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Psychological trauma in professionals working with traumatised children

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STRUCTURED ABSTRACT:

Purpose of this paper: Clinical professionals working with psychologically traumatised children in the care system can experience potential challenges maintaining their own positive psychological health, and when repeatedly being exposed to the traumatic histories of those in their care. The aim of this paper is to increase understanding of vicarious trauma and provide a guide for focusing future research.

Design/methodology/approach: This is a systematic literature review, considering 13 articles that met the criteria and identified five main themes linked to secondary traumatic stress/vicarious trauma in staff.

Findings: 5 main themes were noted. These are: *Lack of organisational support; Lack of health work-life balance; Lack of appropriate training; Failure to use self-care techniques; and staff failure to share when they are experiencing symptoms.*

Practical implications: Various implications are noted from this review. These include the importance of education and support for staff, to be mindful that newer staff may be considered an 'at risk' group for the negative impact of such trauma, and to encourage staff in achieving an effective work-life balance.

What is original/value of paper: This is a focused systematic review on secondary and vicarious trauma on staff working with children exposed to psychological trauma, such as sexual and physical abuse.

KEY WORDS: secondary traumatic stress, vicarious trauma, compassion fatigue, staff, psychological trauma, children and adolescents

INTRODUCTION

Vicarious trauma is considered as alterations in schemas and core beliefs resulting from exposure to the trauma of others. *Secondary traumatic stress* is the transfer and acquisition of negative affective and dysfunctional cognitive states occurring due to prolonged and extended contact with traumatised individuals (Mott, 2012). Some researchers define these terms as two differing concepts, yet they are increasingly being used synonymously, along with *compassion fatigue* (Creamer & Liddle, 2005, McCann & Pearlman, 1990). Compassion fatigue is defined as a state of exhaustion and dysfunction, biologically, psychologically, and socially, resulting from long and repeated exposure to compassion stress and all that it evokes (Weeks, 1999). Compassion fatigue refers to the stress felt by the professionals after exposure to traumatic material of the survivor (Weeks, 1999). Mental health workers who are exposed to highly stressful environments are considered susceptible to burnout, as well secondary traumatic stress (Wagaman et al., 2015). In a study of house support workers (Bishop & Schmidt, 2011), it was noted that the majority of participants had heard of the term vicarious trauma, and 61% identified that their employer had discussed the impact of hearing other people's traumatic stories. However, only around a third of the participants had received specific training (Bishop & Schmidt, 2011).

There is little research looking at vicarious or secondary trauma in residential child placements. Yet, these are environments where staff can be exposed to the developmental trauma of young people, such as sexual and physical abuse, as well as being exposed to distress from this population. As such, research from areas close to this, such as mental health workers and therapists, must then be extrapolated in order to enhance understanding. Overall, working in environments where there is psychological trauma and/or mental health issues can be stressful, as staff can in some instances be exposed to acts of violence (both physical and verbal) and other distressing events, including hearing distressing details regarding the past traumas of their clients (Kindy, Peterson & Parkhurst, 2005; Weeks, 1999). The same challenges may then be considered when working with psychological traumatised children in the care system. Further, there is an increased prevalence of Post-Traumatic Stress Disorder (PTSD) symptoms among individuals working in a variety of environments (Skogstad et al., 2013), and where staff working with such children may be considered to theoretically fit these groups. In brief, the behavioural

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symptoms of PTSD are described as persistent re-experiencing, persistent avoidance of event-related stimuli, negative mood and persistent symptoms of increased arousal. These symptoms are similar to that which is experienced from vicarious or secondary trauma, although these are more likely to result when an individual *listens* empathically while someone shares the graphic details of their traumatic experience over an extended period of time (VanDeusen & Way, 2006). Arguably, staff working with children in care may form part of this group, and where the young people can choose to discuss their traumatic life experiences with staff as part of dealing with their distress.

As such, any PTSD symptoms, either in part or in full, can continue to intensify if left unaddressed. This can potentially result in burnout for the professional (Brady et al., 1999; Way et al. 2004). *Burnout* is described as a general emotional exhaustion that professionals may develop over time as a result of various work-related stressors (Way et al. 2004). The symptoms can ultimately result in the professional no longer working with the traumatised client (Way et al. 2004), and may have further links to compassion fatigue.

Personal Effects of Vicarious Trauma

Therapists who work with traumatised clients over an extended period may begin experiencing similar symptoms to their clients. Symptoms such as intrusive thoughts, nightmares, difficulty in managing intense emotions (such as rage, shame, grief, depression and anxiety), feeling helpless and feeling vulnerable have all been reported (McElvaney & Tatlow-Golden, 2016; Neumann & Gamble, 1995; Osofsky, 2011; Weeks, 1999; VanDeusen & Way, 2006). Therapists have also reported experiencing physical symptoms, such as headaches, nausea, and body aches (Motta, 2012; Neumann & Gamble, 1995), alongside psychological symptoms, such as emotional numbing, hypervigilance and personal difficulties, such as feeling discouraged and cynical (Neumann & Gamble, 1995; Pistorius, 2006; VanDeusen & Way, 2006). Others report experiencing decreased self-esteem and sexual difficulties (Braley, 2010; VanDeusen & Way, 2006), whereas some begin to feel shame as they experience the negative symptoms of vicarious trauma, losing trust in their own ability, especially in less-experienced therapists (VanDeusen & Way, 2006). Disruptions in therapists' own schemas, such as viewing the world as less safe, have

also been reported (Brady et al., 1999; Neumann & Gamble, 1995; Osofsky, 2011; Pistorius, 2006; VanDeusen & Way, 2006).

Symptoms can consequently impact on relationships, from work to personal relationships (Weeks, 1999). Lonergan et al. (2004) noted that therapists with child clients who have been sexually abused became more protective of their own children, and experienced intense fear of sexual abuse occurring in their family. However, another study noted that therapists reported appreciating life more and cherishing their children's innocence (Pistorius, 2006). Brady et al. (1999) found that when therapists listen to their client's trauma, describing the cruelty of some human behaviour, this can challenge their faith and make them question their own sense of meaning and hope (Brady et al., 1999). Damage to the therapist's spirituality is further considered to be one of the more dangerous threats to the individual's well-being (Brady et al., 1999). As such, all of these potential symptoms can apply to staff working with psychologically traumatised children.

Organisational Effects of Vicarious Trauma

If vicarious trauma goes unaddressed, it can lead to short-term and long-term emotional and physical effects, strains on relationships, substance abuse, burnout, and shortened careers (Neumann & Gamble, 1995; Weeks, 1999). These effects can negatively impact the organisation as a whole, as staff become unable to give the quality of care needed. Burnout leads to a high staff turnover, meaning organisations continuously look for replacements and have to train new staff.

Vicarious trauma of staff can further affect the client (Weeks, 1999). For instance, if the therapist experiences feelings of helplessness and frustration, they are more likely to diagnose clients with a mental illness, particularly a personality disorder (Weeks, 1999). Further traumatisation of the client can occur if the therapist focuses on their own needs rather than those of their clients, resulting in incidents such as forgotten appointments or phone calls (Weeks, 1999). This behaviour by the therapist makes the organisation look less professional and clients may choose to consequently transfer to another therapist.

Factors contributing to Vicarious Trauma

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While one study (Wagaman et al., 2015) noted empathy was a significant factor in aiding social workers to cope with the factors related to burnout and secondary traumatic stress, and that it contributes to the maintenance of the well-being and longevity of staff in their career, other studies found *more* empathetic therapists have a higher risk of developing vicarious trauma (Braley, 2010; Osofsky, 2011; Weeks, 1999). This therefore suggests that the *level* of empathic concern may be a factor, and that getting the balance correct is important. Further, if exposed to trauma material that was vivid, graphic, or showed that people can be intentionally cruel to each other, or the therapist shares traumatic re-enactments with clients, it can increase the likelihood of experiencing the symptoms of vicarious trauma (Weeks, 1999). These elements then affect the therapist's self-capacities, frame of reference, and safety schemas (Weeks, 1999).

Characteristics of the trauma event could further affect the likelihood of the therapist experiencing symptoms. The predictability, or unpredictability of the event, the extent to which the traumatic event violated the therapist's worldview or existing schemas, and the presence of any continued threat to the client, are all factors that could increase the individual's likelihood of developing symptoms if those factors are present (Weeks, 1999).

Organisational factors may additionally increase the likelihood of the mental health workers experiencing symptoms. Therapists with caseloads that consisted of over 50% trauma survivors were more likely to experience PTSD symptomatology than therapists that had fewer trauma survivors in their caseloads (Brady et al., 1999; Creamer & Liddle, 2005; Osofsky, 2011; Weeks, 1999). If staff receive no supervision, there is no opportunity to discuss the challenging aspects of the cases and process the information (Weeks, 1999). Without this supervisory support, they can develop a sense of disconnection from the organisation (Weeks, 1999).

Maltreatment history (including any maltreatment, multiple treatment, physical abuse, neglect, and emotional neglect) in the therapists themselves was significantly associated with increased disruptions of schemas (VanDeusen & Way, 2006). However, a factor in this may *not* be their own experiences of maltreatment per se, but whether they have resolved any personal distress that may link to this. It is noted that emotional neglect in the clinicians was particularly associated with more disruptions in cognitions about intimacy with others (VanDeusen & Way,

2006). However, contradictory results have been found, and some researchers conclude that clinicians with maltreatment history in and of itself was not significantly associated with vicarious trauma (Creamer & Liddle, 2005; Way et al., 2004), and other factors may be if such history continues to be a stressor or not. However, a significant predictor of vicarious trauma was noted for those professionals with a history of discussing reactions to their client's traumatic material during their own therapy sessions (Creamer & Liddle, 2005).

Less experienced staff have been observed to have an increased level of disruption in cognitions of trust and intimacy with others (Creamer & Liddle, 2005; Neumann & Gamble, 1995; Pistorius, 2006; VanDeusen & Way, 2006). For example, those under significant or chronic stress were more likely to experience symptoms of vicarious trauma (Brady et al., 1999; Weeks, 1999). Weeks (1999) concluded that coping style was one of the most important factors in regard to the development of symptoms and disruptions in schemas; problem-focused coping style was linked with less PTSD symptoms and fewer disruptions in existing schemas. Using this coping style may increase the therapist's sense of trust in themselves and promote a sense of control of their own problems (Weeks, 1999). An escape-avoidance coping style was linked with significantly higher amount of cognitive disruptions in relation to their feelings of safety of self, self-control, helplessness in relationships with others, intimacy with others, and trust of others (Pistorius, 2006; Weeks, 1999). The escape-avoidance coping style was found to be used more often by individuals experiencing higher levels of symptomatology (Weeks, 1999).

Personal Factors that mitigate or decrease Vicarious Trauma

Therapists indicate a key method to mitigate or reduce the potential for vicarious trauma is to educate themselves (Brady et al., 1999; Lonergan et al., 2004; McElvaney & Tatlow-Golden, 2016; Motta, 2012; Osofsky, 2011). Educating themselves about the field in general and, more specifically, about secondary traumatic stress, allows the mental health worker to understand that this is a common occurrence in the field, and reduces the stress of thinking they are not doing their job correctly if they are experiencing vicarious trauma (Lonergan et al., 2004). Education can also help to identify if they are experiencing any of the common symptoms and may provide helpful ways to reduce or mitigate these symptoms (Weeks, 1999). Training that

focuses on self-awareness, emotional regulation, and affective response, both before entering the field and during their working career to mitigate secondary traumatic stress (Wagaman et al., 2015) is considered an effective approach.

Self-care techniques, such as regular exercise, eating a healthy diet, taking vacations or taking breaks from work, setting appropriate limits on work time, diversifying their caseloads, and limiting the number of particularly difficult cases are further recommended (Motta, 2012; Neumann & Gamble, 1995; Lonergan et al., 2004; Osofsky, 2011). Decompression rituals, such as listening to calming music, spending some alone time reading, changing clothes, and exercising, can be used by the therapist to transition out of work lives into their home lives (Neumann & Gamble, 1995). Furthermore, having a fulfilling personal life and engaging in a healthy intimate relationship can safe-guard the professional's mental health and provide additional support (Neumann & Gamble, 1995; Osofsky, 2011). Also, becoming involved in activities that restore a sense of meaning, connection and hope are beneficial (Neumann & Gamble, 1995). For instance, actively participating in religious services was found to predict lower burnout (Sprang et al., 2011).

Organisational Factors that mitigate or decrease Vicarious Trauma

By providing education to their employees, the organisation can ensure their staff are receiving the information they need (Brady et al., 1999; Osofsky, 2011). Braley (2010) found organisations with higher levels of education and external support for stress were associated with lower compassion fatigue scores. Arguably, organisations should take more care of newer staff and ensure that appropriate measures are in place to reduce or prevent vicarious trauma, especially since they are more likely to experience symptoms (Neumann & Gamble, 1995).

When considering other professionals, social workers with regular support from their superiors, peers and work teams, experienced lower levels of secondary traumatic stress (Choi, 2011). Therapists reported that having supervision and dedicated time to discuss their experiences assisted them (Lonergan et al., 2004; Pistorius, 2006; VanDeusen & Way, 2006). Offering personal therapy to their staff may give the employees an opportunity to discuss matters of their work and evaluate their own responses to their work and to certain clients (Pistorius,

2006). It is important that the organisation displays a willingness to regularly examine systemic issues that may factor into the likelihood of staff developing symptoms (Brady et al., 1999), and they should further aim to ensure their employees have a mixed caseload that isn't too heavy with trauma clients (Pistorius, 2006). It is further recommended that employees have a suitable work-life balance (Pistorius, 2006), and the organisation should try to improve inter-agency communication, as misunderstandings between agencies can increase the level of stress on therapists (Choi, 2011; McElvaney & Tatlow-Golden, 2016).

STUDY AIMS

Clinical professionals, including staff in residential child placements, are likely to work with young people who have survived psychological trauma during the course of their careers. Arguably, policies need to be implemented to minimise the likelihood of vicarious trauma occurring and to reduce the severity of symptoms staff may experience (Weeks, 1999). Research on vicarious trauma can help to inform such staff about ways to detect, prevent, and reduce symptoms. It can provide guidance to formulate appropriate policies. If vicarious trauma goes undetected, it can have detrimental effects on staff, their relationships with others, the organisation and negatively impact their clients (Weeks, 1999). Such considerations need to be applied to residential care staff; in the UK, there are residential homes for children who need care. The residential support workers may also be at risk of vicarious trauma, since they are often exposed to details of the past trauma of these children. There is a lack of research on the effects of this work on residential support workers, and this brief systematic review aims to address initial areas where further research is needed with this population.

METHOD

Search Strategy

Searches of PsychINFO, ERIC, E-journals, Child Development and Adolescent Studies, MEDLINE and SOCIndex databases were conducted. An initial search was conducted with the

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search terms “vicarious trauma” OR “secondary traumatic stress” combined with OR “residential workers” OR “social workers” with “Children” OR “Adolescents” OR “Youth.” This initial search resulted in 3 articles that met the criteria requirements. Therefore, the search was widened, in order to include more mental health professionals. The second search included the terms “vicarious trauma” OR “secondary traumatic stress”, and were combined with “mental health professionals” OR “therapists” OR “psychologists” OR “nursing staff” OR “hospitals” OR “CAMHS”, and combined with “Children” OR “Adolescents” OR “Youth.” There were no limits in terms of date of publication. Relevant papers were then retrieved and 45 articles were initially identified.

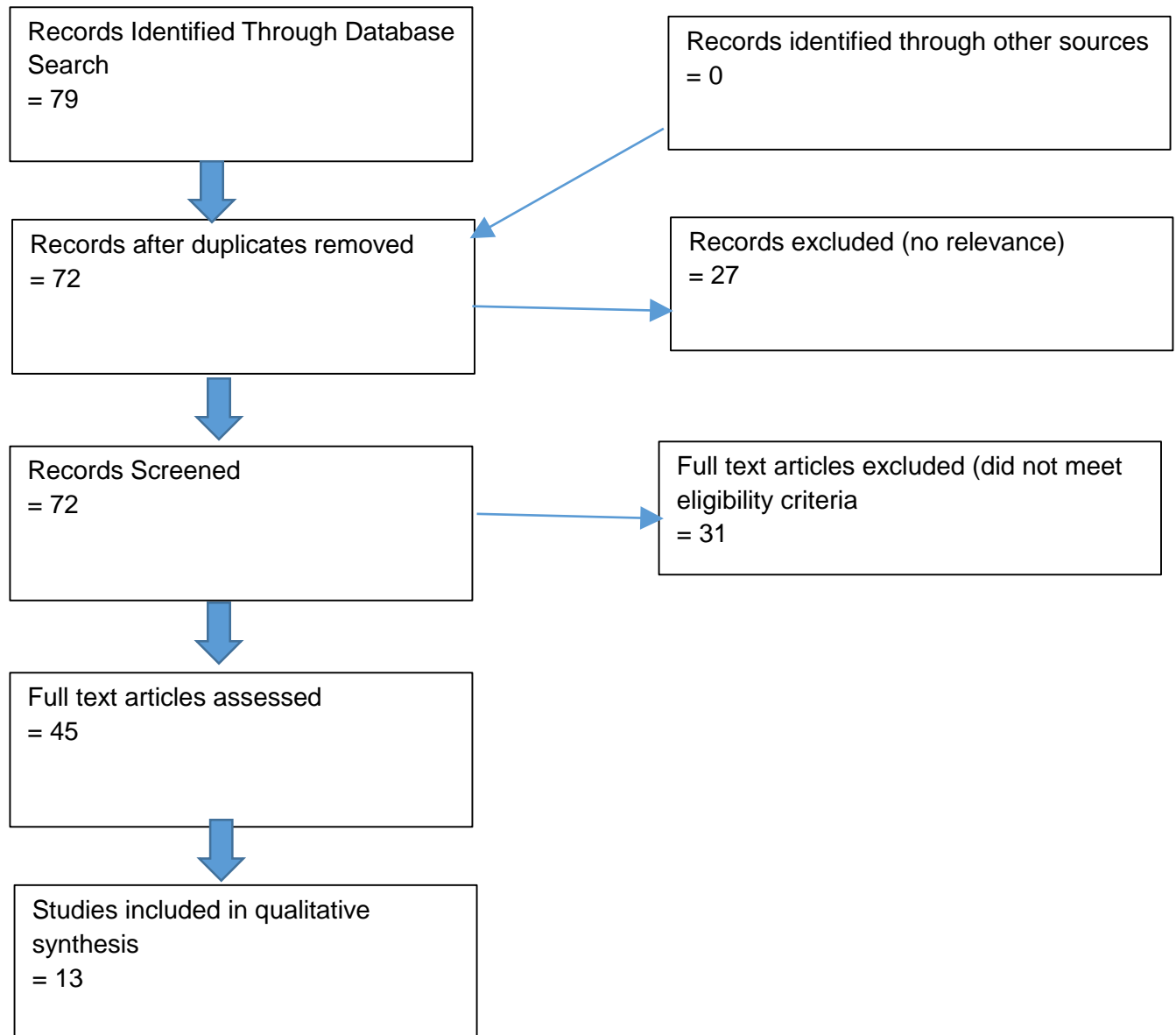
Study selection Criteria

The criteria for *exclusion* from more detailed analyses were: (1) does not mention vicarious trauma or secondary traumatic stress; (2) does not relate to working with children or adolescents; (3) does not relate to mental health professionals (seen in broad terms); (4) duplicate; (5) could not access the article. All other articles that met the previously listed requirements were then included. Of the 45 articles retrieved, 31 were excluded due to not meeting the requirements. The remaining 14 articles were read in full, and 1 article was excluded due to lack of relevance. This left a total of 13 articles for more detailed analysis. Figure 1 provides an overview of how the articles were screened and excluded, retaining the final 13 articles.

Data synthesis

Thematic synthesis (Thomas & Harden, 2008) is a method used for qualitative data synthesis. This approach uses a similar method to analysis as grounded theory. It is based on inductive reasoning and themes are developed continuously using a comparative approach. The selected articles were read multiple times in order to ensure relevance to the study and identify the themes. The themes were discussed and agreed upon with another researcher who was not involved in the study, to ensure reliability of the themes. These themes are discussed in the results and discussion section of this paper.

Figure 1. Search strategy



RESULTS AND DISCUSSION

Thematic analysis was used to determine, analyse and report themes (patterns) within the data (Braun & Clarke, 2006). The data was explored and reviewed on multiple occasions and common themes were identified. The thematic analysis of the articles identified five main themes related to vicarious trauma in mental health staff. Table 1 below provides key methodological features

of the 13 included studies. The majority of the studies were conducted in the US and the UK.

Table 1: Methodological features of the 13 included articles

Citation	Studies Aim	Sample Characteristics	Data Collection Method	Method of Analysis	Trustworthiness Ensured
Sprang et al. (2011)	To examine predictors of secondary trauma stress in child welfare professionals and in contrast to other professional groups.	669 child welfare professionals	Online Questionnaires	T-Tests and one-way ANOVA with post-hoc tests; regression models	(Not included in article)
Creamer & Liddle (2005)	To understand risk factors that may then allow organisations to establish policies designed to minimise these risks.	80 mental health professionals who worked with those clients (adults and children) traumatised by the September 11 th , 2001 terrorist attack in the USA.	Questionnaires	Multiple Regressions	(Not included in article)
McElvaney & Tatlow-Golden (2016)	To explore professionals' experiences of working with young people in the care and youth justice context in Ireland, focusing on the issue of mental health need.	26 professionals working in care and youth justice services in Ireland. Purposeful sampling was used.	Focus groups and Interviews	Thematic Analysis	Codes and themes were reviewed, discussed and agreed upon/ Member checking stage
VanDeusen & Way (2006)	Investigating the effects of providing sexual abuse treatment on disruptions in clinicians' thinking about trust of, and intimacy with others.	Random sample of clinicians (males and female) who treat sexual abuse survivors and	Questionnaires	Sequential Regression Analysis	(Not included in article)

		sexual offenders			
Lonergan et al. (2004)	To explore how trauma therapists made meaning of their experience in working with traumatised children (trauma not specified). Specifically how they understood their work, how the work impacted them and how they held on to hope and persisted in this field despite all the challenges.	Purposeful sampling of 8 therapists who view themselves as specialists in child trauma work.	Semi-structured interviews	Thematic Analysis	Second co-author read transcripts and independently developed initial (first-level) coding schemes/ Member checking
Osofsky (2011)	To look at what vicarious trauma and compassion fatigue are, how the effects may be presented, and the suggestions for individual and organisations for prevention and intervention methods.	Individuals (including: mental health evaluators and therapists, judges, lawyers, children welfare professionals, first responders and others) who work with traumatised young children and their families	Questionnaires	(Not included in article)	(Not included in article)
Way et al. (2004)	To understand the level of VT in therapists working with survivors and offenders, the variables related with VT, and if those variables differ for those working with	Random sample of 347 clinicians who treat survivors of sexual abuse (adults who experienced childhood	Questionnaires	Sequential Regression Analysis	Anonymous Survey

	different client populations.	sexual abuse and those who experienced abuse as adults) and sexual offenders			
Neumann & Gamble (1995)	To look at countertransference responses, the phenomenon of vicarious trauma, and the personal and organisational factors that can ameliorate the negative symptoms of trauma work.	Psychotherapists (especially those new to the field of traumatology) working with survivors of chronic childhood trauma.	(Not included in article)	(Not included in article)	(Not included in article)
Brady et al. (1999)	To examine the VT of women psychotherapists attributable to their work with sexual abuse survivors.	Randomized sample of 446 women psychotherapists	Questionnaires	One-way ANVOAs	(Not included in article)
Motta (2012)	Assessment devices for secondary trauma were reviewed and evaluated the efficacy of therapeutic interventions for secondary traumatisation found in children, school mental health workers and teachers.	Case study of child who experienced secondary trauma from father's experience; mental health professionals working in schools and teachers who experience secondary trauma from students.	Literature Review	(Not included in article)	(Not included in article)
Pistorius (2006)	To understand therapists' personal experiences and how working with sexually	14 female licensed therapists working with	Unstructured Interviews	Thematic Analysis	Transcription of interviews checked; all four analysts assisted

	abused children impacts their personal lives.	sexually-abused children			in coding and used constant-comparative method to extract themes
Braley (2010)	To determine the relationship between exposure to traumatic experiences of hospitalised children and adolescents and the development of secondary traumatic stress in clinical staff working with such patients.	268 faculty and staff in surgery, medicine, nursing, social work, psychiatry, psychology, allied health, and child and family services were recruited to participate.	Questionnaires	Hierarchical regression	(Not included in article)
Weeks (1999)	To examine vicarious trauma and coping in psychotherapists.	95 licensed professional counsellors and licensed psychologists (male and female). Over their careers, they estimated 41% of their clients were trauma survivors (trauma not specified).	Questionnaires	MANOVA and ANOVA	(Not included in article)

From considering the above themes, and after ensuring reliability with another researcher who had not been part of the project, the following themes from the data were noted, and which were linked to vicarious and secondary trauma in staff. These are as follows:

THEME 1: Lack of organisational support

This is referring to support from colleagues, peers, supervisors and the organisation (Choi, 2011). Without adequate support and debriefing, staff can feel overwhelmed with the work and

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experience more stress (Lonergan et al., 2004; Pistorius, 2006; VanDeusen & Way, 2006). Those experiencing vicarious trauma hinder their colleagues by not being available for consultation or supervision, or by lowering moral by displaying cynicism (Weeks, 1999). This cynicism can lead to retraumatising clients by focusing on their own needs, over the needs of the clients, disrupting boundaries. These boundaries can include forgotten appointments, client abandonment, abuse of the client, or professional mistreatment (Weeks, 1999), which has a negative impact on the professionalism of the organisation. Organisations can then face burnout and shortened careers of their staff, leading to high staff turnover and the need for finding and training replacements (Weeks, 1999). Additionally, ineffective inter-agency communication can increase stress on therapists (McElvaney & Tatlow-Golden, 2016). Finding effective ways of sharing information and reducing misunderstandings may help reduce stress (McElvaney & Tatlow-Golden, 2016).

THEME 2: Lack of healthy work-life balance

Being unable to have clear boundaries between work hours and off-work hours was identified to be a source of frustration to mental health workers. Being assigned too many cases, handling too many traumatic cases, working over-time, not taking vacations or holidays all may contribute to the development of vicarious trauma (Pistorius, 2006). Having a fulfilling personal life and engaging in healthy intimate relationships can aid in safe-guarding the professional's mental health and provide support against vicarious trauma (Neumann & Gamble, 1995; Osofsky, 2011). Being involved in activities or hobbies (such as creating art or engaging in religious activities) can restore a sense of meaning, connection with others, and hope, which can lead to lower levels of burnout (Neumann & Gamble, 1995).

THEME 3: Lack of appropriate training

While many mental health staff had heard about vicarious trauma in their work, there was a distinct lack of training on protective measures or information on what to do if they begin to experience the effects of vicarious trauma (Brady et al., 1999; Osofsky, 2011). Staff with higher levels of education and external support for stress were found to have lower compassion fatigue scores (Braley, 2010). Newer therapists, as an example, who generally have less education and training, are more likely to experience symptoms of trauma (Neumann & Gamble, 1995). Trauma-

specific training would be helpful for staff, as it would increase their competency in trauma treatment and provide better care for the client. This is vital since knowledge in this field is advancing quickly (Weeks, 1999).

THEME 4: Failure to use self-care techniques

Many of the staff identified the importance of self-care techniques for others and how beneficial they are, but many failed to specifically implement these techniques into their life (Motta, 2012; Neumann & Gamble, 1995; Lonergan et al., 2004; Osofsky, 2011). Self-care techniques can include regular exercise, eating a healthy diet, taking vacations and breaks from work, diversifying their caseloads, and limiting the amount of particularly difficult cases, could help prevent or reduce the compassion fatigue experienced by staff. Some staff reported using negative coping strategies, such as drinking alcohol to cope, and which is of concern.

THEME 5: Staff failure to share when they are experiencing symptoms

Staff often failed to report when they were feeling overwhelmed with specific cases, or with the workload because they believed that if they were experiencing negative effects from the job, this would mean that they aren't doing their job properly or they are not suited for this field. Since they don't share when they are beginning to experience symptoms, measures cannot be put into place to reduce the effects (Choi, 2011; McElvaney & Tatlow-Golden, 2016). Therapists reported that having supervision and dedicated times to discuss their experiences helped them (Lonergan et al., 2004; Pistorius, 2006; VanDeusen & Way, 2006). Learning how to unofficially debrief with colleagues allowed staff to de-stress. Regular debriefing with colleagues or supervisors, or attending personal therapy, may help to de-stress and allow others to identify vicarious trauma symptoms they may not have noticed in themselves (VanDeusen & Way, 2006). If the individual, or colleagues, notice symptoms, then measures can be put in place to reduce the levels of stress and avoid burnout.

The five main themes highlighted that there are ways to reduce or avoid vicarious and secondary trauma in staff. As previously noted, the symptoms can be detrimental to staff, the organisation and the client, if left untreated. Therefore, it is essential that policies, supported by literature, are developed to mitigate these effects. Education of organisations and individual staff

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members is critical, as it allows staff to understand and recognise when they may be experiencing symptoms (Braley et al., 1999; Osofsky, 2011). The education should focus on various aspects, such as how to recognise symptoms, appropriate self-care techniques, as well as what the organisation offers in terms of support. Employees that are aware of the symptoms may feel less shame and embarrassment, as they realise it is common to experience vicarious and secondary trauma. With less negativity surrounding their symptoms this can help staff feel more comfortable seeking support from colleagues. Further, offering employees' time for discussing their experiences can reduce overall stress and reduce the likelihood of them experiencing vicarious trauma symptoms (Braley, 2010).

Organisations should be mindful to review any systemic issues regularly, and to support help where there are weaknesses (Brady et al., 1999). Ensuring that there is communication within all agencies of the organisation and between management, can decrease the stress felt by staff (Choi, 2011; McElvaney & Tatlow-Golden, 2016). Newer staff members should be monitored closely, as they are more likely to experience symptoms of vicarious trauma (Neumann & Gamble, 1995). Having a healthy work-life balance was significantly linked with decrease symptoms of various trauma (Pistorius, 2006). Organisations can ensure staff are not working too many hours or have too many trauma clients in their case-load, in order to reduce stress felt by staff (Pistorius, 2006).

Limitations

Due to limited research in this area, the search terms had to be widened to include a broader range of professionals who work with children experiencing psychological trauma. As such, these results may potentially not be fully generalisable. There may also be a self-selection bias, where individuals may be either more likely or less likely to volunteer as a participant in the research topic. For instance, and as one of the themes indicated, staff may feel stigmatised if they are experiencing negative symptoms and may not want to participate in these studies. The articles that were analysed did not take into account staff that may have already changed jobs or field of work due to vicarious and secondary trauma. Further, some of the articles relied on self-report and there may be a response bias, to appear in a more positive way.

Implications for Research

There is a limited amount of research undertaken on vicarious and secondary trauma, particularly in those who specifically work with children. The initial search only identified three articles that met the initial criteria, and where it then had to be broadened. Further research is needed specifically with residential workers who work with traumatised children, since they are more involved in the day-to-day care and arguably more exposed to effects of these youths' traumas. This should also apply to foster carers. It should further aim to separate any traumatic responses from staff who have been exposed to direct trauma in the workplace, such as those from clients, versus those that have been exposed to potential trauma through the viewing of distressing material only. Many of the studies found conflicting information regarding factors leading to vicarious and secondary trauma, so there is a need for further exploration and clarification. While the articles in this systematic review highlighted the importance of a staff's coping strategies, there is still a need for research that examines the effectiveness of these coping strategies, as well as what reduces symptomatology.

Implications for staff and policy-makers

This area of research can aid with the development or refinement of specific policies for staff, in order to create an environment that is more likely to reduce or mitigate the effects of vicarious and secondary trauma. The effects are widespread and affect the staff member, the client and the organisation as a whole. Both the staff member and the organisation where they work have the responsibility to take the necessary steps to reduce the likelihood of developing vicarious and secondary trauma, or reducing already presenting symptomatology. This research can provide staff with information that can assist them in understanding some of the risks that come with the job and provide suggestions of self-care. Organisations can further ensure there is sufficient and effective supervision of their employees. Specific training that addresses the issue of vicarious and secondary trauma can potentially provide an environment where employees feel more comfortable discussing such trauma. As part of this, organisations can consider the case load of staff, to ensure they are not overwhelmed, or that their employee's

caseloads are more diversified between traumatised and non-traumatised clients.

CONCLUSION

This review provides an exploration of articles regarding vicarious and secondary trauma in staff who work with children. Due to the severe symptoms individuals can present with, it is important that there is a deeper understanding of such trauma. This systematic review identified 5 main themes which can contribute to the development of symptoms: lack of organisational support; lack of health work-life balance; lack of appropriate training; failure to use self-care techniques; and staff failure to share when they are experiencing symptoms. The results of this review can be used to guide further research and provide staff and organisations with information in order to create guidelines.

Implications for practice

- It is important for the topic of secondary and vicarious trauma to be noted in staff teams, with a clear avenue of support in place. This should further include the use of supportive policies that have an empirical basis. Education and support is crucial as part of this.
- Organisations and staff should be aware that newer staff may be considered an 'at risk' group for the negative impact of such trauma, but not to disregard the more established staff groups.
- Staff should be encouraged in achieving an effective work-life balance, and organisations should be instrumental in this.
- Organisations should ensure mechanisms and procedures are in place to prevent the risk of such trauma, and to minimise the impact if and when it presents in staff teams.

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