# Risk of vicarious trauma in nursing research:

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# Risk of Vicarious Trauma in Nursing Research: A Focused Mapping Review and Synthesis



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# Risk of Vicarious Trauma in Nursing Research: A Focused Mapping Review and Synthesis

## Abstract

**Aims and objectives**. To provide a snapshot of how vicarious trauma is considered within the published nursing research literature.
**Background.** Vicarious trauma (secondary emotional distress) has been the focus of attention in nursing practice for many years. The most pertinent areas to invoke vicarious trauma in research have been suggested as abuse/violence and death/dying. It is not known is how researchers account for the risks of vicarious trauma in research.
**Design.** Focused mapping review and synthesis. Empirical studies meeting criteria for abuse/violence or death/dying in relevant Scopus ranked top nursing journals (n=6) January 2009 to December 2014).
**Methods.** Relevant papers were scrutinised for the extent to which researchers discussed the risk of vicarious trauma. Aspects of the studies were mapped systematically to a pre-defined template, allowing patterns and gaps in authors' reporting to be determined. These were synthesised into a coherent profile of current reporting practices and from this, a new conceptualisation seeking to anticipate and address the risk of vicarious trauma was developed.
**Results.** 2503 papers were published during the review period, of which 104 met the inclusion criteria. Studies were distributed evenly by method (52 qualitative; 51 quantitative; 1 mixed methods) and by focus (54 abuse/violence; 50 death/dying). The majority of studies (98) were carried out in adult populations. Only two papers reported on vicarious trauma.
**Conclusion.** The conceptualisation of vicarious trauma takes accounts of both sensitivity of the substantive data collected, and closeness of those involved with the research. This might assist researchers in designing ethical and protective research and foreground the importance of managing risks of vicarious trauma.
**Relevance to clinical practice.** Vicarious trauma is not well considered in research into clinically important topics. Our proposed framework allows for consideration of these so that precautionary measures can be put in place to minimise harm to staff.

**Keywords:** abuse, bereavement, death, mapping review, nursing, risk, secondary emotional distress, sensitive issues research, vicarious trauma, violence.

## What does this paper contribute to the wider global clinical community?

- Future research should consider how vicarious trauma will be anticipated, prevented, identified and addressed when it occurs.
- The conceptual framework could be used to anticipate the potential for vicarious trauma in order to establish precautionary measures that might lead to early identification or prevention.
- The issue of vicarious trauma should be incorporated into checklists of reporting guidelines such as the consolidated criteria for reporting qualitative research (COREQ).

**Wordage:** 4155

## Introduction

Qualitative research is recognised as an intellectually and emotionally challenging endeavour (Hubbard *et al* 2001). Immersion in participants' stories and prolonged engagement in their data is emotionally demanding, particularly within the context of sensitive or distressing topics (Jackson *et al* 2013). In this paper, we discuss the issue of vicarious trauma, which has been defined as:

> a transformation in the [trauma worker's] inner experience resulting from empathetic engagement with clients' trauma material. That is, through exposure to clients' graphic accounts… the [worker] is vulnerable through his or her empathetic openness to the emotional and spiritual effects of vicarious traumatization. These effects are cumulative and permanent, and evident in both…professional and personal life (Pearlman and Saakvitne 2013, p. 151).

Researchers engaging in topics such as abuse/violence and death/dying are at particular risk of vicarious trauma. Yet, while it is common for ethics protocols and published papers to acknowledge the emotional demands placed on research participants, far less attention has been given to the ways in which the research process impacts personally upon researchers themselves (Warr 2004). Although many applied disciplines deal with violence or death, they are particular relevant for nurses and are a major focus of nursing research. Moreover, there is limited knowledge about how to prevent and address vicarious trauma for individuals in support of the research process, such as transcriptionists and translators. In this paper, we provide a focused mapping review and synthesis of the extent to which vicarious trauma is considered within the published nursing research literature. In so doing, we highlight the need to anticipate and address vicarious trauma risks within the research process and offer a framework to support this.

## Background

The challenges associated with sensitive issues research have been discussed extensively in the international nursing literature (see for example Wilkes *et al* 2014, Dickson-Swift *et al* 2007, 2008, 2009, Elmir *et al* 2011, Wilkes *et al* 2014). Correspondingly, the notion of 'vicarious trauma' - otherwise described as secondary traumatic stress (Jenkins & Baird 2002) - has attracted mounting attention over the past 25 years as a topic relevant to research. McCann and Pearlman (2013 p133) describe vicarious traumatisation as: 'the experience [of] profound psychological effects that can be disruptive and painful… and can persist for months or years' (McCann & Pearlman 2013 p133). Early reference to 'vicarious traumatization' was concerned with trauma among therapists and counsellors (McCann & Pearlman 2013, Schauben & Frazier 1995), rather than those engaging with research. However, the last few decades have hatched a considerable body of literature regarding vicarious trauma and research. The main issues acknowledged as being a risk factor for vicarious trauma in research are violence and abuse (Way *et al* 2004, Butler 2008, Coles *et al* 2014, Wilkes *et al* 2014) and bereavement (Wilkes *et al* 2014). Literature on those who need to be protected from the emotional impact of sensitive issues research cluster around three groups:

(1) interpreters (Harvey 2001, Butler 2008, Hsieh 2008, Splevins *et al* 2010);

(2) transcriptionists (Gregory *et al* 1997, Wellard & McKenna 2001, Tilley 2003, Etherington 2007, Wilke *et al* 2014); and

(3) researchers themselves (Johnson & Clarke 2003, Woodby *et al* 2011, Coles *et al* 2014).

There is thus a wealth of evidence from individual studies regarding the potential for sensitive issues research to cause vicarious trauma. What is less clear, however, is the extent

to which empirical papers discuss the issue of vicarious trauma and/or the strategies taken in the research to address such risk. In a review of the literature regarding vicarious trauma, Kadambi and Ennis (2004) argued that much of the thought and research on the issue has been inconclusive. Nursing research is concerned primarily with real world issues for health care users or providers. As indicated, violence and abuse, and bereavement are key risk areas for vicarious traumatisation. This paper is a report on a type of literature review known as a mapping review and synthesis undertaken to investigate this issue. The mapping and synthesis described in this paper focuses on nursing. Part of our motivation to undertake this research was our awareness from our own work in the field of child protection research of the potential emotional impact on a research team of engaging with painful accounts of child abuse and neglect and the consequences of these. A recent study of deaf and disabled children's views and experiences of child protection also brought new challenges given the involvement of British Sign Language Interpreters (insert author refs).

## Method: Focused Mapping Review

### Aims

Our aim was to provide a snapshot of the extent to which the issue of vicarious trauma is considered within the published literature.

### Design

To provide this snapshot we undertook a comprehensive literature review following the refinements and guidance of the EPPI-Centre (2012). Grant and Booth (2009) described a typology of 14 review types and associated methodologies which are often overlapping. In their typology this study would meet many features of a mapping review/systematic map, where:

> Mapping reviews enable the contextualization of in-depth systematic literature reviews within broader literature and identification of gaps in the evidence base. They are a

> valuable tool in offering policymakers, practitioners and researchers an explicit and transparent means of identifying narrower policy and practice-relevant review questions. Systematic maps may characterize studies in other ways such as according to theoretical perspective, population group or the setting within which studies were undertaken (Grant and Booth 2009 p97).

But it also met their criteria of critical review, where a significant component is concerned with conceptualisation to embody or derive new theory. Thus in addition to the mapping, we carried out a focused synthesis to examine one particular issue, draw attention to its completeness within the literature, and offer a new conceptualisation of a particular phenomenon (in this case vicarious trauma). We have used this method previously with effect (insert author ref) and refer to it now as focused mapping review and synthesis. We mapped and categorised existing literature to determine gaps and patterns.

**Search methods**

This form of review is unique in that it focuses on: 1) a specific subject; 2) a defined time period; and 3) targeted journals. Most other forms of review, such as systematic reviews, also specify the first two, i.e. subject and time period. However, they strive towards breadth and exhaustive searches, whereas the focused mapping review searches within specific, pre-determined journals. These are selected on the basis of their likelihood to contain articles relevant to a certain field of inquiry; in this case to provide a portrait impression of vicarious trauma within the nursing research literature. The distinctive feature of the focused mapping review and synthesis therefore is the purposive selection of journals.

According to the international Scopus (2013) Journal and Country Rank, the top ten nursing journals when we commenced the study are shown in Table 1.

[Insert Table 1]

Despite their 'nurse' listings, following scrutiny of 12 months' of articles we disqualified those that were not exclusively nursing but were more concerned with medicine or administration (1, 3, 6). We also excluded Nurse Education Today (10). Whilst concerned with nursing, the empirical articles we found in the latter were focused on students or issues of pedagogy, not on service users. This left six journals as the basic dataset.

We included all papers (children and adults) that reported primary empirical research dealing with abuse, violence, death or dying, published in the six year period from 1st January 2009 until 31st Dec 2014. We excluded systematic reviews, administrative data and secondary data analysis where studies did not have direct contact with participants.

**Search outcome**

The six journals collectively published 2503 empirical papers during the review period (2009-2014), of which 104 met the inclusion criteria.

**Data abstraction**

Each team member was responsible for one (or in some cases two) specific journals. Every article published in the timeframe was scrutinised against the inclusion and exclusion criteria. Where team members were unclear, discussion within the group resolved such issues and ongoing refinements to the criteria were made in the early stages. Around ten per cent of the papers were blind reviewed to confirm inter-rater consistency. For those papers that met the

inclusion criteria, papers were read in full and each reviewer loaded predefined details onto a proforma developed for the study (Table 2).

[Insert Table 2]

### Synthesis

Because this was a focused mapping review and synthesis we wanted to include only studies dealing with topics and participants most likely to evoke emotional responses. We were guided in this respect by Wilkes *et al* (2014) who found that the principal issues that caused vicarious trauma for the transcriptionists in their study were abuse (including domestic) and bereavement. We expected those studies nearest to service users, i.e. with 'real' participants, were more likely to contain material disturbing to those on the peripheries of the research than studies that used administrative data, or were systematic reviews. We were not concerned whether studies mentioned issues of protection or safety of participants, or the extent to which ethical protocols had been adhered. Potential trauma to those involved with the research (e.g. the study team, transcribers, interpreters) was the focus.

## Results

Summary results across the papers are shown in Table 3.

[Insert Table 3]

There was an even spread between qualitative (n=52) and quantitative (n=51) studies, with one mixed-methods study. There was also an even spread between those papers that dealt with abuse or violence (n=54) and those that dealt with death or dying (n=50). JAN published the largest number of papers concerned with our predetermined traumatic topics, followed by IJNS. Nursing Outlook published the least. The majority of studies (n=98) were carried out in adult populations, with seven involving children and young people aged under 18.

Only two papers meeting the inclusion criteria for our review referred in any way to the issue of potential vicarious trauma within the research team. Both papers were published in JAN; one by Goldblatt (2009) and the other by Jackson *et al* (2013).

Goldblatt's paper reports on a study that investigated the impact on nurses of caring for abused women. The study involved in-depth interviews with nurses and the potential for vicarious trauma to occur amongst them is discussed. However, vicarious trauma is the focus of the study, rather than being something that is discussed as a risk to those involved with the study. No reference is made to potential upset or distress among those conducting the study.

The paper by Jackson and colleagues is also concerned with abuse. Using an observational study design, the verbal abuse experienced by nurses in their everyday work is investigated. This is the only paper out of the 104 included in our review that makes explicit reference to the potential for vicarious trauma to occur in those involved in the research. The study used nine nurses as observers. The observers were provided with 'ongoing support and access to counselling services at all times during the data collection period' (Jackson *et al* 2013, p.2068). Telephone contact and de-briefing with members of the research team were also available. These authors report that although no counselling was required, there were two incidents early in the data generation process where observers *did* require de-brief. The nature of the incidents is not disclosed but the fact that de-brief was required, points to the risk of vicarious harm as a direct result of involvement with research.

**Towards a framework of vicarious trauma**

As a result of the mapping exercise, we propose a framework for vicarious research based on a Johari window approach (Luft, 1969). We conceptualise the risk of vicarious trauma as

fitting within one of the quadrants as indicated in Figure One. The horizontal axis shows a continuum of sensitivity, from research dealing with topics that are considered to be unlikely to cause upset or distress (on the left hand point), such as those dealing with organisational issues, staffing, education and training, and those of a highly sensitive nature at the other end. The vertical axis captures the nature of data in terms of its closeness to participants. So, the upper point indicates the first-hand accounts of participants, for example those of in-depth narrative interviews. The bottom point of this axis indicates data that are removed from the original accounts, such as those of surveys.

[Insert Figure One here]

The bottom left quadrant indicates a green, low risk area because the topic matter and proximity to participant accounts are unlikely to evoke vicarious trauma. On the other hand, the upper, right quadrant constitutes high risk of vicarious trauma, brought about by the coupling of the potentially upsetting topic being investigated and the closeness to participants themselves. We expect that any study could be categorised as being located somewhere within the framework.

**Strengths and limitations**

This was a small focused study to shed light on a particular topic that has hitherto had little attention in the nursing literature. Methods were replicable and transparent. We focused deliberately on a small number of journals and chose those most regarded in the field internationally. However, a larger range of journals may have unearthed more instances of vicarious trauma discussion. It could also be said that many, if not most, topics within nursing

research have the potential to create distress or concern among the study team and those who work with them such as transcribers and interpreters.

Word restrictions in publishing do not allow for full protocols or some peripheral activities to be reported. It is possible that some studies did put in place mechanisms to guard against or address vicarious trauma, but this was not reported in the paper arising from the study. Absence of discussion does not mean an absence of action in regard to vicarious trauma. It may well have been covered in the full ethical protocol.

## Discussion

Where it occurs, vicarious trauma can have significant effects involving a disruption of the professional's frame of reference, including sense of identity, worldview, and spirituality (Pearlman & Saakvitne, 2013). However, it is important to recognise that whilst research involving sensitive data is inherently risky in terms of potential vicarious trauma, many of those involved with the process do feel a sense of satisfaction conducting research on what are often important issues (Wilkes *et al* 2014). In addition, secondary trauma is not an inevitable outcome of empathic engagement and where this does occur, as Splevins and colleagues (2010) observe, there is the potential for posttraumatic growth. Kadambi and Ennis (2004) argue that most professionals cope well with stress and distress in their work and that it is important to recognise wellness and resilience. They suggest that placing emphasis on how to build resilience against traumatic stress responses is important.

We acknowledge that our vicarious trauma framework simplifies a very complex problem. For example, it is not straightforward to identify a topic that is sensitive as this will be context and person specific. Factors other than method will also come into play and we

discuss some of these next. We believe though that this framework offers a helpful starting point for research teams and ethics panels to highlight emotional risk or potential for vicarious trauma.

One factor that may influence emotional risk is not built into the model and that is researcher power. While it could be argued that the distance created by indirect contact with a traumatic story (for example through transcription or secondary data analysis) is a protective factor against vicarious trauma, it is also possible that this distance – and therefore the inability to help or comfort the individual – could actually increase vicarious trauma. Pearlman and Saakvitne (2013 p151) defined vicarious trauma as 'the transformation of the therapist's or helper's inner experience as a result of empathetic engagement with survivor clients and their trauma material'. This definition implies a helping relationship between the person telling a traumatic story, and the person listening to it. When this relationship does not exist, those involved with the research process may experience heightened feelings of helplessness and despair because of their inability to intervene. Unlike counsellors or practitioners who engage with people in therapeutic relationships, researchers have less capacity to intervene in participants' lives. This applies even more so to those on the periphery of the research process like transcriptionists or interpreters. This feeling of powerlessness may also be induced by commissioned research that does not fit with the values or expectations of the researcher or research participants.

Coles *et al* (2014) recommend that researchers should acknowledge that sensitive work is not necessarily for everyone and suggest that researchers undertake basic training in counselling skills. Within health and social care research, however, the majority of researchers will have backgrounds in professions such as nursing, social work and the allied health professions.

They will have had formal training in counselling skills and typically will have amassed clinical experience in supporting people through difficult situations. But does this necessarily mean that they are better prepared to listen and respond to traumatic accounts? There is evidence to suggest that health professionals are skilled at emotional regulation (Hayward & Tuckey 2011) and reflection (Smith 2012). While these skills may help to protect against vicarious trauma, there is still considerable evidence that vicarious trauma is a significant issue for practising professionals. For example, an NSPCC (2013) report identified that social workers, especially those who work with abused children, experience increased stress and are at particularly high risk of vicarious trauma. Similarly, professionals who experience multiple losses, for example professionals working in palliative care settings, have been shown to be at particularly high risk of psychological stress (Strom-Gottfried & Mowbray 2006). Although professionals may be required to balance empathy with a degree of emotional distance from their patients/clients' lives, this is often framed within the boundaries of ethical practice rather than self-preservation and is more related to emotional labour, rather than vicarious trauma. Although related, we see a distinction between the concepts of vicarious trauma and emotional labour. The latter was first described by Hochschild (1983) as a result of observational work undertaken with the 'professional face' of airline crew. It is an issue discussed extensively in nursing and is concerned with the way that nurses regulate their emotional displays even when they are feeling upset or angry. This subconscious regulation is an attempt to conform to perceived expectations of how they 'ought' to appear, such as empathic and caring. Over time, the façade of emotional labour can result in stress and burnout (Smith 2012). Vicarious trauma is also associated with emotions and potential stress and burnout. But it occurs as a result of exposure to another's emotions, rather than dealing with one's own.

Moreover, individual professionals' reactions to trauma will be shaped not only by their training and experience, but by personal factors too. Individual personalities, spiritualties and personal experiences of death and abuse can impact health professionals' responses to traumatic accounts (Strom-Gottfried & Mowbray 2006). Thus, while a professional background may serve to protect against vicarious trauma, it is not necessarily a given that health and social care researchers will be less affected by engaging in emotive and sensitive research topics.

Consideration must be given to how vicarious trauma is anticipated, identified and addressed when it occurs. We suggest that our conceptual framework could be used to anticipate potential for vicarious trauma in order to put in place strategies to attempt to address secondary trauma positively and in a timely fashion. We stress that such strategies should not include emotional or empathic disengagement as such engagement is often central to the research process but should instead create opportunities for personal growth and academic innovation. In order for such strategies and responses to be effective, however, responsibility needs to be acknowledged at four levels, that is, the individual researcher level, the supervisory level, the organisational level and the structural level. An individual researcher is likely to be in a unique position to identify their own vulnerabilities and triggers for distress. A positive supervision process, however this is organised, will enable the researcher to achieve the level or reflection and reflexivity required to anticipate, identify and address emotional risk. These processes though require good organisational systems to support reflective research practice. For example, organisations may encourage and make available mentoring or formal counselling services. They may also provide formal training for members of ethics panels, principal investigators and junior researchers around emotional risk and vicarious trauma. It may also be necessary to address organisational barriers to

implementing these systems such as cultures of individual competition or machismo within academia. Finally, research commissioners or funding bodies could ensure that the additional resources that may be required to provide safeguarding measures within a study fall within eligible costs of awards and are part of the quality criteria used to assess grant proposals. However, such support mechanisms are unlikely to be available to those interacting at a distance with research material.

Codes of practice have been developed aimed at the safety of researcher such as those of the Social Research Association (2006) and Economic and Social Research Council (2015). They currently place more emphasis on physical safety than emotional safety. There would be value in strengthening such aspects of these and other relevant guidelines.

In our analysis we retrieved only studies that fitted into quadrants 3 and 4 of our conceptual framework (figure 1). A fuller analysis across a range of topics and methodologies would provide an indication of the distribution of studies across the framework, and thus a clearer picture of the risks of vicarious trauma within the reporting of our research. According to this conceptual framework, tertiary, non-sensitive research carries the least risk. Most of the research that we conduct in nursing and healthcare is likely to fall into one of the other three quadrants, indicating at the least, an amber alert.

We are cognisant of the consolidated criteria for reporting qualitative research (COREQ) (Tong at al., 2007) that calls upon transparency in the reporting of qualitative research. The COREQ checklist has three domains: research team and reflexivity; study design; analysis and findings. We suggest that the issue of vicarious trauma could be usefully incorporated into the checklist as way of prompting authors or those reviewing their published work, to

describe the steps that they have taken to address the issue. Protecting against the potential significant negative consequences of vicarious trauma is beneficial to all and it warrants systematic consideration in the planning, conducting and reporting of research. Through this, the number of cases experiencing what Baum (2010) describes as 'double exposure', i.e. researchers and supporting services are exposed to the same traumatic event as their research participants, could be diminished.

## Conclusion

As a practice discipline nursing research often deals with real world concerns involving exposure to sensitive issues such as abuse/violence or death/dying. Despite the highly sensitive nature of such research, our paper identified a lack of explicit acknowledgment of how vicarious trauma among those conducting the study has been addressed in published research reports. It is noteworthy that less than one per cent of the papers that we scrutinised as part of this mapping review referred to vicarious trauma. This is in spite of the sensitive nature of the research reported in the papers. Thus, it is our concern to raise awareness among nursing researchers to place more emphasis on how vicarious trauma is anticipated, prevented, identified and addressed. It is likely that different academic disciplines will have different conceptual resources to draw upon to make sense of emotional risk in research. There would be value in exploring these disciplinary differences further.

Bringing vicarious trauma to the forefront of the research process has implications not only for researchers but also for ethics review panels and journal publishers. When planning sensitive issues projects, researchers should anticipate the potential personal impact of engaging in research for the entire research team including supporting services (e.g. interpreters, transcriptionists) and consider precautionary measures. This should include a

clear plan for promoting vicarious resilience and strategies for addressing vicarious trauma if it arises. Mentoring, supervision, debriefing opportunities and access to pertinent literature could be made available for all those involved in the research, regardless of their position to the project, to build resilience against traumatic stress responses. Our conceptual framework offers a way of anticipating and reflecting on how vicarious trauma will be addressed. The framework is also useful for ethics review panels and journal publishers in identifying research projects with a high risk of vicarious trauma. Inclusion within published checklists and guidance for research reporting may focus attention on what is currently an important omission. Nursing research could lead the way in this respect.

## Relevance to clinical practice

Vicarious trauma is not well considered in research into clinically important topics, yet nurses deal regularly with issues of death and dying, and with violence and abuse. Our proposed framework allows for consideration of these so that precautionary measures can be put in place to minimise harm to clinical staff in research and practice who are likely to encounter such issues.

## Contributions

All authors contributed to the study concept and design, participated in data collection and analysis, developed the conceptual framework and assisted in preparing the manuscript.

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## Conflict of interest

The authors have no conflict of interest to declare.

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## Table 1: Top 10 Nursing Journals (Scopus)

1. Journal of Pain and Symptom Management (Excluded)
2. Journal of Nursing Scholarship
3. Journal of the American Medical Directors Association (Excluded)
4. International Journal of Nursing Studies (IJNS)
5. Journal of Advanced Nursing (JAN)
6. Journal of Palliative Medicine (Excluded)
7. Nursing Research
8. Nursing Outlook
9. Research in Nursing and Health (RNH)
10. Nurse Education Today (Excluded)

*NB: To ensure we were not missing crucial data, a further check was made over the articles in the four excluded journals, where we reviewed a year's worth of papers (2013). No further instances of vicarious trauma were discussed in the tranche of papers reviewed.*

## Table Two: Scoping Proforma

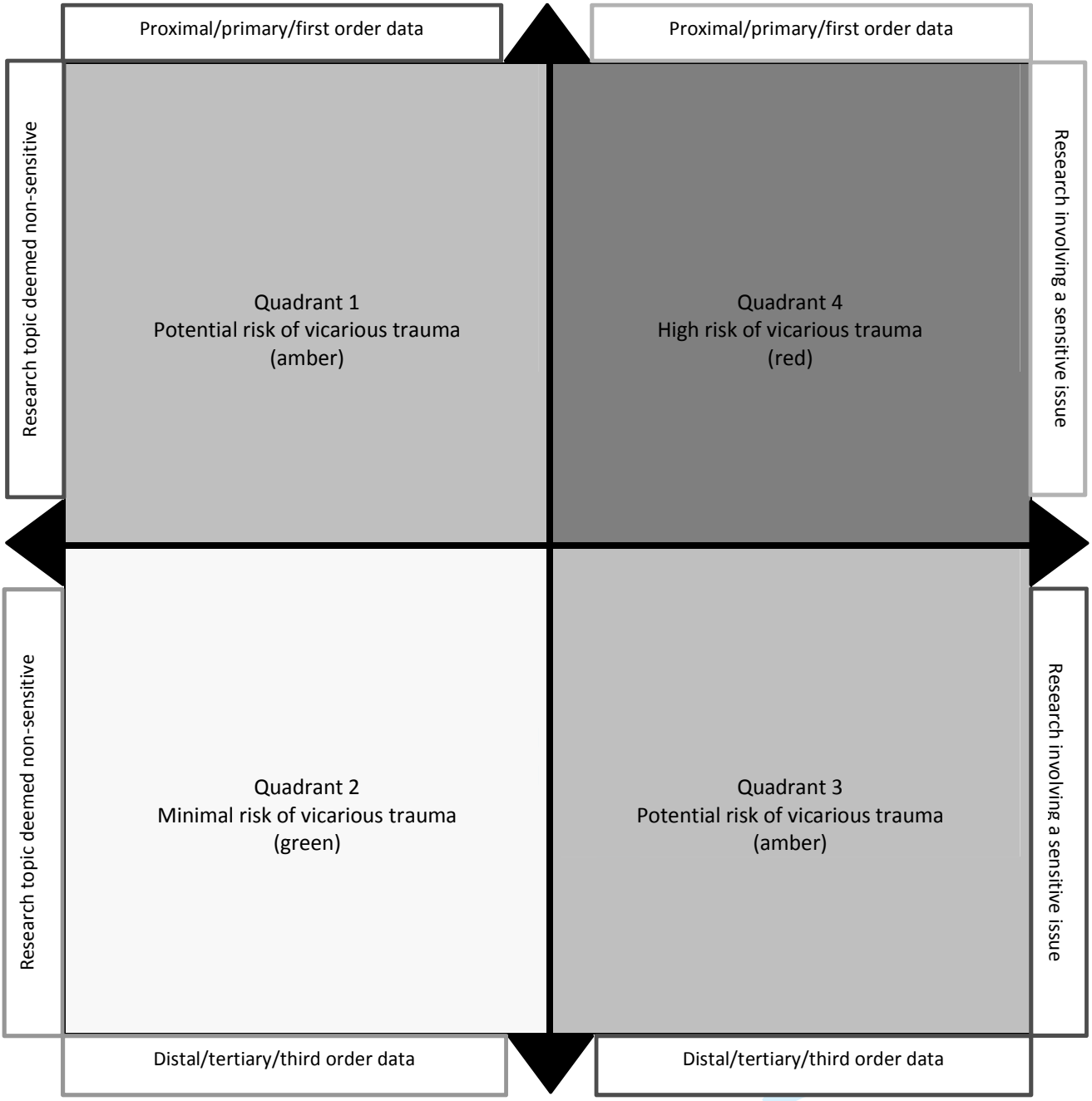
## Journal: (1st January 2009 until 31st December 2014) (Reviewer initials)

| Volume (year) of Journal | Total empirical papers published during review period | Total papers meeting inclusion criteria (i.e. primary research, abuse/violence; death/dying) | Number of papers dealing with abuse/violence (specify) | Number of papers dealing with dying/death (specify) | Number of papers involving children (0-18) | Number of papers involving adults (19+) | Number of papers that discuss vic trauma | Study design/methods used (name) | Method of analysis |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| **Total** | | | | | | | | | |

## Table 3: Summary Table of Scoping Exercise from 1st January 2009 until 31st December 2014 (n=6)

| Name of Journal | Total empirical papers published during review period | Total papers meeting inclusion criteria (i.e. primary research, abuse/violence; death/dying) | Study design (qualitative, quantitative or mixed-method) | Number of papers dealing with abuse/violence | Number of papers dealing with dying/death | Number of papers involving children (0-18) | Number of papers involving adults (19+) | Number of papers where vicarious trauma is being discussed |
|---|---|---|---|---|---|---|---|---|
| International Journal of Nursing Studies | 722 | 22 | Qualitative n=13<br>Quantitative n=9 | 8 | 14 | 1* | 22 | 0 |
| Journal of Advanced Nursing | 1009 | 41 | Qualitative n=19<br>Quantitative n=21<br>Mixed-method n=1 | 21 | 20 | 1 | 40 | 2 |
| Journal of Nursing Scholarship | 188 | 12 | Qualitative n=8<br>Quantitative n=4 | 9 | 3 | 1 | 11 | 0 |
| Nursing Outlook | 112 | 3 | Qualitative n=2<br>Quantitative n=1 | 2 | 1 | 0 | 3 | 0 |
| Nursing Research | 237 | 11 | Quantitative n=11 | 8 | 3 | 3 | 8 | 0 |
| Research in Nursing and Health | 235 | 15 | Qualitative n=10<br>Quantitative n=5 | 6 | 9 | 1 | 14 | 0 |
| **Total** | **2503** | **104** | **Qual=52; Quan=51** | **54** | **50** | **7** | **98** | **2** |

* Please note that figures in this row do not add up because the study involved both children and adults.


Proximal/primary/first order data
Proximal/primary/first order data
Research topic deemed non-sensitive
Research involving a sensitive issue
Quadrant 1
Potential risk of vicarious trauma
(amber)
Quadrant 4
High risk of vicarious trauma
(red)
Research topic deemed non-sensitive
Research involving a sensitive issue
Quadrant 2
Minimal risk of vicarious trauma
(green)
Quadrant 3
Potential risk of vicarious trauma
(amber)
Distal/tertiary/third order data
Distal/tertiary/third order data