EXPLORING SOCIAL WORKERS' SPIRITUAL MEANING OF THEIR RECONSTRUCTION PROCESSES AFTER THE UNANTICIPATED DEATH OF A CLIENT(S)

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Abstract

Background: This interpretive qualitative inquiry explores the spiritual meaning of their reconstruction processes of social workers after the unanticipated death of a client. Identifying existing social networks and using snowball sampling, ten social workers in British Columbia were recruited for this research. From a socially constructed and spiritual perspective, the researcher examines this process in collaboration with the ten participants. Through semi-structured interviews the social work participants gave deep and rich personal stories reflecting on the experience of having a client unexpectedly die. Through a process of thematic analysis, four main themes, and nine sub-themes emerged from the data.

Objective: To explore and gain a better understanding of social workers' experiences of unanticipated client death and the spiritual meaning of their reconstruction processes after this experience.

Methods: An interpretive qualitative inquiry was used for this study. A literature review was conducted to identity existing research and any gaps in research on the thesis question. Subsequently, semi-structured interviews were conducted with ten social worker participants who shared their experiences of unanticipated client death and spiritual meaning of their reconstruction processes. Thematic analysis of the data, guided by Braun and Clark (2018) was undertaken.

Results: Three main themes and eight subthemes about how social workers experience and process the death of a client were found. Results revealed social workers often experience multiple client deaths that can be traumatic and have long lasting impacts/memories and that making sense of this experience is generally complex, unique to the individual, and meaning was

found to be tied to systemic issues in the context of client death. A comparative analysis of Indigenous and non-Indigenous agencies in relation to spiritual supports are also presented.

Conclusion: The experience of having a client death(s) is impactful and was found to be generally traumatic for social workers. Spirituality may play a part in how this experience is processed and understood. Systemic issues and current neoliberal systems were reported to be main factors in how death was understood in the context of worker-client relationship. Informal support in the workplace was perceived as essential and formal workplace supports were seen as ingenuine and challenging to access. Spiritual and culturally based supports naturally found within Indigenous culture were perceived as a welcome support, especially in the context of client bereavement. Finally, through this inquiry it was apparent there needs to be more research about the understudied-impacts of experiencing the unanticipated death of a client, how social workers perceive, and access formal workplace supports, and how individual social workers and organizations draw from and utilize spirituality in social work practice.

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Table 1. Main Themes and Subthemes Emerging from Data Analysis

Main Themes	Subthemes
Theme 1: Experiences of Death, Meaning Making, and Ritual	• The impact of deaths and meaning from systemic failures • Spiritually based meaning • Rituals and ways of mourning at work
Theme 2: Presence of Spirituality in Social Work Practice	• Personal philosophy and spiritual experiences • Inclusion and exclusion in practice
Theme 3: The Workplace	• Perceptions of management • Informal vs. formal workplace supports • Indigenous vs. non-Indigenous organizations

Glossary/ Definition of Terms

Client, Patient

Client refers to an individual or group of individuals (such as a family) who work collaboratively with a service provider such as a social worker. Client is a term commonly used in community-based organizations. Patient is a term commonly used in hospital-based settings to refer to a person receiving services. These terms may be used interchangeably among professionals based on which setting they work, however, in this study the term 'client' will be used for simplicity and consistency.

Bereavement, Grief, Mourning

This study will follow Stroebe, Hansson, Schut, and Stroebe (2008) in using bereavement to refer to the ''objective situation of having lost someone significant through death (p. 4),'' Grief and mourning refer to the individual and social level processes of reaction and adjustment to the death. Grief is typically viewed as the most personal, immediate aspect of the various processes that unfold in the wake of bereavement (Stroebe et al., 2008). Mourning refers to the public processes of displaying grief and interacting with the societal ''death system'' (Kastenbaum, 2008).

Existential or Existentialism

''Existential well-being,'' defined broadly as a sense of coherence in viewing the world, as well as purpose, value, and significance in life, is not only conceptually and statistically separable from measures of positive and negative affect (King, Hicks, Krull and Del Gaiso, 2006) but is part of the folk concept of a good or desirable life (King & Napa, 1998, as cited in Hibberd 2014). Existential well-being is rooted in the work of existential philosophers such as Kierkegaard and Nietzsche dating back to the nineteenth century (Heidegger, Macquarrie &

Robinson, 1962). Ownsworth and Nash (2015) define Existentialism as the overarching human concepts of personal freedom, suffering and death, and the pursuit of meaning and purpose. Existential perspectives focus on the structure of a person's experience and understanding of self at the level of "being" (p. 2). Existentialism as a school of philosophy raises important questions about meaning and purpose and other such factors traditionally associated with spirituality. It also raises important questions about death and dying and the finite nature of human existence (Ownsworth & Nash, 2015, p. 2).

Disenfranchised Grief

Doka (1989) defines disenfranchised grief as "…that person's experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported" (p. 4) and often social support and validation is withheld from the grieving individual because their loss is not viewed as warranting grief.

Social Work

A global definition: Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility, and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (IFSW, 2014).

Helping Profession

Occupations that provide health and education services to individuals and groups, including occupations in the fields of psychology, psychiatry, counseling, medicine, nursing, social work, physical and occupational therapy, teaching, and education are helping professions

(APA, 2020).

Spirituality, Religion

There is some confusion on how to distinguish terms such as spirituality given the personal significance and complexity of meaning. For the purpose of this thesis, the following concept and definition of spirituality will be used. Spirituality is abstract and subjective and is distinguished from religion, although they share overlapping attributes. Due to the highly subjective definition that the concept of spirituality holds there are many definitions throughout the literature. Morgan (1993) refers to spirituality as an "existential quest for meaning" (p. 3) and Koenig (2012) provides a definition, "Spirituality is distinguished from all other things—humanism, values, morals, and mental health—by its connection to that which is sacred, the transcendent. The transcendent is that which is outside of the self, and yet also within the self. Spirituality is intimately connected to the supernatural, the mystical, and to organized religion, although it also extends beyond organized religion (and begins before it). Spirituality includes both a search for the transcendent and the discovery of the transcendent" (p. 3). Ownsworth and Nash (2015) discuss how spirituality may, or may not, have formal religious practices. Spirituality, they note, relates more generally to people's propensity to seek meaning in their lives, grow, and transcend beyond the current conception of self (p. 2). Lastly, Canda (2020) states that spirituality "is a process of human life and development where the focus on the search for a sense of meaning, purpose, morality, and well-being is undertaken (p. 6). Canda also notes the differing relational aspects of spirituality through either a relationship with oneself, connection to people, other beings, the universe, or ultimate reality however understood by the spiritual practitioner (p. 6). Victor and Treschuk (2019) assert that religion tends to be attributed to traditional values and practices related to certain groups of people or faiths and "a religious

person is associated with a particular belief, God, sacred scriptures, values, and ethics," (p. 109). According to White et al. (2011) religion is defined as a "sentiment of learned behaviors and social expressions that reflect cultural values" (p. 50). Religion is considerably more institutionalized than spirituality and tends to be organized by a common set of beliefs which are practiced and agreed upon by a community of individuals.

Spiritual Well-being (SWB)

Phenwan, Peerawong and Tulathamkij (2019) and Ownsworth and Nash (2015) share similar understandings of an individual's spiritual well-being (SWB) as a feeling of one's contentment that stems from their inner self and is directly related to their quality of life (QoL). Spirituality goes beyond religious or cultural boundaries. Spirituality is characterized by faith, a search for meaning and purpose in life, a sense of connection with others, and a transcendence of self, resulting in a sense of inner peace and well-being (Phenwan, Peerawong & Tulathamkij, 2019, p. 2).

Sudden, Unexpected, Unanticipated Death

When death occurs suddenly and earlier than anticipated, it is considered an unexpected death (Bruera, Chisholm, Dos Santos, Bruera, & Hui, 2015; Hui, 2015). The terms sudden, unexpected, and unanticipated death may be used interchangeably in social conversation, however, throughout this study the term 'unanticipated death' will be used for simplicity and consistency.

Ministry of Child and Family Development (MCFD)

MCFD is a provincial agency that specializes in child protection services and delivers both voluntary and involuntary services to children and families either at risk of or under

investigation of child protection concerns. As per the MCFD website, "The Ministry of Children and Family Development's primary focus is to support all children and youth in British Columbia to live in safe, healthy, and nurturing families and be strongly connected to their communities and culture. The ministry supports the well-being of children, youth, and families in British Columbia by providing services that are accessible, inclusive, and culturally respectful." (MCFD, 2022)

Delegated Aboriginal Agency (DAA)

A DAA is an agency that has received the authority from the Provincial Director of Child Welfare through a delegation agreement to undertake administration of all or parts of the Child, Family and Community Service Act. For local examples, see Vancouver Aboriginal Child and Family Services, NIŁ TU, O Child and Family services society or Ayás Mə́n̓men Child and Family Services.

Health Authority (in British Columbia context)

The Ministry of Health works together with a provincial health authority, five regional health authorities, and a First Nations health authority to provide high quality, appropriate and timely health services to British Columbians.

Acknowledgement

First, I am very grateful to my research supervisor, Dr. Indrani Margolin, for encouraging me to trust my instincts through the development of this work, for allowing me to lean into the creative writing process, and for giving me guidance throughout this research and throughout my Master of Social Work Program. Her kindness, sincerity, and expertise has contributed to the successful completion of this research. It has been an honor and privilege to work and study with Dr. Indrani. Without her, this research would not have been possible. I would like to thank my research committee members and advisors, Dr. Dee Horne and Dr. Joanna Pierce, for their willingness to sit on my committee and for their valuable input into this research.

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Finally, I would like to thank my parents and extended family for their endless support, love, and sacrifices they made for me. Thank you for allowing me the opportunity to grow into the woman I am today. I am also very thankful to my friends - my chosen family - for all their understanding, encouragement, and laughs, throughout life and especially during my time as a student. You truly make my life worth living.

Dedication

This work is dedicated to the clients who left this physical earth – your life carried meaning and you left an impact on us all.

Chapter One: Introduction

Introduction

The unanticipated death of a client is an event that many practicing social workers will likely grapple with at some point in their career (Jacobson, Ting, Sanders & Harrington 2004, p. 237; Sanders, Jacobson & Ting 2008, p. 2). This research aims to explore the meaning-making processes of registered social workers who have experienced the sudden and otherwise unanticipated death of a client(s). The ability to make sense of and construct meaning from potentially traumatic events such as the sudden death of an individual where a working relationship was present, is essential for successful coping with this type of experience. This study will be informed by an existential or spiritual perspective of meaning-making in the context of bereavement. Spirituality allows people to explore questions like "Who am I?", "Why is this happening to me?", "What is my purpose on this earth?" and other inquiries into the meaning of life and death. This research aims to explore the spiritual values and beliefs held by social workers, either consciously or unconsciously, and how it informs their ability to process and create meaning from a client dying.

Arndt-Wenger (2016); Malik, Gunn and Robertson (2021); Matzke (2014); Robson and Williams (2017) reveal that due to the highly sensitive and emotionally challenging nature of discussing death in our society, there is a good chance that many social workers and other helping professions who have had these experiences of sudden client death are not freely talking about the experience and/or have limited platforms to support these types of conversations. The literature has used the term disenfranchised grief to explain this phenomenon (Rowling, 1995). The experience of this type of death can be isolating within a society that promotes death

avoidance and combined with the constraints of confidentiality in the social work-client relationship, this position can reinforce the isolating nature of this practice experience. This research focuses on social workers' experiences in the western part of Canada, in the province of British Columbia (B.C.).

Research Question and Objectives

The purpose of this research is to gain a better understanding of unanticipated client death from the perspective of social workers. Essentially, the research question is: What does unexpected client death mean to social workers in B.C.? The objectives are 1. How do social workers understand the experience of unanticipated client death 2. In what ways do social workers navigate disenfranchised grief? 3. Where is spirituality situated and applied in social work experiences of unexpected client death? 4. What does the trauma of unexpected client death mean to social work in how they reconstruct ideas of self and meaning after this experience? I have found minimal qualitative research studies on this topic in the select population, within Canada. The studies I did find were quantitative in design.

I have chosen a qualitative study as a first point of entry to gain a deeper understanding of the unique experiences of social workers. I incorporate a spiritual framework for my inquiry. I am hopeful that this study will contribute to the existing body of research regarding the disenfranchised grief of social workers, provide specifics on spiritual meaning-making processes in bereavement, and add to the conversation around the topic of death and dying while also contributing to bereavement frameworks for clinical practice.

Research Significance

This research aims to explore what unexpected client death means to social workers in British Columbia who have experienced the unanticipated death of a client(s) during their course of practice. The ability to make sense of and reconstruct meaning from a spiritual perspective, after a physically permanent loss through death of a client, is essential for coping with this type of experience. This research is important to the area of social work, and other helping professions. It also has implications across practice, education, and policy development. Current research published at the time this thesis was written, on how social workers experience unanticipated client death(s) and how this group of professionals subsequently create meaning and process these experiences, highlights the gaps in the literature. This inquiry will be a valuable contribution both to existing literature and to social work as a profession. Clinical experience and current literature reflect the fact that losing a client(s) through death is a common experience in social work practice. Social workers typically support people who can be described as "high risk", which may put individuals at an increased risk for death, as well as death from otherwise natural but unexpected demise such as chronic health conditions or advanced age. Since the 'Social Worker-client relationship' has always been central to the social work purpose and identity, a permanent loss through death can have significant impacts on workers. Bembry (2014) and McAdams and Foster (2000) also reveal that professionals reported the experience of client death as stressful. Moreover, the death of a client had a significant and long-lasting impact on their personal and professional identity. The concept of death and dying is not commonly embedded within undergraduate social work education across university programs in Canada according to my own brief internet search. Yet, social workers and social work students are

commonly placed in fields like long term care, hospitals, and mental health settings where the likelihood of losing a client to death is likely (Bembry, 2014).

Holding space for those who experience grief, loss, and suffering is also frequent in the profession and the cumulative effects of witnessing suffering and distress can place a high degree of stress on our own experience. This research allows for a better understanding of how social workers across British Columbia experience, process and reconstruct meaning after experiencing the unanticipated death of a client.

Purpose of the Research

The purpose of this research is to gain a better understanding of unanticipated client death from the perspective of social workers. The literature is abundant with information of grief and loss in the context of personal relationships, meaning making in the context of bereavement, and ways specific professionals experience the loss of a client. However, little is known about how social workers specifically experience the unanticipated death of a client or how their spiritual meaning of their reconstruction processes unfold after this type of experience. I have found minimial qualitative research studies on how social workers find meaning after client death globally or within Canada. I am hopeful that this research will contribute to the existing body of knowledge regarding the disenfranchised grief of social workers, provide some specific paths for spiritual meaning- making processes in bereavement, and add to the conversation around the topic of death and dying while also contributing to bereavement frameworks for clinical practice.

Theoretical Framework

My research has been informed by theoretical foundations of social constructivist theory and meaning reconstruction theory. Creswell (2018) maintains that researchers use theoretical

perspectives in qualitative research to provide an overall orienting lens for the study (p. 108). Social constructivist and meaning reconstruction theories are the combined lens that shape many aspects of my inquiry, which includes the types of questions asked, informs how data are collected and analyzed, and how I, as the researcher position myself in the study (Creswell, 2018, p. 108). Through a constructivist lens, the creation of reality is a product of the interaction between the researcher and participant (Creswell 2013, p. 45; Gubaand & Lincoln, 1994, p. 108). Similarly, this framework puts forward the idea that individuals are active participants in the creation of their own knowledge and in the context of social and cultural settings (Schreiber and Walle, 2013). Creswell (2018) highlighted that constructivist researchers tend to address the process of interaction among individuals when focusing on specific contexts in which people live and work to better understand their settings or environments (p. 46). The aim of constructivism, is to understand lived experiences (Ponterotto, 2005, p.130), therefore is fitting for this qualitative study (Braun & Clarke, 2006, p. 78). Constructivism also serves as a useful framework as it allows for analysis of the data to reveal insight into how people interact with the world (Creswell, 2009). Constructivist theories have been applied in the understanding of grief and loss and highlight the role of meaning-making in the face of bereavement (Gillies & Neimeyer, 2005). The idea in the constructivist framework is that when individuals are confronted with loss, they actively attempt to construct a new understanding of their reality and, in the process, produce multiple realities (Creswell, 2013).

Meaning Reconstruction theory is rooted in constructivism and provides a more focused framework for contexts concerning bereavement and meaning making. Multiple definitions or understandings of meaning-making appear in the literature, how it is conceptualized, and how it is studied or measured (Flesner, 2013; Neimeyer, 2001). To mitigate some of these

inconsistencies, several meaning-making frameworks have been developed for those working with the bereaved. One of these frameworks is the theory of meaning reconstruction proposed by Neimeyer and colleagues (Neimeyer, 2001; Neimeyer, Burke, Mackay, van Dyke Stringer, 2010). In the face of death or trauma, it is theorized that our basic core beliefs or assumptions about the world or of ourselves become challenged and lead individuals to feelings of distress and a strong need to adjust or reconstruct their view of the world. According to Neimeyer and colleagues (Currier, Holland, Coleman & Neimeyer, 2007; Gillies & Neimeyer, 2006; Neimeyer, 2001, 2006), the pain of loss and the meaning making process pushes people to find meaning through a cyclical journey. With new meanings created and integrated into our worldview, feelings of distress may be greatly reduced from engaging in the meaning making process.

This inquiry is informed by a spiritual perspective. Social work has long been linked to religion and spirituality in both historical and philosophical ways (Bullis, 1996) and contained considerable spiritual undertones (Xu, 2016) until undergoing a process of professionalising and secularizing the field of social work (Canda & Fulman, 2010). The spiritual dimension of social work has become more accepted over the last twenty years but remains on the fringes of education and practice in the field (Canda, 2020, p. 6). This is similar to my experience in practice. Spirituality tends to remain far removed from our work, especially in agencies dominated by eurocentric and western views of social work practice where knowledge is contained in what is rational, logical, and empirical. The root word of the English term spirituality is the Latin word spiritus which means “I breathe” (Sen, 2016). Canda (2020) makes a clear distinction between religion and spiritualty, where existential issues like meaning and purpose, are not necessarily tied to religion (p. 6). Canda (2020) conceptualizes spirituality as “a process of human life and development and has a focus on the search for a sense of meaning,

purpose, morality and well-being" (p. 6). From this definition, spirituality can be seen as central to many people's lives. The Canadian Association of Social Work (CASW, 2020) note that scope of practice is defined as the processes, actions and procedures used by registered professionals. Further, registered social workers are required to conduct "holistic assessments and interventions with clients, focus on social functioning and consider social, political, familial, and spiritual components of clients' lives" (CASW, 2020, paragraph two). Given this, social work practice can provide the ideal climate to incorporate spiritual understandings of issues involving meaning-making in bereavement. The process of meaning-making is well suited to explore issues of life, death, and loss. It is not uncommon to draw from spiritual sources after experiencing loss. Burke and Neimeyer (2012) noted that, after experiencing life-altering events, like illness or other loss, people are commonly precipitated into a search for meaning at levels that range from the practical (how do I adjust to this strange new world?) through the relational (who am I now?) to the spiritual or existential (why did the universe let this happen?)" (p. 3). How people engage in this process of questioning will be different and this thesis aims to incorporate a spiritual understanding of professional meaning-making in the aftermath of a client's death.

Research Position and Social Location

My interest in, and reasons for, engaging in this research topic comes from my own personal social work experience where clients have unexpectedly died. Some of these experiences had more of an impact than others but all of them have affected my outlook on life, death, and finding meaning. During my career in child welfare, I had at least two experiences of youth who died via suspect overdose and homicide. They were young and had faced significant early life adversities I will never experience. I feel this added complexity to my experience

because it always felt like they did not have a fighting chance in this world – from the moment of birth through their early years to early adolescence – these young lives were fraught with neglect, abuse, and even the inability to live authentically in their final years. I felt conflicted existing as a social worker within a system that may not directly be responsible for the deaths but one that does not have adequate resources to sufficiently address factors that may mitigate some of the issues I felt were important. I struggled to integrate these death experiences into my understanding of life and into my practice as a social worker. I found myself searching for meaning through asking relational and spiritual based questions such as "who am I now if I don't want to be a social worker?", "why does the universe or the system allow a death like this to happen?". Thinking about this now makes me feel tired and resentful and I no longer have a desire to continue engaging in social work, although I sit here finishing a thesis on the same subject that has made me feel this way. My own search for meaning through a disenfranchised grieving process is ongoing and this thesis has the potential to further my own search for meaning and reconstruction.

Research has the potential to inform others at the individual and policy level. With this inquiry, I hope to learn about the stigmatized topic of client death in the social work field. The profession of social work is characterized by developing strong relationships with clients and in this process expending a large amount of emotional labour on the workers' behalf. These working relationships may still hold meaning in a workers' life and therefore any loss surrounding this bond may affect individuals in ways not often discussed in practice. This study may highlight successful ways social workers have created meaning from traumatic death experiences as well as the challenges they have faced or continue to face.

I am currently a resident of Vancouver, BC and have been living and working here for

the last six years. I am a social worker, and this used to be a large part of my identity. Some of the ways I used to introduce or identify myself include the location I was born and raised, where my family originated, what my parents' names are and what they do for work and my profession, social worker. After experiencing the death of a young client and being heavily involved in the intimate details of notifying the family, assisting in funeral planning, and providing ongoing bereavement support to the deceased family, it became too much. I lost a client, but it went deeper than that for me. I lost a sense of meaning and purpose in my life, my career, and a part of my identity. I struggled to find any meaning in that young person's death, and I lost faith in a "system" that I perceived as not there to help but only to apply bandages. It was challenging to continue working in a field of practice that scrutinizes and places blame on social workers.

The ability to create meaning and integrate experiences into one's life is an essential part of processing traumatic experiences. Meaning making in contexts of bereavement often draw from spiritually based questions individuals ask themselves. This may be especially true for those employed in positions that rely on a high degree of emotional labour such as social work.

Chapter Two: Literature Review

Introduction

Concepts of death, dying and bereavement have been well researched for decades. Death is one of life's few certainties and a universal experience for all of us; all persons will eventually become bereaved (Lekalakala-Mokgele, 2018). However, an overwhelming amount of literature on bereavement has tended to focus on the loss of a "loved one" such as parents, children, spouses or partners (King, Lodwick, Jones, Whitaker, & Petersen, 2017; Holm, Severinsson & Berland, 2019), siblings (Norbeck, 2008), and grandparents (Lai, 2012); less commonly on perinatal loss (Markin & Rilcha-Mana, 2018), and friends (Liu, Forbat & Anderson, 2019); and rarely, on the bereavement experiences of a professional who has lost a client(s); and very minimally on the experiences of social workers, with no research exploring the meaning social workers create from the experience of unanticipated client death. The relationship between professional and client is unique and is characterized by maintaining professional boundaries outlined by various codes of ethics for guiding practice in many countries (BCCSW, 2020; CASW, 2020; NASW, 2020). Although social workers deeply care for our clients, it cannot be viewed as the same relationship we have with others in our lives; therefore, the bereavement process will differ as well.

The experiences of health practitioners who care for the seriously ill, dying, and bereaved has been well documented (Lakeman, 2011; Papadatou, 2000) but the experiences of allied health and social service workers have received little attention in the literature. Further, the specific study of unanticipated death of a client(s) and the subsequent experience of this on social workers or other helping professions has seldom been done. For this research, I focused on

sudden and unanticipated death from the experience of social workers in any role or specialty. My interest in this research topic comes from personal work experiences where clients have suddenly died, and consequently left me struggling to integrate these experiences into my life. I found myself searching for meaning through spiritual based questions and careful reflection on my life story.

An unexpected death is typically considered as a sudden death that occurs earlier than anticipated (Bruera, Chisholm, Dos Santos, Bruera, & Hui, 2015). I focused my literature search on research related to disciplines experiencing the sudden and unanticipated death of a client, negative effects of traumatic death, spiritual meaning of their reconstruction processes in the context of bereavement, disenfranchised grief in social work, and spiritual post traumatic growth. I start with reviewing the more general topic of various disciplines that have experienced unanticipated client death and work towards the more specific area of social workers' experiences with unanticipated death, disenfranchised grief in social work and other helping professions and the spiritual meaning of their reconstruction process in bereavement. I chose these specific research areas because of their relevance to my research topic: social workers' spiritual meaning of their reconstruction processes after experiencing the unanticipated death of a client(s).

The literature review examined the breadth of evidence regarding how social workers experience the unanticipated death of a client(s). The initial factors of the search criteria were focused on social work specific literature, however, as the research topic involving social workers has seldom been done and was identified quickly as a large gap in the existing literature, the search criteria was extended to include other health disciplines including nurses, physicians, healthcare workers, psychologists, paramedics, and others.

Unanticipated and Anticipated Death

Two different categories of client death have been established in the literature as unanticipated or anticipated. Certain fields of social work practice may influence what type of death is more likely to occur in the client population and the way a client dies can impact social workers differently.

The literature collectively refers to anticipatory grief as "the process associated with grieving the loss of loved ones in advance of their inevitable death" (Burke, Clark, Ali, Gibson, Smigelsky & Neimeyer, 2015, p. 244). Those who encounter anticipated client death may work with clients who have an incurable illness, terminal diagnosis or in geriatrics (Strom-Gottfried & Mowbry, 2006). For the workers who experience this category of anticipated death, they may feel a sense of relief as the opportunity to mentally prepare, complete end of life planning and even say their goodbyes to the client is present. The key point in this is that there is a perceived sense of time to account for the death and possibly to have a better ability to process the feelings that arise.

Unexpected death is described across the research as having a common perception of being part of a situation that may be preventable, if only certain interventions were available to intercept the event of death (Matzke, 2014). Deaths caused by medical conditions like a heart attack, stroke, overdose, or through disasters or accidents, or more trauma surrounding the death such as homicide or suicide, tend to fall under this category. These types of deaths are clearly surprising, catch workers off guard and give no ability to prepare when it happens. Gustavsson & MacEachron (2004) discussed the addition of features around the death like violence or other traumatic circumstances such as a child death, which may impact a social worker's ability to process and cope with this experience. The literature concerning non-professional bereavement

after the unanticipated death of a loved one explores complicating factors in coping with this type of death. For example, Keyes, Pratt, Galea, McLaughlin, Koenen and Shear (2014) state "unexpected death of a loved one is the most frequently reported potentially traumatic experience" and suggest this experience is associated with "the development of depression, anxiety, substance use, other psychiatric disorders and a heightened risk for prolonged grief reactions" (p. 2). In addition, Currier, Holland and Neimeyer (2006) report that survivors with an increased risk of trauma and other mental health concerns have the potential to further experience complications in the grieving response. Complicated grief, for example, is essentially an unrelenting and intense state of grieving that keeps one from healing and incorporating a sense of meaning from the experience. Complications in the grieving response may include an unexpected, or violent death, the death of a young person, or even when our experience of grief is invalidated and ignored. I will discuss complicated grief in more detail further on in this literature review.

The unexpected nature of a death can be traumatic. It is worth noting that given the subjective nature of experiencing death and loss, individuals likely experience grief and loss differently and there may be differing perceptions of what constitutes an unexpected death. For example, those that work in long-term care or oncology may feel death is somewhat possible due to advanced age or serious health conditions, or some may feel blindsided by a death in this area of work. It is my reasoning that any area of work may experience unexpected death, if a worker is not prepared for it, however, dealing with death in certain roles are less likely to be expected such as in private practice or primary care centres.

To further explore the concept of unanticipated death, Veilleux (2011) asserted that unexpected death events can be viewed in three categories: novel, unexpected and uncertain.

Veilleux (2011) explained that each category brings different types of emotions or feelings for workers in the bereavement process since these categories are much harder to explain or rationalize. For example, the category "novel" refers to the initial death someone experiences personally or professionally in their career; "unexpected" (Sherba, Linley, Coxe, & Gersper, 2019) incidents refer to methods like suicide, accidental, or homicide; and "uncertain" is referring to deaths that are deemed undetermined by medical examiners, or possibly even missing.

When comparing the available research between professional experiences of client death and the general population's experience of suddenly losing a loved one, much of the research tends to favor experiences of losing a loved one given the high volume of studies. I revealed a research gap concerning the unique experiences of social workers who have unexpectedly lost a client through death. This research contributes to the gap in bereavement research and highlights the unique relationship between worker and client.

Grief Response, Complicated Grief, and Disenfranchised Grief

All of us will experience the death of someone close to us at some point in our life and many who work in the area of social work will lose at least one client at some point during their career. Grief and loss are personal experiences and there is no correct way to grieve a loss. Kristensen, Weisæth & Heir (2012) highlight that certain types of deaths and losses are more challenging to create meaning from or adapt to than others and this will affect how a person grieves the experience. For example, those who experience a violent or otherwise traumatic death of a loved one, may experience a more challenging situation to create meaning or benefit. The meaning-making ability may be further compounded with the addition of stigmatizing factors such as method of death or society's acceptance of the relationship one had with the

deceased. The terms bereavement and grief are used inconsistently, both in society and in research, and tend to refer to either the state of having lost someone permanently via death, or the response to such a loss. Researchers have suggested that the term bereavement be used to refer to the fact of the loss; the term grief should then be used to describe the emotional, cognitive, functional, and behavioral responses to the death (Zisook & Shear, 2009). The term grief also tends to be used more broadly to refer to the response to other kinds of loss such as grieving the loss of one's youth, loss of opportunities, loss of functional abilities or even the loss of one's childhood home.

The typical grief response across the literature has been discussed as "an emotional reaction to the loss of a loved one through death" (Nakajima, 2018). This initial or acute period of grief is characterized by individuals focusing on the reality of the death and then a shift to experiencing a full range of emotions and feelings. The emotions and feelings commonly expressed oscillate from shock, anger, guilt, regret, anxiety, loneliness, unhappiness, intrusive images, and the feeling of being overwhelmed. Zisook et al., (2009) describe the grief experience as an ongoing process, rather than a state in a moment in time. The acute period of grief tends to manifest in waves, at certain points, and eventually is triggered by specific reminders of the deceased person. Zisook et al. (2009) discuss "integrated grief", from which a person's emotional processing shifts from the initial and acute phase of grief to a more permanent response after the loss. Zisook and colleagues suggest that integrating one's grief, means healing occurs and the meaning of the death is successfully created to make sense of the death. To integrate is to heal and eventually the bereaved person can re-engage in activities and relationships that once brought them joy. On the other end of the grief spectrum, the terms "complicated grief" or "prolonged grief" have been used interchangeably, and have been

described by Tang and Xiang (2021) as "a persistent and pervasive grief response characterized by longing for the deceased and/or persistent preoccupation with the deceased, accompanied by intense emotional pain including sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self and an ability to experience positive mood" (p. 2). Scott, Pitman, Kozhuharova & Lloyd-Evans (2020) report that losses that are sudden (natural disasters, accidents) do not allow people the chance to prepare for the loss of a relationship and violent losses (homicide, suicide) are also forms of sudden loss, but have the additional stressors impacting the person's grieving trajectory as they "violate the assumption that human life must be protected" (p. 2). A systematic review by Kristensen et al. (2012) consistently found that losses which are both sudden and violent are distinct from other forms of loss. According to Kristensen et al. (2012), this loss is associated with a much slower acceptance of the death and an increased risk or prevalence of mental health disorders such as PTSD and depression compared to grief resulting from natural deaths.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) included Persistent Complex Bereavement Disorder in Section 3 under Conditions for Further Study (APA, 2013) and will be replaced by a diagnosis also named prolonged grief disorder in Section 2 under Diagnostic Criteria and Codes in the upcoming version of the DSM-5 (APA, 2020). Those with a history of mood or anxiety disorders and those who have experienced multiple important losses have a history of adverse life events and whose poor health, lack of social supports, or concurrent life stresses have overwhelmed their capacity to cope, may be at risk for complicated grief (Shear & Shair, 2005; Zisook & Shear, 2008). Further, Simon (2013) proposes that the nature of death itself, such as sudden and violent death, are risk factors for the development of atypical grief (As cited in Nakajima, 2018, p. 2). Currently, during the COVID-19 pandemic, researchers have

discussed how COVID-19 related deaths will likely lead to an increased global prevalence of Prolonged Grief Disorder (Eisma, Boelen, Lenferink, 2020; Johns, Blackburn, McAuliffe, 2020; Tang & Xiang, 2021) because these types of deaths are usually unexpected. The unexpectedness of death increases levels of prolonged grief symptoms across Australian (Ingles, Spinks, Yeates, McGeechan, Kasparian & Semsarian, 2016), Dutch (Boelen, van Denderen & de Keijser, 2016), Japanese (Fujisawa, Miyashita, Nakajima, Ito, Kato, & Kim, 2010), Chinese (He, Tang, Yu, Xu, Xie, & Wang, 2014), and Thai (Wanna & Lueboonthavatchai, 2015) bereaved individuals. Research has shown that traumatic death can impact people across countries and cultures in significant ways and complicate the otherwise natural and typical grieving process.

The term "loved one" is commonly used to describe those who are bereaved. A 'loved one' refers to a person with whom an individual shares a particularly strong emotional bond, including attachment figures and carers" (Nakajima, 2018, p. 2). An overwhelming amount of research has focused on grief reactions characterized by the loss of a "loved one" but this relationship does not capture losses in other types of relationships such as in professional social work relationships. The working relationships between people who access social and health services and the professionals who provide services are unique and important. Professionals, such as social workers, rely heavily on rapport building and making deep connections to those who access services for support. The losses that result from these working relationships can significantly impact service providers and have been categorized as falling under a different model of grief that is considered disenfranchised.

Social constructionism theorists such as Walter (2006) and Berger & Luckman (1991) discuss that knowledge and meaning of various concepts in our world are culturally constructed by social processes and actions. Therefore, communities and societies have their own

understandings and cultural norms about death and grief experience. Each society creates their own "rules", expectations, and definitions of what is deemed a socially acceptable course of grieving. There is an understanding in society that if we experience the death of people within our immediate family such as a partner or spouse, parent, or child, we are allowed to openly, and without question, experience the full range of emotions in this bereavement period. This is also reinforced through many workplace bereavement policies that often state the loss of someone outside this group of individuals are not afforded the same amount of bereavement leave days after a death. There is a social norm in society that allows certain relationships to carry greater meaning than others and that individuals should contain aspects of their grief because society is unaccepting of diverse types of relationships. Foote and Frank (1999) describe society's need to control the grief experience, "grief, like death itself, is very risky and unpredictable. Society seeks to discipline grief, as part of its policing of the border between life and death, is predictable, and it is equally predictable that modern society would medicalize grief as the means of policing" (p.170). I argue we continue to live in a society that attempts to control the grief experience, as people experiencing grief and loss may require permission and encouragement to grieve and permission to take a break from grieving. Our society controls the definition of what constitutes a legitimate loss, and this is evidenced through limited bereavement leave through an employer. Society also will have unspoken rules dictating how long grief should last and how each culture is "able to identify mourners who obey the rules, and those who do not" (Walter, 2006, p. 74). Different losses and types of relationships are defined by a society's norms as being legitimate or not legitimate. When a loss deviates from this standard, the resulting grief "remains unrecognized and undervalued and a person may feel their 'right to grieve' has been denied," (Albuquerque, Teixeira, & Rocha, 2021, p. 2). Valente and Saunder (2002) report that there are

no clear criteria for grief responses in those employed in helping roles, therefore, academia continues to lack the understanding of how all helping professionals experience and process the death(s) of a client.

A number of factors can impact how grief can become disenfranchised which include: the inability to engage in the "usual rituals, customs and interactions that occur in the context of end of life and after a death", the experience of being deprived access to social support or feeling disallowed/unsupported to express and manage their grief openly and finally, an the experience of multiple deaths in a single time period could impede acknowledgment of each individual's grief (Albuquerque, Teixeira & Rocha, 2021, p. 2). Many helping professions experience the death of client(s) and are not afforded the traditional opportunities to acknowledge the grief this type of loss brings. Certain factors that characterize a professional relationship may complicate the grieving process. These include being bound by confidentiality through professional registration bodies and workplace policies without opportunity to engage in traditional social funerary rites and rituals as well as an inability for many people outside of professional work to understand the complexity of this type of loss. These issues are compounded by the unprecedented nature of the COVID-19 pandemic due to physical distancing measures, the higher rate and amount of documented COVID-19 deaths and other limitations posed by the coronavirus.

Disenfranchised grief can be experienced by anyone; however, professionals have a specific type of relationship that is typically characterized by an inherent power imbalance between helper and helpee. This relationship dynamic is ideally instructed to be authentic, but there are unspoken rules for professionals to enact rigid boundaries with clients and not disclose personal information which does not foster client healing. The underlying contradictory message is, to

build a genuine relationship but remain detached or avoid emotional investment in this working relationship because that is not the role of a professional. This unspoken balance is challenging to maintain and may contribute to enabling, disenfranchised grief for the worker. In a study exploring the disenfranchised grief of Physicians, Lathrop (2017) quoted a compilation work entitled Disenfranchised Grief: Recognizing Hidden Sorrow (1989) which addresses the conflict between the needs of the individual experiencing loss, and the goals of the workplace. It was asserted that at work, "emotions and feelings are discounted, discouraged and disallowed," and therefore all losses are disenfranchised in the workplace (cited from Lathrop, 2017, p. 376). Similarly, Spiegelman (2005) reported that many therapists fear judgement from management for being either codependent or crossing boundaries with a client. They further asserted:

"Who else in our lives do we meet with for an hour every week to discuss issues of such a uniquely intimate and confidential nature? Our grief at the sudden death of a client is real and worthy of being affirmed and supported. But we have authentic relationships with our clients, and so we experience authentic loss," (p. 2). Helping professionals are commonly denied access to typical ways of processing grief and are often forced to carry on with their *business as usual* which serves to minimize and disenfranchise their grief experience. This impacts the healing process and pressures the worker to attempt to create meaning of the client death on their own, if at all. This disenfranchisement can complicate and prolong bereavement for these reasons. Interestingly, Lathrop (2017) suggest that physician loss is under acknowledged due to "limited collegial exchange, the hierarchical nature of the medical milieu, and concerns about career consequences (e.g., being labeled as disruptive or a whiner)" (p. 376) and Lloyd, King, and Chenoweth (2002) suggest that "human service professionals tend to underestimate the extent of distress experienced by social workers" (p. 255).

Experiencing the Unanticipated Death of a Client

A variety of social service roles and healthcare disciplines have been explored in relation to how the grief process unfolds after client death. Specific disciplines and how they experience client death include healthcare aides in long term care settings (Boerner, Gleason & Jopp, 2017), nurses (Valente & Saunders, 2002), school counsellors and teachers (Christianson & Everall, 2009; Kolves, Ross, Hawgood, Spence & De Leo, 2017), psychotherapist's and private practice therapists (Berzoff, 2004; Devilly, 2014; Gill, 2012; Jacobson, Ting, Sanders & Harrington, 2004; Ronningstam, Goldblatt, Schechter & Herbstman, 2021; Rubel, 2004; Veilleux, 2011; Veilleux & Bilsky, 2016), rehabilitation counsellors (Hunt & Rosenthal, 2000), psychologists (Palmieri, 2018), psychiatrists (Lathrop, 2017; Thomyngkoon & Leenaars, 2008), anesthesiologists (Todesco, Rasic & Capstick, 2010), homeless sector workers (Lakeman, 2011), therapists/counsellors-in-training (Foster & McAdams, 1999; Hunt & Rosenthal, 200; Kleepies, Penk & Forsyth, 1993; McAdams & Foster, 2000; Spiegelman & Werth, 2005) and social workers.

Nurses, physicians, social workers, and other helping professions frequently encounter client deaths during their professional career. Many of these helping professionals' practice in settings like hospitals, clinics, and other community agencies where a high volume of diverse clients are served. Certain areas of practice may even have a greater risk of a client death based on the nature of support that client is lacking. For example, research has consistently found that individuals who are unhoused or have inadequate housing have a shorter life expectancy and are more likely to die of homicide, suicide, trauma, AIDS-related conditions, drug overdose, and other alcohol and drug-related problems relative to those who have stable housing (Cheung & Hwang, 2004; Haw et al., 2006; Morrison, 2009; Nordentoft & Wandall-Holm, 2003). People

who work in the homeless sector are likely to encounter individuals at extreme risk of death and to be regularly exposed to the deaths of service users during their work. Researchers also focused their exploration on anticipated client death within specific work settings such as long-term care facilities (Boerner et al., 2017), terminally ill clients (Palmieri, 2018), clients who have a chronic mental health diagnosis (Lathrop, 2017; Thomyngkoon, et al., 2008) and/or are unhoused at the time of their death (Lakeman, 2011) which increases risk for a premature death. Rabow (2021) notes that the grief experiences of healthcare workers were problematic well before the onset of the COVID-19 pandemic, most notably for physicians, where one third reported feeling guilty about patient deaths and one half felt a sense of failure. Rabow (2021) asserts that despite death being a natural and common experience for humans, the experience of grief "has long lived uneasily and this might be especially true for physicians, given that discipline's tendency to see illness as 'the enemy' and therefore death as a professional failure" (p. 2).

Client death is often examined by the specific type of death, such as by suicide. Impacts of client suicide on professionals such as social workers (Alexander, 2007), psychiatrists (Biermann, 2003; Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988), therapists and private practitioners (Carter, 1971; Fox & Cooper, 1998; Hendin, Lipschitz, Maltsberger, Haas & Wynecoop, 2000) has been investigated in the literature. Death by suicide also brings the added complicating factor of stigma for taking one's own life and in terms of professionals, possible perceptions from society that there was a duty to prevent this from happening. In the area of fatal substance overdose, professionals' experience after drug overdose death has not been well studied and "no practice guidelines exist to guide providers after an overdose death" (Yule & Levin, 2019, p. 2). However, families' experiences, after an overdose death, has been explored in a small area of the literature and found that the experiences of parents whose children died from

an overdose is similar to that of parents whose child died from suicide (da Silva, Noto & Formigoni, 2007 & Feigelman, Jordan & Gorman, 2011). Given the similarities between suicide and overdose deaths, professionals may likely experience similar emotional reactions from either method of death. Other similarities and added challenges to processing a client's death during the healing process include the unexpected nature and the social stigma associated with "self-inflicted death" (Yule, et al., 2019, p. 2). The specific meaning making processes undertaken by these groups of professionals have not been addressed in the mentioned studies and this may provide more thorough understanding of how unexpected deaths are experienced.

The loss of a client to suicide is common in practice. Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989) referred to this phenomenon as an "occupational hazard" for psychiatrists and psychologists after finding that 22% of psychologists and 51% of psychiatrists reported losing a patient to suicide at some point during their careers. This experience may even be higher in different populations. In another study with therapists, (Pope & Tabachnick, 1993) reports that approximately 97% reported client suicide as their largest fear in practice.

While the social worker's experiences of a client completing suicide has been studied (Duffy, 2018; Jacobson, et al., 2004; Saunders, Jacobson, & Ting, 2005; Ting, Saunders, Jacobson, & Power, 2006; 2008; 2011) this remains an under studied area and research was also limited to specific employment areas of mental health agencies. This is concerning because social workers routinely provide specialized service to suicidal populations. Other research focusing specifically on social workers explored different types of client death; terminal illness of children in palliative care (Wilkey, 2015), fatal child maltreatment and neglect (Douglas, 2013; Gustavsson, et al., 2004) and both the anticipated and unanticipated deaths of clients across a range of work settings and populations (Matzke, 2014).

The responses of social workers following a client death, (Ting, Jacobson, & Sanders, 2011) highlighted any interaction with client suicidal behavior, either completed suicide or attempted suicide, is extremely stressful for the helper. The resulting grief tends to hold complex layers as both a professional and personal process for those working with the deceased (Strom-Gottfried & Mowbray 2006, p. 10). Similarly, Saunders, Jacobson, and Ting (2005) suggest that social workers experience multiple personal and professional reactions immediately following a client's death such as, in addition to being impacted professionally, a range of emotions are experienced which are commonly viewed as universal reactions after trauma like anger, shock, disbelief and depression. In terms of unexpected loss, which is traumatic, this can also include additional reactions in the form of avoidant behaviors, intrusive thoughts or feelings and other post-traumatic reactions in practice (Saunders, et al., 2005). As for the unique professional reactions after an unexpected death, certain themes have been documented in research with social workers, psychiatrists, and psychologists (Chemtob et al., 1988, 1989) and that includes feelings of anger at the agency, self-blame, guilt, professional incompetence, responsibility, isolation, and justification (Saunders, et al., 2005, p. 338). It is interesting to note that some social workers viewed the death of a client by suicide as evidence that they are incompetent and essentially failed in their role as a helper for not being able to anticipate and protect the client from harm or death (Saunders et al. 2005). Feldman (1987); Jordan, (2020); Ting, Sanders, Jacobson, and Power (2006); Veilleux and Bilsky (2016) shared similar reactions among social workers in terms of intense reactions such as feelings of guilt, self-blame, and self-doubt about decisions in practice. Rabox (2021) suggested that death may be commonly seen as a professional failure in helping professions and that a physician’s grief after a client death might be met with attempts to deny or minimize their grief in order not to be perceived as

unprofessional. This can lead to disenfranchised grief. Many studies also appear to explore the cumulative impact of client deaths on workers resulting in burnout and vicarious trauma as well as impacts on work productivity.

There is a gap in the social work literature with those who have experienced client death and how meaning is created after this type of experience. From the existing literature review, I found no research on registered or licensed social workers, or in western Canada that explored the spiritual meaning of social workers reconstruction process in the context of unexpected client death. In terms of research exploring the issue of "client death", several researchers focus on the social work profession specifically (without indication of registration) as a participant group and focused on the view of one individual role or from an agency-centered perspective toward how client death is experienced and handled in the workplace including; three graduate level theses (Duff, 2018; Wilkey, 2015) focused on an ambiguous role of "social service worker" (Matzke, 2014) which included a range of professions such as social work, nursing and therapist trained individuals. Some studies referenced "child welfare worker" (Douglas, 2013; Gustavsson & MacEachron, 2004) and attempted to explore client death of a child from the perspective of Child Welfare agencies, not individually, where there is a high chance of encountering situations of fatal child abuse or domestic violence with fatal outcomes. The title of "child welfare worker" is ambiguous due to a range of qualifications that can be employed in this area of work. In British Columbia, many areas of employment do not require a social work specific degree or registration with the BCCSW for those staffed in these roles. This issue may impact who is involved in studies focusing on the social work profession. Wallace, Khoo, Hinyard, Ohs and Cruz-Oliver (2018) focused on social workers' experiences in palliative and hospice settings and the emotional impacts of working with this population facing death. One could argue that death

occurring in hospice is not considered unanticipated due to the requirements needed to receive services from hospice settings, however, the concept of unanticipated death may refer to someone passing away sooner than a timeline given by physicians or other hospice staff. Jacobson, et al. (2004) examined the specific field of "mental health social work" and documented the lived experiences of these professionals. Bembry, Poe, and Rogers (2009); Bembry and Rogers (1996); Fulton (2013) all specifically focused on social work students' experiences of client death during a field placement and looked at how students are supported through this experience. Bembry, et al. (2009) found that the students were typically affected by the client death(s) across a range of employment settings and found that approximately 45% of the students' perceived the practicum agency in which they were placed were unhelpful and unresponsive and approximately 70% perceived their BSW program provided no support after a client death (p. 13). The students' suggested ideal support was clinical supervision, informal support from colleagues from the office or through connection with co-students during the practice seminar to debrief and work through emotions (Bembry, et al., 2009). The authors reported they wanted to discover the experiences of social work students to allow for a deeper understanding of how new workers are impacted by a normative experience such as client death and how to better serve students' needs. Future research may help tailor social work education curricula to incorporate courses on death and dying, provide recommendations on how field education faculty can better support students through the event of client death during their program, and further clarify what specific supports are perceived as helpful for students. Fulton (2013) encouraged students to do some personal development work around death and death concepts to better inform their social work practice and therefore better prepare them for the possible death of a client. Bembry (2009) discussed in detail a student who appeared to take the

news of a hospice client's death "very well" and found "comfort in knowing the spiritual views of the deceased client through previous conversations with that client before they passed" (p. 71). This suggests there is a need to explore meaning-making systems to understand how meaning is created in social work. These systems may better inform and support social workers if they lose a client unexpectedly. None of the researchers discussed social workers or explored the spiritual meaning of their reconstruction processes in the context of professional bereavement or disenfranchised grief.

The studies that were focusing on client death experiences in social work used a quantitative or mixed methods research design. Thus, an in-depth understanding of helping professionals' experiences collected through qualitative interviews is missing. Although mixed methods quantitative research has many strengths and provide valuable insight and knowledge to the field, they do not capture the complexity and depth of a qualitative lens. Thus, this investigation is a crucial addition to the area of social work and may well broaden our understanding of meaning-making systems after experiencing the unanticipated death of a client.

As the literature reveals, there is a gap in the research concerning how social workers experience client death and how they create meaning from this event. This thesis not only focuses on how social workers experience the death of a client(s), but also examine the specific spiritual meaning of their reconstruction processes in the context of unanticipated client death.

Trauma and Traumatic Death

Traumatic death and loss refer to the loss of a person in the context of potentially traumatizing circumstances. Examples are commonly reported as deaths due to homicide, suicide, accidents, natural disasters, and even losses resulting from war and terror (Boelen, Olff & Smid, 2019, p. 2). The sudden and surprising death of someone with whom a professional

relationship was shared may also be categorized as a traumatic loss.

A single traumatic experience or cumulative traumatic experiences are seen regularly within many frontline professionals providing care. Research has consistently shown that professionals in helping roles or “helping professionals" experience vicarious trauma, moral injury, compassion fatigue, secondary traumatic stress, and burnout (Ball, Watsford & Scholz, 2020). The symptoms associated with vicarious traumatization and stress related disorders are loss of appetite, fatigue, sleep disorders, irritability, inattention, fear, and interpersonal conflict, which often remain at subclinical levels (Sabin-Farrell & Turpin, 2003; Li et al., 2020, as cited in Benfante, Di Tella, Romeo & Castelli, 2020, p. 4). As the DSM-5 (APA, 2013) indicates, "experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" can be considered as potentially traumatic events (criterion A4: e.g. first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

Those who work in emergency care settings or Intensive Care Units are particularly at risk for developing Post Traumatic Stress Disorder because of the highly stressful work-related situations to which they are exposed. Situations such as management of critical medical cases, caring for severely traumatized people and frequent witnessing of death and trauma, among many other factors are part of the work undertaken in emergency care related settings (Figley, 1995; Crabbe et al., 2004; Cieslak et al., 2014; Berger et al., 2012; Hegg-Deloye et al., 2013; Garbern et al., 2016, as cited in Carmassi, et al., 2020, p. 7). Social Workers are also routinely exposed to either direct or indirect traumatic experiences and may be repeatedly exposed to highly disturbing details that have potential to cause mental health implications. As Fox (2019) states “personal narratives are lacking in the literature from social workers documenting their lived experience of this phenomenon” (p. 1). Reports of hospital social workers routine

experiences in medical settings are also limited (Cleak & Turczynski, 2014). While the literature reveals impacts of traumatic experiences in professions, the experience of traumatic client death has not been well documented in the social work literature.

Exposure to death in the workplace has been found to be highly traumatic for workers in general (Kinder & Cooper, 2009) and people who help survivors may themselves be traumatized in the process (Sabin-Farrell & Turpin, 2003). The impact of exposure to trauma and sudden death on health professionals and emergency workers has been explored particularly in relation to ‘‘emotional labor’’ or dealing with the strong emotions of self and others (Stayt, 2009), stress and coping (Alexander & Klein, 2009), and post-traumatic stress responses (Jonsson & Segesten, 2004). In the context of the COVID-19 pandemic, researchers investigated the psychological impact of COVID-19-related trauma in healthcare workers. Lai et al., (2020) found that holding a frontline worker role, directly engaged in the diagnosis and treatment of patients infected with COVID-19, was an independent risk factor for higher scores of symptoms of traumatic stress. Lai et al. (2020) discovered data that suggests women, nurses, and those working in Wuhan reported more severe symptoms of trauma stress and worse outcomes for anxiety, depression, and insomnia, with respect to men, physicians, and those working in Hubei outside Wuhan and outside Hubei. These findings were similar to those of Zhang et al. (2020), who found that approximately 73.4% of 1,563 healthcare workers were experiencing the presence of traumatic stress symptoms. The area of coping after traumatic events have been mentioned and in the study by Ting et al. (2008), who explored coping strategies of mental health social workers in the context of fatal and non-fatal suicidal client behavior, that a strong need was expressed to “make sense of the unexpected” (p. 12). Victor Frankl (1946) discussed the most common tools used for dealing with unexpected types of stressors were spiritual practices like prayer and meditation and

an increased use of alcohol. Similarly, recent social work literature has established a connection between life beyond trauma using Mahavakyam meditation and other facets of spirituality or spiritual development to facilitate movement toward growth (Margolin & Sen, 2022). This has valuable implications for those who support individuals with mental health challenges as well as general helping professionals who are continually exposed to stressors over the course of their work. Those in helping professions need appropriate support to remain healthy individuals and thus remain in their helping roles to provide the most promising practice to clients and patients.

Impacts of the Covid-19 Pandemic

The COVID-19 pandemic has increased stressors and grief reactions (Rabow, Huang, White-Hammond, & Tucker, 2021) across all helping professions and will likely continue to significantly impact mental health and well-being. This thesis project explores social workers' experiences of client death and how meaning is construed, which is extremely relevant and timely due to the significant increase in deaths worldwide.

COVID-19 is the disease caused by SARS-CoV-2 coronavirus, a new virus that was first recognized in Wuhan, China, in December 2019 (Government of Canada, 2021). The first case of COVID-19 disease was identified on December 8, 2019, in Wuhan, the Hubei province of China by the Chinese Center for Disease and Prevention from the throat swab of a patient (Wu & McGoogan, 2020). On March 11, 2020, just over two months after it began, the World Health Organization (WHO) declared COVID-19 to be pandemic and confirmed over 820,000 cases and 40,000 deaths from SARS-CoV-2 infection as of April 1, 2020. Since the first reported case in December 2019, more than 100 million people globally in over 210 countries have been confirmed to have been infected and two million people have died of COVID-19 (Wang, Wang, Wang, Lau, Zhang, & Li, 2021, p. 1). At the time of writing this report, the United States, Italy,

Spain, and China have the largest number of cases, with certain regions and populations being infected at different rates. This suggests there are distinct social and economic characteristics for the spread of COVID-19 (Sarti, Lazarini, Fontenelle & Almeida, 2020). These differences highlight the gaps in the social determinants of health even more and likely create a wide range of challenges to social work practice (Banks, Cai, de Jonge, Shears, Shum, Sobočan, Strom, Truell, Úriz & Weinberg, 2020; Harrikari, Romakkaniemi, Tiitinen & Ovaskainen, 2021).

Epidemiological studies have shown that male sex characteristics are a significant risk factor for the severity and mortality of the COVID-19 virus (WHO, 2020), however, beyond this subset of data the virus has shed light on an important and silent sex/gender gap for many reasons (Crimi & Carlucci, 2020). For instance, the additional burden on female healthcare workers may stem from the additional physical and emotional demands placed on healthcare workers in the workplace, and higher demands in life outside the workplace as females are more likely to assume the role of family caregiver (Crimi & Carlucci, 2020). Approximately 70% of the global healthcare workforce is made up of women (Boniol, McIsaac, Xu, Wuliji, Diallo, Campbell, 2019), according to an analysis of 104 countries conducted by the World Health Organization, reaching 90% in the Hubei province of China (Wenham, Smith, & Morgan, 2020). One issue is that most of the healthcare workers that tackled COVID-19 on the healthcare frontlines are women and therefore now have additional burdens when caring for an increased volume of critically ill patients, caring for the dead body, and providing support for the deceased patients next of kin (Crimi et al., 2020). Living through a global pandemic has changed both home and work life for healthcare providers; ranging from struggling to wear protective equipment for the length of a shift, not having access to quality protective equipment, and having a high degree of fear around contracting the virus and spreading it to family. This is combined

with the reality of caring for a number of COVID patients, coping with the emotional and difficult task of communicating with patients and their families, supporting people suffering and dying alone and sometimes facing the difficult decision of prioritizing lifesaving care of those in need (Crimi et al, 2020).

The daily emotional and mental pressures have been documented, showing a higher prevalence rate of anxiety, depression (Pappa, Ntella, Giannakas, Giannakoulis, Papoutsi & Katsaounou, 2020; Rossi, Socci, Pacitti, et al., 2020) and suicide in female frontline workers (Rahman & Plummer, 2020). Various studies have explored impacts of pandemics on the mental health of healthcare workers over the last decade including the 2003 SARS, 2012 MERS and the current COVID-19 outbreaks. Carmassi, Foghi, Dell'Oste, Cordone, Bertelloni, Bui, and Dell'Osso (2020) and Cabarkapa, Nadjidai, Murgier, and Ng (2020) found frontline healthcare workers in emergency care settings are particularly at risk for PTSD because of the highly stressful work-related situations they are exposed to, which includes: management of critical medical situations, caring for severely traumatized people, frequent witnessing of death and trauma, operating in crowded settings, and interrupted circadian rhythms due to shift work (Figley, 1995; Crabbe et al., 2004; Cieslak et al., 2014; Berger et al., 2012; Hegg-Deloye et al., 2013; Garbern et al., 2016). Similarly, healthcare workers employed in COVID-19 care centers reported sleep cycle disturbances related to constant work stress, dealing with the death/dying of patients and coworkers and a chaotic work schedule (Jahrami et al., 2021; Galehdar, Kamran). Toulabi and Heydari (2020) explored nurses' experiences of psychological distress who care for patients with COVID-19. The data showed that the nurses experienced a variety of psychological distress across eleven categories including death anxiety, anxiety due to the nature of the disease, anxiety caused by corpse burial, fear of infecting the family, emotional distress of delivering bad

news, fear of being contaminated, emergence of obsessive thoughts, the bad feeling of wearing personal protective equipment, conflict between fear and conscience, and public ignorance of preventive measures (p. 3). The Covid-19 pandemic compounds the typical responses healthcare professionals experience when caring for those seriously ill with infectious disease.

The basic understandings of grief and bereavement have been well researched prior to the current pandemic. Many different forms of grief have been identified including disenfranchised grief, anticipatory grief and complicated or pathological grief, which typically warrants clinical intervention for processing due to the severity and length of time. Grief has been an issue for a long time for helping professionals including social workers. The impacts of trauma and other stress related issues in the workplace have been well documented as well as the resulting issues of burnout or compassion fatigue. Grief is linked to burnout and burnout may very well be an inability to integrate or process cumulative losses into our personal and professional lives. As Rabow (2021) stated, "grief in the time of COVID-19 has novel elements and healthcare workers have had to adapt to the new strains on their patients, as well as to reconcile their own personal and professional relationships to loss in the time of COVID-19" (p. 2). Rabow (2021) highlights four complicating factors for grief during the current pandemic affecting frontline workers: incomplete grief, disenfranchised grief, inadequate government response and social injustice, mistrust, and racism. Frontline healthcare workers are the first to experience COVID-19 and experience grief around the deaths of their patients, their colleagues, and even their own loved ones. Although much has been written about COVID-19 grief of non-healthcare workers (Janssen, Ekström & Currow, 2020; Lichtenthal, Roberts & Prigerson, 2020; Moore, Sampson, Kupeli, Davies, 2020; Morris, Moment, & Thomas, 2020; Selman, Chao, & Sowden, 2020; Shanafelt, Ripp & Trockel, 2020), the unique experiences of healthcare workers grieving during

the pandemic deserves special attention (Rabow, 2021, p. 3). During these unprecedented times, the impact of grief on workers has amplified the grief response in professionals of clients and patients who die from the coronavirus and Rabow (2021) has identified at least eight reasons for this: 1. COVID-19 is causing a large number of deaths; 2. workers often deployed to types and conditions of work where they witness COVID-19 deaths and are unprepared; 3. attention to clinician grief is not perceived as priority during ongoing crisis; 4. absence of a cure and uncertainty about the best ways to treat COVID-19 or perceive the healthcare system is inadequate to provide the best care; 5. the demographics of patients who are dying may present an additional stress; 6. the way patients are dying suddenly and alone brings added distress for clinicians; 7. being surrounded by extremes of dying and inadequate vaccine distribution; 8. a heightened sense of survivor's guilt and being placed in a new and vulnerable place in the context of dying and watching many clients unable to die "a good death" because of physical distancing measures.

Spiritual Meaning Reconstruction in the Context of Bereavement

The field of grief and bereavement has changed significantly over the previous decades in terms of how the human experience of loss is understood and how grief interventions are viewed. Many early theories of bereavement have been rejected, as much of the research conducted has failed to support many variations of experiences around death and loss which include the popular theory that grief is a predictable and linear emotional journey, going from "distress to recovery" (Hall, 2014, p. 7). The literature discusses a movement away from the notion those bereaved need to work toward the "letting go" of the deceased for successful grieving to be achieved, and toward a scenario where a person can maintain healthy continuing bonds with the deceased. The shift in viewing how people grieve now tends to consider the multifaceted nature of loss and

considers a more wholistic approach to a normal human experience. Those going through the experience of bereavement struggle with both the absence of their loved one and a flood of emotion, and often with an overwhelming feeling of meaninglessness.

Meaning reconstruction is just one contemporary theory of bereavement that has gained a significant research base. Meaning reconstruction or spiritual meaning-making has been well researched and incorporated into contemporary theories of grief and loss. Current theory stands in contrast to the dated yet foundational and well-known stage model of grief such as Kubler Ross's five stage model. In contemporary grief research, Robert Niemeyer (2009, 2010, 2011) has made significant research contributions to advance a more flexible theory of grieving as a meaning-making process. The concept of meaning reconstruction or 'meaning-making' can be conceptualized as a blending of spiritual beliefs with an understanding of grief theories.

Contemporary theories of grief and loss tend to focus on the continuous journey of processing a loved one's death by cultivating new meaning after the loss. This journey is personal and does not tend to occur in a linear fashion. Theories of grief and trauma also tend to vary in how they discuss what meaning is and how it is created or found. Neimeyer (2001b) described meaning as "a complex, multidimensional phenomenon existing at multiple levels of an individual mourner's awareness, from explicit, consciously held beliefs to more unsaid ''deep structures'' that are used to organize perception of the world and the self" (as cited in Hibberd, 2013, p. 10).

Contemporary grief theories also tend to emphasize the "sociocultural context in which mourners navigate bereavement and the constructive nature of many important grief processes" (Hibberd, 2013, p. 671). Gillies, Neimeyer and Milman (2014) discuss meaning-making that allows people to engage in a process of "retaining, reaffirming, revising or replacing elements of

their orienting system to develop more nuanced, complex and useful systems" (p. 208). In the context of bereavement, the term meaning-making is commonly used to explore the process of how people make sense of a new world without the deceased and what meaning is attributed to this loss (Neimeyer, 2001; Kalayjian & Eugene, 2010; Steffen & Coyle, 2011; Neimeyer, 2012; Gillies, Neimeyer & Milman, 2014). Similarly, Ignelzi (2000) defined the process of meaning-making as "the process of how individuals make sense of knowledge, experience, relationships, and the self" (p. 5). Regardless of the situation, meaning making has the potential to navigate complex life experiences and our internal processes related to these experiences.

The concept of meaning-making has been used across disciplines taking a constructivist approach in counselling psychology and psychotherapy (Kegan, 1980; Carlsen, 1988; Neimeyer & Raskin, 2000; Mackay, 2003; Neimeyer, 2009), educational psychology (Nash & Murray, 2010; Baxter, Magolda & King, 2012; Fantozzi, 2012) and has roots in philosophy (Frankl, 1962; Kierkegaard, 1849; Sartre, 1946). Meaning is highly subjective in nature as every person is unique and holds different perspectives. Meaning is the assigned personal significance of something. Viktor Frankl, a psychiatrist, and holocaust survivor published the well-known book *Man's Search for Meaning* (1946) which revolves around his idea that human's primary motivation is to discover meaning in life. Frankl held the belief that meaning can be discovered under all circumstances, even in unpleasant experiences of loss and trauma. Frankl did not use the term "meaning-making" in any of his work but his contributions on searching for meaning after experiencing trauma has been highly influential to contemporary theories in psychology. Main concepts from his work have been integrated into contemporary theories of counselling and psychotherapy such as existential and humanistic therapies and acceptance and commitment therapy (ACT). Humanistic-existential approaches, often associated with Carl Rogers, are also

based on the belief that individuals have an inherent drive toward self-actualization and realizing one's true potential and purpose (Winston, 2015). Meaning in existentialism, a form of philosophical thought that explores the problem of human existence, centers on the lived experience of the thinking, feeling, acting individual (Macquarrie, 1972). This form of thinking typically explores issues of finding meaning, purpose and value of human existence. When people are confronted with experiences that challenge their worldviews such as trauma or an unanticipated death, it can trigger an existential or spiritual crisis that can be resolved through the reconstruction of meanings a person once held about the world or their relationship with the deceased. The ability to make sense and understand an experience is a process of coping, to better understand fears around death and fears around a changed and possibly unjust world. Menzies and Menzies (2020) suggest people may develop adaptive ways of coping with their fear of death, such as building meaningful relationships and leaving a positive legacy (p. 2). In contrast, Menzies (2012) asserts awareness of death may also produce a powerful sense of fear or meaninglessness and may contribute to maladaptive coping behaviors.

Dimensions of Meaning

Hibberd (2013) pointed out "consensus surrounding a definition of 'meaning' has remained elusive" (p. 672). My literature review found multiple dimensions of what meaning reconstruction may look like which includes rebuilding shattered assumptive worldviews (Janoff-Bulman, 1992), sense-making and benefit finding (Davis, Noelen-Hoeksema & Larson, 1998), and an over-arching combination of meaning as sense-making, benefit finding and identity change (Gillies & Neimeyer, 2006). These concepts give common language to describe different aspects of meaning reconstruction.

Sense-making

The need to ‘‘make sense’’ of a loss or event is a basic human motivation. Hibbert (2013) reports, “by explaining why it happened in terms consistent with existing worldviews, or by changing worldviews to accommodate the fact of the loss, is perhaps the most well-studied aspect of meaning reconstruction after loss” (p. 677). Constructivist theories of grief such as Gillies and Neimeyer’s (2006) proposed meaning reconstruction theory that emphasize, “the development of a coherent life narrative within which losses make sense” (p. 3). Park (2010) elaborated on making sense in terms of understanding of the loss itself, or toward making sense of their lives, selves, and world now that the loss has occurred” (p.4).

Benefit Finding

The concept of benefit finding is a form of meaning reconstruction or a response to a loss. It is generally characterized by the bereaved identifying a benefit(s), or any positive aspect, to having lost a loved one (Davis et al., 1998). The research appears to show mixed reviews on this sub-type of meaning-making but the general theory is that the perception of benefits may provide a buffer against complicated forms of grief and mental health issues and reports of experiencing less intense symptoms of grief as reported in several studies (Davis et al., 1998; Michael & Snyder, 2005; Neimeyer et al., 2006 as cited in Hibbert, 2013).

Identity Change

The model of ‘meaning’ by Gillies and Neimeyer (2006) considered identity change as a stand-alone form of meaning reconstruction, in combination with sense-making and benefit finding, in grief contexts. Their model suggests that when an individual is confronted with the death of a loved one it has a profound impact on the sense of self and how they view themself. This also aligns with Janoff-Bulman’s (1992) theory of shattered assumptions, as when someone experiences a traumatic event, they may simultaneously experience a change in their worldview

in either an adaptive or maladaptive direction. Romero (2018) examined the ways caregivers of those with Alzheimer's disease construct meaning during bereavement and suggested that participants who reported benefit finding and a change in their identity contributed to reduced levels of reported grief. This can have important implications in grief therapy for those who are at risk of grief complications and therefore those at risk may benefit from grief therapy that can facilitate this portion of meaning-making. Only a limited number of studies have explored issues with identity changes during bereavement (Neimeyer et al., 2006) and only recently, the focus on 'the self' has been recognized as an important dimension of meaning-making in the grief experience (Neimeyer, 2001a). Similarly, Wehrman (2018) noted the lack of research exploring how people understand and manage changes in how they see themselves during grief periods. My literature review yielded no work that explored shifts in identity, in the context of bereavement for social workers who have experienced a client death. Whether professionals, such as social workers, experience changes in identity or view of themselves differently after a client dies remains unexplored in the literature.

Purpose in Life or Life Significance

The literature revealed that the concept of 'purpose in life' has been well documented and is one of the most well-known forms of meaning-making, including in the context of bereavement. This sub-type of meaning has been described in the literature as being a stand-alone concept from either sense-making and benefit finding, although all three appear to be intertwined and related. Hibberd (2013) discussed the differences in those who are bereaved as they "may be able to explain the loss in a larger framework or worldview (sense-making) and may be able to acknowledge having gained something from the loss (benefit finding) but still see nothing worthwhile in their life now that the loved one is gone (life significance)" (p. 681).

Humans create purpose through attaching a feeling of value to a goal and can be anything from having children or being a caregiver, writing a book or even pursuing a specific profession. In addition, to have purpose people must "experience the world and their lives as coherent and controllable so that one's choices can have some effect on valued outcomes" (Hibbert, 2013, p. 682). Victor Frankl (1959/89) was one of the earliest researchers interested in this concept of finding meaning and purpose within one's life and even suggested this is a basic human motivation comparable to hunger and thirst. Frankl drew from his early experiences as a survivor of mass trauma during the Holocaust and from lived experience noting that people who were able to articulate a specific reason to survive beyond their current traumatic condition appeared to function psychologically better than those who had no self-reported purpose. This aligns with current research in bereavement, where Rogers, Floyd, Seltzer, Greenberg, and Hong (2008) note the recovery from grief was associated with having a sense of life purpose in parents who lost a child. Similarly, Boyraz, Horne and Waits (2014) found evidence that while losing a child or a loved one at a young age were associated with increased grief symptoms, those who hold a neutral attitude toward death may help bereaved individuals maintain a sense of meaning and purpose in life following bereavement. In terms of therapies for grief, Lichtenthal and Breitbart (2015) noted that meaning-centered grief therapy was more successful, compared to existing therapeutic interventions, in alleviating emotional pain in parents who lost their children to cancer. Boyraz et al. (2014) noted that clinicians using existential interventions that specifically focus on increasing meaning and existential well-being among individuals going through difficult life experiences. Similarly, Henry and colleagues (2010) work with individuals who were recently diagnosed with late-stage cancer, provide evidence for the effectiveness of an existential meaning-making intervention in increasing meaning and well-being.

Meaning reconstruction is an important aspect of processing grief and loss after a death and can potentially reduce the symptoms associated with intense and prolonged grief reactions. Hibberd (2013) reports areas of further research would be useful to further examine meaning-making processes with "populations that are considered more "at risk," which would include those who have experienced traumatic bereavement (sudden, unexpected, or traumatic death) and individuals who lose an "identity defining relationship"" (p. 11) (Davis, Wortman, Lehman & Silver, 2000). My research responds to this call for more literature in meaning-making processes.

Post Traumatic Growth (PTG)

The concept of post-traumatic growth (PTG) has been available since the mid-1990's and was coined by Tedeschi and Calhoun (Pérez-San-Gregorio, Martín-Rodríguez, Borda-Mas, et al., 2017) post-traumatic growth aims to explain the sense of transformation following the experience of trauma. Jones, Hilton, and Boehm (2020) discuss growth after trauma and use the analogy "just like growth that occurs in a forest after a wildfire, the destruction doesn't render an end to the life of a forest. Fire, like trauma, may activate seeds that bring new life to trees, trees that grow thicker bark than before as an adaptation to the trauma" (p. 4). Margolin and Sen (2022) established those stuck in the trauma response of flight/fight or freeze/fawn pattern commonly lose their sense of identity and life purpose after a tragic loss or experience. The ability to shift beyond one's traumatic experience lies within meaning or sense of purpose and a strong impulse to move forward after loss (Margolin & Sen, 2022). In other words, people may find "seeds of hope" and their worldview, view of self and relationship to others begin to change. Post-traumatic growth can essentially be viewed as a meaning-making process but tends to be more aligned in contexts of traumatic events more than with grief processes.

Margolin and Sen (2022) explained individuals tend to experience "a massive psychic

metamorphosis of selfhood, life priorities, and sense of place in the universe as they seek to make meaning of the loss and destruction in their lives from trauma" (p. 1). Tedeschi and Calhoun (1996) developed a self-report scale to measure and assess growth after trauma, called the Post-Traumatic Growth Inventory (PTGI) and looks for positive responses of participants across five areas: appreciation of life, relationships with others, new possibilities in life, personal strength, and spiritual change. Margolin and Sen (2022) assert, "regardless of an individual's personal belief system, the processes of personal narrative reconstruction, re-evaluation and whole person development, are negotiated through spiritual routes" (p. 1).

The literature has a wealth of information on PTG and has been studied in the context of many different populations and types of trauma. PTG is well-documented in the contexts of abuse (Woodward & Joseph, 2003; Lev-Wiesel, Amir & Besser, 2005), disaster (Siqveland, Nygaard, Hussain, Tedeschi & Heir, 2015) and combat (Tedeschi, 2011), survivors of cancer (Danhauer, Case, Tedeschi, et al., 2013), HIV infection and AIDS (Barskova & Oesterreich, 2009) and heart disease (Sheikh, 2004). For the purposes of my project, I focus on research of PTG in the context of bereavement.

The theory of PTG has also been applied to the area of bereavement research and according to the review by Michael and Cooper (2013) demonstrated that post-traumatic growth can be experienced by bereaved individuals. Death and loss are a common experience, and can be life changing, and can even lead to significant mental health complications like post-traumatic stress, depression, or complicated grief reactions in both the general population and in helping related professionals. In the context of bereavement, the negative reactions have been well studied and as Gamino and colleagues (2000) suggested it is equally important to understand more about adaptive responses to death and the importance of understanding response to loss as

on a continuum (as cited in Wheeler, 2002, p. 3). PTG, in the context of professional bereavement, has received less attention in the literature compared to that of the "loss of a loved one" in the general population. Just as the working relationship between social worker and client is unique among the helping professions, the death of a client is a unique experience, which may lead to many negative outcomes. Therefore, it is important to understand post-traumatic growth in this population in the hope that it may guide improved support within professions that face daily stressors and/or traumatic death at higher rates than others.

PTG that results from bereavement has been identified by researchers in the general population (Schoulte et al., 2012), including bereaved siblings (Hogan & DeSantis, 1992), perinatally bereaved families (Black & Wright, 2012) and bereaved spouses (Hogan, Greenfield, & Schmidt, 2001; Kaunonen, Tarkka, Paunonen & Laippala, 1999). Within the helping professions, PTG has been explored in the nurse population during both the MERS and COVID-19 pandemics (Cui, Ppan, Wang, et. al., 2021; Hyun, Kim & Lee, 2021; Okoli, Seng, Lykins & Higgins, 2020) and it was reported these nurses experienced high levels of PTG during periods of exacerbated trauma in the work environment. Some of the nurses in Cui, et al., (2021) discussed a change in perception and new understanding of life, improvement in relationships with other healthcare staff and patients and a change in spiritual outlook that promoted their growth after traumatic and stressful frontline work experience. Similarly, the authors in Hyun, et al. (2021) suggested that resiliency was the main factor in the development of PTG among the nurses and further identified that a sense of optimism, persistence and feeling of support assisted in more positive outlooks following this work experience. Participants identified as primary healthcare workers (Fino, Bonfrate, Fino, Bocus, Russo & Mazzetti, 2021; Huecker, Shreffler & Danzl, 2020; Xu, Hu, Song, Lu, Chen, Wu & Xiao, 2016;) and aid workers (Veronese, Pepe,

Massaiu, De Mol & Robbins, 2017) have also reported experiences of PTG. In all studies involving healthcare workers, PTG was reported among participants in the context of experiencing stress and trauma directly from their place of work. Researchers Huecker, et al., (2020) were also able to identify predictors of PTG which include active coping, self-control, higher education level, hope, social support, and "deliberate rumination" or making sense of the trauma (p. 1). Researchers have also captured some positive impacts of psychologists and psychiatrists after having a patient die by suicide (Gulfi, Heeb, Dransart & Gutjahr, 2015). These positive impacts included "newfound support from colleagues and management being made more readily available for consults and debriefing (Gulfi, et al., 2015, p. 15). Nurse psychotherapists (Valente & Saunders, 2002) report some aspects of personal growth have been noted following the death of a client by suicide but only if supports are perceived by the worker, such as having a support system to cope, recognizing their own mortality and taking the time to process grief.

Many populations remain under studied and are not well understood including after a serious pediatric illness (Picoraro, Womer, Kazak & Feudtner (2014). There also appears to be a gap in the PTG literature around how other professions experience positive changes in the context of trauma and bereavement in their career or how growth can be facilitated to minimize occupational hazards like vicarious trauma or other serious conditions. At the time of this literature review, I found no studies that explore the social work profession and experiences of PTG in the context of bereavement after a client death.

Considerations from the Literature Related to This Study

The research explored on this topic offers some insight into various helping professionals' experiences with the unanticipated death of a client. Some research was found specifically with

social workers' experiences of client suicide and even social work students' preparedness in dealing with situations of client loss. However, the population of social workers in western Canada and their meaning-making processes after sudden client death has not been thoroughly explored. This research focused on the social work discipline to begin to fill that gap in the literature. Alternate reasons for engaging in this topic area include my personal experience of losing clients unexpectedly and my own journey though disenfranchised grieving.

Conclusion

In conclusion, the experience of how social workers process and make sense of the unanticipated death of a client has been understudied and therefore little is known. Given the information found and the information missing in the literature thus far, this research study and question asks: how do Social Workers across work settings experience the unanticipated death of a client and what does their meaning reconstruction process look like after this experience?

Chapter Three: Research Design and Methodology

In this section I highlight the research design and methodological components important to my research process. I discuss the objective of this research and the research questions guiding this study; participant sample and recruitment methods; data collection instruments and methods; data analysis methods; limitations of this study; and potential benefits of this study. I will also explore the concept of spirituality and how it informs my research.

Research Objective and Question

The aim of this research is to gain a better understanding of unanticipated client death from the perspective of social workers. The objectives of this research is to answer the following research questions: What does unexpected client death mean to social workers in B.C.? The objectives are 1. How do social workers understand the experience of unanticipated client death 2. In what ways do social workers navigate disenfranchised grief? 3. Where is spirituality situated and applied in social work experiences of unexpected client death? 4. What does the trauma of unexpected client death mean to social work in how they reconstruct ideas of self and meaning after this experience?

Methodology

To address the research questions, I selected an interpretive qualitative inquiry. Interpretive description is a methodology that aligns with a constructivist approach and the aim is to generate relevant knowledge to the context or situation of inquiry (Hunt, 2009). Creswell (1998) views qualitative research is "an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem" (p. 15). In this way, an inquiry allows me to establish a holistic and in-depth understanding of the detailed reports of

these participants by analyzing their words and the meaning behind them. Qualitative research explores knowledge that is grounded in the human experience (Nowell, Norris, White, & Moules, 2017). I used a qualitative structure to gather data through the method of semi-structured interviews, analyze the reports from participants' experiences, and compile a final report capturing these unique life experiences. I will use thematic analysis as a tool to capture those experiences. By using this approach, I was able to generate rich descriptions and advance knowledge in areas where little is known (Creswell, 2004).

As noted in my literature review, most of the existing studies on experiences of client death and meaning-making systems have been quantitative in design and many have focused on participant samples who hold non-social work roles within the 'helping professions'. These quantitatively designed studies fail to provide a comprehensive understanding of complex experiences such as sudden client death, disenfranchised grief, and meaning-making systems for the professional. An interpretive qualitative inquiry is well suited for research when it is regarding an issue in which understanding multiple perspectives are necessary (Creswell, 2013). As the social worker experience of client death is unresearched, compared to other professions, it is important to gain understanding through the stories and experiences of registered social workers to gain a better understanding of this type of experience in Canada. This knowledge can potentially have significant impacts such as informing policy and procedures in the workplace across many different agencies, educational programs that train social workers, and add to the existing knowledge of therapeutic interventions focused on grief, loss, and bereavement. Thus, to address the question of how social workers describe their experience of client death and how they make sense and construct meaning of this event in their lives, a qualitative study is best suited for this inquiry.

The strengths of qualitative research include: helping researchers access the thoughts and feelings of research participants, which can enable development of an understanding of the meaning that people ascribe to their experiences (Sutton, & Austin, 2015). This approach to research is also highly suitable for researchers who have a connection or experience with the topic under study, which encourages a thoughtful engagement and analysis of the data collected through reflexivity (Sloan & Bowe, 2014). My practice as a registered social worker who has experience with client death and an interest in spiritual styles of coping makes this research approach well-suited to this study. As reported in Guba and Lincoln (1994) "constructivism aims to understand and reconstruct the meanings individuals give to their experiences to build a consensus of what the experience is like" (p.112). In other words, each person has their own subjective understanding of their world, or their "truth" and it is all "equally valid" (Guba et al., 1994, p.111). This can all end with a complex variety of meanings attributed to a phenomenon across all individuals (Creswell 2013, p. 37). Under social constructivist theory, research participants are viewed as being cocreators of meaning and understanding. In this case, the research participants were ongoing collaborators in the creation of how meaning was experienced personally and socially, and shared aspects of their experience they felt were relevant. Future research may further explore variables that may impact the experiences of this population with the phenomenon to provide better supports and prevention measures. Another important part of constructivism is the appreciation of "historical and cultural norms" (Creswell 2013, p.37) in an individual's reflection of their own experience. Many different people can experience the same phenomenon in very different ways due to their social location/identity (Ponterotto, 2005, p.130). This is also true for the impact of trauma or symptoms of complicated grief; some people may not experience these factors while others do.

This research question is well served by employing an interpretive qualitative inquiry to explore and better understand meanings attached to life experiences and subjective meaning-making process of the selected participants.

Participant Recruitment and Sampling

A purposive sampling of ten social workers were recruited for this research. To be eligible, participants were requested to have the following; at least two years of experience as a social worker with either a bachelor or master's degree in social work or be registered with the BCCSW. There was no restriction on age, sex/gender, or place of employment. Prospective participants were identified through existing informal networks and were provided with a comprehensive information and consent form (See Appendix B) and recruitment poster (See Appendix C). Participants who completed the interview were also asked to share the study information with other social workers who may be interested in participating as per the method of snowballing (Naderifar, Goli, & Ghaliaei, 2017). Social workers interested in taking part in this study were asked to contact the primary researcher via the contact information provided in the participant information and consent form (See Appendix B). Once contact had been made, the researcher followed-up by e-mail to answer any questions and to schedule a Zoom interview.

Participation in this study was voluntary and all participants were required to provide informed consent prior to any data collection via the consent form and verbal consent via zoom. The initial aim was to recruit six to twelve social workers with the experience of unanticipated client death; however, the overall sample size was driven by data saturation, or the point at which no new major themes emerged (Sandelowski, 1995). One criterion used for identifying data saturation is that the researcher frequently encounters repetitive data. Early evidence of some saturation was found after the sixth interview, and recruitment continued to generate ten

interviews, allowing for the examination of perspectives of the diverse range of social workers and to confirm the emerging thematic data.

Data Collection

Qualitative semi-structured interviews were used to collect the study data. Gill, Stewart, Treasure, and Chadwick (2008) highlight the use of semi-structured interviews to gather qualitative data and "the flexibility of this approach allows for the discovery or elaboration of information that is important to participants but may not have previously been thought of as pertinent by the research team" (p. 291).

Questions were designed to allow participants to reflect and share their personal experiences of the unanticipated death of a client and how they were able to understand meaning from this type of experience. When generating the interview schedule (Appendix A), care was taken to ensure that the questions flowed logically and were free of jargon (Rubin & Rubin, 2011). Draft interview questions were reviewed and refined with the supervisory committee and through practice with peers who were not connected or involved in this research. This interview guide aligns with typical qualitative procedures which assists researchers in consciously considering what they predict the interview may cover and helps to be able to highlight any possible difficulties in either wording questions or questioning of sensitive topic areas (Smith & Osborn, 2008; Noon, 2018). The design of the interview guide was crafted to explore specifics regarding reflection on a social worker's experience(s) of a time when they endured the death of a client. This semi-structured and flexible nature is consistent with qualitative practices within the interviewing process and allows the researcher to delve into "unanticipated responses, should any emerge" (Ryan at el., 2009, p. 310). Gill, et al. (2008) discussed that "one-on-one interviews

are particularly appropriate for exploring sensitive topics where participants may not want to talk about certain issues in a group environment" (p. 292).

The semi-structured interview schedule (Appendix A) included four general sections, allowing for a comprehensive examination of social work experience, experiences of unanticipated client death in social work practice, along with perspectives relating to the worldviews of the participant and spiritual views and practices. First, demographic information was collected, including age, gender, ethnicity, highest level of education, and years of social work experience. This data was collected to allow the researcher to describe the study samples and was thought to be useful to the research question and to the audience of the study in determining how such information can impact participants in the study across settings or other factors. Second, the experience of unanticipated death was explored, and participants were asked to reflect on a time, or multiple times, they had this experience and were asked to speak to their meaning-making processes after said experience. Third, questions regarding the Covid-19 pandemic were asked which included a discussion of losses experienced during the pandemic, changes to practice, and perceived working conditions. Fourth, questions aiming to understand more about participants self-care and personal understandings of spirituality and spiritual experiences. The interview was concluded by asking participants to share final words and hopes for future supports for social workers within organizations.

Due to physical distancing restrictions because of the COVID-19 pandemic during the study period, all interviews were conducted using a secure Zoom platform. Interviews were scheduled at a time convenient to them and all participants were provided with a unique passcode-protected log in. Interviews were recorded on Zoom and verbal consent was obtained prior to starting the interview. Each interview was transcribed verbatim within a period of seven

to thirty days from the interview to be consistent and so that information discussed in the interview is conveyed accurately. The process of member checking was used and completed within a period of fourteen days of the date the participant received the final transcript. Six participants checked the data provided in each interview. If no response was given by the participant and the fourteen days has passed, then the researcher determined data from the original transcript as accurate to use in the data analysis phase. All interviews were conducted between February and March 2022.

Data Analysis

Thematic analysis was used to analyze the study data. Thematic analysis "is a method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 6). Braun et al. (2006) discuss the benefits of thematic analysis and assert that "thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" (p. 5). The following six-step analysis was implemented in the present study:

1) Organizing and preparing the data for analysis, through transcription of each interview,
2) Familiarizing oneself with all the data, by reading and rereading each transcript,
3) Coding all the data through a process of transforming the raw data into relevant categories,
4) Generating descriptions and themes by turning groups of codes into larger themes,
5) Defining the descriptions and themes by assigning meaning and interpretation to each one and
6) Producing the final report in a pdf document and power point summary.

The above-mentioned steps guided generating of the data set. The proposed method was used to support the rigor of the data (Creswell & Creswell, 2018, p. 269). This process of analysis included member checking to ensure transcripts portray participants' meaning and that I

begin analysis with the most accurate portrayal of their experiences as possible. This will increase trustworthiness of the data obtained (Rodham, Fox, & Doran, 2013). The participants were given a 30-day time frame to review their own transcript and to provide corrections, clarification, or other feedback. Details that may identify the participants as well as sacred Indigenous ceremonial protocol were deleted from the transcriptions. Following completion of the transcriptions, the Zoom recordings were deleted.

Emerging analysis was presented to my supervisor and areas of interpretation that were unclear were identified and further explored. The analysis of the data concluded three main themes and a range of sub-themes from two to three sub-themes per main theme. The final main themes extracted from the interviews are presented in this research.

An inductive approach was used throughout analysis of this research, allowing me to identify and explore the emerging themes. Each transcription was completed in a separate Word document. While saving the Word document of each participant, a numeric code was assigned, and the personal details were removed to ensure that data were de-identified. The transcripts were then read several times, allowing the researcher to gain familiarity and connection with the data. While reading and reviewing the transcriptions, important points were noted as "new comments" in the review section. As analysis continued, data was coded, and segments of text were grouped and labelled appropriately. I colour-coded and combined relevant findings and these were linked to form themes. The beginning of analysis was presented to the supervisory committee and areas that were unclear or in need of deep interpretation were identified and further explored in relation to the themes. The final themes extracted from the interviews of the present research falls into three main themes; theme one: the experiences of death, meaning

making, and ritual; theme two: the presence of spirituality in social work practice; and theme three: the workplace.

To allow for dependability of this research, I kept a reflexivity journal to record my thoughts, feelings, perceptions, and judgements during the data collection and analysis phase. I worked closely with my supervisor to go through my research processes and reasoning to minimize influences from my own interpretations and used a code and recode method of each transcript (Creswell, 2007; Krefting, 1991; Lincoln et al., 1985). Additionally, I consulted with my supervisor to receive feedback as she was not directly involved in the interviewing of participants.

Data Management and Storage

My data management plan for this research was outlined in five steps and was referenced from the UNBC Research Data Management site found at: https://www.unbc.ca/sites/default/files/sections/research/20171128packagebrownbagsessionresearchdatamanagement.pdf and Chapter five of the TCPS Research Ethics Policy found at: https://ethics.gc.ca/eng/tcps2-eptc2_2018_chapter5-chapitre5.html

1) All data and information was obtained directly from individuals through a secure Zoom platform. This research design followed the UNBC Zoom Best Practices for security of the data and upholding confidentiality to strict standards. The UNBC Zoom license was used for this study which provides enhanced security and protection of your data. The information was digitally recorded through Zoom and stored in the UNBC Zoom Cloud and downloaded onto my personal laptop (which is password protected) and was kept in a locked file in my home office, where only I have access to the locked space. The information was used for

research purposes only and in the development of the final thesis. All recorded information will be deleted after transcription is complete after the 48-hour transcription time-period or automatically after 1 year of recording as per the UNBC Zoom recording policy. The recordings were not be shared, edited, or viewed by others except the interviewer and interviewee.

2) The data was stored on my personal laptop, and in the UNBC cloud drive until disposed of. In accordance with Research Data Management and Managing cloud recordings, I used a password to protect any files generated from the data which are saved on my password protected computer (following instructions through UNBC's IT Security SharePoint site – http://our.unbc.ca and Zoom Best Practices for Securing Meetings and Recordings- http://www2.unbc.ca/information-technology-services/zoom-best-practices).
3) Transcription of the data was done in my secure home office. Sharing of the data was done using Sync file sharing (also recommended by UNBC's IT Security SharePoint site) which will provide double ended encryption to allow for information to be sent between researcher and participant. Sync is password protected, secure and did require some communication for instruction on a different medium such as phone or text to move forward with the appropriate password access. The data was shared with individuals that needed to view it – primarily my thesis supervisor Dr. Margolin. Research participants were asked to review and check their own transcribed interview, to correct for accuracy and/or participants may request a copy of their transcribed interviews, in which an electronic copy was sent using secure and password protected data delivery via the Sync file share for your protection. I asked each participant if they are comfortable having the information in their possession and talk about potential confidentiality issues that can arise should other people around them have access to it (a

physical copy of the information could be handled and read by other people around the participant and an electronic copy could be read if other people have access to the same computer, etc.). I keept a research reflexivity journal to ensure dependability of this research project in the locked cabinet in my securely locked home office. Backup data will also be kept on a USB flash drive using the above-mentioned encryption in my secure and private home office.

4) Research participants were told how the data would be used; their interview will be transcribed and some of the information may be quoted by me, the researcher. I reiterated that the information used was confidential, and no identifiers were used in the final report. This was also covered in the consent forms for the participants.
5) All data and information was used for research purposes until the final report was generated and the thesis is successfully defended. After this point, all raw data will be destroyed after 1 year of the thesis defense.

In this independent research, I was the primary researcher and therefore all costs will be my own. All the tasks to complete this research have been completed by me with the support of my supervisor, Dr. Indrani Margolin, and my thesis committee. Only the primary researcher and supervisor had access to the raw data provided through the transcribed participant interviews and any given demographic information. The raw data was only used and stored for the duration of the research and up to one year after the thesis defense, after which all raw data will be securely disposed.

Ethical Considerations

The online Tri-Council Ethics course (see Appendix G) was completed to ensure the research is conducted ethnically and to do my best to safeguard participant confidentiality and

anonymity. Research Ethics Board review and approval was obtained prior to data collection (E2021.1124.063.00) (See Appendix E). All participants received a comprehensive information and consent form (Appendix B) outlining the details, requirements, and methods of protecting participants' data in the study. To promote the comfort of the participants, the researcher reminded participants that they were free to decline to answer any questions that they were uncomfortable with and could withdraw at any time or have any data removed from their interview transcripts. Data were collected and stored securely, and all data was de-identified. A master list containing the participant information was developed and stored separately from the data. This thesis project presented a medium level of risk to participants, because they were asked to reflect and unpack previous experiences in their professional practice with unanticipated client death that may range from highly unpleasant to traumatic, depending on the experience of the individual. The participants were professionals who presumably have strong knowledge of how to access supportive and therapeutic resources should they need to debrief and decompress as a result of the research interview process. A list of mental health resources was developed to provide to the participants, should they decide they need extra support (Appendix D).

The participants were required to self-identify if they meet the criteria of the study, and thus were assumed able to decide if they are comfortable enough to engage in discussing aspects of occupational stressors related to the death of a client(s). No adverse experiences occurred during the data collection phase.

Rigor and Quality

To ensure that the results obtained from social workers experiences of the unanticipated death of a client(s) and how spiritual meaning of their reconstruction processes could be captured accurately, I chose to take a qualitative approach to data collection. Qualitative research is

examined with criteria that is specifically designed and is different from quantitative studies. Guba and Lincoln (1989) introduced trustworthiness as an approach to determine to the quality of the research. Credibility, dependability, transferability, and confirmability are four criteria of the trustworthiness (Guba & Lincoln, 1989).

Credibility. The credibility of the study is formed when findings or experiences are plausible and recognizable through the interpretation of participants' experiences (Korstjens & Moser, 2018). In this case, the researcher used a number of methods/techniques to establish credibility, including member checking of the interview transcripts, which was offered to the participants for review, prolonged engagement with the data in analysis, using participants' words in the creation of the final report, and researcher use of a reflexivity journal to separate personal biases/views from those of participants.

Dependability. Dependability is considered achieved when findings/the research process of a qualitative inquiry are understandable, and repeatable by other researchers within same or similar cohort of participants' and/or context (Korstjens & Moser, 2018; Lincoln & Guba, 1989). To ensure dependability was achieved in this study, rich descriptions of the data were created, and members of the supervisory committee reviewed and examined the audit trail of the study and the final report (Korstjens & Moser, 2018).

Transferability. Korstjens and Moser (2018) describe transferability as the degree to which the findings of a study can be generalized or transferred to other contexts or settings with other participants. Researchers are able to provide detailed descriptions of the findings, in terms of behaviour, experiences, and wider context, which allow readers to determine how it may impact or apply to their own contexts.

Confirmability. Confirmability occurs when the results are derived accurately from the data. To acquire confirmability, the researcher seeks to ensure that all the stages of analysis are explained and that the results are presented in sufficient detail.

Reflexivity. The concept of reflexivity is concerned with acknowledging one's role in the research, to ensure the rigor of qualitative research. A researcher must engage in a process of self-reflection and critical analysis of their own assumptions, beliefs, values, and preconceptions (korstjens & Moser, 2018) and how these may affect research decisions in all phases of qualitative research. For example, in this inquiry I used a reflexivity journal to document thoughts, feelings, and ideas about the research process and to incorporate this into the analysis process as they come up.

Distribution of Study Results

The data produced through this research will be disseminated as my final thesis and shared with participants through an electronic PDF copy. Those who were not able to participate in the study but showed an interest in my research findings and provided me with an email address, will also be sent my thesis document. I will also offer a PowerPoint presentation of my findings, as a second available option for those interested in reviewing how the research question was achieved for the purpose of this thesis.

Summary

This research has the potential to advance the body of literature focusing on Canadian social work knowledge on how unanticipated death of a client is experienced by social workers and how meaning-making is established from this event. The concept of disenfranchised grief within social work may also be discussed. The data produced by this study may also guide

frontline social workers and policy makers in their work to create supportive and healthy work environments for social workers who are potentially at risk for experiencing the death of clients. Supportive and healthy work environments translate into increased mental health support for workers and ensure a reduction in burnout and the potential challenges with complications in the grief process. The results of this study may open the door for conversations around death and dying and may also provide opportunities to address barriers of service providers accessing mental health support and what it means to be 'death positive' within a society that typically censors facts and feelings around death, dying and grief. It may also open conversations about the role of spirituality in social work practice, either for workers or in the work with clients.

Chapter Four: Research Findings

Introduction

This chapter highlights the findings, or emerging themes from the participant interviews, including information on participant demographics. The principal goal of my research was to explore social workers' experiences with unanticipated client death and the spiritual meaning of their reconstruction processes in the wake of this experience. The following section of findings contains data that has been interpreted by the researcher as a member of the practicing social work community, common and relevant themes were identified, and conclusions subsequently drawn.

Noteworthy themes emerged in every interview, allowing the various similarities and differences in the participants' meaning-making processes of death, grieving rituals, and spiritual philosophy. The context of each participants' situation in terms of type of social work role, personal upbringing, understanding of death and grief rituals, comfortability discussing death and spirituality influenced the participants' perspectives/responses. Some participants were willing to discuss personal impacts of spirituality/spiritual experiences and personal familial losses, and illustrate it with examples, while others only discussed these experiences more broadly or in relation to their work. All participants demonstrated their unique and rich perspectives on experiences of having a client die unexpectedly and how they processed or coped and provided a social work practice context to area of study.

A representation of the findings was created in a thematic map as suggested by Braun and Clarke (2006, p. 90). Creating a visual of the data analysis process is also recommended by

Anderson-Nathe (2008, p. 36) and Creswell (2013, p. 152). The emergent primary and corresponding subthemes are presented in Table 1.

Table 1.

Main Themes	**Subthemes**
Theme 1: Experiences of Death, Meaning Making, and Ritual	• The impact of deaths and meaning from systemic failures • Spiritually based meaning • Rituals and ways of mourning at work
Theme 2: Presence of Spirituality in Social Work Practice	• Personal philosophy and spiritual experiences • Inclusion and exclusion in social work practice
Theme 3: The Workplace	• Perceptions of management • Informal vs. formal workplace supports • Indigenous vs. non-Indigenous organizations

Participant Demographics and Descriptions

The demographic composition of the social workers who participated in this research provides some context and perspective of their experience through the interviews. To protect each participants' confidentiality and the confidentiality regarding their work, every participant except for one was assigned a meaningful pseudonym of their choosing or was randomly assigned one. One participant requested to use their real name and did not wish to have a pseudonym.

Ten social workers participated and were interviewed for this research. Nine of them identified as female and one identified as male. The mean age of the participants was 43.8 years old, and the age range was between 25 and 59. The research participants came from diverse

backgrounds. All ethnic backgrounds of participants are described using the words of each participant. Two participants identified as First Nations persons, one Filipino Canadian, one Chinese Canadian, one Ukrainian, four Settler/Caucasian, and one Caucasian with reported Indigenous ancestry. One identified as a European newcomer to Canada.

In terms of educational attainment, five had a Bachelor of Social Work degree, five had a Master of Social Work degree, and one was currently completing a Master of Social Work program. For registration with the BCCSW, eight currently held active registration, and two were not registered. Research Participants had social work experience in a variety of areas, and many worked in more than one area through the course of their careers. The mean of social work participants' work experience was 17.60 years, ranging from three to thirty-two years of work experience as a social worker. Five participants reported some work experience in rural and northern areas but only one currently worked in a rural and northern context. The area of specialization of the social workers in this study were diverse and included: youth psychiatric inpatient unit, community mental health and addictions counsellor, program planning for health authority, adult inpatient forensic unit, Family Service work, Recruitment and Training of caregivers/foster parents, and Executive Director/management. The titles of participants ranged from frontline staff to clinical supervisor, Child and Youth Care Worker, Resources Social Worker, Foster Parent Recruitment Social Worker, Team Leader, Mental Health and Substance Use Counsellor, and Executive Director. The fields of employment spanned three main areas: three health authorities (Vancouver Coastal Health, Provincial Health Services Authority, and Northern Health), the Ministry of Child and Family Development (MCFD), and a Delegated Aboriginal Agency (DAA) newly named as Indigenous Child and Family Service Agency.

All participants spoke at length about their experience of unanticipated client death as they experienced it and actively made sense of this experience. Interviews were conducted in English and via Zoom with all ten participants.

Theme One: Experiences of Death, Meaning Making, and Ritual

The first core theme that emerged from the data was the fact that all participants in this study reported they have experienced multiple deaths spanning their career; subsequently finding meaning in the state of our current social welfare system otherwise known as our 'systems', spiritually based meaning, and engagement in ritual in their process of mourning.

To these social workers, to have one death was seen as unusual. However, a small number of deaths have carried more significance or impact than others for different reasons that will be discussed later. Many of these experiences were described as traumatic either due to the circumstances/details around a death, the unexpectedness, or experiencing the compounding nature of multiple deaths occurring in a short period of time. Participants discussed how they personally experienced an unanticipated death of multiple clients and commonly described these deaths as sudden, unexpected, shocking, and of course, tragic.

Finding meaning from the death of a client was discussed through several ways and there is no neat and tidy answer for how one processes a permanent loss as in death. All participants brought up several ways in how they understand and explain the 'why's' of client death and it is important to note that many of the participants had different roles, in different work settings, at the point of the interview. Two main and significant ways of making sense of a clients' death emerged from the interview data. The first includes placing a sense of blame on 'the

system'/gaps in service/neoliberalism in the context of client deaths; the second includes spiritually based ways to process and understand death. Each will be discussed in detail here.

Sub-theme One: The Impact of Deaths and Meaning from Systemic Failures in the Context of Client Death

The remembering of participants connection and involvement with clients, their experience of acute grief, and the compounding nature of client death form the basis of the first sub-theme. Participants discussed how they personally experienced the unanticipated death of a client and reflected on the compounding nature of deaths during their careers as social workers. In every interview the reaction was similar "…there's been so many when I think back on it" (Kelley).

Sara discussed her recent work experience in child protection and reported experiencing a high death count during the first few years of her position. "…I've had [a death of client] three times in…two and half years. The first one was the hardest as [a] child died who was 10 years old from neglect. Then…parents or adults pass away from overdose or overdose related…" (Sara).

SC reported on her experience of compounding deaths while working on the front line of child welfare services:

> …I mean, which time?...My first time on the front line, on my caseload there was a crib death, a sudden infant death of a three-month-old baby, and that was three months after…I got them on my caseload…the biggest one for me was…one of my kids had OD'd and was at the hospital….I went to the hospital, and she ended up not making it. I got home quite late and then the next morning I get up…and I'm on my way out the door

> to work and there was the province newspaper right up my door and there was a picture of a very young mother I've been working with, who had been missing. They had found her on the pig farm of that serial killer, Robert Pickton, and…I remember picking the paper up, putting it on the table, it's like 'I'm going to cry about you when I get home' because I have a funeral to plan for a kid and people to call…and then when I was doing that, I got a phone call from my supervisor saying another one of my kids had OD'd and was gone… (SC)

Riley discussed her experience of losing clients unexpectedly while describing her role as the social worker:

> …There's two that stood out as being quite profound…one, we had referred her….to a mental health facility in her hometown…. she was still under the mental health act. They took over the certificates from us. But they had let her out on…they made the decision to let her out on passes…. she went and she suicided a couple weeks after departing the facility. The second one, I was able to integrate a lady well into [a small community] …. she went to [group home] …she was able to live there successfully for over a year. And then she relapsed on substances. The day she relapsed; she had an opioid overdose. (Riley)

The compounding and often traumatic experience of client deaths was understood in the context of repeated system failures and therefore a need to create meaning evolved. This ranged from organizations' approach to practice, what services and programming are available to clients, and built-in mental health support for social workers, which will be described in the final theme. The perception that 'the system' fails clients, was evidenced by a participant's disclosure that a client died because of having to wait on waitlists for mental health support, substance use

treatment, and/or have experienced the impacts of historical trauma. Substance use and mental health systems were specifically mentioned as systems that have seriously failed clients. Several participants described this in the following:

> …they're in waiting lines for treatment…. they're waiting for counselling, and they need it now and I used to see a lot of people who were ready, and we had that small window…. because services weren't available when they needed it, they're back on the streets and you lose them…. death or that window was closed. (SC)

Participants noted being disturbed by the bigger picture of the opiate crisis, especially in the DTES of Vancouver where a high number of people die every minute from substance use overdose. Social workers noted the insufficient amount of government funded treatment centres, high waitlists for admission to treatment and mental health centres, impacts of colonization, and other barriers to resources related to agency policies.

> …the adults who died…I worry about the bigger picture of…the opiate crisis and just all this stuff happening in…the downtown east side….all that worries me…and thinking about how there needs to be a change…there's a huge drug issue right now and…Covid make it worse….with the border shut down for a while…the fentanyl was getting more toxic and less what it's supposed to be….both of these deaths happened after Covid….there's just so many overdoses….it's a government issue…it's sad. (Sara)

Another participant provided her understanding into two of her clients who died by both substance overdose and suicide. Riley discussed the historical implications of colonization and the current impacts of neocolonialism in the lives of two Indigenous women she worked with.

The Indigenous women who accessed her workplace services, were understood to carry large burdens of trauma, pain, and a set of unfortunate life circumstances. Riley reported:

> …. I think the tragedy really lies with the state of our systems. The way that we treat Aboriginal women, the generational trauma and all those things…. that's really where the tragedy lies…for those two women…they're not in pain anymore….in some ways there is a bit of relief there. (Riley).

Other worries regarded having to rely on and be a part of inadequate or broken systems when clients come to you for help but cannot access or don't seek help. Eva noted the approach to care in agencies over relying on solutions focused and outcomes focused care…and how she personally tries to approach client care within conservative and constricting services:

> …the paperwork, the liability aspect, under neoliberalism and how everything's just about data and outcomes…. and barriers to providing the type of services that we want to provide for practicing from a true anti-oppressive, anti-racist, anti-capitalist…that's kind of my practice is…be as radical as I can within the constraints…of who's employing me and the college [BCCSW]. (Eva)

In addition to reflecting on personal responsibility and role in the system failures, one participant disclosed their feelings around workplace policy and bureaucracy that individual workers face when attempting to support clients. For example, SC states:

> …we're dealing with humans and every situation is unique… but you're just so locked in with legislation and what you can and can't do [to support people] … all these channels you have to go through and I'm finding…the executives up top…. there is a real disconnect from the front line and that's always frustrated me. (SC)

Some participants in this study described a common understanding that gaps in services are present and gaps in service can exist when attempting to collaborate with other service providers. Eva talked about her experience working in a non-profit agency that specialised in providing wraparound treatment for youth. She spoke of hitting systemic barriers when interacting with police officers, when young clients are missing, missing persons reports are crucial and time sensitive and gaps in the systems like this impact successful outcomes/the safety and wellbeing of a client. Eva expressed her frustrations here:

> ….I've had to call police a lot about missing persons reports and a lot of times they'd be like…'well we can't file until 24 hours'…I just really start digging in with 'you know this person is 13 years old, they're being sexually exploited…I'm doing my due diligence and part of my due diligence is calling you to make sure that you're going to do your due diligence…and just really pushing it like you need to do something here even if you don't want too…it's like an extra bit of advocacy….for gaps in the overall services that are provided within our type of society. (Eva)

Riley discussed in her interview the frustration with system barriers marginalized clients face when accessing care, they need. She mentioned specifically Indigenous women on her caseload who tend to be over-represented within certain systems/programs and who also face numerous barriers when accessing care through racism, historical impacts of colonization, substance use, and mental health challenges. She explained that some of the clients she supported struggled throughout their entire lives. Riley commented "…seeing the barriers in the system for marginalized folks" as one of the main difficulties of working within the system.

In Riley's initial response she indicated part of her understanding was "they're not in pain anymore", however, she also noted that systems-based issues come into play in her meaning

making in the case of some of her clients. This is interesting because people often try to rationalize tragic and traumatic events like the death of someone while also coming to terms with the impacts of a larger system not working as intended to support those who access social services. Riley discussed her work with two women who struggled deeply with serious mental illness and having them mandated in a custodial facility for self and public safety. The participant describes the mental process of balancing her client's personal autonomy and risk management as part of the system, "…to keep them trapped in the custodial facility….I would go out on a limb and say that…they would be alive today but at what cost…in order to respect someone's autonomy there's risk associated with that….", as she understands the deaths of the two women with whom she worked. Riley further states:

> …they're both very marginalized women who had severe refractory mental illness and had a lot of power and control taken away from them….when you're keeping someone in a custodial facility, you're keeping them alive…when they were in our custodial care, we kept them alive…it gets to a strange place where you start to…in order to allow them some autonomy in their lives…there is an aspect of risk…if we were to…keep them trapped in a custodial facility…I mean if we had never discharged either of women, I would go out on a limb and say that…would be alive today but at what cost?...that's not our right to do that…in order to respect someone's autonomy there's a risk associated with that….and both of these women…the quality of life was so poor…there was this really tragic loss but at the same time we couldn't have not discharged them…I go back to that idea, we could have weirdly kept them both alive…what a horrifying restriction of their personal liberties and autonomy that would have been… (Riley)

Institutional racism and systemic barriers are so ingrained within our systems that it does not seem real or accurate. Social services of all kinds are often funded through a combination of provincial and federal governments which is the care for things like indigenous child welfare services. For decades, indigenous agencies have been significantly under funded which impacts the amount and quality of care being provided to indigenous children, youth and families involved with this type of service. William references the $40 billion government payout to indigenous youth in care to account for the governments choice to purposely underfund Indigenous agencies based on race, devaluing Indigenous lives. William spoke about his difficult experiences losing multiple clients, adults, and youth, while working in this system, he elaborated on his experience providing care to indigenous families:

> …the $40 billion that's been put aside now for our families….by the federal government.…the reason why that's come forward is because it was so blatantly racist….our funding for our agencies and for our children on reserve was less than it was for white children or non-First Nations children in other agencies which is just so…racist...that people were like 'well that can't be real'….it was just so ingrained within the system that it almost became…so normalized that we didn't even see the racism which I think explains why there's an over representation of our First Nations children in care and about the services that are not offered to our children and to our families. You look at everything from clean water in our communities and appropriate housing…all these things are just symptoms of that kind of [institutional] racism and those institutional barriers. (William)

Similarly, social workers discussed a strong dissatisfaction to "the system" and seeing "the barriers that people experience…the inequality…the racism that exists…" (Anna) in our society.

> …within our systems….it really sheds light on the way our system keeps itself running…. even non-profits…and social work…. All that stuff is sort of its own industry that continues to be maintained out of inequality…. I get frustrated from a bigger picture…of how we continue to create the struggles that people experience…. I also get frustrated with the way people are treated in the system and the way the system creates programs that have mandates and expectations and guidelines and that doesn't fit for everyone. Then people suffer as a result…or die as a result…there's several examples that I can think of where, if the system had just been more capable of flexing to someone's needs, then maybe they would still be alive. (Anna)

Relationship Building in Social Work

The heart of social work practice is positive relationship building with clients and families. The participants in this study discussed in detail the working relationships they had fostered with their clients and clients' families. Almost universally, the participants described the closeness of the working relationship with the clients who died. Riley, who works within an inpatient facility for adult females, described how her role as a social worker on a secured unit helped facilitate relationship with clients:

> … I see the woman five days a week…what I see…when they're first getting up and they have a towel in the hair, you see them in a different capacity than I did when I used to work with people in community. And you really… develop this closeness… (Riley)

Another participant reflected on her relationship with a client in community based on the frequency of their meetings and not having this type of frequent contact with anyone other than their immediate family:

> …I saw them every week for outreach visits, and he had confided in me about things that they weren't willing to share with their family…..[we worked together] close to a year, and I remember [thinking]…'I don't see anyone once a week in my life other than my partner and my kid'…I don't spend time connecting with someone in that way for once a week with anyone. (Anna)

William reflected on his extensive experience working within Indigenous community where a high level of community engagement and relationship building is present in the work. William described being at his workplace for approximately 15 years and has seen generations grow up, have children, and shared many significant life experiences with his clients. William described the impact of the losses here:

> …. these are people that we cared about, and people that we knew and…the youth…I can remember them when they were just a little kid. I had worked for a long enough time to see them grow up from a small child to almost an adult…and that loss…will always be with me. (William)

William further reflects on his experience:

> …I have worked there for 15 years so I've seen generations grow up and have children and I've…. built long lasting relationships with people, when people that I've known for a long period of time pass away, they're almost like…I don't want to say family because

> they're not my family…but I've known them as long as my family. And some…I interacted with more than with my own family… I spent a lot of time [with client who died] like countless hours and days with her and it was like losing a fixture in your life…. I wouldn't say she was just a client, like she was someone that I cared about. And I've known her family for so long and her child for so long….and that is a difference to where we work, where were not expected to be these cold automatons to our families that we work with, we're meant to be a part of that community were meant to be interactive with our families… (William)

Participant Raven discussed the relationship with her client and her position that facilitated the building of a strong connection. Raven reflected on how often she was required to meet with her client and commented on the differences between her past and current roles. "…we had a unique relationship because of the job as an employment disabilities worker. I mean, how often do you work 15…hours with one client…. I see 15 to 20 in a week now" (Raven).

Several participants reflected on their role/involvement at the time of a client passing in the assessment or discharge planning. Sara shared a particularly tragic story of a young client who died of neglect after involvement and assessment with child welfare services:

> …I was involved because of a report…of…a single mom…she left her child home alone…. with autism…he was almost nonverbal… he was not able to answer my questions…I've gone in and completed the full assessment with the mom…[which is done] in consultation with my supervisor… [the mom] She wasn't the easiest to get through to…she wasn't taking much accountability. Once I [safety planned with the mom and her supports]…we didn't have anything keeping the file open…we didn't have an

> ongoing concern, so we have to close that…which is pretty standard, if the parent addresses the issue, then you can't just keep the file open just to watch them…There has to be an ongoing protection concern….a few months later I received…a notification….that the child had died…he drowned because no one was watching him. (Sara)

This participant reflected on her role as a social worker given she was one of the last points of formal intervention with the family. She discussed actively following policy procedures in her duties leading up to the death of the client but reported feeling a sense of self-blame, guilt, and obviously sadness. She clarifies how she felt here:

> … [it was] a tougher pill to swallow because…. I had that level of involvement. For that reason,…your mind starts thinking 'I should have addressed this differently, I should have been more mean, I should have been more strict'….my initial response was 'whoa, I could have made a bigger difference here'…. I felt bad. I know it wasn't on purpose on her end but just feeling like…that I could have done more….and just selfishly I was like, 'how could I do this'? (Sara)

Similarly, Anna disclosed her sense of self-blame and guilt in her professional role as the assigned social worker. She pointed out feeling a sense of responsibility as a professional and an assumed sense of being able to control a client's death via available services. She also reflected on deep feelings of how the family viewed her role after the death of her client. Anna disclosed, "…. you can't help but wonder…. did I mess up here and could I have impacted them, could I have prevented their death in some way….and then you get worried…does the family place blame on me?" *(*Anna).

Raven spoke about her feelings with self-blame after she had changed positions and found out a long-term client had suddenly died. This participant reflected on their sense of obligation to the clients they served even after accepting another position in a different agency. She shares her sense of obligation here:

> …when I heard that he died, there was a little part of me that thought…'you know what? maybe he wouldn't have died if you hadn't changed jobs. That was in the back of my mind, even though I know, logically, you can't blame yourself. (Raven)

Another participant, Lilah, reflected on her naive assumptions to "save" clients from their circumstances, alluding to the unspoken hierarchy of professional versus client needing rescuing. Lilah elaborates here:

> …it was really sad because you feel like you take on this saviour role and that was a really hard lesson for me…we did everything we could and at the end of the day…people, decisions, and choices that they make….you're not God, you can't stop that…it's hard not to take it like a failure for the work that you're doing. (Lilah)

Meaning making of client death was found to relate to the larger issue of system failures and became a larger theme throughout all interviews. This ranged from organizations' approach to practice, what services and programming are available to clients, and built-in mental health support for social workers, which will be described in the final theme. A significant portion of meaning making was related to the perception that the system fails clients, as evidenced by a participant's disclosure that a client died because of having to wait on waitlists for mental health support, substance use treatment, and/or have experienced the impacts of historical trauma.

Substance use and mental health systems were specifically mentioned as systems that have seriously failed clients. Several clients described this in the following:

> …they're in waiting lines for treatment…. they're waiting for counselling, and they need it now and I used to see a lot of people who were ready, and we had that small window…. because services weren't available when they needed it, they're back on the streets and you lose them…. death or that window was closed. (SC)

Participants noted being disturbed by the bigger picture of the opiate crisis, especially in the DTES of Vancouver where a high number of people die every minute from substance use overdose. Social workers noted the insufficient amount of government funded treatment centres, high waitlists for admission to treatment and mental health centres, impacts of colonization, and other barriers to resources related to agency policies.

> …the adults who died…I worry about the bigger picture of…the opiate crisis and just all this stuff happening in…the downtown east side….all that worries me…and thinking about how there needs to be a change…there's a huge drug issue right now and…Covid make it worse….with the border shut down for a while…the fentanyl was getting more toxic and less what it's supposed to be….both of these deaths happened after Covid….there's just so many overdoses….it's a government issue…it's sad. (Sara)

Sub theme Two: Spiritually Based Meaning

Spirituality was a common thread in how meaning was created in the context of client death and bereavement. Several participants mentioned they were unable to cultivate a sense of meaning from a tragic client death and occasionally found themselves wavering from finding a glimmer of meaning to no meaning at all. Especially when the unthinkable happens; when a

child dies or there are unusually tragic circumstances attached. One participant spoke directly about the final and permanent nature of death and how she, like all of us on this earth, is unable to fully 'know' what happens or what becomes of us when we die. This uncertainty around the nature of death and the grieving process that follows is best read from the words of SC:

> …I don't know if you can ever 'make sense' of it but death being what it is….so permanent and so final we don't understand what happens after….I don't know if we are even meant too….part of our growth is being able to move on and with these absences in our life, the wounds heal and the holes close up and the pain does go away but they're still….I think it becomes part of us but I don't know if you ever really do make sense of anything…especially when you've got children dying….there's tragic circumstances attached and how unfair the world is….for me where I found pieces….you can't make sense out of things that don't make sense. (SC)

Another participant also reflected on her inability to make sense of a shocking and unexpected death:

> …I don't know if I did [make sense of it] because it was shocking….and a lot of them [client deaths] were, for me anyway, preventable. I didn't think… 'this is what is meant to be' or 'its Gods will' or anything like that because the way they all happen was either an accident or an overdose….it wasn't a natural death. None of them… I'm not sure if I could make sense of somebody dying of accidental deaths. (Charlie)

For another participant, she describes her inability to make sense of the death because she did not have ample opportunity or space to cultivate meaning within the workplace. The sense of

needing to perform as if you're an automation without emotions and attachment to a client was evident across almost all reported experiences. Anna states:

> …I don't know if I fully made sense of it because in the end you still have all the things you have to do at work and…there's not necessarily the space to reflect on it entirely…" (Anna)

Interestingly, Anna further reflected on her meaning-making process and described how relationships and connections built with clients at work carried a lot of meaning and the felt sense of grief in the face of loss meant something meaningful had been present: "…it also brought meaning to the work in the sense that the relationships and connections that were built were very genuine….the depth of the emotions around it were more significant" (Anna).

A few participants spoke of the understanding that death is literally an escape from pain and trauma. This was rooted in the understanding that death was a way to remove the pain and suffering while also balancing the reality of substance use. It is important to note here that this understanding does not mean acceptance or justification of a death, it is simply meaning created from someone attempting to understand and rationalize the unknown. In the care of William, he reflected on his relationship to a young client who died unexpectedly:

> …I think from having a good understanding of what this person has been through…how she had to escape her pain and trauma…with the use of drugs…I understood why there was the [substance] use….you always have that notion of 'why did it take her and not so many others?'….lots of people *use* and that doesn't happen…she was just this kind, beautiful soul that everybody around her…loved her. (William)

The meaning that Eva found in her process of meaning-making was that a client chooses to end their painful life through intentional overdose. This social worker described the traumatic abuse and pain she witnessed her client experience. Eva reported her shared belief and understanding of this through conversations with the deceased client's family. Eva reports:

"…it was a very tragic circumstance… his family basically shared…that it was a purposeful overdose. I think it was just too much for him, this young life…he was 24…" (Eva).

A few participants came to understand a client death by choosing to honour the impact of a client's life on others. Honouring the life of a client was central to their understanding of death. One participant directly spoke about and connected the recent discoveries of the unmarked graves at the residential school in Kamloops and how her meaning-making was triggered from this. She says:

> …it's the meaning making, it's the trauma, it's the getting back to these little ones lives and….it is honouring those children, it's honouring to know that regardless how someone has passed….it's being able to honour their life and honour their dignity of a respectful send off to their next stage or other side to be with ancestors….you have to think we as Indigenous people – and as humans too – we need to be able to do that and respect a person's life. (Kelley)

Another participant elaborated on the life of the client:

> …it wasn't really the death of that youth….it was the life of that youth that kind of made some impact because they were one of the first youth that was…in the community…one of the first youth that was trans…now today we have many youth in our case that are trans…which is very interesting….the strength of that youth…and the courage of that

> youth allowed us to kind of gain more knowledge for the majority of our team that aren't queer or aren't part of that world…I always think of that youth as being so strong and courageous for…being themselves before a lot of youth were. (William)

Sub theme Three: Rituals and Ways of Mourning at Work

The social worker – client relationship is also characterised by legality and confidentiality, often not afforded the 'luxury' to attend funerals if not welcome. Often, family do not want us present at funerals, or we are unable to attend for other reasons. We also cannot share details with family and friends, and this limits our ability to find meaningful coping on our own. The research here found that while some workplaces do support ritual in grieving the death of clients, others do not, or do not have positive/strong informal relationships with peers to be able to engage in coping ritual to make meaning.

Given the subjective nature of how people grieve, or engage in ritual, there were a variety of answers in how the participants cope with death at work. Some talked about attending funerals, arranging memorials, talking to dead people, visiting the site of the death, planting plants in remembrance, and coming together with likeminded peers. A common theme here was that grieving was perceived as an individual process and was not supported in the workplace as Anna states: "there's not necessarily the space to reflect on it entirely…." (Anna) unless you happen to work within an Indigenous agency where a communal approach to grief and ritual is taken.

Some participants spoke about their direct involvement with memorial planning for the deceased, as is the case with Riley who assisted in memorial planning for a client on a long term and locked unit:

> …we arranged the memorial at our facility where patients…have been together for years… I had a big role in those at our facility… I was invited to the funerals, but both were out of town, and it just didn't end up happening that I went… (Riley)

Participant Lilah reflected on her informal experience with colleagues in honouring the deceased client and keeping their memory alive among the staff. Lilah had positive connections with her colleagues and felt comfortable engaging in informal ritual regarding a known client. She also notes how this is not an ongoing event that marks anniversaries or other large services of remembrance. Lilah reports, "…people send a nice email acknowledged that way, we did a memorial…my coworkers and I would reminisce and keep that memory alive, I haven't seen anniversaries come up where we….do something to honour their life or anything" (Lilah).

Similarly, a participant discussed how planting a plant or hanging art in memory of a deceased client was part of ritual and sense-making for herself: "…for another we planted…a plant for them in a spot they loved spending time in…. for another …. we purchased some art for one of them and put it up in the program…" (Anna).

SC reflected on a young mother who passed away and had minimal opportunities to create ritual in the workplace. She discussed how her ritual for this client was similar to how she creates ritual for those in her personal life, by revisiting favorite and shared locations in memory of the client. However, SC noted experiencing some difficulty in creating ritual for client deaths because of the specific relationship and why she was involved with this client. This was also described as a personal ritual and not shared collectively with others in the agency. SC reports:

> I don't have any specific rituals…. work is a little different than personal because with personal you can have these little personal rituals and memories and… going places that

you were together…. work was a lot different. I think I've struggled with that. That's something to think about because…. those rituals are helpful. Other than that, a boy whose mom I worked so closely with, and I was seeing her a lot we did we develop this relationship that was kind of a friendship in a lot of ways. And I remember we used to go for Vietnamese coffee, and I remember doing that as if she were there with me. And it was our thing. (SC)

Participant William spoke about both individual and collective cultural rituals he has engaged in for a client who has passed. In his interview, William discussed using specific cultural-spiritual rituals in his personal life and in the workplace for clients who have died. He explained how the use of Elder wisdom in the workplace facilitated ritual to honour a deceased client and how an Elder is instrumental in bridging the individual and collective grieving experiences among team members in their workplace:

I will offer tobacco at the river…if I've lost somebody or even if it's one of those times where I'm remembering something and it's not good… or if we've had a really big loss…I'll go do a Shúkw'um[1] to take that energy away from…take some of that grief and hurt away from me…let it go down the river…wash myself of it…I've done that with people at work….I like to talk about memories with people around me…I have a very close team….one of them being an Elder who will sit down with [me/us] and just cry with them….I remember doing that multiple times with those people….just to allow me to be there and then they'll brush me off afterwards…. (William)

[1] Traditional Sḵwx̱ú7mesh-ulh, Squamish Nation, ceremony. Also known Spirit Bath in English language.

Theme Two: Presence of Spirituality in Social Work Practice

The second central theme that became apparent from the data was the presence of spirituality in the personal and professional lives of the social work participants.

Across all participants in this study, spirituality was reported to be an important part of their personal lives to varying degrees. On the other hand, the data uncovered discrepancies in how these social workers conceptualize and implement spirituality into their practice with clients or in their place of work. The results of this theme will be further explored in two sub themes.

Sub theme One: Personal Philosophy and Spiritual Experiences

The presence of spirituality for these ten social workers tended to be significant and profound in their personal lives from early life experiences and other significant life events to current understandings of their personal philosophy. Spirituality is hard to define given the highly subjective nature of this phenomena as belief systems are varied and often complex. The participants were able to articulate what spirituality means to them and how it informs their life view in the following ways:

Kelley identified herself as a Sḵwx̱ú7mesh[2] woman who was raised with the values and teachings of family and Indigenous community. She spoke of being rooted in the foundational teachings of her culture and described this in the interview as "…the Sneẇíyelh[3] and what we call the Sḵwálwen[4]…the feelings that are there…that's where I know there's hope. Those are some of the wisdoms and the teachings that have come from the old ones and our ancestors…"

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[2] Sḵwx̱ú7mesh, also known as 'Squamish,' in English language
[3] Laws, ways of the Sḵwx̱ú7mesh people
[4] Sḵwx̱ú7mesh term for Feelings, thoughts, opinions, and mind

(Kelley). Kelley went on to reflect on how she uses these ancestral teachings and used the earth as a metaphor in how it keeps her rooted to her values as a daily practice, especially in times when she feels pulled into uncertainty:

> …on those days…where it's a bit more cloudy, it's getting rooted and grounded back into those foundational pieces and…some days I will put both feet on the ground, like rub my feet on the ground to remind myself of being grounded and actually getting rooted into self and values. Or beyond self. Beyond self and into values and how we are all connected. (Kelley)

In Kelley's definition of spirituality, she also noted a belief in a higher power, a way to cultivate gratitude and embody ways to walk through the world. She elaborated on her personal definition of spirituality:

> …acknowledging that there is a power greater than ourselves…and being able to live with gratitude, to give thanks to the creator, and how we conduct ourselves, how we practice, how we gather…whether it's in ceremony…even our connection to all things….and how we continue to walk softly, gently, and kindly with each other and with all things. (Kelley)

William articulated his current understanding of spirituality in a way that highlights his connection to culture, identity, and the natural world:

> …spirituality it's like the connection to my ancestors and the connection to the beings that are around us…. I have a strong belief that there's spirit in…everything that's around us, the earth, the planets, the ones that swim, walk, fly above us…I have a strong spiritual

> connection to plants. I hold a huge belief that plants are a lot more healing than we give them credit for…. walking through the forest is incredibly healing…. (William)

Speaking about his family values and the way he was raised as a First Nations person, William elaborated on how his spirituality links with values, community, and relationship. "…we were…brought up to know that we should be giving back to our communities and my mother always had people living with us that needed somewhere to live…family, friends, teens from school…there was always an open door to our home" (William). In discussing his childhood, he reflected on how these family values guided his decision to enter social work. "… I think that impacted both me and my sister to take up the profession". (William)

Anna reflected on loss and the exploration of her maternal ancestral heritage. In the interview she described the process of exploration as meaningful but ultimately not something that "rang true for her" for a multitude of reasons. Anna reflects on her experience of spiritual loss and search for identity here:

> …my family does have Indigenous heritage and in my undergrad I was kind of exploring some of that Indigenous cultural ancestry…..I wasn't raised as part of my mom's ancestry but for lots of reasons they….lost their connection to…cultural practices…but ultimately having been raised in…and obviously white presenting…in a very white culture…it never really rung true for me and it didn't feel right, identifying as Indigenous when I wasn't raised with the cultural practices and presenting and experiencing the privilege of being a white person…felt it wasn't quite…who I am…it just didn't feel right for ethical reasons. (Anna)

Eva described her belief in a higher power and the interconnectedness to the natural world. She pointed out that spirituality is complex and multidimensional, with various aspects forming what she understands as her spirituality. She elaborates:

> …it's about the belief in something that's bigger than yourself…that helps you feel connected to…either the natural planet or to other people….to the universe…this whole…non-tangible universe…for me it means getting out into nature, spending time in it, touching or immersing into water, touching trees, just breathing in the air and being very mindful in that present moment there. (Eva)

Eva also mentioned that spirituality for her was paying close attention to the "signs" in life and understanding that this gave meaning and purpose to her life. She further clarifies:

> …. another aspect of spirituality for me…there are signs that help guide your choices and actions in life…if you are able to tap into your intuition and listen to your gut and pay attention to the signs that might come across your day…. that indicates to you that this is where I am meant to be…this was meant to happen. (Eva)

Similarly, SC reflected on her spirituality and how she has experienced many spiritual moments through her life. SC grew up in a rural community surrounded by lots of family and a tight knit community. She described her origins as being rooted in German-Russian culture and part of the Mennonite religion growing up. SC linked spirituality to meaning and purpose in her life and reported "we're all here for a *reason*…". She further reflects on her philosophy:

> …I think every moment, every breath we take is a spiritual experience…and every prayer we say or every day that we're on earth…we're here for a reason…and we take it for granted, we get so caught up doing what we have to do and the details of life that we

> forget that….I think that's where we lose it….any time you recognize a synchronicity or you recognize where things were the right order…or you make plans and then there's a twist…then you find out later why it went off the rails and something else happened and it was mean to be that way…that [is] the spirit…. (SC)

Two participants described early family experiences within the Christian tradition and the evolution of their spirituality being linked to substance use and eventual recovery. Riley commented on the evolution of her spiritual journey, through active addiction and eventually active recovery. "…I was getting clean off substance use, there were a lot of things stacked up against me…and the way that I was able to get into recovery…" (Riley). She discussed her memories of experiencing a sequence of seemingly impossible or illogical events, aligning at the right time, at the right place for her to overcome barriers to treatment. "…the way everything fell into place for that to happen…it just…defies what I saw as...a logical sequence of events…" (Riley). She describes the meaning she takes from that significant period of her life: "…spirituality was there… something in the universe…just keeping me safe and I was able to get into recovery…" (Riley).

Expanding on her spiritual evolution, Charlie disclosed that after certain life challenges in her adult years, she discovered the benefit of spirituality through Al-Anon:

> I have been in Al-Anon for…20 years…it's based on a higher power and the Serenity Prayer, so that's what my spirituality became is [sic], a higher power. I really relied on the Serenity Prayer for a long time…I was saying it every day because of personal challenges…I remember saying it a lot because…my husband and I…we had some issues...we separated, and I relied a lot on Al-Anon. (Charlie)

Her spiritual community developed into Al-Anon and she highlights how the mantras related to the community facilitated coping with difficult feelings and emotions:

> …the 12 steps, the Serenity Prayer and all our slogans are very beneficial. We have so many slogans that help people…just cope even every minute, every hour, every day, if you need to…that is what we say…if you need to just get through minute by minute or hour by hour… (Charlie)

Sub theme Two: Inclusion and Exclusion in Social Work Practice

The presence of spirituality in the personal lives and value systems of most of the social work participants was more matter of fact than was the discussion of how spirituality was incorporated into their social work practice. The data revealed a discrepancy in how spirituality is perceived/viewed in a variety of different social work settings as well as how spirituality is included and excluded in these environments.

Inclusion

Given the complexities of spirituality and of differences in social work practice, there was a high degree of variation in how spirituality was used and viewed in practice. For some participants, the concept of spirituality was easily named, described, and incorporated into workplace practice. This is the case within those employed in First Nations based agencies in this study. For example, when discussing how the Indigenous agency he works for includes spirituality in practice, William, an Indigenous social worker, commented:

> …for my workers, we do assessments through the medicine wheel which includes the spiritual part of the family. I want our families to understand their spirituality and their spiritual…area of their being...it's up to them to determine what that is…what that looks

like…and then we give them the options of what services we have available to help facilitate that if they want to work on that area of their being… (William)

William further discusses how he infuses his teachings into his social work practice in his agency by using the spiritual ability of plants:

> …I have a strong belief in the healing power of plants and just the spiritual connection we have with plants. I teach it to our clients… our families and children…I go to all the schools [in the area] …and at [cultural] camps…and that's how I…connect those two with our community. (William)

William pointed out how the agency develops and hosts cultural camps and school programming.

> … If we ignore that piece, we're ignoring a major quadrant of our being. And in our beliefs…if you're not balanced…there might always be issues. We really want to ensure that we're addressing all areas of someone. And it's up to the family to determine what that is but we like to bring it forward as something that can be put up. (William)

William, as a team leader, went on to describe how he uses spiritual practices in his work with peers in the office: "...we do a lot of community-based programming….my team will go out and we gather medicines for our community because we know that we're going to be doing giveaways of traditional teas for our elders, for our families…" (William). William went on to describe how smaller, Indigenous based agencies are seemingly more able and open to continually changing and refining social work practice to meet the unique needs of the population they serve. He also pointed out a need to fill in educational gaps by training new social workers or social workers who have not worked within Indigenous agencies, in alternative ways to approach/practice Indigenous based social work.

> ….and often when new social workers come on…..getting them to see from our senior workers and from myself, the way that social work can be done because maybe they've only worked for a non-First Nations based organization where we can kind of show them an alternative way of doing social work….it's not perfect but we have the ability to continually change our practice to best serve our families…it's an ability we have at a smaller organization….than at a major organization like the ministry where change is hard to come by because of the bureaucratic structure. (William)

For others, there appeared to be some level of separation between the importance of spirituality in their personal lives and a hesitance or inability to bring spirituality fully into their social work practice. Spirituality was often described as something not belonging in a professional capacity or as something to be used sparingly. Riley explains her experience using spirituality in practice sparingly and at a client's overt request for spiritual needs to be addressed in the helping or counselling process. It alludes to an act that is inappropriate or unprofessional within the confines of a social worker-client relationship. "…only if they [clients] ask. And then if they do ask, I think…. [we use it] a small amount but I'm in a professional capacity, so I try to be quick, measured, and appropriate with holding those boundaries" *(*Riley). This excerpt speaks volumes in how there continues to be a bias in how spirituality is perceived in professional employment capacities.

In other situations, participants discussed using a process of spirituality sparingly and at their own discretion depending on several factors including a client's pre-existing/established beliefs or limited to Christian/organized religious values. Charlie describes: "…depends on the client. I know which clients have a belief in God. Sometimes, I would say 'I'll pray for you' if

they are going through a hard time…. I'll say something about prayers…God… if I know that's what they believe" (Charlie).

Other participants described using spirituality with different age groups such as youth and young adults, or those who are nearing the end of life as in end-of-life or palliative care. Eva, a social worker with a range of experience with different aged clients but primarily with youth, reflected on her own practice and how she uses spirituality with younger clients.

> …we talk about spirituality quite a bit and I have found that most of them espouse similar…kids of this generation…. we're kind of the same…being open to believing in things other than organized religion…most of these kids…are open to the connection to nature…and same with the Indigenous teachings and ceremonies…. regardless of…if they're Indigenous or not. I just know that when I broach the topic, it's always been that they're very interested in talking about….and sharing and I find that a lot of it is that connection back to the natural world, versus belief in a deity of some sort. (Eva)

SC shared her experience of working with an Indigenous family and being welcomed to the funeral in community. She disclosed the impact this experience had on her. It showed her a different perspective on grieving the loss of someone; a way to collectively grieve a client's death among their family and community with the cultural rituals.

> …[a] baby that died on my caseload was from an Indigenous community. I went to the funeral and was completely welcomed on reserve and into the home… an elder came alongside and explained all the rituals…the funeral…they did a whole day, you do a lot of grieving…you do years' worth of grieving in a very short period of time and they walked through the processes of all the ugly stuff and I learned a lot….that was like a

> degree in itself that day….that was the most powerful because I was invited in for that whole day…. (SC)

Exclusion

Several participants had a harder time describing how they used spirituality in their work or did not use it at all. These participants were unsure if they were allowed to use spirituality or if it was ethically possible to use a spiritual lens in the workplace. This is reflected in Sara's words:

> …if you're not allowed…but I've never shared it with any clients…we're *not supposed to* really disclose anything about religion or anything about your personal life but I think some people work around that but for me…I have never shared before…people have shared with me and when they do, it touches my heart, or if they say something like 'God put you in my life for a reason' or something like that….I'm like, that's so nice but I don't think I've ever really shared. (Sara)

Other participants appeared to shy away from using spiritually based language and made a clear distinction between professional practice and practice that includes spirituality. Riley positioned themself as a 'highly spiritual person' and reflected deeply on her personal experience benefitting from the use of spirituality and her path through substance use recovery. Riley's thoughts on her practice and her separation between spiritual and professional practice is indicated well through her reflection:

> …those boundaries…I understand professional support is not about spirituality, but I think I bring in attitudes around resilience, attitudes around meaning-making and supporting them with that, and just feelings around having faith in something. So, I don't…. talk to my patients about the universe…. but I talked about… if they have any

> faith in anything…. things about resilience and going through these experiences and…I'm bringing it in but in a very measured and professional way. (Riley)

Other participants viewed and described their practice as 'holistic' as opposed to spiritually informed. Lilah discussed her practice as open to using alternative methods of understanding the world/themselves but was clear that she did not incorporate this into her regular and standard practice. Instead, she left this choice up to particular or like-minded clients who had a tendency toward or openness to spirituality. Lilah's words conveyed this well:

> …I don't really use spirituality with clients, I think it's just more holistic in the way I work. And I see my [clients] through a…there's a biopsychosocial but there's a *spiritual lens*, energetic lens, but it's not something I use with all my clients like 'hey let me give you energy work' or whatever. (Lilah)

The exclusion of spirituality was also reported in the larger systems wherein social workers are situated. For example, William discusses an aspect of spiritual trauma Indigenous people have long experienced due to historical and ongoing colonialism present in our current systems:

> …I've seen a court judge ask one of our clients to take off….they just came out of the longhouse and their hair was covered and their eyes were covered [with traditional headband] and they asked them to remove it….and I had to step in…and say they are not removing it – it's a spiritual practice…..and I have to let you know, this is why they're doing it, they're not going to be removing that…..but he let it stay on because I wasn't going to let that…because in a Squamish belief….taking it off meant [undoing spiritual

work from the longhouse that would affect the family]….if someone's not educated about something, they might [not understand the significance]…(William)

Theme Three: The Workplace

The last and third core theme that emerged from the participants' stories was the overall perception of ineffective and unsupportive workplace policies across work environments. The social work participants stories highlighted perceptions of management and differences between formal and informal support for social work staff. Participants also described a large gap in supports for workers in their workplaces. Although not all participants reported challenges with their mental health, in accessing or requiring formal support, many of the participants did note challenges.

The data revealed certain impacts of Covid-19 where participants felt policy and system bureaucracies became increasingly difficult to navigate during the onset of the pandemic. Participants felt that their employers or workplace felt emotionally and physically unsupportive, restrictive, and they felt their work was unappreciated, restricted by policies and management that utilized a top-down method of communicating during the pandemic.

Sub theme One: Perceptions of Management

The support from direct supervisors and upper management was generally seen by participants as ingenuine, unhelpful, and acted as an additional barrier to supports. Many of the participants noted that some workplaces were better than others in terms of how they supported and acknowledged a worker's experience of a client death. Some mentioned non-profit managers as being great supports. In these cases, the collective experience of grief was apparent, which was interpreted as "therapeutic and healing". Participants perceived larger organizations as being

harder to bring about change within. Further, larger organizations often make one feel like an automaton, just a number in the workplace. For example, Anna described her experience with a larger organization "working outside of a non-profit has been less supportive but certainly their support felt less like a shared sense of grief and more like a… 'are you okay, I'm obligated to check in with you.'" Similarly, Raven discussed how her current position within a provincial health authority maintains rigid boundaries for practice. In her interview, she mentioned how policy and regulations can impact her interactions with clients, including the length of time spent with a client and the ways in which timelines can impact client care and self-care. Raven describes her experience, "… my [current] position is a lot more authoritative…. the boundaries are a lot tighter…when you work for a health authority…. they have lots of regulations. You have a timeline, and you have to account for every hour" (Raven).

Participants Anna and Eva discussed the concept of self-care as a superficial concept prevalent in the workplace that does not adequately address structural issues in the workplace. Self-care was perceived as a tool for agencies to use in shifting the blame from agency to individual when stress arises in the workplace. Self-care was often seen as a way for agencies to provide limited supports. In Anna's words, "…self-care gets highlighted as the solution…I have had some good laughs about how they're like 'oh, just send out an app about some [counselling] service you can access…when really…. what they need to do is be flexible to people's schedules…" (Anna). Eva similarly describes how the workplace culture can invoke self-care to deflect responsibility for caring for social workers. Blame for burnout and stress is placed back onto the individual. Eva reports:

> …they encourage self-care but in that superficial way….go home, take a bath, drink some wine… but I feel true self care should come from addressing some of the reasons why

> we're going to need that superficial self-care….how can we change some of the systems in place or what can we adjust so that it doesn't produce that need for us to have to engage in that…. (Eva)

Other participants described clearly not having support from management and noted how chronic under staffing and a lack of hiring staff impacts teams. Participant SC stated "…we don't get a lot of support for our personal life…. it's difficult with being short staffed… we're stretched…we've had times where we're screaming and crying at each other…just from stress" (SC). SC describes her sense of public perception of social work during the pandemic and how social work, ultimately, is seen as less deserving of recognition than other helping professionals like nursing and physicians. SC's discussed her feelings of her employer as giving no recognition to what feels like endless sacrifices to be employed and echoed the common sentiment "it's just lip service." In reference to working during the Covid-19 pandemic, SC reported:

> …social work isn't even a recognized profession…when they thank people for their professions, its teachers, its doctors, its nurses, you never hear about social workers. Even our ministry, they give it lip service…they don't show it…they don't give us the money…if there could be some acknowledgement and recognition…that I am bringing skills…(SC)

Regarding management's role in the understaffing of organizations, participant Lilah reflected on her traumatic experience of a client overdosing while being short staffed in a transition house for those struggling with substance use. She reflected on being short staff and therefore having limited support to assist in administering Narcan and feeling a sense of personal responsibility in handling the situation. Lilah stated:

> …I've had…near death experiences with overdoses because I worked…at a transition house and watching someone go blue and you're using copious amounts of Narcan on them like six to seven to get them back and just seeing that…and being single staffed in the middle of the night…it's traumatizing…I don't want people dying on my hands. (Lilah)

On the other hand, some participants did report feeling a sense of emotional support in their workplace regarding a client death, however, it was also noted that support offered by management is not always perceived as genuine. For example, Anna reflects, "… I have felt supported in acknowledging the impact of the loss…. people are like, 'you could see EFAP and make sure you're taking care of yourself'…sometimes it feels genuine, sometimes it doesn't…. but on the whole…people…have grace for it" (Anna). In situations where Anna did not feel supported, she mentioned feeling "…mostly sadness and disappointment, some anger towards the system…or supervisors where I felt like I wasn't supported in the best way…the heart of it was…disappointment and sadness" (Anna).

Almost universally, participants in this study reported experiencing a lack of formal mental health support or significant barriers in accessing mental health support. The participants noted management encouraged staff to access mental health support, however, certain challenges prevent staff from accessing mental health services or benefits. For instance, extremely limited counselling benefits covered through employment benefits, limited income preventing one from paying out of pocket for therapy, high waitlists for therapists in their community, or no short-term disability offered through their employer to treat/manage illness.

Sara spoke about her position with a large government organization and her employment benefits for formal counselling. She noted the employment benefits for her position cover

minimal counselling. Paying out of pocket, with no option for reimbursement, is a known barrier to accessing care. This is especially true for those in a profession that is relatively low paid compared to other health professions. Sara also highlighted the highly stressful and emotionally demanding nature of her position as a social worker in child protection and having to deal with many traumatic circumstances like the death of a client. Sara shares her frustration with management that provided what was perceived as 'lip service':

> …. just saying that a worker should do counselling…isn't very helpful…they need to actually have a better program set up for that… [and is] low cost…we just take enough emotionally from the job…it's like why do I have to pay to deal with this?.... our benefits, you get like how many thousands for dental but there's like $200.00 for counselling. That's kind of ironic that we're doing some of the hardest work…and you're encouraging us to go to a counsellor but we have to pay out of pocket….it's one session 200 bucks….money is usually tight for social workers….just do all the build up with a counsellor and all this talking and it takes a while to get into things in your session and then it's on you moving forward…. (Sara)

Another participant shared her view of the same government organization's approach, namely to suggest the social worker access employment benefits even though there were barriers: high cost and high waitlists for mental health providers: "…the ministry would…probably say access your employment assistance program….but the problem is you have to…wait…you have to call them up, and then they have to find out, set you up with a counsellor that could take weeks." (Charlie).

Eva described her experience within a large health authority and how she has been unable to access healthcare support from a healthcare agency. She stated:

> …I work for a health authority…and part of self-care is having sick time…the ability to be able to take time off if you're sick…. the health authority has no short-term disability. It's…ridiculous…you're expected to build up your sick bank, and your sick bank is what is to serve as your short-term disability until long term can kick in, if you're off for that long. I see that as a major gap….and something that would need to change for me to believe that the authority *actually* values peoples' self-care and health is to have a policy like short term disability or other basic things like that…. (Eva)

Participant SC spoke about her experience with management and the feeling of having to supress feelings and emotions to continue moving on through her daily work duties. She highlights how she did not have appropriate safe spaces at work to process feelings related to her client's death and quickly used up limited counselling benefits. Her struggle is best described in her words:

> …the moments where I was expected to keep going as if nothing happened….for me, if I could have had a counsellor checking in more often….because I blew through my employee assistance plan and then it was coming out of my pocket….employee assistance plans are extremely…I could have used a lot more and I actually ended up going and getting a job in a call centre at one point….just so that I would have the benefits…making $12 an hour…but I really needed more counselling, I was not doing well. I did what I had to do…I had nothing left. (SC)

Sub theme Two: Informal versus Formal Workplace Supports

The participants disclosed they valued and relied on emotional support from informal peer relationships to get them through difficult work experiences, traumatic events like the death

of a client, and this was felt to have contributed to an overall sense of satisfaction in their place of employment. Almost universally, participants reported experiencing a lack of formal mental health support or significant barriers in accessing mental health support, which they could access outside of work hours.

Some participants felt that existing workplace supports were impersonal and therefore did not choose to seek these supports after traumatic incidents at work, preferring to access informal collegial support instead. For example, Lilah described how "…they're kind of irrelevant to me…that's like impersonable…. I rather…my friends and my family and close colleagues….to support me…that's where my support comes from." (Lilah).

The support from informal relationships both in the workplace and in personal lives, cannot be understated. Anna described her informal community support as inherently 'spiritual' and "where I feel the best is when I'm connecting to them." She further explains:

> …I don't have a strong spiritual grounding, other than the relationships and connections that I've build with people in my community; in my circle of work and personal friends…and that's where I feel the best is when I'm connecting with them…. that's where I feel most myself is with my community of friends and supports. (Anna)

Participant Riley described some positive experiences among her colleagues and felt somewhat supported during her processing of a client's death at the workplace memorial in a locked psychiatric unit. Riley explains, "…there was a big team of us that were grieving in the same way. I got teary at the memorial and so I didn't feel alone. I felt like as a culture, it was respectful and appropriate." (Riley)

On the other hand, participants noted informal relationships with colleagues are not always available for different reasons including a high workload (no opportunity to build friendships at work, no time to support peers), friendships among colleagues or obligation to emotionally support peers is not required or grieving at work isn't seen as appropriate.

Participant Charlie described her workplace policy of debriefing in the aftermath of traumatic events in the hopes some of the initial shock can be managed. However, she highlighted that some of strong feelings of traumatic death and grief often require more comprehensive and long-term support to fully process this type of experience.

Charlie noted gaps in formal workplace supports as well as limits to informal supports. She shared:

> … nothing really happens at work or in the office to process it…you just process it yourself. They say 'you could get a grief counsellor'… I don't think…the environment is a place where we are encouraged to grieve a long time…because it happens to so many people. And there's no time. We [talk with] the team leader, but just for that half hour maybe... when you want to talk about it with your colleague…but only if someone has a mutual client… I wouldn't talk about it to another colleague who doesn't know them. They're busy…unless I break down and cry…I'll just go to my office and break down and cry [alone]. (Charlie)

Other participants noted invalidating workplace environments and a culture of normalizing or downplaying an overdose in those who chronically use substances. Lilah spoke about her experience working in the infamous downtown east side of Vancouver, a neighbourhood characterised by extreme poverty, chronic substance use, and homelessness. She

describes a culture of compassion fatigue and insensitivity to those who succumb to substance use. For example, she notes, "... the normalization of overdose deaths…when people…make a comment like 'oh yeah, well you know he was using'…it does kind of play down [the seriousness] …it doesn't happen often, but I mean that has happened." (Lilah)

Participant Riley similarly describes the culture of her workplace, where some colleagues have made colorful remarks about the deceased; therefore, leading the participant to feel emotionally unsafe in the presence of that peer. She explains, "…the ones with the 'dark humour'… [in reference to client] who overdosed, one of them said….'she's in a better place now…cause I hear they have better opioids in heaven' … I can never see those people the same." (Riley)

In terms of formal supports, some participants reported asking for help from their supervisor, but never receiving support they needed during periods of high stress in their work. After experiencing compounding losses in her role, as a team lead, Eva reported:

> …just feeling really disconnected and feeling very overwhelmed. I was…very focused on trying to support everybody around me that I didn't realize the toll that it had on myself. I guess I was a bit detached from all of that in order to keep functioning. I really felt like my performance was suffering. I kept telling my supervisor that and she was like 'no, everything's great, you're doing awesome'…there's just like a major disconnect between how I was feeling and thinking versus how I was *actually* performing. (Eva)

Or not having adequate clinical supervision in a frontline practice role:

> …if you have a good team you can debrief, we do a lot of debriefing with each other in the workplace. That's very helpful. I truly believe that critical stress debriefing and

having a good…. supervisor that has a similar background helps. Where I work now, we don't…its problematic because we have nursing supervisors and it's like…whoa, were just going to have our little corner over here and debrief and help each other…. talking about our feelings versus going to supervisor who they don't have a clue what we do unfortunately. (Raven)

Other participants described not feeling comfortable disclosing feelings around highly emotional events to management. It was perceived by participants that support from management was not available, genuine, or otherwise appropriate to ask supervisors. "…yeah not 100% [comfortable]..." (Riley). Furthermore, Riley elaborated on an experience of feeling invalidated by management:

…my boss let me know but it was on a morning call with a whole bunch of people, and he just said it in passing, so I had to mute myself because I started becoming teary but that was the one where I didn't think it was true either. (Riley)

In other situations, participants described receiving negative reactions and gossip from peers in response to taking time off or taking a leave in response to stress or personal time off. Participant Sara observed colleagues expressing their frustration in peers taking time off work which essentially increases their own workload as someone must cover client care duties, which falls onto the shoulders of staff who remain in the office. For example, Sara reported her experience with negative team dynamics when someone on her team was off work:

…to be honest, there was one woman who people didn't have the nicest things to say… because the problem with *this* work is…someone's off and other people are covering…in

general when people take unexpected time off…some people are vocally not happy with it…there is a bit of judgement. (Sara)

Some participants noted that talking openly about a client death amongst the team members was not common practice and was essentially reserved for those who indicate they require additional support. This speaks to the cultural norms of society, and in this case within the workplace, regarding the open discussion of death and trauma. For example, "…we don't come together and talk about it collectively…. they did offer extra support to people who want to talk…." (Lilah). Furthermore, for those who do seek out formal counselling support, Lilah described how common EAP programs often do not specialize in grief and trauma counselling which may affect the quality of support received, "…sometimes generic counselling doesn't really fit people's values…". She also notes how some workplaces do not offer culturally driven and culturally safe practices for workers, and how employers in her experience provide minimal and generic offers of support: "… if it's an Indigenous person…doing more of a culturally appropriate service…not just offering counselling…. but usually just an email and 'here's some counselling' that's it." (Lilah)

Sub theme Three: Indigenous versus Non-Indigenous Organizations

As research participants stated earlier, a combination of formal and informal supports is commonly drawn from when experiencing serious and critical incidents at work – most perceiving formal supports as inadequate or unavailable and preferring to utilize informal supports. However, several social workers raised the topic of supports within Indigenous agencies during times of experiencing grief, loss, and bereavement in their workplace.

Indigenous agencies as represented through the perceptions of social workers in this research have a strong inclination toward relational practice including connection to community, appreciation and reverence of elder and Indigenous knowledge, and the use of spirituality in supporting clients and the social workers who provide services. The interviews revealed clear differences in how Indigenous agencies provided more 'alternative' or spiritually inclined supports. In these cases, spiritually inclined supports within the agencies are deemed as formal supports but accessed in an informal way.

William, an Indigenous social worker and team lead, discussed how his agency provides a well-rounded selection of supports covering standard formal supports and cultural-spiritual based support:

> …EAP…was always available to us…I would also say that we had our elders that were available to us. We also had an energy healer…made available to us…and then through our benefits we had massage…they reminded us of those things…the big ones for when there has been a loss, has been our elders…coming together with our elders to use ceremony to relieve some of those emotions. (William)

William further elaborates on the important role that elders and traditional knowledge keepers hold in his agency. He describes how they are instrumental in guiding both client practice and facilitating the healing process for social workers through cultural and spiritual practices within the agency. William reported:

> …where we work, as soon as something like this happens, our elders step up and they start organizing…they start telling us what needs to happen, or they'll pull us and be like 'okay, tomorrow morning we're going to be coming together for brushing off because we

need to as a team go through these processes together or to start taking this energy away from you guys because…it can be overwhelming…especially within our work, we are still responsible for another 80 youth…we have to be able to do our work. (William)

Similarly, Kelley, an Indigenous social worker and member of upper management, noted that addressing grief means getting to a place of not being consumed by emotions and she relies on both professional supports and traditional teachings and observes that "it's the professionals of our elders that can help provide some of that grounding." Kelley holds a leadership position within her agency. With respect to her agency's staff, she noted how her practice provides supports that continually strives to bridge Indigenous knowledge and western social work. Kelley specifically describes how she incorporates spiritual well-being and cultural practices into agency protocol to support workplace wellness:

> …it means I am going to ensure that the knowledge keepers and spiritual workers come in to brush off the workplace, to smudge or brush with cedar or light the candles that will help clear the space. I think the brushing off my staff, seasonally, that becomes part of our regular practice but then in a critical incident that might be you're taking care of the people who are impacted by that in the workplace as well, so the spiritual workers will come in and do some of that work…..that is just part of our practice, it's not something that is a one-off, it's something that should be brought into how we take care of one another. (Kelley).

Non-Indigenous social workers commonly noted how Indigenous agencies often have more well-rounded and "built in supports" to help process difficult situations and address spiritual components of their well-being. Raven, Charlie, SC, Eva all voiced similar comments

when they described how they experienced the influence of spirituality in these types of agencies.

Charlie, a non-Indigenous social worker, reflected on her practice within both Indigenous and mainstream agencies and the type of supports she experienced:

> …I know in another agency I worked for, there was always…we called them [name]…and he was Indigenous…he was always there to talk to somebody…like about everything…if you wanted to talk about somebody grieving…now we can access an elder at work. If you want or need somebody when going through stuff, then the elder will be there. Indigenous people seem to have a natural sense of how to support people. (Charlie)

Others specifically described a strong appreciation of Indigenous culture and worldview. Raven described how Indigenous culture helped her process a death of a young Indigenous client and shared conversations about the afterlife. Raven noted her experience working with the family of her Indigenous client, to plan the memorial and how the shared reaction to grief can look different. Raven mentioned her experience here:

> …it all has meaning and symbology, it's incredible… they're so far ahead dealing with their mental and emotional health when someone dies…I think that non-First Nations….they do it as a group, they do it in the community, they do it in the family, whereas often in non-native communities the grief is very individual…you might share and cry with a few people… (Raven)

These different grieving styles may have significant implications in how social workers process and create meaning from experiences of client death. Community and peer support is important, and facilitates connection and healing from difficult experiences. Community support

is vital in the individual's reconstruction of client death, and may even allow for a collective reconstruction of the grief experience through the use of shared ritual and traditions of mourning. SC shared similar perceptions working within Indigenous community where "ways of healing" and the "collective experience" of grief were very useful to her processing the experience.

Chapter Five: Discussion

Merits of Study

There are some potential benefits that may come from this research ranging from micro to macro impacts. For example, potential benefits relating to the micro level may be found directly with participants articulating their lived experience to better inform Canadian social work research, benefits of the mezzo level may come from filling a significant gap in social work literature about social workers well-being, and developing new perspectives that can lead to theory development, and reducing stigma of client death among peers in the profession of social work. Furthermore, this research could inform policy analysts at the macro level in terms of how workplace policy, program mandates, and benefits tied to employee status are developed.

The participants who choose to take part in this research had the opportunity to share their life experience and knowledge around this phenomenon, and thereby contribute to Canadian social work research. The interview process provided a platform for participants to share their perspective and reflect on their experiences of client death, which can be therapeutically cathartic. This study may also help to reduce the stigma around client death by speaking about this topic, inviting social workers and those who experience client death not to be silent, and by having conversations around processing this type of experience. We live in a culture of shame and avoidance of death and dying. For many of us, we work to avoid coming to terms with our own morality or beliefs around death. To reflect on this in our practice would work toward reducing the "novelty" of death and reducing any complicated or prolonged grieving.

Ten semi-structured interviews were conducted with social workers across British Columbia, Canada. One social worker was located in northern British Columbia at the time of the interview and the remaining nine were located within the lower mainland. After conducting these conversations with participants and reflecting on my experience with the existing literature related to my study, I have gained some insight into how a sample of social workers from a variety from backgrounds and practice areas experience client death and cultivate meaning from this event. Participant interviews provided insight into the presence of spirituality in personal and professional life, the experience of traumatic death of clients, spiritual and systems-based meaning reconstruction, and workplace policies that impact social workers and their practice.

This chapter provides a discussion of the key findings under each main theme and sub theme, and explores these in relation to the existing literature, identifying similarities, differences, and areas of expansion. This will be followed with recommendations.

Key Findings

The analysis of the study findings revealed how a sample of practicing social workers in British Columbia have experienced the unanticipated death of a client(s) and what their subsequent spiritual meaning of their reconstruction processes included after this type of experience. Essentially, the end goal was to contribute to the social work literature and to inform the practice of social work for those who may experience the unanticipated death of a client, which may have significant negative impacts. To reiterate, my research objectives were:
1) To understand the experience of unexpected client death from the perspective of social workers; 2) To understand the ways social workers create meaning and understanding of this death experience from a spiritual perspective.

Three main themes included the experiences of client deaths, meaning making, and ritual, the presence of spirituality, and ineffective and unsupportive workplace policies. Sub-themes included the impact of client death and meaning from systemic failures, spiritual based meaning, ritual and ways of mourning, the personal philosophy of social workers, inclusion and exclusion of spirituality in practice, the perceptions of management, informal and formal workplace support, and the contrast between Indigenous and non-Indigenous organizations.

Considering the depth of information from within and across these themes and sub-themes, there is a significant amount to discuss in how it connects to social work practice, education, and policy development. The implications for practice and recommendations are as follows.

Research specifically exploring the personal spirituality of social workers sparsely exists in the literature currently. However, the literature is rich with spirituality as a concept and spirituality as a tool for coping and resilience especially in the face of grief, loss, and bereavement. One theme that became apparent was the presence of spirituality in the personal lives of social workers and how spirituality is included or excluded in their social work practice. Each participant described what spirituality means to them in different ways and described differences in their evolution of spiritual understanding. There is no one agreed upon definition of spirituality.

A common thread across participants is that spirituality is both an individual and community experience in their personal lives and is generally viewed as a positive way to view the world, cope with life events, and create meaning from experiences. Sheldrake (2007) links spirituality with values, defining it as the ‘deepest values and meanings by which people live”. (p. 2). Some commonalities present in their definitions including early life experiences with

religion of their family of origin, spiritual experiences or spiritually significant life events, a connection to nature, community, and having a deep and profound respect and appreciation for Indigenous worldviews/spirituality. After reflecting on my conversations with participants about their personal beliefs and definition of spirituality, it became clear that spirituality was highly personal but important to everyone.

Christianity or Christian influences played a large part in many of the participants early life experiences (e.g., a higher power, belief in a better place after death). However, many of these participants views evolved and shifted away from anything to do with direct Christianity. And many had early influences of Indigenous spirituality in their definition (e.g., either practices like smudging or connection to nature/community). For participants in my study, spirituality or religion was part of their early life experiences, attending church or other services, being raised within a particular denomination, or being raised with questioning caregivers. These participants all have a shared experience of a presence of spirituality in their lives with a somewhat similar process of evolution to their current understanding. For two participants, their evolution of spirituality began within the Christian denomination, then subsequently found their way through substance use and active recovery, to declaring their spirituality as being connected to Al-Anon or Al-Anon affiliated.

Indigenous spirituality played a significant role in the lives of many of the participants. Two participants described their identity as First Nations people, their upbringing within Indigenous community, and the inherent spiritual component within the culture of their families. These specific participants spoke about their deep connection to their family values and traditional teachings, which acts to guide life choices and sense of purpose. They also have a well-defined, clear sense of spirituality with less obvious evolution as in those who wavered

from Christianity to spirituality. Another participant, spoke about having Indigenous ancestry but "grew up in white culture" and "is white presenting" and therefore did not grow up with Indigenous spirituality or in formal community. She reflected on her exploration of her identity and spiritual identity throughout her younger years but eventually found it "didn't ring true" for her for reasons stated. This participant described a sense of spiritual trauma, a familial connection lost because of colonialism and the process of assimilation.

In this research, the use of spirituality in social work practice was mixed across the participant responses. Spirituality is often seen as sitting on the fringes of social work practice, a concept seen as lacking importance to include in discussion. In this way, we do our clients a disservice by ignoring the benefits of spirituality and leaving it out of the professional relationship. Darrell and Rich (2017) argue that the client's need or desire to include conversations about spirituality must be considered an integral part of social work practice and that these concerns cannot be relegated to another service provider, such as the chaplain or pastoral counselor. Furthermore, social workers are guided by the British Columbia College of Social Worker (BCCSW) standards of practice (2022) which includes spirituality as part of ethical and responsible cultural competency.

Some participants easily described how they use spirituality in practice and displayed a level of comfort and connection to spirituality. For those who incorporate spirituality into practice, it was generally used sparingly, in relation to Christianity, and used depending on the previously established client beliefs about spirituality. Eva, for example, used spirituality with youth, who in her experience, are open minded and open to a connection with nature. In her reflection on past experiences, she also described using spirituality with older adults receiving end of life care but only connecting it to religious rites and making referrals to religious/pastoral

care. Another example is Riley, a social worker on an inpatient unit within a large health authority. She provided her experience using spirituality sparingly under the medical model of care. Riley used spirituality "in a measured and professional way" by incorporating threads of resiliency and hope in her work with clients and stated, "professional support is not about spirituality." Interestingly, Riley positioned herself as a "highly spiritual person" and offered her personal experiences of battling substance use and drawing from spirituality in her recovery journey. In this example there was a clear dichotomy between the importance of personal spirituality and its importance in the lives of clients or otherwise in the workplace. More recently, spirituality has started to be viewed as an essential component of holistic practice and person-centred care (Barrerra et al. 2012), however, a 'spiritual gap' remains between health professionals and those who access services (Forrester-Jones, Dietzfelbinger, Stedman, et al. 2018; Thoresen, 1999) as indicated by these participants.

Other participants appeared to shy away from using spiritually based language and made a clear distinction between professional practice and practice that includes spirituality. Lilah also described herself as a "very spiritual person" and described herself as having a "holistic approach" to practice but also reported that she does not specifically use spirituality in practice. The language of the participant suggests an aversion, or feelings of unpreparedness, to applying spirituality in practice. This aligns with the literature, where spirituality is noted to be viewed with stigma or having some negative connotation attached. Eckert (2015) reports that while many social workers have positive attitudes toward client spirituality and are comfortable discussing spirituality, they choose not to.

Several participants had a harder time describing how they used spirituality in their work or did not use it at all. Although how one defines what spirituality is and how it can be used is

highly subjective and personal, several participants reported they were unsure if they could ethically use a spiritual lens in the workplace. Sara, for example, was unsure if staff are allowed to use spirituality and has never shared her spiritual values with clients.

A significant portion of the participants discussed Indigenous spirituality and culture as being influential in their understanding of how to include spirituality in their current personal practice, even incorporating elements into their own understanding of spirituality. Those who were Indigenous or worked within Indigenous organizations viewed spirituality as an essential part of their practice.

The use of spirituality within Indigenous agencies appeared to play a more foundational role in the agency culture and in how it is infused into the environment, and within social work practice, for both clients accessing services and for those employed in the agency. The data here aligns with previous research on how Indigenous social work is conceptualised and carried out in practice. Fleming and Ledogar (2008) discuss how "Indigenous professionals consider spirituality and culture as appropriate responses to historical trauma and how they integrate spirituality and culture into their practice or develop professional practices from within culture and spirituality" (p. 2).

William described spiritually based assessments mandated by the agency he works for. He mentioned the use of spirituality through the use of medicine wheel assessments, the use of comprehensive cultural plans, and the incorporation of culture, community, and identity. William noted the importance of spirituality within Indigenous worldview and how his agency tailors' spiritual assessments and interventions to align with the specific Nation with whom he works. Verniest (n.d.) notes that when social work practitioners use worldviews and models tailored specifically for the client's population, they are practicing appropriate, respectful, and culturally

competent social work with their clients. In these participant cases, spirituality and reconnecting clients to culture were understood as topics for the workers to initiate and facilitate in the work with clients. William also discussed the use of spirituality as a way that facilitates team building and connection among the social work team. For example, he noted how he will facilitate outings for his team to harvest plants and make medicines together. These outings offer a way to incorporate spirituality/spiritual gifts for the community they service. Additionally, it was noted that the use of plants, nature, and harvesting medicines were used in ceremony which the workplace facilitates.

All the participants noted a lack of formal training on how to use spirituality in social work practice and every single participant, except for one, reported having no training during their social work education in this area and no professional development in this area. The literature supports participants' responses as studies show that many practitioners are not taught about Religion/Spirituality as it relates to social work (Canda and Furman, 2010; Oxhandler and Giardina, 2017; Oxhandler, Parrish, Torres, and Achenbaum, 2015; Sheridan, Bullis, Adcock, Berlin, and Miller, 1992).

Lilah, the one participant who did receive some training in spirituality in social work, reported she had one elective course during her graduate education in social work. She reported selecting an alternative wellness course that focused on spiritual interventions and traditional ancient practices. However, this participant reported she rarely brings spirituality into her practice with clients based on a few factors. These factors may include practicing in a work environment that supports/encourages the use of spiritual interventions, personal comfort with spiritual discussions with clients, and comfort drawing from personal spiritual experience. For those participants who did incorporate spirituality into their work, it was noted they mostly drew

from personal experiences and had a high comfort level with spiritual concepts and practices. There was also a general perception that spirituality and clinical practice should be approached with ease, and not relied on. Spirituality was often reported/viewed as a personal and private issue and participants did not want to initiate the conversation, or viewed it as unprofessional. Spirituality continues to be either a relatively taboo or forgotten concept within general social work practice. The social workers who participated in the interviews almost unanimously reported they were not specifically taught about spiritual concepts, spiritual assessments and interventions, or how to otherwise incorporate spirituality into social work practice during their professional education. One participant, Lilah, reported she received training in spirituality and social work practice during her graduate social work education and reported positive benefits of this during her program.

Another barrier for using spirituality may be the place of employment. Agencies with more restrictive environments and requiring more oversight in how social workers support clients, or even how the specific role of the social worker is set up to deliver services might experience high workloads and lack time in a day to explore non urgent issues like spirituality with clients. Most participants discussed their role as being crisis oriented, where time spent with clients was limited and otherwise set out by goal directed treatment which does not leave allocated time in the day to explore alternative issues with a client. Other issues that became a barrier to using spirituality in practice include short staffing, lack of consistent supervision, and fear of placing opposing spiritual or religious views onto clients.

In terms of non-Indigenous organizations, spirituality tended to be either left up to individual workers to use in their practice, left to religious/spiritual specialists from outside programs, seen as something unique to Indigenous people accessing service, or used solely in

specific programs like end-of-life care. There also might be more opportunity to use spirituality in smaller agencies and non-profits, where there may be less strict accounting for time or more open attitudes to alternative practices and/or spirituality.

It is evident that social workers are affected by the unanticipated death of clients and there often are multiple deaths over one's career. The experience of unanticipated client death was found to have occurred multiple times throughout the careers of the participants in this study, often with traumatic circumstances and in compounding frequency. It was unanimously reported by participants that this experience is frequent, disturbing, traumatic, and deeply affects workers. This study specifically examined how social workers experience the unanticipated death of a client.

The experience of client death or other forms of traumatic stress across the helping professions is inevitable, generally frequent, and has been considered in the literature as an "occupational hazard" (Bride, 2007, p. 64). The literature involving social service roles and healthcare disciplines and the experiences of unanticipated client death are consistent with the responses of the participants in this study.

The concept of traumatic death where grief and trauma intersect has rarely been presented in the social work literature from the experience of social workers. Furthermore, the literature tends to focus on aspects of vicarious trauma and secondary traumatic stress in social workers rather than describing it as direct trauma. The connection between social work and trauma is apparent. Social workers regularly watch clients die of health issues, overdoses. In other cases, they are murdered or go missing, abused in every way, and may die by suicide. This is real trauma for social workers who work with these clients. Although it is understood that the death of a client may be considered traumatic it has rarely been documented as a traumatic

experience within the social work literature. This lends to the perception that the deaths of clients or the relationship social workers build with clients is not important, essential, or meaningful.

Traumatic and tragic deaths described by the social workers occurred in all interviews. The method of the death, the age of the client at the time of death, and how many deaths in a short period of time influenced the traumatic nature of this experience as described by participants. The literature has consistently shown that populations who access social services are likely to be unhoused or have inadequate housing, have a shorter life expectancy, and are more likely to die of homicide, suicide, trauma, AIDS-related conditions, drug overdose, and other alcohol and drug-related problems relative to those who have stable housing (Cheung and Hwang, 2004; Haw et al., 2006; Morrison, 2009; Nordentoft and Wandall-Holm, 2003). This is consistent with participants' stories about clients who struggled with substance use, mental health, homelessness, and significant trauma throughout their lives. Some participants also noted sudden accidental deaths as the method of death.

The literature has also highlighted compounding or cumulative impacts of client deaths largely focused on long term and hospice care settings. The phrase "death is part of the job" is overwhelmingly common (Marcella and Kelley, 2015). For participants in this study, none were currently or recently employed in long term care or hospice settings, and none disclosed experience in this specialty area of work. However, all the social workers disclosed experiencing multiple and often compounding deaths of clients in short periods of time.

The findings of this research revealed the youngest participant with the least work experience, described three sudden client deaths over a career spanning three years. For others, they could not recall the total amount of client deaths they endured over their career as a social worker. I noticed that participants with less work and life experience often have less in-depth,

elaborate, or self-reflective responses regarding their experience and personal meaning reconstruction processes related to a death of a client. Those with fewer years of work experience dismiss the potential seriousness of impact an event like an unanticipated death of a client might have on one's personal and work functioning. This may suggest that younger social workers or those just starting out in their career, might lack protective factors of both life experience with client death and with spirituality/spiritual meaning-making abilities. For these reasons, they may have an increased risk of burnout/compassion fatigue. The participants in this study recalled their experience and the effects immediately upon finding out a client has died, and in the days, weeks, and months that followed. Some social workers also recalled their involvement or team involvement in the funeral or memorial planning for a deceased client, depending on the role, relationship, or agency at the time of the death. The initial and acute reactions were stressful, shocking, and sometimes isolating among peers in the office and in personal lives. This has importance for both colleagues/staff in the field and for management, to recognize that social workers, especially on the frontlines, require emotional and practical support following the unanticipated death of a client. The roles of each social worker were varied, but all described this experience in reflection about a time when they have held a frontline role supporting clients. From child protection and other child welfare positions to inpatient units, to community-based positions, deaths occurred and had impacts and lasting impressions on the social workers. These positions assume different levels of client involvement. Therefore, how the social worker feels about the death varies. This varied response also exists for those social workers who blame themselves for not being able to prevent the death. Some roles involved direct assessment and intervention of concerns such as in child protection investigations and guardianship. Other roles such as in inpatient units add severe measures that temporarily impede a client's right to self-

determination in the face of safety and public risk, but it protects a client from engaging in activities that may lead to their death upon being discharged or released from custody.

A significant number of participants described undertones of self-blame, guilt, and a desire to understand where they went wrong in their work. Some of the participants described a sense of blame toward themselves in reflecting on the deaths of clients whom they knew and were part of their care planning, assessment, and other points of contact. This is consistent with the literature on similar reactions among social workers in terms of intense reactions such as feelings of guilt, self-blame, and self-doubt about decisions in practice (Feldman, 1987; Jordan, 2020; Ting, Sanders, Jacobson, and Power, 2006; Veilleux and Bilsky, 2016). Sara, a former child protection worker, reflected on her assessment and intervention of a family with a young child who had special needs. After initial assessment and safety planning, it had been determined that existing child protection concerns were mitigated, and the case was closed. Months later, Sara received confirmation that the young child died while unsupervised which was the initial child protection concern. Sara spoke about this experience in a way that highlighted some level of self-blame as the one to have initial point of contact with that family. This is consistent with the literature examining the grief experiences of healthcare workers, even prior to the Covid-19 pandemic, and most notably for physicians, where one third reported feeling guilt about patient deaths and one half felt a sense of failure (Rabow, 2021). As Sara addressed in her interview, once child protection concerns are addressed and there are no remaining safety concerns, it is not ethical or part of practice to remain involved just to supervise families "in case" there is a death. Her complicated feelings surrounding the death are still present even though logically she is not to blame for the death. She followed policy, received oversight from her team lead, and addressed existing concerns. Certain deaths in society hold more stigma than others. For

example, death by suicide brings the added complicating factor of stigma for taking one's own life and in terms of professionals, possible perceptions from society that there was a duty to prevent this from happening. Similarly, deaths involving children and families with involvement in child protective services is often negatively viewed by the public. There is a high level of expectation that this profession should be able to mitigate every single case of child endangerment. Child protection services and its workers are placed under high amounts of media scrutiny. The literature suggests that when even one child dies from abuse, the child welfare system comes under immediate criticism (P. 20) and events in the media often "grossly misrepresent the dimensions of the problems" (Spector & Kitsuse, 1994; as cited in Clebourn-Jacobs, 2013). Rabow (2021) asserts that despite death being a natural and common experience for humans, the experience of grief "has long lived uneasily and this might be especially true for physicians, given that discipline's tendency to see illness as 'the enemy' and therefore death as a professional failure" (p. 2). Rabow is not wrong to assert that death is natural and common, however, not all deaths follow the natural progression of one's lifespan. How natural is the death of a child? Are accidental deaths natural? Across allied professions like social work, I would argue death is also often perceived as a failure. The profession of social work is built on the notion of helping others and mitigating safety concerns, so if death occurs, it is no surprise that it is taken with difficult feelings of self-blame and guilt. Social workers make point of contact, provide comprehensive assessment and intervention, go through the motions, perform all the required protocols, and clients still die. This does not stop the emotional part of our brain from experiencing human feelings and reactions. When a relationship is permanently broken through death intense feelings often arise. When this is combined with our professional role as a social worker, self-blame is often present and can make us perceive that our role is somehow to prevent

death from happening. Some of the participants here described doing all they could for some clients and others noted some deaths were preventable.

In the area of fatal substance overdose, the literature highlighted that professionals' experiences after substance overdose death has not been well studied and "no practice guidelines exist to guide providers after an overdose death" (Yule & Levin, 2019, p. 2). This aligns with the experience of some of social workers in this research who had a client fatally overdose. The participants who had this experience, reported no formal "postvention" procedures in their place of work for the deaths of clients except for some workplaces offering very brief critical incident debriefing. Some participants described feeling more supported informally by peers rather than by management or formal services. Others felt that peers in the workplace who bring value laden judgements disguised as jokes regarding those who die by substance overdose were not only unsupportive, but disrespectful. This was reported to ruin peer relationships in the workplace and somewhat impact informal networks of support at work.

After reflecting on my conversations with participants about how they experience the death of a client, it became clear that meaningful working relationships were established with many of these clients, or an otherwise positive bond was made between worker and client. Relational theory for social work practice argues that the most important feature of human development and work with others lies in the ability to form connections through relationships (Freedberg, 2009). For participants, connecting with clients and developing a deeper relationship becomes inevitable. People will not have strong or positive relationships with everyone but when we do, it can impact our grief and attachment. In the final act of death, the bond is physically severed, and this can feel the same as when our family and friends die. Many of the participants reflected on feelings around the loss of clients and how it felt similar to a loss of a friend or

relative. One participant even compared the recent loss of a friend and the loss of a client, and the feelings felt the same. Interpersonal relationships are two-way streets. In cases where this relationship is permanently ended, such as in death, the feelings of grief are better understood. The only difference in the context of a social worker – client relationship is that it is characterized by aspects of legality such as confidentiality and a level of responsibility as "the professional." Initial reactions of shock and acute grief may feel and look the same…. but those in the professional relationship will often cope with the grief in some alternative ways as reflected through the participant responses regarding use of rituals for grief and mourning in the workplace. These aspects of the relationship may impact workers or the grief process. Because clients are not our family, we are not always privy to all aspects of a client's life, or we might not know the family of the client, or it may not be a positive relationship.

Rapport building has always been stressed within social work professional education and in the workplace, but we are taught to build one-sided relationships with clients. In our relationships with clients, the client is supposed to feel like a relationship is forming and the social worker is to remain highly guarded and private with information about personal life, thoughts, and ideas. In this way, relationship building is one-sided and reflects an imbalance of power. In reality, and in good social work practice, relationship is the crux of good social work practice. So, when a client dies, it is normal to feel a reaction about this type of permanent loss even though society and many employers view this relationship as one-sided. Many current Western cultures categorize deaths in a hierarchy, labelling some deaths as holding more significance than others.

Meaning making is an active process where people interpret situations, events, or discourses, in light of their previous knowledge and experience (Zittoun & Brinkman, 2012).

Meaning making is, and was, a very personal process for the participants in this study. It is important to consider that every social worker in practice brings their own set of values, beliefs, fears, and life experiences into practice and this can impact one's ability to cope with adverse and traumatic experiences in our practice. Two categorically different types of meaning-making were found in the participants' responses regarding unanticipated client death: spiritually based meaning and meaning from system failures. The social work participants included a range of responses in how they found or created spiritual meaning from the death of a client. The most common spiritual meaning I found in the responses included honouring the life of the client, finding benefits, making sense, engaging in rituals, connecting to shared community, sharing Indigenous perspectives and rituals, being in a better place, escaping from pain and trauma through death, and, to a lesser extent, continuing bonds.

Firstly, religion and spirituality are two of the most used methods for meaning making (Lysne & Wachholtz, 2011) and existing research has shown that those who are "self-efficacious and more religiously and spiritually open to seeking a connection to a meaningful spiritual practice are more able to tolerate pain," (Lysne & Wachholtz, 2011, p.11.). In my study, one way that participants created meaning and understanding from the death of a client was through a spiritual lens. Participants reflected on their client's belief systems and life lived, their personal beliefs and spiritually based ways of making sense of an unanticipated death in their work. Most of the participants described themselves as spiritual and had a solid understanding of what spirituality means to them outside of their working lives. Many participants grew up in homes that were influenced by religion or spirituality. In the event of a client death, many of the participants drew from previous spiritual understandings in the context of death. The literature

has not thoroughly explored how social workers' spiritual beliefs impact the grieving process, and this inquiry begins to fill this gap.

Other participants noted an inability to make sense of such a tragic experience of a client dying, "how do you make sense out of something that doesn't make sense?" especially in cases where the deceased was a young child who relied on others for care, or where the method of client death was violent or accidental. The reported inability to make sense out of this event lies in the unfortunate and untimeliness of the client death. One participant spoke directly about the final and permanent nature of death and how she, as all of us on this earth, are unable to fully 'know' what happens or what becomes of us when we die. Kelley and SC reflected on times where a client was a child and died suddenly. These participants described struggling with being able to make sense of deaths of a child and that it "just don't make sense." Although the literature cannot speak to the relationship between worker and client, it includes parental loss of a child as especially disruptive to one's meaning structures and is often perceived as "senseless" (Davis, Nolen-Hoeksema, & Larson, 1998). This traumatic event can upset a parent's sense of understanding about the way the world works and their purpose in life (Lichtenthal, Currier, Neimeyer, et al., 2010).

Meaning making was challenged, as reported by Anna, who felt there was "no time or space at work to process and create meaning" due to busyness and a lack of supportive safe spaces at work to facilitate meaning making. Her experience mirrored the literature. Boerner, Gleason, Barooah (2016) discovered that healthcare aides who were employed by an agency, without restrictive policy outlining no opportunity for follow-up or contact with the deceased family members, had a more positive experience at work and more opportunity to process the client's death (p. 5).

Honouring the life of the client was central to spiritual meaning-making for many participants, and the opportunity to "send them off in a good way", celebrating their purpose, their relationships in life, and other relational impacts they had on the practitioner were all ways meaning was processed. This was found to align with the responses of many social workers but most specifically with those who identified as Indigenous. The literature supports this finding of honouring the relationship and the life of clients who suffer untimely deaths. Indigenous social work is grounded in relationship and there is a teaching that 'relationships are medicine' (Aitken, 1990, cited in university nuhelot'įnethaiyots'į nistameyimâkanak *Blue Quills*, 2019, p.9) and that all life is connected – not just at the human level, but to the earth, the plants, the animals, and the cosmos (cited in university nuhelot'įnethaiyots'į nistameyimâkanak *Blue Quills*, 2019, p.9).

Lichtenthal, Currier, Neimeyer, et al. (2010) highlight benefit finding as the identification of any type of benefit after an adverse event as a common meaning-making process. William discussed a youth who died that appeared to be a "trailbreaker" in how they left the community after death, when speaking about a trans youth who died. "The strength of that youth and the courage of that youth allowed us to gain more knowledge" [about queer issues] and "now today we have many youth who are trans…".

Research has confirmed that spirituality and social connection are a significant part of the work of mourning and the construction of the sense of loss in the bereavement of a loved one (Testoni, Antonellini, Ronconi, et al., 2021) and how there are "direct spiritual influences on continuing bonds, personal growth, and valuing life" (p. 2). The existing literature is rich with information supporting spiritual based meaning-making in the context of grief and loss for loved ones and with those we have personal bonds. The difference in this study is that the relationship between social workers and their clients is fundamentally very different than relationships we

hold outside of our social work title. This relationship is characterized by aspects of legality, confidentiality, ethical boundaries, and reasons for being in each other's lives.

The other central meaning making theme, across all participants, was the understanding of wider system failures under current neoliberal policies and agency structures. Meaning was derived from the understanding that 'systems' contribute to the deaths of clients and in these contexts death becomes more traumatic. The perceived 'system failures' as it relates to the death of a client made social workers reflect on their role within the larger system as either an agent of control or as a helper. It is worth considering how social workers reconcile their understanding of their role as social worker in a poorly designed system placing barriers on support for everyone who requires it. Social workers are left with no choice but to rely on an inadequate system within which they work. Barriers in the wider system are placed on clients and on social workers who want to provide adequate support to others. Some clients need and want help but cannot access services in a timely fashion or at all. Social work participants in this study spoke about these challenges in the system and reported a firm belief in systems issues contributing to the death of a client. Social workers can only put band aids on problems and then wake up and do the same thing the next day. We do not address any root issues.

In addition to these worries of the system failing clients, many participants disclosed their feelings of being let down by the system in which they are employed. Many social workers felt undervalued in their role by management as evidenced by lack of appreciation, being underpaid, not having adequate benefits to support general and mental health, working under inflexible and unrealistic working conditions, high caseloads, and not having management support to continue doing a quality job or insensitive work environments. Not all participants disclosed dissatisfaction with management and a few participants in this study were part of the

management team at the time of interviews. Many participants also discussed conflicted feelings and challenges with trying to "bend the system" to provide care to clients. Legislation and management were seen as large barriers to client care from the perspective of participants in this study. SC noted an apparent disconnect between upper management and frontline workers which became a major frustration in her work. She noted feelings around workplace policy and bureaucracy that individual workers face when attempting to support clients. Feelings of being locked in with rules and legislation around how you can and cannot support clients. Employers were seen as preventing social workers from helping clients in ways that could truly help. Other participants also noted frustration in hitting barriers in their organization that impede client care such as going through multiple channels to obtain approvals for financial requests or concrete client care planning decisions. One participant directly mentioned the frustration of having to obtain minimal financial requests ($10) from her employer for a client who is under the care of the government.

Substance use and mental health systems were specifically mentioned as systems that have seriously failed clients. For example, social workers SC and Sara, observed and noted the current opioid crisis. For context, this research was conducted with social workers primarily located within the lower mainland, or in Vancouver and with many clients notably in the DTES, a neighbourhood infamously characterised as one rife with serious substance use, overdose, and death. SC noted that clients awaiting treatment or mental health intervention, due to the nature of these challenges, miss these small windows of opportunity for assistance and some end up dying.

Several participants specifically address colonialism and the social work profession's role in upholding/advancing colonial systems. All social workers in this research discussed Indigenous client deaths. Statistics Canada (2021) report that First Nations people were reported

to have a shorter life expectancy than non-First Nations and were more likely to die prematurely from avoidable causes. Overall, the disparity between mortality between First Nations people and non-Indigenous persons has been well documented. Colonization and most notably the intergenerational effects of the residential school policy has stood out as especially damaging across Indigenous communities (Wilk, Maltby, Martin et al., 2017). This has resulted in ongoing discrimination and fewer social determinants of health for Indigenous communities, which significantly affect health and well-being. Freemantle, Ring, Solomon, et al. (2015) report "the World Health Organization now recognizes European colonization as a common and fundamental underlying determinant of Indigenous heath" (p. 644). Further, colonization is directly connected to the overrepresentation of "disease, poverty, and disadvantaged experiences by Indigenous Peoples, who were displaced from their land, culture, and resources" (Sinclair, 1969; cited in Smallwood, Woods, Power, et al. 2021, p. 59).

Participant Riley noted her meaning-making process of how two clients, both young Indigenous women, endured a life of struggle through substance use, mental health issues, and other unfortunate life circumstances understood through a historical and enduring legacy of colonialism. In Riley's words "the tragedy really lies within the state of our systems. The way that we treat Aboriginal women, the generational trauma…they're not in pain anymore…in some ways there is a bit of relief there." In this case, there is a blend between spiritual and systems-based meaning in how this participant created meaning from the death of two clients in her practice. Another participant, Eva, spoke about barriers in her organization that prevent workers from providing the type of services they want to provide from an anti-oppressive, anti-racist, anti-capitalist approach to practice. William specifically addressed colonization and provided an in-depth reflection on his experience working within a delegated Indigenous agency where

chronic government underfunding has occurred over the years. In this way, colonization was understood and discussed as a factor in the deaths of Indigenous clients and this overlaps into meaning made through systems-based failures. A common sentiment in the interviews was "f… colonization" and despite global acknowledgement and recognition of the historical impacts of colonization, only in the last two decades has "evidence-based literature emerged to assist understanding of the trauma and the impacts of colonization had had on the health and well-being of Indigenous Peoples" (Paradies, 2016; Smallwood, Woods, Power, et al. 2021, p. 59).

Current literature and the experiences of social workers in this study have established traumatic experiences regularly occur in social work practice. It is also clearly established in the literature that negative/traumatic experiences impact workers in areas of burnout, leaving jobs, mental health challenges like PTSD, anxiety, depression. However, a significant gap in practice remains in how employers support workers in how they process and mitigate challenges associated with traumatic experiences such as a client death. For the most part, this is still seen as an individual responsibility and the concept of 'self-care' is used to justify the responsibility social workers must take care of themselves in response to traumatic experiences at work. A quote by Naomi Rachel, captures the essence of social workers who have experienced the death of a client and their experiences in the workplace: "the expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet." Social workers mentioned formal supports in their workplace which included clinical supervision, access to supervisor under the 'open door policy', critical incident team debriefing, EFAP benefits, as supports provided in the event of traumatic and stressful situations. Literature evaluating clinical supervision in the workplace suggests supervision is at the "core of practice for all health and social care professionals" which

promotes a “shared sense of responsibility for effectiveness and safety of practice” (Rothwell, Kehoe, Farook, 2021). However, for social workers in this study, many challenges in accessing formal support were discussed by participants. Some views ranged from not having regular and quality clinical supervision in the workplace, that supervisors from alternative clinical backgrounds to social work were less understanding or supportive, some reported an inability to feel safe or to trust a supervisor in disclosing feelings around stressful events where there may be a perception of blame assigned, or that supervision in the workplace focused on case management supervision not accounting for emotional considerations of workers. Rothwell, Kehoe, Farook (2021) provide insight into clinical supervision. Consistent with this research is their analysis of some of the perceived barriers to clinical supervision: lack of time and heavy workloads, lack of staffing, lack of management/organizational support, lack of supervisor training, lack of understanding and support, lack of support when dealing with supervision from another discipline, and lack of relationship and trust with supervisor. In this regard, challenges and barriers to clinical support should be addressed to better support the well-being of social workers and improve staff retention, job satisfaction, and delivery of services.

Many of the participants in this study described aspects of support they receive on the job: some reported that employers “do the best they can” or “my manager understands but kept hitting the roof with higher management”, and others were openly dissatisfied with workplace support, and others relied on informal support networks on personal time. Those within Indigenous agencies reported support coming from a shared sense of community at work, built in cultural-spiritual based supports in the workplace, and more comprehensive benefit packages.

Participants almost unanimously felt employers were ingenuine and frequently adopt a ‘lip service’ attitude regarding the processing of a death of a client by encouraging workers to

"engage in self-care" or attend counselling while barriers to accessing mental health supports remain high. However, those employed by Indigenous agencies and those who had previous work experience within Indigenous agency/community reported there were more formal supports, which includes spiritual and culturally based supports implemented by the employer. Spiritual and cultural supports were reportedly perceived as much needed and helpful supports in the context of a client dying.

Almost all participants mentioned they have experienced a lack of formal mental health supports and benefits from their employers. A lack of mental health supports include minimal to no counselling benefits, low pay to be able to afford out of pocket expenses for private counselling, and even a lack of short-term disability policy. One of the ways that worker well-being is taken seriously and viewed as important in the workplace is to have employment benefits. In this research, participants almost unanimously spoke about feeling under-appreciated, under paid, and reported dissatisfaction with a lack of quality employment benefits. One participant from a health authority reported her employer does not offer short term disability if workers are sick and require time away from work. In these cases, social workers are expected to either come to work sick, take unpaid leave, or rely on limited banked time. Others noted a sick day would cover up to 80% of their salary. Adams (2019) noted the evidence for the effectiveness of workplace wellness and health-promotion programs is growing within the literature and noted several proven actions an employer can take to increase employee well-being. Some of the notable strategies include adequate paid leave (Asfaw, Bushnell, & Ray, 2010), increased wages (McLellan, 2017), greater autonomy, flexibility, and control over job tasks (Joyce, Pabayo, Critchley, et al., 2010), improvements to the way positions are structured, and access to healthcare coverage. Furthermore, aside from increasing salary and covered

counselling services, participant reports placed a high value on benefits that would be fairly low cost for employers such as flexible hours, increased work/life balance, and a work from home option.

Participants reported mixed reactions to working conditions during the height of the Covid-19 pandemic. Some reported feeling more satisfied with working conditions given that public health mandates forced those employed to work from home which allowed for a better work/life balance, and more flexibility in their personal life and work position. These participants reported having a strong reaction to witnessing large scale organizations drastically change policy as directed by the provincial health officer from pandemic necessity, leaving some with feelings of resentment toward their employer for not listening to employee voices and requests about improving work conditions. Others experienced significant challenges resulting from the public health mandates and held strong reactions to having their routine changed. For example, some experienced feelings of loneliness and isolation, diminished sense of purpose, mental health challenges experienced during the pandemic and significant disruption in cultural and spiritual practices for those part of Indigenous communities.

Social workers in this study perceived informal support as most helpful in dealing with stress resulting from the unanticipated death of a client. Informal support in this case includes access to positive peer relationships in the office or work team, informal personal networks of support like friends and family, and culturally based supports (formal) that may be accessed in an informal way.

Social workers noted peer relationships supported coping and processing the experience of unanticipated client death as it was easier to meet and speak with a colleague than a supervisor, it is more supportive, less fear of judgement, blame, or being dismissed, and a greater

chance a client was known by a peer. Some social workers noted that informal support with peers was not available in certain work environments or was not available consistently. These participants did not feel informal relationships were available (no relationships present), accessible (no time during work), and that team environments were "toxic." A few participants noted difficulties in being able to create and build informal relationships with peers on their own time and noted fear of burdening a peer with emotional work.

Workers from Indigenous agencies in this study reported hosting team-building exercises through use of cultural and spiritual activities to foster a sense of connection and community among staff while also serving a purpose (harvesting, making medicines).

Social workers reported that informal peer relationships with colleagues allowed for discussion and debriefing of stressful events in a way that is safe and supportive, lessening fear of reprimand than with management. Many social workers here noted feeling accepted by peers and that colleagues are more approachable than management. Consistent with the literature, informal modes of support and general social connections have shown that these relationships are essential in the well-being and coping of people as well as a basic human need (Winslow, Sabat, Anderson, et al. 2019). Basford and Offerman (2012) highlight how social relationships in the workplace are important for well-being and performance-related outcomes. In this research informal and positive peer connections helped social workers in the face of stressful events such as the unanticipated death of a client. However, this is a relatively under studied area in the social work literature as informal relationships tend to be categorized as supervision in social work rather than professional peer relationships without an element of authoritative power over them (Bryksa, 2020).

One team leader and one director of an agency participated in this study. These individuals did not speak to difficulties or expressed dissatisfaction with supports in the workplace. The participants in this study commonly noted that informal support (from peers who understood the circumstances or also knew the individual) were perceived as most helpful but not always available or possible to have for several reasons including having no authentic relationships with peers. Formal support or involvement of the employer for almost all the participants was frequently viewed as unauthentic, ingenuine, and just another task or box a manager needed to fill for legal purposes. Many participants also noted a lack of consistent and quality clinical supervision.

The findings in this study support the idea that informal and formal workplace supports for social workers should be incorporated into practice. These findings advocate for the support of alternative and generous employee benefits for social workers who regularly deal with traumas and other challenging situations. Supports should be not only offered to social workers but be social work led, ongoing, and authentically facilitated or encouraged by management/employer.

Limitations of the Study

This research focuses on and represents social workers within the province of British Columbia, Canada. According to the British Columbia College of Social Workers (BCCSW) there are just over 4500 registered Social Workers in the province (BCCSW, 2020) and it is unknown how many non-registered social workers are currently in the province. One limitation of this study is the reliance on a small sample which may not be generalizable to population patterns across Canada. Future qualitative studies could incorporate a larger sample size and could provide detailed information about demographics specific to where and how social

workers practice in other areas of the country. A second limitation may be the design of this qualitative inquiry, which assumes and relies on spoken language as a tool that allows people to fully capture their lived experiences (Noon, 2016; Willig, 2013). This assumption eliminates those who struggle with the use of spoken language or recalling detailed information and feelings from the past. Regarding the topic, grief and meaning reconstruction processes either in the past or currently, may affect how an individual recalls the experience when asked (Jacobson et al., 2004, p. 244; Sanders et al., 2005, p. 214; Silverthorne 2005, p. 60). As this study design relies on rich and detailed interviews from participants, those who do not provide significant detail outlining their experience risk providing unsubstantial data to analyze. A third limitation is related to the broad nature of the participant sample. It is speculated that there may be a difference in how rural and urban communities may experience client death. Smaller communities may be closer knit, have different cultural beliefs, values and practices around death, and limited access to formal mental health and counselling support. Exploring these smaller communities in detail would be a valuable topic for future studies.

Regardless of the potential limitations, the object of a master's level inquiry is to unpack the lived experiences of the participants and increase understanding of the phenomenon of unanticipated client death and the meaning-making processes of social workers. The readers of this research may be able to link findings to the existing literature, and to their own personal and professional contexts.

Recommendations

This section highlights specific recommendations from the study. The purpose is to offer suggestions on how the findings can be implemented across social work education, practice, and policy development. Social workers who participated in this research revealed several potential

recommendations. Most notable were areas for development in workplace policy for the health and well-being of social workers and the development of spirituality in social work education.

1. It is suggested that organizations and members of management/decision makers increase both formal and informal methods of support for social workers. This includes access to regular and quality clinical supervision by either a third party or by someone who does not hold 'power over' social work staff participating in clinical supervision. This recommendation stems from participants who described feeling emotional unsafe, a discomfort in disclosing feelings around the experience of a client death with current supervisors in instances where support or consistent clinical supervision was not provided. It was also noted that workplaces did not allow space and time for reflection and meaning making processing in the workplace for reasons stemming from high workloads and a lack of recognition that experiences of client death are significant. Additionally, offering spiritual support, or spiritual activities, or including spiritual values in clinical supervision could be worthwhile. For example, Indigenous agencies reported having regular access to elders and cultural knowledge in addition to or in combination with clinical supervision. Social workers commonly noted that they routinely struggle with challenging and high caseloads, potential liability issues in practice, and frequent overtime. These factors, combined with low levels of professional support, are less-than-ideal for meaning-making to be processed and integrated. Almost universally, participants described zero to very limited supports through their employment benefits. More significantly, mental health counselling coverage, specific types of counselling such as grief and trauma informed counselling, a limited amount of paid sick days, and short-term disability would be welcome supports.

2. Another recommendation includes the formal education and ongoing professional development of social workers. In line with the findings of this study, it was revealed that almost all social workers, except for one, had no formal training about the use of spirituality in social work practice. This leads to the recommendation in providing ongoing professional development training for practicing social workers. Although many participants in this research discussed a strong personal significance to spirituality and many considered themselves to be "spiritual", many had difficulty describing how they incorporated spirituality into practice, described feeling unsupported by the workplace in their process of integrating spiritual concepts into practice, or were generally unsure how to engage clients in spiritually informed work. Other exceptions here were those from Indigenous agencies and those who identified as Indigenous. These participants discussed solid efforts to combine spirituality from a cultural perspective into practice and were required by the agency to initiate these efforts.

3. A third recommendation supports a move away from top-down decision-making and restrictive management styles. Many participants perceived upper management and leadership as being far removed from the frontline sector which encouraged workplace policies that "lack common sense" and either made social workers job more challenging to navigate or added to existing workloads. Participants also felt that a significant portion of their practice was navigating barriers in 'the system' or barriers in the workplace as the result of challenging policy procedures. Participants noted how the Covid-19 pandemic influenced policy and it became clear that large scale organizations and government agencies can alter policy quickly under the circumstances but not when it came to the best interests of staff. For example, multiple social work participants noted that pandemic conditions allowed for a better work-life balance, allowing many social workers to work from home, engage in self-care activities, and

subsequently increase productivity.

4. The final recommendation is regarding informal workplace supports. Participants in this study noted that informal supports were more supportive, easier to access, and offered more perceived benefits like job satisfaction and larger support network. Participants noted there were times where certain workplaces did not encourage or prioritize team-building activities among staff, which hindered ability to develop collegial relationships. Additional factors in the workplace such as high caseloads and high turnover of staff also impacted opportunities for relationships to form. More notable, social workers from Indigenous agencies in this study incorporated spirituality, culture, and tradition into team-building work.

Social workers who participated in this research offered many insights into their experience of unanticipated client death. They gave several recommendations that can be implemented across education and training, practice, and policy development.

Chapter Six: Summary

The spiritual meaning of the reconstruction process of ten social workers who have experienced the unanticipated death of a client(s), in British Columbia, Canada, were explored and discussed in this study. These findings do not necessarily represent the views and experiences of all social workers, given that values, belief systems, spirituality, coping styles, and general life experiences are unique and subjective. A qualitative inquiry provides a way to gain a better understanding of this type of frequent experience in an under studied population. The aim of, and arguably a strength of qualitative research is not to generalize the findings but to acquire transferability (Creswell & Poth, 2018). It will allow for a better understanding how social workers experience, process, and make sense of the unanticipated death of a client. Insights gained from this research can be used to inform and develop policy for agencies which social workers are employed to support mental health and burnout, as well as subsequently informing service user's experience and quality of care received from helping professions. A consistent finding from all participants in this study was the presence of spirituality in their personal lives, a deep respect and appreciation for Indigenous spirituality, a sense of meaning reconstruction regarding both spiritual aspects and a deeply flawed and complicated system of services under neoliberalism. A critique of existing systems issues was revealed through the data for the social workers in this study.

Participants across all work environments and positions reported experiencing multiple unanticipated deaths of clients. Participants described this experience as significant in their work context with instances being recounted or remembered from several years in the past suggesting a long-term impact. Spirituality has been an integral component in the lives of the participants, and many were able to reflect on how they have drawn on spirituality to process and reconstruct

meaning from significant events, guide healing in grief, and facilitate wellness. All participants described themselves as being spirituality in some way. Many participants described varying degrees of the use of spirituality in their work environment or past work environment, with Indigenous agencies being described as significantly more spiritually inclined and much more likely to promote the use of spirituality as an intervention or way of being with clients.

Participants noted non-Indigenous agencies as either completely ignoring the use of spirituality as an intervention/assessment tool or leaving it up to the individual social worker on duty to choose whether spirituality should/can be used in practice. Unanimously, participants noted that they were not taught about spirituality over the course of their social work education or how to use spirituality as an assessment/intervention tool in their practice with clients. It was noted by participants that spirituality is seen as necessary for certain populations such as work with Indigenous populations and some assumed Indigenous people may be more receptive to the use of spirituality in practice.

It can be said that spirituality played a role in how social workers processed and reconstructed meaning from the unanticipated death of a client. For some, spirituality was and is a significant way to cope with the world or is a concept deeply connected to familial values, sense of purpose, and a way to walk through this life 'in a good way'. Spiritual meaning was derived from personal spiritual values or in some cases an understanding of the deceased client's spirituality. Meaning was also created through an understanding that systems-based failures are present in our current social welfare system. Social workers are trained in social policy and are well versed to speak about limitations in our current systems and in this case, meaning was derived from system failures.

Participants discussed workplace policy and supports in the context of an unanticipated death of a client. Most participants described a lack of sufficient mental health supports and employee benefits across employers, various formal and informal supports in the workplace, and the importance of spiritual grief support primarily present within Indigenous agencies and culture. Most notable, participants discussed the perception of informal supports are generally more helpful and supportive in stressful circumstances such as when a client suddenly dies.

Suggestions for Future Research

The research areas of spirituality and social work have gained popularity in recent years, however, much of our understanding and willingness to incorporate these two areas remain understudied. Future research can be done regarding use of spirituality in social work practice considering spirituality in clinical social work is still an understudied topic in the literature. Future areas of research may consider how personal spirituality impacts the well-being of social workers in specialised areas of work as opposed to end-of-life or palliative care, how clinical social workers can incorporate spirituality into practice through spiritual assessments and interventions, the cognitive dissonance social workers may experience where their personal values do not align with their role under neoliberalist systems of care, and a more in-depth analysis evaluating the existing formal supports social workers receive in the workplace after critical incidents. Future research would be valuable in gaining more insight and knowledge into an area of social work that tends to be ignored.

Conclusion

In conclusion, the social workers who participated in this study were deeply impacted by the unanticipated deaths of clients. Research participants described a sense of personal

spirituality, often separate from religiosity, they reflected on their social work practice and how they incorporated or excluded spirituality into clinical practice, how they created meaning from an unanticipated death through both spiritual and systems-based meaning, and the perception of workplace supports and spiritual supports present across workplaces.

Social work participants who participated in this research provided additional discussion on the use of spirituality within social work practice. They spoke about personal spiritual values and practices, agency acceptance of spirituality in clinical practice, and spiritual supports within Indigenous agency/community.

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Appendices

Appendix A: Semi-Structured Interview Guide

These first questions are aimed to collect some demographic information about the participant.

1. Can you tell me your age?
2. How do you describe your sex/gender?
3. How do you describe your ethnicity/race?
4. What is your highest level of education achieved at this time?
5. Are you registered with the BCCSW?
6. How many years have you worked as a social worker?
7. Do you have experience working as a social worker in a rural, remote, or northern community?

These questions are generally aimed to gauge their social work experience and interview warm up.

8. Can you tell me about yourself and your experience working as a social worker?

   Prompts:

   -describe your position and role. What does a typical day look like?

   -how long have you been doing this role?

   -what has your experience been like?
9. What inspired you to pursue social work?
10. What motivates you to continue doing social work?

11. What aspects of social work do you enjoy the most and the least?
12. Can you describe a sense of fulfillment from your or from social work in general?

These questions are aimed to gauge their experience(s) of unanticipated client death.

13. Tell me about a time you lost a client suddenly and unexpectedly.
14. This next question is about meaning making and how you came to understand the death. Can you tell me how you made sense of this experience?

    Prompts:

    -how did you process your feelings and emotions?
15. can you provide some detail on how you coped with this experience and what strategies you used that helped or made things worse?
16. Have you lost multiple clients? Do you feel that multiple losses increase your capacity to understand this experience and how?
17. How do you feel now when thinking about the client death?
18. Can you describe how you acknowledged the loss?

    -did you have any opportunities to honour the deceased in any way?

    -can you describe any specific grief rituals?
19. Have you ever had someone die in your personal life? (e.g., a family member/friend). If yes, think of that time this happened and recall how you felt. Now, reflect on a time when you experienced a loss of a client. - Now my question is - Do you think grief affects you differently when it is a client, versus a loss in your personal life? Did you grieve in similar ways, or can you note any differences?

-Can you tell me about how you were raised to think and feel about death, grief and loss?

20. Did the experience of client death impact your work or personal life? Elaborate.
21. Can you describe attitudes of grief in your workplace? Did you ever feel like your feelings around the death were unwelcome or unaccepted?
22. Do you feel you became more resilient after the experience of client death?
23. Do you feel that your social work education prepared you for grief and loss at work?

These questions are aimed to explore impacts of working during the Covid-19 Pandemic.

24. Did you keep working during the pandemic? Have you experienced any losses related to work during the pandemic?
25. Have you observed any changes in yourself living/working going through the pandemic?
26. What were some of the most challenging aspects of your work during the pandemic?

These questions are aimed to explore the concept of self-care.

27. Can you describe what self-care means for you? Describe what your self-care plan includes.
28. Can you describe how your workplace/employer supports your self-care and wellness?
29. Are these workplace supports helpful?

These questions are to address understanding of ones' spirituality.

30. Can you describe what spirituality means to you?
31. Can you describe how your workplace incorporates spirituality or spiritual elements?

32. Can you discuss any early memories of spiritual practices or experiences from your life?
33. Describe how your own spirituality connects with clients/patients?
34. Did you understand deceased clients' spirituality?
35. Has client spirituality ever influenced your own beliefs?

Final questions to wrap up the interview.

36. What are your future hopes for organizations to provide for workers who experience the event of unanticipated client death?
37. Is there anything else you want to share that I haven't asked?
38. Do you want to use a meaningful pseudonym in this research?
39. Is there any data you want excluded from the interview transcript, at this time?

Appendix B: Participant Information and Consent Form

January 31, 2022

Information Letter/Consent Form

Project Title: Exploring social workers' spiritual meaning of their reconstruction processes after the unanticipated death of a client(s).

Who is conducting the study?

Principal researcher name: Stefani Kolochuk

Program/Department/School: Master of Social Work, School of Social Work

University of Northern British Columbia

Prince George, BC V2N 4Z9

Email address: kolochuk@unbc.ca

Cell: 204-296-8782

Supervisor's name and position: Dr. Indrani Margolin

Email address: indrani.margolin@unbc.ca

This research is for the fulfillment of a Master of Social Work degree and the information gathered in this study will be published in my thesis. The information you provide will be

included as part of this research, providing consent is obtained. This information may be used to inform professionals, policy, and confirm and build upon existing research demonstrating how client death can affect social workers and how they are able to make sense of this event. This information may also be used beyond the thesis project to write papers published in scientific journals, presented at conferences, or shared with other social workers, healthcare professionals or other colleagues. Only the primary researcher and supervisor will have access to the raw data provided through the transcribed participant interviews and any given demographic information. The raw data will only be used and stored for the duration of the thesis research and up to 1 year after the thesis defense, after which all raw data will be securely disposed.

Project Sponsor

This study is self-funded and any/all costs will be covered by the primary researcher.

Purpose of Project

The purpose of this study is to explore social workers' spiritual meaning of their reconstruction processes after experiencing the unanticipated death of a client(s). With this inquiry, I seek to understand how social worker's draw from spiritually based personal resources in the context of bereavement from a clients' death. The experience of having a client die can be stressful and research has highlighted that the experience may lead to complications such as secondary trauma, compassion fatigue, and burnout among social workers. These complications may also thrust someone into spiritual or existential crisis. The concept of Meaning-making through spirituality or existentialism has a significant research base in the bereavement literature and it acts to help individuals cope with loss, as well as develop their own spiritual systems and ways of thinking. The aim of this study is to unpack some of these complex and sometimes traumatic experiences and explore how different meaning is cultivated in the face of grief that

goes largely unnoticed or disenfranchised in the profession. Understanding more about this phenomenon from a social worker's perspective can improve how people understand disenfranchised grief, traumatic stress reactions, treatments, and support within agencies, how beliefs and worldviews shape our recovery and how people are educated about death, grief, and loss in social work education.

You are being invited to participate in this study to explore your experiences on this topic. Learning about social workers' experiences of unanticipated client death and their meaning-making processes can work to provoke questions among readers and those in the profession of helping others. Given our current experience of living and working during a global pandemic, which may exacerbate the experience of sudden and unanticipated losses, questions about COVID-19 will be asked during the interview and responses to all questions are optional. It is my goal with this research to explore with you your personal experience of loss and disenfranchised grief, an area that is under researched and not well understood. This discussion may also lead to a reduction in stigma around client death, open more educational conversations about the taboo subject of death, increase awareness of potential resources and support to draw from during this period. I invite you to join me on our journey of exploration, questioning and conversation about this topic. Sharing your experiences of having a client/patient die suddenly can be traumatic, complicated and affect our personal and professional lives. It can even lead to mental health challenges and a loss of identity or faith in the world. Participation in this study is entirely voluntary. You are in no way obligated to participate in this research or answer any questions that make you feel uncomfortable. You are free to withdraw from this study at any time.

What Will Happen During the Project?

If you agree to participate, you will attend a one-on-one interview via zoom about your experience with suddenly losing a client through death and your meaning-making process after this event. We will meet through Zoom, at a time that is convenient for you. Our interview will take approximately one hour. The interview will be audio-recorded from Zoom onto my personal laptop (which is password protected), then transcribed. I will email the transcript to your preferred email address via my professional UNBC email address, and you will be asked to confirm your preferred email address in the consent form. I will ask you to review the transcript within 7 days of it being transcribed and ensure what is written reflects what you would like to say. Sharing of the data between researcher and participant will be done using Sync file sharing (also recommended by UNBC's IT Security SharePoint site) which is password protected and secure. Using Sync file transfer allows for double ended encryption for the protection of your information and is password protected. You will be provided with further instruction for entering a password to access the Sync platform via separate communication on a different medium such as phone or text. Should a participant not respond, and the 7-day mark has passed, we will use data from the original transcript to write the final report. We estimate that your role as a participant will take approximately two hours total which includes the interview length and member checking the transcript review. Your participation will be kept confidential, and confidentiality will be maintained using a pseudonym you choose. Data from all participants will be combined and your name or any other identifying information will not be published or shared. When the study is complete, I would be happy to share the findings with you. I will email you a link to a summary of the findings and/or the final thesis once it is complete.

Risks or Benefits to Participating in the Project

We do not think there is anything in this study that could seriously harm you. Some of the

questions we ask might upset you and cause some emotional discomfort. Some of the questions specifically ask about the impacts of COVID-19. We recognize the sensitive nature of these questions, and you can opt out of these questions, if you wish. This research may pose social and legal risks which need to be mentioned and should be considered here. The legal risks or impacts of participating in the study would include anything shared with the researcher that falls under the duty to report. These concerns would include a child being abused or neglected or otherwise in need of protection or if a participant is a danger to themselves or others. In these cases, the duty to report will overturn confidentiality only under these specific instances. The social risks or impacts of participating in this study, would be if a participant is identified. To mitigate this risk, we cover the limits of confidentiality in this letter.

Please let me know if you have any concerns. If, at any point in the study, you feel uncomfortable or upset and wish to end your participation, please notify the researcher immediately and your wishes will be respected. A list of available mental health crisis line supports is included for participants, should they wish to access mental health support after engaging in this study. By taking part in this study, it may provide you with an opportunity to discuss a sensitive topic that is rarely openly discussed. In the future, others may benefit from what we learn in this study by informing policy and practice domains.

Confidentiality, Anonymity and Data Storage

Your confidentiality will be respected. The information you provide in the demographic data form may help us to better understand our sample of participants and whether we can generalize findings across the target population. Subjects will not be identified by name in any reports of the completed study. Only the primary researcher, supervisor and research committee

will have limited access to the data you provide. The data will only be used and stored for the duration of the thesis research and will be up to 1 year, after which it will be securely disposed.

In response to the COVID-19 pandemic, and using Zoom to replace in-person meetings, we will be following the UNBC Zoom Best Practices for security of the data and upholding your confidentiality to strict standards. The UNBC Zoom license will be used which provides enhanced security and protection of your data. The following Best Practices for Zoom use will be followed: Passcodes will be used on all meetings; the zoom link will not be shared publicly, and you will be required to be authenticated to join meetings and chat functions will be disabled; This study requires interviews to be recorded and then transcribed. UNBC has enabled cloud recording to do this safely and securely. The recordings will not be shared, edited, or seen by anyone other than the primary researcher and participant. The information will be digitally recorded through Zoom and stored in the UNBC Zoom Cloud and downloaded onto my personal laptop (which is password protected) and will be kept in a locked file in my home office, where only I have access to the locked space. There are certain privacy risks associated with recording activities with Zoom, however, the value of recording for this study has been determined to outweigh the risks by the research team. You will be required to provide verbal consent for the action of recording the interview. All recordings will be deleted after they are transcribed (in the 48 hours after the interview) or up to 1 year after they have been recorded via the UNBC Zoom recording procedures.

Compensation

There is no financial compensation for participating in this study. You will be given a small honorarium in the form of a gift card for your time as it is highly appreciated and respected.

Study Results

The final results of this study will be presented in a graduate thesis and may also be published in journal articles and conferences. The participants may want to receive a summary report of the research outcomes, and this will be provided by the primary researcher. An invitation to receive the final thesis is also an option.

Questions, Concerns or Complaints about the project

Should you have any questions about participating in the study, please contact me directly to further discuss this project. I can be reached at (204) 296-8782 and kolochuk@unbc.ca. You may also speak with my supervisor, Dr. Indrani Margolin at indrani.margolin@unbc.ca.

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the UNBC Office of Research at 250-960-6735 or by e-mail at reb@unbc.ca.

Participant Consent and Withdrawal

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative consequences.

Please circle or check YES or NO.

I have read or been described the information presented in the information letter about the project:

YES NO

I have had the opportunity to ask questions about my involvement in this project and to receive additional details I requested.

YES NO

I understand that if I agree to participate in this project, I may withdraw from the project at any time up until the report completion, with no consequences of any kind.

YES NO

I have been given a copy of this form.

YES NO

I agree to have my interview audio recorded.

YES NO

Signature to consent to participate in this study

(**and note of verbal consent over zoom**):

_____

Name of Participant (Printed):

_____

Date:

_____

Follow-up information (e.g., transcription) can be sent to me at the following e-mail:

(Please print preferred email address) _____

Appendix D: Mental Health Resources for Participants

Free Mental Health Services. The following crisis support services are available should you require any assistance:

Contact:

Anywhere in BC 1-800-SUICIDE: 1-800-784-2433 (24 hours a day, 7 days a week)

Mental Health Support Line: (no area code) 310-6789 (24/7)

Vancouver Coastal Regional Distress Line: 604-872-3311

Sunshine Coast/Sea to Sky: 1-866-661-3311

Seniors Distress Line: 604-872-1234

Online Chat Service for Adults: www.CrisisCentreChat.ca (Noon to 1am)

KUU-US Crisis Line Society provides a First Nations and Indigenous specific crisis line available 24 hours a day, 7 days a week, toll-free from anywhere in British Columbia. KUU-US Crisis Line can be reached toll-free at 1-800-588-8717. Alternatively, individuals can call direct into the Adult Line at 250-723-4050.

First Nations and Inuit Hope for Wellness Help Line. Service is available in Cree, Ojibway, Inuktitut, English and French. Callers may ask about the availability of services in the language of their choice. 1-855-242-3310 or 1-855-242-3310 (Crisis Line).

Appendix C: Participant Recruitment Poster

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

School of Social Work, University of Northern British Columbia

Exploring Social Workers' Spiritual Meaning Reconstruction Processes After the Unanticipated Death of a Client(s)

Client death impacts many different fields of social work practice. How professionals process this aspect of practice is important in understanding the implications client loss has on this field. Research has highlighted that this experience can be stressful and may lead to complications such as secondary trauma, compassion fatigue, and burnout among social workers. These complications may also thrust someone into spiritual or existential crisis. The concept of Meaning-making through spirituality or existentialism has a significant research base in the bereavement literature and it acts to help individuals cope with loss, as well as develop their own spiritual systems and ways of thinking.

The aim of this study is to unpack some of these complex and sometimes traumatic experiences and explore how different meaning is cultivated in the face of grief that goes largely unnoticed or disenfranchised in the profession.

What is involved: Participation will involve a short demographic questionnaire and an interview via Zoom. At the end of the study, you will receive a summary report of the research findings. This study may reveal information that could lead to a greater understanding of this phenomenon, enhance therapeutic bereavement methods, and facilitate conversations and reduce stigma of death and dying in a death denying society. Questions regarding the impact of COVID-19 will be discussed in the interview.

What we are looking for: We will recruit between 6-12 participants for this study. Participants will be selected on a first come first serve basis for the study intake. If we cannot accommodate an interview spot you will be notified.

Purpose:

To explore your lived experience with the sudden, unanticipated death of a client(s) and how you created meaning from this event.
**This is a student research project to meet the requirements for a MSW degree.*

Participant Eligibility:

- Must have a BSW, MSW degree or RSW in B.C.
- Have practiced in British Columbia for at least two years
- Self-identify as having the experience of unanticipated death of a client(s)
- Must be comfortable reflecting and sharing lived experience of death

If interested or for more information, please contact primary researcher:
Stefani Kolochuk

Phone: 204-296-8782
Email: kolochuk@unbc.ca

[E2021.1124.063.00; reb@unbc.ca]

3333 University Way | Prince George BC, Canada | V2N 4Z9 | unbc.ca

Appendix D: Recruitment Email to Organizations

Dear Reader:

I am a MSW student at the University of Northern British Columbia (UNBC) and I am actively recruiting participants for my thesis research exploring social workers' meaning-making processes after experiencing the unanticipated death of a client(s). I would like to ask that the recruitment poster be distributed to all social work contacts as they may wish to participant in this study.

This study focuses on social workers in British Columbia, across areas of specialization. The participant eligibility is as follows: one must currently have a BSW, MSW or hold the active title of RSW in B. C., must self-identify as having the experience of an unanticipated (sudden and unexpected) death of a client or multiple clients, and must be comfortable reflecting on and sharing the lived experience of client death during the interview process. Participant interviews will take place via Zoom and will take approximately 1.5 hours. Please see the recruitment poster and participant information letter for more detailed information regarding what is being asked of you and what your role as a participant will include.

Alternatively, if you have any questions or comments related to this study or what is expected of you as a participant, please do not hesitate to contact me and I would be happy to speak with you directly.

Appendix E: Research Ethics Board Approval

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Stefani Kolochuk
CC: Indrani Margolin

From: Davina Banner-Lukaris, Chair
Research Ethics Board

Date: January 28, 2022

Re: **E2021.1124.063.00**
Exploring social workers' spiritual meaning reconstruction processes after the unanticipated death of a client(s)

Thank you for submitting revisions to the Research Ethics Board (REB) regarding the above-noted proposal. Your revisions have been approved.

We are pleased to issue approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the REB.

During the COVID-19 pandemic, no *in-person* interactions with participants are permitted without an approved Safe Research Plan and the protocol mitigations for COVID-19 being submitted as an amendment and approved by the REB. Please refer to the Chair Bulletins found on the REB webpage for further details. If questions remain, please do not hesitate to email reb@unbc.ca.

Good luck with your research.

Sincerely,

Dr. Davina Banner-Lukaris
Chair, Research Ethics Board

3333 University Way, Prince George, BC, V2N 4Z9, Telephone (250) 960-6735

Appendix G: Certificate for TCPS 2: CORE

PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

stefani kolochuk

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **16 January, 2020**