TRAUMA-MANAGEMENT AND EMOTIONAL SUPPORT IN CHILD WELFARE

NORTHEASTERN ONTARIO CHILD WELFARE WORKERS' EXPERIENCES OF TRAUMA-MANAGEMENT AND EMOTIONAL SUPPORT PROVIDED BY AGENCIES FOLLOWING THE DEATH OF A CHILD CLIENT

By ANDREW BARTON, B.A., B.S.W.

A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment of the Requirements for the Degree Master of Social Work

McMaster University © Copyright by Andrew Barton, September 2020

McMaster University MASTER OF SOCIAL WORK (2020) Hamilton, Ontario (Social Work)

TITLE: Northeastern Ontario Child Welfare Workers' Experiences of Trauma Management and Emotional Support Provided by Agencies Following the Death of a Child Client AUTHOR: Andrew Barton, B.A. (Nipissing University), B.S.W. (University of Waterloo) SUPERVISOR: Dr. Tara La Rose NUMBER OF PAGES: v, 101

ABSTRACT

Although the death of a child client is among the worst work-related events that a child welfare worker can experience, the phenomenon is tremendously understudied concerning how the event impacts the staff involved and how, or if, their employing agencies supported any mental health needs that may have arisen after the death. This study investigates what types of mental health/emotional support was made available to Northeastern Ontario child welfare workers following the death of a child client, and how effective that support was in helping the worker cope with any difficulties related to the death. This study was guided by principles of Constructivist Grounded Theory and semi-structured qualitative telephone interviews were conducted with five (5) participants. My analysis found that the death of a child client can negatively impact both the mental wellbeing of involved workers as well as the organizational climate of an agency. My analysis also found that workers may delay the emotions associated with the grieving process to effectively focus on the administrative requirements resulting from the child's death, potentially to their detriment. The different ways child welfare organizations supported staff through these events included individual and group psychological debriefings, grief counselling, and providing information regarding additional support options. Only three of the five workers engaged in the strategies provided to them by their agency, and of those three, only one found the services to be helpful with managing emotional difficulties related to the child's death. What remained true among all five participants was that they each had very personalized ideas as to what they felt would have best helped them through this difficult event. I conclude that based on related literature and the findings of this study, child welfare organizations are recommended to invest in a thorough and embedded agency framework of trauma-management that addresses policy and procedure development as well as support coordination at the pre-trauma, immediate trauma, and post-trauma levels. Additionally, trauma-management should not be a singular standardized response and should be tailored to the individualized needs of each worker. Agencies should be well-versed in delivering different strategies of trauma-management and letting the worker lead in determining what type of support they are looking for and when would be best to receive it.

ACKNOWLEDGEMENTS

I would like to thank Dr. Tara La Rose for supervising this thesis project and supporting me throughout the research process. Both your academic and employment background was ideally suited for this study and it was a pleasure to get to know you over this past year. I would also like to thank Dr. Bonnie Freeman for agreeing to be the second reader for this project and Dr. Randy Jackson for chairing the oral exam.

I would like to thank all of my fantastic family members who helped me both at home and while I was away during this past year.

I would like to give my deepest and most heartfelt thanks to my incredible wife. You are my best friend and my life partner. Without your support and encouragement, completing this program would have been impossible. To my daughter, you are so marvelous. Knowing you would soon be in my arms was all the motivation I needed to keep me going throughout all of my travel and stress this past year. To my little one on the way, I already love you and cannot wait to meet you.

Finally, I would like to extend my gratitude to the child welfare staff who participated in this study. The work you do is so incredibly valuable. Thank you.

Table of Contents

Introduction 1
Chapter One: Literature Review 7
I. The Current Organizational Climate of Child Welfare 7
II. Child Client Deaths and the Pain of Helping Others: Negative Stress Reactions and Grief 14
III. Workplace Crisis Management and Trauma-Response Strategies 25
Chapter Two: Theoretical Frameworks and Methodology 36
Symbolic Interactionism and Pragmatism 36
Constructivist Grounded Theory 38
Chapter Three: Methods 43
Study Population 43
Recruitment 44
Recruitment Results 47
Data Collection and Analysis 49
Chapter Four: Findings 51
Analysis Part 1: Overarching Categories 52
Category 1: "It never left me" – The Experience of Child Client Deaths 52
Category 2: "The Process" and its Impact on Organizational Climate: Fear, Blame, and Silence 56
Category 3: Delayed Grief and Processing 60
Analysis Part 2: Agency Trauma-Management and Emotional Support 65
Primary Agency Responses for Participants 65
Additional/Secondary Trauma-Management Responses 67
Desired Support for Workers After a Child Client Death 68
Chapter Five: Discussion 71
Practice Implications for Northeastern Ontario Child Welfare Agencies 71
Concluding Recommendations for Child Welfare Agencies 82
Limitations 85
Future Research 86
Conclusion 87
BIBLIOGRAPHY 89
Appendix A – Question 13 Instructions for Participants 99
Appendix B – Interview Guide 100

Introduction

Police officers, firefighters, paramedics, and child welfare workers (CWWs) all have one thing in common: their careers may, in one way or another, bring them into close contact with the death of a child. What sets child welfare apart from these other careers is that CWWs often have long-term and sometimes very close relationships with both the child and their guardians (Regehr, Chau, Leslie, & Howe, 2002). Even though child deaths are acknowledged as one of the worst work-related events that a CWW can experience (Dane, 2000; Horwitz, 1998; PSHSA, 2016; Regehr et al., 2002), this phenomenon is tremendously understudied (Douglas, 2013a, 2013b; Gustavsson & MacEachron, 2002; Pollard, 2018). While there exists a small number of studies that have explored the impact of child death on CWWs in the United States and the United Kingdom, Canada is lacking the development of scholarship in this area. More importantly, few of the studies completed on child deaths and the CWW experience take a particular focus on how, or if, agencies supported workers' mental health needs that may have arisen after the death occurred.

This research examines the aforementioned phenomenon in the Northern Ontario setting, which is vital considering that the region is greatly overrepresented with respect to society-involved child deaths. Between 2005 and 2016, the annual number of child deaths in Ontario has remained fairly consistent, ranging anywhere between 1092 and 1335 (Office of the Chief Coroner Province of Ontario, 2018). This number includes deaths that are natural, accidental, a result of homicide, suicide, and deaths that remain undetermined (Office of the Chief Coroner Province of Ontario, 2018). In 2016-2017, there were a combined 2113 deaths of children and youth in Ontario, and of these, 237 children had active or recent (within the past 12 months)

involvement with child welfare agencies or organizations (Office of the Chief Coroner Province of Ontario, 2018).

In Ontario, the statistics on child deaths vary greatly between geographical regions, and unfortunately, the data continually indicates a massive overrepresentation in rates of society-involved child deaths in Northern Ontario. According to the boundaries of the Northern Ontario Coroner's Offices, this region constitutes Algoma, Cochrane, Kenora, Rainy River, Thunder Bay, Parry Sound, Manitoulin, Nipissing, Sudbury, and Timiskaming (Ministry of the Solicitor General, 2019b; Office of the Chief Coroner Province of Ontario, 2018). These Northern regions account for merely 7% of *all* paediatric deaths in the province, but 26% of paediatric deaths with child welfare involvement (Office of the Chief Coroner Province of Ontario, 2018).

In yet another significant overrepresentation, of these Northern Ontario child and youth deaths with child welfare involvement, nearly 70% were Indigenous[1] children (Office of the Chief Coroner Province of Ontario, 2018). The majority of these society-involved children and youth deaths had open child welfare files at the time of their passing, as opposed to having their file closed within the preceding year (Office of the Chief Coroner Province of Ontario, 2018). For every death in an open case, many individuals have the potential to be severely impacted, which beyond the child's immediate family can include child welfare workers, supervisors, and support workers.

Research Questions and Objectives

In situating myself within this research, I am directly implicated/represented in the statistics I have presented above, as I am a CWW practicing in Northeastern Ontario who has

[1] 68% in 2016 and 64% in 2017

experienced the death of a child on my caseload. The child's passing was completely unanticipated and tragic for all of those involved. My daughter was just slightly older than the little one that passed, and I fear that I may have over empathized with the parent's emotions, intermingling and confusing my elatedness of new fatherhood with their grief. That being said, this level of empathy which developed from the shared connection of parenthood resulted in what I felt was highly compassionate case management and emotional support for this parent. A child's death in child welfare is an all-consuming occurrence and can take weeks, months, or even years to resolve concerning certain aspects such as the cause of death and police determination of parental criminality.

The month or so following this child's death was extremely difficult for me; during this time, I balanced many roles, including supporting the parent's emotional needs, completing the administrative tasks of the police/child welfare investigation, tending to all my other families, as well as grieving the loss of a child that I spent time with frequently from their birth to their death. I found that my experience of child client death was simply an emotional one. It turns out that I did not have as good a set of coping skills as I thought. While I managed to present well while at work, I found myself quite emotional at home, thinking about the child and parent often.

A CWW has a unique relationship with their clients. Whether working on a voluntary or involuntary basis, they gain access inside a family unit, seek to learn their most intimate and sometimes troubling details, and then the relationship is simply over when the risks have been mitigated, the file has been transferred to another worker, or no more children remain in the parents' care. In child welfare practice, there are ample "administrative" endings with clients, but emotional endings are often lacking. To elaborate, in my experience with child client death, there

were no other children involved and there were no criminal charges, so soon after the death of this child the file needed to close from an administrative standpoint.

The abrupt administrative ending was not able to provide me with what I believe was proper closure of the death, considering that I worked closely with the family for an extended time and then was integrally involved in one of the worst moments of their lives. However, from an institutional standpoint, this kind of closure is simply the nature of child welfare work. CWWs are not meant to be friends with their clients and they are not meant to become members of the family. The child welfare worker's job is to protect children and foster familial growth and strength in an effort to ameliorate any future risk of abuse/neglect. But at the end of the day, CWWs are human. It is inevitable that I and other workers in the field find certain clients and families likable and develop strong connections. When one of these positive connections ends with the death of a child, it seems almost inevitable that it would cause some degree of psychological harm to the workers involved.

I feel that I could have dealt with the death better with additional supportive resources, but child welfare culture doesn't seem to allow for a "pause" after the death of a child; this culture demands that the work just continue. Ever since this experience, I became immensely interested in understanding how child welfare work impacts staff and the workplace mental health supports that are available in child welfare settings; in particular, as it relates to the deaths of child clients. I often wondered how agencies were supporting worker mental health (in the context of child death) across the province, how they were responding to critical incidents, the range and timeliness of these supports, and how effective they were at minimizing various negative stress reactions such as vicarious traumatization and burnout.

My research aims to explore how CWWs practicing in Northeastern Ontario experience agency-provided trauma-management and emotional support after the death of a child client. This will effectively bring further qualitative data on child death and CWWs to the Canadian context, while also bringing additional attention to a region of the province in which child-welfare related fatalities are greatly overrepresented. Additionally, this study recruited participants from both Indigenous and non-Indigenous child welfare/wellbeing agencies, which I believe is vital due to the tragic overrepresentation of Indigenous child welfare-related deaths. This thesis was guided by four underlying questions:

1. How do CWWs experience the death of a child client?
2. What level and types of mental health/emotional support was made available to the workers by their agencies after the death?
3. How effective was that support in helping the worker cope with any difficult emotions/stress reactions related to the child's death?
4. What level and types of mental health/emotional support do workers feel is needed after the death of a child client?

Overview

In this thesis, I will begin by conducting a review of the literature, covering topics such as the current organizational climate/culture of child welfare, child deaths as experienced by CWWs, grief and negative stress reactions, and workplace trauma-management and support techniques. Following the literature review, I will outline this study's guiding theoretical perspectives and methodology, which are Symbolic Interactionism, Pragmatism, and Constructivist Grounded Theory, respectively. Following the chapter covering theory and methodology, I will outline this study's methods before summarizing the findings that arose

based on my analysis of the interview data. The thesis will be concluded with a discussion on the implications for practice stemming from the findings, as well as noting the study's limitations and addressing recommended trauma-management strategies for child welfare agencies specific to the experience of child client deaths.

Chapter One: Literature Review

Broadly speaking, my study is situated within several areas of literature including child welfare, workplace stress/trauma, child maltreatment fatalities, death and dying, mental health, and trauma-management. This literature review will begin by outlining the current organizational climate of child welfare and what events and phenomena have shaped this culture. Next will be a review of literature on child welfare workers' experiences of child deaths and their impact, before concluding with an overview of trauma-management and emotional support strategies both generally and as it pertains to child welfare and the challenge of child death in the practice context.

I. The Current Organizational Climate of Child Welfare

My first day as a child welfare worker went a little something like this: I spent the morning shadowing a worker to an emergency response call in a neighbouring community after allegations arose about the state of the parents' substance use/mental health. While my co-worker was permitted in the home, the father went "chest-to-chest" with me and strongly assured that I was not going inside. I uncomfortably slid around the father to support my co-worker in the home, an action I am not sure I would repeat today. Once inside, I was being so aggressively targeted by the father that my co-worker asked me to wait in the car. After my co-worker was able to successfully investigate the concerns in the home, they concluded the home visit and we left soon after.

When work was over that day, I reflected on the high emotional and physical tension I had experienced in only my first few hours of work. Soon after 4:30 pm, I received a call at home asking if I could support a worker at the hospital who was bringing an infant to a place of

safety. I rushed to the hospital and met this co-worker. The worker needed to leave the hospital to look into a foster home as a potential placement for the baby involved in the case; I was asked to remain while the infant was thoroughly assessed by a physician. There I was, alone in the hospital with an infant. Up until that point in my life, I had only held a newborn on one occasion and had certainly never fed or changed one. The nursing staff was continually asking me for direction as I nervously tried to explain that it was my first day and I had no answers to their questions. As the clock eventually reached 7:30 pm and I sat there rocking the infant, I thought, "what on earth did I get myself into?"

While this story may sound extraordinary, this kind of work experience is certainly not unique for people engaged in child welfare practice. The present climate of child welfare is remarkably frenetic with exhausted workers managing extraordinarily high caseloads, all the while trying to keep up on increasing administrative demands with dwindling resources. The day-to-day pressures on child welfare workers are immense. It is often thankless work on a good day, and on a bad day, mistakes may contribute to a child being harmed or killed, which may lead to workers experiencing public outrage, media persecution, and being obliged to participate in an inquest; while these outcomes may sound extreme they are not uncommon in many child welfare workers careers (Choate, 2017; Jagannathan & Camasso, 2017; Richardson, 2011).

To illustrate this, Richardson (2011) insightfully notes that in the context of child welfare service, the public is nearly impossible to please, as too much child welfare intervention and too little child welfare intervention are both received poorly and used as proof of the field's ineptitude. The previously outlined troubles plaguing the field are all set within a backdrop of defensive child welfare practice, which can breed organizational climates of fear, blame, silence, and intense "cover your rear end" accountability. This climate did not emerge overnight but has

arisen slowly along with the growth of neoliberal ideologies, managerial practices, high-profile inquests, and an increased focus on investigation and risk management that has been evolving since the 1970s.

Ideology

Canadian social policy is, generally speaking, oriented in the neoliberal; meaning it relies on the capitalist economy and the family to meet individual needs accompanied by limited government assistance as a last resort (Mahon, 2008). There are many versions of liberalism, such as classical liberalism, new/social liberalism, inclusive liberalism, and neo-liberalism (Mahon, 2008). Beginning in the postwar era, Canada saw the growth of widespread social services to address the collective needs that were not being met by the market; which could be seen as a period of social liberalism (Baines, Charlesworth, Turner, & O'Neill, 2014; Mahon, 2008). However, since the 1970s and 1980s, Canadian social welfare has increasingly moved away from social liberalism while embracing neoliberalist ideologies, which can be described as a focus on promoting individual agency within a free market system (Aronson & Smith, 2011; Samson, Tanchak, Drolet, Fulton, & Kreitzer, 2019). This shift resulted in a common contracting-out of social services to a mixture of public, private, and for-profit organizations (Aronson & Smith, 2011; Baines et al., 2014).

Paralleling the rise of neoliberal ideologies and the contracting out of social services, high-efficiency models of management (e.g. New Public Management) aim to save costs and increase efficiency at the organizational level (Baines et al., 2014). Within social work, this ultimately led to the introduction of quality assurance measurements, performance indicators, and an attempt to quantify the practice of social work (Baines et al., 2014). Overall, the ideological shift to neoliberalism and introduction of high-efficiency management models have ushered in an era of

social work defined by accountability, efficiency, and high caseloads, all while service funding is decreased to save costs (Samson et al., 2019); meaning social workers are attempting to perform increasing tasks and to hold increasing responsibility with increasingly fewer resources.

I feel it is important to further consider the concept of accountability in modern social work practice as it relates to neoliberalism. Leung (2008) considers accountability to be a social process made up of "account giving and account receiving, which is embedded with explicit or implicit power" (p. 534). In this social process, there exists an "agent", who is responsible, and a "principal" who has entrusted the agent with the responsibility; the agent is answerable to the principal (Leung, 2008). The rise of accountability in social work can be traced back to neoliberal ideologies, with models of quality assurance demanding increased feedback from, and accountability to, clients and service users (Leung, 2008). Under the previous model of accountability, social workers were primarily accountable to those above them but they are now also involved in "downward" accountability to service users (Leung, 2008). Additionally, in this neoliberal accountability discourse, social workers are not only answerable to those below and above them, but also to a complex web of various principals, including funders, political bodies, professional bodies, and the public (Leung, 2008).

Inquests

While neoliberal ideologies impact how social work is practiced and social welfare organizations operate, certain unique phenomena contributed significantly to the current climate of defensiveness, blame, and accountability often found in child welfare organizations. For example, inquests are a common response to child welfare deaths and are designed to objectively investigate the facts surrounding a death (Ministry of the Solicitor General, 2019b), and can, in the course of these evaluations, draw attention to procedural errors; the process of identifying

errors is sometimes described as a means of "naming and shaming" (Cradock, 2011, p.364). There are several categories of death that prompt a mandatory inquest, one of which is a child's death resulting from a criminal act committed by a custodial guardian (Ministry of the Solicitor General, 2019a).

At the end of an inquest, it is common (although not mandatory) for the jury to make recommendations intended to prevent future deaths (Ministry of the Solicitor General, 2019a). Beginning in the 1990s and continuing to this decade, Ontario saw several high-profile inquests and subsequent recommendations leading to sweeping changes within child welfare and helped shape practice into a strict form of familial surveillance with an intense focus on worker and agency accountability (Swift & Parada, 2004). It has been argued that it was the media that first started questioning how these child deaths were *allowed* to happen and thus introduced the "fault-oriented bias" when looking into child welfare deaths (Ayre, 2001).

During an inquest, workers are required to recall events at an extremely high level of scrutiny, knowing that their career may be on the line, and in worst-case-scenarios, that criminal or civil charges may result. Kanani, Regehr, and Bernstein (2002) highlighted some of the first cases in which Canadian child welfare staff were held criminally and civilly liable for the death/abuse of children[2]. CWWs being established as individuals who can be held accountable for inadequate child protection work created a monumental shift in the climate of child welfare, which can be summarized as the "personal liability paradox" (Kanani, Regehr, & Bernstein, 2002). This paradox describes the dilemma of child welfare decisions being based on the risk to personal/agency liability rather than based on the best interest of the family (Kanani et al., 2002).

[2] In 1982, 1997, and 1999.

Concerning how this changes organizational culture, CWWs being held "responsible for what they cannot prevent raises an inherently stressful responsibility to an unattainable and morale destroying level of accountability" (Kanani et al., 2002, p. 1036).

Some have noted that the increasing use of inquests and their subsequent recommendations have helped move the profession's scope from child *welfare* to the much narrower child *protection* (Rogowski, 2015). In this shift, the profession switched focus from a more medical model of diagnosing and treating ("medico-social" model), to a litigious focus on investigation, risk assessment/management, and evidence gathering ("socio-legal" model) (Rogowski, 2015; Thomlison & Blome, 2012). Rogowski (2015) acknowledges that this shift is not solely the result of inquests and is only one part of several impacting phenomena such as neoliberal ideologies and managerial practices.

In situating this overall conversation within the local context, Ontario child welfare is organized through the Child, Youth, and Family Services Act (CYFSA - previously titled the Child and Family Services Act - CFSA) (Information and Privacy Commissioner of Ontario, 2020). The CYFSA organizes vital aspects of child and youth services, such as child welfare, youth justice, and mental health (Information and Privacy Commissioner of Ontario, 2020). Many high-profile inquests and subsequent recommendations contributed to an overhaul of the CFSA in the year 2000 (Swift & Parada, 2004). Some have argued that these events led child welfare to a point where workers, not the government, bear the primary burden of liability for the deaths of children (Swift & Parada, 2004), thus directly contributing to the current climate of fear, blame, and defensive social work.

Organizational Silence

Organizational silence is another crippling aspect of the modern neoliberal work culture. Elizabeth Wolfe and Frances Milliken (2000) present this concept as the idea that employees are entirely aware of agency troubles, but do not voice such concerns. Some explanations of why employees fail to voice such concerns as expressed by these authors are the idea of *fear of reprisal* and the feeling that speaking up would not change anything within the work context (Wolfe Morrison & Milliken, 2000). This notion of organizational silence is argued to have developed for two primary reasons: 1) managers fearing negative feedback, and 2) managers holding unspoken negative beliefs about employees (e.g. employees are dishonest, managers know what is best) (Wolfe Morrison & Milliken, 2000).

Although Wolfe and Milliken orient their writing more in the context of the business/corporate world, it is reasonable to assume that this phenomenon is present in child welfare as well, particularly given how much the profession has adopted managerial and business-style practices in the past few decades. While not speaking to organizational silence as a whole, one child welfare study did find that harmful agency culture actively contributed to silencing workers from seeking help (Oates, 2019). This study found that the workplace culture dictated that inadequate coping with stress and trauma meant a worker was incompetent in their role (Oates, 2019). As a result, staff felt silenced and did not speak up for help out of fear of losing their job (Oates, 2019).

In summary, the neoliberal reframing of risk means that in child welfare practice contexts, determining the risk of culpability to an agency is becoming just as important (if not more so in some contexts) as determining the risk of harm to a child. As demonstrated above, decades of legislative revisions, high-profile inquests, bleak media coverage, and massive

upswings in administrative tasks and worker accountability have created a practice of child protection where the role "is less about the 'right decision' and more about a defensible decision" (Pollack, 2008, p. 12, in Beddoe, 2010). The impact this has had on child welfare culture is toxic, resulting in employees feeling silenced, fearful, and left with the feeling that protecting yourself, and the agency, is the true driving force behind the work.

II. Child Client Deaths and the Pain of Helping Others: Negative Stress Reactions and Grief

The purpose of this section is to outline the ways in which child welfare practice impacts workers, both generally and as it relates to the deaths of child clients. The first area of focus will be the various negative stress reactions that CWWs may experience as well as some studies that highlight their prevalence in the field. Attention will then be paid to the few studies on child client deaths and how this unfortunate phenomenon can impact CWWs.

Negative Stress Reactions

Klein & Alexander (2011) argued that an event is considered traumatic when it has overwhelmed or could overwhelm the coping capabilities of an individual. When employed in fields such as social work, emergency medical services, or policing, staff can frequently be exposed to traumatic details and events, with incidents ranging from acts of terrorism, murder, or child abuse (Molnar et al., 2017). In the literature on workplace trauma, Secondary Traumatic Stress (STS), Vicarious Traumatization, (VT), Compassion Fatigue (CF), and Burnout are commonly studied in fields with high proximity to the pain of others. It is fairly easy to get lost in an inquiry of these stress reactions as they are outlined in the literature, as many terms are used interchangeably [e.g. STS interchangeable with VT (Molnar et al., 2017), STS

interchangeable with CF (Conrad & Kellar-Guenther, 2006), and CF interchangeable with VT (Anne Dombo & Whiting Blome, 2016)]. The reason that the terms are so often used interchangeably is that they all essentially describe the same phenomenon, which is the human consequence of helping others in painful/traumatic situations (Figley, 2012).

STS and VT both generally reference the impact stemming from indirect trauma exposure (Figley, 1995; Ludick & Figley, 2017; Nelson-Gardell & Harris, 2003; TEND, 2020a). Where they differ is that STS involves measurable symptoms that closely align with PTSD expressed through symptoms like intrusive images, avoidance, and physiological arousal (Bride, Jones, & MacMaster, 2007; Figley, 2012; Ludick & Figley, 2017; Molnar et al., 2017), while VT refers to a shift in world view and a negative transformation of self over time (Bride et al., 2007; Figley, 2012; TEND, 2020a). While PTSD and STS, generally speaking, have the same symptomology, the primary difference is that PTSD involves an individual who has experienced direct trauma, while STS is more in reference to individuals witnessing/hearing details of someone else's direct trauma (TEND, 2020a).

To exemplify STS, imagine a CWW who is experiencing unwanted intrusive images following a child's graphic disclosure of sexual abuse; these unwanted images may be a result of secondary traumatic stress. Using the same example to showcase VT, repeated exposure to such graphic disclosures resulting in a CWW's distrust of any adult interacting with the CWWs own child may be the result of a shift in worldview due to vicarious traumatization (i.e. the shift being that all adults are now considered potential predators and cannot be trusted). This shift in worldview/self-transformation occurs when a worker has, over time, absorbed the various experiences of the trauma survivors they work with (Anne Dombo & Whiting Blome, 2016; Bride et al., 2007).

CF is an additional phenomenon related to experiences of working in environments with high levels of trauma exposure. CF can be simply thought of as the significant wearing down of a clinician, both emotionally and physically, which results in an inability to replenish one's self to help others (Conrad & Kellar-Guenther, 2006; TEND, 2020b). This inability to effectively help clients is not necessarily permanent, and in the same way that CF takes time to embed in a social worker, it takes time, increased self-care, and establishing a proper work-life balance to remedy (TEND, 2020b).

Burnout differs from the aforementioned stress reactions as it can be applied to most careers, not just the ones with high-trauma populations (Anne Dombo & Whiting Blome, 2016). Burnout can arise when workers have low levels of satisfaction with work, perceive themselves as powerless in the workplace, and are overwhelmed with work demands (TEND, 2020b). Burnout has also been established as having three distinct properties: tremendous emotional exhaustion, depersonalising/detachment from work, and feeling a lack of personal accomplishment/effectiveness at work (Anne Dombo & Whiting Blome, 2016; Conrad & Kellar-Guenther, 2006; Maslach & Leiter, 2016; Travis, Lizano, & Mor Barak, 2016)

Within my thesis, I refer to all of the above typologies generally as Negative Stress Reactions (NSR). I chose this terminology because I am not measuring the prevalence of specific typologies in my study, nor am I seeking out their symptoms in the participants' narratives. My study is working on the assumption that the death of a child client triggers a continuum of NSRs for a worker, from little impact to extraordinary impact. As will be outlined below, it is fairly well established that NSR's are extraordinarily prevalent in the field of child welfare. I do not intend to contribute to the upcoming literature on NSRs within child welfare, but rather, to illuminate the more limited field of the child welfare worker experience of child death and

subsequent mental health support. I, therefore, believe that outlining the types of NSRs that exist and their prevalence within child welfare is a necessary starting point for any discussion within the realm of workplace trauma (such as child death) and workplace trauma-management.

Negative Stress Reactions in Child Welfare

It is almost stating the obvious to say that intimate work with the physical, sexual, and emotional abuse of children and infants places CWWs at risk for the side effects and symptoms of STS (Bride et al., 2007; Figley, 1995). Bride et al. (2007) found that of 187 Tennessee (US) CWWs, 92% had experienced a symptom of STS in the week prior to being surveyed. Another sample of US CWWs coping with symptoms of STS highlighted that over time, workers experienced behaviour changes such as setting work limits so as not to "take cases home" and detachment from emotions (Dane, 2000). In a large-scale Ontario study regarding worker safety and violence, there was a minor focus on secondary trauma. The researchers were able to obtain data from 5,800 of Ontario's roughly 8,665 CAS employees and found that, at some point in their career, nearly 50% had experienced secondary trauma, and of that 50%, 45.3% were psychologically distressed by the incident (SPR Associates Inc., 2014). However, one of the challenges with the SPR study was that the contexts and specifics of this trauma-exposure were a bit unclear.

Bride et al. (2007) also found of CWWs sampled in their study, 34% met the criteria for PTSD. Other literature also reports that social workers, in general, have higher rates of PTSD than the general population (15.2% versus 3.5%, respectively) (Douglas, 2013b) and that CWWs have higher levels of psychiatric distress than the general public (Bride et al., 2007). Douglas (2013b) argues that PTSD within the CWW workforce is quite obviously a hindrance, as it increases the chance of burnout and CF. Some authors even argue that CF (Conrad & Kellar-

Guenther, 2006) and burnout (Drake & Tadama, 1996) are "inevitable" due to the nature of child welfare.

The rates of burnout and CF can also be quite high within the realm of child welfare, with some literature showing rates of CF within CWWs ranging between 37% and 50% (Conrad & Kellar-Guenther, 2006). Baker (2018) found that in a survey of Southern Ontario CWWs, 87% felt worn out and emotionally exhausted. Burnout in child welfare has been attributed to several sources including emotional exhaustion, high caseloads, confrontational clients, and a lack of public support, to name a few (Conrad & Kellar-Guenther, 2006). Interestingly, Drake and Tadama (1996) found child welfare to have more role conflict than any other type of social work position, and it was later determined that role conflict was a significant predictor of emotional exhaustion (Travis et al., 2016).

In addition to various NSRs, a study of Kentucky (US) CWW's found that the stress of the job led some workers to engage in unhealthy habits such as overeating, unhealthy eating, substance use, and high-risk alcohol use, in addition to workers displaying physical health problems such as weight gain, fatigue, and high blood pressure (Griffiths, Royse, & Walker, 2018). Other studies have found more unanticipated consequences to being a CWW. For example, as a result of working with violent and aggressive parent clients, some workers have had to change their names, their vehicles, and have even received police surveillance for protection (Littlechild et al., 2016). In conclusion, CWWs are exposed to several types of traumas and events in the course of their work and as a consequence, can suffer from NSRs as well as health and social problems.

Child Client Deaths and Child Welfare Workers

The work of a CWW may bring them into close contact with a wide range of deaths. Studies have shown that CWWs may be exposed to parental substance overdose deaths, terminally ill children, one parent murdering another, and of course, a child dying at the hands of their parent or guardian (Csikai, Herrin, Tang, & Church II, 2008). When a Child Maltreatment Fatality (CMF) occurs, it means that a child has passed away either as a direct or indirect result of abuse or neglect (Douglas, 2013a). CWWs may also be involved with families where a child's death lacks any abuse or neglect, such as suicides, car accidents, or accidental drownings.

The prevalence rate of CWWs who have experienced child client deaths is sometimes generalized, but I am not sure an *exact* number exists for a region such as North America. As mentioned previously there were 2113 child and youth deaths in Ontario in 2016/2017, and 237 of those children had active or recent involvement with child welfare agencies or organizations (Office of the Chief Coroner Province of Ontario, 2018). This quite obviously means *237 workers either experienced a child's death on an open file or a file they recently closed.*

Some researchers estimate that between 531-885 of American CWWs are involved in child deaths on an annual basis (Douglas, 2013a).[3] Several studies that have sampled from large groups of CWWs also provide some further context as to how many workers may experience the death of a child client. Douglas (2013a) obtained data from 452 CWWs across multiple states and 193 (43.4%) had experienced a child's death. Similarly, a study of 138 CWWs in a single Southern State found that 42% had been involved with a child's death (Csikai et al., 2008).

[3] However, this number seems a little conservative in comparison to just the province of Ontario, considering the massive disparity in population between the U.S. and Canada.

There is an extremely small, but growing, body of literature about the impact of child client deaths on child welfare workers (Csikai et al., 2008; Douglas, 2013a, 2013b; Gustavsson & MacEachron, 2002, 2004; Horwatch, 1995; Pollard, 2018). The book *Beyond Blame: Child Abuse Tragedies Revisited* was published in the UK in the early 1990s, and is among the first works that considered how child deaths impact on CWWs (Reder, Duncan, & Gray, 1993). Since *Beyond Blame*, there have been a small number of studies published that more directly focus on the CWW experience of child death.

In both qualitative and quantitative inquiries into the CWW experience of child death, the personal impact is palpable and sometimes enduring. CWWs may end up with feelings of guilt and worthlessness (Gustavsson & MacEachron, 2002; Horwatch, 1995), nightmares and flashbacks of the event (Horwatch, 1995; Regehr et al., 2002), and mental/physiological effects such as depression and post-traumatic stress disorder (Douglas, 2013b; Regehr et al., 2002). Studies also show that after child deaths workers may question themselves and their abilities, wondering if they missed signs and questioning why they couldn't see the death coming (Douglas, 2013a; Gustavsson & MacEachron, 2002). Child deaths may also be traumatic for workers based on having children the same age as the deceased child, which may result in CWWs imagining their child in the scenario of the deceased (Horwatch, 1995). By extension, child deaths may impact how CWWs behave with their children, as some reported being unwilling to allow any other individuals to supervise their child after experiencing the death of a child client (Douglas, 2013a).

Gustavsson and MacEachron (2002) took a particular focus on the relationship dynamics that exist when a child dies, and posited that negative stress reactions (NSRs) may depend on the nature of the death (sudden/traumatic vs anticipated) and the worker's relationship with the child

and parents (strong/positive vs vague/negative). In other words, the situation that places workers at the highest risk for NSRs[4] would be a positive relationship and a sudden/traumatic death, while the lowest risk situation would be a negative relationship and an anticipated death (Gustavsson & MacEachron, 2002). Two additional categories in this matrix should be considered in the context of causing NSRs: positive relationship and anticipated death; and negative relationship and sudden/traumatic death (Gustavsson & MacEachron, 2002). These concepts are mapped out in the following table, which has been adapted from the original for enhanced clarity:

Table 1 – Model of Child Death Grief for CWWs (from Gustavsson and MacEachron, 2002)

	Sudden Death	**Anticipated Death**
Positive Relationship	Initial pain Limited grieving PTSD Risk	Painful loss Extended grieving Complicated grief risk
Negative Relationship	Initial shock Transitory sadness	Little/no shock Existential evaluation of life/death

Gustavsson and MacEachron's (2002) assertions are consistent with a more recent study that found CWWs who were closely working with the family right up until the child's death yielded higher rates of post-traumatic stress symptoms (Douglas, 2013b). Further, Douglas (2013b) found that workers who felt responsible for the death were at higher risk of mental distress. This was a key finding in their study and suggests that workers who experience child deaths when they are actively and closely working with the family and also feel that they could have done more to prevent the death are at the highest risk for mental distress (Douglas, 2013b).

[4] They refer to this model in relation to workers experiencing grief, which I am including in the umbrella of NSRs.

Child welfare agencies assigning individual blame following a death is another common theme noted in the literature about CWW experiences of client child deaths. Workers sometimes feel that when their agency is examining what led up to the death, it is done so with a lens of critique and assigning blame as opposed to learning about what could have been done differently (i.e. educational) (Douglas, 2013a). This can likely be traced back to the previously established culture of accountability and agency exposure to risk. This organizational culture of blame may further alienate workers, as in some instances, workers felt they were avoided by colleagues after child deaths (Horwatch, 1995; Regehr et al., 2002). In another study, workers felt interrogated about what happened in the case and did not believe that they were allowed to tell their side of what occurred (Pollard, 2018). While it is understandable that an agency may need to determine its culpability, Gustavsson and MacEachron (2002) note that this investigatory preference toward organizational processes does not enable workers to address their own grief.

In examining the state of the literature, I have noted several significant works that will directly guide my research, but I have also identified important gaps that need to be addressed. My research expands upon the definition of child death to include all types, which will add another layer of understanding of this phenomenon. For example, Douglas (2013a) used the precise definition of "Child Maltreatment Fatalities" which only includes children that have died as a direct or indirect result of abuse and/or neglect. This excludes workers whose child client may have died as a result of an accident or by completing suicide, both of which are situations that may be traumatizing for a worker depending on their relationship with the client, the details of the death, and the worker's trauma history and life circumstances.

Additionally, I aim to bring a qualitative side to this research as Douglas's (2013a) exploration of workers' experiences consisted of open-ended survey questions in a quantitative

inquiry, which did gather great data but did not allow for supplemental questioning or in-depth exploration of the phenomenon and workers experiences of these phenomena. I also hope to partially answer Douglas' call for future research, which involves exploring "the extent to which workers are provided with formal assistance…and its effectiveness in preventing emotional distress" (Douglas, 2013a, p.69).

Gustavsson and MacEachron have written two salient publications relevant to my work, one of which focuses on the experience of child death from the worker's perspective (2002) and one of which focuses on child death from an agency perspective (2004). My study builds off of these two articles in several ways. First, both their 2002 and 2004 studies were assertions based on the literature and did not include any new original data from CWWs. Additionally, given the year of publication of these pieces, many of the cited studies were conducted almost 30 years ago, which raises questions about current relevance and transferability to today's child welfare sector. This gap in research also raises concern as to why there has not been more research done during this time, considering child deaths have not ended, nor will they. Secondly, I am trying to address at least a few items outlined in Gustavsson and MacEachron's (2004) proposed agenda for future research. One item is to study how stress varies across crisis events and different child welfare workers, which will be present in my analysis of how the child's death impacted each worker in the study. Also, just as in Douglas (2013a), Gustavsson and MacEachron (2004) suggested further research into agency interventions and support following child client deaths.

It also makes sense to briefly touch on the extensive 2014 report by SPR Associates to look at how I can build upon their massive inquiry. As previously mentioned, SPR Associates (2014) managed to collect data from 5,800 child welfare employees in Ontario (67%) thanks to the participation of 34 of the province's 46 child welfare agencies. In noting the limitations of their

study, the authors highlighted the lack of participation from Indigenous agencies. While I was unable to recruit participants from all Indigenous Northeastern Ontario organizations, two of the five participants in this study are from the indigenous child welfare/wellbeing sector. More importantly, the issue of child deaths was merely categorized into an "other" category regarding a question on secondary trauma, and so it was not known how many of the 5,800 workers had experienced said phenomenon nor was it explored in more nuanced and complex detail as part of this provincial inquiry. It is disheartening to think that likely one of the largest provincial inquiries missed such a vital opportunity to gather data on the impact of child client deaths[5]. Considering the loss is one that some scholars already believe is disenfranchised, purposeful exclusion or careless oversight in this massive study may further contribute to this type of loss not being seen as one that is significant for workers.

Grief: Delayed and Disenfranchised

A few studies have highlighted the unique way in which grief over the death of a child may be experienced by child welfare workers in that their grief may be delayed and/or disenfranchised. Originally conceived by Kenneth Doka, disenfranchised grief refers to the idea that an individual is not given a right to grieve (Attig, 2004). Doka outlines various types of bereavement that hold the potential to be disenfranchised: non-traditional relationships, or relationships not seen as traditionally close (e.g. social worker and client); losses wherein the death is not seen as a significant loss (e.g. pets); losses where the griever is not seen as someone who could grieve (e.g. young children); and circumstances of the death that may limit support (e.g. suicides, death from a stigmatizing disease) (Attig, 2004). In the context of child welfare, Gustavsson and MacEachron

[5] Although to be fair, secondary trauma was not the primary purpose of their inquiry.

(2002) note the lack of bereavement groups for CWWs to resolve the grief of child death, and Pollard (2018) more directly ties the experience of child client death to the concept of disenfranchised grief. A CWWs grief may be disenfranchised based on more than one of the categories above, for example, as a relationship that is not seen as traditionally close, and as a griever who is not seen as someone who could grieve.

While grief is a perfectly normal and acceptable response to death, there can be considered normal and abnormal grief reactions. Of the various abnormal/complicated grief processes, one particular reaction relevant to this study is *delayed* grief (Ginzburg, Geron, & Solomon, 2002). Delayed grief can be thought of as a gap between the loss and the start of grieving, a gap that could be anywhere between weeks, months, and years (Ginzburg et al., 2002). Delayed grieving in the context of child welfare deaths was addressed by Gustavsson and MacEachron (2004). In their paper on child client deaths, they note the various responsibilities that follow a death may result in a CWW postponing the grieving process, which could lead to worse psychological coping and further negative consequences (Gustavsson & MacEachron, 2004). In this sense, delayed grieving in child welfare may not simply be an unconscious delay of the grieving process, but a more conscious delay due to the enormous job requirements.

III. Workplace Crisis Management and Trauma-Response Strategies

When it comes to trauma-management and emotional support in the workplace, both primary and secondary prevention strategies may exist. Primary prevention strategies (PPS) look to reduce the negative stress effects of trauma by intervening *before* the traumatic event (Handa, Krantz, Delaney, & Litz, 2011). Most commonly found in emergency response careers such as firefighting and policing, PPS can include activities such as classroom teachings (Handa et al.,

2011). The classroom pre-trauma training may focus on anything from setting expectations for what could happen in their specific line of work, to discussing behaviour, coping skills, and risk identification (Handa et al., 2011). In short, the goal of PPS is to equip staff with information that better prepares them for managing negative stress reactions in the wake of trauma (Handa et al., 2011).

In contrast to PPS, secondary prevention strategies (SPS) are interventions undertaken *after* the traumatic event and may include several approaches, such as critical incident stress debriefing (CISD), psychological first aid (PFA), cognitive behavioural therapy (CBT), and Eye Movement Desensitization and Reprocessing (EMDR) (Handa et al., 2011; Molnar et al., 2017). The goal of SPS is to, expectedly, lessen the direct impact of trauma after it has happened (Handa et al., 2011). Although by no means is this discussion exhaustive, I will briefly outline some of the most commonly utilized trauma management strategies with an emphasis on their efficacy.

PPS and SPS Efficacy

PPS – Pre-Trauma Training/Education

In their scan of the literature, Handa et al. (2011) found that there was extraordinarily little evidence to support PPS as being effective to prevent negative stress reactions. Oppositely, some studies have found a link between receiving education/training on traumatic stress (e.g. how to treat it) and having lower levels of STS (Molnar et al., 2017). Besides efficacy, some studies highlight a desire from both child welfare workers and supervisors to receive ongoing and specialized training that helps prepare them to deal with trauma (Anne Dombo & Whiting Blome, 2016; Douglas, 2013a).

Studies have also suggested that end-of-life education may help CWWs prepare for such events. In a sample of 138 CWWs in the U.S., Csikai et al. (2008) found that 94.2% of participants had encountered end-of-life situations involving their clients. When asked about what specifically made the death difficult to deal with, two of the three most common responses by workers were having little or no experience with death and having little or no past education in death and dying (Csikai et al., 2008). Based on these findings, the authors recommended that child welfare agencies and organizations provide ongoing education and training that can aid in preparing workers for end-of-life situations. Unlike Handa et al. (2011), these studies do not speak to, or claim, PPS as a way to *prevent* negative stress reactions, but rather as a way to make CWWs more prepared to deal with such scenarios.

SPS – Psychological Debriefing

When it comes to SPS programming, the leading form of agency-provided trauma management presented in the available studies is *psychological debriefing* (PD). To some scholars, PD can be seen as an umbrella term that includes any short-term post-trauma intervention intended to reduce/alleviate psychological distress and long-term post-traumatic stress symptomology (Pack, 2013). Within PD interventions, Critical Incident Stress Debriefing (CISD) is by far the most dominant workplace response (Handa et al., 2011; Rick & Briner, 2012). CISD is an internationally used strategy of trauma-management by various agencies and organizations that dates back to the 1980s (Handa et al., 2011; Molnar et al., 2017; Rick & Briner, 2012). CISD is a guided 3-4-hour group discussion (for 4-25 people), provided anywhere between one day to two weeks after a potentially traumatic event (Handa et al., 2011; Pia, Burkle, Stanley, & Markenson, 2011).

Despite its universal acceptance, the evidentiary support for CISD has been fiercely contested for nearly two decades (Handa et al., 2011; Molnar et al., 2017; Rick & Briner, 2012). When it first emerged, the creators of the CISD strategy asserted that the debriefing process would reduce the effects of trauma and stimulate natural recovery (Rick & Briner, 2012). This assertion would go on to be tested various times with extraordinarily mixed results. A commonality found within various systematic reviews is that CISD has no impact on reducing trauma symptomology, with most studies finding that individuals who have experienced a debriefing are no better off (psychologically) than individuals who had no debriefing whatsoever (Rick & Briner, 2012). In fact, Molnar et al. (2017) cited several studies all supporting that CISD should *not* be recommended as an intervention to reduce negative stress reactions. In addition to not preventing long-term stress reactions, common criticisms include uncertainty regarding which work populations are most appropriate for CISD and the group process being seen as intrusive and even forced upon employees (Gustavsson & MacEachron, 2004; Handa et al., 2011; Molnar et al., 2017). This latter criticism is rather interesting because, despite the creator of CISD cautioning about making attendance mandatory, many agencies and organizations have opted to make participation a requirement in their delivery of CISD (Pia et al., 2011).

There has been a fairly recent evolution of CISD, in which the debriefing method is just *one aspect* of a larger agency model, known as Critical Incident Stress Management (CISM). Under CISM, CISD is not a standalone strategy, but rather is accompanied by other interventions and supports such as training or preparation prior to crises, as well as defusing, and referrals to additional assessment and treatment services (Pia et al., 2011). That being said, as CISD remains a core aspect of CISM, it falls victim to the same failings in systematic reviews that continue to determine it to have no impact in reducing long-term trauma reactions (Pia et al., 2011).

A worthwhile question to answer at this junction is why exactly CISD/CISM remains so prevalent, despite numerous reviews that seem to condemn its process and abilities. Many studies have found that it is the employees themselves that report the debriefing process to be helpful (Handa et al., 2011; Pack, 2013; Rick & Briner, 2012). For employees who speak highly of the process, described benefits include emotional release, having their emotions normalized, and not having to attend formalized individual therapy (Handa et al., 2011; Pack, 2013; Rick & Briner, 2012). The scholarship also suggests CISD may fulfill a symbolic need at an agency (Rick & Briner, 2012). In other words, although CISD has largely been proven ineffective, the gesture may show employees that the organization is concerned about their mental wellbeing.

SPS - Peer Support/Assistance Programs

One of the more common alternatives to CISD is that of peer support, sometimes known as peer assistance programs (Molnar et al., 2017; Pack, 2013). The idea of peer support as a method of trauma management is predicated on the idea that workplace peers are ideally located to assist one another through the specific stressors and traumas of their work environment (Molnar et al., 2017). Within a peer support model, selected individuals are trained in how to respond to and support peers following stress/trauma, both immediately and in the long term (Molnar et al., 2017). Some reviews of peer support models have found similar issues in establishing efficacy as CISD, primarily due to inconsistent program designs (Molnar et al., 2017). Although, there are certainly some peer assistance programs that show promise.

Trauma Risk Management (TRiM) was a strategy developed by the UK Royal Navy (Rick & Briner, 2012). TRiM describes itself as a post-trauma peer group to ensure staff can function after a traumatic event, while also providing support, education, and helping to identify

those individuals who may need referrals to additional assistance (Rick & Briner, 2012)[6]. In this model, junior managers are chosen to become trained and certified TRiM practitioners; training which covers planning for psychological needs, assessment interviews, psycho-education, and more (Rick & Briner, 2012). In addition to military settings, TRiM has also been adopted (and positively received) by emergency services (Whybrow, Jones, & Greenberg, 2015). Systematic reviews of TRiM have highlighted a positive impact on organizational performance and decreased sick leave (Whybrow et al., 2015). A key finding is that unlike CISD, which in worst-case scenarios can cause psychological harm and impede natural trauma recovery (Rick & Briner, 2012), TRiM has not been found to cause any harm (Whybrow et al., 2015).

SPS - Specialized Referrals

In addition to providing on-site trauma-management and support, some agencies choose to refer their employees outward to some type of specialized therapeutic services, for example, eye movement desensitization and reprocessing (EMDR), and trauma-focused cognitive-behavioural therapy (TF-CBT) (Molnar et al., 2017; Rick & Briner, 2012). Unlike the highly contested CISD and CISM, EMDR and TF-CBT are emerging therapeutic approaches to trauma exposure showing much more evidentiary promise for reducing the risk of PTSD. Although, as these methods are merely emerging, it remains unclear whether this evidence translates to positive benefits for recipients or a way to further the more neoliberal agenda of Evidenced-Based Practice (EBP).

[6] Essentially, TRiM is a balanced mixture of PPS and SPS

PPS/SPS – Health Promotion and Wellness.

For workplaces where staff may be indirectly exposed to trauma and are therefore at risk for VT/STS/CF, some of the most supported approaches are health promotion and wellness strategies (Molnar et al., 2017). These nontherapeutic approaches can be used both pre- and post-trauma, therefore qualifying them as both PPS and SPS. Strategies under this paradigm may include establishing an appropriate work-life balance, exercise, and even meditation or yoga (Molnar et al., 2017). There are of course more guided wellness activities such as mindfulness-based stress reduction (MBSR) and the accelerated recovery program (ARP); the former of which is recommended for STS while the latter's efficacy is rather unknown (Molnar et al., 2017). As with specialized referrals, ongoing health promotion and wellness is somewhat of a new phenomenon. It has already been established that the current practice of child welfare is fraught with overworked staff and high caseloads. And while these methods may certainly have merit, there is some anecdotal evidence found within this study that indicates high turnover and caseloads as a major barrier to staff engaging in wellness strategies.

Guidelines for Workplace Intervention

In the UK, there exists the National Institute for Health and Clinical Excellence (NICE), which is responsible for giving advice regarding various treatments and assessing their evidence (Rick & Briner, 2012)[7]. Of particular interest to this research, NICE has developed a simple guideline for how and when organizations can support staff after a trauma (Rick & Briner, 2012):

[7] On a related note, NICE also conducted a formalized review of psychological debriefing in 2005 and, like other reviews, concluded that following a trauma, these types of single-session debriefing interventions should *not* be provided to staff (Rick & Briner, 2012).

1. Provision of practical, emotional, and social support is important immediately following exposure to a traumatic incident.
2. Consider watchful waiting when symptoms are mild and have been present for less than 4 weeks after the trauma
3. Arrange for follow- up contact within 1 month (Rick & Briner, 2012, p.25)

Certain staff may be determined to be of higher risk for negative stress reactions, and NICE recommends these individuals are screened via some type of assessment tool for trauma reactions one month following the trauma (Rick & Briner, 2012). While the above discussion on PPS and SPS interventions is by no means exhaustive, it provides a general understanding of some of the most common strategies used in various workplace contexts.

Trauma-Management and Support in Child Welfare

In my review of the literature, there were many studies and authors making recommendations about what child welfare agencies could be offering (more so related to stress reactions), but uncovering what agencies are *actually* doing was far scarcer. In terms of how child welfare agencies are managing trauma in their workforce, responses are significantly varied. Beginning on the lowest end of the support spectrum, some studies find child welfare workers receiving no support after experiencing a child client's death. For example, Douglas (2013a) studied 135 child welfare workers from various regions in the United States who had experienced a child fatality and only 44.6% were offered therapy by their agency. And while only half of that 44.6% used the offered therapy, an overwhelming majority found the therapy helpful (91.7%). In research conducted by Pollard (2018), none of the four CWWs interviewed were offered any formal support/counselling following the death of a child client. Although one worker received a phone call from a manager to check on their mental state, they insightfully noted that they felt this

call would not have happened if they did a poor job managing the file leading up to the child's death (Pollard, 2018).

While the following study was more focused on Negative Stress Reactions within CWWs such as Compassion Fatigue and Vicarious Traumatization, Baker (2018) found that in a sample of Southern Ontario CWWs, only 36% felt supported by their supervisor when needing to discuss emotional and mental work demands and a similarly small number (38%) felt supported by their agency overall. In line with Douglas (2013a) and Pollard (2018), Baker (2018) found that 56% of workers[8] *disagreed* when asked if their workplace has supports for STS, which included supports for cumulative stress and burnout. Interestingly, SPR Associates, (2014) found that in Ontario, a barrier to addressing STS in the workplace was that some managers felt it was not a concern as "it's already happened" (p.18).

Oppositely, other studies of agency support found a wide range of responses for staff. Horwatch (1995) found that after the death of a child, CWWs were generally offered some therapy and/or time off, but interestingly, workers felt that these offers only reinforced feelings of incompetence and they desired a debriefing instead. Dombo and Whiting Blome (2016) interviewed American child welfare managers from different regions and found that some agencies implemented very informal support strategies.[9] For example, Executive Directors engaging in "listening tours" where they would go door-to-door and check in on staff, jean days for morale, and even monthly awards for strong management of difficult cases (Dombo & Whiting Blome, 2016). Some of the more formal responses at agencies included screening workers for trauma exposure during the hiring process as well as during their employment, and

[8] 36% disagreed and 20% strongly disagreed
[9] However, this study was in the context of Vicarious Trauma, not child client deaths

bringing in a psychologist for 3-4 sessions as needed by workers (Dombo & Whiting Blome, 2016).

Studies have also suggested that peer support is generally the largest source of assistance in the workplace for CWWs (Baker, 2018; Pollard, 2018; Regehr et al., 2002; SPR Associates Inc., 2014). The popularity of peer support might have to do with its limited cost, convenience, and the fact that peers are one of the only constants across the child welfare sector. More specifically, SPR Associates (2014) found that out of 5,800 Ontario CWWs, nearly all who were psychologically distressed by a physical assault during their career (50% of the sample) were able to access formal support via peer support teams, along with Employee Assistance Programs and 'other' methods. While SPR Associates (2014) does contradict some of the research that highlights failing agency support within the field, this study did not elaborate on the efficacy of the support for workers, nor was it undertaken in the context of child deaths.

Inquiries have also asked CWWs more directly how their agencies could be supporting workers after child deaths. CWWs have indicated a desire for individualized or group debriefing, with follow-up support offered (Horwatch, 1995). CWWs in other contexts have echoed the need for emotional support and therapy but also indicated a desire for additional training prior to child deaths, and administrative assistance in some cases (e.g. a break from receiving new cases) (Douglas, 2013a).

As mentioned, SPR Associates (2014) completed an Ontario child welfare study on a massive scale, which did lead them to some important recommendations for agencies regarding psychosocial support. I feel that it is fitting to end this segment on the recommendations that arose from their review for trauma management in child welfare. In their opinion, organizations needed to utilize effective psychosocial support to manage the emotional and traumatic risks to

staff (SPR Associates Inc., 2014). To fill some significant gaps that were identified in the provincial system, SPR Associates (2014) recommended that all CASs have peer-support/assistance programs and that there should be in-house procedures to manage post-traumatic stress and secondary trauma. Stipulations of these primary recommendations included peer support being accessible anonymously and without the involvement of management, and additional procedures to grant workers outside emotional support (SPR Associates Inc., 2014).

Chapter Two: Theoretical Frameworks and Methodology

I believe that each person has a unique understanding of their reality. A personal anecdote I have always used to describe the fascinating nature of trauma exposure and its subsequent impact is imagining four people getting into a car accident, but only one ending up with symptoms of post-traumatic stress. The point of this narrative is that people can all experience events differently based on their personality, history, coping skills, and social contexts. In seeking to understand workers' experiences of trauma-management and emotional support after the death of a child client, I situated my theoretical lens within aspects of Symbolic Interactionism and Pragmatism and borrowed guiding methodological principals from Constructivist Grounded Theory. It should be noted that I am not claiming this research as a true study in grounded theory, but rather as a study that takes up a grounded theory approach. Given the limited space and time to conduct research within the MSW program, it was not practical or possible to attempt to undertake all elements of the approach. As such, this study is best described as a qualitative inquiry inspired by principles of Constructivist Grounded Theory.

Symbolic Interactionism and Pragmatism

Symbolic Interactionism (SI) is a way of knowing that views human actions as resulting from how a situation is interpreted, with symbols and language aiding in the construction and application of actions (Charmaz, 2014; Mann, 2011). Under this paradigm, *meaning* is a dynamic concept that is continually modified as a result of social actions, contexts, and reflections (Adams & Sydie, 2002). While these concepts emerged from the thinking of individuals such as George Herbert Mead, it was Herbert Blumer (1969) who formally theorized SI into three concepts. As outlined in Mann (2011), the first concept states that the meaning of a phenomenon

impacts how a human acts toward it, the second concept states that these meanings come from social interactions, and the third concept argues that these meanings are maintained, and adjusted, through a person's interpretations of these phenomena.

Symbolic Interactionism (SI) has direct roots to the American philosophy of pragmatism, more specifically, pragmatism born out of the University of Chicago in the mid-century (Adams & Sydie, 2002; Charmaz, 2014). As it is understood generally, pragmatism is a philosophy that sees experiences as being organized by knowledge and views reality as dynamic and (to some extent) unknown (Charmaz, 2014; Schwandt, 2011a).

In this thesis, I set out to learn more about how CWWs experience both the death of a child client and the trauma-management and emotional support provided by their agencies afterward. As such, this research draws on Symbolic Interactionism as it is outlined by Thomas Schwandt, (2011b):

> The meanings an actor forms in interpreting the world are instruments for guiding and forming action. Symbolic interactionism…also evinces a profound respect for the empirical world; to understand the process of meaning making, the inquirer must attend carefully to the overt behaviors, speech, and particular circumstances of behavior settings in which interaction takes place. The inquirer can understand human action only by first actively entering the setting or situation of the people being studied to see their particular definition of the situation, what they take into account, and how they interpret this information (p.284)

Additionally, pragmatism is utilized in this project as it is understood by its original thinkers, William James and John Dewey, in which "ideas are the result of humans adaptation to their environments, and the meaning of "truth" is determined by the practical results of such adaptations. Consciousness, therefore, has a "transitive character" according to the nature of experience(s)" (Adams & Sydie, 2002, p.323).

Taken together, SI and pragmatism are informing my understanding that participants' experiences of child client deaths and subsequent mental health supports will be varied due to differences in knowledge, organizational climate, beliefs, and social contexts. SI helps to focus on how participants make meaning of and interpret both the child's death and the emotional support the worker may or may not have received from their agency. Pragmatism's attention to environmental adaptation is particularly important because I also believe the manner in which a participant has internalized the culture of their agency will also impact how they interpret and make meaning of their experience.

Constructivist Grounded Theory

Grounded Theory (GT) methodologies aim to gather and analyze qualitative data in a way that is both systematic and flexible to construct a theory or a representation of a process, that is "grounded" in this data (Charmaz, 2014, 2017a; Chun Tie, Birks, & Francis, 2019; Creswell, 2007). Grounded theorists make use of inductive data and reasoning, that is to say, using an array of individual data to deduce understandings and ideas using iteration and constant comparison (Charmaz, 2017a; Creswell, 2007). It is through this process of paralleling data collection and data analysis that allows grounded theorists to develop and test hypotheses in real-time in a process meant to lead to the "discovery of theory from data" (Glaser & Strauss, 1967, p.1, in Sebastian, 2019). Kathy Charmaz is credited with developing a methodological digression known as Constructivist Grounded Theory (Sebastian, 2019). While the goal of Classical GT is to create, or discover, a theory which can only be verified afterward through quantitative analysis, CGT *constructs* a theory which is an interpretation of the participants' meanings of a phenomenon (Chun Tie et al., 2019; Sebastian, 2019).

Utilizing principals of CGT made the most sense for this study for several reasons. Generally speaking, grounded theory methods fit with my underlying desire is to use the experiences of my participants to develop recommendations for how agencies can better support workers, which aligns more with the GT examination of a *process* as opposed to constructing a theory. CGT also fits nicely with principals of my theoretical perspectives, particularly when it comes to their roots of meaning-making and interpretation. I will now outline various methodological aspects of CGT that I utilize in this study, including initial coding, focused coding, memo-writing, constant comparison, and categorizing.

Initial Coding, Focused Coding, and Memo-Writing

As with other forms of GT, CGT makes use of coding in the analysis phase. In fact, Charmaz (2014) considers coding to be the "bones" of CGT analysis (bones that are later assembled into a skeleton, as she poetically writes). Put simply, coding is a process that names pieces of data to bring the researcher closer to what is happening (Charmaz, 2014; Gibbs, 2013). CGT consists of two phases of coding: initial coding and focused coding (Charmaz, 2014).

The first phase of my analysis used initial coding to move quickly through the transcripts and name all pieces of data (Charmaz, 2014; Sebastian, 2019). In this phase, I focused on line-by-line and incident-with-incident coding. Line-by-line is among the most commonly chosen approaches to CGT coding and involves naming all lines of written data (Charmaz, 2014). Line-by-line coding helps to uncover hidden patterns and allowed me to examine compelling experiences (e.g. child death) (Charmaz, 2014). I then used incident-with-incident coding to compare each participants' experience of agency-provided trauma-management (Charmaz, 2014).

My second phase of analysis involved focused coding, which is a process of examining and comparing all previous codes to construct “focused” codes that are either important on their own or can summarize several initial codes (Charmaz, 2014). I used focused coding to help elevate my initial codes to a more theoretical level, while also allowing me to identify commonly occurring codes and codes of great merit to this study.

In addition to focused coding, my second phase of analysis also uses memo-writing, which occurred *after* focused coding as per Charmaz (2014). Memo-writing, which can be thought of as a way to think “out loud” about your coding, allowed me to deeply reflect on my emerging focused codes (Charmaz, 2014; Gibbs, 2013). This highly reflexive process (almost like a research “diary”) gave me yet another avenue to analyze and think about my data (Charmaz, 2014; Gibbs, 2013). Of particular relevance to this study, Charmaz discusses the use of memos to aid with individuals who are researching the same environment that they work in, as I used memo-writing as an opportunity to reflect and question how I was seeing the data based on my positionality (Gibbs, 2013).

Categorizing and the Constant Comparison Method

I used all of this coding and conceptualizing to lead me to the development of categories, which involves taking the important codes, or the ideas conceptualized from codes and organizing them into analytical concepts (Charmaz, 2014). Categorizing helped me to further elevate the data to a theoretical level (Charmaz, 2014). Once my categories were chosen, I explored and defined the makeup of these categories, or as Charmaz writes, the “properties” of the category (Charmaz, 2014). In addition to explicating the category properties, I also sought to learn how the categories operate, how they change, and their potential relationships with each other (Charmaz, 2014).

The constant comparison method informed my ongoing comparing of different levels of data throughout the research. In levels of succession, this involved "comparing data with data, data with code, code with code, code with category, category with category, and category with concept" (Charmaz, 2014, p. 650). This constant comparison allowed me to see similarities and differences in pieces of data with the overall aim of identifying patterns (Merriam & Tisdell, 2016). The final step of my constant comparative analysis was comparing my major categories with existing scholarly literature (Charmaz, 2014).

Theoretical Sampling and Saturation

There are two additional characteristics of CGT, theoretical sampling, and saturation, which are relevant to this study in that they could not be applied. Theoretical sampling is a way of gathering new data to fully define the properties of established categories (Charmaz, 2014). For example, as I chose interview methods for primary data collection, theoretical sampling could have involved a modification to my question guide and re-interviewing participants, finding new participants, or even changing the setting of my participants (e.g. child care workers vs. protection workers (Charmaz, 2014). Separately, saturation refers to reaching a point where a researcher cannot produce any new category properties in the theoretical sampling stage (Charmaz, 2014). In other words, if I did re-interview past participants or new participants through theoretical sampling and over time, I saw no new properties emerging, then I would have been able to claim "saturation" (Charmaz, 2014). As theoretical sampling and saturation are defining characteristics of GT (Charmaz, 2014), failing to incorporate them speaks to a primary limitation of this study (covered further in the final chapter).

Limitations and Critiques of the CGT Methodology

As a final note on CGT, I will very briefly outline some of the methodology's limitations and critiques. Although the pragmatist roots of grounded theory are present as demonstrated above, some argue that grounded theory is not at all pragmatic, at least literally speaking, as the methods can be seen as exhaustive and complicated (Timonen, Foley, & Conlon, 2018). Timonen et al. (2018) note that a common obstacle in constructing theory is the often-limited student timeline common in research projects, which was among the primary limitations to my full application of CGT. Some authors, such as Clarke (2011), have noted recurring critiques that arise when researchers use GT. Some of these critiques raised by Clarke (2011) relevant to my work include small sample sizes, the ultimate generation of thematic analysis (as opposed to *theory*), and using GT symbolically rather than as actual research practice; this will be covered with more depth in the limitations section of the concluding chapter.

Chapter Three: Methods

Study Population

Within my research process, I have identified the study population as past or present child welfare workers (CWWs) from the geographic region of Northeastern Ontario. As a CWW practicing in Northeastern Ontario, I wanted to complete a study that was local and relevant to my practice and area. Additionally, for a region in which child-welfare related deaths are significantly overrepresented, there is an utter lack of data regarding the impact these deaths have on child welfare workers. Northeastern Ontario can almost be considered a character all on its own as its geographical size and mix of urban and rural settings does have an impact on how social work is practiced. The region is vast, running all the from North Bay to Moosonee (557km). The same distance trip South from North Bay would end in Buffalo, NY with kilometers to spare. Just my single child welfare office covers an area that runs roughly 100km both North and South and 60km both East and West; a catchment that could hold the City of Toronto a dozen times over.

I sought up to five participants for this study. The small scope of the study was chosen for several reasons, one of which is that there are fewer CWWs in the Northern region compared to the South; attributed to the massive size and relatively small population, as well as disparities in resource allocation. Further, I am not confident that I could have reached a significant number of participants as child deaths in child welfare are, thankfully, not an extraordinarily common occurrence. Additionally, a small study made sense given the resources available for completing an MSW thesis. I wanted to complete a qualitative study with in-depth interviewing that

considered workers' experiences. This study also needed to be conducted in a relatively short timeframe.

Recruitment

This study utilized a horizontal sampling and recruitment strategy as outlined in Geddes, Parker, and Scott (2018). The authors reviewed two prior studies involving traditional snowball sampling techniques (i.e. one participant helps find more) where their snowball "failed to roll", and so they expanded to what they describe as a more "horizontal" strategy (Geddes et al., 2018). They argue that snowball sampling is a network-based recruitment strategy but based on their experience it should not be considered the *only* method of network-based recruitment. As opposed to traditional snowball sampling, which uses strong social ties to build a "vertical" chain of participants through continual referral, horizontal sampling uses both strong and weak social ties as bridges into various networks where contacts and participants can be found. This strategy employs methods such as "cold-calling" and grants researchers numerous points of entry into a sample population. Ultimately, the authors offer horizontal sampling as a way to invigorate stifled snowball methods but do not see any reason why this strategy could not be used by researchers from the very beginning of a project.

I certainly required many points of entry for this study as I was trying to recruit a relatively small population of CWWs dispersed across a large geographic area. The Children's Aid Societies and Indigenous Child Wellbeing agencies that fall within the Northeastern Ontario District are Children's Aid Society of the District of Nipissing and Parry Sound, Children's Aid Society of the Districts of Sudbury and Manitoulin, Kina Ghezhgomi Child and Family Services,

Northeastern Ontario Family and Children's Services, Kunuwanimano Child and Family Services, and Payukotayno James and Hudson Bay Family Services.[10]

Participants were screened via three questions to ensure eligibility in the current study. Participants must have been a past or present child welfare worker from the region of Northeastern Ontario. To define these criteria further, I was looking for individuals employed at the investigation or ongoing service levels of child welfare practice. More specifically, I was looking for protection workers who had experienced a child's death on an open file, meaning they were actively servicing the family and had not closed/transferred their file.

Finally, the child's death must have occurred in Northeastern Ontario while they were employed as a child welfare worker. My rationale for the third criterion was to exclude workers who experienced a child client death at an agency outside of the target region of this study (such as Toronto or Hamilton Children's Aid Society) and the workers had moved to Northeastern Ontario to continue their child welfare career. This exclusion was made because many Southern Ontario child welfare agencies are exceptionally large and typically work with a much higher operating budget and thus have more resources at their disposal. Therefore, the worker may have experienced a level of response and care that may not typically occur in the North, leading to thoughts about trauma-response that may not be realistic for this region. This screening occurred after the participant read the Letter of Information and before gathering oral consent. I completed received my final clearance from the McMaster Research Ethics Board (MREB) on April 8th, 2020; recruitment officially began on April 10th, 2020.

[10] It should be mentioned that there is one additional agency, Niijaansinaanik Child and Family Services, which is a newly established wellbeing agency, receiving its pre-designation in Fall 2019.

In trying to allow me as many entry-points as possible, I initially proposed five different methods in which to access my study population. I felt that the most logical way to begin recruiting CWWs in Northeastern Ontario was to go to the agencies themselves. The next two methods were to try to access the population through the Ontario Association of Children's Aid Societies (OACAS), and any University and College in the Northeastern Ontario region that has child welfare/human service-related programs. The final proposed methods involved networking through strong and weak ties within my workplace who I knew had connections to other Northeastern Ontario agencies and a social media post regarding participation in this study.

A key component within all of these recruitment strategies, save for the social media post, was the establishment of "key intermediaries" to act as bridges into this population (Geddes et al., 2018).[11] In describing their horizontal sampling method, the authors talked about using several key intermediaries, which were people located on the outskirts of their social network, but directly located in the social network they were trying to access (Geddes et al., 2018). Through utilizing several key intermediaries, the authors were granted multiple points of entry to access the population. In this study, key intermediaries included labour union presidents, directors of service, and even a former supervisor from my agency. The majority of these key intermediaries were established through "cold-calling" agencies, as outlined by Geddes et al. (2018). For labour union representatives and directors, they were asked to share information about this study with their membership via email, and the former supervisor at my agency was asked for a contact that could grant me entry into a mainstream agency I had yet to access.

[11] Although, Geddes et al. (2018) do consider online postings as a method of weak-tie recruitment under this paradigm.

It should be noted that there was additional consideration applied to the recruitment within indigenous-focused agencies given the study's potential to gather indigenous knowledge and ways of knowing. Based on feedback from the MREB, it was determined that indigenous agencies should be consulted about the content and methods of this study and seek their feedback concerning any potential issues. More importantly, these agencies were to be consulted about whether or not they felt the indigenous communities they served needed to be consulted in order for their staff to participate in the study. If there were no concerns with participation or the study itself, then there would be a request that an agency representative share information about this study with their employees.

Recruitment Results

I began recruitment chronologically with the first method of working directly through agencies, and in total, this strategy yielded *three* participants. I contacted all child welfare/child wellbeing agencies as outlined above and heard back from one of two[12] mainstream agencies, and two of three indigenous-focused agencies. As per my commitment to the MREB, I successfully consulted with representatives at the two indigenous agencies I reached, and neither representative had concerns or suggestions with this study and indicated that they did not assess a need to consult with the Indigenous communities they served. From there, I purposefully skipped the next two proposed access points (i.e. OACAS, Universities, and Colleges) and moved directly into my final two methods, a decision made based on my experience with the first recruitment strategy. The first method was an unexpectedly lengthy process and involved making the first contact with an agency,

[12] There are three mainstream agencies in the region, but my agency was purposefully excluded from this stage of recruitment due to ethical considerations of power and prior relationships.

determining the appropriate representative, reaching said contact, explaining the study, allowing them time to consider the agency's participation, and finally, following up with all of these individuals. This is noted as one of the limitations of the method, as horizontal sampling can be inefficient and time-consuming (Geddes et al., 2018).

In returning to my more direct social network, I contacted a previous supervisor from my agency who I knew had employment experience with other Northeastern Ontario child welfare agencies. This supervisor reached out to their previous agency, which eventually led me to a virtual meeting with the Director of Service of a mainstream agency that I could not reach previously. This strategy, unfortunately, did not result in the recruitment of any new participants. As my final recruitment strategy, I shared a social media post on Facebook which contained a poster advertisement for this study with a description of the project and my full contact information. This post was shared nearly 30 times and led to the recruitment of *two* new participants, totaling my desired five.

Telephone Interviews and Qualitative Research

From the onset of this project, I had planned to utilize telephone/Skype interviewing methods for my data collection. As discussed, Northeastern Ontario is a large geographic area and so face-to-face interviews would have likely required extensive travel. However, face-to-face interviews would not have occurred even if I accounted for this distance and made appropriate travel arrangements, as the COVID-19 pandemic was beginning its peak in Ontario just as my data gathering process was beginning. As we now know, this pandemic ultimately led to massive societal shutdowns, quarantining, and adapting to a new "virtual life". While all participants were offered the option to use either Skype or telephone to complete their interview, all five participants opted for the telephone.

That being said, I did not feel at a disadvantage in conducting qualitative in-depth interviews via telephone. There have been several advantages to qualitative telephone interviews uncovered in the literature, including an ability to reach distant and/or spread out participants, cost savings, higher response rates, increased participant comfort, anonymity, and is optimal for populations in which scheduling face-to-face interviews would be difficult (Novick, 2008; Turgeon & Taylor, 2014). Some scholars are critical of qualitative telephone interviews, reporting the problematic absence of visual/nonverbal cues and issues with telephone coverage in areas with poor reception (Novick, 2008; Turgeon & Taylor, 2014). While I did not find the absence of visual cues to be an issue as I could still note sighs and long pauses, telephone coverage was particularly weak during one interview that occurred during a rainstorm, resulting in several miscommunications.

Data Collection and Analysis

All data were collected via telephone and audio-recorded with participant consent. The interviews were externally recorded via a simple audio recording app on a Google Chromebook computer; a portable audio recorder was used to complete a backup recording. Audio files were then uploaded to NVivo Transcription. While my voice on the audio was often picked up verbatim by the program, the audio of my participants was poorly transcribed due to speakerphone audio limitations, and so I went through each transcript manually to correct all conversion issues.

Interviews were guided by a set of questions which I constructed (see Appendix B). The interview guide was organized into three broad categories: 1) the experience of child client deaths; 2) agency-provided trauma-management/support; and 3) recommended trauma-response

strategies. Concerning the third category, I gathered this data through two methods. One method was to simply ask workers what they feel agencies should be doing to support the mental health needs of workers after child deaths. The second method involved providing participants with a list of worker-proposed trauma-management strategies that have come up in related studies (see Appendix A). The provided strategies were used as a prompt to initiate discussion while also covering aspects such as which methods were most and least important to participants.

As soon as audio files were fully transcribed, they were exported from NVivo Transcription in Docx format. Once the file was exported and the transcript was vetted for accuracy, I began my initial coding. In my initial coding, the line-by-line method was chosen to move through the data quickly and freely. Initial codes were then analyzed and compared between participants and my focused codes were built upon that comparative analysis. These focused codes were then carried into a separate document for memo-writing. As a result of the comparative analysis and memo-writing process, I developed three categories that I saw as naturally appearing in the data sets when each one was looked at as a whole. In addition to the development of these categories, two primary and compelling incidents were compared among the participants, those being: the reported agency response and its efficacy, and the perceived ideal agency response. I felt that for the underlying purpose of this research, it was paramount to compare and contrast these areas of inquiry.

Chapter Four: Findings

This chapter is structured into two sections of analysis. The first section of the analysis covers the three categories that emerged from the data as a result of my data analysis. The second section of the analysis then examines the participants' experiences of agency-provided trauma-management and support. Before moving into the first section of the analysis, I will briefly explore the participant demographics in a bit more detail. This study recruited a total of five participants. The youngest participant in the study was in their 30s, while the eldest was in their 60s; the average age of the five participants was 48.2. Four participants identified their gender as female and one identified their gender as male.

Although this study explicitly sought child welfare workers who were in a protection role at the time of the child's death, two participants were in roles *outside* of protection. Both of these participants were included in this study as they were employed in Child Welfare roles that required closeness with the child; these workers shared similar experiences to those of the core protection workers relating to child death. For one of these workers, I learned they were not in a protection role during the interview. For the second worker, they informed me from the outset that they were not in a protection role during the death, but again their experience held value for my research due to their closeness with the family and child. As the latter situation fell outside of what I originally proposed to the MREB (i.e. recruitment criteria), I consulted with the board about including this participant. As a result of this consultation, a For Information Only (FIO) form was completed and this participant was incorporated into the study.

The participants had varying years of child welfare experience, ranging from four years to 18 years, with an average of 11.6 years. For education, three participants had obtained

undergraduate degrees while two had obtained college diplomas. The following table visually illustrates the demographic characteristics of the sample:

Table 2 – Demographic Characteristics

Sample Characteristics (*N* = 5)	
Age – Average	48.2
Identified Gender	
Male	1
Female	4
Child Welfare Position at the time of the Child's Death	
Child Welfare Worker: Protection	3
Child Welfare Worker: Non-Protection	2
Years Employed in Child Welfare – Average	11.6
Highest Education Achieved	
University – Undergraduate Degree	3
College Diploma	2

Analysis Part 1: Overarching Categories

Category 1: "It never left me" – The Experience of Child Client Deaths

An undisputed fact is that the death of a child client impacted all five participants in this study, albeit in different ways and to different degrees. Four of the participants had emotional experiences revolving around feelings such as anger, sadness, and grief, while one worker's primary experience was that of fear. This latter participant felt scared after the death as the agency was actively looking for someone to hold responsible and so they were fearful of potential legal culpability. This fear was also driven by seeing the traumatic impact the death had on another worker who was actively involved in the file. As stated, the other participants had more emotional responses, exemplified in the following quotes:

"I took it pretty hard-like, really hard. I'm not going to lie" - P2

"It's really hard to…deal with the death of such a young child" - P3

> *"I hung up the phone, and I think the shock kind of dissipated a bit, because then you start crying" - P4*

An interesting, but not surprising, relationship in this study is that the workers who were actively involved and provided longer-term services with families were also the ones who experienced more emotional responses. The worker who had a more fearful response to the death was fairly new to the file, while the other four workers with more emotional responses had been involved for much longer periods, ranging from months to years.

In examining the impact of the child's death, a recurring theme was lasting physical and psychological symptoms. The first notable impact was sleep disturbance, which ranged in duration and severity. Participants described sleep disturbances as everything from racing thoughts to unsettling nightmares, as highlighted in the following statements:

> *"[B]ut the nights were…that's when my brain started going and I thought the same things over and over." - P4*
>
> *"I couldn't sleep…that night, I just kept picturing the child like that. Uhm, it was - it was a really hard night for me" – P2*
>
> *"I actually don't know when I got a decent night's sleep for the longest time after that, because every time I would close my eyes, I mean, I would have all of these visions, you know, in my head" - P3*
>
> "*I had nightmares about that for a few weeks, of this [child] dead… [the child] would sit up and ask me why I didn't come." - P5*

The unsettling nightmare described by Participant 5 (above) also speaks to the psychological impact that child client deaths can have on CWWs. One participant reported a diagnosis of Post-Traumatic Stress Disorder as a result of the child's death. Another described enduring flashbacks of how they pictured the child dying and two described experiencing ongoing triggers in the workplace. The impact of a child's death can also take the form of physical health problems, as one participant described emerging stomach complications that they

directly associated with the death; this participant described the experience in the following quote:

> *"I would force food into myself just to be able to, you know, have some energy to be able to get through my days…I knew the cause of it…It was a result of everything I had experienced and gone through and observed" - P3*

Aside from physical and psychological impacts, child deaths can create a dissonance between a worker's values and their purpose as it relates to their career in child welfare. For instance, one participant ultimately questioned whether or not the work they do is more harmful to families than not. Apart from conflicting values and purpose, a child's death may also cause workers to question their capabilities and skills. Consider the following quotes:

> *"I just, I didn't really know what I was doing at the agency. I felt like 'what am I doing here? Am I causing harm to these people?'" – P2*

> *"[There was] a lot of questioning my own ability to what I did" – P4*

Workers were also asked whether or not they had ever received any training or supervision relating to child death or preparing them for the potential death of a child client (Please see Appendix B to refer to the full interview guide). Only one worker received any training from their agency that discussed or prepared them for this scenario, but that training was only minor module coverage and nothing extensive. Three workers indicated that no prior training was provided by their agency. Another worker did have some prior training but received this education within their university studies and not through their agency of employment. Two participants did talk about receiving child death training, but only in the context of child deaths that changed agency policy. After being asked this question, one worker even stated that the closest thing to training about child deaths they had ever received was being told to document absolutely everything to keep yourself safe from liability.

Participants were also asked about any positives that came out of the experience and if they learned anything new about themselves. The participant who had prior education in this topic learned that this knowledge of PTSD and VT did help them cope with the death, the participant stated:

> *"I recognized and I understood where my emotions were coming from. I understood what I need to do. I understood how to handle my emotions, and I understood how to talk about my emotions" – P1*

One participant said that they discovered resiliency in themself because after taking a personal leave they have returned the agency and feel they are again thriving in their role. This worker also felt that they now know how to handle work-related stress a bit better. If faced with another child's death, this participant would take the personal time needed and not just push through with work. A separate participant learned that they could rely on their agency for support and that they should be more vocal about their ideas of trauma-management and support in the workplace. For another participant, the death was a humbling reminder that they were not invulnerable and that all CWWs can be susceptible to the psychological impacts of child welfare work. This participant also highlighted that the experience taught them that no matter how hard a CWW works with a family, things can always go wrong, and you might not have a clear answer as to why.

Child Deaths and Case Management Quality

While recounting their experience with child client death, one participant highlighted that they felt their case management leading up to the child's death was quite well done. This participant went on to highlight a relationship between the supportive resources offered to them and how their work performance was perceived by their agency, exemplified in the following statements:

> *"I think in my situation, I would say [the agency support] was like slightly above the experience that other workers have had, and I think that has to do with the fact that like there wasn't anything that they could pinpoint on me in terms of not having done my job" – P3*

When asked further, the participant confirmed that at their agency, it feels as though when a worker is at fault, they receive significantly less support. This participant also went on to talk about how while managers/supervisors may present themselves as supportive of the CWW, their support only goes so far:

> *"[T]hey're supportive, but they're not supportive because even though they know you're going through, you know, a really difficult time, the expectation is still that you service your other files and you still cross all your T's and dot all your I's and get all your paperwork and everything else done" – P3*

Category 2: "The Process" and its Impact on Organizational Climate: Fear, Blame, and Silence

One participant concisely labeled all of the immediate administrative and case management responsibilities that follow a child's death as "the process", a term I have selected to adopt for this category. The process encapsulates everything from the initial death investigation, Ministry inspection, administrative responsibilities, the determination of worker/agency culpability, providing parental emotional support, and in some cases, involvement with the child's funeral; they are all a part of "the process". In this category, I illustrate that the death itself and the subsequent process, at least temporarily, impacts upon the organizational climate, which emerges in the forms of fear, blame, and silence. This shift in climate can be felt and noticed by workers within an agency:

> *"[T]he death happens, it spreads like wildfire" - P5*

> *"[When a child dies] you kind of pick up on that quickly" - P4*

Fear and blame are concepts that were closely connected by the participants. These workers often described experiencing fear of being blamed for the death of the child. For some workers, this feeling was described as so strong it sometimes parallels the initial processing of the death itself, as some workers quickly went from "what happened?" to "am I in trouble?":

> *"So I started the processing: how did this happen, when did that happen, did I do anything wrong, did I miss something?" - P4*

> *"[W]hat the hell happens to me now? Because you hear, you know, how other people's experiences have gone… [In past child deaths] I know other workers were disciplined" - P5*

Fear of being blamed largely fueled some participants' anxiety about agency managers reviewing the case file and potentially uncovering case management mistakes. One participant highlighted that, generally, workers feel they cannot trust their management after a death as they are too afraid of being evaluated and having any mistakes uncovered. This worker went on to suggest that this fear may be instilled by the managers themselves, who regularly and openly talk about fears of being held accountable in court relating to child deaths; knowing that other agencies have been found culpable meant that it could happen to their agency as well. Workers are acutely aware of the scrutiny that follows a death from both their agency management and the regulators above them. These sentiments are expressed in the following statements:

> *"The first thing they would have done was like opened up my database and gone into my file … to see that I had, you know, everything well documented, right, because they always want to point a finger somewhere" - P3*

> *"[W]hen they're evaluating…on the Ministry level…it is…traumatizing in itself. You're basically treated like a criminal…it's, you know, like they want to catch you doing something almost" - P5*

I feel that the latter quote highlights a unique position faced by some CWWs following a death, in that there is an investigation hierarchy. It seems that in some cases, while a worker is

investigating the parents/guardians about how the child may have died, the worker is simultaneously being investigated by the agency/Ministry about their culpability in the event. A second participant also echoed the difficult Ministry scrutiny, citing it as the hardest part of the process.

Participants feelings of being silenced following the child's death was a recurring theme across the interviews. This theme is related to a number of different contexts and reasons. On some occasions, participants were silenced by their agency managers, overtly, and covertly as a result of the agency culture. In other instances, participants were silenced by police departments conducting criminal investigations related to the deaths, who indicated that workers were not to discuss any details of the child's death. While feeling silenced was expectedly frustrating for some participants, one participant highlighted the importance of respecting the privacy rights of the family during workplace discussions, as stated in this quote:

> *"The only limit was obviously talking about it in the office. So, you still have the privacy rights of the parent and the children involved, so the confidentiality of your files can't be shared with everybody in the office or talking about in the hall." - P4*

For other participants, however, the experience was more negative. One participant felt that following the death, there was a lack of cooperation with the investigation process by their agency managers, police, and medical professionals. This experience was reflected in the following statement:

> *"You're just amazed at the quietness of the people, professionals, they all went quiet ... We gotta be careful. We can't say nothing. Don't talk to anybody, we have that kind of environment: don't talk, don't trust, don't feel" - P1*

For this participant, the silence from their own managers resulted in them feeling unsupported by the agency as a whole. They opted to have "off the record" debriefings in private with a small group of trusted workers.

While the above participant's silence stemmed from the agency management fearing legal consequences, another participant noted a more unexpected reason for being silenced, which was the new privacy section of the Child, Youth, and Family Services Act (CYFSA), Part X, which took effect in January 2020 (Ministry of Children Community and Social Services, 2018). This particular participant argued that as a result of moving toward Part X, their agency management actively discouraged team discussions about experiences of the child's death as a result of the new privacy law. This worker questioned how their team was supposed to work through all the emotions attached to a child's death if they could not rely on co-workers for support. While the agency encouraged workers to go see counselors instead of talking to co-workers, this participant felt that peer support was going to be more helpful than talking with "strangers"; they stated:

> *"[The agency was] not supportive of us, my team, sitting around and having discussions about our experiences [of child deaths]…it was like, you know, 'hush hush, everybody be quiet, don't be talking about it', and it's like, OK, well, if you can't talk amongst…your team, your co-workers, who some have experienced… deaths as well, of children, like… who do you talk about it with?" - P3*

In analyzing this assertion, I feel that this worker is raising a significant point here, in that there is potential that Part X has a role in the monitoring of peer support in the workplace; a point to be explored further in the coming chapter.

Participants were asked to discuss their experiences of the work environment following a death; they were asked specifically if they felt it was emotionally safe to vent/talk about the death. Only one participant indicated an outright "yes" when asked if the culture in the agency felt emotionally safe for this kind of disclosure. Two participants indicated they felt "conditional" safety, for example, only with a specific supervisor, and oppositely, only with a small group of workers in private, but especially not with management. Another worker did not

answer directly whether it felt safe or not, but rather stated when they tried to talk about it and were actively discouraged by the agency managers.

Category 3: Delayed Grief and Processing

Delaying grief and processing of the child's death was another prevalent theme in this study. In this context, delayed grief took on the properties as described by Gustavsson and MacEachron (2004), in that participants focused their energy and attention on administrative/investigatory tasks without allowing the emotions of grief to take over. Simply put, they often shelved their emotions to be dealt with at a later time while focusing on administrative requirements resulting from the child's death.

As outlined in Category 1, which recall highlighted the personal impact of child client deaths, participants often had an immediate and emotional reaction to learning of the death. The current category is almost an extension of that reaction, as it covers what happens after these initial feelings. There were several different reasons for workers delaying their grief and emotional processing, including an obligation to the child to determine what happened, staying strong for their children at home, being discouraged from discussing emotions at work, and not being aware that taking time off to grieve was an option.

One participant, who was particularly impacted by the death, delayed their grief initially out of simply not knowing if taking time off to process was something that was allowed, they stated:

> *"I didn't really like know… if I should have went home, or like I kinda wish I would have got more direction, like, 'can you take the rest of the day off', like 'do you want to?'" – P2*

Despite being emotional over the loss, they *knew* they had to go into work and sort everything out. And while acknowledging that they would have wanted what they described as "normal" time to grieve and process, the participant understood the expectation that the significant administrative duties following a child's death take precedence. Interestingly, this worker continued to delay the grief beyond the immediate timeline of the child's death, shown in the following quote:

> *"I guess I wasn't dealing with it…I was just trying to push through with work, but I wasn't really talking about it as well, and I was like 'yes, yes, everything's fine, everything's fine'" – P2*

Another participant was not required to attend to the file immediately and thus had an opportunity to process the event a bit more than the other workers in this study. When asked what impact they thought immediately attending to the death would have had on their processing, they stated:

> *"I don't think I would have functioned the next day at work. It would have been too many questions too quickly, right in your face without having the ability to let it all sink in on my own" - P4*

However, even without an immediate investigation to complete, this particular worker still felt obligated to shelve and delay their grief for the sake of their children:

> *"Just for my own sanity…I couldn't deal with the complete feeling of it because I also knew I had to parent my children at that time…so it was a little more difficult to process it all at once" - P4*

Two workers attended to the child's death investigation immediately and described a natural shift into a "work mode" after being notified of the death. It was a purposeful deferral of grief and processing so that vital work could be completed correctly. Regarding their work mode, P3 stated:

> *"I stepped in, and I'm in my…professional role now…I know I need to keep my head on straight because now I need to be reporting back to… supervisors and managers because*

> *this is now like a critical incident, right? So, you have to be able to… maintain your composure" - P3*

These workers who shelved their emotions and allowed their work selves to take over also did so out of a sense of duty and obligation, as evidenced by the following quotes:

> *"I needed to see it through to the end…I just did what I needed to do, what I felt I needed to do" - P3*

> *"[I] felt like I had a job that needed to be done, and then … I'll feel it… In my head, it was like, the least I can do for [the child] is figure out what the hell went on" - P5*

In looking at all the reasons these two workers delayed grief, another was pure selflessness. One participant outlined that taking the appropriate time off to grieve and process the loss of this child meant that their workload responsibilities would be transferred to other workers/supervisors, something they were not willing to do.

The Two Selves

My analysis revealed an interesting property of delayed grief and processing, and that is the notion of having two selves being present after a child client's death: a work self and an emotional self. I chose these terms based on how participants described their deferral of emotions and how they operated within their "work modes". The work self seems to encompass the various responsibilities that follow a child's death such as investigating, supporting the parents, completing documents, and sometimes, planning the funeral. The emotional self contains the raw feelings related to the death: grieving, sadness, anger, confusion, etcetera. It seems that the situation of child deaths may cause a fracture between these two selves, as the work self seems to be the identity preferred from an agency perspective; and permitting too much emotion may come with consequences.

The aforementioned fracture between these identities was exemplified in two participants, who had differing results when trying to work through the emotions of anger they felt toward the parent who was thought to be responsible for the death. One worker was able to see past that anger and maintain professionalism with the parent in their continued work. For another worker, the lingering questions surrounding the death were too much to maintain that supportive and professional role, they stated:

> *"I have to say, it got to the point where I couldn't be professional with [the parent] anymore in a supporting role. Like I had too many questions, too many, there were too many unanswered questions" – P3*

Interestingly, whichever self is more present may impact a worker's capacity to engage in supportive resources and have a long-term impact on trauma outcomes. For example, one participant overtly expressed that they were in a "work mode" after the death and felt that the debriefing may have resulted in their feelings and emotional self taking over, potentially jeopardizing the quality of their ongoing investigation. They questioned how easily and fully they would be able to return to their work self afterward:

> *"[I]f I would have just let myself meltdown, let it all out, all that stuff. OK, well…now I've fallen apart. So, I have to now pull myself back together, compose myself, try to find my focus, because the other stuff still needs to get done. And you can't, well, I can't, function like that…are you writing paperwork and doing things from an emotional standpoint or a factual standpoint then?" – P5*

Another participant, who did not end up completing the death investigation, also spoke to a potential loss of objectivity if a CWW's feelings and emotional self dominates during "the process":

> *"[J]ust remembering how I felt at that time, I don't think I would have been able to [complete the investigation] in a professional manner" – P2*

Based on this participant's disclosures, the emotional self was very present for them after the death, perhaps too much for their agency:

> *"I'm not exactly sure why [the investigation was given to someone else]. Maybe it was because I was too emotional. I don't know… I didn't ask why." - P2*

However, this participant was ultimately grateful they did not have to complete the investigation based on how they were feeling at that time and how they may not have been able to complete the investigation professionally. Similarly, certain investigatory responsibilities, which are typically completed by a family's protection worker, were given to a non-protection participant (P3). In response, P3 noted that the protection worker involved with the file was quite emotional over the death and was having a difficult time coping. They stated that the worker's difficulty coping was the reason they took over their responsibilities, highlighted in the following quote:

> *"I think [child deaths] affect everybody differently. So the protection worker that was involved with the family…had a much more difficult time processing, dealing with [the death] than I did, which is why…[I became] the main contact person, you know, for the doctors and everything. Because…my supervisor knew that I was going to remain level headed and objective and whatnot throughout the process" – P3*

Taken together, the disclosures from P2 and P3 seem to suggest a relationship between CWWs being overly emotional and how an agency perceives their competence with respect to the duties of their role.

What this overall category is essentially saying is that CWWs are compelled to have a professionalized response to death, which is markedly different from a normal human response to death, which is expectedly emotional. In trying to maintain professionalism following end-of-life situations, it seems that workers may delay, suppress, or mask feelings of grief and pain. It may be difficult to maintain this postponement over time, and the emotional components of pain and grieving may emerge in unexpected and negative ways.

Analysis Part 2: Agency Trauma-Management and Emotional Support

Primary Agency Responses for Participants

When examined in its entirety, three participants' (P1, P4, P5) primary experience of support from their employing agencies was through offered "debriefings", in both group and individualized formats. It should be noted that it is not known if these debriefings utilized formalized CISD curriculum, or if "debriefing" was a more colloquial term. Separately, P3's agency organized a session with a grief counselor, while P2 was given a list of mental health resources/support contacts (phone numbers) to reach out to if needed. The focus of this section of the analysis is on how participants experienced the support provided to them by their employing agencies.

Agency Response: A List of Resources

For P2, the list of resources and telephone numbers did not prove useful in their case. In this instance, the participant opted not to use the numbers as they did not want to open up to "strangers" about feelings related to the death. Instead, they relied on their own support network. This participant stated in their interview what they *were* looking for, which was an agency check-in to see if they needed anything beyond the numbers, a formal sit-down debriefing to check in on their mental state, and more direction on what was acceptable to do after the death (for example, go home/take time off).

Agency Response: Grief Counselling

As stated above, P3 was offered a counselling session provided by a trained grief specialist, and they did not mince words in discussing its efficacy:

"[I]t was a total waste of time" – P3

This participant explained they felt this way primarily because of the grief counselor's lack of practicality. While within counselling there were simple discussions about the workers' feelings of the death, there was an absence of practical suggestions or recommendations about how to deal with and manage the grief-related difficulties they were experiencing. In contrast to another worker who indicated an "outsider" is needed to conduct debriefings due to worker/management mistrust, this participant felt that the counselor's lack of child protection work awareness resulted in a poor approach to the workers. For this participant, what would have made the grief debriefing more effective was a counselor with a better understanding of child protection work and receiving tangible suggestions for how to handle and address stressful emotions related to the death, as well as being provided further resources to explore (e.g. websites and written information related to grief management). Thankfully, this worker had a better experience when accessing resources through agency supports at a later time.

Agency Response: Debriefing

There were varying experiences for the three workers offered formalized debriefings. One worker did not participate in the offered individual debriefing and instead relied on their own support network. The two remaining workers, however, participated in their offered debriefings, a process that produced opposite experiences.

For one individual, the group debriefing process was helpful as it normalized how they were feeling and thinking about the death and helped remind them that they were not alone. This worker also tried individual counselling and found it significantly less helpful than the group process. In the individual counselling, they felt too alone as they could not exchange ideas, thoughts, and feelings with workers who shared the same experience. Additionally, individual

counseling did not produce the same emotional release that occurred during the group process, which was another perceived benefit of the debriefing.

Oppositely, the other participant who also experienced a group debriefing process found it to be ineffective, and in fact, they felt it was counterproductive. In this case, there were two driving factors in the failure of this response. The first factor was the worker desiring a more intimate and personalized debriefing as they felt vulnerable before the group. The second factor was the worker feeling that the debriefing was held too soon after the death, which is expanded upon below.

For this individual, the early debriefing occurred at a time when they were in the peak of "the process" and burdened by countless administrative and investigatory tasks. For this reason, the worker chose to not fully engage in the debriefing process and allow themselves to become vulnerable to maintain their "work mode" until the completion of the process. The finding also highlights the issue of trauma-management timing. In particular, if a debriefing is held too soon, there may be support lacking for any traumatic events that happen in the investigation afterward; they described this through the following statement:

> *"[I]t was systemic things that were in the way, not that I wasn't willing. But until those things are out of the way, what am I debriefing about, what I experienced so far? But what about all the other things that happened after that?" - P5*

Additional/Secondary Trauma-Management Responses

In speaking with the participants, they each mentioned a number of other resources that were offered but were not necessarily common among multiple participants. Unfortunately, I did not have enough time to complete a full analysis of these secondary trauma-management

strategies, but I do feel that the strategies are worthwhile to include in this thesis. These secondary/additional supports were as follows:

1. Protected self-care time that can be used once per month.
2. Short-term (up to 5-day) paid mental health leave after a critical incident like a child's death.
3. Being notified by the union of mental health support options through Employee Assistance Programs (EAP) after a critical incident like a child's death.
4. A certain supervisor making themselves available to "debrief" whenever it was needed (present with three participants).
5. Being given workplace accommodations to minimize triggers related to the child's death.
6. Informal peer support from co-workers (present with all participants).
7. The agency encouraging workers to follow up with counselling.
8. A counselor being brought in following every critical incident that remains in the office for one to two days, allowing workers to access the service at their convenience.
9. An offer/reminder for counseling at various significant points in the death investigation.

Desired Support for Workers After a Child Client Death

Worker-Proposed Strategies. A key component of this study was to evaluate how CWWs feel agencies can best support staff who experience a child client's death. To understand the CWW perspective, I began by simply asking participants for their overall opinions about how agencies can best support CWWs after the death of a child client (Please see Appendix B for the full Interview Guide). The participants' various responses are listed below:

1. Avoid approaching the post-death process like a business (i.e. be compassionate and human)
2. Short-term (up to 5-days) paid mental health leave after a child's death if needed
3. Avoid blaming/finger-pointing
4. Orient workers quickly after the death of what mental health services are available, the costs, and the coverage under their benefits.
5. Inform workers of their time off options should they need it. Time off should be offered without scrutiny or judgement.
6. Introduce a new mental health position within the agency. This person would be responsible for providing ongoing counseling support to agency workers as needed and the fees would not come out of the worker's benefits, but rather, be covered by the

agency. This person could also guide workers who have questions about mental health/illness and make recommendations based on worker assessments (e.g. recommending a temporary reduction in caseload due to significant stress). This position would not necessarily need to be on-site to maintain the confidentiality of workers.

7. Occasionally workers can find themselves in a situation where they are responsible for intimate death-related activities (e.g. planning funerals). Workers should not be tasked with such responsibilities without ample consideration for alternatives and, most importantly, without gauging how the worker feels about taking on such responsibilities.

8. Consult the worker about the debriefing process and their unique individualized needs.

9. Management/supervisors should be mindful of how "the process" feels for the worker, in that they can feel extremely scrutinized and investigated.

10. Ongoing mental health check-ins by the agency and being mindful of potential triggers for the worker in the future.

Other Worker-Proposed Strategies. The second way I gauged how CWWs felt agencies can best support workers was by asking participants to discuss other worker-proposed strategies presented in the literature on child welfare deaths and related studies. Participants were provided with a list of five worker-proposed strategies (Please see Appendix A to refer to the document that participants received). These strategies were employed as a prompt to initiate a broad discussion on which strategies participants felt were most and least important. The strategies provided are as follows:

a) Provide emotional/legal support (Douglas, 2013a; Gustavsson & MacEachron, 2002);

b) Debriefing (Pollard, 2018);

c) Avoid blaming the worker (Douglas, 2013a);

d) Training about topics such as secondary trauma prior to child deaths (Douglas, 2013a); and

e) Administrative support such as paid leave and/or a temporarily reduced caseload (Douglas, 2013a).

The following table highlights which strategies emerged as the most important to each participant as a result of our discussions:

Table 3: Most Important Worker-Proposed Strategies

P1	P2	P3	P4	P5
Emotional/Legal Support	Death Education/Training	Administrative Support	Debriefing	Debriefing
Death Education/Training	Administrative Support		Death Education/Training	Administrative Support
			Administrative Support	Avoiding Blame

As shown in the table, some participants discussed multiple strategies as being important; P3 chose only one strategy as being very important. Avoiding blame and emotional/legal support only came up once, while increased training and administrative support were important to three of five participants. Debriefing was also noted as being an important strategy for two of the five participants.

During our discussions, only a few participants fully explained their choices. P1 preferred the legal support/advice as they felt this is the aspect of child deaths that makes workers the most fearful. P1 also felt that training in death/trauma/grief was so important it should be mandatory for all CWWs. For P3, administrative support stood out due to their experience that managers may express empathy for CWWs struggling with grief, but still expect they service all other files. Interestingly, P3 noted training as the least important, but because they doubted that any amount of training could prepare workers for this type of trauma. P4 echoed the importance of administrative support and felt that not necessarily paid leave, but a reduced workload and/or protected time to complete administrative duties related to the death would reduce the stress and burnout of workers.

Chapter Five: Discussion

This chapter is organized into four sections. The discussion will begin by highlighting the practice implications for child welfare organizations stemming from the findings of this study. I will then use these findings, and existing trauma-management literature, to offer concluding recommendations for child welfare agencies, which includes a sample trauma-management framework. The chapter will conclude by outlining the limitations of this study and highlighting a possible agenda for future research.

Practice Implications for Northeastern Ontario Child Welfare Agencies

Throughout this discussion on practice implications, there will be further analysis and considerations stemming from both the study's underlying theoretical perspectives (i.e. Symbolic Interactionism and pragmatism) and related contextual aspects such as neoliberalism. This section will begin by outlining the implications stemming from the three constructed categories before discussing the implications for agencies when providing trauma-management strategies and emotional support. Recall that the three categories which emerged were:

1. The Experience of Child Client Deaths
2. "The Process" and its Impact on Organizational Climate
3. Delayed Grief and Processing.

Practice Implications: The Experience of Child Client Deaths

First and foremost, this study supports related literature which finds that child client deaths can have a particularly negative impact on the life and mental wellbeing of a child welfare worker. In this study, experiences ranged in severity, from fears of legal culpability to post-traumatic stress disorder, and the lasting physical and psychological symptoms consisted of

everything from stomach pain to recurring triggers, horrific nightmares, and flashbacks. It might seem obvious that the death of a child would be traumatic for a CWW, but if that is the case, why is there research that highlights workers receiving inconsistent levels and methods of support from their agencies, or no support whatsoever? If anything, this frequent finding of the profound and enduring impact of child deaths warrants further research into child welfare trauma-management and places added pressure on child welfare organizations to develop and implement trauma-management policies and procedures.

Each situation of child client death elicited unique reactions among the five participants, these responses can be analysed further by considering them in the theoretical perspectives of Symbolic Interactionism (SI) and pragmatism. These philosophies take up multiple perspectives and view experiences as related to context (Adams & Sydie, 2002; Charmaz, 2017b; Schwandt, 2011b). When understood this way, it is normal and completely expected that workers would all experience the death of a child client differently. This range of reaction demands that agencies give greater consideration of the individual needs of workers when responding to workplace trauma. It is unlikely that two workers will experience an event in the same way and therefore different responses are needed.

Concerning the impact of child death, it is fascinating to note that the four workers in this study who had more intense emotional responses to the death had higher proximity to the file and long-term working relationships. This emerging relationship lends some support to Gustavsson and MacEachron's (2002) matrix of grief and Douglas's (2013b) finding that workers who were actively involved with the family right up until the child's death yielded higher rates of post-traumatic stress symptoms. These results imply that following the death of a client, supervisors should be immediately considering the worker's proximity to the file, length of the working

relationship, and relationship affect (positive/negative). Supervisors and managers may use this information to provide additional consideration and support for workers who may be at higher risk for negative stress reactions (there will be further coverage of this implication later in the chapter).

Practice Implications: "The Process" and its Impact on Organizational Climate

Several implications are stemming from the second category. As discussed, the death of a child client and the subsequent "process" impacts upon organizational climate, which can manifest in the forms of fear, blame, and silence experienced by the workers involved. Agencies need to keep in mind the intense feelings of loss and grief workers may be experiencing after a child's death, and how interrogating the worker and investigating the file for agency culpability only causes further fear in the worker and exacerbates the blame culture within child welfare. While I completely understand the need to uncover what circumstances led up to a child's death, the process can certainly be handled from a compassionate and learning lens, rather than critiquing and blaming.

With respect to prior training in child deaths and grief, only one worker in this study ever received such training from their agency; the worker also described the amount of training on the topic as quite minimal. I feel that this finding speaks to a gap in training for child welfare workers, and it is recommended that child welfare agencies consider how they are preparing their workers for end-of-life situations with their clients from an emotional standpoint. Two participants did raise an interesting point, in that the only child death training they received was in the context of child deaths that changed agency policy (e.g. inquest recommendations that altered aspects of child welfare practice such as record-keeping methods, home visit frequency,

determining risk, etc.). I feel that this finding speaks both to the state of modern child welfare practice and the impact of neoliberal ideologies.

As discussed earlier, neoliberalism and accountability are integrally related, and child welfare agencies are becoming increasingly concerned with their risk of culpability in the aftermath of child deaths, sometimes more so than the mental wellbeing of their staff. I believe that one reason child death training primarily relates to changes in practice, as opposed to mental health awareness, is because the former, unlike the latter, is a valued aspect of neoliberalism. Therefore, these practices would work to further deflect agency accountability and enhance service "quality"[13]. Furthermore, pragmatism would say that workers adapt to their organizational environments, and the nature of these adaptations impacts the nature of experience (Adams & Sydie, 2002). By adapting to a culture that reinforces accountability and efficiency while often ignoring the traumatic impact of child welfare work, staff may internalize neoliberal notions of accountability and defensive child welfare practice as normative. This adaptation may impact how a child's death is experienced as well as the worker's grieving process. When child welfare agencies focus on child death only in its relationship to inquest recommendations and policy changes, they may further disenfranchise this potential loss for CWWs and elicit a delayed grieving process.

Many workers felt silenced when it came to discussing the death of the child in the workplace; a silence that emerged for several reasons: police direction, an agency's fear of legal consequences, family privacy, and even the Part X legislation. Employee silence is harmful to the workplace, whether corporate or social service-oriented. When employees are discouraged

[13] I.e. mandating increased standards that need to be met, and when met, service-delivery is considered passable.

from speaking up or voicing feelings, they may feel devalued and like they lack any real control (recall that the latter can lead to burnout) (Wolfe Morrison & Milliken, 2000). These feelings may manifest in low commitment and trust within an agency, and decrease motivation and satisfaction, thereby resulting in employee turnover (Wolfe Morrison & Milliken, 2000). To foster healthy morale and employee retention, child welfare agencies should be actively working to create emotionally safe environments that encourage feedback and the regular exchange of ideas between management and front-line staff.

Issues of confidentiality also play a role in worker experiences. For example, the new Part X legislation was tied to participants' understandings of their experiences. Part X is a newly created section of the Child, Youth, and Family Services Act (CYFSA) focused on privacy rights (Ministry of Children Community and Social Services, 2018). For example, one participant cited their agency's interpretation of Part X legislation as the reason behind their silencing. As a result of moving toward Part X implementation, this particular agency discouraged team discussions which focused on experiences of child client deaths.

For clients, Part X allows them access to their personal information and increases control and transparency over how their information is shared and handled by providers (Ministry of Children Community and Social Services, 2018). For service providers, Part X sets new rules about how clients' information is shared and protected (Ministry of Children Community and Social Services, 2018). I see this transition to Part X as directly related to accountability as outlined by Leung (2008), as this is legislation that *mandates* the downward accountability to service users, thereby formalizing this relationship within child welfare.[14]

[14] Although, there already were several systems operating that formalized this downward accountability to service users for many years (e.g. the Child and Family Services Review Board).

Given that peer support is among the leading, and sometimes only, source of emotional support for CWWs who have experienced trauma, I find it highly distressing that child welfare agencies are already interpreting the Part X legislation to monitor peer support and discussion. I also worry about workers internalizing this climate wherein peer support is not acceptable, as it is yet another factor that risks further disenfranchisement of the loss and may also negatively impact perceptions of emotional safety within an organization. Agencies should be considering how they are interpreting this new legislation as it relates to peer support, and how peer support might be able to operate within this new paradigm. There are ways and means that privacy and peer support can coexist and made to be mutually exclusive.

As an extension of organizational climate, workers were asked about how emotionally safe the agency environment was when talking/venting about the death. Overall, I would say there was a questionable level of emotional safety with the participants in this study. Only one person indicated an outright feeling that “yes” that their agency was emotional safety while two only felt “conditionally” safe with select individuals. This question was not arbitrary but rather was inspired by the Trauma-Informed Climate Scale 10 (TICS-10). Refined by Hales, Kusmaul, Sundborg, and Nochajski, (2019), TICS-10 is a scale that measures how staff feel regarding organizational climates concerning safety, trust, choice, collaboration, and empowerment. Organizations such as child welfare would benefit greatly from adopting a trauma-informed climate (TIC), as studies have shown TICs result in higher staff satisfaction, increased commitment to the organization, less burnout, and positive outcomes for clients (Hales et al., 2019). In other words, it can be inferred that “going trauma-informed” may help to reverse or combat many of the problematic aspects of modern child welfare culture.

Practice Implications: Delayed Grief and Processing

This final category speaks to a prominent issue within not only child welfare but likely many crisis-driven careers where clients may die traumatically. The personal impact of delaying grief is quite real. As noted by Gustavsson and MacEachron (2004), delaying grief, or ignoring it altogether "may accentuate negative consequences for the worker psychologically and for the agency in terms of lower productivity due to tardiness, absences, impaired effectiveness, or even turnover" (p. 324). As a result, agencies have a vested interest in avoiding disenfranchised/delayed grief and should openly acknowledge that the death of a child client may be a considerable loss for certain CWWs. As indicated in the findings of this study, CWWs may even need to be told outright that it is normal to grieve and it is okay to take time off work. If workers are delaying and shelving their feelings because of their organizational culture, or because they are not allowed an opportunity to express this grief, agencies will likely pay for this in the long run with burnout and turnover. If not from a moral perspective, agencies should feel obligated from a managerial perspective to ensure proper trauma-management of staff as the aforementioned aspects of grief would arguably impact service quality and an ability to meet provincial standards.

Concerning the *Two Selves*, this concept that workers may be balancing both a professionalized and emotional response to death has implications for how supervisors and managers are monitoring the mental wellbeing of their staff. Child welfare agencies must understand that while some workers are going to be able to maintain this professionalized grief response[15], others may not. If a worker is having a particularly emotional response to a death,

[15] Potentially to their detriment.

responsibilities should not be removed without explanation, but rather, there should be an empathetic and supportive conversation about what may be temporarily best for the family and the worker's mental wellbeing. Additionally, managers and supervisors may want to consider the behaviour of their workers in the weeks/months following a death. If supervisors note certain uncharacteristic behaviour (for example, a sudden lack of professionalism with the family), this could indicate that emotions such as grief and anger are overwhelming the professionalized work identity and it may be time to check-in and assess whether the CWW needs additional supports, referrals, or time off.

Practice Implications: Trauma Management and Emotional Support

Beginning with the provided list of worker-proposed trauma-management strategies that came from related studies, three of the five participants included both administrative support and training prior to child deaths in their top choices. The first finding (increased administrative support) simply speaks to the current state of child welfare practice as a result of neoliberal ideologies, specifically high-efficiency management models and accountability. Decades of inquest recommendations and increased quality assurance measurements have resulted in child deaths being one of the most administratively demanding aspects of modern child welfare practice. In addition to these increased post-death demands, workers are also trying to service their remaining families and continue to meet provincial standards; something they understandably would appreciate assistance in completing.

The second finding related to increased child death/trauma training was touched on earlier, but essentially speaks to a desire from workers to be more prepared in matters of death, something that agencies could most certainly be providing. P1 also provided some evidence for what this training/education may accomplish. P1 was the only participant who indicated prior

education in topics such as PTSD and VT. They felt that this knowledge helped them better cope with the child's death by having an understanding of what emotions they were feeling, where they were coming from, and what they needed to do about it. Increased pre-trauma preparedness and administrative support are aspects of practice that I believe agencies should be considering, but the latter could prove difficult considering the overburdened state of the field.

Considering that the most common agency response was offering some form of Psychological Debriefing (PD), I will now discuss the practice implications for agencies when providing child welfare staff with debriefings. While three of the five participants were offered debriefings, only two participated. Although, even the participant who did not take part in the offered debriefing had a unique cultural insight into the process that does have implications for Indigenous child welfare/wellbeing agencies. P1, speaking from the perspective of an Indigenous person within an Indigenous-focused agency, noted that in their discussions with other workers on debriefings, some have had poorer experiences when the debriefer was too young. P1 explained that this problem likely stems from their cultural need and tradition of having advice given by an elder. This finding could mean additional consideration from Indigenous organizations to ensure that debriefings, or any type of professionalized trauma-management strategy for that matter, are compatible with their culture and that debriefings may need to be conducted by someone who Indigenous CWWs would view as an elder.[16]

The data from the two workers who did participate in their debriefings raises additional implications, albeit in different ways. For the participant who had a positive experience with group debriefing (P4), their data provides further support as to why CISD remains so popular.

[16] This also raises questions/concerns for mainstream trauma-management strategies such as CISD and how compatible they are with various cultures and traditions.

Recall that CISD's evidentiary base is found to be extremely mixed in the literature, but the primary reasons that it remains so popular are because employees appreciate the debriefing process as it normalizes their feelings and it is an alternative to formalized therapy (Handa et al., 2011; Pack, 2013). For P4, this is almost the verbatim reason as to why group debriefing was effective and recommended. P4 felt that their difficult emotions were normalized by being with other staff who experienced the same event. The group process also allowed them to communicate common feelings and thoughts with people in a way that individual counseling did not. Thus, P4 provides some support as to why agencies could still consider and offer debriefings as a method of trauma-management, but given its highly debated status, it should not be the only response offered.

The other participant who had a poor experience with debriefing (P5) attributed it to wanting a more intimate/private process, and also that the debriefing was held too soon and interrupted the focus of the investigation. Handa et al. (2011) state that CISD is commonly provided days after the critical incident, but P5 provides evidence as to why this timing could be problematic in child welfare. P5 was primarily situated within their work self and had effectively delayed grief and processing to conduct the investigation properly. They were insightfully cautious of the early debriefing, fearing that it would bring out the painful grief they were shelving and then jeopardize a full return to investigative objectivity. What this all speaks to is the significance of consulting CWWs as to what support they desire and when they feel they need it, rather than the agency dictating the type and timing of the support.

The final two participants had two very different agency responses (i.e. a list of resources and grief counselling). P2 did not use any of the provided resources so I am unable to provide a deep analysis of this trauma-management strategy. That being said, P2 did not recommend that

their agency put an end to this offer and acknowledged that other workers may find the resources helpful; it was simply not what they were looking for.

P3 felt their experience of grief counseling was a "waste of time" and attributed it primarily to a grief counselor without knowledge of child welfare practice and a lack of practical suggestions for how to manage grief emotions. Agencies may want to vet prospective grief counselors (if that is their chosen method of trauma-management) to ensure their work goes beyond simply discussing feelings and provides workers with tangible suggestions for how to handle various emotions and difficulties related to the death as well as providing additional resources.

Conditional Agency Support

One participant raised the disconcerting issue that there is a relationship between offered trauma-management and emotional support and how the agency perceives the quality of work performed by the CWWs involved in the case. I feel that even workers facing highly negative scrutiny as a result of mistakes need some type of support, maybe even more so. Perhaps a worker became negligent in their duties not out of malice, but rather was burnt out, overworked, managing extraordinarily high caseloads, and had little or no emotional support provided by the agency. It is much easier for an agency to distance themselves from the actions of an individual than it is to acknowledge systemic and organizational failings that may have contributed to a worker's negligence. Ultimately, I am not arguing that these workers do not need to be held accountable for failing to fulfill their duties as an authorized CWW, but I am concerned that through "knee-jerk" dismissals and failing to consider the intense guilt and responsibility these particular workers may be feeling, child welfare sends the message that workers are disposable and replaceable, and further embeds the culture of intense "cover your rear end" accountability.

Concluding Recommendations for Child Welfare Agencies

What is clear to me is that based on numerous factors, CWWs can experience the death of a child client in distinct ways and desire different levels and types of emotional support. This means that trauma-management and emotional support within child welfare should not be a standardized, blanket response with minimal to no worker input. It is not enough for an agency to implement, for example, a peer support team as the *only* method of trauma-management and emotional support. As highlighted in this study, some CWWs may find this method perfectly adequate for addressing their trauma, while others may want a group debriefing, individualized debriefing, a session with a grief counselor, or a few days off of work. This means that agencies should be well-versed in delivering several methods of trauma-management and, most importantly, letting the worker lead in terms of what kind of support they are looking for and when would be best to receive it. This is not to imply that agencies should sit idly by and wait for CWWs to voice what they are looking for and when. Oppositely, workers need to be actively consulted immediately following a death regarding their mental state, their options for trauma-management/support, and when this support would work best for them.

Child welfare agencies are highly recommended to invest in some sort of trauma-management and emotional support team. This is not merely the adoption of a single aspect of response, such as peer support or debriefing, but rather, an embedded agency framework of PPS and SPS which covers everything from policy/procedure development to support coordination and implementation. Taking CISM and TRiM, for an example, while the two approaches differ in their primary methodology (psychological debriefing versus peer support), what they have in common is that their trauma management strategy is just one element of a larger program (Pia et

al., 2011; Rick & Briner, 2012). CISM and TRiM have elements of education/pre-trauma preparedness, follow-up, and plans for additional referrals (Pia et al., 2011; Rick & Briner, 2012).

I have chosen to further develop the model of NSR/grief risk reaction as first outlined by Gustavsson and MacEachron (2002), with additional findings from Douglas (2013b) and findings from this study. The following table considers which workers may be at higher and lower risk of experiencing negative stress reactions and/or complicated grief reactions after the death of a child client:

Table 4 – Updated Model of NSR and Grief Risk for CWWs

Higher Risk	Lower Risk
Positive affective relationship	Negative affective relationship
Long-term working relationship	Short-term working relationship
Sudden and/or traumatic death	Anticipated death
Feels responsible for the death	Feels no responsibility for the death
Close work with family leading up to the death (High Proximity) – e.g. weekly visits	Minimal work with family leading up to the death (Low Proximity) – e.g. monthly visits
Feels that they could have done more to prevent the death	Feels that nothing could have prevented the death

As previously mentioned, supervisors can use this type of model to immediately begin considering a CWWs' proximity to a file, their relationship with the family, and any other circumstances that may lead them to believe their worker is at a higher risk of experiencing negative stress reactions and/or complicated grief. However, this model is by no means definitive and it is not to say that, for instance, workers who just recently became involved with a family will not be traumatized by a child's death. There will, of course, be workers that fall outside of

both ends of the spectrum, because ultimately, everyone experiences traumatic events differently as a result of numerous factors.

In adapting the framework for workplace trauma intervention as outlined by NICE, the recommendations from the SPR Associates review, previously outlined literature, and the data from this study, the following is a sample framework that agencies may consider when organizing trauma-management and emotional support after the death of a child client[17]:

I. Pre-Trauma

1. Train/educate workers in death, dying, and grief. Such education would cover child welfare client deaths, negative stress reactions, grief, methods of coping, and agency options for emotional support/coverage under benefits.
2. Agencies should promote self-care (such as protected self-care time that workers can use once per month), health promotion, and wellness in their staff on an ongoing basis.

II. Trauma

1. Provide social, emotional, and mental health support immediately following a child client's death:
    a. Workers are to be quickly oriented of available trauma management resources and/or personal leave options (e.g. short-term paid mental health leave).
    b. Agencies could make available psychological debriefings, peer assistance programs, psychological first aid, grief counselors, or specialized referrals (e.g. TF-CBT, EMDR) as trauma-management resources. The worker would lead in terms of which support they feel would benefit them, and when they would need it. The type of support provided should not be determined by the agency without staff input.
    c. Agencies should consider administrative support such as assistance with the post-child death administrative process, workplace accommodations to minimize triggers, assistance in managing the worker's remaining caseload while they oversee the child death investigation, and a temporary caseload pause (i.e. no new cases).

        Additional suggestions:

        i. Agencies should approach the child's death with a lens of learning and not blaming/finger-pointing; keep in mind what this process may feel like for the CWW.

[17] With some modification, there is no reason this type of guideline could not be used for any critical incident.

ii. Agencies need to take great consideration when looking to assign CWWs with intimate death-related activities such as planning funerals and seek their input about carrying out such tasks.
iii. Depending on the circumstances, it may also be beneficial to allow the worker a choice in completing the child death investigation or taking time off of work.

III. Post-Trauma

1. Plan a formalized follow-up with staff one month after the trauma.
2. If staff are identified to be of high risk for NSRs (e.g. using a tool such as Table 4), a brief screening and assessment tool for trauma reactions should be conducted at this time. This may help to determine if any additional supports and/or specialized referrals may be necessary.

Both the above framework and the proposed model for grief/stress reaction risk (Table 4), are rooted in SI and pragmatism as the theoretical basis (in addition to being framed from the findings of this study and related literature). Essentially, both the risk reaction model and the proposed framework are asking for child welfare organizations to *consider the unique needs of the individual*. Again, when considering the aforementioned perspectives, it is understood that there exists multiple perspectives and that experiences relate to context (Adams & Sydie, 2002; Charmaz, 2017b; Schwandt, 2011b). Therefore, in developing a framework of trauma-management, I felt it was key to consider individuality, as staff will ultimately experience the event differently and may desire different levels and types of support in response.

Limitations

One of this study's primary limitations relates to the application of Constructivist Grounded Theory, and as a result, is not a true grounded theory study. While I was able to successfully adopt and utilize certain aspects of grounded theory (e.g. in-depth interviewing, coding, memo-writing, comparative analysis, and categorizing) this study was unable to attain a traditionally appropriate sample size, utilize theoretical sampling, and claim saturation.

Concerning the limited sample size, Charmaz (2014) notes that for *small* grounded theory projects, 25 interviews could be an acceptable number of participants. Due to the limited resources in completing this MSW thesis, there was simply no way I could have recruited that many individuals, interviewed them all, transcribed the data, and conducted a thorough analysis. A condensed timeline and limited resources are also what prevented me from applying theoretical sampling and claiming saturation, as mentioned earlier, and therefore limit the overall depth of the study.

Some of the recurring critiques of grounded theory application as described by Clarke (2011) and reflected in the early sections of the thesis, may also be present in this study. One such critique relates to researchers ultimately generating a thematic analysis as opposed to theory. As mentioned, the limited timeline of this research prevented the ability to use theoretical sampling to fully explicate the properties of the categories and reach saturation. It could be argued that the findings in this project are mere thematic analysis as opposed to a true explanation of a process/generation of theory. Additionally, Clarke (2011) noted that researchers often use grounded theory methods symbolically rather than as actual research practice. Although I was able to successfully apply several aspects of CGT, the fact that I am not able to call this an actual grounded theory study could lend weight to the criticism that this research is grounded theory only in a symbolic sense.

Future Research

This study has provided me with insight into several different areas that could warrant additional research. Concerning a potential research agenda, future studies may: 1) Look further at the impact of client deaths on child welfare staff outside of protection departments, such as

child care workers, clinical roles, and supervisors; 2) Consider the impact of adult client deaths on child welfare staff; 3) Conduct a similar study (e.g. child death impact and trauma-management), but focused on child welfare workers who are no longer employed with child welfare; whether workers were terminated or quit of their own volition, it would be fascinating to see what lasting impact the death may have had on these harder to reach individuals and how their agency experiences may have varied; 4) Continue to update and test a model of NSRs/grief reaction risk such as Table 4; further explication and testing of a CWW grief risk model may assist child welfare agencies in assessing, intervening, and managing the trauma-reactions of their workers; 5) I do not believe that the concept of delaying grief and processing is exclusive to child welfare and could be explored in numerous front-line and crisis-driven workplaces where clients my die traumatically; 6) Future research may also want to explore how child welfare agencies are interpreting Part X while examining its potential impact on peer support.

Conclusion

On a macro level, neoliberal ideologies and high-efficiency models of management have translated into child welfare organizations facing funding restraints, high rates of turnover, and seemingly never-ending workloads in the face of increasing responsibilities and administrative tasks. On a micro level, child welfare workers are confronted with some of the most traumatic aspects of child abuse and neglect, which includes the tragic deaths of young children and infants. Investing in an embedded framework of trauma-management and emotional support may seem daunting for agencies, considering most supervisors and workers may feel like they are spending their days just trying to keep their heads above water. But, as overwhelming as the task may seem, it is not something agencies can afford to ignore as they will inevitably see the impact

of trauma exposure in the forms of burnout, turnover, sick leave, and absenteeism (SPR Associates Inc., 2014).

An embedded framework of trauma-management and emotional support is among the most important commitments a child welfare agency can make. I believe that appropriately investing in the mental wellbeing and emotional safety of workers may create a ripple effect of positive change within an agency, including improved staff mental wellbeing, decreased use of sick time, less turnover, increased quality of service for clients, and improved staff morale and commitment to their agency. What remains true is that no matter what, agencies are paying for the impacts of trauma exposure, whether they are managing sick leave and turnover or contracting a trauma-management service.

Child welfare practice has reached a point where the death of a child client triggers a flood of time-sensitive administrative and investigatory responsibilities, none of which stop to consider the CWWs mental wellbeing. I hope that an embedded framework of policies and procedures makes trauma-management and emotional support a normalized component of this demanding process and helps to create healthy and emotionally safe workplaces that are responsive to the mental health needs of child welfare workers.

BIBLIOGRAPHY

Adams, B. N., & Sydie, R. A. (2002). *Classical Sociological Theory* (1st ed.; M. C. Tropp, Ed.). Thousand Oaks, California: Pine Forge Press.

Anne Dombo, E., & Whiting Blome, W. (2016). Vicarious Trauma in Child Welfare Workers: A Study of Organizational Responses. *Journal of Public Child Welfare*, *10*(5), 505–523. https://doi.org/10.1080/15548732.2016.1206506

Aronson, J., & Smith, K. (2011). Identity work and critical social service management: Balancing on a tightrope? *British Journal of Social Work*, *41*(3), 432–448. https://doi.org/10.1093/bjsw/bcq102

Attig, T. (2004). Disenfranchised grief revisited: Discounting hope and love. *Omega: Journal of Death and Dying*, *49*(3), 197–215. https://doi.org/10.2190/P4TT-J3BF-KFDR-5JB1

Ayre, P. (2001). Child protection and the media: Lessons from the last three decades. *British Journal of Social Work*, *31*(6), 887–901. https://doi.org/10.1093/bjsw/31.6.887

Baines, D., Charlesworth, S., Turner, D., & O'Neill, L. (2014). Lean social care and worker identity: The role of outcomes, supervision and mission. *Critical Social Policy*, *34*(4), 433–453. https://doi.org/10.1177/0261018314538799

Baker, J. (2018). *Beyond Spa Days and Self-Care: An Examination of Workplace Culture and Wellness in Child Protection Work*. McMaster University.

Beddoe, L. (2010). Surveillance or reflection: Professional supervision in "the Risk Society." *British Journal of Social Work*, *40*(4), 1279–1296. https://doi.org/10.1093/bjsw/bcq018

Bride, B. E., Jones, J. L., & MacMaster, S. A. (2007). Correlates of Secondary Traumatic Stress in Child Protective Services Workers. *Journal of Evidence-Based Social Work*, *4*(3/4), 69–80. https://doi.org/10.1300/J394v04n03

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed.; J. Seaman, Ed.). London, UK: SAGE Publications, Inc.

Charmaz, K. (2017a). Constructivist Grounded Theory. *Journal of Positive Psychology*, *12*(3), 299–300. https://doi.org/10.1080/17439760.2016.1262612

Charmaz, K. (2017b). The Power of Constructivist Grounded Theory for Critical Inquiry. *Qualitative Inquiry*, *23*(1), 34–45. https://doi.org/10.1177/1077800416657105

Choate, P. W. (2017). Jeffrey Baldwin: A thematic analysis of media coverage and implications for social work practice. *Child Care in Practice*, *23*(1), 21–33. https://doi.org/10.1080/13575279.2015.1126225

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, *7*, 205031211882292. https://doi.org/10.1177/2050312118822927

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse and Neglect*, *30*(10), 1071–1080. https://doi.org/10.1016/j.chiabu.2006.03.009

Cradock, G. (2011). Thinking goudge: Fatal child abuse and the problem of uncertainty. *Current Sociology*, *59*(3), 362–378. https://doi.org/10.1177/0011392111400788

Creswell, J. W. (2007). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches* (Second; J. Robinson, Ed.). Thousand Oaks, California: SAGE Publications, Inc.

Csikai, E. L., Herrin, C., Tang, M., & Church II, W. T. (2008). Death in Child Protection and Preparation for End-of-Life. *Child Welfare*, *87*(6), 49–71.

Dane, B. (2000). Child welfare workers: An innovative approach for interacting with secondary

trauma. *Journal of Social Work Education*, *36*(1), 27–38. https://doi.org/10.1080/10437797.2000.10778987

Douglas, E. M. (2013a). Child Welfare Workers Who Experience the Death of a Child Client. *Administration in Social Work*, *37*(1), 59–72. https://doi.org/10.1080/03643107.2012.654903

Douglas, E. M. (2013b). Symptoms of Posttraumatic Stress among Child Welfare Workers Who Experience a Maltreatment Fatality on their Caseload. *Journal of Evidence-Based Social Work*, *10*(4), 373–387. https://doi.org/10.1080/15433714.2012.664058

Drake, B., & Tadama, G. N. (1996). A structural equation model of burnout and job exit among child protective services workers. *Social Work Research*, *20*(3), 179–187.

Figley, C. R. (1995). Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview. In C. R. Figley (Ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who Treat the Traumatized* (1st ed., pp. 1–20). New York, New York: Routledge.

Figley, C. R. (2012). Helping that Hurts: Child Welfare Secondary Traumatic Stress Reactions. *Secondary Trauma and the Child Welfare Workforce*, (Spring), 4–6. Retrieved from http://www.cehd.umn.edu/ssw/cascw/attributes/PDF/publications/CW360_2012.pdf

Geddes, A., Parker, C., & Scott, S. (2018). When the snowball fails to roll and the use of 'horizontal' networking in qualitative social research. *International Journal of Social Research Methodology*, *21*(3), 347–358. https://doi.org/10.1080/13645579.2017.1406219

Gibbs, G. R. (2013, September 4). A Discussion with Kathy Charmaz on Grounded Theory. *YouTube*. Retrieved from https://www.youtube.com/watch?v=D5AHmHQS6WQ

Ginzburg, K., Geron, Y., & Solomon, Z. (2002). Patterns of Complicated Grief among Bereaved

Parents. *OMEGA - Journal of Death and Dying*, *45*(2), 119–132. https://doi.org/10.2190/xuw5-qgq9-kcb8-k6ww

Griffiths, A., Royse, D., & Walker, R. (2018). Stress among child protective service workers: Self-reported health consequences. *Children and Youth Services Review*, *90*(May), 46–53. https://doi.org/10.1016/j.childyouth.2018.05.011

Gustavsson, N., & MacEachron, A. E. (2002). Death and the child welfare worker. *Children and Youth Services Review*, *24*(12), 903–915. https://doi.org/10.1016/S0190-7409(02)00251-7

Gustavsson, N., & MacEachron, A. E. (2004). When a child welfare client dies: An agency-centered perspective. *Child Welfare*, *83*(4), 317–340.

Hales, T., Kusmaul, N., Sundborg, S., & Nochajski, T. (2019). The Trauma-Informed Climate Scale-10 (TICS-10): A Reduced Measure of Staff Perceptions of the Service Environment. *Human Service Organizations Management, Leadership and Governance*, *43*(5), 443–453. https://doi.org/10.1080/23303131.2019.1671928

Handa, S., Krantz, L., Delaney, E., & Litz, B. (2011). Models of crisis management. In N. Tehrani (Ed.), *Managing Trauma in the Workplace: Supporting Workers and Organisations* (pp. 204–217). Hove, East Sussex: Routledge.

Horwatch, J. (1995). The Impact of Fatal Child Abuse Cases on Staff: Lessons for Trainers and Managers. *Child Abuse Review*, *4*, 351–355. https://doi.org/10.1002/(SICI)1099-0852(199608)5:3<152::AID-CAR274>3.0.CO;2-9

Horwitz, M. (1998). Social worker trauma: Building resilience in child protection social workers. *Smith College Studies in Social Work*, *68*(3), 363–377. https://doi.org/10.1080/00377319809517536

Information and Privacy Commissioner of Ontario. (2020). Overview of the CYFSA. Retrieved

August 13, 2020, from Information and Privacy Commissioner of Ontario website: https://www.ipc.on.ca/part-x-cyfsa/introduction/overview-of-the-cyfsa/

Jagannathan, R., & Camasso, M. J. (2017). Social outrage and organizational behavior: A national study of child protective service decisions. *Children and Youth Services Review*, *77*(November 2016), 153–163. https://doi.org/10.1016/j.childyouth.2017.03.015

Kanani, K., Regehr, C., & Bernstein, M. M. (2002). Liability considerations in child welfare: Lessons from Canada. *Child Abuse and Neglect*, *26*(10), 1029–1043. https://doi.org/10.1016/S0145-2134(02)00375-7

Klein, S., & Alexander, D. (2011). The Impact of Trauma within Organisations. In N. Tehrani (Ed.), *Managing Trauma in the Workplace: Supporting Workers and Organisations* (2nd ed., pp. 117–138). Hove, East Sussex: Routledge.

Leung, T. T. F. (2008). Accountability to Welfare Service Users: Challenges and Responses of Service Providers. *British Journal of Social Work*, *38*(3), 531–545. https://doi.org/10.1093/bjsw/bcl351

Littlechild, B., Hunt, S., Goddard, C., Cooper, J., Raynes, B., & Wild, J. (2016). The Effects of Violence and Aggression From Parents on Child Protection Workers' Personal, Family, and Professional Lives. *SAGE Open*, *6*(1), 1–12. https://doi.org/10.1177/2158244015624951

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology*, *23*(1), 112–123. https://doi.org/10.1037/trm0000096

Mahon, R. (2008). Varieties of Liberalism: Canadian Social Policy from the “Golden Age” to the Present. *Social Policy & Administration*, *42*(0144–5596), 342–361. https://doi.org/10.1111/j.1467-9515.2008.00608.x

Mann, D. (2011). *Understanding Society: A Survey of Modern Social Theory* (Second). Don Mills, Ontario: Oxford University Press.

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103–111. https://doi.org/10.1002/wps.20311

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative Research: A Guide to Design and Implementation* (4th ed.). San Fransisco, CA: Jossey-Bass.

Ministry of Children Community and Social Services. (2018). Part X (Personal Information). Retrieved July 18, 2020, from Ontario website: http://www.children.gov.on.ca/htdocs/English/childrensaid/part-x.aspx

Ministry of the Solicitor General. (2019a). Death Investigations: About inquests. Retrieved March 23, 2020, from Ministry of the Solicitor General website: https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/Inquests/AidToInquests.html

Ministry of the Solicitor General. (2019b). Death Investigations: Common Questions about Death Investigations. Retrieved June 15, 2020, from Death Investigations website: https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/CommonQuestionsAboutCoronersInvestigations/OCC_common_questions.html

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing Science and Practice for Vicarious Traumatization/Secondary Traumatic Stress: A Research Agenda. *Traumatology*, *23*(2), 129–142. https://doi.org/10.1037/trm0000122

Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare*, *82*(1), 5–26.

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research*

in Nursing and Health, *31*(4), 391–398. https://doi.org/10.1002/nur.20259

Oates, F. (2019). You are not allowed to tell: Organisational culture as a barrier for child protection workers seeking assistance for traumatic stress symptomology. *Children Australia*, *44*(2), 84–90. https://doi.org/10.1017/cha.2019.12

Office of the Chief Coroner Province of Ontario. (2018). *Paediatric Death Review Committee and Deaths Under Five Committee*. Retrieved from https://www.mcscs.jus.gov.on.ca/sites/default/files/content/mcscs/docs/PDRC DU5C 2017 Report Final.pdf

Pack, M. J. (2013). Critical incident stress management: A review of the literature with implications for social work. *International Social Work*, *56*(5), 608–627. https://doi.org/10.1177/0020872811435371

Pia, F., Burkle, F. M., Stanley, S. A. R., & Markenson, D. (2011). ACFASP Review: Critical Incident Stress Debriefing (CISD). *International Journal of Aquatic Research and Education*, *5*(1). https://doi.org/10.25035/ijare.05.01.09

Pollard, L. W. (2018). Social worker experience of fatal child abuse. *British Journal of Social Work*, *48*(7), 1948–1966. https://doi.org/10.1093/bjsw/bcx138

PSHSA. (2016). *PTSD Awareness for Children's Aid Workers* (pp. 1–4). pp. 1–4. PSHSA.ca.

Reder, P., Duncan, S., & Gray, M. (1993). *Beyond Blame: Child Abuse Tragedies Revisited* (1st ed.). Routledge.

Regehr, C., Chau, S., Leslie, B., & Howe, P. (2002). Inquiries into deaths of children in care: The impact on child welfare workers and their organization. *Children and Youth Services Review*, *24*(12), 885–902. https://doi.org/10.1016/S0190-7409(02)00250-5

Richardson, K. (2011). Child Protection Social Work and Secondary Trauma. In N. Tehrani

(Ed.), *Managing Trauma in the Workplace: Supporting Workers and Organisations* (1st ed., pp. 3–16). Hove, East Sussex: Routledge.

Rick, J., & Briner, R. B. (2012). Evidence-based Trauma Management for Organizations: Developments and Prospects. In R. Hughes, A. Kinder, & C. L. Cooper (Eds.), *International Handbook of Workplace Trauma Support* (pp. 17–29). John-Wiley & Sons, Incorporated.

Rogowski, S. (2015). From Child Welfare to Child Protection/Safeguarding: A Critical Practitioner's View of Changing Conceptions, Policies and Practice. *Practice*, *27*(2), 97–112. https://doi.org/10.1080/09503153.2015.1014337

Samson, P., Tanchak, S., Drolet, J. L., Fulton, A., & Kreitzer, L. (2019). The Contribution of Clinical Supervision to Wellness in the Workplace : Implications for Social Work Field Education. *Field Scholar*, *9*(May), 1–24.

Schwandt, T. A. (2011a). Pragmatism. In *The SAGE Dictionary of Qualitative Inquiry* (p. 240). Thousand Oaks, California: SAGE Publications, Inc.

Schwandt, T. A. (2011b). Symbolic Interactionism. In *The SAGE Dictionary of Qualitative Inquiry* (p. 284). https://doi.org/10.4324/9781315573946-16

Sebastian, K. (2019). Distinguishing Between the Types of Grounded Theory: Classical, Interpretive and Constructivist. *Journal for Social Thought*, *3*(1). Retrieved from https://ojs.lib.uwo.ca/index.php/jst/index

SPR Associates Inc. (2014). *CAS Workers at Risk: A Current Assessment of Worker Safety, Client Violence and Child Protection in Ontario's Children's Aid Societies – A System under pressure*. Toronto, ON.

Swift, K. J., & Parada, H. (2004). Child Welfare Reform: Protecting Children or Policing the

Poor. *Journal of Law and Social Policy*, *19*, 1–17. Retrieved from https://digitalcommons.osgoode.yorku.ca/jlsp/vol19/iss1/1

TEND. (2020a). Defining Vicarious Trauma and Secondary Traumatic Stress. Retrieved July 27, 2020, from TEND ACADEMY website: https://www.tendacademy.ca/resources/defining-vicarious-trauma-and-secondary-traumatic-stress/

TEND. (2020b). What is Compassion Fatigue. Retrieved July 27, 2020, from TEND ACADEMY website: https://www.tendacademy.ca/what-is-compassion-fatigue/

Thomlison, B., & Blome, W. W. (2012). Hold the Presses : A Commentary on the Effects of Media Coverage of Fatalities on the Child Welfare System Hold the Presses : A Commentary on the Effects of Media Coverage of Fatalities on the Child Welfare System. *Journal of Public Child Welfare*, *6*, 243–254. https://doi.org/10.1080/15548732.2012.683327

Timonen, V., Foley, G., & Conlon, C. (2018). Challenges when using grounded theory: A pragmatic introduction to doing GT research. *International Journal of Qualitative Methods*, *17*(1), 1–10. https://doi.org/10.1177/1609406918758086

Travis, D. J., Lizano, E. L., & Mor Barak, M. E. (2016). "I'm so Stressed!": A Longitudinal Model of Stress, Burnout and Engagement among Social Workers in Child Welfare Settings. *British Journal of Social Work*, *46*(4), 1076–1095. https://doi.org/10.1093/bjsw/bct205

Turgeon, B., & Taylor, T. (2014). *Contrasts and classtalk : A critical discourse analysis of welfare-to-work program managers*. https://doi.org/10.1177/0957926514536827

Whybrow, D., Jones, N., & Greenberg, N. (2015). Promoting organizational well-being: A comprehensive review of trauma risk management. *Occupational Medicine*, *65*(4), 331–

336. https://doi.org/10.1093/occmed/kqv024

Wolfe Morrison, E., & Milliken, F. J. (2000). Organizational Silence : A Barrier to Change and Development in a Pluralistic World. *The Academy of Management Review*, *25*(4), 706–725.

Appendix A – Question 13 Instructions for Participants

Instructions for Participants – Question 13

CHILD CLIENT DEATHS AS EXPERIENCED BY CHILD PROTECTION WORKERS IN NORTHEASTERN ONTARIO: AGENCY RESPONSES, EFFICACY, AND A WAY FORWARD

Andrew Barton (Master of Social Work Student)

McMaster University – School of Social Work

Information to be provided to participants via email before the interview

Instructions: The following are suggested trauma-response strategies put forth by other child protection workers in one American study (Douglas, 2013) and one British study (Pollard, 2018) of child welfare client deaths. The previous studies were based on samples of child protection workers while Gustavvson and MacEachron (2002) based their study on existing literature.

Read through each strategy at your own pace and then we'll discuss them:

a) Douglas (2013)/Gustavsson and MacEachron (2002): **Provide emotional/legal support** – These workers talked about voluntary/mandatory counseling, legal advice, and peer/supervisor support. They also suggested openly discussing the death with staff involved and providing support/counseling as needed. Gustavsson and MacEachron (2002) framed this recommendation as on-site support.

b) Pollard (2018) – **Staff debriefing** – Workers in this study suggested that agencies provide individual and/or group debriefing for the staff involved.

c) Douglas (2013): **Avoid blaming the worker** – This study found that workers felt the focus after the death was on blaming rather than on what everyone could learn from the situation.

d) Douglas (2013): **Training prior to child deaths** – These workers felt that staff should be better prepared to deal with secondary trauma (for example, preparation through training and clinical supervision).

e) Douglas (2013): **Administrative responses** – In this study, the workers felt burdened by the administrative duties following the death and suggested things such as paid leave and a reduced workload (which was described as giving workers a "time out" from new cases and then referring to counselling services).

Appendix B – Interview Guide

Interview Guide

CHILD CLIENT DEATHS AS EXPERIENCED BY CHILD PROTECTION WORKERS IN NORTHEASTERN ONTARIO: AGENCY RESPONSES, EFFICACY, AND A WAY FORWARD

Andrew Barton (Master of Social Work Student)

McMaster University – School of Social Work

Introductions/Participant Background

1) I just want to start with some basic background information so I know a little more about you:

a) What is your age?

b) How do you identify your gender?

b) What is/was your child welfare position (i.e. investigations/ongoing services)?

c) How many years have you been employed/were you employed with child welfare?

d) What degrees or credentials do you have?

2) Tell me a bit about what life is like/was like for you as a Child Protection Worker (e.g. what you like about it, maybe what you don't like about it, positive experiences, etc.).

Experience of a Child Client Death

Preamble to Q3: "So we're going to continue to talk about your child protection work in more detail and we might get into some emotionally difficult things as I would like to begin discussing your experience with child client deaths. Please remember that you don't have to answer any questions you do not want to and we can pause the interview at any time if you need a break. Also, remember that I have provided you with the number to ConnexOntario and they can redirect you to a local mental health service if needed."

3) With all of this in mind, can you tell me about your experience with the death of a child client?

[*If participant needs more information about what exactly I am asking for, prompts can include: how long the file was open to them, did they lead the investigation into the death, the nature of the death, the age of the child, the year the death occurred, and so on.*

Agency Responses and Efficacy/Prior Training/Workplace Culture

4) Did your agency provide (or offer) any formal emotional/mental health support after the child's death, for example, a staff debriefing, individual therapy, and so on?

a) *If participant used the emotional/mental health support*: How helpful did you find [type of support]?

b) *If participant was offered no formal agency support:* Do you have an explanation or understanding about why that was?

5) Did you experience informal emotional support at your agency, for example, from your supervisor or co-workers?

a) *If participant experienced this type informal support*: Tell me what this looked like. What did that do for you?

6) After the client's death, were you made aware of how to access employee programs for counselling/therapy?

7) Does your agency offer anything else to workers that you know of?

8) Have you heard of other types of responses for other workers that have experienced a child death?

9) Was your agency's response sufficient, or was there something else you were expecting/looking for?

10) Did you feel like the work environment was emotionally safe to vent/talk about your feelings of the death?

11) Did you ever receive any training or supervision that discussed or prepared you for the death of a child client?

Recommended Trauma-Response Strategies

12) What do you think agencies should be doing to support the emotional/mental health needs of workers after experiencing child client deaths? How do you think this could be delivered or organized for workers based on how your agency is set up? Was your response sufficient or was there something else you were looking for?

Preamble to Q13: "My overall goal with this research is to update and further develop best practice guidelines regarding agency trauma-response that are specific and relevant to child welfare. Building off of the last question, I would like to get your thoughts about the following strategies for supporting workers that have come up in other similar studies. Please refer to the document I provided you."

13) *After participant has gone through the strategies:* What do you think about these strategies? Which strategy do you think is the most important? Which strategy do you think is the least important? Why? Do you think it is possible for any, or all, of these strategies to be introduced in your work context?

Wrapping Up

14) Did anything positive come from this experience? Did you learn anything new about yourself?

15) Is there something important we did not discuss? Is there anything else you want to talk about?

END