Understanding the Experiences of Homelessness Hostel Staff who have Found the Body of a Deceased Hostel Resident: An Interpretative Phenomenological Analysis

Josh Valoroso and Jacqui Stedmon

University of Plymouth, UK

Abstract_ *Working in a homelessness hostel can involve exposure to stressful and distressing situations. Finding the body of a deceased resident may be an example of such a situation, but little is known about what experiencing this might be like. The aim of this cross-sectional research was to explore experiences of UK homelessness hostel staff who had found the body of a deceased resident. Eight participants completed semi-structured interviews and an Impact of Events Scale-Revised questionnaire (Weiss, 2007). Interview data were analysed via interpretative phenomenological analysis. Most participants described emotional distress seemingly influenced by bodies' often-upsetting physical presentations, feeling unprepared, and reminders of the experience. Participants attempted to understand their experience to cope and obtain closure, and found meaning in awareness of existential issues and fundamental changes. Perceptions of inadequate organisational support appeared frustrating but informed views on what support should involve. The findings demonstrate the potentially distressing and traumatic experience of finding a dead body in this context and the perceived lack of support. Staff reactions have been theoretically linked with aspects of bereavement and grief. Implications for homelessness practice are discussed. Homelessness organisations should consider staff experiences and review their ability to provide proactive, timely, and adequate support.*

Keywords_ *Homelessness, staff, death, trauma, bereavement*

ISSN 2030-2762 / ISSN 2030-3106 online

Introduction

Working in homelessness hostels can be challenging; hostel staff report high levels of stress, vicarious trauma, and burnout (Waegemakers-Schiff and Lane, 2016), and have complained of feeling frustrated, powerless, and unheard (Cockersell, 2015). Working with homeless people might be particularly challenging because of their pronounced physical, psychological, and social needs: people classified as homeless are more likely to have experienced childhood abuse than the general population (Sundin and Baguley, 2015), often have complex histories including experiences of trauma, abuse, and violence (Hopper *et al*., 2009), and experience higher-than-typical rates of mental health difficulties (Rees, 2009; Mental Health Foundation, 2015) characterised by complex trauma (Maguire *et al*., 2009).

Homelessness sector staff are regularly "faced with highly stressful events" (Waegemakers-Schiff and Lane, 2016, p.7) and are "constantly exposed to those who are traumatised and to traumatic situations" (Waegemakers-Schiff and Lane, 2019, p.454). This research focuses on one specific and potentially stressful, distressing, or traumatic situation hostel workers encounter by exploring the experiences of staff who have found bodies of deceased residents.

Homelessness and mortality

Some evidence has suggested that mortality rates in people classified as homeless are higher than in the general population; age-adjusted risk of death for these people is up to six-times higher than those in the UK general population (Thomas, 2012). However, the data used to calculate these mortality rates do not differentiate between those that could be categorised as transitionally homeless (approximately 80%; Culhane and Kuhn, 1998; The People's Project, 2020) and those who are episodically (approximately 10% (Culhane and Kuhn, 1998) to 15% (The People's Project, 2020)) or chronically homeless (approximately 5% (The People's Project, 2020) to 10% (Culhane and Kuhn, 1998)). This is meaningful given evidence suggesting that episodically or chronically homeless individuals have higher rates of death than those who are transitionally homeless or the general population (Culhane and Kuhn, 1998). Regardless, people classifed as homeless in the UK appear more likely to die young: the mean age of death for people classified as homeless in the UK in 2017 was 44 for men and 42 for women, compared to general population means of 76 and 81 respectively (Office for National Statistics (ONS), 2018). Over half of deaths of people classified as homeless in the UK in 2017 were caused by suicide, drug poisoning, or liver disease, causes which accounted for only 3% of general population deaths (ONS, 2018). Compared to the general population, people classified as homeless are three-and-a-half times more likely to die by suicide, seven to nine times more likely to die of alcohol-related causes, and 20 times more likely to die of drug-

related causes (Thomas, 2012). The Museum of Homelessness (2019) estimated that in the first six months of 2019 more than 30% of deaths of people classified as homeless occurred in accommodation settings including hostels. In the UK, rates of deaths of people classified as homeless sadly appear to be increasing; per-year deaths have increased by 24% since 2013 (Independent, 2018). Compared to 9% homeless population growth in the three years between 2016 and 2018 (Shelter, 2018), latest three-year figures (2015 to 2017) for deaths of homeless people indicate an increase of 18% (ONS, 2018), meaning the likelihood of hostel staff encountering death in their work has probably increased in the UK.

Relevant research

There is limited research related to the topic of homelessness sector workers and death of homeless people. However, grounded theory research conducted by Lakeman (2011) explored how workers in the Irish homelessness sector "make sense of, respond to, and cope with" (p.925) sudden deaths of homeless people. Lakeman found that workers wanted to positively frame the death, had not anticipated the deaths, and suppressed difficult emotions.

Although the topics are similar, this research differs from Lakeman's (2011). Firstly, this research focuses specifically and exclusively on experiences of homelessness hostel staff who found bodies of deceased residents, whereas participants in Lakeman's research worked in various settings and multi-disciplinary professions. Further, only "some" (p.931) participants had found dead bodies; others were informed of deaths by service users, other staff, or in meetings. Secondly, Lakeman utilised a modified grounded theory methodology which generates constructs that cannot be traced back to individual participants. In contrast, data in this research were analysed thematically and interpretatively with a phenomenological underpinning to preserve fidelity and identify patterns common to the individual experiences of staff. In this approach an audit trail of the data analysis ensures that emergent themes can be reconnected to individual interviews. Such findings in turn contribute to generating tentative new theories that can be further tested empirically.

Rationale

In the UK, mortality rates of people classified as homeless are higher than the general population and while both are increasing, rates of deaths of these people appear to be increasing faster than the rate of growth of the number of people classified as homeless. Therefore, the likelihood of homelessness staff encountering death has probably increased. Due to the lack of specifically relevant research, the experiences of homelessness staff finding dead bodies are not well understood. Understanding this specific experience may benefit homelessness practitioners and organisations.

Aim

The aim of this research is to explore the experiences of homelessness hostel staff who had found the body of a deceased resident.

Method

Design

A cross-sectional interview design was employed. Qualitative data obtained via semi-structured interviews were analysed using interpretative phenomenonological analysis (IPA) because it facilitates analysis of "detailed examinations of personal lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions" (Smith and Osborn, 2015, p.41). IPA is therefore particularly useful for exploratory research such as this where there is little underpinning theoretical understanding. Data from the Impact of Events Scale-Revised (IES-R) (Weiss, 2007) were also collated. Responses on this questionnaire provided reference points relating to trauma-related symptoms with which inteview responses were contextualised.

Researcher background and subjective position

The first author is a Clinical Psychologist who, prior to the research, facilitated reflective practice groups for staff in two homelessness hostels for nine months. During these groups, three instances of bodies of deceased residents being found by staff were discussed. The first author's subjective position prior to the research was that the experience appeared to have been considerably upsetting to some staff. The second author is a Consultant Clinical Psychologist and Programme Director for the Doctorate in Clinical Psychology course at the University of Plymouth. She is a member of the committee for the Bereavement Research Forum and a founder member of a chartiable bereavement support service.

Ethics

Ethical approval was provided by the University of Plymouth (18/19-1085). All identifying information has been removed or anonymised. Informed consent was obtained.

Recruitment

Representatives of 15 homelessness hostels in nine UK locations were contacted about the research. Managers of four of these hostels agreed to facilitate recruitment via purposive sampling.

Participants

Eight staff from three of the four recruiting homelessness hostels participated. Participants were heterogenous in age, gender, time spent working in homelessness, time since finding the body, and job role. Table 1 outlines basic demographic characteristics of participants and the respective deceased people whose bodies were found. To protect confidentiality, specific ages, time working in homelessness, and organisations are not listed. Seven participants were White British, one was White European. Participant ages ranged from 22 to 52 (mean 40.3). Time working in homelessness ranged from 15 months to 28 years (mean 7.9 years). Five participants were support workers; three were in leadership roles. Two participants found the same deceased person, Rose. Four of the seven deaths were caused or suspected to have been caused by overdose; three had natural causes.

Table 1. Participant and Deceased Resident Demographic Information

Participant Name[1]	Time Since Body Found	Deceased Resident Name	Deceased Resident Age Range	Cause of Death
Catherine	2 years, 1 month	Rose	30-39	(Suspected) Overdose
Roz	2 years, 1 month	Rose	30-39	(Suspected) Overdose
Chloe	6 months	James	30-39	Overdose
Samuel	6 years	Simon	40-49	(Suspected) Overdose
Jessica	1 year	Fred	55-64	Pulmonary embolism
Danielle	6 years	Peter	40-49	Brain haemorrhage
Joel	8 months	Christopher	50-59	(Suspected) Cardiac arrest
Jim	1 year	Bill	50-59	(Suspected) Overdose
N females=5 *N males=3*	*M=2.5 years* *R=0.5-6 years*		*(Estimated) M=46.3* *(Estimated) R=38-59*	

Procedure

Participants completed the IES-R (Weiss, 2007) prior to interviews, which lasted 60 to 100 minutes. Following interviews participants were debriefed. Additional signposting information was provided to participants whose IES-R scores were above a suggested 'clinical concern' cut-off (Asukai *et al*., 2002).

Method of analysis

Interview transcripts were analysed individually in chronological order using a stepwise IPA process outlined by Smith *et al.* (2009).

[1] All names are pseudonymised to protect confidentiality and reduce likelihood of identification.

Results

Six master themes were identified.

Table 2. Master Themes

Master Themes	Subordinate Themes
Memories of the body	-
Preparedness to find a body	Feeling unprepared
	Part of the job[(d)]
Significant impacts	Feeling distressed
	Environmental reminders
Trying to cope	Coping well
	Coping poorly
Searching for meaning and understanding	Understanding the death
	Existential issues and fundamental changes
Support	Positive organisational support[(d)]
	Inadequate organisational support
	The value of informal support

Master themes were recurrent in the majority of participants' responses. Additional subordinate themes were mostly recurrent, although two represent divergence[(d)] from the other subordinate themes encapsulated by a master theme. This section describes identified themes, including exemplar quotes, and represents an interpretation of the participants' interpretations of their experiences.

'Memories of the body'

All participants were able to recall detailed information about the physical presentation of the body they had found. Six participants noted disturbing and emotionally upsetting physical bodily presentations, most commonly its appearance and smell:

> *"the smell was a very distinctive smell, it was… like knacker's lorries that pick up dead animals from farms." – Samuel*

> *"what we saw that day was really severe, like really horrific… I've never seen a human body look like that." – Chloe*

Physical processes relating to death such as *rigor mortis*, fluid leakage, and discolouration seemed to cause distress. These processes made physical contact particularly challenging:

> *"the horrible thing was as I touched him, he sort of went that way (gestures falling sideways) because he - obviously rigor mortis or whatever. He was stiff…" – Danielle*

Some participants were so averse to physical contact that they were hesitant to interact with the body physically, even when requested by emergency call handlers:

> *"they wanted me to flip her over, do CPR (cardiopulmonary resuscitation)… and I said "Look, you know, I can't". I did move her as requested, which is when I realised that she was stuck solid and I said "Look, I'm not flipping her over, I'm not doing any of that stuff"." – Roz*

The body being moved from its original position caused discomfort for some participants:

> *"The way he was found was absolutely fine but to remove him from that position, put him on the floor… it was just unnecessary, and it caused unnecessary stress." – Jessica*

Some participants perceived that the dignity of the person had been impacted by the presentation of the body:

> *"He never, I'm sure, would ever want anyone to find him like this because it was very, obviously, undignified because of how we found him." – Chloe*

Overall, the physical presentation of the body was central to participants' accounts and understanding of the experience, and the severity of the physical presentation seemed to influence the impacts experienced:

> *"he had nothing on and it was all so open and graphic… I don't think it would have affected me as badly if I had found someone clothed or in bed." – Chloe*

'Preparedness to find a body'

Participants reported differing degrees of preparedness to find a dead body or to be exposed to death in the course of their work.

'Feeling unprepared'

Six participants reported feeling unprepared for their experience. Some reported feeling unprepared to find a body at work in general terms:

> *"Before that day I'd never really thought I would see that." – Chloe*

> *"it was a life-changing experience that I wasn't prepared for, that I didn't expect." – Roz*

Some also felt unprepared for the death of the specific resident because of prior good-health or engagement with hostel programmes:

> *"But it wasn't very expected because in other ways he was quite fit and he was quite healthy and… he'd been on quite a good spell." – Jessica*

Some reported their belief that the work should not include exposure to death, and a sense of injustice:

> "*staff in hostels come to work with people to ultimately get them to live independently. They don't come in… to find dead bodies, deal with dead bodies." – Samuel*

'Part of the job'

Contrastingly, Jim and Danielle described their preparedness to find a dead body, believing it was an inevitable part of the job:

> *"In this line of work, you are going to come across it." – Danielle*

Six participants discussed the need for prospective staff to be made aware of the realities of the role including the possibility of finding a dead body:

> *"once they're being interviewed… there needs to be some kind of explanation that… "we do have deaths in here; we've had them in the past. And there might be a chance that you might find that" and make them very aware. And then if they still want to come and work here, they fully know what they're in for." – Chloe*

Feeling unprepared, like the physical presentation of the body, seemed to relate to the impacts experienced:

> *"had I have felt prepared maybe I wouldn't have responded in the way that I initially did." – Jessica*

'Significant impacts'

Participants described the significant impacts and seemingly unavoidable reminders of the experience.

'Feeling distressed'

Most participants described feeling significantly distressed, and some traumatised, by the experience.

> *"it is… the most distressing thing that I've ever dealt with, ever seen in my life. It'll never leave me. I'll always be traumatised by it and I'll always have times when I'm reminded of it." – Samuel*

> *"It was horrendous and it massively… I think traumatised me in a way I didn't expect… But finding Rose, yeah, it shocked me how much it affected me." – Roz*

However, three participants described not being particularly distressed by the experience:

"I don't feel that find(ing) somebody dead has had any impact on, on my work or made me regret or made me think I, you know, why I am doing this (type of work)?" – Joel

Some participants described factors they believed prevented further distress, including maintaining professional boundaries, not knowing the person well, and not seeing the person's face:

"I didn't see her face, I think that could have- that was a massive, massive, thing. I think if I'd have seen her face it would have been completely different." – Catherine

'Environmental reminders'

Participants reported substantial physical and emotional difficulties associated with returning to the place in or task during which the body was found, most commonly welfare checks:

"maybe it was about a week and a half (later), I had my first panic attack… I would be physically sick every morning knowing that I had to go and knock on people's doors, because as soon as I went to open that door all I could see, hear, and smell was that day." – Roz

"The only vulnerable part that I find is after the death and then knocking on people's doors. I'm quite shaken up when I do that, for some reason." – Jim

Participants also reported anticipating future negative events, especially when entering residents' rooms:

"I like expect to see someone hanging, even though that's not how I found James. I'm just thinking about all the things that could go wrong and all the gruesome things I could find." – Chloe

'Trying to cope'

Participants described the various coping mechanisms and strategies they adopted after finding the body.

'Coping well'

Some participants described coping strategies they believed to have been effective, at least in the short-term. These strategies included reassuring themselves that there was nothing they could have done:

"it was natural causes, could have happened to anybody, there was nothing (that) could have changed or been done differently." – Jessica

Similarly, participants made 'downward comparisons', noting that experiences and their impacts might have been worse:

"I think it could have been completely different if I'd seen her face." – Catherine

For some, coping strategies seemed to begin immediately, such as the use of avoidance: Jessica left the building to avoid seeing the body being removed; Catherine avoided confirming Rose's death to her family; and Roz avoided seeing them completely:

"I was also very avidly avoiding her step-dad who I knew was only up here (in the offices), and I was in the room below so I just stayed in the room (with Rose's body) for what felt like hours."– Roz

In some cases, participants relied on their self-perceptions of resilience to reassure themselves that they could cope with the experience:

"I think I've been through so much in my life, you kind of have to take whatever life throws at you on the chin." – Catherine

Joel believed he coped well because he was able to 'block out' the experience:

"I think I have blocked quite a lot of things that happened. I do remember things, but I think the way I deal with something like this is by blocking memories." – Joel

Many of the participants reported trying to take support from people in their personal lives:

"I then just left feeling like a child, I reverted to like- almost like a child-like state. I just wanted to go and see my mum and have a little cry." – Roz

'Coping poorly'

Sometimes attempts to cope with the experience were not effective, including failed attempts to move on:

"I think she's (colleague) a lot more, you know, "He had an overdose, and this happened"… I wish I could be a bit more like that. It would be a bit more helpful." – Chloe

Some participants reported that trying to carry on like normal or using typical coping strategies had been ineffective:

"(Trying to carry on like normal) I made myself ill. I was just really unwell. I was run down. I wasn't coping at all. I was not talking to anyone." – Roz

'Searching for meaning and understanding'

A way for participants to process, and perhaps cope with, the experience appeared to be to seek meaning in and try to understand the death and their own experience.

'Understanding the death'

Some participants struggled to understand the actual death, including the cause, intentionality, and circumstances:

> *"I was googling 'If you overdose, how long does it take you to die?'… 'What fluid leaks out of a body?'… really graphic things… I needed to know the name of it or, you know, the process of things." – Chloe*

Participants tried to understand the experience of the person who had died:

> *"I just wanted to know if he had suffered, if he knew, if he just thought "This is normal for me"."– Chloe*

Some also wanted to understand elements of their own experience:

> *"it (the aim of private therapy) was understanding me better to understand why I reacted the way I did." – Roz*

Some participants sought closure. Those who found it typically did so via positive contact with the family or by engaging in death rituals such as attending the funeral:

> *"there was like one positive out of it… we found a contact number for his brother in his room and his brother actually flew over from (country of origin) and they flew Fred back… for his funeral… that was around about the seven-day point when I started to feel better because my feelings were immediately "This guy's been found here, will anyone ever know?", so when there was progress made with his family, that helped me to feel better." – Jessica*

> *"I think the real sense of closure comes when you go to the funeral." – Samuel*

However, others struggled to obtain closure, which seemed especially prevalent when the cause of death was unclear:

> *"I guess it's almost like closure… it just kind of, I guess, gives a bit of closure. But we often don't get told or hear about it (cause of death)… yeah, I think it would be nice to know." – Roz*

Struggling to obtain closure was also the case where contact with the family was less healing:

> *"I just want(ed) to let her know that, you know, her Dad was a good man. But she said "Well, you know, I just don't want to talk". And I respect that." – Joel*

'Existential issues and fundamental changes'

For some, the death led to existential issues arising or fundamental changes taking place in their own lives. Participants noted an increased awareness of their own and others' mortality:

"I started to become very aware of my own mortality as well." – Samuel

Significant social relationships changed because of the impacts of the experience and increased mortality awareness:

"it certainly was at least 50% of why my marriage come to an end, definitely." – Samuel

"I don't want to be in that situation where somebody pass(es) away and I haven't had the opportunity to, you know, say goodbye or say how much I care and I love that person." – Joel

Additionally, fundamental changes to practice and beliefs about themselves or the work occurred:

"you constantly catastrophise things after that, because before that I didn't think of welfare checks as that… for that purpose, but now I think of it more for that purpose… just like a death watch really." – Jessica

'Support'

Participants described the support they received, inadequate organisational support, and the value of informal support.

'Positive organisational support'

Three participants described positive formal organisational support (structured, procedural, or 'official' rather than informal support). These people also seemed to be least affected by the experience overall:

"his (the hostel manager) responsibility was to come in and in fact he was here on both of those occasions we've spoken about… so I felt supported. I guess that's important." – Danielle

'Inadequate organisational support'

The other five participants described organisational support as being ineffective or absent:

"I was asked if I was okay but there was no offer of support." – Catherine

"Nothing (was offered by way of support). Nothing at all. Nothing at all." – Roz

Samuel described trying to obtain organisational support as a battle:

"I asked about support for it and that was an absolute battle to get any kind… I think that that had a massive impact on me and in many ways in my view what it does is embed the trauma…" – Samuel

Some also discussed their resentment and feelings of being mistreated by their organisation, in some cases because they felt blamed for the death, but primarily because of the lack of support:

> *"they didn't give a shit then and I should have taken time for myself and I didn't. I allowed myself to continue working like an ass when actually I should have taken time for myself… They didn't give a shit." – Roz*

Some reported feeling as though organisational operations merely continued as normal, leaving participants feeling alone:

> *"she (colleague) said "Things tend to just go on as normal". And I think that's awful… when we had our next regular team meeting… it was just part of an agenda with lots of other things. It wasn't just about what had happened, what we had gone through." – Chloe*

All participants, even those who experienced organisational support as positive, acknowledged the need for better support when a body is found. They discussed what support should involve, arguing that it should be proactive;

> *"it shouldn't be that we have to make (the) first step… not a single one of us wanted to make that first step." – Roz*

> *"One of the things that I've always said is that the onus should not be on me to ask for support. I shouldn't have to chase it." – Samuel*

timely;

> *"I'd say maybe the day after would be a good time (for support)." – Jim*

> *"But I would prefer (support) maybe within a week? You know, to give people a few days to maybe get through the practical bits and think about how they're feeling." – Danielle*

and include the death being acknowledged and discussed, as they believed their experiences and the death were not acknowledged by the organisation:

> *"remember saying to (the hostel manager), and I suggested… that it would be good for everybody to come together and just talk about that (death)." – Chloe*

'The value of informal support'

Most participants described receiving informal support, mostly from colleagues but occasionally from other sources. Many spoke positively of informal support provided by colleagues:

> *"Colleagues were really supportive… they made me a cup of tea and a fag and… because I was all shaky took me outside to get some fresh air."– Jessica*

Others reflected on the importance of support obtained in other ways, including staff reflective practice groups, via external professionals, or by seeking private therapy:

> *"I did have like a reflective practice session the day after. That was quite helpful because it was time to just be like you know… like get it out there." – Jessica*

> *"I found it (therapy) really, really useful. It was a really positive experience. And, yeah, I went for a long time, so it wasn't like a quick-fix treatment." – Roz*

Discussion

Finding the body of a deceased resident appeared to be distressing to most people, and this seemed to relate to the physical presentation of the body, feeling unprepared for the experience, and environmental reminders. Attempts to cope were mixed in effectiveness. People tried to understand their experience and the death by searching for information and closure. Some existential issues arose including mortality awareness, which influenced personal relationships. Most people described their organisations as not providing adequate support but valuing informal support provided primarily by colleagues.

Three interpretative findings that encapsulate elements of the six master themes identified in the analysis are described in this section. These findings are: that most found the experience distressing, and some found it traumatic; that most considered their organisation's response to the experience to be inadequate; and that most reported trying to make sense of their experience.

Distress and trauma

The experience was considered distressing by most participants. Elements of the experience that appeared to relate to distress included the physical presentation of the body, unpreparedness to find a body, identification with the deceased, environmental reminders, and anticipatory processing of future negative events.

The physical presentation of the body was recalled in detail by all participants and considered distressing by most. Consistent with past research (Fullerton *et al*., 1992) the physical presentation, including the "visual grotesqueness, smell, and tactile qualities" (Ursano and McCarroll, 1990, p.398), of the bodies appeared to lead to emotional distress.

Lack of preparedness to find the body of a deceased resident also appeared to relate to the distress experienced by participants. Feeling unprepared potentially having led to greater distress is consistent with the findings of Lakeman (2011, p.932), who reported that deaths of homeless people were "almost always accompanied by shock" of homelessness sector workers, and findings that unex-

pected exposure to dead bodies or unexpected elements of the experience can be particularly distressing (Ursano and McCarroll, 1990; McCarroll *et al*., 1993; Delahanty *et al*., 1997).

Participants who reported more significant impacts appeared to identify with the deceased resident. This is consistent with findings that identification with the deceased appears to increase distress (Ursano and McCarroll, 1990), and predict post-traumatic distress and post-traumatic stress disorder (PTSD) (Ursano *et al*., 1999; Hargrave, 2010; Coleman *et al*., 2016). Identification by participants occurred via acknowledgement of similarities between themselves and the deceased, identifying with the family of the deceased, and obsessing about the deceased person's experiences and lives. Disidentifying with the deceased can be protective (Ursano and McCarroll, 1990; Rowe and Regehr, 2010). General disidentification appeared to be a strategy adopted by the participants seemingly less impacted by the experience, who reported the maintenance of emotional distance and professional boundaries.

Participants described distress associated with returning to places in or tasks during which they found the body, most commonly welfare checks. These and other reminders of the experience, including smells or temperatures, might be considered trauma triggers – stimuli that lead to recall of a traumatic experience – via behavioural conditioning, a process called "trauma coupling" (Goultson, 2011, pp.39-41). Complete disidentification with the deceased and avoidance of distressing environmental triggers appeared to be difficult for most hostel staff. This might differ from emergency or disaster workers who, in many cases, may not know the deceased or return to the location of the incident.

One of the most universal elements of the experience was increased worry about imagined further negative events. This may be understood as an example of anticipatory processing; repetitive thoughts about the future associated with anxiety (Clark and Wells, 1995), and is similar to findings reported by Lakeman (2011) that homelessness workers anticipate more harm to homeless people following a death.

People working in various professions exposed to death are at greater risk of experiencing post-traumatic distress or developing PTSD (Wagner *et al*., 1998; Clohessy and Ehlers, 1999; Corneil *et al*., 1999; Regehr *et al*., 2002; Mealer *et al*., 2007; Violanti, 2014; Petrie *et al*., 2018). Participant interview responses and IES-R scores suggest this might also be true of homelessness sector staff. Three participants scored above the IES-R cut-off where PTSD is a 'clinical concern' (Asukai *et al*., 2002) (two of whom scored above the 'probable diagnosis' cut-off (Creamer *et al*., 2003)). Additionally, one participant scored one point below, and another scored below but reported an earlier formal PTSD diagnosis after finding the body. Subjectively, participants reported significant distress and trauma. Finding the

body of a deceased resident was traumatic for at least three, and potentially five, of the eight participants. This is demonstrative of the potentially serious nature of the experience, and the resultant need for appropriate support.

Inadequate organisational support

Participants described some positive elements of support, including informal and extra-organisational support. However, the majority described inadequate organisational responses to their experience.

Informal social support was provided, mostly by colleagues, and was the only way many felt helped. Social support, including from peers, can be protective to those exposed to dead bodies (Fullerton *et al*., 1992; McCarroll *et al*., 1993; Declercq *et al.*, 2007) and more generally protect against burnout (Lavoie *et al*., 2011).

Three participants, who also seemed to be least negatively impacted, described positive formal organisational support. Although the direction of this relationship cannot be established here, it is possible that for these participants the provision of organisational support reduced negative impacts associated with the experience. However, most participants described their frustration with absent or ineffective organisational support, and argued that proactive and timely support was necessary. Participants also described their belief that organisations should inform prospective staff of the possibility of finding bodies of deceased people in their work, as suggested by Lakeman (2011).

Many of the participants reported trying to carry on as normal. For some this aligned with natural coping styles, whereas for most it appeared to be a consequence of the busy hostel environment. Some participants described the short-term benefits of carrying on as normal. However, participants also reported longer-term difficulties, explaining that trying to carry on as normal in the immediate aftermath led to fatigue and merely delayed emotional responses.

For most, opportunities for individual or commmunity-wide reflection on the deaths, which Lakeman (2011) recommended, were not facilitated. This appeared to contribute to participants feeling unsupported by their organisations.

Making sense of the experience: bereavement and grief

The deceased were not friends, family, or loved ones of the participants. However, participants' responses to the experience appeared similar to some elements of bereavement, including aspects of grief.

Participants feeling unsupported by their organisations was characterised by the perception of some that the hostels merely operated in a 'business as usual' fashion, failing to formally provide support or assess their wellbeing. Some partici-

pants also reported feeling that organisations did not mark their experiences. This seemed to result in feelings similar to disenfranchised grief – grief experienced after a loss that is not or cannot be socially supported or openly acknowledged (Doka, 1999). For most, opportunities to mark the death were not available or facilitated, which appeared to be frustrating, consistent with previous findings (Lakeman, 2011). It is plausible that these absences and failures led some to develop an implicit belief that any grief or difficult emotions associated with their experience was disenfranchised, which can be isolating and lonely as the "right to grieve" (Doka, 2002, p.5) is not respected.

Rituals, such as attending the funeral or marking the death including via positive family contact, appeared to help some participants process their experience. However, these opportunities were not available to all participants. In order to counter potential feelings of disenfranchised grief or distress, organisations might consider ensuring that deaths and the experiences of those impacted, including those who find the bodies, are marked in a way that enables a sense of social support and closure.

The perceived lack of organisational support left participants feeling alone with their attempts to understand and cope with what had happened. Most sought to understand and derive meaning from their experiences. For many, the first step appeared to manifest as attempts to obtain or review information about the deceased, the deaths, or their experience. Attempting to understand a death can be important to those affected: "making sense of loss requires developing an 'account', an explanation of how it happened." (Parkes and Weiss, 1983, p.156).

Participants attempting to understand their experience and find meaning in the lives and deaths of the residents might be considered a normal manifestation of bereavement as an "active process of meaning reconstruction" (Gillies and Neimeyer, 2006, p.32). People who struggle to find meaning in loss experience more painful and prolonged grief (Coleman and Neimeyer, 2010). Searching for meaning is more common when losses are traumatic (Davis *et al*., 2000; Neimeyer, 2011), such as deaths involving suicide or accidents. Participants unable to gather important information about the cause of and circumstances surrounding the death reported that the degree to which they could obtain closure was limited. In the absence of closure, some attempted to reassure themselves that the death was unpreventable, perhaps defending themselves against self-blame.

Another potential source of distress was that the death of the homeless person seemed to cause consideration of of wider, societal factors. Some participants talked about societal attitudes towards homelessness and death, reporting frustration about perceived injustices. Homeless people are marginalised, existing on the periphery of society (Lakeman, 2011). The death of the residents might have rein-

forced their marginalised status to staff: "Workers do grieve in this sense, but how they do so is affected by the marginalised social position of the homeless person and indeed themselves as workers in the sector." (Lakeman, 2011, p.943).

As well as reinforcing the sense of marginalisation of the residents, the deaths seeming random or unfair might have contributed to participants finding very little meaning in their experience, perhaps leading to increased motivation to obtain it. The experiences of the participants were consistent with this interpretation; those seemingly most affected appeared to have more unresolved questions about the deaths and their experiences. In more typical grief, bereavement disrupts survivors' self-narrative, resulting in searching for meaning in the loss and their own lives (Neimeyer, 2011). The equivalent reaction for hostel staff appeared to have been to search for meaning in practical, relational, and existential terms (Neimeyer, 2011), in their roles and their lives. Participants noticed fundamental changes to their practice or to their beliefs about the workplace or their roles. Participants searching for meaning in their own lives appeared to be associated with an increased awareness of existential issues, such as their own and others' mortality. Participants reporting this seemingly experienced positive changes in personal relationships, including apologising to those they felt they had wronged, spending more time with loved ones, and ending a relationship with a long-time but unsupportive spouse. These positive relational shifts might be examples of post-traumatic growth – positive psychological changes that can follow traumatic experiences (Park and Helgeson, 2006).

Clinical implications

Homelessness staff and organisations may wish to be aware of the following to inform policy and practice:

- The experience of finding the body of a deceased resident can be distressing and potentially traumatic.
- Many staff felt unprepared to find the body of a deceased resident and believed that prospective staff should be made aware of this possibility. Discussions of or training regarding this prospect may be protective.
- Staff described the value of informal support but also wanted proactive and timely organisational support to be provided.
- Staff who were distressed and able to experience marking of the death via rituals or closure described these opportunities as beneficial. Homelessness organisations might consider ensuring this occurs after deaths.
- Environmental tasks or reminders of the experience can be anxiety-provoking, distressing, or potentially retraumatising. Support relating to potential triggers

of distress could be provided in a similar fashion to a 'site visit', an intervention utilised during trauma-focused cognitive behavioural therapy (TF-CBT) (Murray *et al*., 2015) that should be delivered by a suitably trained professional.

- PTSD appeared to be a risk for staff who find bodies of deceased residents. Appropriate sources of professional support for the prevention, assessment, and treatment of PTSD should be identified and provided in a proactive and timely manner. Currently, recommended treatment for PTSD in the UK includes TF-CBT (National Institute for Health and Care Excellence, 2018).

Future research

Potential areas for future research are broad given the lack of existing relevant research. Firstly, future research could explore the experiences of other hostel residents following a resident's death. Hostel residents (Ko *et al*., 2015) and staff (Hudson *et al*., 2017) have previously suggested that such deaths may be distressing to other residents.

Further qualitative exploration of the experiences of, or quantitative exploration of the range of symptomology displayed by, homelessness staff who find bodies of deceased residents might be valuable. Foci of this research could be on trauma symptoms specifically, broader mental health difficulties such as depression and anxiety, or work-related difficulties homelessness sector staff are known to experience such as burnout (Waegemaker-Schiff and Lane, 2016).

Further research could also examine the efficacy of interventions that are designed to mitigate negative impacts of the experience. Examples of possible interventions include informing prospective staff about the realities of the role or introducing mandatory 'rituals' with which to mark deaths of residents.

Limitations

The findings of this research may have been influenced by a participant selection bias. The first author is anecdotally aware of two otherwise participation-eligible people who left the homelessness sector because of distress caused by finding the body of a deceased resident, and another participation-eligible person who declined to participate because of concern about potential upset. It is possible that the recruited participants were those comparatively less negatively impacted by the experience.

The findings may not be as widely generalisable as if participants had been recruited from additional overarching organisations. Other organisations may operate differently to those whose staff were recruited, for instance by providing formal organisational support when bodies of deceased residents are found.

Similarly, the homogeneity of participant ethnic and cultural background limits generalisability. Finally, because the research was conducted in the UK, applicability and generalisability to wider cross-national contexts is unestablished.

Conclusion

The experience of finding the body of a deceased resident can be distressing, and for some, traumatic. Distress experienced related to the physical presentation of the body, feeling unprepared, identification with the deceased, and environmental reminders. Staff attempted to make sense of the death and their experience, and perceived a lack of formal organisational support. Support provided might include the facilitation of site visits, deaths being marked, or appropriate discussion of the experience including via reflective practice groups. Exposure to dead bodies should be acknowledged as potentially distressing and traumatic by homelessness organisations and policy makers, and support should be provided where this might be the case:

> *"I think as a standard, if we're going to be in this role and it's going to be the norm… finding dead bodies going forward, there needs to be that support because else how can you- how can you do your job?" – Chloe*

References

Asukai, N., Kato, H., Kawamura, N., Kim, Y., Yamamoto, K., Kishimoto, J., Miyake, Y. and Nishizono-Maher, A. (2002) Reliabiligy and Validity of the Japanese-language Version of the Impact of Event Scale-Revised (Ies-RJ): Four Studies of Different Traumatic Events, *The Journal of Nervous and Mental Disease* 190(3) pp.175-182.

Clark, D.M. and Wells, A. (1995) A Cognitive Model of Social Phobia, in: R.G. Heimberg, M.R. Liebowitz, D.A. Hope and F.R. Schneier (Eds.) *Social Phobia: Diagnosis, Assessment, and Treatment*, pp.69–93. (New York, NY: Guilford Press).

Clohessy, S. and Ehlers, A. (1999) PTSD Symptoms, Response to Intrusive Memories and Coping in Ambulance Service Workers, *British Journal of Clinical Psychology* 38(3) pp.251-265.

Cockersell, P. (2015) The Process of Social Exclusion, *Clinical Psychology Forum* 265 pp.13-18.

Coleman, J.A., Delahanty, D.L., Schwartz, J., Murani, K. and Brondolo, E. (2016) The Moderating Impact of Interacting with Distressed Families of Decedents on Trauma Exposure in Medical Examiner Personnel, *Psychological Trauma: Theory, Research, Practice, and Policy* 8(6) pp.668-675.

Coleman, R.A. and Neimeyer, R.A. (2010) Measuring Meaning: Searching for and Making Sense of Spousal Loss in Later Life, *Death Studies* 34(9) pp.804-834.

Corneil, W., Beaton, R., Murphy, S., Johnson, C. and Pike, K. (1999) Exposure to Traumatic Incidents and Prevalence of Posttraumatic Stress Symptomatology in Urban Firefighters in Two Countries, *Journal of Occupational Health Psychology* 4(2) pp.131-141.

Creamer, M., Bell, R. and Failla, S. (2003) Psychometric Properties of the Impact of Event Scale – Revised, *Behaviour Research and Therapy* 41(12) pp.1489-1496.

Culhane, D.P., and Kuhn, R. (1998) Patterns and Determinants of Public Shelter Utilization among Homeless Adults in New York City and Philadelphia, *Journal of Policy Analysis and Management: The Journal of the Association for Public Policy Analysis and Management* 17(1) pp.23-43.

Davis, C.G., Wortman, C.B., Lehman, D.R. and Silver, R.C. (2000) Searching for Meaning in Loss: Are Clinical Assumptions Correct?, *Death Studies* 24(6) pp.497-540.

Declercq, F., Vanheule, S., Markey, S. and Willemsen, J. (2007) Posttraumatic Distress in Security Guards and the Various Effects of Social Support, *Journal of Clinical Psychology* 63(12) pp.1239-1246.

Delahanty, D.L., Dougall, A.L., Craig, K.J., Jenkins, F.J. and Baum, A. (1997) Chronic Stress and Natural Killer Cell Activity after Exposure to Traumatic Death, *Psychosomatic Medicine* 59(5) pp.467-476.

Doka, K.J. (1999) Disenfranchised Grief, *Bereavement Care* 18(3) pp.37-39.

Doka, K.J. (2002) *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice* (Champaign, IL: Research Press).

Fullerton, C.S., McCarroll, J.E., Ursano, M.D. and Wright, K.M. (1992) Psychological Responses of Rescue Workers: Fire Fighters and Trauma, *American Journal of Orthopsychiatry* 62(3) pp.371-378.

Gillies, J. and Neimeyer, R.A. (2006) Loss, Grief, and the Search for Significance: Toward a Model of Meaning Reconstruction in Bereavement, *Journal of Constructivist Psychology* 19(1) pp.31-65.

Goultson, M. (2011) *Post-Traumatic Stress Disorder for Dummies* (Hoboken, NJ: Wiley).

Hargrave, P.A.L. (2010). *Sudden Death: The Impact of the Immediate Aftermath on Police Officers, Victim Support Workers, and Bereaved Survivors. A thesis presented in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Psychology at Massey University, Wellington, New Zealand* (Wellington: Massey University). Retrieved from https://mro.massey.ac.nz/bitstream/handle/10179/3872/02_whole.pdf?sequence=1&isAllowed=y.

Hopper, E.K., Bassuk, E.L. and Olivet, J. (2009) Shelter from the Storm: Trauma-Informed Care in Homelessness Service Settings, *The Open Health Service and Policy Journal* 2 pp.131-151.

Hudson, B.F., Shulman, C., Low, J., Hewett, N., Daley, J., Davis, S., Brophy, N., Howard, D., Vivat, B., Kennedy, P. and Stone, P. (2017) Challenges to Discussing Palliative Care with People Experiencing Homelessness: A Qualitative Study, *BMJ Open* 7(11).

Independent (2018) *Nearly 600 Homeless People Died Last Year, Figures Show*. Retrieved from https://www.independent.co.uk/news/uk/home-news/homeless-deaths-2017-last-year-figures-streets-rough-sleeping-a8692101.html.

Ko, E., Kwak, J. and Nelson-Becker, H. (2015) What Constitutes a Good and Bad Death? : Perspectives of Homeless Older Adults, *Death Studies* 39(7) pp.422-432.

Lakeman, R. (2011) How Homeless Sector Workers Deal with the Death of Service Users: A Grounded Theory Study, *Death Studies* 35(10) pp.925-948.

Lavoie, S., Talbot, L.R. and Mathieu, L. (2011) Post-Traumatic Stress Disorder Symptoms among Emergency Nurses: Their Perspective and a 'Tailor-Made' Solution, *Journal of Advanced Nursing* 67(7) pp.1514-1522.

Maguire, N.J., Johnson, R., Vostanis, P., Keats, H., and Remington, R.E. (2009) *Homelessness and Complex Trauma: A Review of the Literature* (Southampton: University of Southampton). Retrieved from https://eprints.soton.ac.uk/69749/.

McCarroll, J.E, Ursano, R.J., Wright, K.M. and Fullerton, C.S. (1993) Handling Bodies after Violent Death: Strategies for Coping, *American Journal of Orthopsychiatry* 63(2) pp.209-214.

Mealer, M., April, S., Berg, B, Rothbaum, B.O. and Moss, M. (2007) Increased Prevalence of Post-Traumatic Stress Disorder Symptoms in Critical Care Nurses, *American Journal of Respiratory and Critical Care Medicine* 175(7) pp.693-697.

Mental Health Foundation (2015) *Homelessness and Mental Health* (London: Mental Health Foundation). Retrieved from https://www.mentalhealth.org.uk/blog/homelessness-and-mental-health.

Murray, H., Merritt, C. and Grey, N. (2015) Returning to the Scene of the Trauma in PTSD Treatment–Why, How and When?, *The Cognitive Behaviour Therapist* 8 pp.1-12.

Museum of Homelessness (2019) *Shocking New Statistics – The Dying Homeless Project.* Retrieved from https://museumofhomelessness.org/2019/08/14/shocking-new-statistics-the-dying-homeless-project/.

National Institute for Health and Care Excellence (2018) *Post-traumatic Stress Disorder: NICE Guideline [NG116]* (London: National Institute for Health and Care Excellence). Retrieved from https://www.nice.org.uk/guidance/ng116.

Neimeyer, R.A. (2011) Reconstructing Meaning in Bereavement, *Rivista di Psichiatria* 46 pp.332-336.

Office for National Statistics (2018) *Deaths of Homeless People in England and Wales: 2013 to 2017* (Newport: Office for National Statistics). Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/localauthorityestimates2013to2017.

Park, C.L. and Helgeson, V.S. (2006) Introduction to the Special Section: Growth Following Highly Stressful Life Events – Current Status and Future Directions, *Journal of Consulting and Clinical Psychology* 74(5) pp-791-796.

Parkes, C.M. and Weiss, R. (1983) *Recovery from Bereavement* (New York, NY: Basic Books).

Petrie, K., Milligan-Saville, J., Gayed, A., Deady, M., Phelps, A., Dell, L., Forbes, D., Bryant, R.A., Calvo, R.A., Glozier, N. and Harvey, S.B. (2018) Prevalence of PTSD and Common Mental Disorders amongst Ambulance Personnel: A Systematic Review and Meta-Analysis, *Social Psychiatry and Psychiatric Epidemiology* 53(9) pp.897-909.

Rees, S. (2009) *Mental Ill Health in the Adult Single Homeless Population: A Review of the Literature* (London: Crisis). Retrieved from https://www.crisis.org.uk/media/20611/crisis_mental_ill_health_2009.pdf.

Regehr, C., Goldberg, G. and Hughes, J. (2002) Exposure to Human Tragedy, Empathy, and Trauma in Ambulance Paramedics, *American Journal of Orthopsychiatry* 72(4) pp.505-513.

Rowe, A. and Regehr, C. (2010) Whatever Gets You Through Today: An Examination of Cynical Humor among Emergency Service Professionals, *Journal of Loss and Trauma* 15(5) pp.448-464.

Shelter (2018) *320 000 people in Britain are now homeless, as numbers keep rising* (London: Shelter). Retrieved from https://england.shelter.org.uk/media/press_releases/articles/320,000_people_in_britain_are_now_homeless, _as_ numbers_keep_rising

Smith, J., Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis. Theory, Method and Research* (London: SAGE).

Smith, J. A. and Osborn, M. (2015) Interpretative Phenomenological Analysis as a Useful Methodology for Research on the Lived Experience of Pain, *British Journal of Pain* 9(1) pp.41-42.

Sundin, E.C. and Baguley, T. (2015) Prevalence of Childhood Abuse among People who are Homeless in Western Countries: A Systematic Review and Meta-Analysis, *Social Psychiatry and Psychiatric Epidemiology* 50(2) pp.183-194.

The People's Project (2020) *What is Homelessness?* Retrieved from https://www.thepeoplesproject.org.nz/homelessness/.

Thomas, B. (2012) *Homelessness Kills: An Analysis of the Mortality of Homeless People in Early Twenty-First Century England* (London: Crisis). Retrieved from https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf.

Ursano, R.J., Fullerton, C.S., Vance, K. and Kao, T.C. (1999) Posttraumatic Stress Disorder and Identification in Disaster Workers, *American Journal of Psychiatry* 156(3) pp.353-359.

Ursano, R.J. and McCarroll, J.E. (1990) The Nature of a Traumatic Stressor: Handling Dead Bodies, *Journal of Nervous and Mental Disease* 178(6) pp.396-398.

Violanti, J.M. (2014) *Dying for the Job: Police Work Exposure and Health* (Springfield, IL: Charles C Thomas).

Waegemakers-Schiff, J. and Lane, A. (2016) *Burnout and PTSD in Workers in the Homeless Sector in Calgary* (Calgary: Calgary Homeless). Retrieved from http://calgaryhomeless.com/content/uploads/Calgary-Psychosocial-Stressors-Report.pdf.

Waegemakers-Schiff, J., and Lane, A. (2019) PTSD Symptoms, Vicarious Traumatization, and Burnout in Front Line Workers in the Homeless Sector, *Community Mental Health Journal* 55(3) pp.454-462.

Wagner, D., Heinrichs, M. and Ehlert, U. (1998) Prevalence of Symptoms of Posttraumatic Stress Disorder in German Professional Firefighters, *American Journal of Psychiatry* 155(12) pp.1727-1732.

Weiss, D.S. (2007) The Impact of Event Scale: Revised, in: J.P. Wilson and C.S. Tang (Eds.) *Cross-cultural Assessment of Psychological Trauma and PTSD*, pp.219-238. (New York, NY: Springer).