

SUPPORTING GRIEVING PATIENTS AND THEIR FAMILIES WITHIN THE INTENSIVE
CARE AND PALLIATIVE CARE UNITS

A Field Practicum Report
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Abstract

This report reviews my practicum experience as a medical social work student at St. Paul's Hospital in Saskatoon, Saskatchewan within the Intensive Care and Palliative Care units. The ultimate goal of the practicum was to support grieving patients and family members as they encountered experiences of death, dying, and loss. First, a reflection is shared on how my personal experiences, social location, and values impacted my professional growth followed by a literature review on death and dying, the concept of grief, a feminist lens, narrative therapy, cognitive-behavioural therapy (CBT), and prevalent themes within a medical social work assessment. Second, I discuss the practicum objectives, goals, and activities that I accomplished from January 2019 to April 2019 with further examination of how I integrated a feminist lens, narrative therapy, and CBT when supporting patients and families. Next, I present the challenges I experienced within the practicum placement that undoubtedly enhanced my time management and therapeutic skills. Lastly, the report analyzes a few ethical considerations I encountered in skill-building situations. Clinical examples are found in many sections of the report in order to highlight my learning achievements.

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Chapter 1: Introduction

“Something will grow from all you are going through and it will be you” (as cited in Lanser, 2016). While the author of this quote is unknown, this sentence truly reflects my experience through the Master of Social Work program at the University of Regina. Since obtaining my bachelor’s degree in Social Work, I always knew that was not the end of my academic career. However, what I did not prepare for was the amount of work, time, and effort it would take to make it to where I am at in the program today. While the process has comprised sacrifice and maintaining balance, the amount of growth I have noticed within myself personally and professionally is something I do not regret.

Most of my social work career has been situated within Mental Health and Addiction Services with the Saskatchewan Health Authority. This time, I wanted to pursue medical social work because I have always been interested in death and dying and grief since obtaining my bachelor’s degree in 2013. Thankfully, I was offered a placement by two MSW Senior Medical Social Workers at St. Paul’s Hospital within the Intensive Care Unit (ICU) and the Palliative Care Unit (PCU). The ICU is comprised of a multidisciplinary team that works diligently in treating life-threatening illnesses (Ahrens, Yancey, & Kollef, 2003) in up to 15 patients at a time. As for the PCU, a group of health professionals compassionately care for up to 12 patients who have a terminal illness and holistically treat the needs of the patients and their families (Saskatchewan Health Authority, 2018). The length of this practicum was from January 2, 2019, to April 5, 2019, comprising 450 field hours. Overall, my practicum goal was focused on supporting grieving patients and their families within both units.

This report begins with a reflection on my personal experiences with death and dying followed by a discussion of social location and values. Afterward, I present a literature review

on: death and dying, the concept of grief, a feminist lens, narrative therapy, cognitive-behavioural therapy (CBT), and common elements within a medical social work assessment.

Next, I identify my learning accomplishments in regards to my practicum objectives, goals, and activities along with a detailed explanation of how I integrated theory and practice. The report ends with a discussion of my practicum challenges and I share some ethical dilemmas I encountered.

Chapter 2: Reflecting Inward

Within the ICU and PCU, your personal experiences, social location, beliefs and values will certainly be present as you work with grieving patients and their families. Below lie detailed descriptions of my personal experiences with death and dying, as well as an explanation of the impact my social location had within my practicum experience. The last component of this chapter highlights the values I upheld on the ICU and PCU.

2.1 Personal Experience

Before my field practicum began, my relationship with death and dying was solely based on personal experience. I have had a handful of family members die, and I attended each one of their wakes, funerals, and burials. One individual, who had an immense impact on my life, was my Aunty Shelley. The words “resilient,” “independent,” “successful,” “stubborn,” “caring,” and “selfless” come to mind as I attempt to define her as a person. While Aunty Shelley was medically unable to have biological children, this did not stop her from treating her nieces and nephews as her own. She was a strong and courageous woman who, when diagnosed with breast cancer in 2012, fought the illness with as much energy as her body and mind would let her until her death on March 7, 2015. Although I now walk my life journey without her, I am reminded of her spirit when I encounter dragonflies. These dragonflies tend to present themselves around significant milestones in my life. These include my wedding day as one sat on my veil during the ceremony and the final days of my practicum. These moments I have with dragonflies grant me the opportunity to spiritually connect with her. They are a constant reminder that no matter what I do, she will always be with me.

I believe the death of my aunty along with the death of others, helped me to prepare for this academic experience even if my experiences of grief may be different from the patients and

their families that I worked with in this practicum. Ultimately, I am grateful for the turmoil I have encountered in relation to death, dying, and grief as these moments enhanced my abilities to connect, empathize, and care for patients and families of the ICU and PCU.

2.2 Social Location

As Daynes (2007) stated, our social location defines who we are, where we stand, and how we have developed from our social and cultural contexts. Social location also makes us mindful of how our society is structured and how we, and others, live within these systems (Daynes, 2007). I am a young, married woman living in a patriarchal world, who chose to pursue an academic career rather than becoming a mother. I am Caucasian and healthy and have lived in Saskatchewan all my life. I was born into a blue-collar family and was raised Roman Catholic, even though I have not practiced this religion for a few years.

My social location has allowed me not only to reflect on who I am as a person but on how my characteristics have affected my interactions with patients and their families as also explained in Daynes' 2007 study. My social location exposed differences in upbringing, lifestyle, values, and beliefs which can be challenging when you are seeking a connection with patients and families. However, the use of empathy and compassion allowed me to make these connections even though my personal background was different from that of the people I worked with. Ultimately, I experienced the most professional growth in the situations where I had to step back and recognize how the patient's and family's social locations were interconnected with their presenting problems.

2.3 Values

My field practicum experience not only demonstrated the value of life and living but also exposed the importance of valuing death and dying. Whether I was on the ICU or PCU, I

wholeheartedly believed that every human being at St. Paul's Hospital deserved a quiet and peaceful death regardless of race, religion, culture, socioeconomic status, and gender. I also believe patients are the experts of their own lives and thus should choose the end-of-life care decisions they feel are right for them, regardless of staff members' and/or families' spiritual and cultural beliefs.

In addition, I recognized the importance of the patient's relationship with myself and their family. As a social worker, I believe that a therapeutic alliance is truly more significant than the types of modalities we use because without the patient's trust, we will not have the privilege in knowing the challenging issues connected to the patient's presenting problem. I also believe that the patient's support system is important because their care and devotion provides health professionals with the space to provide quality care. This can be seen in the family's commitment to attending family meetings, arranging transportation and housing, and locating community supports for the patient. It is important to note, however, the amount of responsibility the health care system places on the patient's family (Dubus, 2010), and thus I believe we need to meet the family's needs as much as the patient's because they are encountering significant changes and struggles as well.

I continue to value a holistic approach to care which treats the physical, social, spiritual, and psychological health of the patient and/or family members. This can only be accomplished through the use of a multidisciplinary team, where all team members can contribute a wealth of expertise and knowledge on how to best support a patient's and their family's needs.

Lastly, I uphold the belief that staff, family, and patient need to embrace vulnerability and ongoing communication. As one of my mentors once told me, the more we communicate, the more likely the messages are being relayed and absorbed by the people who need to hear them

(Z. Teed-Mckay, personal communication, October 2016). Thus, I believe we all need to express how we think and feel through a constructive and honest approach as well as communicate endlessly with each other in order to make sure questions are answered, care plans are understood, and prognoses are explained. This in turn will support the grieving processes of the patient and family as well as the effectiveness of our care.

Chapter 3: Literature Review

A literature review was completed focused on the concepts and topics that supported my ability to aid grieving patients and their families within the intensive care and palliative care units. First, a review of the literature is shared on society's approach to death and dying, followed by the perceptions of death and dying in southern Saskatchewan Indigenous cultures. There is also information provided on medical assistance in dying (MAID), as this has created a new ideological shift in Canada and was present in my conversations with patients and families. Studying these various ideas, beliefs, and perspectives on death and dying was important because it helped me to understand how they were impacting the grieving processes of the patients and families I worked with.

Second, literature was reviewed on the concept of grief, including an analysis of anticipatory and complicated grief as I wanted to learn how to recognize the risks and symptoms of these two grief processes within my practicum experience. Additionally, a review of Kubler-Ross's (1969) stages of grief is also included as her theoretical approach was the sole knowledge I had on grief prior to the practicum placement.

Third, a literature review on feminism is highlighted as this was the theoretical lens that guided my practice with grieving patients and their families in the ICU and PCU. Afterward, narrative therapy and CBT is explained because I wanted to enhance my skills and knowledge on these two modalities within my practicum placement.

Lastly, I outlined in my plan for practicum activities that I wanted to develop a social work assessment guide for use by the medical social workers of St. Paul's Hospital. To accomplish this, a literature review was completed and five prevalent themes emerged to be included in a medical social worker's clinical assessment guide. Each of these reviews of the

literature enhanced my knowledge of the concepts of death and dying and how to effectively support patients and families struggling with their grief.

3.1 Death and Dying

The first area I wanted to review in the literature was focused on how Western society and the Indigenous peoples of Saskatchewan conceptualize death and dying in order to articulate in practice how their ideas, perspectives, and beliefs impact their grief. It is important to note that in the 1950s, family members were more involved in taking care of their dying loved ones within their homes (Arnup, 2013). These family members would be expected to: provide the medical attention, care for the lifeless body, offer viewings, and bury their loved one in a grave dug by family members (Corr et al., 2009). However, death and dying in the present time has shifted towards a hospital setting under the care of a medical team (Arnup, 2013; Corr, Nabe, & Corr, 2009; Jenkinson, 2015). The downfall of family members no longer acting as primary caregivers is that they have little to no opportunity to experience death and dying (Arnup, 2013; Corr et al., 2009; Jenkinson, 2015). Ultimately, this has led people to avoid and fear death and dying, and in turn has added pressure on medical professionals to cure and save people from life's finality (Arnup, 2013; Corr et al., 2009; Jenkinson, 2015).

The anxiety and fear that Western society has towards death and dying is so powerful it can be found within the language. Euphemisms are used by Western society to cover and hide the reality of death as it has become too emotionally painful to accept (Corr et al., 2009; Walker & Wong, 2018). One example of a euphemism is when parents tell their children that their beloved dog "went to sleep" rather than saying the dog died (Corr et al., 2009). Euphemisms have also been used amongst medical professionals (Corr et al., 2009). Frankly, words related to

death and dying are more acceptable to use on inanimate objects (e.g. car died), than on the living themselves (Corr et al., 2009).

As for the Indigenous cultures in southern Saskatchewan, the elders explained that their communities view death and dying as a "...completion of the circle of life..." (Hampton et al., 2010, p.9). According to the southern Saskatchewan elders, a dying person needs to be surrounded by many family members as their energy is passed onto the dying individual in order to help them in preparing for their journey after death (Hampton et al., 2010). Other cultural practices include the preparation of sacred meals for the dying individual, openly communicating that death is near, and refusing to cry as this can hold the dying person back from crossing over (Hampton et al., 2010). Thus, these social and cultural views depict an alternative approach towards death that disallows fear to take away from a pivotal experience in an Indigenous person's life.

Medical assistance in dying (MAID). It is important to highlight MAID in this section of this document as I experienced this new perspective with the patients and families in my field practicum experience. New to Canadian law as of June 2016 is legislation for medical assistance in dying that, according to Health Canada (2018b), allows a patient to request their life to be ended following confirmation by two physicians. In regards to eligibility, the patient must be over 18 years of age, a permanent resident of Canada, have cognitive capacity, ability to provide informed consent, have experienced no coercion, and been diagnosed to have a severe terminal illness (Health Canada, 2018b). Since legalization, roughly 3,700 people have used MAID in Canada (Health Canada, 2018a). Ultimately, the presence of MAID in our legislation supports a different conversation that includes individual choice and freedom while challenging the taboo of death talk (Jenkinson, 2015; Walker & Wong, 2018). However, any form of death can still

perpetuate grief reactions in the deceased person's family members. Thus, the concept of grief is explored in further detail in the next section of this chapter with a closer look at anticipatory grief and complicated grief as well as an analysis of Kubler-Ross's (1969) stages of grief.

3.2 The Concept of Grief

I wanted to review the concept of grief in order to enhance my knowledge of this concept in practice. I also wanted to review literature on anticipatory and complicated grief in order to achieve my learning objective of understanding and recognizing the differences between the two grief reactions. This in turn would help me provide support to patients and families who might be struggling from either one of these forms of grief.

To begin, grief is commonly seen as a natural response to situations in our lives that are utterly distressing (Malkinson, 2001). In other words, grief is a holistic experience that one personally endures when a significant loss has occurred (Corr et al., 2009). The process of grief allows an individual to move on without their loved one by creating new perspectives and beginnings within their life (Malkinson, 2001). However, health professionals need to be mindful that not all grief will follow the same regime (Hedtke & Winslade, 2017). Therefore, anticipatory grief and complicated grief are discussed below.

Anticipatory grief. Commonly found within palliative care, anticipatory grief is an emotional experience where an individual begins a grieving process before the patient's inescapable death (Burke et al., 2015; Overton & Cottone, 2016; Schuler, Zaider, & Kissane, 2012; Toyama & Honda, 2016). This grief process may begin for families who witness their loved one's health status worsen or when they clear out their loved one's possessions (Burke et al., 2015). Family members also encounter changes to their roles and relationships with the patient as the terminal illness progresses (Overton & Cottone, 2016; Toyama & Honda, 2016). It

is important to note that some family members may be at risk of experiencing a heightened form of anticipatory grief. These are family members who are highly anxious, have no emotional support system, resist intimacy, lack a spiritual connection, and have difficulty accepting the patient's imminent death (Burke et al., 2015). Additionally, dementia caregivers are at higher risk of psychiatric issues due to ongoing experiences of loss throughout the disease progression of their loved one (Meichsner, Schinkothe, & Wilz, 2016). Thus, understanding the various experiences of anticipatory grief supports family members in recognizing that grief is a unique and individualistic reaction to a difficult moment in their lives.

Complicated grief. Complicated grief is a prolonged condition that interferes with an individual's ability to emotionally connect with others as intense mental health issues are experienced for at least six months after a loved one's death (Anderson, Arnold, Angus, & Bryce, 2008; Kentish-Barnes et al., 2015; Maccallum & Bryant, 2011; Schmidt & Azoulay, 2012; Schuler et al., 2012). Complicated grief tends to occur in family members who were involved with loved ones in the ICU, and one study found complicated grief to be present in over one-third of family members (Schmidt & Azoulay, 2012). Family members who are at risk of complicated grief tend to live alone, identify as female, be unable to say goodbye, witness their loved one die with intubation, and/or witness the patient's death (Kentish-Barnes et al., 2015). Recognizing the psychological impact of complicated grief from the literature is important as it demonstrates how variable grief reactions can be across family members who are faced with the death and dying of a loved one.

Kubler-Ross's stages of grief. I reviewed Kubler-Ross's (1969) stages of grief as her work was the basis of knowledge that I had on the concept of grief when entering the practicum placement. Her work is widely known as she illuminated the emotional experience of grief, a

topic that tended to be avoided by health professionals and society at the time of her research (Corr et al., 2009; Hedtke & Winslade, 2017; Stroebe, Schut, & Boerner, 2017). Kubler-Ross developed her grief model from working with patients in Switzerland who were dying of cancer (Hedtke & Winslade, 2017). The five stages she developed are found in her 1969 book “*On Death and Dying*,” (Kubler-Ross, 1969) and are as follows: denial, anger, bargaining, depression, and acceptance. This model was meant to be used descriptively (Hedtke & Winslade, 2017; Stroebe et al., 2017); however, numerous clinicians utilized the stages as a strict, step-by-step guideline to grief which did not accurately reflect the vast variety of grief reactions individuals may face (Corr et al., 2009; Hedtke & Winslade, 2017; Stroebe et al., 2017). This caused anxiety in individuals because they worried they were not progressing through the stages appropriately (Stroebe et al., 2017). In addition, the simplicity of the stages did not help in determining which individuals were at risk of unhealthy grieving reactions (Stroebe et al., 2017), such as complicated grief. This led to professional criticism of Kubler-Ross’s (1969) stages of grief because of its use as the universal model in understanding all grief reactions (Corr et al., 2009). The criticism of Kubler-Ross’s (1969) work resonated with me as I encountered diverse experiences of grief among patients and family members that could not be met with a linear model. Thus, this next section describes the use of a feminist lens followed by a literature review of narrative therapy and CBT.

3.3 Feminist Lens

Within my practicum objectives, I wanted to incorporate a feminist lens in my practice with grieving patients and their families due to this worldview’s belief in self-determination and valuing the importance of communication and connection. The idea of feminism first began around the time of the First Wave, also known as women’s suffrage in roughly the 1800s and

provided political rights to women, such as the right to vote (Butler-Mokoro & Grant, 2018). The Second Wave began in the 1960s around the same time as the civil rights movement (Butler-Mokoro & Grant, 2018). The most significant outcomes of the Second Wave were women's right to employment and sex and gender as separate concepts (Butler-Mokoro & Grant, 2018). In the Third Wave of the feminist movement, activists in the 1990s began to redefine femininity by challenging the advertisement industry and social media's oppressive beliefs towards females (e.g., women are dependent and gentle) (Butler-Mokoro & Grant, 2018). These movements allowed women to begin creating space in a patriarchal society that supported equal rights for their gender.

Around the beginning of the Second Wave, a feminist approach to counselling developed (Evans, Kincade, Marbley, & Seem, 2005; Draganović, 2011). This approach focused on tackling the political, social, and cultural stereotypes placed upon individuals due to their gender (Butler-Mokoro & Grant, 2018; Evans et al., 2005; Magnet & Diamond, 2010). A feminist theoretical lens promoted two significant ideas: the patient was seen as the expert of their situation, and the professional relationship between therapist and patient was rooted in equality (Butler-Mokoro & Grant, 2018; Draganović, 2011; Evans et al., 2005; Magnet & Diamond, 2010). Together, the therapist and patient identified the patient's ability to overcome oppressing obstacles in his or her life (Evans et al., 2005), which in turn, promoted self-worth and respect (Draganović, 2011).

Additionally, there are other theoretical approaches rooted in feminism that can be utilized in counselling such as relational-culturalism, and social constructivism. In a relational-cultural approach, there is a focus on highlighting the significance of relationships and encouraging women to build connections with others who can relate to their concerns (Butler-

Mokoro & Grant, 2018). In social-constructivism, a feminist therapist will embrace and promote social change for the patient as the political and social contexts of the individual are seen as socially constructed (Butler-Mokoro & Grant, 2018; Evans et al., 2005). Both of these approaches are helpful within a feminist lens in allowing the individual to understand how the cultural, political, and social domains of Western society impact not only on themselves, but others as well.

3.4 Narrative Therapy

The first therapeutic modality I wanted to learn and utilize in my practicum placement was narrative therapy as I connected with the overall message that meaningful stories we create influence how we view not only the world and others, but ourselves as well. Developed by Michael White and David Epston (1990), narrative therapy consists of reviewing a patient's problematic story, constructed out of their social, political, and cultural perspectives and beliefs, followed by re-authoring this damaging narrative into one that generates meaning (Aloi, 2009; White, 2011). The theoretical roots in narrative therapy come from a French theorist named Michel Foucault, who studied how various understandings of existence and the self, held by individuals and institutions in his era, were implemented and accepted into mainstream society due to their overall held power (Besley, 2002; White, 2007, 2011). White (2011) claims that these understandings engrained within today's Western society are the basis for how an individual constructs their problematic story. Thus, grief counsellors can use narrative therapy to socially-construct a new meaningful story that is supportive of the individual overcoming the death of their loved one (Beaumont, 2013; Hedtke, 2000, 2014; Hedtke & Winslade, 2017; Neimeyer, 1999; Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010).

According to Besley (2002), narrative therapy is also situated within post-structuralism and post-modernism. In regards to post-structuralism, language is seen as the most significant tool in how individuals share their personal views of the world and identify their sense of self (Besley, 2002). This worldview in narrative therapy does not seek to reveal a wealth of knowledge that the individual has not recognized they carry within themselves, nor does post-structuralism rely on facts (Besley, 2002). As for post-modernism, this framework posits that the meaningful narratives we construct from significant interactions influence how we choose to live our lives (Aloi, 2009). Each one of these philosophical frameworks shapes the foundation of narrative therapy and provides a deeper understanding of the therapeutic process. Below is a detailed depiction of the therapeutic process by reviewing three core themes: deconstructing the narrative, externalizing conversations, and re-authoring stories followed by a discussion of narrative therapy and grief.

Deconstruction. Within the first core theme, the therapist and individual deconstruct the problematic story held by the individual (Aloi, 2009). White (2011) defined this stage as “...unpack[ing] the stories of people’s lives and identities” (p.8). Throughout the deconstruction process, the therapist must come from a place of curiosity by carefully listening for the missing gaps in the story that deserve attention (Aloi, 2009; Besley, 2002). Narrative therapy also deconstructs the individual’s cultural and historical perspectives that influenced their cognitive process in developing the problematic story in the first place (Besley, 2002; White, 2011). It is important to note that within the full therapeutic process, the individual is seen as the expert of their story and the therapist must decentre themselves and offer a space that is comfortable, respectful, and safe for the individual (Besley, 2002; White, 2007, 2011). This will aid the individual in being more open in exploring elements of their problematic story where they

contradict themselves or presume a part incorrectly and in working towards developing a new awareness of why this problematic story was constructed to begin with (Besley, 2002, White, 2007).

Externalization. Externalizing the problem from the story is done in order to salvage the identity of the individual who may have internalized this problem (Besley, 2002; White, 2007). White (2007) has written that people tend to believe their problematic issue defines who they are as an individual and this dangerously leads to them accepting this as a factual component of their identity. Thus, the therapist will help the individual choose a metaphor that helps them to significantly understand how the problem negatively impacted their life and entice them to change their negative views of their sense of self (Besley, 2002; White, 2007). The art of externalizing, “employ[s] practices of objectification of the problem against cultural practices of objectification of people” (White, 2007, p.26). This can be seen in the medical system where there is a cultural practice of over-diagnosing individuals. The use of narrative therapy helps to challenge the current medical system’s cultural practices by visualizing the patient as a person and not another diseased service user requiring treatment.

Re-authoring. The last core element of narrative therapy consists of re-authoring a new, alternative narrative to the once problematic story (Aloi, 2009). This new narrative captures meaningful and positive parts that were missing from the once-problematic story due to the individual’s previous inability to recognize these important details (White, 2011). With the therapist’s help in collaboratively identifying these significant cultural parts, the individual is able to redefine their identity (White, 2011). As White (2011) writes, these new stories help individuals to tap into new forms of understanding of the world and their existence. This in turn, builds confidence and purpose for the individual and allows them to recognize the power that

their problematic story had over them (Aloi, 2009). These alternative stories created in narrative therapy prove that individuals can have a multitude of stories about themselves which can lead to many new opportunities to create meaning within their lives (White, 2011).

Narrative approach to grief. It was important for me to analyze the literature focused on how I could use narrative therapy to support grieving patients and their families in the intensive care and palliative care units. The literature shared how loved ones are taught in our society that they must forget about the deceased in order to recover from their grief (Hedtke, 2000; Hedtke & Winslade, 2017). Yet in a narrative approach, the relationship between the grieving individual and the deceased does not perish after death (Hedtke, 2000, 2014; Hedtke & Winslade, 2017). Therefore, clinicians need to be attentive to the meaningful aspects that the relationship had and may still, provide for the grieving individual after their loved one's death (Hedtke, 2014).

Social workers utilizing a narrative approach are encouraged to collaborate with the grieving loved one, honour their privacy, respect their struggle to change, provide assignments (e.g., scheduling grief and loss journaling a few times a week), and be mindful that grief is a slow, delicate process (Neimeyer, 1999). They can also incorporate re-membering activities such as reflexive writing, photo use, tape recording, imprints, keepsake objects, and epitaphs (Beaumont, 2013; Hedtke, 2000; Moxley-Haegert, 2015; Neimeyer, 1999; Neimeyer et al., 2010). These activities support an ongoing relationship with the deceased and help the family member explore their understanding of the loss (Beaumont, 2013). This in turn, promotes the additions of new narratives that encapsulate hope, resiliency, and love to the grieving individual's story of their endless bond with the deceased loved one (Hedtke, 2000, 2014; Moxley-Haegert, 2015).

3.5 Cognitive-Behavioural Therapy

The last therapeutic modality I wanted to use in my practicum experience was cognitive-behavioural therapy (CBT) due to its common use in effectively lowering negative emotional symptoms. CBT was developed by Dr. Aaron T. Beck who studied the cognitive processes of patients with depressive symptoms (Beck Institute for Cognitive Behavior Therapy, 2016).

Widely researched and used by mental health professionals today, CBT is based around the idea that an individual's thoughts towards an experience affect their behaviours and vice versa (Beck Institute for Cognitive Behavior Therapy, 2016; Mallick, 2009). CBT addresses an individual's irrational thoughts and unhelpful behaviours that cause troubling emotions and, in turn, works to help the individual reconstruct a new perspective of their problematic situation (Chawathey, & Ford, 2016; Gibson, 2012; Malkinson, 2001; Mallick, 2009; Matthews & Marwit, 2004). The patient and therapist need to have a common outlook towards the patient's issue in order to together develop a series of objectives and tactics that will tackle the problem (Gibson, 2012).

For grieving patients and families on the ICU and PCU units, CBT techniques can be helpful in dismantling disturbing thoughts and beliefs as well as in introducing them to new behavioural patterns to aid their mental health and grief concerns. In one study, mild anxiety and depression symptoms in eight out of eleven palliative care patients were reduced by the application of CBT tools (Anderson, Watson, & Davidson, 2008). Other research articles have discussed the effectiveness of CBT tools in not only neurotic mental illnesses but also with patients struggling with pain and sleep issues (Chawathey, & Ford, 2016; Gibson, 2012; Mallick, 2009) as well as in those struggling with complicated grief (Maccallum & Bryant, 2011). It is important to note that CBT techniques can be used by health care professionals with limited training (Anderson et al., 2008), and CBT strategies can be taught not only through individual

therapy but also through books, operating systems, and electronic communication devices (Mallick, 2009). Listed below are various CBT tools that were utilized throughout the field practicum.

Psychoeducation. This CBT technique has clinicians link individuals and their families' behavioural patterns to their medical condition in order to gravitate towards an acceptance of their losses (Meichsner et al., 2016). Psychoeducation also consists of reframing the concept of hope regarding the current situation more realistically by tackling the patient and/or family's unrealistic cognitive views (Meichsner et al., 2016). In addition, providing psychoeducation normalizes and encourages grief (Meichsner et al., 2016) and explains how an individual can be affected by a death emotionally, physically, cognitively, and behaviourally through Padesky's "Hot Cross Bun" tool (Anderson et al., 2008, p. 816) which is further explained in a chapter below. This visual tool helps patients and families to identify their current problem and how this problem is affecting them holistically (Anderson et al., 2008).

Relaxation exercises. In a study with palliative care patients who suffer from Parkinson's disease, breathing exercises, and meditation techniques such as guided imagery were utilized with those experiencing depressive symptoms (Mallick, 2009). These relaxation tools were also used when pain or sleepless nights were the patient's primary concerns, as the exercises would help to calm the body from emotional and physical stress (Mallick, 2009) by changing the focus from the individual's pain to their breathing. This allowed the patient to experience a sense of control over the symptoms of the disease (Mallick, 2009). Guided imagery can also act as a form of exposure where the patient and/or family member immerses themselves in their distressing situation through mental visualization exercises with a clinician (Chawathey & Ford, 2016).

Journaling. While also known as thought records, journaling can be an effective tool in challenging whether there is evidence to support the negative beliefs and views of the individual and if a new belief towards the issue can be formed (Anderson et al., 2008; Chawathey & Ford, 2016). Journaling also helps in becoming mindful of events that provoke physical pain and negative emotions (Mallick, 2009). Patients may be asked to reflect on their emotional and/or physical discomfort roughly three times daily and to explain the severity on a visual scale (Mallick, 2009).

Exceptions. While the use of CBT tools can help with a variety of problematic issues, there are instances where the techniques may not be appropriate with certain individuals. Individuals with neurodegenerative diseases, learning disabilities or severe mental health concerns should not engage in CBT due to the intense cognitive work expected in this form of therapy (Anderson et al., 2008; Chawathey, & Ford, 2016; Gibson, 2012). Additionally, patients who are lethargic and/or struggle with communication are also inappropriate for CBT exercises (Anderson et al., 2008); thus, it is important for social workers to have a variety of tools within their therapeutic tool box in order to meet the needs of the patient and/or family member. Nonetheless, CBT techniques should be reviewed as options to incorporate in therapeutic conversations with patients and/or their families of the intensive care and palliative care units.

3.6 Medical Social Work Assessment

A medical social worker's assessment is a vital tool that helps the interdisciplinary team in providing quality, efficient care to patients and their families (Dubus, 2010). Many authors advocate for a holistic assessment and a multidisciplinary team to be utilized (Dubus, 2010; Kinrade, Jackson, & Tomnay, 2011; Stewart, 2014; Zittel, Lawrence, & Wodarski, 2002) along with ongoing communication between patients, families, and the health professionals when

meeting a patient's and their family's needs (Ahrens et al., 2003; Dubus, 2010; Hansen, Martin, Jones, & Pomeroy, 2015; Hartman-Shea, Hahn, Fritz Kraus, Cordts, & Sevransky, 2011; Kinrade et al., 2011; Rose & Shelton, 2006).

A goal for my practicum placement was to create a social work assessment guide for the medical social workers at St. Paul's Hospital. After conducting a literature review, I determined that the following five themes should be incorporated in a medical social work assessment guide: the patient and family's understanding of the illness, the emotional health of the patient and family, the spirituality of the patient and family, the presence of a health proxy and end-of-life care decisions, and lastly, any housing and finance concerns. These themes are shared in detail below.

Understanding the illness. A crucial piece for social workers to identify in an assessment is whether the family understands their loved one's diagnosis and prognosis (Dubus, 2010; Hansen et al., 2015; Hartman-Shea et al., 2011; Kinrade et al., 2011; Lang & Quill, 2004; Rose & Shelton, 2006). Kinrade et al. (2011) write that a pivotal moment for ICU families is when the medical team shares the current medical status of the patient. If the family is struggling to decipher the information shared with them, the social worker can assist as a bridge between the family and medical staff (Kinrade et al., 2011; Rose & Shelton, 2006). Understanding the diagnosis and prognosis of the patient is not only informative for the family but also impactful in emotionally processing and accepting the severity of the illness (Lang & Quill, 2004). Additionally, if a family is uninformed of the patient's condition, there is a risk of their grieving process being negatively impacted (Dubus, 2010). Thus, a social work assessment should include information to assist the family's understanding of the illness in order to support their psychosocial well-being and to include them as members of the multidisciplinary team.

Emotional Health. The second theme identified from the literature pertains to the importance of social workers assessing a patient and/or family member's emotional health (Ahrens et al., 2003; Dubus, 2010; Hartman-Shea, 2011; Kinrade et al., 2011; Rose & Shelton, 2006; Taylor, 2012; Zittel et al., 2002). For families in the ICU, Rose and Shelton (2006) write that a family member's mental health concerns may affect their end-of-life choices for their loved one; therefore, social workers should assess whether psychological concerns are present. Likewise, social workers should provide counselling to those families affected by psychological concerns (Hartman-Shea et al., 2011) as counselling is a social work skill that can improve the mental well-being of the patient and family (Kinrade et al., 2011). In one study, Kinrade et al. (2011) found that the "the need for assurance and anxiety reduction" (p.679) was the greatest desire of families in the intensive care unit. Narrative therapy could provide space for the patient and/or family to develop meaning in their identities (Moxley-Haegert, 2015), while CBT may reduce the power of an individual's thoughts and unwanted emotions by focusing on healthy coping strategies (Mallick, 2009). Regularly assessing families allows medical social workers to connect at-risk family members to support services sooner (Schuler et al., 2012, 2017) and help to reduce the impact the grief process can have on a family member's emotional well-being.

Spirituality. The third theme highlights the need for social workers to assess the spirituality of the patient and/or family as this may aid them in coping with emotional turmoil, loss, and grief (Hansen et al., 2015; Hartman-Shea et al., 2011; Kinrade et al., 2011; Reese et al., 2006; Rose & Shelton, 2006; Stewart, 2014; Zittel et al., 2002). Spirituality can be explained as a powerful existence outside of ourselves that makes us feel connected to all forms of life and embodies one's beliefs, meaning, values, and purpose (Reese et al., 2006; Stewart, 2014). In Kinrade et al.'s (2011) study, they found that families rated "...feel[ing] there is hope" (p.671) as

the highest need when dealing with an acute loved one in critical care. This essence of hope may derive from a family's spiritual beliefs, which act as a profound coping tool in even the most crucial moments. In one study, a family member experienced emotional release because the social worker connected them to a chaplain who reduced their stress, which in turn led to this person being able to participate in end-of-life decision-making (Rose & Shelton, 2006). Hence, medical social workers should assess the patient's and/or family's spirituality in order to uphold a holistic, and compassionate approach to care (Stewart, 2014), especially on units where increased stress and traumatic loss frequently occur.

Health proxy and end-of-life care. Many articles identified the importance of locating the patient's health proxy as well as discussing end-of-life care (Ahrens et al., 2003; Dubus, 2010; Hansen et al., 2015; Hartman-Shea et al., 2011; Lang & Quill, 2004; Reese et al., 2006; Rose & Shelton, 2006). According to the *Health Care Directives and Substitute Decision Makers Act of Saskatchewan* (2015), a health care proxy is a person who is appointed by the patient and listed in the patient's Advance Health Care Directive (AHCD) to carry out the patient's end-of-life care decisions when the patient is unable to communicate. If the end-of-life decisions are carefully laid out in an AHCD prior to the patient's health complications, family members will not have to endure the decision-maker role, which puts them at risk for emotional distress (Ahrens et al., 2003; Rose & Shelton, 2006). However, if an AHCD is not completed, the social worker's therapeutic discussions can help the family make decisions that their loved one would have wanted, which in turn helps the medical team to provide legitimate care (Hartman-Shea et al., 2011; Rose & Shelton, 2006). Thus, the social worker's assessment in this area is a valuable component in assisting the patient, family, and other team members by upholding the patient's

desires, supporting the family's mental well-being, and balancing the multidisciplinary team's capacities of care.

Housing and finance. The final theme evident from the literature review pertains to the assessment of the patient's financial and/or housing concerns (Hansen et al., 2015; Kinrade et al., 2011; Rose & Shelton, 2006; Zittel et al., 2002). Rose and Shelton (2006) explained that family members may be heavily preoccupied with the patient's sudden admission, and that they may need assistance with connecting to financial and housing supports. The assistance from the social worker in these areas of concern may help to lower stress for families (Kinrade et al., 2011). In addition, it has been shown through research that patients who have no housing and financial concerns are at lower risk of a health decline as one's socioeconomic status is connected to the development of a diagnosis (Zittel et al., 2002). Once a patient stabilizes in their hospital stay, it is important for the social worker to assess their financial and housing needs in order to support them with a successful discharge plan that will in turn support their physical and emotional health.

With the results from the above literature review, a social work assessment guide was developed and is currently being trialled in the ICU. This guide was reviewed and edited by my professional associates in order to create a helpful social work tool that supports consistent and quality practice within the profession. A copy of the guide is located in Appendix A.

Chapter 4: Learning Accomplishments

Before I began my field practicum at St. Paul's Hospital, a proposal was completed which described the objectives, goals, and activities I hoped to accomplish within the four-month placement. This section of my report will outline these desired learning areas and how they were accomplished, followed by an explanation of how I integrated theory and practice.

4.1 Practicum Objectives

Due to my continued interest in death and dying and a devotion to working within the health care system, I decided a medical social work placement would be most suitable. The ultimate goal was to support grieving patients and their families in both the intensive care and palliative care units. Here, I list the practicum objectives that led to a humbling and enlightening practicum experience:

1. To gain experience working within a multidisciplinary team as a medical social worker with patients and their families through the ICU and PCU.
2. To learn and develop therapeutic skills in narrative therapy and cognitive-behavioural therapy for patients and families within the ICU and PCU.
3. To increase knowledge of supportive community-based resources and utilize these supports to meet the patient's and/or family's needs.
4. To provide patient/family-centered care and a feminist approach as well as other effective therapeutic interventions as the patient and/or family members work through end-of-life care decisions. This includes: legacy work, mindfulness, and life review.
5. To develop an understanding of the clinical assessment and consultation process for medical social workers through the use of a psychosocial-spiritual assessment tool,

such as the Palliative Performance Scale (PPSv2) developed by Victoria Hospice, and genograms.

6. To learn how to recognize anticipatory and complicated grief in the patient's and/or family members' on either the ICU and/or PCU.

Each of these learning objectives was accomplished by carefully balancing my time between both the ICU and PCU. The amount of personal and professional growth I experienced has affected my outlook on life and the direction of my career.

Achievements in practice. The following discussion will highlight how I achieved the completion of objectives one, three, five, and six. Objectives two and four will be further explained in the Integration of Theory and Practice section.

In the first objective, I came to understand the multidisciplinary teams on both units by attending rounds and family meetings and by observing the team members while they worked. On the intensive care unit, the team is made up of nurses, physicians, respiratory therapists, physical therapists, dietitians, pharmacists, client care coordinators, residents, clinical nurse educators, social workers, speech and language pathologists, occupational therapists, unit clerks, and management. As for the palliative care unit, the multidisciplinary team is comprised of the same disciplines identified above, except there is no clinical nurse educator and spiritual care is included in team discussions. I also found volunteers to be more of a presence on the PCU, providing companionship, baking, and/or music for the patients and their families. It is also important to note that both units' teams would meet with their patients and/or families daily. I found this approach to rounds as inclusive and promoting patient/family-centered care.

As for the third objective, I was able to increase my knowledge of community-based resources by listening and observing my professional associates recommend referrals to patients

and their families. I also attended in-services and visited agencies within the community. The agencies I visited were: Prairie Hospice, The Saskatchewan Cancer Centre (SCC), Geriatric Evaluation and Management (GEM), and Community Social Work. Each one of these agencies was kind enough to provide a tour and explain the services their agency provides. Additionally, the social workers at these agencies allowed me to shadow them for a day in order to capture the responsibilities of their role. The time I spent with these agencies also allowed me to network and build an understanding of how care is provided before or after the patient's hospital stay.

Within the fifth objective, I read and studied the PPSv2 scale from the book, *Transitions in Dying & Bereavement: A Psychosocial Guide for Hospice Palliative Care* by Marney Thompson and Wendy Wainwright (2017). The scale tracks the physical and cognitive abilities of a palliative care patient as their disease worsens (Thompson & Wainwright, 2017). The scale is percentage-based with 100 percent indicating full independence and cognitive capacity and 0 percent representing death (Thompson & Wainwright, 2017). The PPSv2 scale also helps social workers and other health professionals to decipher the condition of the patients' and their families' mental wellness by locating the patients' current baseline on the scale (Thompson & Wainwright, 2017). On the PCU, my professional associate and I would use this scale to help in channelling the types of therapeutic discussions we should be having with a particular patient and their family. It also helped us to analyze what type of services and resources may be a benefit according to the current status of the patient's illness.

As for the genograms, these were routinely used on the PCU as a way of capturing the members of the patient's family and deciphering who the substitute decision-maker would be if an advance health care directive did not exist. As Pistole (1997) writes, genograms help us to understand how the person's social systems impact their identity and interactions. At first, I

observed my professional associate complete genograms and then began to complete them on my own. I found this systematic tool to be of value and began to incorporate the technique on the ICU. I also noticed other staff members reviewing the finished genograms, as a way to personalize who they were caring for and to better anticipate which family members to expect at the bedside.

For the final objective, I was able to recognize the differences in anticipatory and complicated grief by observing the varying grief reactions from patients and families, debriefing these reactions with my professional associates and other health professionals, and by reviewing the literature. As stated in the literature review, anticipatory grief tends to begin in those individuals where a loved one is expected to die from a terminal illness (Burke et al., 2015; Overton & Cottone, 2016; Schuler et al., 2012; Toyama & Honda, 2016). Symptoms of anticipatory grief include: sleepless nights, low food intake, feelings of nausea, tiredness, reduced cognitive abilities, frustration towards their spiritual faith, emotional disturbances, and headaches (Shore, Gelber, Koch, & Sower, 2016). I found in my experience that most of the patients and families who were on the PCU or connected to palliative care services were experiencing this form of grief.

While complicated grief may not be present until just over six months has passed since the patient's death (Miller, 2012), I learned the risk factors that health professionals can look out for in family members around the time of the patient's death. These are: missing the death of their loved one, unanswered questions about the treatment plan, upset at the level of support they personally gave to their loved one, violent outbursts and behaviours, pre-existing mental health concerns, previous unhealthy relationships and experiences of traumatic deaths, and feelings of loneliness (Shear, 2012). Other risk factors are if the family member is female, acts within a

caregiving role, has poor health, little understanding of prognosis, or current social stressors (Simon, 2013). Predominantly these risk factors existed in family members in the ICU during my practicum. When I noticed these risk factors after my clinical assessments, I would try to offer what community resources I could because currently, the social workers do not provide post-ICU follow up and grief counselling programs are scarce.

4.2 Practicum Goals and Activities

A part of this practicum experience required identifying practicum goals in order to help me stay focused on what I wanted to learn. Listed below are the practicum goals I had set to accomplish during my practicum experience in the ICU and PCU.

1. Develop clinical skills in selected therapies and theoretical grief frameworks with individuals and/or family members.
2. Understand and carry out the administrative work of a medical social worker such as clinical assessments, charting, and community referrals.
3. Learn and provide support to patients and their family members in end-of-life decision-making.
4. Review and address complicated and anticipatory grief experienced by patients and their families on the ICU and/or PCU.
5. Promote personal and professional growth through other social work practices.

Within each goal was a set of practicum activities that I developed with my professional associates' guidance in order to experience the most during my placement. These activities are explained in more detail followed by a review of how I incorporated feminist theory, narrative therapy, and cognitive behavioural therapy into practice.

Achievements in practice. The activities I completed to meet my first practicum goal were: attending the LEAP (Learning Essential Approaches to Palliative Care) Core training, completing a literature review on narrative therapy and CBT as it pertains to grief and loss, observing and utilizing narrative therapy and CBT in practice, and reviewing grief theorist Robert A. Neimeyer's idea of meaning reconstruction (1999; Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010) and Kubler-Ross's (1969) stages of grief in order to understand other professionals' perspectives on grief.

The LEAP Core training provided me with an overview of what palliative care is and how we implement this model with patients and their families. According to Pallium Canada (2016), an association that promotes the enhancement of palliative care services, palliative care is a holistic approach that promotes quality of care to patients and works to reduce any symptoms of physical discomfort for patients with a terminal illness. This course taught me how to identify complicated and anticipatory grief and gave me tools and techniques I could use when providing grief support to patient and families (e.g. the use of silence, and common statements to avoid).

Reviewing the literature allowed me to develop a stronger sense of both narrative therapy and CBT, which in turn increased my confidence in using these therapeutic approaches with patients and their families. In addition, studying these modalities enticed me to explore and reflect on Kubler-Ross's (1969) stages of grief and Neimeyer's reconstruction of meaning (1999; Neimeyer et al., 2010). As mentioned earlier, Kubler-Ross's linear approach fails to explain and support the complex emotions and behaviours an individual can experience when overcoming a loved one's death. On the other hand, Neimeyer et al. (2010) believed in a constructivist approach to grief that recreated a new meaningful story through narrative techniques, such as metaphors, therapeutic writing, and a mindfulness exercise called "evocative visualization"

(p.73). Neimeyer (2017) also believed in the three R's, which are to *retell* stories in order to find meaning, *rebuild* a new relationship with the deceased, and *reinvent* ourselves after the death of a loved one as life will be different without them. Due to this, I felt I connected with Neimeyer's approach and narrative therapy. I found they provided a gentle and understanding approach in creating new stories of the deceased that were holistically healing to the living. I believe Neimeyer's approach and narrative therapy, alongside the use of CBT techniques, was helpful as CBT lessens the intensity of thoughts and feelings that narrative therapy or Neimeyer's approach may struggle to address.

For my second goal, I wanted to participate in practicum activities that would help me to enhance my administrative skills as a medical social worker. This was accomplished by completing a literature review on the use and structure of a medical social work assessment, developing a psychosocial-spiritual assessment guide based on the research, reviewing chart notes written by my professional associates and completing my own with appropriate feedback, learning how to complete referrals to community agencies, and completing genograms.

A medical social work assessment helps the multidisciplinary team in understanding what psychosocial-spiritual factors are impacting the patient and/or their families' lives. Dubus (2010) stated that meeting the patient's identified needs from a medical social worker's assessment may reduce the number of visits the patient makes to the hospital. Thus, my professional associate and I decided I would develop a social work assessment guide for the social workers who complete these assessments for the ICU.

It is important to note that I found it difficult to find research articles that only pertained to ICU social work. This led to my professional associate asking me if I thought medical social workers assess the same psychosocial-spiritual issues within various hospital units. I pondered

this question and decided that, in general, medical social workers do assess the same common themes. Therefore, I reviewed articles focused on the ICU, oncology, hospice/palliative care, an end-of-life care team within hospital settings, community health professionals and their struggles with the older population, and medical social work.

As described in the literature review, the social work assessment guide was developed and is currently being piloted by some of the ICU medical social workers at St. Paul's Hospital. My overall goal in using this assessment guide is to obtain consistency and enhance the quality of our professional work on all units of the hospital.

Other parts of this administrative goal consisted of observing, reviewing, and completing my own charting, as well as genograms. Since I had worked in a hospital setting before, I was aware of the Saskatchewan Health Authority's standards on charting. What I was not familiar with was completing initial assessments. After reviewing my professional associates' assessments, I began to complete my own and found I adapted to the task quickly. I had a similar experience with genograms, which may be due to prior practice in the Master of Social Work program.

As for referrals to community agencies, I became acquainted with programs and services that I was not familiar with (e.g. compassionate care benefits) by listening and watching my professional associates integrate these recommendations in conversations. I also learned how to complete referrals by shadowing other social workers at their agencies. As I learned of new referral processes, I would write them down in case I needed to refer back to them in the future.

My third practicum goal focused on learning how to support patients and their families with end-of-life decision-making. The practicum activities entailed: observing my professional associates facilitate a discussion on advance health care directives (AHCD) with patients and/or

their families, reviewing literature on AHCD and a substitute decision-maker, facilitating AHCD discussion on my own and receiving feedback, and learning how to decipher who a substitute decision-maker is by law.

According to a project developed in British Columbia called My Voice, an advance health care directive is a document that a person can choose to complete that outlines their health care decisions (Ministry of Health, 2013). By doing so, their health care team and family will have direction on what types of medical treatments he or she would want when communication and/or mental capacity is a barrier (Ministry of Health, 2013). When an AHCD is not completed, the *Substitute Decision-Maker's Act* is instated. In Saskatchewan, the substitute decision-maker must be the nearest relative to the patient who is an adult with the mental capacity to make health care decisions on their relative's behalf (Health Care Directives and Substitute Health Care Decision Makers Act, 2015). Both the AHCD and *Substitute Decision-Maker's Act* were utilized during my field practicum; however, some cases were more challenging than others.

For instance, I found that in some ICU cases where the *Substitute Decision Maker's Act* was used, the family members disagreed with each other on what the end-of-life care decisions for the patient would be. In these types of situations, the multidisciplinary team and I would try to provide as much emotional support as needed to all the family members while the physician compassionately explained the illness and prognosis. Another example pertained to an AHCD. I worked with a mentally competent patient who wanted to complete an AHCD before her disease progressed. However, this patient had physical limitations and could not fully sign her name. Thus, I brought a notary public to the unit who witnessed her mark in order to have her end-of-life care decisions respected and honoured by the PCU.

The fourth objective identified as part of this practicum consisted of supporting patients and their families with complicated, and/or anticipatory grief. The practicum activities included: engaging in a self-reflective journal in order to understand the differences in the two grief processes, researching literature on the characteristics of anticipatory and complicated grief, assessing families at risk for complicated grief and heightened anticipatory grief, and providing at-risk families with resources.

As time passed, I began to notice the differences between anticipatory and complicated grief. For those families with anticipatory grief, many began to grieve when the disease was diagnosed, when their role changed to caregiver, or when treatment was discontinued. One family member stated, “death is not the worst enemy” because the losses over the course of their loved one’s progression of illness were harder to experience. As for anger, some family members would express this towards God for letting their loved one suffer, while others would show anger towards immediate family members who chose not to visit before their loved one’s death. Sometimes we would remind these families to practice self-care and that my professional associate and I were there if they needed to talk. When able, I would try to provide self-help books, one-on-one sessions, and community resources to support their grief.

Those at risk for complicated grief displayed different symptoms. For example, I noticed their past traumatic issues would resurface as they grappled with whether or not their loved one would survive. I also noticed passive-aggressive behaviours, especially when family members did not agree with the substitute decision-maker’s decisions. Some could not stand the sight of intubation while others would beg for any machine possible. Additionally, some families would openly discuss their own history of mental illness while some did not but showed signs of extreme or very little emotion. I witnessed some families’ violent-like behaviours (e.g. verbal

aggression) and unhealthy relationships (e.g. drug use). I also met families with their own social stressors (housing and finances) and families who had experienced multiple recent deaths. With all of these families I offered emotional support as well as the individual and family counselling provided by the Saskatchewan Health Authority. However, not all accepted support and I can only hope the ideas I planted began to flourish.

The final practicum goal was to promote other means of personal and professional growth through the following activities: facilitating two lectures to the social work team, practicing self-care activities, and reading the aforementioned book by Thompson and Wainwright (2017).

I provided two lectures to the St. Paul's Hospital's medical social work team: the first on the roles and competencies of social work, and the second on assessing psychosocial morbidities in grieving family members. According to Thompson and Wainwright (2017), the competencies of a hospice/palliative social worker are "advocacy, assessment, care delivery, care planning, community capacity building, decision-making, education and research, evaluation, information sharing, interdisciplinary team [and] self-reflective practice" (p.20-21). I explained each of these competencies and how they can all be applied within our work on other hospital units. I also shared that reflecting on these competencies as a group helps us to remember that we are an important part of the multidisciplinary team for the patient, family, and staff. As for the second lecture, I explained the research I discovered within literature reviews that advocated for the need to assess the emotional health of families. I shared the psychological concerns authors found in their participants and shared the risk factors for complicated grief and heightened anticipatory grief. Near the end of the lecture, I provided the social work team with a list of

mental health and addiction resources within Saskatoon. Both of these presentations included a power point as well as a discussion period where questions could also be asked.

I understood the importance of self-care due to my personal and professional experience with mental health issues. Frankly, I was concerned how I would react psychologically when working within two units that are entrenched in death and dying. However, I made a promise to myself that if something ever personally affected me, I'd seek out my support system. I also promised to stay committed to my recreational activities: soccer, dance, journaling, having tea with a close friend, watching a comedic show, or enjoying some laughs with my husband. Sometimes, excuses to avoid these activities would fill my mind but I have come to know when my mental health is dictating my courses of action. Thus, I would make sure to have check-ins with myself and, when needed, ask my informal support people to encourage my participation during those moments where I was struggling.

Lastly, Thompson and Wainwright's book was impactful to my learning as it helped me to understand what types of issues families in hospice/palliative care endure while navigating the journey of their loved one's terminal illness. My professional associate and I would review parts of the book together and apply some of the theory learned to particular patient situations. One example is of a patient who had a PPSv2 below 40 percent. This individual was experiencing a severe reduction in independence but vocalized that she was not afraid of death. Due to this, I decided to use a reframing question from the book by asking in a family meeting if she was instead afraid of the dying process. She shared that she was and we began to brainstorm ways we could make her more comfortable. This led to a referral for a talking device when she was no longer able to vocally communicate and to ask the paramedics to provide her with one last visit

to see the Saskatchewan River. This excited her and her family as well as the team because we were able to provide her with as much normalcy as possible during the last weeks of her life.

4.3 Integration of Theory and Practice

This section will analyze and review my use of a feminist lens, as well as the use of narrative therapy and CBT. Clinical examples will be shared in order to illustrate how I integrated theory into practice.

Feminist lens. As a social worker, I have always connected with the use of a feminist lens in practice. The reason for this is because I believe that patients and families truly are experts of their own lives and we are there to support them while they make their own decisions. One example centres on a patient's decision to accept MAID. In these situations, family members do not always agree with the end-of-life decisions the patient has chosen. You have to support the family in understanding that the patient chose a way to die that was meaningful to them while tackling the stigma the patient may face from their family.

Within this lens, it is believed that an individual's trauma is rooted in the individual's experiences of discrimination (Magnet & Diamond, 2010). Rather than trying to improve the individual's weaknesses from the endured oppression, a feminist counsellor will focus on highlighting the individual's strengths and resiliency (Draganovic, 2011). I appreciate this approach because it has the ability to enhance a person's self-confidence and self-worth.

I also value this worldview's encouragement of "...relationships over independence" (Butler-Mokoro & Grant, 2018, p.164) because I believe humans are social beings and therefore we physically need others to help us through difficult times. Lastly, I believe we are who we are by the past social constructs that shaped and influenced our identities. This is why I decided to

add relational-culturalism and social-constructivism to the literature review on a feminist framework.

As a female professional, I believe my gender gives me an advantage in connecting with female services users. For instance, the majority of the physicians are male in the intensive care unit and their position requires them to have difficult conversations with family members on the code status (e.g. do or do not resuscitate) of a patient. Due to my feminist lens, I am aware of the power dynamic between a highly educated male and a female substitute decision-maker. When I was invited into these emotionally charged family meetings, I tried to act as an advocate, mediator, and facilitator for the female family member and offer a debrief session after the meeting was complete. I believe these debrief sessions were a safe place for their vulnerability to flow because of the gentle and warm female presence that I provided. While this may sound like I am gender stereotyping, the reality is that our society perceives women this way and sometimes we need to embrace these labels and use them in practice for the sake of the patient's well-being.

Narrative therapy. There were countless times where I encountered problematic stories from patients and their families of the ICU and PCU. Many of these stories portrayed their fears surrounding the illness and prognosis, and if they had provided enough care to save their loved one. Others were concerned that suffering would be present before death. Listed below is an example of how I used narrative therapy in the ICU followed by a discussion of the narrative remembering techniques: legacy work and life reviews.

Deconstruction. I found that families who had a loved one in the ICU for substance misuse had a lot of anger, disappointment, and feelings of hopelessness towards the patient. As Hedtke (2014) suggested, blame can be placed on certain individuals that we constructed into our problematic story. I also found these families often felt they had failed to save the patient from

their substance misuse. In these instances, I would deconstruct their problematic story by looking for elements of meaning. Many times, I would find these elements to be acts of unconditional love towards the patient. These acts included: offering safety and security, maintaining boundaries, providing emotional check-ins, receiving help from professionals, and offering professional help to the patient. Before sharing my thoughts with the family members, I would work on externalizing the problem of self-blame from the story.

Externalizing. In order to do so, I would talk about the addiction issue from the third person and sometimes refer to it as the monster that was ruining both the patient's and their family's lives. This was helpful as it allowed the family members to approach their situation in a different way that resonated with them (Neimeyer, 1999; White, 2011). When they were able to start envisioning the problem outside of the patient and the family, we were able to move onto the next phase of narrative therapy which consisted of re-authoring the story.

Re-authoring. It is within re-authoring that the family members were able to see their displays of unconditional love to be a meaningful part of their story that was not given credit. I would provide examples of how they were displaying this love and affection through their countless visits to the ICU and their presence for bedside rounds. This new, positive story showed the family members that other narratives can exist and these stories offered healing from blame, fear, and despair.

Re-membering. There are other ways to use narrative therapy and one technique I would like to share is referred to as re-membering practices. As White (2007) shared, the important people from any moment in a person's life are re-membered for the impact they had on shaping their identity. In order to honour these individuals, I would engage in legacy work and life reviews with the patient.

In legacy work, family members hold close meaningful possessions in order to feel they are still connected to their deceased loved one (Thompson & Wainwright, 2017). Sometimes these possessions are left by the dying patient to express their love and appreciation towards their family members. One example is of a terminally-ill patient who I helped write four letters: one for her husband and the other three for each of her sons. In each letter she would tell me word for word what she wanted it to say and, at the end, I would read it back to her. When she was satisfied with the work, I would type them up and come back with cards that she could put the letters inside. It was a request from her that the cards be received after her death. Thus, we arranged for her sister to hold onto the letters until the time came to pass them on to her loved ones. Even though this exercise took time, I knew it meant a lot to her and I thanked her for the experience of witnessing her undeniable love for her family.

As for life reviews, this is a moment for the patient to share the past experiences and the past relationships that emotionally impacted them (Thompson & Wainwright, 2017). Life reviews are a positive exercise for terminal patients to use in releasing any emotions that may be causing distress before death (Jenko, Gonzalez, & Seymour, 2007). These stressful emotions were evident in the patients' narratives of childhood, motherhood/fatherhood, marriage, divorce, employment, pleasure, travelling, war, overcoming obstacles, religion, culture, addiction, illness, death, etc. For some, it was a time to reminisce and for others it was a time to let go. It made me think of them as human beings with a wealth of knowledge and experience that I had the privilege to learn from and care for.

Cognitive Behavioural Therapy. During my practicum, I was able to employ CBT techniques with some of the patients and family members I worked with. These techniques

included: psychoeducation, journaling, and relaxation exercises. Below are clinical examples of how each technique was used in practice.

Psychoeducation. In order to help an anxious patient struggling with the loss of independence, I used ideas from Padesky's "Hot Cross Bun" tool (Anderson et al., 2008, p.816). This tool helped me to explain to the patient and their loved one how triggering events bring on thoughts that affect our emotional reactions and bodily sensations, which in turn leads us to engage in unhealthy coping strategies (Anderson et al., 2008). Together, the patient and I wrote down examples for each component on a piece of paper and then I connected the components to show how our thoughts affect our overall well-being. I then explained that as human beings, we do not have power over our thoughts but we can choose how we react to them. It is here that we began to explore healthy coping strategies that Mallick (2009) writes, will provide joy and excitement to their lives. I encouraged the patient to continue this exercise through journaling in order to build awareness and insight into what triggering events were causing the uncomfortable feelings of anxiety and fear.

Journaling. Some of the patients I worked with would focus heavily on their physical symptoms to the point that they were unable to see these symptoms as bodily reactions to their negative thoughts and emotions. Due to this, I encouraged some patients to journal not only their physical symptoms but also disturbing thoughts and feelings as well. By keeping track of physical, emotional and cognitive disturbances, unhealthy reactions to these experiences can be identified and replaced with positive coping strategies (Mallick, 2009). Overall, journaling offered a chance for me to teach them that, in a stressful situation, we are impacted mentally, physically, and emotionally.

Another use for journaling was to decipher the level of a patient's pain. This was beneficial for both the medical team and for me because when no other medication options were available, I could offer other CBT tools such as relaxation exercises as a positive coping strategy (Mallick, 2009). Journaling the pain also made them realize that, when the pain isn't as severe, we can look to other options for relief that are not dependent on medications.

Relaxation exercises. It is not uncommon for patients to be under emotional and physical distress while grappling with past regrets and the uncertainty of the future. However, the beauty of CBT consists of focusing solely on thoughts, emotions and behaviours that are experienced in the present moment (Gibson, 2012). Most of the patients I met lacked coping strategies to help with their symptoms of pain, anxiety, and sleep disturbance. Thus, I would offer my services for mindfulness and meditation exercises. I believe my services offered a way for patients to escape the reality of their situation and spend some time befriending stillness, serenity, and tranquility.

Chapter 5: Challenges

Within my practicum, I developed personally and professionally from the challenges I encountered. Listed below are three notable challenges I faced within my practicum placement.

My first challenge reflected my experience in Mental Health and Addictions Services. Mental Health and Addictions Services is where I have spent most of my career and, therefore, it is where I have been professionally trained. However, my practicum was situated in two areas that focus specifically on physical rather than mental health. This was a challenge for me as I would want to implement mental health resources at times when it might not be appropriate. An example of this is on the PCU. Grief can mimic depression. As Gibson (2012) states, cognitive disturbances, loss of hope, negative emotions, low participation in recreational activities, sleepless nights, and little food intake are symptoms of both grief and depression. Due to these similarities, I needed to be able to decipher between the two and decide whether intensive therapy was appropriate for an individual who had only weeks to live. Thus, continual reflection on the patient's goals of care is needed in order to guide the type of support to be provided.

The second challenge centered on my ability to balance my time between the intensive care and palliative care units. At first, I would try to plan my time by flipping every 2-3 days between units. This became an issue, however, because I was struggling to grasp the social worker's role on either unit due to a lack of consistency. As a result, I moved to switching weekly between units but then struggled with maintaining rapport with patients and their families on both floors. I then decided I would spend my time where a planned therapeutic event, conversation, or meeting was going to occur. Thus, I would choose to start my morning off on one unit and receive updates from my professional associates throughout the day if a unique learning opportunity presented itself on their floor. I would then make the decision whether to

join them on their floor or to stay on the floor I was currently on. I also started to develop a case load where I would follow certain patients and their families on the ICU and PCU. Ultimately, this balancing act between both units took time to master. Nevertheless, I feel very fortunate to have been given a field placement that was situated in two very different death, dying, and grief environments.

The last challenge pertains to my work ethic. In my previous position at the Dubé Centre, my pace had to be quick and efficient in order to keep up with the demands of the job. This led me to be very task-oriented, which works well on hospital floors with a fast turnover of patients but not on the ICU and PCU because their patients may be medically unstable for a longer period of time. Therefore, both of my professional associates explained to me that completing a task on their floors may take a week, depending where the patient and family are at physically and mentally. One of my professional associates told me that sometimes as social workers we are meant to “dip our toe in.” By this, she meant we may begin our rapport with the patient and their family by introducing ourselves and then come back at a later date to complete our clinical tasks. She also mentioned that for some patients and families “we plant seeds” of recommendations by letting them sit with it and then see if the idea we planted grows.

Overall, these units were a reminder that no matter how busy my caseload may have been, I needed to slow down and recognize that completing the tasks isn't the important part. What is the important part is mimicking the pace of the patients and families and accepting that it is okay not to have all the work on the desk complete at the end of a shift.

Chapter 6: Ethics

Reflecting on the social work *Code of Ethics* (CASW, 2005) has become a common practice in every position I have worked in so far in my career. My field practicum placement as a medical social work student was not an exception to this rule. I was faced with many ethical dilemmas during my practicum to reflect on with my professional associates. Overall, these discussions were enjoyable as it helped me to choose acceptable paths amongst grey and cloudy situations.

In this practicum I learned the importance of not only upholding our professional ethics for the living but also for the dying. In many instances, I was faced with ethical concerns around end-of-life decisions. Some examples include the substitute decision-maker misusing their role, concerns with advance health care directive and capacity, and family members never receiving an explanation for why they were making treatment decisions. In these situations, multiple values from the social work Code of Ethics were utilized. These include the inherent dignity and worth of persons, pursuit of social justice, and integrity in professional practice (CASW, 2005). In situations where there were more ethical complications, I could turn to the Mission Office where the Saskatchewan Health Authority's notary public and ethicist reside. These individuals were undoubtedly helpful during my practicum and I appreciated their availability and openness.

Another situation that arose involved the patients' and families' dissatisfaction with the care they received in rural areas or within Saskatchewan hospitals. In these scenarios, I wanted to hear their concerns but to also maintain a professional courtesy to the health care professionals that cared for them. As a medical social worker, it is difficult to be in these situations because you understand the socioeconomic pressures on the health care system of a growing population but also value the Code of Ethics core values of the pursuit of social justice, service to humanity,

and competence in professional practice (CASW, 2005). Therefore, in my practicum I offered the patient/family the SHA client representative's office number and also recommended them to speak to their MLAs because change can only occur if we express to those in power where the gaps in service are experienced.

A pivotal understanding I took away from this practicum was the patient's right to die in the way they would like, and for health care professionals to honour their wishes without letting their own values, opinions, and beliefs impede. As the CASW (2005) mentions, social workers believe in self-determination as long as competency is not a concern and rights of others are protected. To me, this includes choosing medical assistance in dying, which is commonly known as a controversial topic within Canada. As for the families, they may not always agree on the care plan and/or end-of-life decisions that their loved one has decided upon. Thus, the patient also has the right to keep parts of their care plan confidential from family and friends if they so choose and we as social workers must respect this right and abide by it so long as there is no foreseeable risk of harm to the patient (CASW, 2005). While these ethical situations may not always be easy to navigate, the Code of Ethics, clinical supervisors, and ethicists are there to support us in making respectful and honourable decisions for the people we tirelessly strive to provide quality care to.

Chapter 7: Conclusion

To conclude, this report highlights the personal and professional experiences I encountered when supporting grieving patients and their families on the Intensive Care Unit (ICU) and Palliative Care Unit (PCU) at St. Paul's Hospital. I developed deeper insight into the experience of death and dying and learned how to decipher anticipatory and complicated grief. I utilized a feminist lens to support grieving patients and their families alongside the therapeutic approaches of narrative and cognitive-behavioural therapy. I learned that, as medical social workers, we should assess a patient's proxy and end-of-life care decisions, the patient's and family's emotional health and spirituality, the patient's and family's understanding of the illness, and lastly, the patient's housing and financial status in order to provide an effective quality of care. In addition, I was able to achieve the learning objectives, goals, and activities originally established, and encountered professional growth through many challenges and ethical dilemmas throughout this practicum.

Overall, I was privileged to discover a new area of interest that left me fully engaged with curiosity and excitement as I think about where my social work career path will lead. I feel very fortunate to have met many brave and resilient people who have inspired me to tackle the stigma of fear that our society places on death and dying. We, as social workers, should encourage end-of-life conversations with our family, friends, staff members, and patients in order to be prepared for a significant experience to which none of us are immune. We should also advocate for more programs that support families who are struggling in their grief. This experience has encouraged me to fully embrace and prioritize my loved ones while remembering the astonishing individuals who touched my life prior to their deaths. On this note, I end with honouring and thanking my aunty for pointing me towards this spiritual message:

Dragonflies are the keepers of dreams, the energy within that sees all of our true potential and ability. Dragonflies inspire spirituality and creativity, they help us on the path of discovery and enlightenment. They remind us that anything is possible (as cited in Dettmer, 2018, para. 4).

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Appendix A
Social Work
Initial Assessment Guide

Date	Time	Printed Name
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Reason for Referral**Information Source** (Chart review, patient, other)**Reason for Admission to Intensive Care Unit****Demographic Data** (Name, age, single/married/widowed/common-law, children, Identified gender, hometown, education, diagnosis/PMHx, admission to unit)**Documentation** (Enduring/non-enduring POA and SDM/AHCD)**Housing/Living Arrangement****Finances/Work History** (Including medical insurance)**Spirituality** (Beliefs, Values, Purpose, Connection, Religion, Culture)**Patient/Family's Understanding of Illness/Prognosis****Patient/Family's Emotional Health** (psychosocial morbidities, grief, coping skills and support system, MHAS resources)**Other** (pertinent information)**Safety Concerns** (Risk for abuse/neglect, Involvement of CPS, SI/SI attempt, Care Needs-ADLS & iADLS, Capacity/Cognitive screening)**Patient/Family's Goals of Care****Intervention****Plan****Signature, Credentials/Registration, Phone/Pager #**