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Social Work Crisis Interventions With Traumatic Death Survivors in Medical Settings

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This is to certify that the doctoral study by

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Abstract

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MSW, Our Lady of the Lake University, 2011

BA, Texas A&M University, 2006

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

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Abstract

Traumatic death survivors are an at-risk population that could benefit from social work interventions. This action research study explored social work perspectives on crisis practice with traumatic death survivors in acute medical settings. The research questions focused on whether early crisis interventions by social workers would benefit traumatic death survivors, which interventions were recommended in crisis practice with this population, the potential effects of repeated trauma exposure on the social workers providing the crisis interventions, and recommendations to manage this professional exposure to trauma. The purpose of the study was to explore social work perspectives on potential benefits of crisis interventions with traumatic death survivors and potential effects of crisis practice on the social workers providing the services. Crisis theory and family systems theory informed the study. Participants were selected from a convenience sample of licensed social workers, and data were collected in 1 focus group and 3 in-depth interviews. Data were analyzed using descriptive and thematic analysis. Findings supported the benefits of social work crisis interventions for traumatic death survivors and the need for self-care, self-awareness, and support to reduce the risks of negative effects of crisis practice on social workers. Specific crisis interventions recommended for practice include the roles of advocate and guide, grief support, viewing of the body, and explanation of next steps. An increase in knowledge and recommendations for future practice based on study findings might promote positive social change by raising awareness about the problem and improving social work practice with traumatic death survivors.

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Dedication

This project is dedicated to Roberto and Cynthia.

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Section 1: Foundation of the Study and Literature Review

This action research study was an exploration of the perspectives of social workers on crisis interventions for the surviving individuals of traumatic death victims in acute medical settings. In this study, social workers were asked to discuss the potential benefits of crisis interventions for the population of survivors of traumatic death victims and the potential effects of crisis practice with this population on the social workers providing the interventions. The term *survivor* is well-established in current literature, especially on the topics of homicide and suicide victims, to describe the surviving loved ones of individuals who died (Aldrich & Kallivayalil, 2013, 2016; Boelen, van Denderen, & de Keijser, 2016; Connolly & Gordon, 2015; Englebrecht, Mason, & Adams, 2014, 2016; Jacobs, Wellman, Fuller, Anderson, & Jurado, 2016; Johnson & Armour, 2016; Rheingold & Williams, 2015; Rubel, 1999; Smith, 2015; Vincent, McCormack, & Johnson, 2015; Williams & Rheingold, 2015). *Traumatic death survivors* is the term used in this study to describe the surviving loved ones of victims who died by a traumatic mechanism, including homicide, suicide, traffic fatality, and other unintentional fatal injury.

This qualitative, exploratory study was conducted with one focus group of six licensed social workers and individual in-depth interviews with three licensed social workers. The social workers who participated in the focus group were different than the social workers who participated in the individual in-depth interviews, for a total number of nine participants. Thematic analysis was the primary method of data analysis. A large Level 1 trauma center in Texas was the setting for participant selection. Findings from

the study can potentially impact social work practice with an increase of knowledge on the topic and recommendations for practice and future research.

Problem Statement

This problem is an area of concern in clinical social work practice because traumatic death survivors are a vulnerable population who would benefit from social work crisis interventions. A medical setting was chosen for this study because it is more common for individuals to die in a hospital (see Whelan & Gent, 2013). Immediate crisis interventions for survivors are needed following a traumatic death, especially during the death notification process in an acute hospital setting (Rubel, 1999). Despite this need, there is limited research on the social work role in unexpected deaths in hospitals (Whelan & Gent, 2013). Unexpected and violent deaths in medical settings can negatively impact the involved staff members (Kobler, 2014; Morrison & Joy, 2016). Support and self-awareness are recommended for professionals who are exposed to death and trauma in the work setting (Chan, Tin, & Wong, 2015; Leff, Klement, & Galanos, 2017; Whelan & Gent, 2013).

Scope of the Problem

The extent of the problem is widespread throughout the United States. Traumatic deaths occur in a variety of ways, such as homicide, suicide, traffic fatalities, and other unintentional fatal injuries. According to the Federal Bureau of Investigation (2017), there were an estimated 17,250 murders and nonnegligent manslaughters in the United States in 2016. This is a significant increase in the raw number and rate by population from 2012 and 2015 data (Federal Bureau of Investigation, 2017). The Centers for

Disease Control and Prevention (2016) reported 146,571 deaths by unintentional injury and 44,193 deaths by suicide out of a total 2,712,630 deaths in the United States in 2015. A reported 35,092 traffic crash fatalities occurred in 2015, which included drivers, passengers, pedestrians, and motorcyclists (National Highway Traffic Safety Administration, n.d.).

Selection of participants was initiated at a large Level 1 trauma center in Texas. The Centers for Disease Control and Prevention (2018) reported that there were 3,353 deaths by firearm, 1,669 homicides, 2,831 drug overdose deaths, and 10,536 accidental deaths in Texas in 2016. Traffic fatalities in Texas in 2016 totaled 3,776 and occurred at a higher rate of 13.55 per 100,000 individuals than the rate of 11.59 for the United States and 3.96 for the best reporting state (National Highway Traffic Safety Administration (n.d.).

Problem Description

Traumatic death survivors are at risk for complicated grief reactions, physical health conditions, mental health symptoms, substance use, future violence, isolation, stigma, relationship difficulties, and financial stressors (Boelen et al., 2016; Jacobson & Butler, 2013; Rynearson, 2012; Smith, 2015; Vincent et al., 2015). Immediate and effective services that are appropriate to the context and provided by trained professionals are beneficial to traumatic death survivors (Boelen et al., 2016; Jacobson & Butler, 2013; Rynearson, 2012; Smith, 2015). Social workers are qualified to assist traumatic death survivors with immediate crisis services due to the ability to offer comprehensive and individualized services in a variety of practice venues. Recommendations for this

population that are applicable to social work practice include grief support, crisis intervention, social support, education, counseling/therapy, advocacy, coping skills, and connection to resources (Jacobson & Butler, 2013; Smith, 2015; Vincent et al., 2015). In addition, a multidisciplinary, culturally sensitive, and comprehensive approach is beneficial (Jacobson & Butler, 2013; Smith, 2015).

The perspectives of social workers on potential effects to both the clients receiving services and the social workers providing the services were explored in this study. In addition to the impacts of traumatic deaths on the surviving loved ones, social workers in practice with this population have a risk of negative consequences. Repeated trauma exposure in practice places professionals at risk of vicarious trauma and related issues, such as secondary traumatic stress, compassion fatigue, burnout, and countertransference (Aldrich & Kallivayalil, 2013; Aparicio, Michalopoulos, & Unick, 2013; Bearse, McMinn, Seegobin, & Free, 2013; Chan et al., 2015; Dombo & Gray, 2013; Hammerle, Devendorf, Murray, & McGhee, 2017; Hayes, 2013; Izzo & Miller, 2010; Mairean, Cimpoesu, & Turliuc, 2014; Wagaman, Geiger, Shockley, & Segal, 2015). This is important to address both for the health of the practicing social workers and the population in need of consistent and effective social work interventions.

Purpose Statement and Research Questions

The purpose of this action research study was to explore the perspectives of social workers on the potential benefits of early crisis interventions for traumatic death survivors and the potential effects of crisis practice with this population on the social workers providing the services. The study can have a positive impact with increased

knowledge on the topic and by providing recommendations for future research and practice. Research questions that were answered in this study are as follows: How could early crisis interventions by social workers benefit traumatic death survivors? Which interventions are recommended in crisis practice with this population? What are the potential effects of repeated trauma exposure on the social workers providing the crisis interventions to traumatic death survivors? What are the recommendations to manage this professional exposure to trauma for social workers?

Key Terms and Concepts

Professional trauma exposure: Professional trauma exposure as defined in this study is the primary and secondary trauma that social workers encounter during professional practice, especially when traumatic deaths occur. Trauma exposure for social workers in practice potentially includes vicarious trauma, secondary traumatic stress, countertransference, compassion fatigue, and burnout (Aldrich & Kallivayalil, 2013; Bearse et al., 2013; Chan et al., 2015; Hayes, 2013; Izzo & Miller, 2010; Wagaman et al., 2015).

Trauma-informed practice: Trauma-informed practice includes trauma-informed care and refers to the recognition of the prevalence of trauma, acknowledgement of the impacts of trauma, and incorporation of safety, trust, choice, collaboration, and empowerment in practice with clients (Griese, Burns, & Farro, 2018; Hales, Kusmaul, & Nochajski, 2017; Levenson, 2017). The trauma-informed practice interventions that were specifically explored during this study were crisis interventions offered to traumatic death survivors by social workers.

Traumatic death survivors: Traumatic death survivors as a term refers to the surviving individuals who experience the death of a loved one by traumatic means, such as homicide, suicide, traffic fatality, and other unintentional fatal injury. *Survivor* is a term found often in current research in topics related to traumatic deaths (Aldrich & Kallivayalil, 2013, 2016; Boelen et al., 2016; Connolly & Gordon, 2015; Englebrecht et al., 2014, 2016; Jacobs et al., 2016; Johnson & Armour, 2016; Rheingold & Williams, 2015; Rubel, 1999; Smith, 2015; Vincent et al., 2015; Williams & Rheingold, 2015). The survivor may be any relation of importance, including nonfamily, to the victim and may experience the death in person or secondarily through notification.

Nature of the Doctoral Project

This action research study had a qualitative, exploratory design. One focus group of six licensed social workers and three in-depth interviews with licensed social workers were the methods for data collection. To elicit a sample of six to nine participants for the focus group and three participants for in-depth interviews, the nonprobability method of convenience sampling was used for selection. The sample was initiated by contacting social workers employed at a large Level 1 trauma center in Texas via electronic mail.

Following the appropriate protocols for informed consent, the focus group and interviews were conducted. Data were electronically recorded with a voice recorder for subsequent transcription, coding, and analysis. Descriptive and qualitative thematic analyses were conducted, which were followed by findings and recommendations for future practice and research.

Significance of the Study

The findings can potentially impact a wide variety of agency settings that provide services to individuals who have lost a loved one by a traumatic death. Agency settings of acute medical hospitals were the focus of this study. Potential positive impacts are an increase of knowledge on the topic and recommendations for social work practice with the population of traumatic death survivors. Contributions to overall social work knowledge were gained due to the focus on the perspectives of social workers and the explorative nature of the research design. This study promotes positive social change because traumatic death survivors are a vulnerable population who can benefit from research knowledge and recommendations for practice. Social workers in practice with the affected population can benefit from an increase in knowledge and recommendations on how to manage professional exposure to trauma.

Theoretical/Conceptual Framework

For this study, crisis theory was chosen as the primary theoretical framework. Family systems theory was chosen to complement crisis theory. As the focus of this study is on crisis interventions rapidly following a traumatic death, these theories were selected for their applicability to the immediate effects of a traumatic event on individuals and families.

Crisis Theory

Crisis theory was founded based on the experiences of the victims of the Cocoanut Grove nightclub fire in 1942 (Parikh & Morris, 2011). Eric Lindemann and Gerald Caplan are credited with developing crisis theory (Parikh & Morris, 2011). The

basic tenet of crisis theory is the disruption of homeostasis in response to a significant stressor (Dixon & Burns, 1974; Woolley, 1990). This disruption provides an opportunity for crisis intervention to begin progress toward stability (Dixon & Burns, 1974; Parikh & Morris, 2011; Woolley, 1990). Service provision with a crisis-oriented perspective should be individualized and account for multilevel environmental factors (Dixon & Burns, 1974; Parikh & Morris, 2011; Woolley, 1990). Crisis theory concepts directly related to this study include loss of stability, reestablishment of homeostasis, and comprehensive crisis response services.

The concepts of crisis theory guided the understanding of social work perspectives on crisis interventions to a vulnerable population and the effects of crisis practice on the professionals. Social work crisis interventions with survivors of traumatic deaths in a hospital setting is consistent with a crisis theory framework (Wang, Chen, Yang, Liu, & Miao, 2010; Whelan & Gent, 2013). When an event overwhelms the ability of an individual to cope using existing resources, it is considered a crisis (Parikh & Morris, 2011; Wang et al., 2010). The death of a loved one is established in literature as a potential crisis, and crisis theory is established in literature as an appropriate framework to guide research in crisis interventions (Parikh & Morris, 2011; Wang et al., 2010). Crisis interventions consistent with crisis theory and appropriate to provide following a traumatic death include defining the crisis, verifying safety, establishing trust, offering support, providing information, considering options, forming a plan to reestablish stability, and committing to action (Parikh & Morris, 2011; Wang et al., 2010). These interventions closely resemble elements of trauma-informed practice, including safety,

trust, choice, collaboration, and empowerment (Griese et al., 2018; Hales et al., 2017; Levenson, 2017).

Family Systems Theory

An additional theoretical framework of family systems theory was chosen to complement crisis theory. Family systems theory is credited to Murray Bowen based on his professional experiences with families in therapy (Brandon & Goldberg, 2017). The basic concepts of family systems theory include family equilibrium, family functioning, family roles and abilities to fulfill roles, and communication patterns (Brandon & Goldberg, 2017; Walsh, 2016). A crisis in the family can lead to disruption in the family system (Brandon & Goldberg, 2017; Griese et al., 2018; Walsh, 2016). Disequilibrium, interruptions in functioning, reduced abilities to fulfill roles, and negative communication can occur (Brandon & Goldberg, 2017; Griese et al., 2018). Stabilization with professional help is recommended to increase coping abilities, restore functioning, and encourage positive growth (Brandon & Goldberg, 2017; Griese et al., 2018; Walsh, 2016).

A death in the family is considered an extremely stressful event and one of the most traumatic experiences for a family (Griese et al., 2018; Walsh, 2016). Potential impacts to the family system after a death include disrupted family processes, decreased functioning abilities, relationship changes, and debilitating grief reactions (Griese et al., 2018; Walsh, 2016). To address a death in the family, trauma-informed care that is individualized to the family is recommended (Griese et al., 2018). In addition, families may benefit from acknowledgement of the loss, normalization of grief reactions,

connection to resources, effective communication, and encouragement to form meanings and rituals (Griese et al., 2018; Walsh, 2016). With assistance, families may experience a realignment in the family system and increased family resilience (Walsh, 2016).

Review of the Professional and Academic Literature

The Walden University library databases were searched for professional and academic literature related to the topic. Databases searched included Academic Search Complete, SocINDEX, PsycARTICLES, and PsychINFO. The search parameters were peer reviewed and full text articles published within the last 10 years with a focus on the last 5 years. Search terms using Boolean/phrase included the following: *traumatic death survivors, death, grief, homicide, motor vehicle collision, car accident deaths/fatalities, suicide, hospital, emergency department, social work, crisis practice, crisis interventions, child abuse deaths/fatalities, burnout, secondary trauma, vicarious trauma, trauma-informed practice, crisis theory,* and *family systems theory*. Despite limited research in the specific area of social work crisis interventions with traumatic death survivors in medical settings, a wealth of information in related subjects was found using the search terms named above.

Traumatic Death Survivors

There are a plentiful number of current research studies on the general topic of traumatic death survivors. The research method for most of the current studies about traumatic death survivors was qualitative. Methods of research included case studies, in-depth interviewing, focus groups, surveys, needs assessments, questionnaires, literature reviews, records reviews, secondary analysis, and presentations of practice experience

(Aldrich & Kallivayalil, 2013, 2016; Carpenter, Tait, & Quadrelli, 2014; Englebrecht et al., 2014, 2016; Jacobs et al., 2016; Jacobson & Butler, 2013; Johnson & Armour, 2016; Rheingold & Williams, 2015; Rynearson, 2012; Schneider, Steinberg, Grosch, Niedzwecki, & Cline, 2016; Vincent et al., 2015; Wellman, 2014).

Traumatic deaths can elicit different grief reactions than natural deaths (Rynearson, 2012). An exceptionally difficult form of death for survivors is homicide, and homicides are studied most often in current literature on traumatic death survivors (Aldrich & Kallivayalil, 2013; Boelen et al., 2016; Englebrecht et al., 2016; Rynearson, 2012; Smith, 2015; Vincent et al., 2015). Homicides are unique because they are characterized by violent, sudden, and intentional death (Aldrich & Kallivayalil, 2013).

Traumatic death survivors are at significant risk for complicated grief reactions (Aldrich & Kallivayalil, 2013; Boelen et al., 2016; Englebrecht et al., 2016; Jacobs et al., 2016; Rheingold & Williams, 2015; Rynearson, 2012; Smith, 2015; Vincent et al., 2015; Youngblut, Brooten, Glaze, Promise, & Yoo, 2017). Complicated grief is characterized by prolonged and atypical grief reactions with decreases in functional abilities and negative changes in schemas (Simmons, Duckworth, & Tyler, 2014). Traumatic death survivors are also at high risk for posttraumatic stress, anxiety, and depression (Aldrich & Kallivayalil, 2013; Englebrecht et al., 2014, 2016; Jacobs et al., 2016; Johnson & Armour, 2016; Rheingold & Williams, 2015; Vincent et al., 2015; Wellman, 2014; Williams & Rheingold, 2015). Other potential negative effects that are documented in current research include physical health deterioration, future violence, substance use, financial problems, disturbed sleep, stigma, isolation, and relationship difficulties

(Aldrich & Kallivayalil, 2013, 2016; Boelen et al., 2016; Englebrecht et al., 2016; Jacobs et al., 2016; Jacobson & Butler, 2013; Rheingold & Williams, 2015; Rynearson, 2012; Smith, 2015; Vincent et al., 2015; Wellman, 2014; Youngblut et al., 2017).

Interacting factors that can increase vulnerability for traumatic death survivors include young age, minority ethnicity, and lower socioeconomic status (Rubel, 1999; Smith, 2015; Vincent et al., 2015; Wellman, 2014; Youngblut et al., 2017). Traumatic death survivors need developmentally and culturally appropriate interventions (Carpenter et al., 2014; Smith, 2015; Youngblut et al., 2017). Recommended services that can benefit traumatic death survivors include crisis intervention, grief support, counseling or therapy, trauma-informed care, advocacy, education, and case management (Carpenter et al., 2014; Englebrecht et al., 2016; Jacobson & Butler, 2013; Knight & Gitterman, 2014; Rheingold & Williams, 2015; Rynearson, 2012; Smith, 2015; Vincent et al., 2015).

Rapport development, validation of emotions, and normalization of individualized grief reactions should be emphasized during services (Jacobson & Butler, 2013; Knight & Gitterman, 2014; Watts, 2013). Flexibility and the understanding that traumatic death survivors may experience a new normal and modified world view are important (Aldrich & Kallivayalil, 2013, 2016; Englebrecht et al., 2016; Johnson & Armour, 2016; Wellman, 2014). Sensitive language should be used, especially when discussing subjects that may lead to traumatic reexperiencing of the event or memories of the event (Aldrich & Kallivayalil, 2013; Englebrecht et al., 2014).

Crisis Interventions for Survivor Population

Crisis interventions for survivors immediately following a traumatic death can be beneficial (Chauvin, McDaniel, Banks, Eddlemon, & Cook, 2013; Jacobson & Butler, 2013; Rubel, 1999). In particular, crisis interventions are recommended for survivors who were close to the victim or had close exposure to the event (Chauvin et al., 2013). It is important for crisis interventions to be offered within a short time frame of the traumatic death (Chauvin et al., 2013; Rubel, 1999).

A person is in crisis when a stressor exceeds normal coping abilities and resources, and disequilibrium ensues (Chauvin et al., 2013; Vecchi, 2009). The primary goals in crisis interventions are to provide a safe environment and reestablish stability (Chauvin et al., 2013; Rubel, 1999; Vecchi, 2009). Additional goals in crisis interventions are to listen, address emotional needs, offer resources and coping skills, prevent further harm, and progress toward crisis resolution (Chauvin et al., 2013; Rubel, 1999; Vecchi, 2009). Prevention may target emotional distress, severe grief reactions, and development of traumatic stress symptoms (Chauvin et al., 2013; Rubel, 1999; Vecchi, 2009).

When offering crisis interventions, skilled practitioners are needed who can provide individualized services (Chauvin et al., 2013; Rubel, 1999; Vecchi, 2009). Recommendations for crisis interventions with traumatic death survivors are to validate the loss, normalize the grief process, focus on positive traits of the deceased person, and use the name of the deceased person (Chauvin et al., 2013; Rubel, 1999). Crisis interventions may be first-order, such as psychological first aid, debriefing, and support,

or second-order, such as therapy, coping skills, and regaining control (Chauvin et al., 2013).

Trauma-Informed Practice

Trauma-informed practice, including trauma-informed care, incorporates the recognition of the prevalence of trauma and the acknowledgement of the potential impacts of past traumatic experiences into practice with clients (Hales et al., 2017; Levenson, 2017). The basic tenets of trauma-informed care are safety, trust, choice, collaboration, and empowerment (Griese et al., 2018; Hales et al., 2017; Levenson, 2017). Trauma-informed practice is applicable to multiple social work practice situations and is consistent with the social work ethical responsibilities of commitment to clients and self-determination (Levenson, 2017; National Association of Social Workers, 2018).

The death of a loved one, especially when the death is unexpected, can be an extremely traumatic experience (Griese et al., 2018). This may lead to excessive grief reactions and impacts on functioning, schemas, and coping abilities (Griese et al., 2018; Levenson, 2017). In addition to safety, trust, choice, collaboration, and empowerment, trauma-informed care in the context of grief after a traumatic death may involve education about grief, acknowledgement of the importance of grief, and grief support (Griese et al., 2018).

Grief in Context of Traumatic Deaths

Grief reactions of traumatic death survivors are individualized expressions of grief. Factors that influence grief reactions are age, especially young age, and cultural considerations (Chauvin et al., 2013; Rubel, 1999). Examples of grief reactions after a

traumatic death are negative emotions (such as shock, anger, sadness, and fear), survivor guilt, sleep disturbance, poor concentration, reduced trust, and decreased daily functioning (Chauvin et al., 2013; Rubel, 1999; Vecchi, 2009). Traumatic death survivors are at risk for suicidal thoughts and suicide attempts (Chauvin et al., 2013; Rubel, 1999; Vecchi, 2009).

Social support is an important protective factor in grief reactions (Rubel, 1999). Traumatic death survivors are at risk for limited social support due to isolation after the event (Rubel, 1999). The most important tasks of clinicians in the context of survivor grief are to develop rapport, normalize grief reactions, provide active listening, validate emotional expressions, and be genuine (Chauvin et al., 2013; Knight & Gitterman, 2014; Rubel, 1999). Offering support and encouraging counseling are helpful for follow up (Chauvin et al., 2013).

Social Work Practice in Medical Settings

Difficult working conditions, such as a fast paced and high workload, contribute to vicarious trauma and burnout in medical settings (Hunsaker, Chen, Maughan, & Heaston, 2015; Schwab, Napolitano, Chevalier, & Pettorini-D'Amico, 2016; Wagaman et al., 2015). In addition, long hours and complex roles are work environment risk factors in emergency departments (Hunsaker et al., 2015; Schwab et al., 2016). Another consideration regarding medical settings is potential conflict between the medical model and social work values when working with clients affected by trauma (McCormack & Adams, 2016). This conflict exacerbates vicarious trauma development and can lead to emotional distress for practitioners (McCormack & Adams, 2016).

The medical model is dominant in medical settings (Casstevens, 2010). This approach is a maintenance approach that emphasizes diagnosis and treatment (Casstevens, 2010). Diagnoses are viewed as the primary problem, and labels with stigmatizing language are common in the medical model (Casstevens, 2010). A biopsychosocial approach is more consistent with the social work profession but is less prevalent in medical settings (Casstevens, 2010; Craig & Muskat, 2013). The biopsychosocial approach is individualized and comprehensive with emphases on multicultural factors and consideration of the person within their environmental setting (Casstevens, 2010; Craig & Muskat, 2013). Social workers practicing in medical settings can experience conflict due to the popularity of the medical model and limited acceptance of the biopsychosocial model (Casstevens, 2010; Craig & Muskat, 2013).

Professional Trauma Exposure for Social Workers

The possible effects of trauma exposure in practice for social workers encompass vicarious trauma, secondary traumatic stress, countertransference, compassion fatigue, and burnout (Aldrich & Kallivayalil, 2013; Bearse et al., 2013; Chan et al., 2015; Hayes, 2013; Izzo & Miller, 2010; Wagaman et al., 2015). Symptoms of vicarious trauma and secondary traumatic stress tend to mimic symptoms of posttraumatic stress, such as reexperiencing the traumatic exposure, intrusive thoughts, sleep disturbances, negative emotions, and avoidance (Aparicio et al., 2013; Cohen & Collens, 2013; Hayes, 2013; Kanno & Giddings, 2017; Mairean et al., 2014). Secondary trauma and vicarious trauma can also lead to fatigue, isolation, and feelings of hopelessness (Wagaman et al., 2015). Vicarious trauma contributes to burnout, which is characterized by emotional exhaustion,

reduced sense of professional achievement, and depersonalization (Bearse et al., 2013; Hammerle et al., 2017; Hayes, 2013; Wagaman et al., 2015).

Professional exposure to trauma is the primary risk factor for development of vicarious trauma (Aparicio et al., 2013; Dombo & Gray, 2013; Hammerle et al., 2017; Hayes, 2013; Izzo & Miller, 2010; Kanno & Giddings, 2017; Mairean et al., 2014; Wagaman et al., 2015). Exposure occurs through directly witnessing a traumatic event, witnessing effects of trauma on others, and hearing about details of the traumatic event from clients or loved ones (Hammerle et al., 2017; Izzo & Miller, 2010; Kanno & Giddings, 2017). Professionals in emergency departments who are exposed to unexpected deaths, trauma, and violence are at high risk for secondary traumatic stress (Kobler, 2014; Morrison & Joy, 2016). Self-awareness, coping skills, education, social support, and debriefing are recommended for professionals exposed to trauma and death in practice (Chan et al., 2015; Kobler, 2014; Morrison & Joy, 2016).

An additional risk factor for the development of secondary traumatic stress symptoms is controlled empathy. This is defined as the repeated need for professionals to control personal reactions and maintain a calm and empathetic response to clients sharing traumatic experiences (Bearse et al., 2013; Izzo & Miller, 2010; Kanno & Giddings, 2017). Lack of organization and supervisory support are also risk factors for vicarious trauma and burnout (Bearse et al., 2013; Hayes, 2013; Kanno & Giddings, 2017). These risk factors are particularly important for work in emergency departments (Hunsaker et al., 2015).

Summary

Social work crisis practice with traumatic death survivors was the focus of this study. The purpose of the study was to explore the perspectives of social workers on the potential benefits of early crisis services for traumatic death survivors and the potential effects of crisis practice with this population on social workers. Crisis theory and family systems theory were chosen to inform the study. A qualitative design with one focus group and three in-depth interviews was used. Extensive literature exists on homicide survivors, but there is a gap in research on social work crisis practice with traumatic death survivors, especially immediately following the death notification in acute medical settings. This study has the potential to positively impact social work practice with increased knowledge on the topic and recommendations for future practice and research. In the following section, research design and data collection are addressed.

Section 2: Research Design and Data Collection

This action research study was an exploration of social work crisis practice with traumatic death survivors. The purpose of the study was to explore the perspectives of social workers on the potential benefits of early crisis services for traumatic death survivors and the potential effects of trauma practice with this population on the social workers providing the services. Research design, methodology, data analysis, and ethical procedures are included in this section.

Research Design

To explore the perspectives of social workers on the potential benefits of crisis services for traumatic death survivors and the potential effects of trauma practice on social workers, four research questions were developed. The research questions were developed to achieve the twofold purpose of the study, which is to explore the effects of crisis services on the study population and to explore the effects of trauma exposure on the professionals in practice with the study population. Specifically, the questions addressed potential effects and practice recommendations for both traumatic death survivors and social workers providing crisis services to the survivors.

Research questions for this study included the following: How could early crisis interventions by social workers benefit traumatic death survivors? Which interventions are recommended in crisis practice with this population? What are the potential effects of repeated trauma exposure on the social workers providing the crisis services to traumatic death survivors? What are the recommendations to manage this professional exposure to trauma for social workers?

The research design was a qualitative method. Qualitative methodology is important in social work research and is found often in social work dissertations (Aguirre & Bolton, 2014; Gringeri, Barusch, & Cambron, 2013). It is valuable for practice applications, especially when research is synthesized (Aguirre & Bolton, 2014).

Recommended strategies to improve rigor in qualitative social work research include peer review, critical awareness, inclusion of theory, and acknowledgement of power in the researcher/participant relationship (Gilgun, 2015; Gringeri et al., 2013). All of these strategies were used in this study. The project was reviewed by a research committee and by peers. Two theories were included to inform the research project. Critical awareness was maintained to acknowledge the limited ability to generalize qualitative research and the potential power differential that could affect the participants.

Methodology

The methodology to collect data on social work perspectives on the topic was to conduct one focus group and three in-depth interviews. For the focus group, the goal was to recruit six to nine participants. Six participants were successfully recruited and participated in the focus group. An additional three participants participated in individual in-depth interviews.

Focus groups are valuable in social work research (Gaizauskaite, 2012). Advantages of focus groups in research are the range of perspectives available from participants, the potential applications to practice, and the relevance to social problems (Gaizauskaite, 2012). Skill is needed from the researcher to effectively moderate the

focus group and seek interaction from all participants (Gaizauskaite, 2012). In-depth interviews were chosen to gain detailed knowledge from social workers about the topic.

Study Population

Traumatic death survivors were the study population. For the purpose of this study, traumatic death survivors were studied as the recipients of social work crisis services during and immediately following the notification of the death of their loved one. The social workers who provide crisis services to this population were integral to this study because the purpose of the study was to explore the potential effects of social work crisis services for the study population and the potential effects of trauma exposure on the social workers.

Study Participants

The study sample was licensed social workers with at least 2 years of professional experience and knowledge, interest, or experience on the topic. A nonprobability sampling method was used. Participants were obtained by convenience sampling initiated at a practice setting of an acute medical hospital. A large hospital that is located in Texas was chosen because approximately 30 to 40 social workers are employed at the facility, and the hospital is a Level 1 trauma center.

Contact information for the social workers was obtained from the director of the Care Coordination Department and included social workers in the Care Coordination Department, Behavioral Health Department, and Trauma Department. The total number of potential participants in the list provided was 38 social workers. Approval from the Research Department at the hospital was obtained prior to recruiting the participants.

Potential participants were contacted by electronic mail, which included a brief explanation of the study (including voluntary participation) and the eligibility criteria to participate. Participants were notified of the option to respond by electronic mail or telephone for more information. Options to participate included either the focus group or one of the in-depth interviews. The focus group and interviews were scheduled for 9 to 10 days after recruitment letters were sent.

Recruitment letters were electronically mailed to 38 potential participants. Nine participants responded by electronic mail, and one participant responded by telephone with interest to participate. All of the interested participants who responded were eligible and chose to participate. Seven of the interested respondents requested to participate in the focus group, and three of the respondents chose to participate in an individual in-depth interview. Two of the respondents interested in the focus group did not arrive to the group, but one participant who did not respond arrived to the group with interest to participate. All three of the in-depth interview participants arrived to their scheduled interview. The sample size of successfully recruited participants was six participants in the focus group and three participants in the individual in-depth interviews for total of nine participants.

Data Collection

Data for the focus group were collected by audio recording with an electronic voice recorder. An additional voice recorder was used for back-up data recording in the event of loss of data on the primary recorder. The same data collection method of audio recording with a primary and secondary voice recorder was used for the individual in-

depth interviews. Data about the demographics of participants were collected in a short written questionnaire. Field notes were used to organize and track the questions in the focus group and interviews. All interviews and the focus group were conducted within the expected time frame of approximately 1 hour each.

Data Analysis

The data were first transcribed from the recordings and coded for organization. Thematic analysis was conducted with NVivo 12 software and organized into a display figure (Appendix B: Summary of Findings). Data collected in the demographic questionnaires were organized and displayed in a descriptive table (Appendix A: Participant Demographics). The choice of thematic analysis was made for its relevance to qualitative research in social work, especially with research using focus groups as a data collection method (see Kapoulitsas & Corcoran, 2015; Rejno, Berg, & Danielson, 2012). Rigor was maintained with committee review, peer review, inclusion of theory, and critical awareness.

Ethical Procedures

Ethical procedures for this study included informed consent, voluntary participation, confidentiality, consideration of potential ethical issues, and oversight by a research committee and institutional review boards. These concepts are consistent with the National Association of Social Workers' (2018) ethical standards. The ethical responsibilities related to evaluation and research, including informed consent, confidentiality, voluntary participation, right to withdraw without penalty, consideration of potential consequences, access to appropriate supportive services, protection from

unwarranted harm, avoidance of conflicts of interest, accurate reporting, and development of knowledge were upheld (National Association of Social Workers, 2018). All participants were adult licensed professionals with capacity to understand ethical procedures, including informed consent, voluntary participation, and confidentiality.

Informed consent was obtained from participants with verbal and written explanations and signatures from the participants acknowledging receipt of the explanations. The completed informed consent forms will be kept for research records for the required period of 5 years. All participation in this study was voluntary, which was explained to participants during recruitment and informed consent.

Confidentiality was protected by securing research data and removing all identifying information about participants from published findings. The participants in the focus group were asked to keep all information shared and observed in the group confidential, and the participants signed a confidentiality agreement. Data accessibilities were limited to me, the research committee, and the applicable review boards. Data will be destroyed after 5 years.

Oversight is maintained by Walden University Institutional Review Board (approval number 05-09-2019-0636940) and the institutional review board applicable to the research site. The action research committee also maintained oversight to ensure that ethical procedures were followed. Prior to research with participants, potential ethical issues were considered and reported to the applicable institutional review boards. One potential ethical issue identified was the discussion of difficult topics during the research. Potential participants were informed of the issue during recruitment. Participants were

again informed of the issue during informed consent and were reminded of the voluntary nature of the study and right to withdraw without penalty at any point. The participants were provided with information about appropriate services (included crisis and counseling services) to manage any reactions to a difficult discussion.

No ethical dilemmas occurred during this research. If an ethical dilemma related to this research is discovered in the future, the potential ethical issues will be identified, relevant ethical and legal codes will be reviewed, consultation will be sought from the appropriate institutional review boards, possible courses of action will be considered, and an appropriate plan to address the dilemma will be chosen.

Summary

A qualitative and exploratory research design was chosen for its relevance to social work practice and the topic. The methodology was one focus group and three in-depth interviews. Data were collected with audio recordings and short demographic questionnaires completed by the participants. These data were analyzed with descriptive statistics and thematic analysis after transcription and coding. Ethical procedures for the study included informed consent, voluntary participation, confidentiality, consideration of potential ethical issues, and oversight by a research committee and appropriate institutional review boards. Analysis of data and findings are included in the next section.

Section 3: Presentation of the Findings

The purpose of this research study was to explore the perspectives of social workers on the potential benefits of early crisis interventions for traumatic death survivors and the potential effects of crisis practice with this population on the social workers providing the services. Research questions for the study were as follows: How could early crisis interventions by social workers benefit traumatic death survivors? Which interventions are recommended in crisis practice with this population? What are the potential effects of repeated trauma exposure on the social workers providing the crisis interventions to traumatic death survivors? What are the recommendations to manage this professional exposure to trauma for social workers? Data were collected in one focus group and in three individual in-depth interviews. In this section, data analysis and research findings are discussed.

Data Analysis Techniques

Data were collected in one focus group and three individual in-depth interviews with audio recordings. Participant demographic data were collected in a voluntary demographic questionnaire. Of the 38 potential participants who were sent a recruitment letter via electronic email, nine participants were successfully recruited. Six participants attended the focus group, and three participants attended an in-depth interview. The focus group and interviews were held between 9 and 10 days after recruitment began.

All participants chose to complete and return the demographic questionnaire and to verbally participate in the interviews or focus group. The demographic questionnaire data were compiled and organized into a descriptive table (Appendix A: Participant

Demographics). Audio recordings were transcribed for coding. The transcribed data were reviewed for accuracy and coded using NVivo 12 software with nodes. Validation techniques included committee review and peer review of the final project write-up. No significant problems were encountered during data collection or analysis.

Findings

The research questions for the study were answered with the findings below. Findings are organized into crisis interventions for traumatic death survivors in the first section and effects of crisis practice with traumatic death survivors on the social workers providing the interventions in the subsequent section. Demographic data are presented first.

Participant Demographics

Participants identified their age in years from 18 to 49 years. One participant identified in the 18 to 29 years range, four participants identified in the 30 to 39 years range, and four participants identified in the 40 to 49 years range. All participants identified as female gender. Participants were given the choice to select as many options as applicable for ethnic identity. Five participants identified as Chicano(a)/ Hispanic/ Latino(a), three participants identified as African/ African American/ Black, and three participants identified as Caucasian/ European/ European American/ White.

All of the participants in the study were licensed social workers with an education level of Master Degree and a minimum license status of licensed master social worker. The choices for license status were based on options available in Texas at the time of the study as all participants were licensed and practicing in Texas (Texas State Board of

Social Work Examiners, 2019). Six of the nine participants identified as licensed master social worker, and three participants identified as licensed clinical social worker. Years as a licensed social worker varied from less than 3 years to 20 years, with most participants in the 6 to 9 year range. The years in the current employment setting of a Level 1 trauma center varied from less than 2 years to 15 years, with most participants in the less than 2 years range.

Crisis Interventions for Traumatic Death Survivors

The following research questions were answered in this section: How could early crisis interventions by social workers benefit traumatic death survivors? Which interventions are recommended in crisis practice with this population? The findings in this section are organized into benefits of social workers in crisis practice with traumatic death survivors, recommended social work crisis interventions for traumatic death survivors, and special issues in social work crisis practice with traumatic death survivors in medical settings.

Benefits of social workers. A pervasive theme the participants noted was that the presence of social workers to provide interventions to traumatic death survivors in the immediate hours after the death of a loved one is beneficial. Social workers provide a valuable connection to traumatic death survivors. The communication, compassion, and support from social workers can help traumatic death survivors process the death of their loved one. Social work crisis interventions for traumatic death survivors could also benefit the medical setting by providing effective services and eliciting improved

customer feedback. One participant stated, "I've yet to have a family leave angry. You know, they kind of leave more relieved."

The participants discussed potential negative effects of not having a social worker present to provide crisis interventions to traumatic death survivors in medical settings. One participant provided the opinion that traumatic death survivors "would just be lost… really confused, empty, broken, not having any connection" without a social worker. Another participant stated that a traumatic death survivor may feel that "no one helped me through this." Other participants discussed feelings of abandonment, lack of effective communication, and exacerbation of grief and trauma for traumatic death survivors.

Recommended crisis interventions. The most prevalent theme among participants when discussing social work crisis interventions for traumatic death survivors in medical settings was the roles of the social worker as an advocate and guide. Other recommended crisis interventions included grief support, assistance during the viewing of the body, and the explanation of next steps. Special issues that are specific to social work crisis interventions for traumatic death survivors in medical settings are next of kin as a legal and ethical issue and the use of terms related to death and to the loved one who died.

Roles of advocate and guide. Participants identified the roles as advocate and guide as an essential component of social work crisis interventions for traumatic death survivors. The word guide was mentioned multiple times by different participants. According to one participant, the social work role as a guide includes "being that first face that they see, being able to walk them through everything that's going to happen."

Participants opined that social workers should be present to help traumatic death survivors through the process by facilitating and explaining. Social workers are the first point of contact for traumatic death survivors and provide emotional support throughout the process. One participant provided the opinion that "they just lost their loved one. They need to have someone there who knows exactly what they're talking about."

In addition, social workers act as a guide for medical staff when communicating with traumatic death survivors. This was especially important during the death notification. Per the participants, social workers should accompany the medical staff during a death notification. They should also help explain clinical and medical terminology in language that is more comforting and understandable.

The advocacy role of the social worker includes advocating for traumatic death survivors with law enforcement and medical staff. An example of advocacy with law enforcement provided by participants is to intervene when law enforcement declines to speak with the family members of a deceased loved one or denies a parent the right to see their deceased child. Advocacy efforts with medical staff include ensuring that the appropriate loved one is provided with the correct information and encouraging physicians to provide timely death notification. If traumatic death survivors arrive to the medical setting before their loved one has died, participants expressed concern that medical staff may allow them to watch resuscitative efforts without adequate preparation. Social workers can prepare them by explaining what they will see and asking if they want to be present.

Grief support. The presence of social workers aids in grief support for traumatic death survivors. Being present or understanding when a traumatic death survivor prefers time alone is an important part of grief support. One participant summed up their message to traumatic death survivors as, "I understand you're grieving. I'm going to be there with you. You're allowed to grieve however you want."

Compassion. Compassion was discussed widely among the participants as an element of grief support. Participants voiced that social workers have the professional ability to be "the compassion piece" or the "human compassion component" for traumatic death survivors during a crisis. Compassion includes increasing comfort and decreasing the clinical aspect of a traumatic death in a medical setting, according to participants. Connection and support for traumatic death survivors is important to demonstrate that "we don't just care about your loved one, but we care about you as well" in the words of one participant. In addition, one participant highlighted compassion for the deceased person by "extending their dignity even after death has occurred. There's still dignity in death. And I think we honor that."

Cultural awareness. Another part of grief support per the participants is cultural awareness. Participants considered the right of traumatic death survivors to grieve in different ways. Social workers support traumatic death survivors by being respectful of individualized expressions of grief. Participants recommended that social workers be aware and observant of cultural distinctions. Another recommendation from participants is that social workers ask traumatic death survivors about their cultural preferences and assist in cultural expression.

Listening and processing. A final theme of grief support as a recommended social work crisis intervention for traumatic death survivors is listening and processing. According to participants, listening is a skill that social workers provide throughout the situation. Social workers can also help traumatic death survivors start to process the death of their loved one. Participants talked about aiding traumatic death survivors in identifying their feelings and reflecting on their loved one. One participant also stated that social workers can help participants understand how processing the death of their loved one may progress over days, months, and years.

Viewing of the body. Although a viewing of the body does not occur in every death, participants noted that traumatic death survivors tend to want to view the body. Social workers provide support to traumatic death survivors when viewing a body. One participant observed that "they may have a hard time walking to that room or being in that room if they're alone." The environment of the viewing room can impact a viewing in a positive way if it is clean, private, and comforting instead of clinical.

A common barrier to a viewing in terms of traumatic deaths in medical settings was identified by participants as a criminal investigation. Law enforcement may require restrictions on viewing, such as no viewing, limits on time, limits on touching, limits on who can view, and limits on altering the condition of the body. Social workers are essential in preparing traumatic death survivors for any restrictions and on what they will see. If a body cannot be cleaned in preparation for a viewing, social workers can provide an explanation on the condition of the body, education about the potential for further traumatization to the survivor, and offer the choice of a viewing.

Explanation of next steps. The explanation of next steps refers to what will happen after traumatic death survivors leave the medical setting. For example, the transition of the body to the morgue, the involvement of the medical examiner if applicable, the disposition of the body, and the bereavement supports available in the community are explanations of next steps that were discussed by participants. In traumatic deaths, participants stated that the survivors benefit from knowing that they do not have to make immediate decisions on disposition of the body. For example, the next of kin has multiple days to determine disposition in Texas (Texas Funeral Service Commission, 2015).

Supplying traumatic death survivors with the resources that they will need is an intervention identified by the participants. Examples include contact information for important entities (such as the hospital morgue, medical examiner, and law enforcement), funeral or memorial planning services, funding assistance, and community bereavement services. Participants asserted that early social work interventions in this area ease the tasks and processes that traumatic death survivors will face in the future.

Special issues. Participants explored two special issues that are specific to social work crisis interventions for traumatic death survivors in medical settings. One special issue is identification and communication with the next of kin of the deceased person. The other special issues is the use of terms related to death and to the deceased individual.

Next of kin. Correct identification of next of kin is a legal and ethical issue that social workers face when providing crisis services to traumatic death survivors in medical

settings. Social workers need to be well-versed on the applicable laws and ethical codes related to next of kin and deaths in their state of practice. Next of kin has the right to be notified of death first according to the participants. The most common ethical issue with next of kin that was identified by the participants was the difference between a legal spouse and a significant other. The participants shared examples of significant others who claimed to be spouses, estranged spouses, individuals who had both a legal spouse and a significant other, and family dynamics when a parent does not communicate well with a spouse. Social workers need clear communication and may need to involve an ethics department or legal department to resolve such issues in a medical setting.

Use of terms. Participants examined and provided opinions on the use of terms related to death and to the deceased individual. The participants were in agreement on the need to use clear terms, such as "die," "death," and "dead" when communicating with traumatic death survivors in medical settings. There was also consensus that it is respectful for social workers to use the name or the relationship of the dead individual when talking to traumatic death survivors about their loved one. For example, participants suggested asking the survivors their preference on the name of their loved one or following their lead in reference to the relationship ("your daughter, your mom, your father").

Effects of Trauma Exposure on Social Workers

The following research questions were answered in this section: What are the potential effects of repeated trauma exposure on the social workers providing the crisis interventions to traumatic death survivors? What are the recommendations to manage this

professional exposure to trauma for social workers? This section is divided into potential negative effects of trauma exposure on social workers, contributing factors to potential negative effects, potential positive effects of trauma exposure on social workers, and recommendations to manage professional exposure to trauma.

Potential negative effects. The potential consequences of trauma exposure on social workers in reference to providing crisis interventions for traumatic death survivors in medical settings are analyzed below. Participants identified two primary themes in regard to the potential negative effects of professional trauma exposure. These themes are burnout and traumatic stress.

Burnout. Burnout was mentioned by participants numerous times. Participants described their feelings of burnout as desensitized, monotonous, robotic, indifferent, numb, jaded, irritable, and emotionally drained. One participant reported a dread of coming to work. The possibility that burnout could lead to less effective social work crisis interventions for traumatic death survivors was deliberated. A participant expressed concern that burnout could negatively affect traumatic death survivors with the following statement: "You're trying to be there as a support, not to add to the trauma." Another participant expressed a similar concern with this statement: "In those crucial, vulnerable, traumatic times, the families need you, and you're not able to be that compassionate listener." A participant summed up by saying "It's another death for you, but it's the family's first, and it has to be treated as such."

Traumatic stress. Traumatic stress as a potential negative effect of trauma exposure on social workers references both primary traumatic stress and secondary

traumatic stress. Both types of trauma exposure were evident in this participant statement: “You’re literally seeing blood, guts, and gore. And you’re there hearing what the doctor says and seeing the reactions.” Participants described physical and emotional personal reactions, especially feelings of sadness and depression. One participant recounted crying in the parking lot before work due to fear of what could happen during the shift. Other participants reported feeling the effects carry over to their home and personal lives. Deaths of children were noted as particularly difficult situations for some participants to handle.

Contributing factors. Factors that contribute to potential consequences of trauma exposure for the social workers providing crisis interventions to traumatic death survivors were pointed out by the participants. One such factor is controlled empathy. Another factor is social work practice in medical settings, especially acute hospital settings.

Controlled empathy. Controlled empathy as defined earlier in this study is the repeated need for professionals to control personal reactions and maintain a calm and empathetic response to clients sharing traumatic experiences (Bearse et al., 2013; Izzo & Miller, 2010; Kanno & Giddings, 2017). Participants related the thoughts that they must maintain composure due to being the professionals. In addition, participants communicated the obligation to be strong and focus on the survivors. The struggle with these responsibilities is evident in the comments that “you see these people’s lives change in an instant” and “we don’t see things through a microscope.” Participants offered the advice to leave the room if necessary to avoid an emotional display in the presence of the survivors.

Medical setting. Social workers practicing in medical, especially acute hospital, settings have additional stressors that can exacerbate reactions to trauma exposure. Participants named high workloads, demanding shifts (such as night shifts and long hours), and an intense pace as examples of such stressors. Unclear or unhealthy boundaries with physician and nursing staff members were also stressors pinpointed by some participants. One notable comment was that "I don't know if there's anything out there to really prepare you for a job like this."

Potential positive effects. The permeating theme from participants when exploring potential positive effects of trauma exposure on social workers was resilience. Participants discussed the potential for personal and professional growth, especially the ability to better serve future clients. They also found the value of learning experiences, especially in medical terminology and end of life situations in medical settings. Improved self-awareness and empathy were positive effects for other participants. To sum up as one participant stated, "If you can handle this, you can handle any other place. You got it. Everything else is a piece of cake after working here."

Recommendations for social workers. The participants provided recommendations for social workers to manage professional exposure to trauma in the context of crisis practice with traumatic death survivors in medical settings. Self-care and self-awareness were advised by most of the participants in the study. Support was also suggested, but there were significant barriers to support encountered by the participants in their work setting.

Self-care. The primary example of self-care recommended by the participants was time away from work. In addition, recommendations included counseling, hobbies, volunteering, short breaks, and processing stressful experiences. An obstacle to self-care voiced by participants was guilt.

Multiple participants expressed feelings of guilt related to taking time away from work. This was particularly noted because time off from work was the primary suggestion for self-care. Participants described feeling guilty about leaving their peers to cover their work while they are away and feeling guilty if they do not work long and extra hours. They appeared to recognize the importance of managing those feelings of guilt in the interests of self-care by accepting that self-care is essential and allowing others to help with coverage.

Self-awareness. Self-awareness is recommended for social workers exposed to trauma per the participants in this study. Specifically, social workers need to recognize when they are experiencing negative effects of trauma. Negative emotions and effects carrying over to home and personal lives were identified as important to recognize. In addition, participants discussed the aspect of desensitization and how essential it is for social workers to perceive when a traumatic death is not as impactful as expected or when their reactions to families are characterized by a lack of feeling.

Support. Participants identified the significant areas of support as peers, management, and multidisciplinary team members. Peer support was explored in the context of working with a peer when handling a traumatic death, informal debriefing with peers, camaraderie with peers, and seeking help from peers when social workers need

time away (briefly during a stressful situation or coverage for time away from work). Most of the participants voiced strong support from their peers in their work setting.

Management support included the importance of adequate training and preparation, effective communication, consistency, encouragement of adequate time away from work, and recognition of the difficult nature of the work. Though participants recommended that these management supports be in place, there were several comments suggesting that such supports are not in place or not consistent at their current work setting. Participants indicated that they can improve management support by being honest with management about their needs.

Support from multidisciplinary team members was primarily examined in the area of social work roles during traumatic deaths in medical settings. A widespread opinion among participants was that multidisciplinary team members have a lack of understanding of the social work role. This appeared to be a source of significant frustration for the participants.

The recommendation was stated and supported that the multidisciplinary team members need education about the social work role. This could benefit the social workers, the traumatic death survivors, and the multidisciplinary team members with more cohesive services and appreciation of the value of each team member. According to one of the participants, social workers "need to be seen as the expert in the process."

Summary

Findings answered the research question of the benefits of social work crisis interventions for traumatic death survivors. These benefits included more effective

services and mitigation of potential negative effects that could arise with a lack of social work crisis interventions for this population. The second research question was answered with the recommended social work crisis interventions for traumatic death survivors, which included the roles as advocate and guide, grief support (including the aspects of compassion, cultural awareness, and listening/ processing), viewing of the body, and explanation of next steps. Special issues discussed were the need to appropriately identify and communicate with next of kin and the use of terms related to death and the deceased individual.

Research questions related to professional trauma exposure on social workers providing crisis interventions to traumatic death survivors in medical settings were also answered. The possible negative effects of social work professional trauma exposure were identified as burnout and traumatic stress. Contributing factors were controlled empathy and the medical/ hospital setting. Potential positive effects of social work professional trauma exposure were resilience in terms of personal and professional growth. Recommendations to manage social work professional exposure to trauma were self-care, self-awareness, and support. Barriers to these recommended strategies were included in the discussion.

Positive aspects related to findings that were encountered during this study were the answers provided for all of the research questions and the consensus among the participants in their responses. One finding that was unanticipated was the precedence of the social work roles as guide and advocate for traumatic death survivors. Grief support was the expected primary recommendation for social work crisis interventions for

traumatic death survivors and was instead identified by participants as a secondary role. The findings related to social work professional exposure to trauma were consistent with previous research in this subject. In the next section, applications for professional social work ethics, recommendations for social work practice, and implications for social change are explored.

Section 4: Application to Professional Practice and Implications for Social Change

This qualitative study was conducted to explore the perspectives of social workers on the potential benefits of early crisis interventions with traumatic death survivors and the potential effects of crisis practice with this population on the social workers providing the services. Key findings related to services for traumatic death survivors were the benefits of social work professionals and the recommended social work crisis interventions in practice with this population. Findings related to professional exposure of trauma on social workers providing crisis interventions to traumatic death survivors included potential negative effects, contributing factors, potential positive effects, and recommendations to manage professional exposure to trauma.

Social work crisis interventions for traumatic death survivors in medical settings is a specific subject not easily found in current literature. The findings of this study may help to fill this gap by increasing knowledge on the subject and providing recommendations for practice. In this section, application to professional ethics in social work practice, recommendations for social work practice, and implications for social change are examined.

Application to Professional Ethics in Social Work Practice

The practice problem of social work crisis interventions for traumatic death survivors in medical settings is related to the social work ethical principles of service and competence and the social work ethical standards of responsibilities to clients, responsibilities as professionals, and responsibilities to the profession. Service as a social work ethical principle involves helping individuals in need and addressing social

problems (National Association of Social Workers, 2018). This project addressed services for the at-risk population of traumatic death survivors. Competence as a social work ethical principle includes increasing practice skills and contributing to professional knowledge (National Association of Social Workers, 2018). This study provided recommendations for social work crisis interventions in practice and increased knowledge in the subject.

The social work ethical standard of responsibilities to clients incorporates commitment to clients and cultural awareness (National Association of Social Workers, 2018). A commitment to clients and cultural awareness was evident in the recommended social work crisis interventions for traumatic death survivors in this study. This study was also consistent with the ethical standard of responsibilities to the social work profession because evaluation and research with knowledge development and use in practice is part of this standard (see National Association of Social Workers, 2018).

Responsibilities of professionals as a social work ethical standard encompasses impairment (National Association of Social Workers, 2018). Professional impairment as an ethical concept involves protecting client interests and ensuring that personal stressors do not adversely impact professional services to clients (National Association of Social Workers, 2018). This is related to the study due to the potential impairment of social workers who are in practice with traumatic death survivors and are exposed to professional trauma. Recommendations are offered to manage professional exposure to trauma and mitigate the risk of adverse effects to professionals and clients.

Recommendations for Social Work Practice

It is recommended that social work crisis interventions be provided to traumatic death survivors in medical settings to improve services. The crisis interventions that are recommended include the social work roles as advocate and guide, grief support (including compassion, cultural awareness, and listening and processing), assistance during the viewing of the body, and an explanation of next steps. Recommendations for social workers to manage professional trauma exposure when providing crisis interventions to traumatic death survivors in medical settings are self-care, self-awareness, and support.

Two action steps that I will implement in clinical practice are to organize the crisis interventions for traumatic death survivors in my setting based on this new knowledge and to educate peers and management in the medical practice setting about the importance of social work crisis interventions for traumatic death survivors and management of professional exposure to trauma. The recommendations offered in this study are applicable to medical settings, especially settings in which traumatic deaths often occur. Applicability is possible to other practice settings in which social workers provide crisis interventions and to broader social work practice in which social workers experience professional exposure to trauma.

This study is limited in generalizability due to the nonexperimental design, lack of random sampling, and small sample size from a single practice setting. Future research in the subject is recommended to replicate results and to increase knowledge. Possibilities for future research in the subject are similar studies in different settings and with different

participants. In addition, a possibility for future research is to explore the perspectives of traumatic death survivors in the subject. The findings from this study will be disseminated by publication by the sponsoring university and in presentations at medical practice settings and/or conferences applicable to the subject.

Implications for Social Change

There is potential for social change by raising awareness about the social problem of the need for social work crisis interventions with traumatic death survivors. Social change in practice with traumatic death survivors was implicated in this study. The population of traumatic death survivors is at risk for negative consequences, such as complicated grief reactions (Aldrich & Kallivayalil, 2013; Boelen et al., 2016; Englebrecht et al., 2016; Jacobs et al., 2016; Rheingold & Williams, 2015; Rynearson, 2012; Smith, 2015; Vincent et al., 2015; Youngblut et al., 2017). This population would benefit from social work crisis interventions following the death of a loved one in a medical setting, which was supported by the knowledge gained in this study. Recommendations for crisis interventions for traumatic death survivors were provided in this study, which can improve practice with this population and reduce their risk of complicated grief and other negative reactions.

Social change is needed for social workers who are exposed to trauma in practice. Professional exposure to trauma can lead to personal and professional negative outcomes for social workers according to the knowledge provided by the participants in this study. The participants provided suggestions for social workers to mitigate the possibility of these negative outcomes. This could reduce the possibility of personal risks to social

workers and the risks of professional impairment with consequences for clients and organizations.

Summary

Traumatic death survivors are an at-risk population who would benefit from social work crisis interventions in medical settings following the death of a loved one. The social work crisis interventions for traumatic death survivors that were supported by the information collected in this study are the social work roles as advocate and guide, grief support, viewing of the body, and explanation of next steps. Professional exposure to trauma, especially for social workers in medical settings, can lead to positive and negative effects. The recommendations for social workers exposed to professional trauma were self-care, self-awareness, and support. Knowledge gained in this study has implications for improvements in social work practice with traumatic death survivors and opportunities for future research in the subject.

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Appendix A: Participant Demographics

Demographic	Number of participants	Percentage of participants
Age (in years)		
18-29	1	11.11%
30-39	4	44.44%
40-49	4	44.44%
50-59	0	0%
60-69	0	0%
70-79	0	0%
80+	0	0%
Gender		
Female	9	100%
Male	0	0%
Transitioning Female	0	0%
Transitioning Male	0	0%
Other	0	0%
Ethnic identity [a]		
African/ African American/ Black	3	33.33%
Asian/ Asian American/ Pacific Islander	0	0%
Caucasian/ European/ European American/White	3	33.33%
Chicano(a)/ Hispanic/ Latino(a)	5	55.56%
First Nations/ Native Alaskan/American/Hawaiian	0	0%
Other	0	0%
Highest education level		
Bachelor	0	0%
Master	9	100%
Doctorate	0	0%
License status (Texas)		
LBSW	0	0%
LMSW	6	66.67%
LMSW-AP	0	0%
LCSW	3	33.33%
LCSW supervisor status	0	0%

Demographic	Number of participants	Percentage of participants
Years as licensed social worker		
Less than 3	1	11.11%
4-5	2	22.22%
6-9	4	44.44%
10-15	1	11.11%
16-20	1	11.11%
21 or more	0	0%
Years in current employment		
Less than 2	3	33.33%
2-3	2	22.22%
4-5	2	22.22%
6-9	1	11.11%
10-15	1	11.11%
16-20	0	0%
21 or more	0	0%

[a] Participants were instructed to select as many categories as applicable to them.

Appendix B: Summary of Findings