HOW HOMELESS SECTOR WORKERS DEAL WITH THE DEATH OF SERVICE USERS: A GROUNDED THEORY STUDY

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Homeless sector workers often encounter the deaths of service users. A modified grounded theory methodology project was used to explore how workers make sense of, respond to, and cope with sudden death. In-depth interviews were undertaken with 16 paid homeless sector workers who had experienced the death of someone with whom they worked. Transcripts of interviews and field notes were analyzed using the constant comparative method and a theory that described the positive framing of death emerged. Dealing with death and trauma is not something that most workers expect when they begin work but exposure to the death of a service user heightens expectations that other service users may be harmed. How workers cope or positively frame death depends on several interlinked processes. These include how the death is encountered; how the worker and others mark the death; and the extent that the vulnerability of self, peers, and service users is recognized and responded to. Successfully framing death enables the worker to continue working in the sector whilst maintaining enthusiasm for the work and compassion for service users.

Homeless populations around the world have been found to have much higher rates of both morbidity and mortality relative to those who are securely housed. Homeless people tend to have high rates of alcohol and drug dependence and associated

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problems, communicable diseases, psychiatric disorders, and exposure to violence and trauma (Kushel, Evans, Perry, Robertson, & Moss, 2003; Schanzer, Dominguez, Shrout, & Caton, 2007). Rates of suicidal thoughts and suicide attempts have also been found to be exceptionally high, with some surveys finding rates 10 times higher than the general population (Desai, Liu-Mares, Dausey, & Rosenheck, 2003; Fitzpatrick, Irwin, Lagory, & Ritchey, 2007; Haw, Hawton, & Casey, 2006). Research has consistently found that homeless or marginally housed individuals 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 the domiciled population (Cheung & Hwang, 2004; Haw et al., 2006; Hwang, Orav, O'Connell, Lebow, & Brennan, 1997; 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 the course of their work.

Exposure to death in the workplace has been found to be highly traumatic for workers (Kinder & Cooper, 2009) and people who help survivors may themselves be traumatized in the process (Sabin-Farrell & Turpin, 2003). Some groups, such as emergency personnel, are regularly exposed to mutilation, death, human suffering, and pain. The impact of exposure to trauma and sudden death on health professionals and emergency workers has been explored particularly in relation to "emotional labor," that is, dealing with the strong emotions of self and others (Stayt, 2009), stress and coping (Alexander & Klein, 2009), and posttraumatic stress responses (Jonsson & Segesten, 2004). The experience of health professionals who care for the seriously ill, dying, and bereaved has been the subject of extensive study (see Papadatou, 2000), but the experiences of welfare workers and non-health professionals have received little attention.

Homeless sector workers may respond to trauma and sudden death of service users differently to other occupational groups because of the nature of their work and the people whom they serve. Workers are less likely to share clear professional identities and role demarcations as people who work in hospitals or emergency services. They provide services to people who are often marginalized and excluded from mainstream society in situations that are fraught with risk. Their relationships with service users are

likely to be different (sometimes more intense and sometimes fleeting), and for some service users the homeless sector worker may be the most significant person in their lives as relationships with family, friends, or professionals may be tenuous or strained. Some workers, such as those who work in street outreach or in shelters in which drug or alcohol intoxication of service users is tolerated, are exposed to exceptionally high levels of risk and uncertainty. How front-line homeless sector workers experience and deal with the deaths of people whom they are charged with helping is the topic of exploration.

Local Context

There are at least 250 agencies delivering services to homeless people in Dublin. Some, such as emergency shelters, work exclusively with people deemed to be homeless whereas others, such as alcohol and drug treatment agencies, serve a broader population. Services may be considered on a continuum (from low to high threshold). *Low-threshold services* are those that have few if any conditions associated with access and tend to be available to whoever needs them. These include street outreach services, emergency shelters, needle exchange programs, sexual health services, soup kitchens, and homeless drop-in services. *High-threshold services* tend to serve fewer people and have conditions relating to access (e.g., requiring a referral from another agency or requiring adherence to rules such as abstaining from drugs or alcohol). These include residential alcohol and drug treatment facilities and longer term housing. Services may also involve varying degrees of intensity of involvement with homeless people. Intensive forms of case management and residential drug treatment tend to involve more intensive relationships with service users than drop-in services or those that provide a discrete service such as methadone dispensing. However, the strength of attachments between people in these various services is not solely a function of the threshold or intensity of the service provided (as shall be discussed later).

The Homeless Agency attempts to count the number of people sleeping in public spaces in Dublin City on a regular basis. Between 2007 and 2009 the minimum number counted (which is likely to considerably underestimate the actual number) has varied between 98 and 115 people on a given night (Homeless Agency,

2009). Many of these individuals are likely to episodically use one of the 15 emergency accommodation facilities in the city. Most of the 2,366 adults reported as homeless in Dublin in 2008 accessed emergency accommodation or were in longer term transitional accommodation (Homeless Agency, 2009).

Since 2006, the Homeless Agency has maintained a death notification policy that requires homeless services to report the death of a service user within the Dublin area. From January to December 2007, 53 deaths were reported (41 men and 12 women) aged between 26 and 59. These individuals were residing in homeless accommodation or were in recent contact with homeless services before their death (Homeless Agency, 2008). This suggests, and interviewees in this research confirmed, that workers in any of the homeless services are likely to encounter the death of a service user frequently. Detailed information on the causes of death is not publically available but it appears that the most common causes of death are related to alcohol use in men and drug overdose in women.

Methodology

The methodology used in this project was most closely aligned to classical grounded theory as first outlined by Glaser and Strauss (1967) and further elaborated by Glaser (1978, 1992, 1998, 2001). Glaser and Strauss argued for an increased emphasis on generation or discovery of theory derived from data in the social sciences rather than on the verification of "thought up" or logically deduced theories. An assumption of grounded theory is that human behavior is characterized by latent patterns or processes that grounded theory seeks to make visible and explain. Conceptualization rather than description is at the heart of grounded theory, which Glaser (2001) asserted transcends the descriptive in "its ability to generate 'wise' propositions that explain behavior in an area, especially its main concern, its ability to organize and make meaningful many seemingly disparate incidences" (p. 25). He goes further by asserting that grounded theory is concerned with the generation of concepts that are abstract in terms of time, place, and people. Corbin and Strauss (2008) take a softer line in relation to abstraction in grounded theory, suggesting that concepts devoid of context are "like jelly donuts devoid of jelly" (p. 306)

and that contextualization of concepts is necessary for readers to fully understand the research. The present project errs toward conceptual description rather than theory in places; so, as such it might be more properly described as a modified grounded theory.

Several related techniques, characteristic of grounded theory, were used in this project. A form of sampling called *theoretical sampling* (Glaser, 1998) involved allowing the emerging theory to guide where to go next, what data to collect or further review so as to arrive at the main concern of the participants as quickly and efficiently as possible. The constant comparative method of analysis involved processes of both coding and theoretical sampling. In-depth interviews with front-line homeless sector workers were the primary source of data. Numerous memos were made about the data, concepts, and properties (substantive codes) and their relationships to capture, track, preserve, and develop conceptual ideas (Glaser, 1998, p. 180). The aim was to analyze and code to generate an emergent set of categories (a higher level concept) and their properties. Sampling or data collection and analysis involved an iterative or near-constant process. From the outset, each indicator was compared to others, assigned a conceptual code, and then the indicator was compared to each concept. The data were revisited many times in order to elaborate, saturate, and verify the emerging categories (this is known as substantive coding).

Transcripts of interviews were subject to an initial, painstaking line-by-line coding in keeping with Glaser's (1978) recommendations. Subsequent coding was guided by theoretical sampling. Early coding produced mostly in-vivo codes, that is, derived from the language of participants (e.g., lighting a candle or paying respects). As these incidents were compared they gave rise to more conceptual in-vitro codes reflecting a higher level of conceptual abstraction (e.g., marking death). As these emerged, the entire pool of data was further reviewed for further examples of the concept and properties. Framing death and moving on, the overarching process and subordinate categories emerged from the data, rather than being forced by applying preconceived theories or ideas.

Ethical Considerations

The project received ethical approval from both the Dublin City University and James Cook University ethics committees. It was

recognized that discussing experiences associated with sudden death might be traumatic for people; so, a free and confidential consultation with a local counseling service was offered to interviewees. To the author's knowledge, no respondents availed themselves of this opportunity. The potential for retraumatization was reduced by the sensitivity of the interviewer who had a background in psychotherapy as well as mental health work in the homeless sector.

Recruitment and Interviewees

Homeless sector workers were recruited through an advertisement in a sector-wide newsletter and via information sheets left at various agencies. People then contacted the researcher directly for further information. Approximately 40 people made contact via e-mail or phone and discussed their experiences. Sixteen homeless sector workers were interviewed in depth at a place of their choice for between 40 and 120 min. Initially convenience and availability dictated who would be interviewed, but, later, theoretical sampling was used. The interviews commenced with the worker being invited to share any thoughts or observations about sudden death in the sector, and then usually one or more experiences were explored in depth. In keeping with the grounded theory methodology, no schedule of questions was used; rather, emerging themes in analysis guided choice of questions. The interviews were recorded and transcribed and approximately 100 detailed memos were made relating to interviews.

The ages of interviewees ranged from the late 20 s to mid-50 s and their experience working in the homeless sector ranged from 2 to 30+ years. A small number of interviewees identified a professional affiliation such as psychiatry or social work. The majority did not have a professional affiliation, although most had completed some university level education in areas such as addiction studies. Some were employed in low-threshold outreach capacities focusing on particular target groups such as those with HIV, sex workers, people sleeping in public spaces, or with alcohol problems. Others worked in supported accommodation including emergency shelters, high-support hostels for individuals or homeless families, and residential alcohol- and drug-treatment facilities involved in providing intensive therapy. All had experience

directly providing some kind of service to people who had subsequently died. Some had attended the funeral or had discovered the body of a service user on the day they were interviewed.

Results

The products of a grounded theory study are conceptual and ought to be of a higher level of abstraction than description. Nevertheless, in presenting the findings, some quotes from interviewees are used to illustrate concepts. The main concern of participants was to positively frame the death of service users and move on. This and associated processes are illustrated in Figure 1. Some participants were able to reflect on a completed process of framing death, whereas others were immersed in the process. The straight line in Figure 1 reflects work as usual, although homeless sector work takes place against a backdrop of expectation that harm may befall service users. Encounters with death always demand a response and a deviation from the usual rhythms and responsibilities of work. The processes of responding to death, marking death, and recognizing and responding to vulnerability are interlinked processes that bring people more closely in contact with the deceased (or the death encounter) and may be considered components of the core concern of workers to positively frame death. These are not necessarily linear processes (following one after
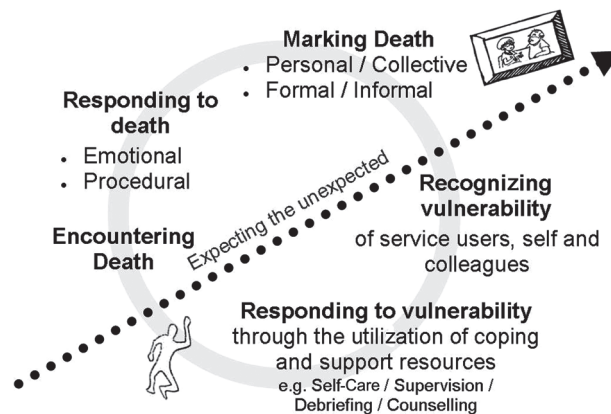
FIGURE 1 The process involved in positively framing the death of a service user.

another) but may occur simultaneously, have greater salience at particular points in time, and be returned to. Positively framing the life and death of the service user is both an end product of the aforementioned processes and a process in its own right. If successfully resolved, the worker is able to carry on their work, revisiting the framed picture at their leisure without being preoccupied or overly distressed by death.

Expecting the Unexpected

Even before workers directly encounter the death, they hold expectations about their work and the likelihood of harm befalling service users. The concept "expecting the unexpected" describes the paradox that homeless sector workers understand that service users are often at high risk of death, and when it occurs, it is almost always accompanied by shock. This realization of the vulnerability of service users to harm can come to workers quite abruptly. Rarely do workers commence employment expecting to encounter death, and seldom is this possibility discussed when people began employment or during their orientation to the workplace. Some people described a moment in which they realized that the people whom they worked with could not possibly sustain the levels of drinking, drug taking, or risky behavior without some serious consequences.

People who are homeless for long periods of time inevitably experience many losses. In long-term accommodation or care environments, some workers noted being initially surprised at how frequently and casually service users spoke of the deaths of friends, family, and acquaintances. In drug treatment environments these losses are not so often acknowledged, or there may be superficiality to discussions in which the impact of death and loss on oneself is not spoken of. Sudden death is the "ghost in the room" in many discussions with homeless people. The frequency of death and loss among some groups such as intravenous drug users can be very high. One experienced worker (Interviewee 6) recalled working with someone close to her own age and discussing a photograph of children taken in the 1950s. All of the acquaintances and family members had died in this photo leaving the service user the lone survivor. All had died from alcohol, drug use, or violent assault. In contrast to service users who had lost the

majority of their friends in some deprived areas, she noted that she had lost one personal friend in her life.

Exposure to the stories of service users and other staff and a recognition of the vulnerability of service users in a sense primes workers to expect and deal with death. However, when confronted by sudden death, people noted that it often was not who they expected or when. This illustrates the paradox of expecting the unexpected. Encountering death of a service user can in turn lead to a heightened sense of expectancy in the future, and if death is not worked through adequately or framed positively, a sense of futility may ensue.

Encountering Death

How death is encountered makes a substantial difference to how it can be dealt with. Whether the person witnessed or is present at death, how the body is discovered, and in what circumstances are dimensions of encountering death. In residential facilities, a terminal illness may be diagnosed, or the person may become acutely ill and is admitted to hospital. The homeless sector worker may observe the service user's deterioration and accompany the person to consultations with health professionals. The person may die in the hospital. To some extent, this expectancy of death attenuates the emotional impact of the person's death. Dying and death is medically contained, and the worker is in a similar position to those who may work in palliative care or aged care. The emotional labor of caring for the person is or ideally should be acknowledged by colleagues through gestures of support. The degree to which dying or suffering is witnessed is a property of encountering death.

Sudden, unexpected death, in contrast, is associated with more ambivalent and sometimes conflicted responses. Some kinds of death, such as those that occurred as a result of overdose, suicide, and homicide are particularly shocking. Homeless sector workers rarely see coroners' reports, and the actual cause of death (even whether the death is classified as suicide) often remains unclear for workers. People noted that opiate overdoses often occurred when people seemed to be doing well and perhaps had been abstinent for some time. The death of someone who appears to be doing well or improving, or the death of a child, can be particularly difficult. As one worker who had encountered many deaths

of young people commented, "sometimes there is no dignity in dying" (Interviewee 7).

The directness of the encounter with death varies as well. For some, the news can be broken in passing by service users or other workers face-to-face, over the phone, or formally through staff meetings or briefing sessions. Rarely, workers may be called at home by staff or emergency workers to assist in identification of the body. Sometimes, the worker may not hear of the death for some time, and there may be no opportunity to see the deceased. More direct encounters include discovering the body or being with the service user when the person dies. Discovering the body can be particularly difficult especially when there are signs of trauma or body fluids. Encountering the broken body is a more visceral, shocking experience, and some respondents spoke of experiencing intrusive recollections of the dead body.

Responding to Death

The initial reactions to encountering death vary as a function of the personal vulnerability of the worker, the relationship that the worker had with the service user, the worker's role in the agency, how the death was encountered, and how recently the death occurred. Workers need to respond according to the procedures laid out, and death also provokes a psychological response. Almost everyone spoke of being shocked or surprised and going into "autopilot" when discovering a body or first hearing the news of death. On encountering death, people took solace from following procedures (where they are clearly laid out). Minimally, this involved verifying whether the information received was true, such as in the case of a service user who was reported dead by another service user. When a worker discovers a body, procedures included securing the scene and then notifying police, ambulance, and the line manager. The police or ambulance personnel typically directed how the body needed to be handled from that point forward. Once the death had been officially confirmed, there is then a need to notify other staff, other service users as appropriate, and mobilize support for the other service users.

A common psychological response was to feel guilty and to project blame onto agencies that failed to intervene to protect service users. Workers generally appreciated that they could not and

did not intervene to save the person from harm or death but that in many cases more could have been done to help or protect them. The person was seen as responsible for the choices and actions, but rarely did respondents speak of being angry with the deceased. More often, people discussed being angry with services that were perceived to have failed the person who died in some way, such as failing to provide shelter, not trying hard enough to engage with the person, or not marking the death in a respectful way.

People described experiencing the full gamut of emotions around the death of service users, from little emotional response to being overwhelmed by grief. Strong emotional responses typically occurred days or weeks after encountering death when the initial shock or surprise subsided. Emotional responses were typically triggered by encountering an event that reminded them of the deceased or was particularly stressful. Workers may carry particular hopes or aspirations for service users that are shattered when the service user dies. For example, one worker with a lengthy history working in the sector and who stated that he was rarely emotionally affected by the work described having a professional relationship with a service user over several years:

> The social worker rang me up and said, "Oh, have you heard about [the person]?" And I said, "No." And, "Well he died last night in [the hospital]." And my immediate response was, thank goodness he didn't die alone, thank goodness he was surrounded by people who cared about him and he was in a place where he was getting care . . . The next day my colleague rang me on the way into work and he said, "Have you seen the paper?" . . . And there was a big article about [the person] who had died in a hospital in Dublin and died in the waiting room on his own. Now that kind of really upset me . . . the one thing I never wanted to happen for him was that he would die alone. (Interviewee 2)

In order to carry on with necessary work, and perhaps also to prevent one from being overwhelmed with emotion, several people spoke of putting their emotions, ambiguous or disturbing images, or thoughts and memories "in boxes" or "pushing them back." Although initially functional or helpful in maintaining equilibrium, most ultimately found that it was not helpful in the longer term. There was a need to experience rather than suppress thoughts and feelings. One person (Interviewee 9) stated she felt numbed as a consequence of attempting to put so many thoughts and feelings in boxes, and this was interspersed by emotions and

thoughts flooding unbidden through flashbacks (akin to post-traumatic stress responses).

Marking Death

Marking death serves a therapeutic function in that it helps people to experience emotions and is part of properly framing death. Marking death is undertaken in highly personal and private ways as well as collectively through formal mechanisms such as memorial services and funerals.

How death is marked or memorialized, collectively, is in part culturally determined. In Irish society, a "good turnout" at a funeral is recognized as a sign of respect for the deceased. Some workers (most notably those aligned to one of the professions) described making a conscious decision not to attend the funerals of service users. Others stated they do attend funerals or their decision to attend would be conditional on how well they knew the service user or their personal feelings towards the person. At least for some people, marking death with other people is an important means of closure.

People were aggrieved if they perceived that death was not marked respectfully, for example, when the death of a service user is announced at a team meeting and immediately followed by discussion of more mundane matters. Some people also felt disrespected if they were not given the choice to attend the funeral. However, attendance at funerals sometimes poses problems for homeless sector workers who may have had a highly sensitive role in relation to the deceased or if they were aware of behavior of the deceased that was highly shameful or stigmatizing. Out of respect for the family and the deceased, sometimes knowledge cannot be shared or processed at the funeral and needs to be dealt with through other means. For example, one worker spoke of attending a funeral and making herself known to the mother of the deceased:

> I felt really uncomfortable afterwards because I knew that he was up in the [park] selling himself and his mother didn't know that, I found that really difficult to have that information and this mother didn't know that about her son . . . I kind of struggled with that a little bit. (Interviewee 4)

Funerals can also sometimes be difficult when only a small number of people turn up or the attendees are only from the

homeless sector. The extent to which people have lived margina-lized lives is brought home to the worker, which can itself be trau-matizing rather than consoling. There may also be complications around the circumstances of a death that preclude the possibility of attendance at funerals by both other service users and workers. In one instance, a person's identity was unable to be confirmed, and no funeral arrangements could be made. A worker stated,

> So eventually I just organized [the memorial service] myself, and it was great, it was nice. It wasn't just for him, it was for all people but his name was mentioned and the residents loved it, it was very important for them . . . it gave some closure to it because up to then there was nothing, he died and that was it. (Interviewee 5)

In some agencies, workers arranged their own collective ways of marking and memorializing death outside of the traditional funeral such as convening a special group, planting a tree, or hav-ing a sing-along. People also spoke of small things that they person-ally did to mark death, for example, lighting a candle or spending a few moments in quiet reflection at some point during the working day. In Dublin, there are more communal means of memoralizing or remembering those whom have died. For example, some work-ers attend annual church memorial services dedicated to homeless people or victims of drug-related deaths. A publication entitled the *Brass Munkie* written by and for drug users routinely includes a remembrance page and stories about people who have died. This is read by both service users and workers.

Recognizing the Vulnerability of Service Users, Self, and Colleagues

Workers were acutely aware of the vulnerability of other service users in relation to the death of a friend or acquaintance, and this sensitivity is heightened immediately postbereavement. Many ser-vice users use self-destructive methods of coping and events, such as the death of a friend or acquaintance leave some people vulner-able to exacerbation of drinking, illicit drug use, or reckless beha-vior. Some respondents cited examples of dramatic breakdowns in the cohesion of therapeutic groups when a member of the group died. Workers took great care with how they broke the news of death to service users and facilitated opportunities for them to express their thoughts and feelings.

In well-functioning work teams the emotional vulnerabilities of colleagues are recognized. People may be particularly vulnerable because of past experiences, such as the suicide of a family member, miscarriage, personal bereavement, the accumulation of stress, or personal identification with a service user. All respondents described at least one relationship with someone who had died that they recalled was characterized by special bonds. These relationships could all be characterized as "professional," but the worker had a particularly warm relationship, held high hopes for, or worked particularly well with the service user. Astute and sensitive colleagues would recognize these bonds.

The deaths of service users can be wounding in different ways for different people. One worker commented that she found it easier to deal with the death of a friend or personal acquaintance because she "knew where to park it" (Interviewee 8) and it is clearer how one can and ought to respond. Encountering death can confront service users and workers alike with their own mortality. For the worker, the death of a service user may undermine professional confidence and sense of effectiveness, and people may be vulnerable to posttraumatic stress symptoms and professional burnout.

Responding to Vulnerability

People appreciated it when their vulnerability was recognized by others through a kind word, an inquiry as to their well-being, permission to leave work early, or an invitation to talk about how they were feeling. Some spoke of ringing up or making a point of contacting a worker whom they knew would be affected by the death of a particular service user. Some workers had established semiformal networks with people from other agencies who worked with particular service users. The frequency of meeting would be increased after a service user died, and these would take on a more supportive function.

A number of formal processes were available to people to assist them make sense of, learn from, and deal with the emotional impact and trauma of death. Most respondents had refused the offer of formal debriefing or counseling, at least initially, and worried that they might be perceived as "weak" or "unprofessional" if they immediately availed. Those who had experienced formal

debriefing, personal counseling, or supervision from someone not in a line-management position reported it as being immensely valuable to express and process ambiguous, irrational, and painful thoughts and feelings about the deceased person:

> At the debriefing . . . you can say what you want and you can allow yourself to be completely irrational and be angry about it, that is fine. It is important to vent, like everyone needs to vent, but you have to have a safe place to do it and I don't think internally is a safe place regardless of how brilliant the organization is, it is not safe. (Interviewee 5)

Some workers reported that similar needs were met through informal peer networks, although most of these workers acknowledged they felt lucky and such networks were not available to all.

Strategies to care for one's self were described by one as "critical" to enduring the traumas associated with front-line homeless sector work and particularly the deaths of service users. Some more experienced workers spoke about maintaining clear boundaries in their working relationships and between their working and home lives. Maintaining compassion, hope, and a friendly, optimistic, and professional demeanor is essential to effective work in the homeless sector, but it is helpful to make a clear distinction between being friendly and being friends and to make a demarcation between home life and professional life. Fostering a positive personal/home life helps in coping with the traumas of working life. People spoke of exercise, such as going to the gym, kick boxing, or walking, and various activities with loved ones as helping to "switch off" from work.

Personal counseling was of value to many people to help distinguish between the professional and personal problems, and supervision to prevent encroachment of work-related issues into people's personal lives. This is an ongoing struggle for many people who make a personal investment in helping others and often spend lengthy periods of time with people and come to know them well. Framing the death of a service user as a professional loss rather than a personal one enabled the worker to more easily continue in her or his role. If failings or blame is to be apportioned, framing the failure as a service/system or professional failing rather than a personal one at least enables the worker to begin to address service problems or weaknesses.

The importance of acknowledging successes (however small) in the job was highlighted as a self-care strategy, particularly useful to stave off a potential sense of futility and to maintain enthusiasm.

> What kind of compensates for the work that I do . . . are those joys that come along when you see somebody just finally getting to the point of being drug free and who starts making good decisions about their future . . . or families that are reunited because someone has got stable on methadone. (Interviewee 6)

Others had combined activities in their work that gave more immediate rewards with front-line outreach work. It may be unreasonable to expect most people to continually engage in low-threshold outreach work over a long period of time without some personal cost.

Positively Framing the Death of a Service User

Positively framing the death of a service user is both an ongoing cognitive process of sense making, and an outcome of the inter-linked processes of responding to death, marking death, and recognizing and responding to vulnerabilities. A positive frame enables people to continue working in their roles or with vulnerable populations with enthusiasm, optimism, and compassion. Positively framing the death of a service user entails both a general way of viewing oneself in relation to service users generally and to the deceased person specifically.

Workers who reported obtaining great satisfaction and enthusiasm for their work described particular ways of framing their work and their relationship to deceased service users. They tended to articulate an awareness and acceptance of the limitations of their power and role in relation to the deceased service user and service users generally (e.g., "You can only do as much as you can" [Interviewee 1]) and focus their attention on what assistance they can provide to others (e.g., "[T]here is nothing more I can do for that person now but the living still need looking after . . . It is an acceptance, this is part of life" [Interviewee 2]). These workers recognized that at best they could influence people toward making good decisions.

Positively framing the death of service users can involve acknowledging and holding on to a memory of work that has been

done well or contributions made by workers or services to the person's quality of life. One worker described how a former homeless man and heavy drinker was housed in transitional accommodation:

> He got the best service that we could possibly give him here, we kind of went above and beyond a lot of times...he was happy...he had his own apartment...he had his own pictures up in his own apartment. (Interviewee 3)

The traumatic and seemingly senseless deaths of some service users pose challenges to positively framing the person's death, making sense of their life and homeless sector work. When confronted by particularly traumatic experiences, a positive frame may involve a renewed commitment to justice, advocacy, or work in general so as to give meaning and significance to a person's death:

> There was one fellow who was shot dead.. Yeah I think something happened inside me when that happened because I really did get affected by that, definitely something kind of...It made me question, "Jesus, is this the job for me and is this what I want to do?" But in a way it has kind of pushed me harder to try even better or to try and stick with people and see how they are doing and things like that. (Interviewee 4)

Confronting death can challenge people's capacity to carry hope or continue to invest in others. The importance of maintaining hope for others was repeatedly highlighted:

> I think it is really important that people always keep the vision, no matter the circumstances, how awful it is for homeless people, or how awful it is for the drug users or the sex workers, that there is always a vision ahead that things can get better or things can change. (Interviewee 6)

When a service user dies, vulnerabilities of both self and others are laid bare. If these vulnerabilities not adequately attended to, or the experience processed, people may remain trapped in a cycle in which they continue to encounter the death through intrusive recollections and memories, or they remain hypervigilant and anxious that harm may befall other service users. In a sense the experience is poorly contained. In contrast, a successful response or outcome is a positive frame in which an image of a deceased person and the homeless sector worker is captured, contained, and preserved much like a picture frame on a

mantelpiece or wall assists in preserving and sustaining a memory. The frame enables the person to be remembered and revisited rather than details being suppressed or strong emotions spilling out unbidden. Many factors impinge on the process of framing the life and death of homeless service users, or to process the death in the way that people might when working in other capacities or with other populations. These processes enable people to keep working effectively in their work despite confronting trauma and death.

Discussion

How to establish the credibility of a grounded theory study has been well described in the literature (Charmaz, 2006; Corbin & Strauss, 2008; Glaser & Strauss, 1967). Glaser and Strauss (1967) suggested that a grounded theory should fit the phenomena, be understandable, and be sufficiently abstract to apply to a variety of contexts. The credibility of a grounded theory depends on "grab and fit," that is, whether the concepts make sense and fit with the data and the real world experience of the social actors involved.

These findings were presented to a diverse selection of homeless sector workers undertaking a course of study on case management in the homeless sector, and the expressed consensus was that the theory appeared to fit with their experiences and made sense. Diligence in the application of open coding, comparative analysis, memoing and theoretical sampling go some way to ensure that the theory generated fits the data.

The grounded theory in this study accords with findings relating to how other groups respond to death, but there are subtle differences relating to the role of worker and service user. The work of the homeless sector worker intersects with other social care and health workers. However, homeless people have been found to have particular concerns around dying, death, and end of life. These include fears of dying anonymously, alone, and without remembrance and a generally positive attitude toward developing advance directives or "living wills" (Song, Bartels, et al., 2007; Song, Ratner, et al., 2007). Although homeless people can experience a "good death," that is, an awareness, acceptance, and preparation for death (Beverley, Charles, & Margaret, 1995) by all those concerned, death is more likely to be unexpected

and traumatic. In research involving other groups, the mode of death has been found to make a difference to how people cope and grieve. Reed (1998) conducted a survey of survivors of sudden loss from suicide or accident and concluded that the mode of death and the availability of social support are important determinants of grief symptomology. Similarly, aspects of the way death was encountered in this study affected emotional response and how the death was ultimately framed.

The impact of caring for dying people by health professionals has been explored (Redinbaugh et al., 2003), and the process has been conceptualized as "grieving" (Papadatou, 2000). Although respondents in this study sometimes used the term *grief* (for want of a better word) to describe some feelings, the processes described were different from and broader than conventional understandings of grief and loss. Grief is understood to be triggered by losses such as personal bonds, valued relationships, the nonrealization of professional goals, realization of one's own mortality, and the emergence of past unaddressed losses (Papadatou, 2000). Workers do grieve in this sense, but how they do so is affected by the marginalized social position of the homeless person and indeed themselves as workers in the sector. Traditional rituals such as funerals help many people accept the reality of loss (Worden, 2001), but the homeless sector worker often cannot engage in such rituals in the same way as family members and others, rendering other ways of dealing with the experience of death more important.

The homeless service user typically inhabits the margins of society and for the most part is invisible except for the occasional intrusion into our collective consciousness through newspaper headlines or requests for spare change. The homeless sector workers (even those with conventional professional identities) are also to a large extent invisible and are relatively powerless to address or control the circumstances that lead people to be at risk of death. The homeless sector worker must sometimes confront the death of the service user that is colored by violence, gross injustice, and death with little dignity in which the worst fears of individuals are sometimes realized. It is hardly surprising that the experience of dealing with such issues is sometimes marginalized and dealing with the impact sometimes difficult.

Homeless workers also tend to have different relationships with service users that vary in attachment, intimacy, and role

expectations to those of other professional groups. Nevertheless, some of the concepts derived from this grounded theory have resonance with research undertaken with physicians, nurses, and others. Physicians who have found particular patient deaths to be emotionally powerful (and these have been categorized into good, overtreated, or shocking/unexpected death) have reported changes in their clinical behavior and career paths (Jackson et al., 2005). Medical doctors who cared for patients for longer periods of time reported stronger emotional reactions and were more vulnerable to feelings of loss (Redinbaugh et al., 2003). Those results are consistent with the present grounded theory, which suggests that the nature of the death encounter as well as the worker's identification with the deceased impacts on the response to the death and the process of framing death.

O'Hara, Harper, Chartrand, and Johnston (1996) examined the impact of death on a small cohort of nurses working in long-term hospital wards and found that they coped by sharing feelings, framing death positively, and framing their work as contributing to a good death. Those who were more affected by death tended to "take their stress home" and to consider their relationships with patients as more personal. Ekedahl and Wengström (2006) concluded that being careful about maintaining professional boundaries was an important strategy in coping with the deaths of patients by 15 nurses who worked in cancer care. Although homeless workers may have more difficulty in framing their work as contributing to a good death, they can frame their work with the person and others in positive terms. Making a "boundary demarcation" is similar to both the self-care strategies described by homeless sector workers (such as fostering a positive personal life) and the positive framing of their relationship with the deceased, which in some instances involved seeing the relationship as professional rather than personal.

There are some limitations inherent in this grounded theory. A grounded theory methodology may faithfully account for what is going on in a social field, but the resulting theory may not address what ought to be happening. For example, this theory holds that encountering death provokes a personal emotional response and demands a procedural response (as a worker). This theory falls short of determining what the optimal initial emotional response is (a concern that some participants had) or what the best

kind of policies or procedures are. Similarly, marking death in some way collectively and personally is helpful in terms of positively framing death. However, the theory does not reveal how one ought to mark death. The level of abstraction of this theory does not describe how the various subprocesses (expecting, encountering, responding, and marking death) contributes to positively framing death. It is possible, for example, that psychological theories relating to attribution may provide a different and useful account of the process. There are also limits to the extent that each concept can be explored in one publication. Further, elucidation of the attributes of each concept would assist in illuminating the theoretical links and operationalizing concepts for future research and verification with different groups.

Research with other groups and utilizing different methodologies has highlighted concepts that are similar to those induced in this present study. Exploration of the phenomenology of nursing students encountering death for the first time revealed how part of the process involved "integrating patient death into the realm of professional practice" or reconstructing a view of work that incorporated patient death (Kelly, 1998). This has similarities to the task of framing discovered in this study in which both the deceased individual is remembered and the relationship with the worker and the worker's relationship with their work is also reflected upon. For the experienced respondents in this study, most had managed to construct a view of work that incorporates the possibility of encountering death and trauma.

How workers can be supported in positively framing death and their work can be inferred from the theory as follows:

- It is likely to be helpful to raise the possibility of encountering death or trauma of service users during workplace induction.
- Clear policy and procedures relating to what to do when death is encountered ought to be in place. The worker needs to consider, and make known to others, how and when they would like to be notified if a service user is involved in a traumatic incident.
- Workers ought to be encouraged to mark the death in a personal way and ought to be offered the opportunity to participate in collective activities to memorialize the death.
- Workers ought to receive some training around maintaining personal and professional boundaries.

- Clinical supervision should be available to frontline staff in difficult roles, and one-to-one professional psychological debriefing should be available to everyone following traumatic incidents.
- Individual workers and organizations need to be able to review events leading up to death and trauma, to learn from experience and prevent harm to others.

For some, positively framing death becomes easier with time. Rather than suppressing thoughts, feelings, and images, the main concern of homeless sector workers confronting sudden death is framing the experience as intensely human, acknowledging the tragedy and indignity of death, but also preserving hope and optimism that they can make a difference to those who remain.

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