Abstract

This paper is a reflection of my experiences at the St. Paul’s Palliative Care Unit during my field practicum placement from January 2015 to April 2015. The following report will share a bit of palliative care history and relay the story of my palliative care practicum. A literature review reflects palliative care competencies, feminism as a world view, narrative therapy, death, dying and grief, somatic experiencing, family resiliency theory, and caregiver/compassion fatigue. I will share the development of my practicum objectives and the activities experienced throughout the practicum. Bits and pieces of people’s stories told and heard portray the importance of hospice palliative social work in practice. The theory and practice of companioning with patients and families through their palliative experience will be shown as a vital component of their journey. Ethical considerations, practicum challenges and achievements, and self-care practices will be discussed. This report will close with the meaning-making I derived from my lived experience in palliative care and the legacy I gained from my clinical practicum.
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Role of Social Work in Hospice Palliative Care

**Introduction**

As a social worker I had companioned with clients and patients who were grieving. I knew that grief was not something that could be “fixed” nor did it need to be. What helped the families and friends the most was for me to be with them when they were in their grief. I was raised in a family and community that honoured and respected grief and loss. I believed it was okay for people to grieve differently and there was no “right” way to grieve. As a somatic practitioner I had gained practice in holding space for activated responses, and as a registered yoga instructor I had studied and practiced non-judgment. Although I have absorbed many concepts, ideas, and theories in my social work training, one statement that a professor shared in my undergraduate degree has never escaped me. It was the first day of my death and dying class and the professor introduced herself and then the class syllabus. She continued by sharing, “You think you are here to learn about death and dying, but what I hope you really learn about is life and living” (Toh, J. 2007/09/12). As a professional social worker, I have practiced in rural health care as an adult mental health counselor and within the Saskatchewan Cancer Agency. Now, as a Master in Social Work student, I have entered the doors of the palliative care unit, about to experience the differences between this world and other health care areas.

Personally, I am grounded in a post-modern feminist world-view. I believe that our body and mind are like the plants and flowers and our spirit like the soil. Each area requires care and attention in different ways and, when cared for, the most beautiful garden is created regardless of the season. It is my perspective that our human capacity is
designed to be resilient and that we live in connection and relation to the people and world around us.

I began to wonder about what elements patients and families need when dying, how they differ based on individual situations, how best practice assures respect and dignity for individuals and their families, and how social workers can ensure the needs of the whole are honoured. Brene Brown (1999) challenges social workers to question, “Who benefits by that?” as they practice and create change within society, and within the social work profession. It occurred to me this was what I needed to start asking myself as I moved through my practicum.
Historical and Personal Background

History of Hospice Palliative Care

Dying has been a part of living from the beginning of time. Over the course of history this final stage of life has been influenced by culture and religion. Both time and cultural origin have influenced our understanding of death and dying and led to today’s hospice palliative care. Crusaders in the 11\(^{th}\) century are believed to be the first people to set up homes for the terminally ill. These homes were called hospices from the Latin word, *hospes*, meaning either a “travelling guest or a traveler’s host” (Lutz, 2011). Early hospices cared for both travelers and terminally ill people. Moving closer to the 18\(^{th}\) and 19\(^{th}\) centuries, religious organizations began to focus on the role of caring for the terminally ill while they were dying and unto death in hospices.

Even though hospice care had existed since earlier times it was Cicely Saunders’ work that evolved the hospice movement (Clark, 2007; Lutz, 2011). Cicely Saunders was a British nurse in the 20\(^{th}\) century who became a social worker and chose to focus her professional life on the care of terminally ill patients. Her experiences led her to obtain a medical degree in 1957 allowing her to found St. Christopher’s Hospice in 1967. Dr. Saunders was a pioneer in the hospice palliative care movement. To this day her work is the foundation of the tenets used in hospices worldwide.

Dr. Saunders’ three palliative tenets, along with Elizabeth Kubler-Ross’s publication of *On Death and Dying* (1969) led to palliative care being defined as a medical specialty. This report will honour how Dr. Saunders’ tenets continue to guide hospice care: (a) the concept of “total pain”, (b) the proper use of opioids for patients.
with physical pain, and (c) attention to the needs of family members and friends who provide care for the dying (Lutz, 2011).

It may appear at times as if the terms hospice and palliative care are used interchangeably. It is important, however, to differentiate the two while still honouring how they work and exist in relation to each other. Both hospices and palliative care units build their care on the tenets of Dr. Saunders. A Canadian doctor named Balfour Mound coined the term palliative care in 1974 as the setting in which treatment is given with the goal of symptom relief. However, hospice care is designed to companion terminally ill patients through to their end stage of life when medical treatment is no longer an option or a choice.

It was in the late 1980s that the Royal College of Physicians designated palliative medicine as a specialty and established a formal training program (Lutz, 2011). However, palliative and hospice care are multidisciplinary specialties, and I believe it is valuable to further explore Saunders’ introduction of palliative care as a specialty within social work. Later in this paper I will explore the strengths and competencies of the social worker role within the palliative multidisciplinary team.

**Personal Experiences**

I have not personally experienced the palliative hospice care environment, but I have experienced the death and loss of my elderly mother-in-law, our dance teacher who was my mentor and friend, the tragic accidental death of our son’s classmate and friend, a sister-in-law who died of cancer who was close to my current age and had two young sons, and an uncle who died when I was in grade 12. Although each death and loss was a unique experience, as I worked through my practicum the memories of all these deaths
seemed to whisper the same thing to me, “Please help me; help my family; see us for who we are and treat us with respect and kindness.”

Along with these messages I also heard echoes from my personal values, work experiences, classes and professors from my social work training. It is my personal value that all of life’s experiences count, including the experiences of birth and death. Having been a part of and witness to birth as well as death, it seems the birth experience is not that different from the death experience. Both are a natural part of living. Both have phases linked with transitions. They are filled with work and recovery and, perhaps most importantly, both are a time to be cherished.

I began my Master of Social Work (MSW) clinical practicum at the Palliative Care Unit (PCU) on Monday January 5, 2015 at St. Paul’s Hospital, Saskatoon. It was the beginning of a new year and a new experience. I arrived early allowing myself time to orient to a new environment. I had only been in St. Paul’s Hospital as a visitor on Maternity and Medicine. Although St. Paul’s Hospital was still a new environment to me, there was a calm that came over me as I sat in the lobby. The area I chose to sit in was surrounded with a wall display of the history of the hospital and its foundation. It was during this time I recognized a sense of depth and wisdom within the space. Today, nearing the end of my practicum, I recognize the foreshadowing of this primitive experience.

I met my Professional Associate who provided clinical supervision, in the social work office. She introduced me to the social work team and I joined in for morning huddle as would become the standard routine. As we made our way up to the 5th floor we chatted casually. Her gentle nature was calming and I felt assured my learning would be
supported yet guided. Once on the Palliative Care Unit (PCU), my Professional Associate toured me around the 12-bed unit including kitchen, family room, two quiet rooms, two bathrooms, tub room, conference room, and nursing station and introduced me to the nurses and doctors. Little did I know at the time that the unit and staff would become my second home for the next three and a half months with their seeds of wisdom fostering my learning.

The fullness of the first day encompassed what would become standard routine: office prep, morning report, coffee, rounds, assessment, charting, counseling with patients and families, and office catch up (returning calls, answering emails, reviewing practice and literature). As the first week came to a close, I felt as though my soil had been cultivated and I was being prepared for an immeasurable amount of growth. Looking back, all the toiling, seeding, fertilizing, weeding, and hoeing created a lush growth experience for me.


**Literature Review**

The following literature review explores research related to the role of social work in hospice palliative care. This review includes literature on the core palliative care competencies, feminism as a world-view, narrative therapy, death, dying and grief, somatic experiencing, family resilience and caregiver/compassion fatigue. The following literature review guided both my learning and my practice as a hospice palliative care social worker.

**Feminism as a World-View**

The creation of patriarchy disturbed the natural root system of life. Imposing forces of power and hierarchy caused disconnection between relationships on both inter and intra levels (Jordon, 2004b). The feminist world view attempts to look for and work towards ways in which relationships can successfully restore the ecology of human worth.

Third wave feminism is anchored in the social movement of connection and meaning by valuing the importance of self in relation with others (Miller, 2004). In a society that attaches prime importance to individual achievement, the experience of connectedness has traditionally been misunderstood and has led to a loss of storytelling as a means of understanding the meaningfulness of life events (White, 2007).

Telling our personal stories is a meaningful way to learn, grow, and heal. Connection is developed when we hear, see, feel, and understand the ways of life (Cairns, Thompson, & Wainwright, 2003). Miller (2004), at the Stone Center at Wellesley College describes connection as self in relation, relational self, and being in relation. We inhabit an inner ecosystem where our mind/body and spirit reside as well as an outer
system of community and natural environment. Third wave feminism is about restoring the ecology of the relationships between these two systems.

Growth in connection stands at the forefront of the ongoing feminist movement by examining and reshaping psychosocial theory and practice (Miller, 1991). Feminism recognizes that pain is shared collectively. Similarly, palliative social work companions with patients and families in an effort to reconnect to one as a human being rather than to a person’s disease.

**Core Palliative Care Competencies**

As noted earlier, the profession of social work was a pioneer in end-of-life care. Anecdotal reports reveal that social work interventions were both positive and significant although social work roles and functions had not yet been clearly defined (Bosma et al., 2009).

As a result of anecdotal reports, Social Work Competencies on Palliative Education (SCOPE) identified the following eleven core competencies essential to social work practice in hospice care: (a) advocacy, (b) assessment, (c) care delivery, (d) care planning, (e) community capacity-building, (f) evaluation, (g) decision-making, (h) education and research, (i) information sharing, (j) interdisciplinary team, and (k) self-reflective practice (Bosma et al., 2008; Canadian Hospice Palliative Care Association, 2015). The National Association of Social Work (NASW) has also established palliative care standards stating that ethics and values, knowledge, assessment, intervention/treatment planning, attitude/self-awareness, empowerment and advocacy, documentation, interdisciplinary teamwork, cultural competence, continuing education, along with supervision, leadership, and training, need to guide practice (2004).
Narrative Therapy

Narrative therapy is a commonly accepted practice modality for social workers providing therapy and care to people who are grieving. White (2007) describes how narrative family therapy provides psychosocial support to families who are journeying through grief (i.e. life review, re-authoring). Nichols (2014) explains that the key process in narrative therapy is the client’s story. It is through one’s story that understanding and expansion is gained (Carr, 1998). The evolution of narrative therapy is rooted in the premise that “personal experience is fundamentally ambiguous” (Nichols, 2014). A narrative therapist believes in the importance of integrating the client’s stories in a more cognitive way so the client’s thinking becomes expanded, allowing them to consider a broader view of themselves and their situation. Therefore, narrative therapy provides people with an opportunity to review and re-author their lives, thereby reshaping their identity. Life reviews and re-authoring allow individuals to integrate their story with their lived experience (White, 2007).

Historically, it is valuable to know that Foucault initially challenged the idea of positivity and pioneered the movement towards social constructivism (Nichols, 2014). Michael White, founder of the narrative movement, along with David Epston, Jill Freedman, Gene Combs, Jeffrey Zimmerman, Vicki Dickerson, Stephan Madigan, Harlene Anderson, and Harry Goolishian, all played an important role in creating and developing narrative therapy (Malinen, Cooper & Thomas, 2012; Nichols, 2014). Although the narrative approach found its way into psychotherapy during the hermeneutic era in the 1980s, it was revolutionized to incorporate the positivist conception into the present-day narrative family therapy understanding that truth is
created not discovered (Nichols, 2014) This is one outcome of the evolutionary shift from historical truth to narrative intelligibility.

Strategic therapists use the technique of “reframes” to provide a way for clients to manage their arousal and reshape their interpretation of their experiences/stories (Nichols, 2014). Narrative therapists believe in the importance of integrating client stories in a cognitive way so the client’s thinking becomes expanded, allowing them to consider a broader view of themselves and their situations (White, 2007).

Narrative family therapy borrows from Bowen’s knowledge of family systems by including and involving not only patient’s stories but also the story of the family. Social workers begin to form assessments by gathering information about the patient’s family of origin stories, including cycles of closeness and togetherness, and by identifying the client’s life stage (Nichols, 2014). These early assessments develop an understanding for clinicians about the counterbalancing forces of individuality and togetherness (Nichols, 2014). Gaining insight and understanding into how clients and families have moved though the various stages of the life cycle helps to weave important times and places together. It is through this weaving that understanding is gained, meaning takes place, and re-authoring is possible (White, 2007).

The intention of narrative therapy is to deconstruct the intertwined meanings of a story which limit and oppress a client’s progression. It is the belief of narrative therapy that pathologizing maintains rather than resolves the problems of living (Carr, 1998). The idea is to externalize the problem so as to remove shame, blame, and guilt. Carr (1998) shares that assumptions are not representations or reflections of identity, lives, and problems; rather, human problems occur when peoples’ lives are storied in ways that do
not align with their lived experience. Narrative therapy safeguards people by giving them the opportunity to share their stories in a safe, therapeutic environment and to re-author their lives in ways that are integrated with their lived experiences. The term re-authoring comes from the field of anthropology (Myerhoff, 1982, 1986). The therapist is neither a one-upped expert nor a one-downed strategic icon (Nichols, 2014; White, 2007). Rather, the role of the therapist is to walk alongside the individual as they make goal-oriented changes through their re-authoring.

White’s (2007) definition of narrative therapy offers nine principles to foster re-authoring in clients’ lives: (a) positioning of the therapist as collaborative, (b) externalizing the problem, (c) evacuating unique outcomes, (d) thickening the plot, (e) linking the new story to the past and extending it into the future, (f) inviting outside witness groups, (g) providing therapeutic documents, (h) re-membering practices, and (i) taking-it-back practices. The above nine principles will be applied to numerous stories to show how narrative family therapy can be used in practice.

Although narrative therapy gathers and honours the competency of assessment in numerous ways, the Victoria Hospice Palliative Performance Scale (PPSv2) includes a psychosocial framework providing guidance for practice and assessment (Cairns, Thompson, & Wainwright, 2003). The PPSv2 psychosocial framework draws from research on the impact that disease progression has on patients and their families. This framework aids the palliative care social worker as it correlates beginning the journey, the path not chosen and reoccurrence, entering the unknown, the long and windy road, watching and waiting, and the parting of ways with the palliative performance scale of
disease (Cairns, Thompson, & Wainwright, 2003). Having a framework that binds the medical with the psychosocial further facilitates multidisciplinary work.

**Death, Dying, and Grief**

Death is an inescapable part of living; therefore, grief is inevitable. How people move through the experience of grief depends largely on culture, the nature of relationship with the dying person, and the individual’s or family’s perception of loss (Cairns, Thompson, & Wainwright, 2003; Drenth, Herbst, & Strydom, 2010; Levine, 2007; Strada, 2013; Wolfelt, 1996, 2003). Rotter (2000) states “Grief is the expression of one’s reactions to loss”. Cairns, Thompson, and Wainwright (2003) assert that there are two grieving styles: the intrinsic griever and the instrumental griever. It seems these two styles are the ends of a continuum between feeling and action. Some people need to spend time with their feelings, while others need to put their grief into action.

There is an abundance of literature on death and dying as well as traumatic, anticipatory, and complicated grief (Cairns, Thompson, & Wainwright, 2003; Fulton, 2003; Howarth, 2011; Rando, 2007; Rotter, 2000; Strada, 2013; Walsh, 2006; Wolfelt, 1996, 2003; Worden, 2009). Terms such as anticipatory, complicated, and traumatic grief are often used interchangeably. Traumatic grief conceptualizes a grief experience that encompasses trauma reactions such as intrusive thoughts and reminders that trigger an autonomic nervous system response (Howarth, 2011; Levine, 2010). Furthermore, traumatic grief can be understood and recognized as a prolonged state of grief in which individuals and families are unable to integrate the loss into their life (Drenth, Herbst, & Strydom, 2010; Cairns, Thompson, & Wainwright, 2003). Grief that becomes traumatic is due in part to the person becoming stuck in their loss (Klass, Silverman, & Nickman,
Individuals and families become conflicted in their ability to integrate the loss experience into their current life (Drenth, Herbst, & Strydom, 2010).

When loss occurs, attachments are threatened. As humans we are in constant relationship with self and others which creates bonds. Regardless of the style or grief process one experiences, the literature encourages the importance of continuing bonds (Klass, Silverman, & Nickman, 1996). Continuing bonds is a concept that has been widely accepted and practiced throughout some of the eastern cultures and is moving its way into western cultures. It is the realization that the deceased remains in relation with us and we to them.

Although society commonly expects grief to occur at the time of death, grief is often experienced upon diagnosis and during treatment of a life-threatening illness, again with reoccurrence, when people have chronic illness, and through the transition to palliative hospice care and impending death (Cairns, Thompson, & Wainwright, 2003). Elizabeth Kubler-Ross is one of the pioneer researchers of grief. Her initial research was developed during her time spent with dying patients. She identified grief in linear stages: denial, anger, bargaining, depression, and acceptance (1996).

Rando (1993) describes grief as phases one moves through. The first phase is known as avoidance. The avoidance phase is managed by recognizing and honouring the reality of one’s loss. The second phase is that of confrontation. Individuals and families confront the separation with their loved one by recollecting and re-experiencing the loss of relationship in order to relinquish old attachments. Rando’s third phase involves accommodation to readjust and reinvest in the world.
Worden (2009) proposes grief as a series of non-linear tasks in the process of integrating a loss: accepting the reality of the loss, working through the pain of grief, adjusting to a world without the deceased (or relationship), and finding an enduring connection with the deceased (or relationship) in the midst of embarking on a new life. Both Rando’s and Worden’s models provide a framework for practitioners who support individuals and families throughout the dying process. Furthermore, Rando’s and Worden’s frameworks provide a roadmap for individuals and families while they journey through the phenomenon of loss.

Allen Wolfelt (1996, 2003) suggests that counselors set aside assessment and treating models. He coins his philosophy as companioning, which is the art of bringing comfort to another by becoming comfortable with their story. Such a philosophy echoes the principles of both narrative and resiliency theory. Wolfelt challenges grief counselors to be learners, not experts, and to keep their hearts open so as to be truly present with another human being’s intimate pain. He uses an analogy of grief being like a garden where space represents the following facets of grief: acknowledge reality, move towards the pain of the loss, convert the relationship, develop new self-identity, search for meaning, receive ongoing support, as well as explore spirituality, relationship with the dead person, personality, nature of the death, support systems, and tools (Wolfelt, 1996, 2003).

**Somatic Experiencing**

Dr. Levine has studied physiology through observation, research, and hands-on-development for forty years. Levine’s (2010) theory of somatic experiencing allows therapists to embrace the body by honouring the physiological reaction to loss as
supported by Porges’s polyvagal theory. Polyvagal theory describes how physiological states dictate behavior (Porges, 2003). In everyday life this means that our behaviors, including emotions and cognition, are in relationship with the state of our nervous system.

The study of science and biology has identified three areas of the brain often referred to as the triune brain together governing our sympathetic, parasympathetic, and autonomic nervous systems that are involved in self regulation (Levine, 2010). These three areas are like the mother board of the autonomic nervous system. The neocortex governs our thinking or intellectual tasks, such as cognition, language, thought, and speech (Porges, 2003). The limbic system is responsible for emotions, including expression and mediation of emotions and feelings (includes emotional responses linked to attachment and social engagement) (Porges, 2003). Whereas the reptilian brain fundamentally processes our instinct for self-preservation, this occurs through the processing of our senses and includes regulating our basic functions, such as digestion, reproduction, and the fight/flight/freeze response.

The sympathetic nervous system mobilizes us and readies us for action by heightening our alertness and focus. When we are within a functional range, it provides us with a sense of pleasure or excitement allowing us to participate in activities such as dancing, exercise, and adventure. The hormones within the sympathetic nervous system are intended to prepare us for short-term fight and flight (Levine, 2010). The parasympathetic nervous system at its best provides us with deep relaxation. This rest and recovery relationship restores the parasympathetic nervous system to equilibrium post fight/flight response and is ideal for storing facts and acquiring information (Levine,
At its most extreme, the automatic nervous system is responsible for the freeze response. Behaviorally the freeze response can be recognized as immobility, shame, and collapse (Levine, 2010).

When the autonomic nervous system becomes activated, individuals experience sensation responses within and throughout their body. Some of these sensations, such as numbness, hollowness, tightness in the stomach, shoulders and throat, have also been identified in the grief literature (Cairns, Thompson, & Wainwright, 2003; Levine, 2007; Rando, 1993; Strada, 2013). Somatic experiencing is a practice modality in which practitioners provide support to people so they can allow their system to move through chaos, self-regulation, and then let go (Levine, 2010). Such symptoms are psychosomatic of a traumatic experience. Levine (2007, 2010) asserts that human beings have an innate ability to overcome the effects of trauma. Neuroplasticity supports the notion that we are ever changing and have the innate ability to restore balance within our system, allowing us to integrate and connect our perceived experience with our present reality (Siegel, 2007).

**Family Resilience Theory**

Connection to self as well as others and our environment are essential to resiliency. “A nervous system accustomed to experiencing and releasing stress is healthier than a nervous system burdened with an ongoing, if not accumulating level of stress” (Levine, 2007, 2010). Therefore, once a body learns that reaction can turn to discharge, relaxation and security, the nervous system is more resilient and better able to support the person while weathering life’s ups and downs (Levine, 2007, 2010).
Resilience as a theory is becoming more evident within the literature. Bonanno (2005) asserts resilience, not recovery, is the most common response to trauma. Resilience is the ability to learn to live with and through adverse experiences in a way that fosters adaptation, flexibility, and healthy relationships. Bonanno (2005) proposes “isolated traumatic events often oblige a more pragmatic form of coping; a ‘whatever it takes’ approach”. This perspective of coping means behaviors and strategies that are less effective in other contexts may be appropriate, if not necessary, during events such as grief. By allowing such coping it increases an individual’s or family’s resiliency to cope with short-term adversities.

Walsh (2006) supports such notions specifically in relation to the context of grief. She strengthens the concept of adaptation by explaining adaptation does not mean resolution and recovery does not mean quickly getting to closure. Walsh states “recovery is best understood as a gradual process spiraling over time, rather than an outcome”. Individuals and families will extend their energy by oscillating within the adaptive process of facing grief some times and avoiding it at other times (Walsh, 2006).

Family resilience theory is founded on the idea that humans can face and live through adversity without carrying open wounds from adverse experiences. It is important to understand resilience is more than surviving adversity as many people live through devastating experiences. Rather resilience often involves growing from the adverse experience. It is the ability to stay connected to one’s life and the people we share it with, and it is the ability to share one’s vulnerability while still feeling safe and secure (Jordon, 2004a). The resilience model aligns with social constructivism by valuing people’s inherent ability to heal, survive, and thrive but is dependent upon resources in
the environment. It expands our individualistic perspective from the notion that resilience is somehow inborn and people who survive were born with the right stuff (biological hardiness) to a perspective Walsh (2006) describes as an active process of endurance, self-righting, and growth in response to crisis and challenge.

Historically, resilience was seen as the rugged individual with its association to masculinity (Walsh, 2006). Led by the work of Rutter (1999), we have come to understand resilience as an “ongoing interaction between nature and nurture, encouraged by supportive relationships” (Walsh, 2006). This shift parallels the emergence of third wave feminism in which relationship and connection are valued. Walsh (2006) proposes that family resiliency honours an ecological world-view by providing value and understanding towards belief systems, organizational patterns, and communication processes linking individuals with social groups all the while considering the process of their connection.

The process of resiliency is validated through recent developments in neurobiology (Siegel, 2007) as well as Brown’s (2006) work on shame resilience and Levine and Kline’s (2008) work on instilling confidence and resilience in children. Such research verifies that resiliency is the integration of new experiences and altered relationships, providing opportunity to rewire neural connections.

Although resilience theory has primarily been applied to individuals Walsh (2006) confirms that a resilience framework can also be used as a family therapy method. This model acknowledges and borrows from family systems theory, gaining the added depth of a systemic perspective as well as the knowledge of the family life cycle. Through the use of genograms (Bowen’s theory) and understanding of feedback loops (systemic
theory), clinicians are able to gather a systematic understanding of the family unit (Nichols, 2014). Since the family is a cohesive unit, it too can be resilient and develop from adversity.

Family resilience theory provides clinicians with practice guidelines (Walsh, 2006). Together, families can build safety by sharing strengths, courage, vulnerabilities, and constraints, thus reducing shame and blame. Normalizing the family response expands kinship, thereby strengthening family resources during times of crisis. These guidelines allow the family focus to shift from problem to probability while weaving adverse experiences into the fabric of family life (Walsh, 2006). These guidelines are built on the following framework: human resilience is fostered by a relational understanding, clinicians shift from a deficit view, practice is grounded in a developmental systemic perspective and guided by a bio-psychosocial and spiritual influence (Walsh, 2006). Crisis events impact family systems thereby valuing the recovery process of all family members and the family unit as a whole and, last but not least, having a contextual view of crisis includes symptoms of distress and adaptation (Walsh, 2003).

Belief systems, organizational patterns, and communication processes are three realms that formulate the ecology of a resilient family (Patterson, 2002; Walsh, 2006). Walsh further identifies how families adjust and develop within these three realms. A resilient belief system will find meaning in adversity allowing a positive outlook, transcendence, and spirituality. Flexibility, connectedness, social and economic resources are organization patterns which provide families with the ability to absorb shock. Family communication processes connect the family to their environment
fostering mutual support and problem-solving skills. By having clarity, open emotional expression, and collaborative problem-solving the family will be able to effectively problem-solve and process the events. A therapeutic relationship is valued.

**Caregiver/Compassion Fatigue**

The training to become a social worker is onerous, demanding, and complex. Such training intends to prepare students for the profession of social work, which involves ongoing demands and development. The literature on self-care implies that the stressful nature of the occupation of social work may lead to or exacerbate stress patterns (Christopher et al., 2011). One stressor that commonly impacts many social workers in palliative care is compassion fatigue, which in general terms is described as “the overall experience of emotional and physical fatigue that social work professionals experience due to the chronic use of empathy when treating patients who are suffering in some way” (Newell & MacNeil, 2010). When chronic fatigue is left unmanaged, social workers put themselves at higher risk for burnout. Thompson (2010) notes periods of either acute or prolonged stress impairs mindfulness.

The literature reveals mind/body/spirit practices such as yoga and meditation foster mindfulness, which in turn builds self-awareness (Hardy & Laszloffy, 2002; Siegel, 2007). Various journals in the areas of humanity, social science, medicine, nursing, and clinical social work contain research promoting the personal and professional benefits of mindfulness and self-awareness through regular self-care practice. Research reveals that self-care practice supports social workers in maintaining and cultivating personal and professional wellbeing (Patsiopoulos & Buchanan, 2011; Turner, 2008). Such research is grounded in the knowledge that self-care reduces stress,
which in turn aids in self-regulation, attunement, self-compassion, mindfulness, and professional development (Moore, Bledsoe, Perry, & Robinson, 2011).

Articles by a number of authors support the idea that regular, mindful self-care practices improve focus, decreases anxiety, strengthen mind-body awareness, increase self-esteem, improve mood, increase self-awareness, increase flexibility and strength, as well as decreasing stress and increasing hope (Brisbon & Lowery, 2011; Emerson & Hopper, 2011; Forbes, 2011; Garret, Immink, & Hillier, 2011; Kabat-Zinn, 1990; Saradananda, 2009; Smith, Greer, Sheets, & Watson, 2011; Taylor, Booth-LaForce, Elven, McGrath, & Thurston, 2008; Valente & Marotta, 2005). Moreover, Coster and Schwebel (1997) found self-awareness provided therapists with the necessary capacity for self-regulation. Through self-exploration practices, therapists gain deeper insight into their strengths and limitations, which then allows them the awareness of how their wellbeing influences their service delivery. Hardy and Laszloffy (2002) echo research that states self-exploration practices are imperative for a therapist’s personal and professional wellbeing.

The literature sketches a picture in which mindfulness becomes the central focus for holistic self-care practices. Creswell (2013) defines a ‘holistic account’ as a complex picture. “It seems that our relationship with our self is most critical to all other aspects of healing work…it starts with self and moves in concentric radiating circles out to all whom we touch” (Watson, 2005). Although the literature reveals much support for mindfulness practices as a tool for self-care, they rely on the willingness and commitment of the professional.
This information amplifies the importance of self-care as a practice for the profession of social work. If increased levels of stress reduce mindfulness and practice skills and professional development hinge on one’s ability to be mindful, it becomes apparent that caring for one’s stress level is imperative to professional practice. Literature reveals self-care minimizes burnout, allowing individuals the opportunity to enjoy a rewarding and integrated personal and professional life (Williams, Richardson, Moore, Gambrel, & Keeling, 2010).
Practicum Experience

Development of Practicum Goals

The core competencies defined by Social Work Competencies on Palliative Education (SCOPE) and the standards of practice defined by NASW (2004) are where I began searching for my practicum goals and objectives. It was important to me that my goals met best practice standards and were supported by the research in the literature. To gain this insight, I went back through my studies reviewing things I have questioned while personally reflecting on my Master of Social Work journey. I have always been drawn to the following learning areas: human development, social work with families, groups, feminism, self-care, communication, and death, dying, and grief. As I settled into my practicum I modified my objectives to more closely articulate what I wanted to achieve while adhering to my original goals.

My first goal was to understand and facilitate hospice palliative care and end-of-life decision-making. The creation of advanced health care directives (AHCD) has greatly influenced how end-of-life decisions are communicated. As a result, is it important for social workers to understand how end-of-life care impacts patients and their families. My objective was to gain skills in facilitating patient AHCD and other practical issues associated with palliative care, to support decision-making as well as advocate for patients, ensuring their wishes were respected.

The second goal I set was to develop clinical competency in supporting patients and families through the grief process. I set three objectives to meet this goal. They were to study the literature, attain hospice palliative care training in Victoria, BC, and facilitate a bereavement group. Each objective was intended to provide insight
and knowledge on how to improve my practice skills when supporting patients and families throughout the death, dying, and grief process.

Palliative care competencies state assessment skills are core to practice. Therefore, my third goal was to learn graduate-level assessment skills while working in the role of a medical social worker on a palliative care unit. My objective to achieve this goal was to immerse myself in direct palliative social work practice both on the Palliative Care Unit (PCU) and in the community.

My final goal was in respect to the social work profession. Self-care research reveals social work is a high-stress, high-demand profession, placing social workers at risk of compassion fatigue and burnout. As an ambassador for the social work profession, my goal was to gain deeper understanding and knowledge into caregiver/compassion fatigue and how such stress can be managed. I had studied the literature on self-care/compassion fatigue throughout my MSW classes and was curious to learn more about it in professionals' work life. So, my objective was to discuss experiences with self-care practice with colleagues and observe how palliative care workers adjust to the demands of work. Furthermore, I wanted to reflect on my own self-care and my work/life relationship.

**Practicum Activities**

**Conferences.** To enrich my learning I attended two conferences on hospice palliative care. One was an intensive hospice palliative care training course in BC from February 23-27, 2015, at the Victoria Hospice. The other one was Education in Palliative and End-of-Life-Care Oncology Canada (EPEC-O), offered in Saskatoon on March 20-21, 2015, and hosted by the Saskatchewan Cancer Agency and the Canadian Hospice
Palliative Care Association. Both conferences offered inter-professional palliative care education addressing holistic care and the needs of palliative patients and their families. Combined, the two conferences immersed me in learning more about grief, anticipatory grief, complicated grief, children’s grief, psychosocial assessment using the PPSv2, bereavement, relationship management in palliative care, and the concepts of total pain, sexuality, intimacy and end-of-life care.

I found the concept of total pain new and it fascinated me as it allowed me a clearer window to view patient assessment. Total pain is a term used to encompass suffering experienced in all realms of one’s life: bio-psychosocial and spiritual. Total pain is a challenge for everyone, including the patient, their family, and the palliative care team. Medication, regardless of the dosage, does not relieve this pain as it is a culmination of unprocessed hurts. Palliative social workers aid by supporting the patient and their unresolved psychosocial issues and end-of-life planning, with the intention of caring for patients holistically. Without the depth of knowledge and skill gained at the palliative training courses, I might not have recognized this concept in the patients that I served, leaving the patients’ and palliative care team’s needs unrecognized.

**Report/Assessment/Charting.** The Palliative Care Unit (PCU) at St. Paul’s Hospital has a rhythm of its own. As a multidisciplinary team, each discipline tends to its own competencies while participating and fostering the patients’ and families’ care holistically. As a palliative care team we began each morning with reports. Reports took place in the conference room with the doctor, head nurse, social worker, and music therapist. As the palliative ward doors opened, the vastness of my learning activities expanded.
Assessments were the key to good services and were developed over a couple of meetings with patients and families. Clinical assessments were gathered primarily through a narrative approach. As part of my practicum, we practiced using the Victoria Psychosocial Assessment Tool (PPSv2) developed by the Victoria Hospice (2014). The intention of psychosocial assessments is to aid patients and families throughout the disease process by attending to both formal business as well as informal status. Through a thorough assessment, I was able to identify gaps in the plan and ensure holistic care plans were developed.

As a palliative care social worker, I drew on Bowen’s Family Systems Theory through the use of genograms (part of the PPSv2) to assess family functioning. Genograms provided a framework for collecting information including who the patient’s support people were, their cycles of closeness and distance, emotional connection based on attachment, and the family life cycle. I created a genogram with each new patient as it provided an opportunity for introductions, initial relationship-building, as well as the beginning of a gentle life review. Genograms were drawn simply on a piece of paper so it could be seen by both the team and the patient.

The Victoria Psychosocial Assessment Tool (2014) was piloted to collect both formal and informal data. Areas of assessment covered practical considerations, including the patient’s wishes regarding power of attorney, decision-maker authority (AHCD/Proxy/SDM), financial support, financial/housing/employment concerns, last will and testament, and funeral planning. Capturing details regarding time of death requests as well as special rituals were important for the palliative care team so that patients’ and familys’ wishes could be honoured. It is common social work practice
within hospice palliative care to ask about and listen to patients’ descriptions of their spirituality. These stories assist the palliative care team in supporting patient’s spiritual care, thereby honouring the holistic model of care.

All formal assessments were placed in the patient’s chart to guide their hospice palliative care. Assessments, including the patient’s life review, cultural beliefs and practices relevant to care, community supports, strengths, coping and decision-making styles, along with self-care practices, provided depth and understanding of the patient. It is important to assess patients’ past experiences and awareness of their current illness, including their goals, expectations, hopes, fears, and concerns. It is widely researched and respected that both current awareness of their illness and previous loss experiences impact patients’ capacity to process and adapt throughout the disease process.

Throughout the assessment and care planning process, I included families as caregivers, supporting their strengths and hopes while respecting their fears, current demands, and coping styles. Family needs were honoured when information regarding anticipatory grief, children and grief, as well as what can be expected as the dying process progresses, was provided.

**Counseling.** As a palliative social worker I provided grief counseling to both patients and families. Grief counseling encompassed many facets. Some of the grief responses were anticipatory in nature. It is common, understandable, and expected that patients experience increased stress responses as they moved through the disease process. Key concepts from narrative therapy, family resilience therapy, as well as research on death and dying guided my grief counseling practice (Rando, 1984; Worden, 2009; Wolfelt, Klass, Silverman, & Nickman, 1996). The role of a palliative social worker is to
companion alongside patients and families as they reflect on their life, authoring and re-authoring their life reviews while finding and creating legacy and meaning for themselves and their family. Grief counseling within palliative care is to support and hold space for people while they ebb and flow within the transitions of loss. Grief is not something that can be fixed or taken away as much as one may wish for that to be possible. Grief is the expression of losing something you love. Although we cannot fix the grief, it is possible to help people find a healthy range for their stress responses. I used somatic experiencing as a counseling modality to provide support to individuals as they navigated their own nervous system, allowing them to find their own range of homeostasis. It was my intention as a hospice palliative social worker to honour people where they were at and encourage and support them as they found comfort in continuing their bonds with their loved ones in new ways.

Security and financial stress add to the weight of uncertainty causing fear and powerlessness. Families often need to relocate to unfamiliar places during a health crisis. Financial challenges increase as families try to balance transportation, lodging, meal costs, and work demands. I assisted families to navigate new systems and unfamiliar territory.

Uncertainty creates dissonance, resentments, and fear as time and life expectancy become threatened. Both patients and family members go through phases of feeling isolated and abandoned as well as fatigued and stressed. These phases may impact relationships in both positive and negative ways. Such responses are typically experienced as grief, requiring the social worker to honour, respect, and support patients and their families as they move through their responses.
Groups/Presentations. My professional associate and I offered two groups to the public and one drop-in relaxation group on the Unit for patients and families. Advocacy, care planning, community capacity-building, education and research were four of the competencies we respected by offering and facilitating groups. The relaxation group was offered once a week for approximately twenty minutes in combination with the music therapist. This group provided guided relaxation, mindfulness, and gentle stretching and was primarily attended by family members. Each week was a different group of people. This group was very well received and participants expressed feeling calmer and more at peace as they returned to their loved ones.

The first public group was a one-day expressive arts workshop with approximately 10 participants. My professional associate and I developed this group in combination with the Mendel Art Gallery and held it there. It was designed to be an experiential group so it was more about process than identifiable outcomes. The activities included an introduction to grief with the use of colors to exemplify the various layers and styles of grief, drumming, journaling, word art, water colors, and tissue art, ending with a memorial service. Individuals were encouraged to participate in their own way and as they felt comfortable. Over the course of the day I reflected on the process and noted people connecting and normalizing each other’s experiences. Witnessing the drumming and watercolor activities was an honour as both activities appeared to shift people’s grief in therapeutic ways.

Being cognizant that people process grief both intuitively and instrumentally, our second group was a ‘talk group’ based on Alan Wolfelt’s (2003) 10 essential touchstones for finding hope and healing in your heart. This group was held at and was supported by
the W. A. Edwards Family Centre. It was advertised through the palliative mail-out and public posters. Attendance included five ladies of a similar age who had all experienced the loss of their husbands on the Palliative Care Unit.

The talk group brought with it many learning opportunities for me. The group was designed to follow Wolfelt’s book *Understanding Your Grief* (2003), which provided us with a framework to explore the 10 touchstones of grief as well as his model of the grief garden. My greatest learning opportunity presented itself in the very first session about half way through our time together. As we were going around the tables taking turns sharing what people hoped to get out of the group one of the ladies challenged my professional associate and myself stating, “How can the two of you possibly help us ladies? We have all lost our husbands…our lives and neither of you know what that is like. We are in the water drowning and you two cannot possibly understand that. If you have not experienced it, there is no way you can understand or help us. So, I am concerned.”

The literature on groups prepares counselors for situations like this. Although the participant’s comments could have elicited a defense response from us, it was helpful to have both Wolfelt’s philosophy of companioning, along with narrative therapy, as a foundation for practice because it was easier to respond in a curious manner. We affirmed that her concerns were heard and we reflected on the hopelessness she expressed.

As the group continued to develop, the women were able to share that they had some common struggles; however, they also differed in some areas. I believe by supporting the group to develop and form relations with each other they benefited by
having their grief normalized. Further to this it is my hope that they gained space to
honour both themselves and their own grief garden.

On February 4, 2015, I presented to one of the Bachelor of Social Work classes
on death and dying. It was a very rewarding experience for me as I was able to pass on
some of my learning. My presentation shared the practice skills and theories of a
palliative social worker. The goal of my presentation was to discuss and explore how the
PPSv2 framework for understanding the psychosocial impact of physical decline, dying,
and death guides practice. Furthermore, I shared the importance of positioning yourself,
knowing and checking your own baggage before being of help as well as self-care to
ensure work/life harmony.

Although assessments, grief counseling and bereavement groups are major facets
of care planning for palliative social workers, I also facilitated other formal and informal
tasks, such as facilitating family meetings, providing forms for compassionate care and
other employment insurance benefits, creating memorial legacies such as a thumb print
impression, and supporting families as they contacted funeral homes at the time of death.
These and other smaller tasks were a part of my day as a palliative social worker.
Assessment of Practicum Experience

Achievements of Objectives

Looking back at my practicum goals and objectives which were: facilitate palliative care and gain skills facilitating Advanced Health Care Directive (AHCD) and advocate and support decision making; develop clinical competency in palliative care by studying the literature, attending training and facilitating bereavement groups; learn graduate-level assessment skills through immersing myself in practice on the Palliative Care Unit (PCU) ward and community; gain deeper understanding and knowledge into caregiver/compassion fatigue through indirect practice with colleagues and families, I successfully accomplished the learning goals I had set for myself through the objectives identified earlier in this report. I am proud of my achievements.

Throughout the practicum on PCU I gained knowledge of Advanced Health Care Directive (AHCD)/Proxy/Substitute Decision Maker (SDM) by studying the various documents, participating in discussion about which documents were the most useful, using them, and observing how each supported patients and captured their wishes. I gained knowledge in the process of substitute decision-making if and when patients did not have an AHCD or a Proxy named. I was mentored by observing how the social worker and physicians assessed patients’ wishes and assisted them in expressing their wishes, and then had numerous opportunities to support patients in this process independently.

Other practical issues that presented themselves were related to compassionate care benefits, assessment and referral processes for determining patient competency, parking passes, and contacting funeral homes with families after a patient’s death and
provided me with opportunities to offer support to patients and families. I was able to support the team on a multidisciplinary level by liaising with the doctor and family to obtain written documentation supporting their wishes to obtain power of attorney or confirming their absenteeism from work while they companioned with their loved one to death.

Through the literature review I discovered both the Canadian and NASW national standards and competencies for hospice palliative care and end-of-life care (Canadian Hospice Palliative Care Association, 2015; National Association of Social Workers, 2004). These standards and competencies led me to further literature regarding theories and frameworks of practice. These theories and frameworks enhanced my practices of narrative therapy, such as storytelling, re-authoring and objectification, as well as models of grief, such as companioning, continuing bonds, legacy work, and meaning-making. Furthermore, literature on companioning and the expressive arts were studied as models to guide facilitators offering grief support groups.

Literature was also gathered and studied regarding assessment. I improved my skills in gathering stories, creating genograms, and documenting this information in patients’ charts. Using the Palliative Performance Scale (Cairns, Thompson, & Wainwright, 2003), I began by reviewing the psychosocial framework when prepping to meet patients or families as well as in my written assessments. As a part of my assessment learning I participated in implementing and adapting the Victoria Hospice Assessment strategy (2014) to provide rich patient care while ensuring the PCU team had access to accurate patient information.
Some of my routine tasks became direct social work practice, such as attending and participating in daily rounds as well as providing daily and weekly reports. I provided both practical and clinical support to patients and families regarding palliative care, end-of-life care, and grief. Clinical support was offered to patients and families individually, as a whole, and oftentimes with a larger group in the form of family meetings. I also facilitated and co-facilitated relaxation and grief groups both on and off the Unit.

By listening and attuning myself to staff stress levels during report and during the Unit activities, I gained insight and understanding about caregiver and compassion fatigue and provided informal support to staff. Through informal anecdotal methods such as talking with staff about their experiences and self-care practices and spending time in the staff room, which was a safe place to connect with colleagues, I was able to hear many individuals’ stories of how they manage work stressors. My colleagues had numerous stories on how they manage workplace stress. Each story seemed unique to the individual however all centered on themes of family/friends, fun, and rest.

I made a concerted effort to share positive feedback with staff, disengage from drama, encourage sleep and fun, and attempt to see, hear, and understand team members in efforts to foster stronger resilience for personal autonomy as well as for team building. Personally, I upheld my commitment to myself and my practicum to focus on maintaining adequate energy by ensuring proper sleep and limiting extra outside responsibilities. I prioritized my energy for family, supportive friends, creative expression, daily spiritual practice, and a restorative yoga practice on top of daily living responsibilities (groceries, cleaning, and taking care of finances).
The one correlation I believe I read in literature, heard from staff, and witnessed throughout the practicum is that increased stress equals increased sick time, which in turn results in an increased workload on others. I believe because humans are complex creatures, stress in the workplace is a complex phenomenon to address. I believe it is important to recognize that working with people and families who are experiencing dying can be challenging. Patients and their families bring all the complexities of their life with them. It seems to me that the key to work-life harmony may be our ability to foster resilience to workplace stress rather than expecting it to be diminished.

Challenges

Growth includes both achievements and challenges. In reflection on my practicum I have identified five unique challenges. Some of these challenges were based on personal values, while others seemed to be imposed by political values.

My first challenge was political. The longer I worked in the palliative care world, the more frustrated I became by the lack of funding. It seems unjust to me that as a society we do not put more time and energy into providing hospice palliative care throughout health care. I think the lack of attention is due in part to society’s discomfort with death and the fact that society does not want to hear about the value of hospice palliative care because those who have experienced the value are often enveloped in their post-care grief. I do believe the government as a whole and health care specifically will need to look at and address this issue as the number of people diagnosed with life-threatening illnesses continues to rise. Political change is driven by society and with large numbers settling into retirement and on the cusp of requiring end-of-life care one can suspect their voices will resound demanding these concerns be addressed.
My second challenge was in regards to relationships. I had spent time considering how working in end-of-life care would challenge me, but it wasn’t until about three quarters of the way through my practicum that I had my “ah-ha moment.” One week we had 10 deaths and it was then that I realized, ten deaths meant 10 new admissions, which meant 10 new patients and families to connect with. My own personal challenge was connecting while simultaneously letting go. Even as a professional there is sadness with the death of a patient. I knew I had relationship strengths for connecting with the patients and their families and dealing with closure; however, the challenge was doing both at the same time.

This challenge of letting go while connecting created another challenge. My third challenge was that of personal energy. There were times when the work demands exceeded my energy. Because I was mindful of my goal, I was able to recognize these moments and make positive decisions accordingly. I have come to know and recognize my signs of fatigue. Although knowing and recognizing them was important to my self-care, being able to tell others and ask for help was still challenging. One day specifically, I recognized that I felt overly sensitive and less empathic, perhaps even somewhat disconnected from myself and others. I recall feeling neutral or bland about topics that on previous days had brought me joy or concern. During report I spent some time thinking about what I should do. I thought I could push through the day covering my assessment, but I also knew based on the literature and workshops that I had attended on compassion fatigue and burnout that this was not the way to go. So I chose to share my concerns with lack of energy with my professional associate and explained how I was feeling. She normalized this experience and we made a plan to assure patient and family
care was not compromised. I would triage patient care while making a list of demands to ensure I either delegated or followed up the next day.

When I arrived home from the day I felt exhausted. I engaged in extreme self-care by being transparent with my family so as to safeguard relationships and then made time to sit and allow myself to feel my exhaustion without judgment. To keep my exhaustion from affecting my health, I took my vitamins, ate a healthy supper, had a light visit with a friend on the telephone, and then went to bed. The next day I felt a bit better. With mindfulness, I maintained steady energy for the remainder of my practicum.

The piece of self-care I found challenging, and recognized that I will need to continue to work on was infusing fun into my days. Although I have a happy disposition, it seems my time and energy was mostly invested into meeting other people’s needs and completing tasks. I trust this will not always be the case but rather see it as a stage of life. With marriage, children leaving home, adolescents in the home, aging parents, work and school, I am stuck in the sandwich generation. I find it helpful to view this as a stage of life and not a landing point. With perspective I am better able to find the joys in the everyday moments rather than requiring fun events.

My fourth challenge was connected to the PCU environment. The PCU is designed to function as a home or community with a public kitchen, family room, and quiet rooms. I became conflicted as a social worker when one patient’s or family’s difficult behaviors began to impact the whole PCU environment. At one point all public areas needed to be closed for about 10 days. It was difficult for me to witness this loss of community for patients, families, and staff during this period of time. Care felt more forced or imposed rather than fluid and organic. Whereas I would once have joined
families at the kitchen table or in a rocking chair, I now had the challenge of creating the same atmosphere with only the patient’s room and the conference room to use.

There is one more challenge that continues to linger with me: “Is a graduate-level education important as a social worker serving palliative care?” Other provinces within Canada require master-level social work training for palliative social work as a specialty area. I believe palliative principles can and should be infused in various levels of social work; however, I also believe it is important to honour and respect the specialty of palliative hospice care and the people they serve. As a professional, I think specialty training is necessary to gain the skills required. The challenge is how do we as social workers ensure this happens.

**Ethical Considerations**

Early in my practicum my professional associate shared the practice of asking oneself, “What am I being asked to do?” when patients or families made requests. This proved to be a valuable tool to guide my practice as numerous times the concern families stated was not actually what they were asking me to help them with. By keeping this in the back of my mind I remained open and curious about providing care, allowing me to become what Wolfelt (2003) defines as a learner not an expert. Ethically I believe this tool, as well as Brown’s (2006) quest to consider, “Who benefits by that?” are simple ways in which social workers can ensure practice aligns with professional ethics.

As palliative social workers, we have the guidance of both the CASW Code of Ethics and the Palliative Care Code of Ethics to help govern practice. Further to these guiding principles the Hospital also had a board of ethics that could be consulted if needed. I found these guiding bodies, which inform practice, to be very comforting and
helpful when it came to decision-making about capacity as well as child protection concerns.

Part of social work is advocacy, not only for patients and their needs but also for service delivery. As part of my practicum, I was honoured to support my professional associate as she was interviewed (by the local TV station) about HOPE Cancer Society to raise awareness of their services and give information about an upcoming fundraising event they were planning. I attended the fundraising event along with some of the PCU team in support of all the work the HOPE Society does to help patients and their families.

**Meaning Making**

My time on the Palliative Care Unit at St. Paul’s Hospital was rich beyond measure. Not only did I meet the professional learning goals I had set out for myself, but I also gained insight into areas I had not focused on but had wondered about and believe to be very important to social work practice. The following were lessons taught to me by the patients, families, and team at PCU.

**Spirituality.** In today’s practice as a social worker, the topic of spirituality needs to be treaded on lightly. The caution lies in the belief that if we discuss our spirituality or spirit, it will imply dogma, often understood as a religious facet. However, it seems impossible to work in and study palliative care without considering spirituality. Spirituality is a common facet of discussion as well as an area of tension at times for palliative patients. Michele Butot (2007) recognizes that spirituality continues to emerge as a theme in contemporary mainstream social work. During my time at PCU, I was blessed to provide care to a Mennonite woman whose daughter was a missionary; a woman who identified her faith to be that of Oneness; a man who believed in Einstein’s
theory of energy E=MC²; and a cowboy who believed living was about passion.

Essentially spirituality is about meaning-making. Spirituality is what grounds us. It frames our view of the world and our deepest beliefs. Spirituality includes our sense of order and chaos, our understanding of good and evil, and our belief in a form of a higher power (Butot, 2007).

Spirituality includes the perspective that all life has purpose individually as well as collectively.

**Holding space.** Prior to this practicum placement I had learned the importance and skill of holding space through both my somatic experiencing and yoga training. What I gained was countless opportunities to hear stories of how others embraced difficulty: how a mother and daughter shared tea in the kitchen, how a son companioned with his mother while questioning his own mortality, and how a brother cared for his sister’s children in the midst of family chaos. Each and every day the doctors would leave each patient’s room saying, “I wish you a gentle day” or “It was nice to see you today.” These actions and words taught me more than the mere skill of managing uncomfortable situations. They taught me how to be present in the space that I was holding.

**Suffering.** I think the hardest part of my learning was to companion with suffering, to stay engaged and present for people whose lives had been difficult as were their deaths. Just a few of the situations depicting this journey include the patient who spent her dying days having to be protected from visitors, the shame of her diagnosis being neither understood nor accepted by society; the children who were left without a mother and without a care plan; the wear and tear on the PCU team as they hovered on
the edges of burnout; and the young man who passionately expressed his wishes for assisted suicide in order to end his suffering from a disease that was robbing him too soon of a life with so much potential for good.

**Sticking together.** There is power in numbers; you have to stick together when the going gets tough. Each and every day on the Unit I witnessed the beauty of people who stuck together: the farmer who spent each and every day with his wife because she had stuck by him through all their years of marriage; the brothers who fundraised for their sister’s treatment; the son who worked to reconcile his own childhood with his mom; and the grandson who organized a wedding in short order at the hospital so that his grandpa could be there. One day a patient’s friend phoned the social worker because she was concerned about the patient’s wife who had mild dementia. Without this friend we may not ever have known this added component of the patient’s care. Often large families would all show up for a family meeting and organize themselves around the care of their loved one. Another family brought cultural awareness to families less fortunate. These examples of sticking together reflected not only family resilience but served to build legacies.

Many patients worked to create legacy pieces for the family and friends they left behind, whether it was photo albums, letters, or cards. Each legacy piece will be cherished in its rightful way. One of the most beautiful pieces of legacy work that I witnessed was a supper one family held in honour of their mother and grandmother. They ordered supper in and shared a meal in the family room while their beautiful matriarch was still well enough to participate. After supper they read her a letter recalling all the blessings she had given them and how her legacy will live on in each of
their lives. They then offered up a prayer of gratitude, love, peace, and acceptance for the gift of her life. The patient died just days later, calm and in a state of peace.

In the midst of these deeper learning moments, I recalled a poem I found while studying in my feminist class. This poem struck me then but perhaps makes more sense to me today as a result of my practicum at the PCU. The following poem is by Ganga White (1998):

What it?

“What if religion was each other?

If our practice was our life?

If prayer was our words?

What if the temple was the Earth?

If forests were our church?

If holy water-the rivers, lakes, and oceans?

What if meditation was our relationships?

If the Teacher was life?

If wisdom was self-knowledge?

If love was the center of our being?
Conclusion

During the conference I attended at Victoria Hospice it was suggested one should ask oneself three questions when entering and working within palliative care. I answered the first question, “What brought you to this work?” at the beginning of this report. Therefore, it seems fitting to close with questions two and three, “What impact does this work have on your life?” and “How would friends and family say this work has changed you?” The past three years as a Master of Social Work student, including my PCU practicum, impacted me both professionally and personally. Expanding my studies to include narrative therapy, feminism, self-care, relationships, family systems theory, and studying both qualitative and quantitative research on dying and living has shifted my career focus from mental health to hospice palliative care. Personally this work has impacted my life more deeply. Although I have spent time away from my husband and family, missing out on events and moments I will never get back, it has allowed me to bring to the table my various areas of previous study and experience. It is hard to know if this work chose me or if I chose it, but regardless it has become a part of me and the life I live.

Palliative social work has provided me with the opportunity to build capacity, balancing my scales of empathy, understanding, and compassion with knowledge, skills, and professionalism. Moreover I believe this work has brought me to a more balanced work/life harmony. Through flexibility and adaptability, I have added capacity to both sides of my fulcrum yet I am amply able to return to the scale of rest, balance, and homeostasis. Although in daily practice it is not uncommon for me to borrow from
numerous practice theories, possibly reflecting an eclectic practice, my palliative practice is rooted in somatic experiencing, narrative, and resilience theory.

As a social worker I now have the skills and knowledge to align palliative/hospice theory with practice to best serve patients and families while being an ambassador for the social work profession. Through this experience I have become more grounded and settled in my feminist world-view. It is not us versus them or we versus they, it is all of us, together as a whole. We all will and do encounter strife at some point, but as a feminist, I believe that it is being in connection or relation that softens the edges of strife, allowing for an opportunity for healing. My family and friends would now say I am more intentional in my relationships and mindful of the life I am living. I am clearer in my boundaries around time, energy, and priorities while staying connected to the world and people around me.

I have pondered the statement my professor offered to our death and dying class 10 years ago (“You think you are here to learn about death and dying but I hope what you learn is about life and living.”), and I am happy to share that through this practicum I have learned exactly that! As a social worker on the PCU, I was witness to, and was able to companion with many stories of life and living. Sometimes in health care people are known or seen as a new admittance with a health number, first and last name, and with a room and a bed number. As a palliative social worker I quickly began to know people through their stories and relationships of being a cowboy, brother, bampa (grandpa), mom, dad, antique furniture salesman, minister, wife, husband, carpenter, accountant, grandma, health and safety officer, teacher, sister, brother, cousin, niece, nurse, contractor, truck driver, and farmer’s wife to name a few. There are states in life that
medicine cannot cure. However, I believe when patients and families feel seen, heard, and understood there is hope for healing. The wise teacher I had was right: I did think I was here to learn about death and dying, but in fact what I learned about was life and living.

“You don’t choose a life, you live one.” (Estevez, 2010)
References


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