effectiveness, concerns about the size and severity of their caseload, and episodes of anxiety or depression. Examples of common behavioral patterns that can signify burnout if self-care is not properly tended to are social isolation, neglecting meal breaks, and putting clients' needs first. Impairment can lead to poor clinical judgment, an increased risk of ethical breaches, boundary violations, and inappropriate emotional involvement with clients (Hernandez-Wolfe, 2018).

Maintaining attunement with one's mind and body can be achieved in many facets. However, mindfulness is the most commonly referenced resource to achieve this. A study conducted by Keane, 2014 examined the influence of mindfulness practices on psychotherapists and their work. The study was two-phases, in which 40 psychotherapists completed a survey

delivered by mail. The survey included open ended questions regarding mindfulness practices and their perceived ability to provide empathy. The second phase was in-person, conducted with 12 of the participants, and consisted of the same follow up questions they answered in the postal survey. Clinicians who reported to engage in mindfulness practices endorsed significantly higher attention to self-awareness, awareness of self-care needs, and awareness of the level of presence with their clients. (Keane, 2014).

Furthermore, clinicians are advised to maintain a culturally competent approach to practice as this may also influence their vicarious trauma or burnout experiences (Hernandez-Wolfe, 2018). Multicultural competence is a counselor's ability to reach appropriate levels of self-awareness, knowledge, and skills in working with people from diverse cultural backgrounds, including an awareness of cultural values and the sociopolitical importance of privilege or discrimination and oppression (Hernandez-Wolfe, 2018).

Forensic psychologists may find relief from vicarious trauma symptoms by increasing their capacity for resourcefulness, just as they expect their clients to do (Hernandez-Wolfe, 2018). Although forensic psychologist's often have cases that are limited in scope and breadth due to the nature of the evaluation, the recommendation to increase variety within their overall caseload gives the clinician an opportunity to harness growth and resourcefulness with other evaluations or clients. Paying close attention to their client's specific trauma narrative is vital to staying present with their client as well as delivering quality care (Hernandez-Wolfe, 2018). Therapeutic attentiveness is believed to embody these aspects and is considered crucial for the success of the therapeutic process and involves three types of professional conduct: "being in the here and now," "being open," and "being with-and-for the client" (Hernandez-Wolfe, 2018, p. 10). Factors that may interfere with the therapist's attentiveness include hyper-intellectualization,

fear, fatigue, overreacting (interpersonal or intrapersonal), and distraction (Hernandez-Wolfe, 2018). These factors that may interfere with the therapist's attentiveness are warning signs and symptoms of vicarious trauma, compassion fatigue, and burnout, which is why building resiliency is crucial for the field of forensic psychology (Hernandez-Wolfe, 2018).

Personal Techniques Utilized to Abide Burnout in the Field of Forensic Psychology

Clinicians choosing to either combat burnout or alleviate existing symptoms must take an active role in their process of self-discovery (Sansbury et al., 2015). Often, clinicians with busy caseloads and busy personal lives neglect the work necessary to actively fight the presence or combat symptoms of compassion fatigue or vicarious trauma that leads to burnout. To provide a framework, Sansbury et al. (2015) developed a four-step process clinicians can utilize during their self-care process. Step one is referred to as "know thyself," (Sansbury et al., 2015, p. 4), which essentially indicates that a clinician must be aware of their own arousal states, also referred to as triggers and/or biases. How a clinician first responds to stress, followed by the behavioral, cognitive, and emotional patterns they feel when burnout begins to set in refers to their typical arousal state. It has been proposed that clinicians are most vulnerable to compassion fatigue or vicarious traumatization when they are unaware of the state of their own body and mind, which is the first step to creating an individual climate of self-care (Sansbury et al., 2015).

Step two, "committing to addressing the stress" is advised to closely follow step one (Sansbury et al., 2015, p. 4). Step two also requires recognizing that distress may, at times, be present at a physical level. Clinicians should pay attention to their own body posture, facial expressions, muscle tensions, breathing patterns, and other bodily sensations. Particularly during the process of joining with the client and providing empathy while the client is sharing emotional experiences, it is quite possible for clinicians to start unconsciously overly mimic the emotional

feelings of their clients. Therefore, it is essential for clinicians to develop the skills in which they can dually monitor the somatic/emotional experiences of not only their client but also of themselves (Sansbury et al., 2015). An element of this process is understanding and adhering to personal boundaries (Keane, 2014). Boundaries are related to a work-life balance and boundaries within the work setting. Proper boundaries can aid in protecting the clinician from becoming overly emotionally invested in their client's experiences, while also providing a point of reference to refer to if they are beginning to feel burnt out or stretched thin. Keane (2014) has suggestions that pertain to a therapeutic setting specifically, such as adjusting the room or chair space. However, such boundaries can be set in the forensic setting, as well, such as not engaging with disrespectful clients, establishing proper compensation rates for one's services, and developing a screening process for clients the clinician chooses to take and those one chooses not to take (Keane, 2014). Step two further encompasses making meaning of why a clinician entered the field initially (Sansbury et al., 2015). Often, placing a spiritual or personal meaning on the core decision to pursue the field of forensic psychology can shift the clinician's perspective and aid in engaging resiliency factors (Keane, 2014).

Step three is to "make a plan of action" (Sansbury et al., 2015, p. 5). Now that the clinician has identified their stressors and is committed to addressing them, they must discover how, when, and what tools they will utilize (Sansbury et al., 2015). Research has documented that planning for a behavioral change is an essential element whenever someone attempts to change a behavior. The stages of change model view this phase as the "preparation" stage that combines intention to make changes coupled with specific ways to attempt the change (Sansbury et al., 2015). The process of clinicians making an active plan for self-care is no exception. Self-care is an active process; thus, a plan should be in place to achieve sustainable success. In this

step, it is also advised to utilize observations of colleagues, loved ones, and friends to gain a larger perspective. Questions observers should ask themselves include, but are not limited to; "what do they first notice when the clinician's stress levels are high? What do they observe as your typical coping mechanisms? Have they noticed a pattern between stress load and specific times of the year?" (Sansbury et al., 2015, p. 5).

The final step, Step four, is to "begin action" (Sansbury et al., 2015, p. 5). During this phase, it is also recommended to create support systems within the work setting to hold each other accountable for healthy coping and self-care. This process can look different across different organizational structures, but essentially, it is about finding a trusted colleague where, together, you actively "check in" with each other about the action plan for self-care (Sansbury et al., 2015). The process of checking in can opportunity to also discuss how personal experiences may be contributing to work-related stress responses (Sansbury et al., 2015).

Furthermore, it is recommended to reflect on the positive aspects of the difficulty the clinician is facing during this phase (Sansbury et al., 2015). These reflective moments may be opportunities to explore how the provision of trauma services has contributed to personal growth for some individuals, particularly those providers who have their own trauma histories. Working in the trauma field while creating a few "scars" (physical and/or psychological) can be enormously "rewarding, restorative, and fulfilling" (Sansbury et al., 2015, p. 5). The ability to assist another human being on their journey to healing brings many trauma providers significant satisfaction and enjoyment of their profession (Sansbury et al., 2015).

Clinicians should also maintain personal awareness of warning signs, which may be unique, but commonly share traits or characteristics with other clinicians. In 2009, Laura van Dernoot Lipsky and Connie Burk proposed 16 warning signs that can be utilized to determine if

a clinician is having a vicarious trauma response. Sign one is feeling helpless and hopeless. Even though a person may be part of a very successful program, environmental or otherwise, the positive may be overshadowed and the negative proliferated (van Dernoot Lipsky & Burk, 2009). Successes, markers of improvement, and opportunities for growth can be difficult to keep in focus. Personally, an individual may feel overwhelmed, as if nothing can remedy their experience. The second warning sign is a sense that one may not be doing enough. No one is immune from circumstances that instill a sense of inadequacy. Almost everyone has had to withstand negative life lessons to some degree. At the same time, certain people are likely to receive these lessons more often and, in more ways, than others. Clinicians may become overly invested in certain clients given traits or experiences they divulge that trigger an emotional response within the clinician. The third sign is hypervigilance, which is not exclusive to mental health professionals. Hypervigilance in mental health professionals creates a dynamic of being wholly focused on the job, to the extent that being present for anything else in an individual's life can seem impossible. Hypervigilance is often an attempt to restore safety and prevent any further victimization by anticipating and recognizing everything as a potential threat and acting accordingly. The fourth, fifth, and sixth signs are diminished creativity, inability to embrace complexity, and minimizing. All three of the mentioned signs can happen exclusively or in combination with each other. When clinicians sense diminished creativity, they feel stagnant and less capable of conceptualizing and distinguishing client variables. Diminished creativity can influence the clinician's ability to embrace complexity within one's caseload. As a protective factor, the clinician may begin to minimize their clients' experiences, becoming calloused or jaded in an attempt to preserve resources, which is usually an unconscious process (van Dernoot Lipsky & Burk, 2009).

Clinicians may start out being moved by each person's story, but over time it may take more intense or horrific expressions of suffering to deeply move them. They may consider less extreme experiences of trauma as less "real" and, therefore, less deserving of their time and support (van Dernoot Lipsky & Burk, 2009). "Minimizing" occurs when the therapist trivializes a current situation by comparing it with another situation that they regard as more traumatic. This coping strategy is at its worst when one has witnessed so much that one begins to downplay anything that does not fall into the most extreme category of hardship Forensic psychologists are often faced with the worst forms of trauma and assault, both physically and interpersonally. Therefore, actively working to not minimize client's experiences is imperative to remaining objective; however, this approach further raises the potential of exposure to vicarious experiences given that an emotional shield is not protecting the clinician. Following less obvious signs of vicarious trauma exposure, somatic and emotional symptoms may begin to occur and are the remaining warning signs, which include physical and mental exhaustion, inability to listen or avoidance, dissociative moments, a sense of persecution, guilt, fear, anger and/or cynicism, inability to empathize or a numbing effect, addictions, and grandiosity (van Dernoot Lipsky & Burk, 2009). Grandiosity is unique given it may be helpful in some situations as it gives the clinician an inflated sense of self and makes them feel capable. However, when work becomes the center of one's identity, it may be because it feeds the person's sense of grandiosity, which can be particularly challenging to acknowledge. Many people become absorbed in involvement in others' lives: solving their problems and becoming a powerful figure for them, getting increasingly attached to the feeling of being needed and useful. Grandiosity may be referred to as a double-edged sword, as while it may be useful to a certain degree, it may also be used as a mechanism of avoidance of emotional or behavior dissatisfaction (van Dernoot Lipsky & Burk,

2009). Forensic psychologists may feel a sense of grandiosity when discovering a client is malingering or advocating for a defendant who was not given proper assessments in the past, which can give temporary satisfaction and enjoyment in one's work, while allowing the clinician to avoid other warning signs or burnout that may be present (van Dernoot Lipsky & Burk, 2009).

Symptoms of vicarious trauma, compassion fatigue, and burnout begin to worsen in severity the longer they are not addressed (van Dernoot Lipsky & Burk, 2009). Forensic psychologists are strongly urged to remain diligent and remain aware of their own warning signs to combat symptoms of exhaustion prior to them negatively impacting the clinician's well-being.

Organizational Techniques to Decrease Burnout in Forensic Settings

Organizational techniques are imperative to a well-rounded clinician and are often neglected. Ashley-Binge and Cousins (2020) discussed 11 non-mutually exclusive elements that should be implanted in organizations with a heightened risk of personnel experiencing vicarious trauma or compassion fatigue, which include:

> making supervision and consultation available, encouraging self-care, creating a team environment, fostering a team of supportive colleagues, having a variety in one's caseload, debriefing meetings, continuous psychoeducation on vicarious trauma and/or resiliency, promotion of ongoing professional development, hosting staff meetings/retreats, encouraging staff health and wellness, and encouraging peer support. (p. 2)

Given organizational demands and the nature of work performed by a forensic psychologist or clinical psychologist performing forensic evaluations, not all options proposed by Ashley-Binge and Cousins (2020) are feasible. However, the elements of promoting self-care, professional development, encouraging consultation with peers, and encouraging health and wellness are

strategies that can be promoted with no disruption in client/patient care time. Furthermore, organizations are encouraged to have annual formal evaluations to monitor vicarious trauma and burnout rates (Ashley-Binge & Cousins, 2020). Clinicians should choose to complete these assessments independently and process them either directly with a supervisor or as a group (Sansbury et al., 2015). Because the processing structure could be intimidating for some clinicians, it becomes vitally important that the organization sets the tone of being trauma-informed by integrating the organizational-level concepts of safety, empowerment, trust, collaboration, and choice. If the organizational environment does not set this tone, it may be unlikely that staff would be willing to process openly with each other how they are feeling in terms of self-care. Empirical studies continue to suggest a positive correlation between vicarious traumatization and the number of client cases with violent experiences such as sexual abuse, with an inverse relationship with the educational attainment of professionals. Studies have further suggested that even the most seasoned clinician can be negatively impacted by repeated complex trauma cases with no reprieve. These findings suggest that psychologists working forensic caseloads are highly likely to experience vicarious trauma, compassion fatigue, and burnout multiple times throughout their forensic career. Due to this likely inevitability, organizations have a particularly important responsibility to be proactive in preparing their workers for the inherent crises that will come. Staff training and ongoing staff development are essential in these organizations, and organizations are encouraged to foster resiliency within their organizational framework (Sansbury et al., 2015). The stress management and resiliency training (SMART) program has been utilized in the medical field with positive results (Bilal et al., 2007). The SMART program focuses on mindfulness techniques, stress reduction, and self-awareness.

Although the medical field differs from forensic psychology, the widespread applicability could easily be applied within mental health settings (Bilal et al., 2007).

McCann and Pearlman (1990) coined the term “Feeling Time” (McCann & Pearlman, 1990, p. 3) within the research area of vicarious traumatization. Feeling time refers to the normalization of sharing difficult reactions to working with trauma survivors, especially because personal isolation often complicates how clinicians work through adverse psychological responses (McCann & Pearlman, 1990). Based on McCann and Pearlman’s (1990) research, Sansbury et al. (2015) developed a treatment model. There is a 2-hour weekly meeting in this model, with the first hour devoted to discussing challenging cases (Sansbury et al., 2015). Participants pay careful attention to noting any discomfort they feel about revealing or hearing particularly horrific details. This caveat is important so that clinicians practice setting boundaries based on individual concerns, especially if certain traumatic material resonates with salient need areas. The precaution also provides a relative guarantee that they can assimilate contents of violent cases over an extended period. In the second hour, clinicians shift to dialogue about more personal feedback and strictly avoid pathologizing what they hear. Instead, the clinicians process how trauma work impacts them and their organizations. The hope is that the group format will grant participants a positive, productive setting for disclosing apprehensions (Sansbury et al., 2015). Each clinician discusses vicarious traumatic experiences through their world perspective, giving them an outlet to express their needs through their own belief system. The curriculum recognizes balance, awareness, and enforcing boundaries, limiting weekend and evening shifts, activism, eliminating unrealistic expectations of work, and leisure activities as strategies to reduce negative responses. Participants are encouraged to share what works or does not work for them (Sansbury et al., 2015). The overall configuration of Feeling Time is similar to that of a

single-session seed group, which intends to connect clinicians who are exposed to potential vicarious traumatic experiences regularly with other clinicians who are as well (Sansbury et al., 2015).

Clemans (2005) proposed a 2-hour psychoeducational course for mental health providers who are exposed regularly to vicarious experiences. The course includes introductory information regarding vicarious trauma self-care strategies and allows the participants to provide feedback. Once group expectations are established, clinicians utilize a handout to identify their feelings about working with individuals who experience violence or grief. Group leaders then answer questions related to how they are personally impacted by their job and how they cope with client material, either positively or negatively (Clemans, 2005.) The act of sharing these reflections sets the stage for later content and process discussions in the group (Clemans, 2005, p. 12). The following sessions provide detailed education to clinicians regarding vicarious trauma and suggest self-care strategies. They also label damaging and beneficial clinician practices when reviewing case vignettes related to vulnerability and fear, trust issues, and altered belief systems (Clemans, 2005, p. 13). The last phase of the curriculum is dedicated to an activity referred to as “Letter to Myself” (Clemans, 2005, p. 18). During this process, the clinicians review the lesson in a letter format addressed to themselves, focusing on the most influential part for them and what coping strategies they plan to utilize. This allows the clinician to revisit their chosen coping strategies after the group session (Clemans, 2005).

In summary, two psychoeducational groups and processing groups for mental health professionals have been discussed and should be considered as framework to build upon for future treatment. Although the resources above are not empirically tested, they have been utilized to effectively treat burnout and vicarious trauma for helping professionals.

CHAPTER IV: PROPOSED PROCESS GROUP FOR PSYCHOLOGISTS WHO PERFROM FORENSIC EVALUATIONS

Based on previously described personal and organizational elements that may be implemented to combat the development of burnout and help reduce symptoms once burnout has developed, a process group specific to mental health providers performing forensic evaluations or working with the forensic community is proposed. The following group proposal is recommended to be used as a blueprint and may be tailored to specific organizations, such as state or local prisons, jails, behavioral hospitals, and private practices.

Rational for Forensic Psychologist Process Group

The proposed group would be targeting forensic psychologists and give them an opportunity to work through burnout and vicarious trauma symptoms. Given that general burnout as a syndrome involving a process of gradual loss of emotional, cognitive, and physical energy, which manifests in the symptoms of mental, emotional exhaustion, personal detachment, and reduction of satisfaction in professional activities (Kulakova, 2015). “A gradual change in the individual personality deprives the expert from being fully realized in the profession and causes addiction to negative trends, which are gradually becoming an integral part of the self” (Kulakova, 2015, p. 1). Clinical psychologists are subjected to extra demands, which increases their risk of burnout. Psychologists continually hear about horrific traumas, losses, deaths, injuries, physical abuse, emotional abuse, and sexual abuse clients face. These factors can easily become emotionally draining and cause a decrease in work continuity and quality. Studies have shown that individuals in the forensic work environment, not forensic psychologists specifically, consistently display moderate to high levels of work burnout (Kulakova, 2015). There is limited research on burnout within the forensic psychologist population specifically. However, a study

conducted by Perron and Hiltz (2006) found that forensic interviewers have moderate to high levels of burnout and vicarious trauma consistently. For forensic psychologists specifically, numerous factors increase the risk of burnout in addition to clinical psychological factors. The additional factors include continual ethical dilemmas, excessive documentation, less control over treatment modalities, malingering from clients, decreased validation, and conflicts between expectations and personal morals. The factors mentioned become taxing emotionally and mentally and lead to decreased work productivity, enthusiasm, and quality (Perron & Hilts, 2006). Given the high demands placed on forensic psychologists, the purpose of this process group is to provide an outlet for forensic psychologists to share, reframe, and process difficulties with clients, vicarious trauma, and organizational difficulties.

Theoretical Group Approach

The theoretical orientation of the group will be an integrated combination of CBT approaches, psychoeducation, person-centered, and brief psychodynamic therapies. Previous treatment groups for vicarious experiences and burnout have utilized multiple strategies, such as psychoeducation, implementation of self-care strategies, and labeling damaging tendencies (Clemans, 2005), as well as incorporating time for discussion to dissect challenging cases or scenarios openly and freely (Sansbury et al., 2015). Therefore, the integrated approach was chosen to allow members the opportunity to explore all avenues of their burnout, process their experiences, discuss with one another the here and now while also working on reframing/meaning-making and gaining knowledge they may have forgotten while working so closely in the field. A study conducted by Hernandez et al. (2010) found that in addition to self-care and having an avenue to decompress, seven specific factors lead to resiliency for vicarious trauma and burnout. Specifically, the seven factors mentioned include “reflecting on the capacity

for people to heal, remembering the value of therapy and psychology, hope, reassessing the dimensions of one's own difficulties, spiritual healing, community healing, and keeping the public informed" (Hernandez et al., 2010, p. 8). Given the broad yet impactful dynamics of these factors, an integrated approach would be best suited for a group of this type. Often, psychologists and professionals, in general, forget the fundamentals regarding self-care, work boundaries, and the ability to say no, and the more experienced professional often is exposed to less consultation and supervision. Professionals of all kinds fall prey to neglecting these fundamentals because life gets busy and demands become high. In addition, from a social psychology lens, humans often misinterpret current abilities when stressed or when fewer resources are available. Therefore, it is vastly important to incorporate psychoeducational components of current literature regarding vicarious trauma, burnout, and ways to self-care/cope.

Group Goals and Objectives

The goals of the proposed group would be to decrease burnout and vicarious trauma symptoms and reeducate forensic psychologists on ways to combat these symptoms when not in the group setting. Ideally, the group would promote an increase in productivity and enthusiasm in the work setting, positively influencing accuracy and quality of work. Due to the nature of burnout, members may also notice irritability or less patience at home and in personal life. Therefore, a personal goal for the members may be to notice an increase in the quality of interaction with loved ones and in personal life. Long-term goals for the group would be the ability for members to recognize the signs of burnout prior to them happening or at the cusp of burnout symptoms and be able to utilize some of the learned strategies to address the burnout potential prior to it globally influencing them. The group's objectives include providing a space for the members to process what leads to their burnout, what their personal burnout looks like,

and how it has influenced their life and personal goals. Other objectives would be to allow the members to openly discuss with each other potential vicarious traumas that have contributed to their burnout. The group would then provide the members with tools and current psychoeducation on burnout, including how to build resiliency for future potential burnout. Specifically, the group can discuss factors that place who work with the forensic population at higher risk for burnout and vicarious traumas.

Criteria and Screening Process

The criteria for the group would be exclusive to forensic psychologists or clinical psychologists who specialize in and perform forensic evaluations or who work with the prison and/or jail population. The prison and jail population can be seen in those settings, in private practice, or in community mental health settings with clients who are mandated for court treatment or have a forensic history. The psychologist does not need to be working full time in a penal institution but does need to be continually working with the forensic population in some capacity. Experience is not an inclusion criterion as burnout and vicarious trauma can happen at any point in the clinician's career. Screening criteria would include being a practicing clinician working with forensic clients. In addition to occupational contingencies, participants would be screened for the presence of psychosis and suicidal ideation. Due to the group being a closed format, screening for these symptoms would be conducted prior to starting the group in a self-report format. Screening for extraneous variables such at these would be important to group continuity and safety as the group format is not intended to treat or diminish acute symptoms. In addition, a clause would be given in the informed consent that if a member at any time displays these traits, they would be assessed and referred out if appropriate. The group format would be a closed group that cycles every 8 weeks with a maximum of 10 members at one time.

Group Setting

The group would be offered via zoom or other online communication due to increase accessibility and accommodate COVID-19 restrictions and regulations. However, once the group has begun in a virtual format, an option to convert to an in-person format would be offered if all group members agreed. If the group was to convert to in-person, it would include the same weekly topics to ensure continuity of the group regardless of delivery method. A study conducted by Dreison et al. (2016) compared treatment modalities for burnout in the mental health provider population. Researchers completed a literature analysis spanning between 1990 and 2015. Each chosen study was independently coded and analyzed utilizing a random effects model. The researchers chose 27 eligible studies, which encompassed 1,894 mental health workers who reported being frequently subjected to trauma. Moderator analysis suggested that in-person, person-directed groups were significantly more beneficial than groups lead by a member of their organization. Although implementing other organizational interventions to address burnout may be beneficial and convenient, the process group should be conducted by a group leader who is not part of the group member's organizations. However, strategies to eliminate some of the unnecessary work stressors that contribute to burnout could be proposed and implemented in organizational settings, different from process group interventions. Lastly, it should be noted that virtual groups were not common at the time these studies were conducted, so their efficacy was not evaluated or compared to in-person groups.

Sessions and Session Goals

Sessions were derived utilizing an approach similar to that of Clemans (2005), in which the researchers implemented a 2-hour psychoeducational course for professionals who were often exposed to vicarious trauma, as previously described. However, this proposed group aims

to expand the content of the 2-hour psychoeducational group and tailor it to burnout by considering that burnout is a gradual process, as defined by (Kulakova, 2015).

Sessions would meet once per week for 1 hour and 30 minutes. Previous resources have proposed 2-hour long group sessions, such as Clemans (2005) 2-hour proposed psychoeducational group and Sansbury et al. (2015) 2-hour weekly process meeting. However, the current proposed group is designed to be 1 hour and 30 minutes due to the multidimensional approach and to avoid further burnout and emotional exhaustion for participating members. Each session would begin with time for members to discuss what has been going on for them the past week pertaining to what was discussed in group the previous week and have the opportunity to support one another. Six of the eight sessions will have specific topics to touch on following the free time to discuss current personal struggles related to burnout and work stress. The first session would be the time for every member to introduce themselves and share why they are here. They would have the opportunity to ask questions and share what they hope to gain from the group. The leader would share the objectives and topics that will be discussed. The second session would help the members address the level of burnout they are experiencing by discussing the 12 primary sequential stages of how burnout develops over time (Winker, 2014) and having them write down which they identify with. The 12 primary stages include excessive work drive, pushing themselves to work harder than usual, neglecting their personal needs and self-care, feeling displaced in either their work or home environment, little or no time for non-work-related activities, denial of how the previous stages are impacting them personally, behavioral changes, depersonalization or not feeling like themselves, emptiness, depression, and mental and/or physical exhaustion (Winker, 2014). After discussing the steps of burnout, each member would identify one new activity or thought pattern to implement within this next week that would help

them decrease their burnout level. The next session would be a psychoeducational portion regarding aspects of the forensic field that put them at greater risk for burnout. The fourth session would be utilized to discuss vicarious trauma, the differences between vicarious trauma and burnout, and how vicarious trauma may lead to burnout. The group would utilize reframing and meaning-making CBT strategies to process their experiences with vicarious trauma. The fifth session would be strictly a process session to discuss what they have been working on and potential personal issues that contributed to burnout that they have not dealt with or thought they had but continued to be an issue for them. The sixth session would be information and education regarding resiliency in vicarious trauma and burnout, what they can do to become more resilient, and who to communicate with when they feel less resilient. The seventh session would address workplace stress reduction strategies that are in their control. The group would discuss and brainstorm realistic ways the members could implement professional and personal boundaries that they have not discussed before in order to decrease their burnout levels and be the best clinician possible. Further strategies would also be discussed, such as encouraging open communication with colleagues and supervisors, mindfulness techniques that can be utilized throughout the day, and time management strategies to aid in making their workday smoother. The eighth and final session would be focusing on termination, reflecting on their progress, what they hope to continue to work on, and if they feel further guidance, possibly individual therapy is desired or needed.

Outcome Measures

Upon entering the group, each clinician would be given a variation of the Counselor Burnout Inventory (CBI; Carrola et al., 2016). This preestablished and empirical measure would be used as a baseline and outcome measure. The CBI is a 20-question survey that includes 5

subscales: exhaustion, incompetence, devaluing clients, negative work environment, and deterioration in personal life due to burnout (Carrola et al., 2016). This measure has been normed on United States counselors a has been found to be valid and reliable (Carrola et al., 2016). The survey is a Likert-type response scale with responses ranging from 1 = *never true* - 5 = *always true*. This survey would show a baseline and demonstrate growth throughout attending the group. Members would be given the survey at the beginning of the group, after 4 weeks, and at termination at 8 weeks. Ideally in the future, a new measure specifically developed for forensic psychologists could be empirically tested and implemented in the group.

Strengths and Weaknesses

This group is unique in that there is limited research on the topic and limited resources for burnout symptoms for forensic psychologists. For example, a burnout measure tailored to the uniqueness that occurs within the forensic psychology practitioners has yet to be developed, in addition to a lack of research on the applicability of vicarious trauma and resiliency to these psychologists. However, the lack of research in this area should be considered a limitation to this group. In addition, the baseline and outcome measure to be utilized is not specifically tailored for use with forensic psychologists, which may skew the results. Clinicians who work with the forensic population have a different stress and expectation baseline than clinicians who do not work with this population (Hernandez-Wolfe, 2018). However, the proposed group would provide empirical data to examine the effectiveness of this specific type of group and attempts to bridge the gap in existing research, which is a strength. An additional strength of this group is that it attempts to have a personal impact on the clinician and an impact on competency, client care, and the work environment. Last, this group is closed, short-term, and efficiently planned so it could be conducted virtually or in the office setting.

CHAPTER V: DISCUSSION

Research regarding burnout and compassion fatigue within helping professions, such as clinical psychology, forensic personnel, and law enforcement has been documented. However, burnout specific to the forensic psychology realm has limited research regarding susceptibilities specific to the field, such as vicarious trauma and vicarious experiences, as well as how gender differences and COVID-19 contribute in a unique manner to burnout in the field of forensic psychology.

Professional burnout has been defined as a process of gradual loss of emotional, cognitive, and physical energy, which is manifested in the symptoms of mental exhaustion, emotional exhaustion, personal detachment, and reduction of satisfaction by professional activities (Kulakova, 2015). Forensic psychologists are continually exposed to perpetrators, traumatic experiences, high-risk clients, and organizational demands that differ greatly from clinicians practicing general clinical psychology (Sansbury et al., 2015). Given the heightened demands and risk factors forensic psychologists face, burnout likely has a higher prevalence within the forensic psychology field. Vicarious trauma is different from a personal traumatic experience, as it is an experience the client or defendant shares which may be potentially traumatizing to the professional (Figley, 1982). Vicarious traumatization or VT has been clinically defined as "the profound shift in world view that occurs in helping professionals when they work with individuals who have experienced trauma: helpers notice that their fundamental beliefs about the world are altered and possibly damaged by being repeatedly exposed to traumatic material" (Pearlman & Saakvitne, 1995, p. 3). Forensic psychologists are exposed at a higher rate than other helping professions to trauma, violent crimes, and assaults of all magnitudes, which often must be reviewed or assessed in great detail dependent on the purpose

of the evaluation. Research conducted in 2010 by Meadors et al. examined the differences between burnout and secondary trauma, as well as the impact secondary trauma has on the professional. Researchers discovered that burnout was correlated with compassion fatigue *(r = .56),* while compassion fatigue was correlated with secondary trauma responses ($r = .72$). Researchers deduced that that both constructs of secondary trauma responses and compassion fatigue have a positive relationship with burnout within helping professionals despite not providing statistical evidence.

In addition to vicarious traumatization, risk factors associated with burnout include organizational demands that are placed on psychologists working in community settings, hospitals, state facilities, and government facilities, that make it difficult for psychologists to maintain a balance of workload (Simpson et al., 2019). Furthermore, ethical, and moral standards may often clash, placing the forensic psychologist in a unique predicament, which often results in one's own morality being compromised to remain ethical, such as when conducting death row evaluations (Simpson et al., 2019). Additionally, psychologists of all facets are expected to have an empathetic understanding for all clients (Atzil-Slonim et al., 2019). This may be particularly challenging for forensic psychologists' who as previously mentioned are often subjected to perpetrators of all facets. Awareness and empathetic understanding of the client's current and past affective experiences may be emotionally taxing when faced with strong or misplaced affective stimuli from the client (Atzil-Slonim et al., 2019). For example, a study conducted in 2013 by Gallavan and Newman explored the relationship between burnout and empathy in correctional mental health professionals of all qualifications. Researchers found that negative work experiences demonstrated a significant relationship to contributing to burnout ($r = .62$). Feelings associated with negative work experiences were described as less control over their

work environment, lower optimism, and emotional exhaustion. Furthermore, higher optimism was found to have a negative relationship with burnout (Gallavan & Newman, 2013).

Female forensic psychologists also face heightened risks of burnout due to discrimination, defeminization, and sexism within the field (Shelley et al., 2011). Furthermore, a vast majority of perpetrators offend against women (Shelley et al., 2011), which makes vicarious trauma more prevalent. In 1999 a survey study was conducted by Morgan and Porter examining the work-related experiences of female mental health trainees. Results indicated the vast majority of participants endorsed unwanted sexual contact, such as deliberate touching, cornering, and receiving sexual phone calls or letters. Research further discovered that female clinicians were significantly less likely to discuss these encounters with their supervisors due to the sexual nature. (Morgan & Porter, 1999). This evidence is vastly important especially given that supervision can be used as a protective factor and/or aid in diminishing burnout (Ermshar & Meier, 2014). Lastly, COVID-19 is a unique and recent contributor to burnout within the forensic psychology field as forensic psychologists are often more susceptible to exposure or contracting the disease given, they typically work in jails, prisons, and hospitals. COVID-19 is reported to spread at higher rates in close contact areas, in addition to the environmental factors of jails and prisons, such as shared lavatories, limited medical support, diminished hygiene, and geriatric incarcerated individuals (Sims et al., 2021).

Given all of the risk factors, data, and unique contributors to burnout within the field of forensic psychology, ways to diminish or combat burnout within the forensic psychology field are imperative. Vicarious resilience is a term used to describe the positive impact on and personal growth of therapists resulting from exposure to their client's resilience, which may be drawn upon as a mechanism to deter burnout (Hernandez-Wolfe, 2018). Other elements that

have been documented to aid in alleviating or combating burnout are self-awareness, cultural competence, resourcefulness, supervision, and therapeutic attentiveness (Hernandez-Wolfe, 2018). Personal techniques such as mindfulness have proven to be useful as well as a commitment to addressing one's burnout, maintaining boundaries, and having a sustainable plan with realistic ways to execute that plan (Sansbury et al., 2015). Organizations are also encouraged to make supervision attainable, to encourage their personnel to engage in self-care, to create a team environment, to foster an environment for supportive colleagues, to provide debriefing meetings, to increase variety in caseloads, to provide psychoeducation, and to promote ongoing professional development in order to reduce burnout within their forensic psychologists (Ashley-Binge & Cousins, 2020).

Considering that forensic psychologists are at a heightened risk for professional and personal burnout, a process group specific to this population is recommended. Research has demonstrated the combination of organizational strategies, in combination with personal strategies to be the most effective method at combating general burnout (Clemans, 2005). Given the high demands placed on forensic psychologists, the purpose of the proposed group is to provide an outlet for forensic psychologists to share, reframe, and process difficulties with clients, vicarious trauma, and organizational demands unique to forensic psychology practitioners. The theoretical orientation of the proposed group will be an integrated combination of CBT approaches, psychoeducation, person-centered, and brief psychodynamic interventions to address the multiple manifestations of burnout. Goals of this proposed group include decrease burnout and vicarious trauma symptoms and reeducate on ways to combat these symptoms when not in the group setting discover personal symptoms and signs of burnout and enhance the ability for members to recognize the signs of burnout prior to them happening and be able to utilize

some of the learned strategies to address the burnout prior to it influencing them. The objective of providing this group to forensic professionals is to provide a space for the members to process what leads to their burnout, what their personal burnout looks like, and how it has influenced their life and personal goals. The members would also have the opportunity to openly discuss ways vicarious trauma has contributed to their burnout, as well receiving psychoeducation and ideas for ways to build vicarious resilience. Given the sensitive nature of the group, a closed group consisting only forensic psychologists would facilitate the development of trust and connection between group members and could provide a model for seeking additional supervision or consultation in the future.

Limitations

Overall, current research has significant limitations that impact knowledge pertaining to burnout within forensic psychology and ways to combat it. Therefore, there are limitations to the findings within this work due to a lack of available research. The vast majority of the available studies examined burnout as a separate entity, as well as burnout and vicarious trauma within more general groups of helping professionals and first responders (Eckleberry-Hunt et al., 2018; Kelty & Gordon, 2015; Linzer et al., 2017; Simpson et al., 2019). Empirical based evidence as to how forensic psychologists or psychologists who work with the forensic population are uniquely impacted is very limited, leaving a large gap in research and resources available to this population, such as support groups, specific organizational techniques, and psychoeducation.

Additionally, research within the past 5 years is very limited, as most studies are significantly older (Lockwood, 2016; Perron & Hiltz, 2006; Xanthakis, 2009; Singer et al., 2004). The ack of newer research can be seen as a significant limitation given a rise in cultural competence expectations, hate crimes committed against populations of ethnic minorities, and a

more diligent movement toward self-care. Current research pertaining to how forensic psychologists are viewed within the system following a crucial civil rights era may illuminate an added element or risk factor to burnout. Furthermore, self-care has culturally become more acceptable and viewed as a necessity (Sansbury et al., 2015). Therefore, the impact of cultural and societal acceptance in regard to self-care and interpersonal boundaries may be influential on burnout rates within forensic psychologists. Recent empirical research regarding interventions or groups for mental health providers would aid in the development and efficacy of a process group.

Lastly, research regarding women specifically within the field of forensic psychology is extremely sparce. It has been documented that female forensic psychologists' face gender discrimination and sexism in the field, which diminishes the respect for the position and makes delivering quality assessments difficult (Shelley et al., 2011). Women within this field are forced to engage in "code switching" more so than their male counterparts within the field (Ermshar & Meier, 2014). It has also been heavily researched that gender stereotypes, de-feminization, and societal expectations are regular expectations and occurrences for woman within the field Furthermore, female forensic psychologists are reportedly subjected to inappropriate client behaviors, such as sexual gestures and inappropriate comments regularly (Ermshar & Meier, 2014). Given the known research surrounding what woman are exposed to and expected to engage in, significant limitations are evident as to how woman in the field are emotionally and professionally impacted.

Clinical Implications

Forensic psychologists are at a heightened risk of being exposed to vicarious trauma, compassion fatigue, and burnout. Professionals who routinely interface with trauma and violence, such as those working in corrections, the legal system, and mental health, can develop

symptoms related to what is referred to as vicarious trauma, compassion fatigue, or burnout (Pirelli et al., 2020). Experienced symptoms can include diminished sense of satisfaction within the work environment, diminished personal satisfaction, and emotional fatigue. Due to the pervasiveness of these symptoms, client care is likely diminished while a clinician is experiencing VT or burnout due to limited mental and emotional resources available for the client. Clients may experience a lack of empathy from the clinician, a lack of objectiveness from the clinician, and a lack of attention to proper assessment, which can negatively impact their diagnosis and/or sentencing. Forensic psychologists have been documented to experience other unique susceptibilities, such as maintaining awareness of both general and specialized competencies relevant to those who engage in forensic mental health assessment (FMHA), intervention, consultation, research, supervision training, and management administration (Pirelli et al., 2020). They are also subjected to various types of evaluations that require civil commitment matters (Pirelli et al., 2020), which may not be as vicariously traumatizing, but have the potential to influence a provider who has a personal history similar to that of the client's chief complaint or referral reason. Additionally, administrative evaluations more often include lengthy record reviews, lengthy reports, and specific templates regarding how the report should be written for submission, which may also contribute to burnout. Clinically, knowing unique vulnerabilities for the forensic psychology field can aid in minimizing burnout, which would therefore increase the quality of work, as well as work satisfaction within the field.

Recommendations

Despite the studies included in this work, there are many gaps within the research that need to be built upon and improved. It is recommended that future research examine burnout and VT in the forensic psychology field specifically, within the assessment as well as therapy realms.

Empirical research would aid in developing appropriate and useful interventions for this specific group of psychologists that can be evidenced based. Future research further extending to specific techniques that would be most effective for this population in combating burnout and compassion fatigue, while increasing vicarious resilience would be largely beneficial. Furthermore, it is recommended that research focus on civil rights matters within the judicial system and how this impacts the forensic psychologist's role, as well as client interactions. Specifically, research should examine how ethical standards forensic psychologists interact with civil injustice that often occurs within the judicial system and if those factors also increase job stress, contributing to burnout.

Furthermore, research specific to the female population within the forensic psychology field is recommended. Inequalities that occur within the forensic psychology field specific to woman have been documented. However, previous researchers have neglected to investigate the emotional and professional implications these inequalities have on the female practitioner. Research should further evaluate how women within the field typically cope with work stress and inequalities, highlighting strengths and weakness of typical coping strategies, comparing them to other women within the field, and empirically assessing the most effective strategies for female forensic psychologists to combat burnout.

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