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Researching risk, abuse and violence in the context of health

Centre for Crime, Justice and Policing
Anniversary Conference 26th June 2017

Caroline Bradbury-Jones & Julie Taylor, University of Birmingham
c.bradbury-jones@bham.ac.uk j.taylor.1@bham.ac.uk
@jones_bradbury @bulawayojulie
Website: http://www.birmingham.ac.uk/schools/nursing/research/rav.aspx

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RISK, ABUSE AND VIOLENCE (RAV) RESEARCH PROGRAMME

- ‘Our aim is to build a body of research and scholarly evidence in relation to Risk, Abuse and Violence that dovetails with and informs teaching and clinical activities in the University of Birmingham’

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RAV Research: Pushing the boundaries

- Empirically
- Philosophically
- Methodologically
- Theoretically
- Conceptually

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Health and Social Care in the community

Health and Social Care in the Community (2013) 21 (5), 489–499 doi: 10.1111/hsc.12037

Health professionals' beliefs about domestic abuse and the issue of disclosure: a critical incident technique study

Julie Taylor RN MSc PhD[1], **Caroline Bradbury-Jones** RN RM PhD[2], **Thilo Kroll** PhD Dipl-Psych (GER)[3] and **Fiona Duncan** RN RM BA[4]

[1]NSPCC Child Protection Research Centre, University of Edinburgh, Edinburgh, UK, [2]School of Nursing and Midwifery, University of Dundee Scotland, Dundee, UK, [3]Social Dimensions of Health Institute, Universities of Dundee and St Andrews, Dundee, UK and [4]National Health Service (NHS) Cardenden Fife, UK

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Correspondence
Julie Taylor
NSPCC Child Protection Research Centre
University of Edinburgh
Moray House,
3.15 St Leonard's Land
Holyrood Road,
Edinburgh EH8 8AQ, UK
E-mail: julie.taylor@ed.ac.uk

What is known about this topic

- Domestic abuse is a serious public health issue.
- Women who experience domestic abuse often conceal their experiences.
- Health professionals' responses to domestic abuse are sometimes inadequate.

What this paper adds

- Health professionals and abused women do not always share the same beliefs about domestic abuse.
- Discussing abuse with women is something that health professionals find difficult, but women want to be asked.
- Several practices can be adopted by health professionals to keep women safe post-disclosure, including 'code talk'.

Abstract

Domestic abuse is increasingly recognised as a serious, worldwide public health concern. There is a significant body of literature regarding domestic abuse, but little is known about health professionals' beliefs about domestic abuse disclosure. In addition, the intersection between health professionals' beliefs and abused women's views remains uninvestigated. We report on a two-phase, qualitative study using Critical Incident Technique (CIT) that aimed to explore community health professionals' beliefs about domestic abuse and the issue of disclosure. We investigated this from the perspectives of both health professionals and abused women. The study took place in Scotland during 2011. The study was informed theoretically by the Common Sense Model of Self-Regulation of Health and Illness (CSM). This model is typically used in disease-orientated research. In our innovative use, however, CSM was used to study the social phenomenon, domestic abuse. The study involved semi-structured, individual CIT interviews with health professionals and focus groups with women who had experienced domestic abuse. Twenty-nine health professionals (Midwives, Health Visitors and General Practitioners) participated in the first phase of the study. In the second phase, three focus groups were conducted with a total of 14 women. Data were analysed using a combination of an inductive classification and framework analysis. Findings highlight the points of convergence and divergence between abused women's and health professionals' beliefs about abuse. Although there was some agreement, they do not always share the same views. For example, women want to be asked about abuse, but many health professionals do not feel confident or comfortable discussing the issue. Overall, the study shows the dynamic interaction between women's and health professionals' beliefs about domestic abuse and readiness to discuss and respond to it. Understanding these complex dynamics assists in the employment of appropriate strategies to support women post-disclosure.

Keywords: commonsense model, critical incident technique, disclosure, domestic abuse, intimate partner violence, routine enquiry

Domestic abuse is a common cause of: physical injury (Campbell 2002); depression and alcohol/drug misuse (Lazenbatt *et al.* 2009); and suicide (World Health Organization 2005). In its most extreme form, violence kills women. In the United Kingdom, two women are killed every week by a current or former partner (Hester 2009). We acknowledge that domestic abuse can take place against men by women (Flinck

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Leventhal's Common Sense Model

Table 1 Interpretation of Common Sense Model applied in this study

Domain	Original understandings	Interpretations in this study
Identity	The label given to a condition	Identification and recognition of domestic abuse
Cause	Ideas about perceived causes	The context in which domestic abuse occurs
Timeline	Beliefs about how long the condition will last	Temporal aspects of domestic abuse, such as the 'right time' for routine enquiry and disclosure
Curability/controllability	Beliefs about the extent to which a condition can be cured	Where the responsibility lies for disclosure and subsequent response
Consequences	Perceptions regarding the consequences and impact of a condition	Consequences of domestic abuse for women; their children and health professionals

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ORIGINAL ARTICLE

Domestic abuse awareness and recognition among primary healthcare professionals and abused women: a qualitative investigation

Caroline Bradbury-Jones, Julie Taylor, Thilo Kroll and Fiona Duncan

Aims and objectives. To investigate the dynamics of domestic abuse awareness and recognition among primary healthcare professionals and abused women.

Background. Domestic abuse is a serious, public health issue that crosses geographical and demographic boundaries. Health professionals are well placed to recognise and respond to domestic abuse, but empirical evidence suggests that they are reluctant to broach the issue. Moreover, research has shown that women are reluctant to disclose abuse.

Design. A two-phase, qualitative study was conducted in Scotland.

Methods. Twenty-nine primary health professionals (midwives, health visitors and general practitioners) participated in the first phase of the study, and 14 abused women took part in phase two. Data were collected in 2011. Semi-structured, individual interviews were conducted with the health professionals, and three focus groups were facilitated with the abused women. Data were analysed using a framework analysis approach.

Findings. Differing levels of awareness of the nature and existence of abuse are held by abused women and primary healthcare professionals. Specifically, many women do not identify their experiences as abusive. A conceptual representation of domestic abuse – the "abused women, awareness, recognition and empowerment' framework – arising from the study – presents a new way of capturing the complexity of the disclosure process.

Conclusion. Further research is necessary to test and empirically validate the framework, but it has potential pedagogical use for the training and education of health professionals and clinical use with abused women.

Relevance to clinical practice. The framework may be used in clinical practice by nurses and other health professionals to facilitate open discussion between professionals and women. In turn, this may empower women to make choices regarding disclosure and safety planning.

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

- A conceptual representation of domestic abuse – the 'Abused women, awareness, recognition and empowerment' (AWARE) framework – presents a new way of capturing the complexity of the disclosure process.
- The framework can be used as a pedagogical tool for nurses and other health professionals.
- The framework could be used to facilitate open discussion between health professionals and women and empower women to make choices regarding disclosure and safety planning.

Key words: awareness, disclosure, domestic abuse, domestic violence, empowerment, health visitors, interpersonal violence, Johari window, midwives, nurses, recognition

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Authors: *Caroline Bradbury-Jones*, MA, PhD, HV, Senior Lecturer, School of Nursing, Midwifery and Social Work, University of Manchester, Manchester; *Julie Taylor*, MSc, PhD, RN, Professor and Co-Director, NSPCC Child Protection Research Centre, University of Edinburgh, Edinburgh; *Thilo Kroll*, PhD, Professor and Co-Director, Social Dimensions of Health Institute (SDHI), Universities of Dundee and St Andrews, Dundee; *Fiona Duncan*, BA, MSc, HV, Gender Based Violence Nurse Advisor, NHS Fife, Auchtermuran Centre, Cardenden, UK

Correspondence: Caroline Bradbury-Jones, Senior Lecturer, School of Nursing, Midwifery and Social Work, University of Manchester, Jean McFarlane Building, Oxford Road, Manchester M13 9PL, UK. Telephone: +44 0161 3067656.
E-mail: caroline.bradbury-jones@manchester.ac.uk

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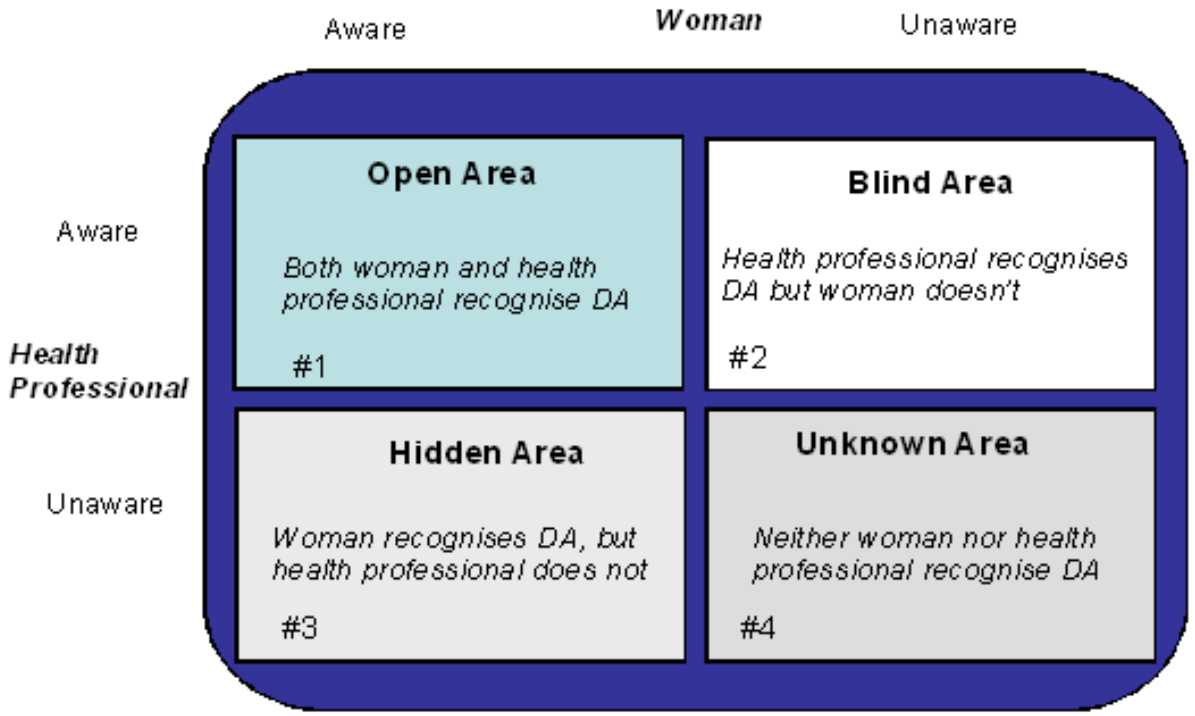
The Johari Window



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Original article

Domestic abuse as a transgressive practice: understanding nurses' responses through the lens of abjection

Caroline Bradbury-Jones* PhD MA RN **and Julie Taylor†** PhD MSc RN

*Senior Lecturer, School of Nursing, Midwifery and Social Work, University of Manchester, Manchester, and †Co-director, NSPCC Child Protection Research Centre, University of Edinburgh, Edinburgh, UK

Abstract

Domestic abuse is a worldwide public health issue with long-term health and social consequences. Nurses play a key role in recognizing and responding to domestic abuse. Yet there is considerable evidence that their responses are often inappropriate and unhelpful, such as trivializing or ignoring the abuse. Empirical studies have identified several reasons why nurses' responses are sometimes wanting. These include organizational constraints, e.g. lack of time and privacy; and interpersonal factors such as fear of offending women and lack of confidence. We propose, however, that these factors present only a partial explanation. Drawing on the work of Julia Kristeva, we suggest that alternative understandings may be derived through applying the concept of abjection. Abjection is a psychological defence against any threat (the abject) to the *clean* and *proper* self that results in rejection of the abject. Using examples from our own domestic abuse research, we contend that exposure of nurses to the *horror* of domestic abuse evokes a state of abjection. Domestic abuse (the abject) transgresses established social boundaries of clean and proper. Thus when exposed to patients' and clients' experiences of it, some nurses subconsciously reject domestic abuse as a possibility (abjection). They do this to protect themselves from the horror of the act, but in so doing, render themselves unable to formulate appropriate responses. Rather than understanding the practice of some nurses as wilfully neglectful or ignorant, we argue that through a state of abjection, they are powerless to act. This does not refute existing evidence about nurses' responses to domestic abuse. Rather, as a relatively unknown concept in nursing, abjection provides an additional explanatory layer that accounts for why some nurses respond the way they do. Crucially, it elucidates the need for nurses to be supported emotionally when faced with the transgressive practice of abuse.

Keywords: abjection, disgust, domestic abuse, horror, nursing, responses.

Correspondence: Dr Caroline Bradbury-Jones, Senior Lecturer, School of Nursing, Midwifery and Social Work, University of Manchester, Jean McFarlane Building, Oxford Road, Manchester M13 9PL, UK. Tel: +44(0)1613067656; fax: +44(0)1613067707; e-mail: caroline.bradbury-jones@manchester.ac.uk

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Julia Kristeva's Abjection

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Breckenridge et al. BMC Pregnancy and Childbirth 2014, 14:234
http://www.biomedcentral.com/1471-2393/14/234

BMC Pregnancy & Childbirth

RESEARCH ARTICLE Open Access

Access and utilisation of maternity care for disabled women who experience domestic abuse: a systematic review

Jenna P Breckenridge[1*], John Devaney[2], Thilo Kroll[1], Anne Lazenbatt[2], Julie Taylor[3] and Caroline Bradbury-Jones[4]

Abstract

Background: Although disabled women are significantly more likely to experience domestic abuse during pregnancy than non-disabled women, very little is known about how maternity care access and utilisation is affected by the co-existence of disability and domestic abuse. This systematic review of the literature explored how domestic abuse impacts upon disabled women's access to maternity services.

Methods: Eleven articles were identified through a search of six electronic databases and data were analysed to identify: the factors that facilitate or compromise access to care; the consequences of inadequate care for pregnant women's health and wellbeing; and the effectiveness of existing strategies for improvement.

Results: Findings indicate that a mental health diagnosis, poor relationships with health professionals and environmental barriers can compromise women's utilisation of maternity services. Domestic abuse can both compromise, and catalyse, access to services and social support is a positive factor when accessing care. Delayed and inadequate care has adverse effects on women's physical and psychological health, however further research is required to fully explore the nature and extent of these consequences. Only one study identified strategies currently being used to improve access to services for disabled women experiencing abuse.

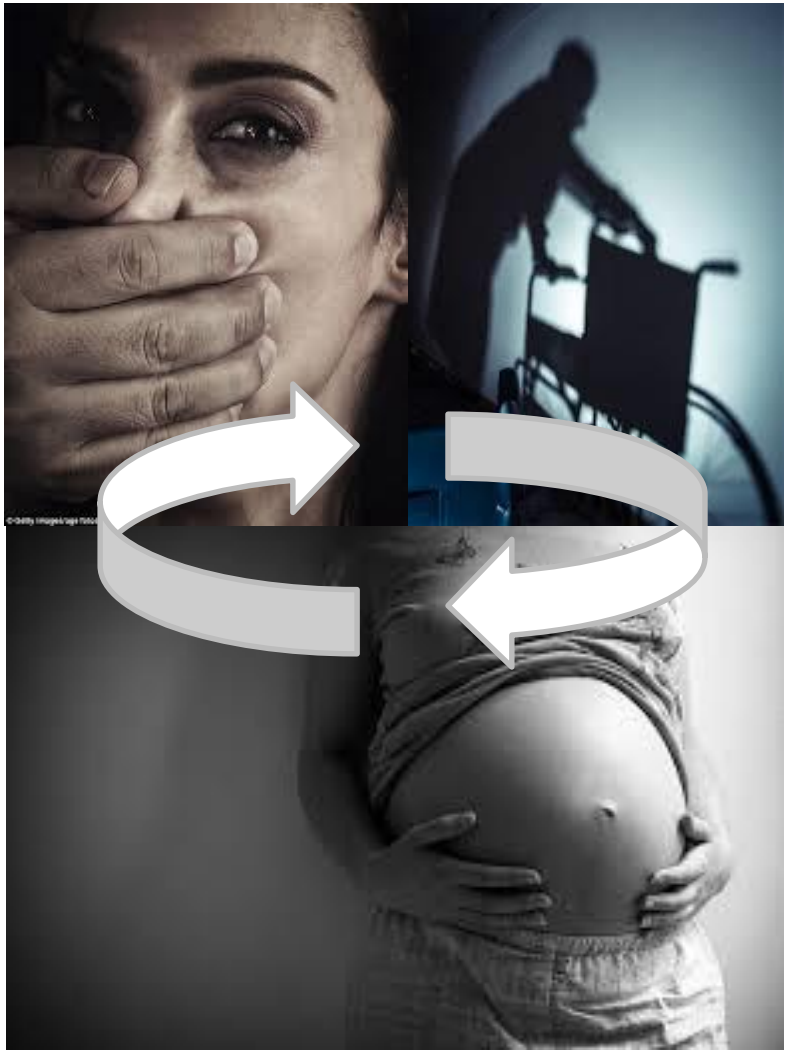
Conclusions: Based upon the barriers and facilitators identified within the review, we suggest that future strategies for improvement should focus on: understanding women's reasons for accessing care; fostering positive relationships; being woman-centred; promoting environmental accessibility; and improving the strength of the evidence base.

Keywords: Disability, Domestic abuse, Pregnancy, Maternity, Access, Utilisation, Review

Background

Domestic abuse during pregnancy has such negative consequences for maternal and infant health that the World Health Organization (WHO) has declared it a significant global concern [1]. More than 30% of domestic abuse begins during pregnancy [2,3] and evidence suggests that pre-existing abuse may escalate during the prenatal period [4-6]. Although 10% of women giving birth in the United Kingdom (UK) are reported to have some degree of disability, there is little understanding of disabled women's experiences of domestic abuse during pregnancy. Disabled women are two times more likely to suffer physical abuse from an intimate partner than non-disabled women [7], and it is therefore likely that disabled women may be particularly vulnerable to pregnancy-related abuse. Nixon [8] has suggested that disabled women who experience domestic abuse face compound oppressions. Several studies have linked domestic abuse with adverse maternal and infant outcomes [9-13]. Potentially compounding these negative consequences, certain disabled women may be more susceptible to pregnancy complications than non-disabled women [14,15]. Moreover, studies have suggested that abused women delay accessing maternity services until the third trimester [16-18] and that disabled women are also likely to have delayed or suboptimal access to healthcare [14,19,20].

*Correspondence: j.breckenridge@dundee.ac.uk
[1]Social Dimensions of Health Institute, University of Dundee, Dundee, UK
Full list of author information is available at the end of the article



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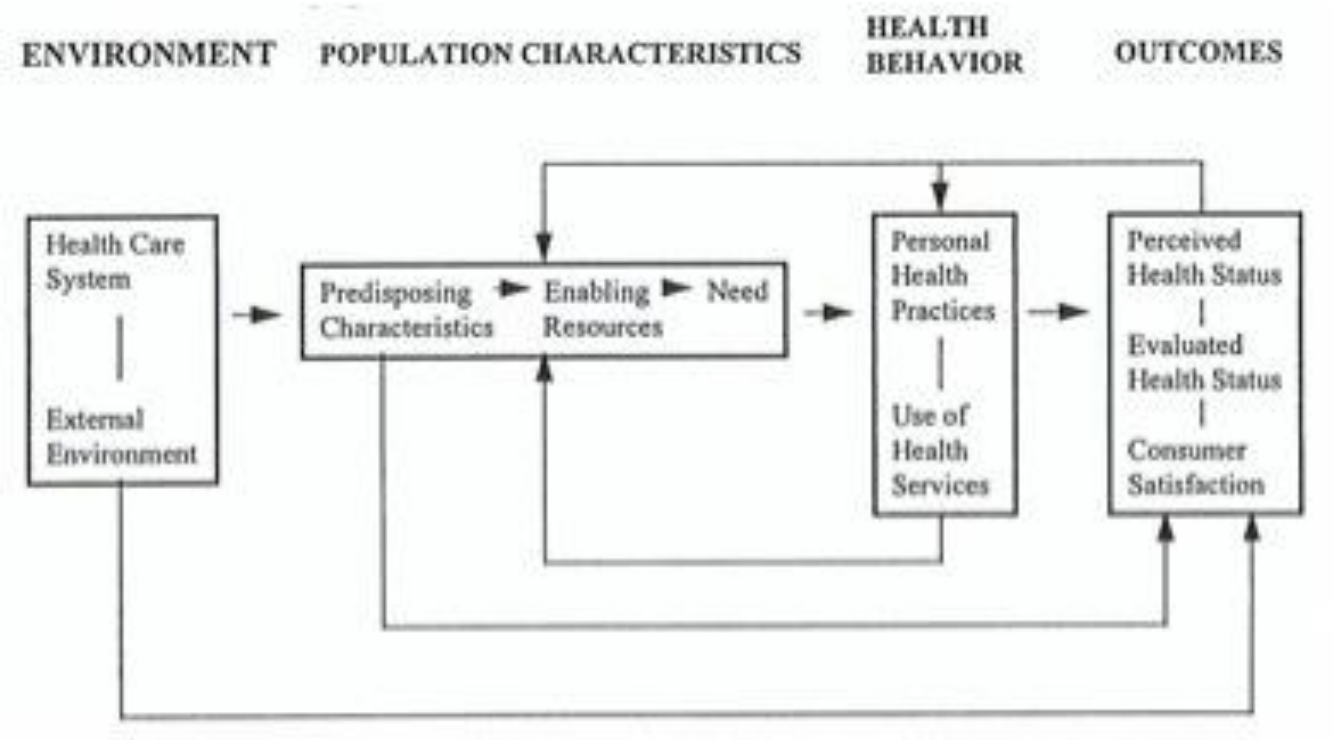
Andersen's Model of Health Care Utilisation



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DISCURSIVE PAPER

Development of a practice framework for improving nurses' responses to intimate partner violence

Caroline Bradbury-Jones, Maria T Clark, Jayne Parry and Julie Taylor

Aims and objectives. The aim of this article is to discuss critically the theoretical concepts of awareness, recognition and empowerment as manifested in intimate partner violence and to show how these can be translated into a practice framework for improving nurses' response.

Background. Intimate partner violence is a universal problem and is considered a significant public health issue. Nurses are in an ideal position to recognise and respond to intimate partner violence, but many lack confidence in this area of practice. In our previous empirical work, we identified three concepts through which nurses' responses to intimate partner violence can be understood: awareness, recognition and empowerment. In this article, we advance nursing knowledge by showing how these concepts can form a practice framework to improve nurses' responses to intimate partner violence.

Design. A discussion paper and development of a practice framework to improve nurses' responses to intimate partner violence.

Discussion. The framework comprises three principal needs of women and three related key requirements for nurses to meet these needs. Arising from these are a range of practice outcomes: enhanced understanding of intimate partner violence, increased confidence in recognising intimate partner violence, establishment of trusting relationships, increased likelihood of disclosure and optimised safety.

Conclusions. Nurses sometimes lack confidence in recognising and responding to intimate partner violence. Awareness, recognition and empowerment are important concepts that can form the basis of a framework to support them. When nurses feel empowered to respond to intimate partner violence, they can work together with women to optimise their safety.

Relevance to clinical practice. Access to adequate and timely intimate partner violence education and training is important in improving nurses' responses to intimate partner violence. Getting this right can lead to enhanced safety planning and better health outcomes for women who experience intimate partner violence. Although difficult to measure as an outcome, nurses' improved responses can contribute to higher rates of referral for help and reduction in intimate partner violence rates.

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

- A new practice framework shows how the concepts of awareness, recognition and empowerment can be translated into IPV-related practice outcomes.
- The simplicity of the framework makes it a practical resource that might assist nurses in unravelling the complexities of IPV, and it can be used as a clinical or pedagogical tool.
- IPV is a global public health issue, and the framework presented in this article should have transference to multiple settings and countries.

Author: *Caroline Bradbury-Jones*, PhD, RM, RN, Reader in Nursing, School of Nursing, Institute of Clinical Sciences, University of Birmingham, Birmingham; *Maria T Clark*, SCPHN-HV, PhD, RM, RGN, Lecturer in Nursing, Programme Lead: MSc Advanced Clinical Practice, School of Nursing, Institute of Clinical Sciences, University of Birmingham, Birmingham; *Jayne Parry*, MD, FFPH, Professor of Policy and Public Health, Institute of Applied Health Research, University of Birmingham, Birmingham; *Julie Taylor*, MSc, PhD, RN, Professor of Child Protection, School of Nursing, Institute of Clinical Sciences, University of Birmingham, Edgbaston and Birmingham Children's Hospital NHS Foundation Trust, Birmingham, UK.

Correspondence: Caroline Bradbury-Jones, Reader in Nursing, School of Nursing, Institute of Clinical Sciences, University of Birmingham, Birmingham B15 2TT, UK. Telephone: +44 (0) 121 414 3951.
E-mail: c.bradbury-jones@bham.ac.uk

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Developing a Theory of Change

Concept	Principal needs of women	Key requirements for health professionals	Practice Outcomes	Public Health Outcome
Awareness	Naming the abuse	Access to appropriate domestic abuse education and training	Enhanced understandings of domestic abuse Increased confidence in recognising domestic abuse	Increased rates of domestic abuse referral and reduction in domestic abuse rates
Recognition	Support with disclosure	Support in having difficult conversations	Establishment of trusting relationships Increased likelihood of disclosure	
Empowerment	Control over safety choices	Working in partnership for safety planning	Optimized safety	

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Child maltreatment: pathway to chronic and long-term conditions?

Julie Taylor[1], Caroline Bradbury-Jones[2], Anne Lazenbatt[3], Francesca Soliman[1]

[1]Child Protection Research Centre, University of Edinburgh/NSPCC, [illegible], Edinburgh [illegible], UK
[2]School of Health and Population Sciences, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham [illegible], UK
[3]Institute of Child Care Research, School of Sociology, Social Policy and Social Work, Queen's University Belfast, [illegible] College Park, Belfast [illegible], UK
Address correspondence to Francesca Soliman, E-mail: [illegible]

ABSTRACT

The manifesto *Start Well, Live Better* by the UK Faculty of Public Health (Start Well, Live Better—A Manifesto for the Public's Health. London: UK Faculty of Public Health, 2014) sets out 12 compelling priorities for the protection of people's health. The focus of this document is preventative, calling for a comprehensive strategy to target a wide-ranging set of challenges to public health; however, it fails to mention child maltreatment and its negative impact on long-term health outcomes. In this article, we explore the long-term negative consequences of child maltreatment and how these can be conceptually aligned with four different characteristics of long-term health conditions. We suggest that situating child maltreatment within a long-term conditions framework could have significant advantages and implications for practice, policy and research, by strengthening a commitment across disciplines to apply evidence-based principles linked with policy and evaluation and recognizing the chronic effects of maltreatment to concentrate public, professional and government awareness of the extent and impact of the issue. We argue that a public health approach is the most effective way of focusing preventative efforts on the long-term sequelae of child maltreatment and to foster cooperation in promoting children's rights to grow and develop in a safe and caring environment free from violence and abuse.

Keywords child maltreatment, chronic disease, management and policy

Introduction

In its 2014 manifesto *Start Well, Live Better*, the UK Faculty of Public Health[1] sets out 12 compelling priorities for the protection of people's health. The priority areas fall under four broad categories: give every child a good start in life; introduce good laws to prevent bad health and save lives; help people live healthier lives; take national action to tackle a global problem. The focus of this document is clearly preventative, calling for a comprehensive strategy to target a wide-ranging set of challenges to public health, such as addressing inequality, low wages and poor access to services, while advocating for targeted measures such as more stringent regulation around the sale and advertising of tobacco, alcohol and unhealthy foods (Table 1).

While some priority areas focus specifically on children, the manifesto fails to mention child abuse and neglect (collectively maltreatment) and their well-known negative impact on long-term health outcomes. According to the manifesto, 'obesity and climate change are two of our biggest public health challenges' (p. 12). We argue, however, that child maltreatment also constitutes a significant threat to public health. Child maltreatment is not a disease process, but its consequences may create pathways to disease; these are overlapping, and include determinants which span emotional, psychosocial, cognitive, behavioural and biological perspectives. In this article, we explore the long-term consequences of child maltreatment and how these might be conceptually aligned with the characteristics of long-term health conditions. By looking at maltreatment through this lens, we cannot only improve the practitioner community's understanding of its impact on public health, but also devise a more efficient and comprehensive public health strategy.

Julie Taylor, Chair of Child Protection
Caroline Bradbury-Jones, Reader in Nursing
Anne Lazenbatt, NSPCC Reader in Childhood Studies
Francesca Soliman, Research Assistant

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Applying a long term conditions framework

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Young People's Experiences of Going Missing From Care: A Qualitative Investigation using Peer Researchers

Julie Taylor*
University of Edinburgh/NSPCC Child Protection Research Centre, University of Edinburgh, UK

Caroline Bradbury-Jones
School of Nursing, Midwifery and Social Work, The University of Manchester, UK

Helen Hunter

Kate Sanford
Quarriers, Scotland's Family Charity, Bridge of Weir, Glasgow, UK

Tom Rahilly
NSPCC Strategy and Development, London, UK

Nayla Ibrahim
Independent Researcher, Glasgow, UK

Looked after children are significantly more likely than other children to go missing. They face significant risk of harm through, for example, exposure to alcohol, drugs and sexual victimisation. While research identifies some factors which may reduce the likelihood of looked after children going missing, it is recognised that a greater understanding of effective practice is needed. The aim of the study was to investigate young people's experiences of going missing from care and to identify the issues that contributed to them running away; trigger factors that prompted episodes of going missing; support received during or following instances where they went missing; and factors that might prevent future absconding. Research on children's experiences is often reported from the adult's perspective rather than allowing children to have a voice. We therefore recruited two young people to collaborate with the researchers as peer researchers. A qualitative study was undertaken using the Critical Incident Technique. Twenty-eight young people with a history of running away were recruited from different locations in Scotland. They took part in six focus groups, which were held during May 2012. Data were analysed using a framework approach. Four themes were identified regarding reasons for running away: authority and power; friction; isolation; and environmental issues. Commonly cited consequences were being 'grounded' and having shoes removed (to prevent further running away). Young people were critical of a lack of support on return and a lack of boundaries. They stressed the importance of being heard, being treated with respect, being able to exercise autonomy and feeling that someone cares. Copyright © 2013 John Wiley & Sons, Ltd.

KEY PRACTITIONER MESSAGES:

- Looked after children are significantly more likely than other children to go missing.
- When missing, young people are exposed to significant risk of harm.
- Reasons for running away are: authority and power; friction; isolation; and environmental issues.
- Approaches to responding to young people who go missing should be supportive and facilitative rather than punitive.
- Being heard, being treated with respect, being able to exercise autonomy and feeling that someone cares are crucial preventative factors.

KEY WORDS: care; looked after; peer interviewer; running away

*Correspondence to: Professor Julie Taylor, University of Edinburgh/NSPCC Child Protection Research Centre, St Leonard's Land, Holyrood Road, Edinburgh EH8 8AQ, UK. E-mail: Julie.Taylor@ed.ac.uk

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'Research on children's experiences is often reported from the adult's perspective'

'Young people were critical of a lack of support on return and a lack of boundaries'

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Children and co-researchers – ‘they put ketchup in my shoes’

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REVIEW

Risk of vicarious trauma in nursing research: a focused mapping review and synthesis

Julie Taylor, Caroline Bradbury-Jones, Jenna P Breckenridge, Christine Jones and Oliver Rudolf Herber

Aims and objectives. To provide a snapshot of how vicarious trauma is considered within the published nursing research literature.

Background. Vicarious trauma (secondary traumatic stress) 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. What 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 practice and from this, a new conceptualisation seeking to anticipate and address the risk of vicarious trauma was developed.

Results. Two thousand five hundred and three papers were published during the review period, of which 104 met the inclusion criteria. Studies were distributed evenly by method (52 qualitative; 51 quantitative; one 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 account 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.

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).

Authors: *Julie Taylor*, MSc, PhD, RN, Professor of Child Protection, School of Nursing, University of Birmingham, Birmingham and Birmingham Children's Hospital NHS Foundation Trust, Birmingham; *Caroline Bradbury-Jones*, PhD, RM, RN, Reader in Nursing, School of Nursing, University of Birmingham, Birmingham; *Jenna P Breckenridge*, BSc (Hons), PhD, Postdoctoral Researcher, Scottish Improvement Science Collaborating Centre (SISCC), University of Dundee, Dundee; *Christine Jones*, BA, MSc, PhD, Lecturer, School of Social Work and Social Policy, University of Strathclyde, Glasgow; *Oliver Rudolf Herber*, BScN, PhD, RN, Lecturer in Nursing, School of Nursing, University of Birmingham, Birmingham, UK

Correspondence: Julie Taylor, Professor of Child Protection, Institute of Clinical Sciences, and University of Birmingham, Birmingham B15 2TT, and Birmingham Children's Hospital NHS Foundation Trust, UK. Telephone: +44 (0) 121 414 8671.

E-mail: J.Taylor.36@bham.ac.uk

Twitter: @tolawayojulie

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The Focused Mapping Review and Synthesis: A new way of reviewing literature

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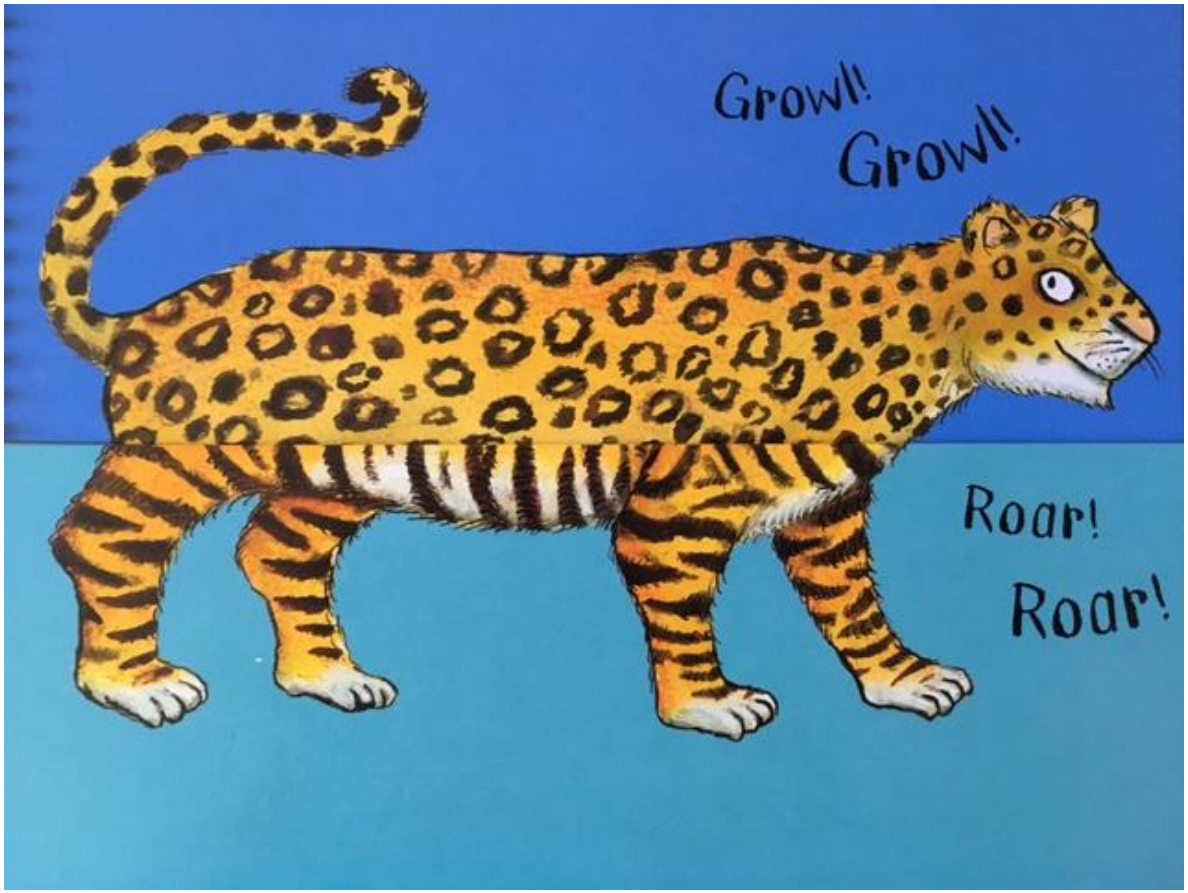
Possible limitations of hybridity: A Leopiger? Tiopard?



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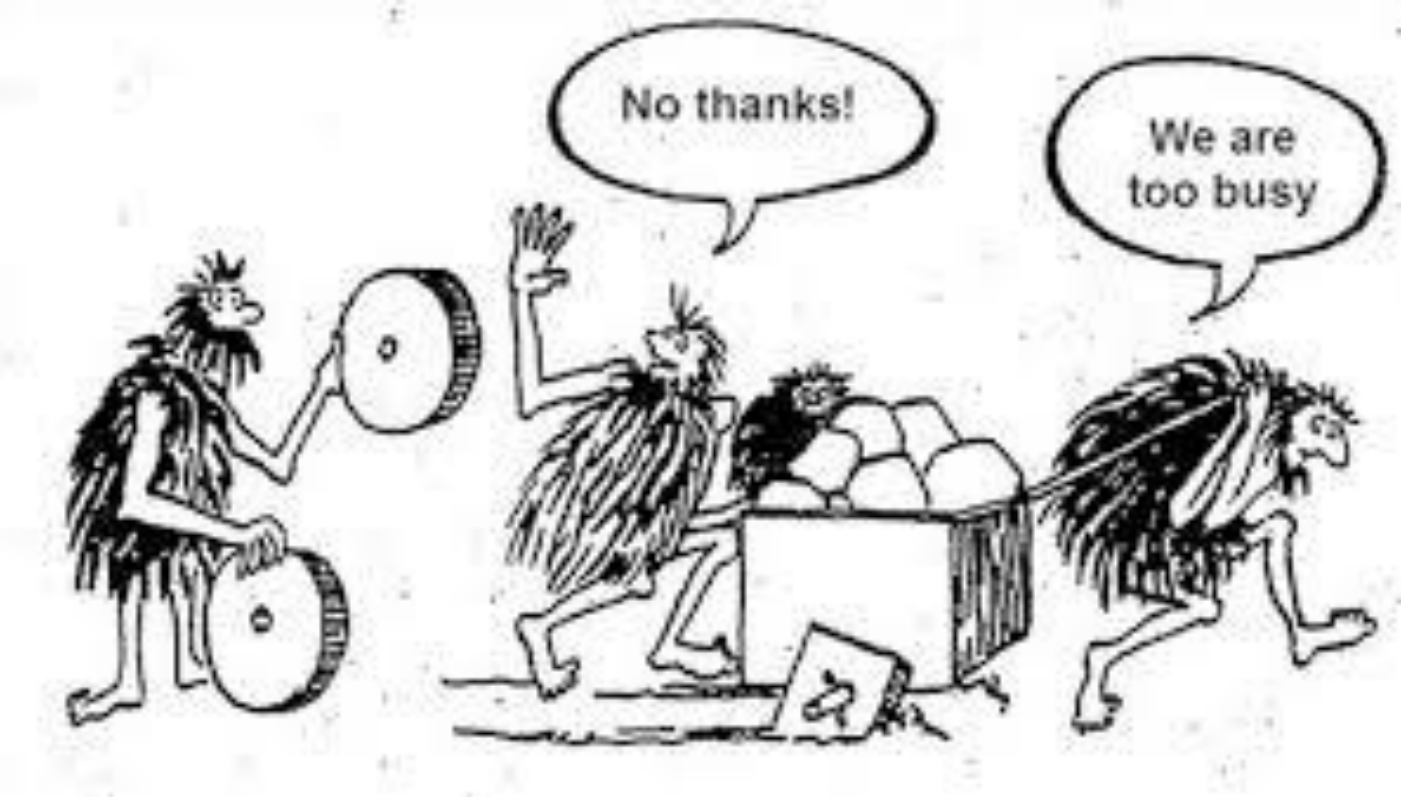
Conclusions



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