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Abstract

This 450-hour advanced practicum took place with the Supportive Care Program (SCP) at the Northeast Cancer Centre (NECC) in Sudbury, ON. The social workers of the SCP provide emotional and practical support to individuals with a cancer diagnosis and their families. My learning focused on knowledge acquisition; improving direct practice skills; self-reflection; and was inspired by the question: how can I support cancer patients on an individual level, as well as, a systemic level? A generalist-eclectic approach was used during one-on-one counselling sessions in order to address the complex and varying needs of the cancer patients seeking services. Due to the COVID-19 pandemic, the majority of these sessions occurred via telephone or videoconference in order to adhere to social distancing guidelines and reduce the rate of transmission. In addition, a literature review was conducted exploring the impacts of systematic concerns within the Canadian healthcare system, as well as, the principles required to practice cultural humility and person-centred care. Social workers have a crucial role within oncology settings by supporting patients and encouraging the treatment of the patient as a whole in order to improve overall quality of life. The development of assertiveness skills are necessary to effectively advocate for patients, families, structural change, and the expertise of the social work profession. Social workers must also have an understanding of the historical systemic concerns present within our healthcare institutions informed by the core concepts of cultural humility.

Résumé

Ce stage avancé de 450 heures a eu lieu dans le cadre du programme de soins de soutien (SCP) du Northeast Cancer Centre (NECC) à Sudbury, en Ontario. Les travailleurs sociaux du SCP offrent un soutien émotionnel et pratique aux personnes ayant reçu un diagnostic de cancer et à leur famille. Mon apprentissage s'est concentré sur l'acquisition de connaissances, l'amélioration des compétences en pratique directe et l'autoréflexion. Il a été inspiré par la question suivante : comment puis-je soutenir les patients atteints de cancer au niveau individuel et au niveau systémique ? Une approche généraliste-éclectique a été utilisée lors des séances de conseil individuelles afin de répondre aux besoins complexes et variés des patients atteints de cancer qui recherchent des services. En raison de la pandémie de COVID-19, la majorité de ces séances se sont déroulées par téléphone ou par vidéoconférence afin d'adhérer aux directives de distanciation sociale et de réduire le taux de transmission. De plus, une revue de la littérature a été effectuée pour explorer les impacts des préoccupations systémiques au sein du système de santé canadien, ainsi que les principes requis pour pratiquer l'humilité culturelle et les soins centrés sur la personne. Les travailleurs sociaux jouent un rôle crucial dans les milieux oncologiques en soutenant les patients et en encourageant le traitement du patient dans son ensemble afin d'améliorer la qualité de vie globale. Le développement de compétences d'affirmation de soi est nécessaire pour défendre efficacement les patients, les familles, les changements structurels et l'expertise de la profession de travailleur social. Les travailleurs sociaux doivent également comprendre les préoccupations systémiques historiques présentes dans nos institutions de soins de santé, en s'appuyant sur les concepts fondamentaux de l'humilité culturelle.

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Chapter 1 – Introduction

According to Cancer Care Ontario (2018), nearly 1 out of every 2 Ontarians will develop cancer in their lifetime. While incident rates of cancer are increasing so are the survival rates resulting in an overall increase in the amount of people living with cancer (Cancer Care Ontario, 2018). Receiving a cancer diagnosis can have a profound effect on an individual with up to 75% of people experiencing significant distress (Galway et al., 2012; Hoeck, 2017). Common psychological challenges experienced by cancer patients include somatization, anxiety, depression, adjustment disorders, anger, feelings of loss, and disturbances in body image which may lead to low self-esteem, poor self-concept, and sexual dysfunction (Daem et al., 2019; Hoon et al., 2013; Van Halteren et al., 2004). These psychological challenges tend to intensify during transition points throughout the cancer trajectory such as when receiving the initial diagnosis, beginning their treatment regime, continuing into survivorship, or the advancement of the disease (Nekolaichuk et al., 2013). In addition, social and economic factors can compound these concerns, such as, the loss of employment, health care related costs, and changing role expectations within the family unit (Daem et al., 2019).

Since the early 1980s psychosocial care and counselling services has been present in oncology programs (Nekolaichuk et al. 2013). Research indicates a strong link between psychosocial interventions and positive impacts on patients' quality of life by assisting with mood regulation, improving coping ability, relieving psychological distress, as well as, reducing anxiety and depression levels (Daem et al., 2019; Hoon et al., 2013; Nekolaichuk et al., 2013). As patients rely heavily on their support system, psychological distress frequently impacts significant others and family units. Studies indicate that psychosocial interventions can also be beneficial to the partners and families of the cancer patient (Hoeck et al., 2017). A study by

Nekolaichuk et al. (2013) indicated that some patients reported receiving benefits from attending a single session as they were able to express their emotions and no longer felt alone in their experience.

In this thesis report, I describe my 450-hour advanced practicum that took place at the Northeast Cancer Centre (NECC), and I reflect on the role of the social worker in an oncology outpatient setting. In this Chapter, I provide the rationale for the practicum, describe the learning goals, and outline the strengths and challenges of implementing different theoretical frameworks when working with an adult cancer population. Chapter 2 consists of a review of the literature describing systemic concerns within the Canadian healthcare system while Chapter 3 summarizes the completion of the learning goals and includes a reflection of the practicum experience Chapter 4 describes a personal self-reflection, my future goals for professional development, and implications for the social work profession.

Rationale for the Advanced Practicum

As I have a bachelor of psychology degree and a social service worker diploma, I had to complete a qualifying year which involved attending some fourth-year level bachelor of social work classes and completing a placement before I was able to pursue my master of social work degree. My qualifying year placement took place on an inpatient unit. This was my first experience working in a medical institution as my previous work experience primarily involved community-based programs that centered around poverty, addictions, and homelessness. While there are numerous compassionate individuals who work in the healthcare industry, I was shocked by the oppressive environment that placed physicians at the top of the hierarchy followed by nurses, allied health professionals, and at the very bottom, patients and their families. I also witnessed instances throughout the hospital of staff openly mocking patients;

judgments made regarding a person's culture or race, and poor patient care. These experiences made me want to continue exploring the systemic concerns of hospital institutions and be a positive agent for change. My field supervisor at the time was aware of my desire to further my education and made arrangements for me to shadow the graduate level social workers who worked with the Supportive Care Program (SCP) at the NECC.

During my brief experience with the SCP, I became interested in the complex psychosocial needs of individuals diagnosed with cancer and how to support these individuals throughout different cancer trajectories. While there is no history of cancer in my family there have been other life changing health concerns, such as strokes which resulted in permanent personality changes and left-sided paralysis. Based on my personal experiences, I see the value in helping patients and their families by providing support, psychosocial services, and guidance when navigating the healthcare system. The advanced practicum was inspired by the question: how can I support cancer patients on an individual level as well as a systemic level?

After Jillian Romanko, social worker with the SCP, accepted my request to provide field supervision for my advanced practicum, the clinic manager offered me a temporary casual position. The offer involved working two days a week performing case manager type duties. It was clear that my role would be strictly assisting patients with practical concerns such as assisting with income replacement applications, providing information about local resources, and helping with travel arrangements as I did not possess the graduate level credentials needed by the SCP to provide psychosocial interventions. Patients who required additional support aside from practical concerns would be referred to one of the three social workers available. I agreed to this opportunity as it allowed additional time to be fully immersed within the hospital environment and supplemented my advanced practicum learning by increasing my awareness of the practical

concerns and barriers that cancer patients experience in addition to the physical and emotional challenges.

Initial Training

As I am an employee of the NECC, the mandatory training modules were completed prior to my practicum and I have received training sessions on the NECC and Health Sciences North electronic patient charting systems, Mosaiq and Meditech. The mandatory training modules included Health and Safety Awareness in 4 Steps; Accessibility for Ontarians with Disabilities (AODA); Hazard, Incident, and Accident Reporting; Four Moments of Hand Hygiene; the Workplace Hazardous Materials Information System (WHMIS); and Workplace Violence and Harassment Prevention. My police background check and social service worker registration with the Ontario College of Social Workers and Social Service Workers (OCSWSSW) has remained in good standing.

Practicum Learning Goals

By the end of my practicum, I met the objectives necessary to accomplish the five primary learning goals that were identified at the onset of the practicum. The goals were selected in order to focus on skill acquisition, as well as, facilitated deeper understanding and comprehension. I tried to incorporate different areas of oncology social work to encourage a well-rounded and holistic practicum experience. My learning goals were:

- 1) To improve my direct practice skills in order to implement effective psychosocial interventions and support individuals managing acute and chronic health concerns. In order to obtain this goal, I focused on gaining additional knowledge regarding theoretical frameworks, specifically cognitive behaviour theory, dialectical behaviour therapy, mindfulness, meaning making, strengths perspective, existentialism, as well

as embodiment theory and how to appropriately apply these interventions when working with cancer patients.

- 2) To increase my knowledge of the cancer trajectory and understand common cancer treatment procedures, side effects, as well as, become familiar with medical terms and jargon. This would allow me to comprehend information being provided by medical staff and patients and is an essential requirement to maintain competency as an oncology social worker.
- 3) To become proficient in providing support to patients through telephone and video conferencing. This was heavily influenced by the COVID-19 pandemic and the sudden reliance on remote counselling services. When conversing with an individual over the telephone, nonverbal cues are no longer available. I felt that I started this practicum as a strong individual with many skills and I wanted to ensure that these assets were transferable when not interacting with a patient face-to-face.
- 4) To increase my advocacy skills in order to communicate patient needs to professionals within the NECC, as well as, with community-based services.
- 5) To develop my self-reflexivity skills to improve my social work competency. Daily journaling and reflective questions posed during supervision were used to facilitate this process.

In addition, the SCP staff requested that during times when a patient was unavailable or too ill to attend their appointment that I begin preliminary work on a PowerPoint for a virtual class intended for patients experiencing unwanted cancer related physical changes.

Theories in Practice

In order to address the complex and varying needs of the cancer patients seeking services a generalist-eclectic approach was used. Elements of the generalist-eclectic approach include: utilizing a person-in-environment perspective; developing a helping relationship that fosters empowerment; problem solving processes; a holistic perspective that includes a patient's strengths, and the flexibility to utilize a wide range of theories dependent the patient's situation (Coady & Lehmann, 2016). The following section describes the primary frameworks used, as well as, the strengths and challenges of utilizing these approaches with adults within an oncology context. I decided to review the foundation of these frameworks prior to the start of my practicum in order to take advantage of the counselling opportunities available and get the most out of the practicum experience. These frameworks were selected after discussions with my field supervisor and advanced practicum thesis readers in order to focus on frameworks and interventions commonly used at the SCP, as well as, to ensure an in-depth learning experience. While I was somewhat familiar with most of these theories prior to my practicum, I never applied these theories to patients experiencing medical concerns or receiving active treatment and had very little pre-existing knowledge about existential and embodiment theories. How I was able to expand and apply these frameworks during my practicum experience will be described in Chapter 3.

Cognitive Behaviour Theory

Cognitive behaviour theory (CBT) is the result of a merger of two pre-existing theories, cognitive theory and behavioural theory. Cognitive theory utilizes an ABC model to describe how thinking patterns impact human functioning (Cobb, 2016). "A" is the antecedent which is the event/stimulus that triggers the individual's belief represented by the letter B (Cobb, 2016). Beliefs are learned patterns of thinking that impact the way we process information and provide

the lens in which we perceive the world (Cobb, 2016). This is followed by “C”, the individuals cognitive, emotional, or behavioural response (Cobb, 2016). Individuals who have learned and adapted an irrational and/or dysfunctional belief system about themselves, their environment, or future outcomes can struggle with interpersonal relationships, mood regulation, and low self-esteem (Cobb, 2016).

Behavioural theory includes three general paradigms that relate to the behavioural learning process: classical conditioning, operant conditioning, and modeling (Cobb, 2016).

Classical conditioning occurs when a neutral stimulus (ringing a bell) is frequently paired with a naturally occurring event (a dog salivating at the presence of food) until an association is learned where the once neutral stimulus can trigger an innate behaviour without the naturally occurring event (dog salivates at the sound of the ringing bell without the presence of food) (Cobb, 2016).

Operant conditioning, on the other hand, occurs when the frequency, duration, and/or intensity of a behaviour can be increased or decreased depending on the response the behaviour triggers.

Responses that the subject considers positive will increase the behaviour and responses that the subject considers negative with decrease behaviour. The more closely the response follows the behaviour increases the likelihood an association will form (Cobb, 2016). Modeling, also known as, vicarious learning involves memory and occurs when an individual observes, reads, or hears about another individual’s behaviour and the response it evoked then repeats this behaviour after some time has passed (Cobb, 2016). Modeling indicates that individuals can learn from the experiences of others, as well as, their own experiences.

In CBT, the participant is actively involved in the learning process to identify and address irrational/dysfunctional thoughts and behaviour patterns that are counterproductive to their lives (Cobb, 2016). Common interventions that incorporate cognitive behaviour theory that I

observed during advanced practicum included behavioural activation (helping patients identify pleasurable activities or events and encouraging them to engage in these activities in order to increase instances of positive reinforcers and offset punishers), and cognitive restructuring (Cobb, 2016). Regardless of the prognosis, simply hearing the word “cancer” caused distress for some individuals. Some imagined that their situation will be similar to a loved one they saw die of cancer decades ago in pain or mirror situations they have viewed in television shows, however, there are many factors that impact prognosis. The location of the cancer, how much the cancer has progressed before it was diagnosed, and the general health of the individual are all important factors. In addition, even if the cancer diagnosis is similar to their deceased loved one, treatment options continue to advance with research so it is important to review and reiterate the patient’s understanding of their prognosis and determine if it accurately reflects the oncologist’s chart notes. If not, the patient may require further education or an additional consult with their oncologist. Pain management strategies have also improved and there is a Palliative Symptom Management team available at the NECC that can provide additional support and services to those in need. Helping patients restructure their unhelpful thoughts surrounding cancer into a more constructive and realistic version tended to help patients cope with the reality. Some other individuals I met felt physically healthy and their forms of cancer were detected from routine screening procedures (ex. Pap test, mammogram, colonoscopy), yet they began to spend excessive amounts of time in bed and withdrew from loved ones, as well as, enjoyable activities due to feelings of depression and/or anxiety. These behaviours tended to compound their feelings of depressing/anxiety as they were no longer experiencing positive reinforcers. With encouragement and starting with achievable goals, patients could begin re-engaging with their life by re-introducing aspects that they found meaningful and enjoyable.

A literature review conducted by Hoon et al. (2013) indicated that CBT was the second most common psychosocial intervention used with cancer patients following psychosocial educational interventions. Considering the high lifetime prevalence of depression and anxiety disorders in the general population many individuals diagnosed with cancer may have pre-existing psychosocial challenges that are exacerbated by the concerns and demands that follow treatment and their predicted prognosis (Greer et al., 2010). However, other individuals may not have a pre-existing psychosocial condition but struggle with adjusting to the sudden changes and fears that coincide with a cancer diagnosis (Greer et al., 2010).

Although CBT is considered an effective intervention for anxiety disorders in the general population, traditional CBT techniques, such as restructuring negative thoughts, might be inadequate or inappropriate for cancer patients (Greer et al., 2010). The premise of CBT assumes that individuals overemphasize the likelihood of negative outcomes which results in avoidant and maladaptive behaviours. However, many cancer patients experience realistic fears of death, severe pain, and physical impairment (Greer et al., 2010). Fortunately, CBT techniques can be adapted to better fill the needs of individuals with cancer.

The implementation of CBT in an oncology setting should begin with explaining to the patient the rationale that informs CBT interventions. For example, if a patient is experiencing heightened anxiety, the clinician would explain how anxiety and other symptoms (i.e., shortness of breath) influence one another creating a negative cycle (Greer et al., 2010). The goal of CBT is to break this cycle by using cognitive and behavioural interventions to encourage positive coping strategies (Greer et al., 2010).

Next, the clinician helps the patient identify if their concern is an unrealistic worry, a realistic worry, or if it is unclear if the concern is realistic or not (Greer et al., 2010). Standard

CBT techniques, such as restructuring can be used if the concern is unrealistic (Greer et al., 2010). If the patient and the clinician are unable to determine if the concern is realistic or not then more information is required through credible sources, such as consulting with the medical care team or the patient's oncologist (Greer et al., 2010).

Realistic concerns can be addressed by taking action and using problem solving skills where appropriate (Greer et al., 2010). If no further action can take place the focus shifts to acceptance and distress tolerance-based interventions such as mindfulness and self-soothing behaviours (Greer et al., 2010). The use of CBT interventions has been shown to increase and maintain a patient's quality of life (Hoon et al., 2013).

Dialectical Behaviour Therapy

Dialectical behaviour therapy (DBT) is one of several psychotherapies that are considered part of the third wave of cognitive behavioural therapies (Mohabbat-Bahar et al., 2015). Originally developed as an intervention for chronically suicidal individuals, DBT evolved to treat multi-disordered individuals with borderline personality disorder (Dimeff & Linehan, 2001).

DBT applies a dialectical biopsychosocial approach for borderline personality disorders (BPD) that theorizes that these individuals are biologically more emotionally vulnerable (heightened sensitivity and reactivity) and grew up in an invalidating environment (punishing, ignoring, minimizing) (Lynch et al., 2006). The push from clinicians to change harmful behaviours was believed to be interpreted by individuals with BPD as another example of an invalidating environment and many individuals would stop attending therapy sessions (Lynch et al., 2006). As a result, both acceptance and change-based strategies were integrated during therapy sessions (Lynch et al., 2006). Acceptance in DBT refers to mindfulness techniques while

the change component involves behavioural analysis, skill training, cognitive restructuring, problem-solving techniques, and exposure-based strategies (Dimeff & Linehan, 2001). DBT has since been applied to several populations with behavioural disorders involving emotional dysregulation (Dimeff & Linehan, 2001).

Although there appears to be minimal literature regarding the application of DBT with cancer patients, women with breast cancer who participated in a study by Cogwell Anderson et al. (2013) reported that the skills they learned through DBT increased their ability to cope with diagnosis and treatment related stressors, lead to a greater ability to identify stress triggers, and an increased recognition of their ability to cope with emotional stressors. Another study involving women with breast cancer indicated that DBT was effective in reducing distress of the participants (Faraji, 2015).

While these studies with women who have breast cancer show promising results, additional research is required in order to confirm the effectiveness of DBT with men and individuals with different types of cancers.

Mindfulness

Mindfulness-based therapies are influenced by the Buddhist concept of mindfulness which is described as the ability for an individual to be intentionally aware of their present experience and address their thoughts, feeling, sensations, etc. in a non-judgmental manner (Zhang et al., 2015). Individuals are encouraged to shift their perspective away from perceiving unhelpful thoughts as distressing and instead acknowledge these thoughts as part of a process (Zimmermann et al., 2018). This process allows individuals to detach from their unhelpful thoughts and emotions while increasing emotional balance and decreasing distress (Xunlin et al.,

2020). Mindfulness interventions promote acceptance, letting go, and openness to current experiences (Xunlin et al., 2020).

The mindfulness interventions that are the most frequently used with cancer patients are Mindfulness-Based Stress Reduction (MBSR), Mindfulness-Based Stress Reduction for Breast Cancer (MBSR-BC), Mindfulness-Based Care Recovery (MBCR), Mindfulness-Based Cognitive Therapy (MBCT), Mindfulness-Based Art Therapy (MBAT), and Acceptance and Commitment Therapy (ACT) (Xunlin et al., 2020). MBSR and MBCT primarily focus on mindful breathing, body scans, and other forms of mindfulness meditation (Xunlin et al., 2020). MBSR-BC adds an educational component to the mindfulness interventions while MBAT makes use of art therapy techniques to convey emotions (Xunlin et al., 2020). MBCR includes reflective exercises and ACT focuses on the acceptance of the diagnosis and identifying the patient's values in order to enrich their lives (Xunlin et al., 2020).

Many advanced cancer patients fluctuate from ruminating about regrets from the past and anxiety about the future while others exhibit avoidant behaviours (Zimmermann et al., 2018). Unfortunately, denial does not alter the reality of the diagnosis and the untreated anxiety may result in poor treatment adherence (Oberoi et al., 2020). Alternatively, focusing on the "here-and-now" allows cancer patients to refrain from developing expectations and better cope with their situation (Zimmermann et al., 2018). This should not be confused with pessimistic attitudes or resignation (Zimmermann et al., 2018).

The nonjudgmental awareness of negative thoughts decreases rumination which has a positive effect on psychological health (Xunlin et al., 2020). Mindfulness interventions have been shown to decrease anxiety, depression, emotional distress, fatigue, and stress levels while simultaneously increasing quality of life, self-compassion, and overall mood of patients across

different cancer types (Oberoi et al., 2020; Xunlin et al., 2020; Zimmermann et al., 2018).

MBAT had the largest effect on anxiety and depression followed by MBSR and MBCR (Xunlin et al., 2020).

Two separate systematic reviews conducted by Tate et al. (2018) and Xunlin et al. (2020) concluded that the majority of the studies involving mindfulness interventions focused predominantly on women with breast cancer. Further research is required in order to determine if mindfulness interventions are effective for men, children, and for individuals with other types of cancer (Tate et al., 2018; Xunlin et al., 2020). In addition, some patients found that rumination increased during mindfulness exercises or, alternatively, some patients found that they were unable to remain focused due to fatigue and physical discomfort (Tate et al., 2018).

Meaning Making

Meaning Making interventions (MMi) involve a combination of cognitive and narrative techniques resulting in an exploration of the individual's belief systems and sense of self in order to find purpose in life even amongst suffering (Boerger-Knowles & Ridley, 2014). MMi is an individualized brief therapy that typically involves 1-4 sessions (Henry et al., 2010). The three main tasks of MMi can be summarized as: review the meaning of the cancer diagnosis to the patient, examine significant events from the past and identify successful coping strategies, and discuss the individual's goals and priorities that provide meaning to their life (Henry et al., 2010). It is crucial that the clinician begins with the narrative process and allows the patient sufficient time to tell their story and share their suffering before moving on to cognitive-based strategies (Boerger-Knowles & Ridley, 2014). This process allows the patient to reflect on their past, present and future and identify meaningful aspects of their life, and not to dismiss the realities of their diagnosis (Boerger-Knowles & Ridley, 2014).

Existential issues can arise when individuals are faced with their own mortality and can manifest as feelings of powerlessness, disappointment, remorse, and death anxiety (Lee et al., 2006). Existential issues can occur at any time during the cancer trajectory and may include concerns regarding relationships, control, grief, and identity (Boerger-Knowles & Ridley, 2014). MMi has been identified as one way to address existential concerns (Lee et al., 2006). In addition, MMi has been used with cancer patients as an effective approach to decrease depression, hopelessness and anxiety; increase self-esteem; and improve quality of life (Boerger-Knowles & Ridley, 2014).

Sherman et al. (2010) cautioned that a long drawn-out preoccupation with searching for meaning may not lead to an improved quality of life for cancer patients once they have moved beyond early diagnosis and treatment and have entered a period of stable survivorship. A fixation on searching for meaning in illness during the survivorship stage may be counterproductive and lead to rumination and increased distress (Sherman et al., 2010). Patients who lack perceived purpose in other areas of their life are more likely to struggle with finding event-related meaning when experiencing a serious illness, such as cancer (Sherman et al., 2010).

Strengths Perspective

In the research, variations of the terms strengths-based approach and strengths perspective appear to be used interchangeably. For clarity and consistency, strengths perspective will be the term used throughout this paper.

Since the 1960s there has been an interest in examining factors that promote resiliency in individuals who experience adverse events (Maton et al., 2004). Emmy Werner's research exploring resiliency among youth native to Kauai, Hawaii is credited as being foundational to the strengths perspective (Maton et al., 2004; Saleebey, 2001). A dissatisfaction with the current

deficit-based perspective in the 1980's resulted in Dennis Saleebey and a team of scholars from Welfare College of Kansas University exploring and promoting a strengths-based model of case management (Min, 2011).

In direct contrast to the deficit perspective, the strengths perspective avoids pathologizing the client in favor of a more empowering approach through its basic principles. Saleebey (2008) outlines the first basic principle of the strengths perspective as:

First, everyone – every child, every individual, every family, every group, every community and, yes, every teacher and school – has assets, resources, and capacities.

There are no exceptions to be made here. Even in the most downtrodden, or most angry, or most defeated of us, there are strengths to be found and nurtured. In this regard, it is also important to understand that everyone has a basic faculty for health and self-righting.
(p. 69)

Helping an individual recognize and build on their existing strengths is a crucial role for the clinician to uphold. The second concept is the belief that every individual knows on some level what is good for them (Saleebey, 2008). This client-centered belief disputes the deficit perspective's approach that the client is in need of "fixing" by the clinician; therefore, creating an oppressive, dependent environment (Maton et al., 2004). The third concept emphasizes that simply believing in an individual, especially once rapport has been built, can be a strong catalyst for change (Saleebey, 2008). For the fourth concept a clinician must be open to the potential growth and development of an individual, as well as, themselves (Saleebey, 2008). The placement of arbitrary limits only prevents individuals from reaching their full potential.

When used correctly, the basic principles of the strengths perspective correspond with the Canadian Association of Social Workers' core values and principles. Specifically, respecting the

dignity and inherent worth of the persons, as well as, service to humanity (Canadian Association of Social Workers, n.d.). It is essential that the social worker's core values and principles are not only understood on a theoretical level but are reflected in a clinician's practice.

The strengths perspective has a history of focusing on the individual instead of family, community, and environmental systems and dismissing how macrosystems can directly impact the individual (Maton et al., 2004). Critiques of the strengths perspective assert that by focusing on the strengths of the individual, the approach dismisses the problem(s) that are being experienced by the patient; therefore, rendering the approach ineffective (Saleebey, 1996).

While awareness of the depersonalized and deficit-based aspects of the medical model continues to increase, attempts to restructure and ameliorate the health care system has fallen short (Gottlieb & Gottlieb, 2017). Isolation from care partners and loved ones may add to the potential risk of oppression as, depending on the number of active COVID-19 cases, visitors may be restricted at the NECC; therefore, utilizing a strength perspective to facilitate resilience, hope, empowerment, and self-determination was essential in this practicum setting.

Existentialism

Existential theory has its foundation rooted in the existential philosophical approach of Søren Kierkegaard, a Dutch philosopher who encouraged individuals to seek individualized pathways to the divine and argued against religious conformity (Randal, 2016). While there are many contributors to existential theory, the collective works of Irvin Yalom, Rollo May, and James Bugental are credited with the shaping of existential theory (Randal, 2016). According to Yalom (1980) there are four ultimate concerns of human existence: death, isolation, meaninglessness, and loss of freedom. The work of therapy is to help individuals come to terms with these concepts.

Individuals struggle with the conflict that arises between the unavoidable nature of death and the individual's desire to continue living (Randal, 2016). When an individual is faced with their own mortality, which can occur when receiving a cancer diagnosis, they may experience death anxiety as a result. Death anxiety can be broken down into several specific fears that tend to fall into three categories: what comes after death (Who will care for my children?), the event of dying (Will it be painful? Will I suffer?), and ceasing to be (I will no longer have any new experiences) (Yalom, 1980). Exploring the source of a cancer patient's death anxiety may allow the opportunity to address some of these concerns such as, making arrangements for childcare or having a discussion with the palliative care team regarding pain management options.

Existential theory acknowledges that an individual cannot fully express their innermost thoughts and feelings; therefore, they can never be fully understood by another person resulting in an inability to escape the feeling of isolation (Randal, 2016). A goal of existential therapy is to foster the relationship within oneself as it is the only relationship that is guaranteed to be lifelong (Randal, 2016). This is not to say that other relationships are not beneficial and enhance lived experiences, however, all other relationships are finite and time limited, therefore, the relationship with the self should be prioritized and not be sacrificed for significant others (Randal, 2016).

An individual's feeling of meaninglessness can be addressed by engaging in aspects beyond themselves, for example, purposeful engagements with other individuals, causes that hold significance to the individual, and creation through the arts (Randal, 2016). What gives purpose and meaning to one's life is subjective to the individual and their life goals. Existential theory describes the duality of freedom as it acknowledges the enormous amount of possibilities

an individual could choose and being immobilized by the overwhelming nature of making those choices (Randal, 2016).

Criticisms of existential theory identify the lack of empirical support as much of the evidence that supports existential theory is anecdotal in nature (Randal, 2016). Existential theory is heavily influenced by the individualistic nature of Western culture; therefore, clinicians must make adjustments for individuals who have cultures that value the needs of the social group, such as family or community, above the needs of the individual (Randal, 2016).

Embodiment Theory

In recent years, traditional cognitive science has faced criticism regarding the lack of emphasis on the connection between the mind, body, and environment (Chrisley & Ziemke, 2006). Previously, Western views of cognition followed a dualistic perspective which regarded the mind as a separate and independent entity (Chrisley & Ziemke, 2006). Behaviouralism rejected dualism yet did not address concepts such as cognition and consciousness, however, this dismissal permitted the exploration of what would later be referred to as the embodied mind (Chrisley & Ziemke, 2006). Embodiment theory has influenced several fields including psychology, neurobiology, linguistics, robotics, and philosophy (Rohrer, 2007).

One of the fundamental concepts of embodied cognition is that the mind, body, and the environment are interrelated and mutually dependent (Schaaf et al., 2019). The sensorimotor process is one of the factors that informs cognition along with the body within the physical and cultural environment (Chrisley & Ziemke, 2006; Schaaf et al., 2019). Phenomenology is another concept within embodiment theory that draws distinction between an individual's "lived body" and their "corporeal body". The lived body is the subjective first-person experience of the individual within their body whereas the corporeal body is the objective biological body that is

present in the world and tends to be the focus of medicine (Carel, 2007). During periods of good health, the two “bodies” are aligned and in harmony and the functioning of the healthy corporeal body is not the focus of attention (Carel, 2011). When faced with health concerns, the functioning of the corporeal body is brought to the forefront of the mind and the sense of harmony is disrupted (Carel, 2011). Where an individual once had confidence in the ability of their body to complete tasks easily and pain free is now replaced with feelings of anxiety and doubt (Fernandez, 2020). Change in physical function or appearance that is different from the “norm” does not occur in isolation but also impacts the individuals lived experience within their environment (Fernandez, 2020). Many people with disabilities or chronic illness report difficulties in maintaining their social life as participating in activities such as work or certain social outings are no longer possible causing them to withdraw (Carel, 2007).

As previously stated, many cancer patients experience body changes; therefore, it is essential to not compartmentalize the individual’s body by focusing solely on the physical functioning and appearance but also include cognitive, environmental, and cultural implications. For example, a study by Parton et al. (2016) explored the impact of changes to women’s bodies from cancer and cancer treatment and the reported psychosocial adjustments that occurred in regard to their experiences of sexuality. These women reported disruptions in their meanings of survivorship, femininity, and heterosexuality, as well as, the sense of their body as being “out of control.”

Embodiment theory argues that since the experience of the body and illness is subjective generalized perspectives are not helpful to patients. Embodiment based interventions would focus on obtaining a better understanding of the individual’s experience of cancer and how it is impacting their lives going beyond the medical diagnosis to improve quality of life (Carel, 2011).

Using strategies such as video work, lived experience diaries, and exploration of what the patient considers meaningful aspects of their life can establish a new relationship between the corporeal body and the lived body although this requires a great deal of adaptability and creativity (Carel, 2007).

These theoretical frameworks, while different in nature, are compatible with the Ontario College of Social Workers and Social Service Workers (OCSWSSW) code of ethics. However, ensuring a social worker maintains integrity and verifies that their patients are protected from the abuse of power while receiving services can be challenging to implement within a medical oncology setting due to historical systemic concerns which will be further explored in the next chapter.

Chapter 2 – Literature Review

As my practicum continued, I observed larger systemic factors that were present which conflicted with the Ontario College of Social Workers and Social Service Workers (OCSWSSW) Code of Ethics and Standard of Practice. For example, according to the Code of Ethics and Standard of Practice, social workers are expected to protect patients from the abuse of power; advocate for social change; encourage patient participation and decision making; and not engage in discriminatory behaviour against anyone based on race, culture, gender, sexual orientation, age, political alignment, disability; and socioeconomic status (Ontario College of Social Workers and Social Service Workers, 2018). Unfortunately, these principles were not always upheld. While I had a surface level understanding of these concerns, I was unaware of the prevalence, severity, and long-term effects of experiencing discrimination in a healthcare setting. In order to provide support to the patients of the Northeast Cancer Centre (NECC) and advocate for quality care a social worker must have an understanding of the systemic factors that are present in healthcare institutions. Therefore, in this chapter I will focus on the literature that describes the role of social work in a medical setting; colonization and racism within the Canadian healthcare system; cultural humility; sex differences; and person-centred care.

Social Work in a Medical Setting

In the 1980s, oncology social work was designated as a specialty within medical social work and this field of practice was recognized as supporting positive treatment outcomes (Fobair et al., 2009). In fact, in the 1940s, it became essential to have a social worker on staff in order for a hospital to be accredited (Fobair et al., 2009). While social work in medical settings is not new, there are several areas that can be particularly difficult for a new social worker to navigate such

as conflicting values, role confusion, and power dynamics within a multidisciplinary team. (Heenan & Birrell, 2018).

The dominance of the medical model within healthcare institutions can create challenges as it conflicts with anti-oppressive paradigms resulting in social workers having to develop assertiveness to advocate for their professional values, identity, and expertise (Ambrose-Miller & Ashcroft, 2016). Criticisms of the medical model include that it takes a disease or deficit-based perspective to healthcare while ignoring an individual's strengths and abilities (Fuller, 2017). In addition, the medical model has been described as reductionistic as it has a strong focus on biological components and treating body parts instead of incorporating psychological and social components that are involved in treating the person as whole (Fuller, 2017). This perspective is problematic since, as mentioned in the previous chapter, it is common for cancer patients to experience significant distress and psychological challenges throughout the cancer trajectory. When the medical model is the sole or primary framework within an oncology setting, the focus is on the disease instead of the person being impacted by the disease and the psychosocial challenges they may be experiencing.

The role of a healthcare social worker includes education; counselling; coordinating internal and external resources; and they are frequently the primary contact for patients throughout the healthcare trajectory (Heenan & Birrell, 2018). Unfortunately, non-social work colleagues can lack an understanding of the role of social work within the multidisciplinary team (Heenan & Birrell, 2018). In addition, the majority of hospital staff in managerial positions have a professional background that differs from social work further increasing role confusion (Judd & Sheffield, 2010). Social workers also have an important role in patient advocacy which can create tension between the social worker and their colleagues when advocacy efforts differ from

the multidisciplinary designed care plan. A study by Ambrose-Miller and Ashcroft (2016) interviewed social workers who recognized patient advocacy as a key part of the social work identity, yet they reported colleagues discouraging this role.

Although social workers are credited with providing a unique perspective to patient care, as they utilize a holistic approach to a patient's care needs, multidisciplinary decision making and discussions tend to follow old power hierarchies that are physician focused (Heenan & Birrell, 2018). Social workers in the Ambrose-Miller and Ashcroft (2016) study reported numerous behaviours that I also witnessed during the practicum which discounted the contribution of allied health professionals. Meetings were scheduled around the physician's schedule, the perspectives of medical professions appeared to be held in higher regard and dominated the discussion during decision making, and physicians interrupted and/or talked over colleagues from other professions.

In order to increase collaboration between multidisciplinary teams, education and clarification of the role of social work in a clinical setting is required, as well as, increasing communication and respect among team members (Ambrose-Miller & Ashcroft, 2016).

Colonization and Racism in Canadian Healthcare

The Canadian healthcare system has a long history of racial and colonial violence resulting in discrimination and inadequate/harmful healthcare for Indigenous people, racial minorities, and immigrants (Boyer, 2017; Hassen et al., 2021; Tuyisenge & Goldenberg, 2021). A systematic review of healthcare provider racism found that over two-thirds of the studies showed evidence of racism in the surveyed health care providers with many of the studies indicating that race impacted the healthcare provider's medical decisions for minority groups (Paradies et al., 2014). Paradies et al. (2014) defines racism as:

phenomena that maintain or exacerbate avoidable and unfair inequalities in power, resources or opportunities across racial, ethnic, cultural or religious groups. Racism can be expressed through beliefs (e.g. negative and inaccurate stereotypes), emotions (e.g. fear or hatred) or behaviors/practices (e.g. discrimination or unfair treatment) and can occur at three levels: internalized (incorporating racist beliefs into one's worldview); inter-personal (racist interactions between individuals); and systemic/institutional (racism occurring through policies, practices or processes within organizations/institutions). (p. 364)

Next, I will discuss the impacts of colonization and racism within the Canadian healthcare system, strategies to improve patient experience, and encourage cultural humility.

The effects of the Indian Act of 1876, the placing of Indigenous children in residential schools, the unnecessary apprehension of Indigenous children by the child welfare system, the establishment of reserves, and the loss of land have been profound and long lasting for the Indigenous people of Canada (Horrill et al., 2019; Kitching et al., 2020). These horrific atrocities sanctioned by the Canadian government have resulted in intergenerational trauma which continues to dramatically impact the health and wellbeing of Indigenous individuals, families, and communities today (Horrill et al., 2019; Kitching et al., 2020).

Indigenous people report inequitable access to healthcare services related to socioeconomic factors, the remote location of reserves, and the fear of experiencing racism, harassment, and dismissal from healthcare providers (Horrill et al., 2019). A study by Hole et. al (2015) interviewed Indigenous individuals in British Columbia regarding their experiences with the healthcare system. Several patterns emerged from these interviews including situations where the Indigenous person felt that they were not being listened to and/or ignored; healthcare

professionals did not believe the indigenous individual when discussing their health concerns; as well as, feeling as if they were more likely to be judged negatively compared to non-indigenous patients. One individual in the Hole et al. (2015) study stated:

To me when I look at the hospital, it's no different than looking at the residential school building. What they represent it's not good things and so they're gonna have to work damn hard to convince me, and other folks like me, that, that they've changed. (p.1668)

In these situations, the humanity of Indigenous patients was ignored and negated while simultaneously drawing attention and treating these patients as “problems” thus repeating historical systems of oppression (Hole et al., 2015).

Discrimination from healthcare providers can have an impact on a patient's quality of care. Kitching et. al (2020), utilizing a health assessment survey completed by self-identified Indigenous individuals within the Toronto region, found that there was a strong relationship between the reported experiences of discrimination that an Indigenous individual encountered from a healthcare provider and having unmet healthcare needs. These unmet healthcare needs fell within two categories: procedural neglect (care that is below industry standards), and caring neglect (lack of empathy and compassion from the healthcare professionals) (Kitching et al., 2020). In addition, the division of healthcare services between the provincial and federal government creates additional barriers for Indigenous individuals to navigate in order to receive cancer services (Horrill et al., 2019). For non-Indigenous Canadians, healthcare services are provided/funded by the provincial government.

It is speculated that these barriers to accessing care have contributed to the health disparities between Indigenous and non-Indigenous people of Canada. In general, Indigenous people have a higher incidence of some cancers that are part of routine screening processes, tend

to be diagnosed at a later stage than the general population, and have a lower survival rate (Horrill et al., 2019). Internalized colonialism and negative experiences have contributed to many Indigenous people not feeling comfortable being proactive in their care, as well as, a deep distrust for healthcare providers and institutions (Hole et al., 2015; Horrill et al., 2019).

Structural changes to the healthcare system are required in order to address these inadequacies and to provide better services to Indigenous patients (Boyer, 2017). The overall lack of Indigenous services available to patients contribute to the unmet health needs experienced by Indigenous patients (Kitching et al., 2020). Medical institutions leave little room for the teaching and practices of other cultures and display a predominantly Eurocentric approach to healthcare. This perspective results in a dismissal of Indigenous teachings and cultural approaches to healing (Hole et al., 2015). Healthcare policies and procedures ignore the positive contributions of Indigenous teachings such as having physical, mental, emotional, and spiritual balance while focusing on eliminating “negative behaviours” that are strongly linked to social determinants of health such as avoiding or delaying accessing healthcare services which could be the result of financial/transportation barriers or fear of stigmatization (Christ, 2015; Horrill et al., 2019). To help mitigate some of these factors, Indigenous patients of the NECC can access an Indigenous patient navigator who can help provide culturally-based services and guidance through the healthcare system. As previously mentioned, Indigenous patients have their healthcare services funded/provided by both the federal and provincial government meaning navigating healthcare services are more complex. In addition, Indigenous patients who live on a reserve might be located further away from major cities where treatment can be provided and the available services through band offices can vary. During my practicum, the Indigenous patient services department at the NECC was also examining how to provide Indigenous patients the

opportunity to self-identify during the new patient intake process in order to be referred to the Indigenous patient navigator earlier if needed.

Structural racism within the Canadian healthcare system also negatively impacts individuals who have immigrated from another country (Tuyisenge & Goldenberg, 2021). An Ontario based study by Vhabi et al. (2016) described low breast cancer screening rates for low-income and immigrant women. Women who immigrated from South Asia (48.5%) had the lowest breast cancer screening rate while Caribbean and Latin American women (63.7%) had the highest screening rate. Breast cancer is the most commonly diagnosed cancer in Canadian women and is the second leading cause of cancer death (Canadian Cancer Society, 2021b). It is estimated that in 2020, the number of new breast cancer diagnoses comprise 25% of all new cancer diagnoses in women that year (Canadian Cancer Society, 2021a). Early detection through the use of breast screening procedures, such as mammograms, are important healthcare practices as early detection generally contributes to a better prognosis (Canadian Cancer Society, 2021c). Unless otherwise recommended by a physician, it is typically recommended that women age 50 to 74 years receive a mammogram once every two years (Canadian Cancer Society, 2021b).

Breast cancer screening rates for immigrant women are also impacted by other factors including: immigration status, length of time in Canada, and their primary care physician (Vhabi et al., 2016). Lack of access to a primary care physician and having a male physician were linked to lower breast cancer screening rates for immigrant women across most regions of origin (Vhabi et al., 2016)

Furthermore, there is an overall lack of research addressing the health inequalities between White Canadians and Black Canadians (Veenstra & Patterson, 2016). When controlling for demographic characteristics, Black Canadian women were less likely than White Canadian

women to report breast cancer while Black Canadian men are less likely than White Canadian men to report heart disease (Veenstra & Patterson, 2016). Unfortunately, while self-reporting breast cancer is low, the mortality rate from cancer is higher for Black individuals compared to White individuals indicating that cancer has an increased risk of death and/or cancer is diagnosed later in this population (Veenstra & Patterson, 2016). A scoping review from Hassen et al. (2021) described examples of racial bias in the administration of analgesics for bone fractures within an emergency department with White patients receiving more prescriptions than Black patients (74% versus 57%), as well as, the under-screening of cervical and breast cancer for Black women.

The literature provided some recommendations to begin addressing racism within the Canadian health care system and the unmet health care needs of these patients. Many studies exploring racism in the health care system tend to refer to the people who immigrated to Canada as one homogenous group instead of accounting for the individual differences and unique needs which can heavily impact their experience (Vhabi et al., 2016). Organizations must also be prepared to address racism on a systemic level by reviewing anti-racism policies not only interventions at the individual or interpersonal level which tend to be overemphasized (Hassen et al., 2021). Any decisions regarding interventions, education, or policies need to be informed by individuals with lived experiences (Tuyisenge & Goldenberg, 2021). Also, leadership positions should include individuals who are Black, Indigenous or part of another racialized community (Hassen et al., 2021). In addition, there is an overall need to increase accessibility to cultural and language services related to cancer screening programs, as well as general health care practices (Vhabi et al., 2016). These recommendations are important considerations in order to fulfill healthcare needs as the population of the Greater City of Sudbury continues to diversify. Based

on the 2016 Statistics Canada census, 5.9% of Greater Sudbury's population immigrated from another country while people who immigrated from another country contribute to 29.1% of Ontario's population. (Statistics Canada, 2017a). The top places of birth for Sudbury based-immigrants are Italy, United Kingdom, and Finland; however, recent immigrants from 2011 to 2016 originated from India, Philippines, and Pakistan (Statistics Canada, 2017a).

Cultural Humility

As a Canadian of white settler decent it is crucial that I continue to develop my awareness of the privilege I experience based on my heritage and appearance, as well as, challenge my own internal biases while advocating for systemic change within the medical system and other social structures. Incorporating the core concepts of cultural humility into my clinical practice can help guide my professional and personal development as I continue to grow within my social work career.

A concept analysis from Foronda et al. (2016) provides the following definition of cultural humility,

In a multicultural world where power imbalances exist, cultural humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals. The results of achieving cultural humility are mutual empowerment, respect, partnerships, optimal care, and lifelong learning. (p.213)

Expanding on these concepts, first, a clinician must have an open mind and be willing to interact with individuals from diverse backgrounds, as well as, possess the desire to explore new perspective and engage in self-reflection (Foronda et al., 2016). Awareness of one's social location, strengths, challenges, and values and how these factors play a role within their

environment and impacts their perspective is the second concept needed for cultural humility (Foronda et al., 2016). Egoless, in this context, refers to exhibiting humility when interacting with others while appreciating that everyone has something to contribute and that patients are the experts regarding their own lives (Foronda et al., 2016; Masters et al., 2019). Respecting a patient's values and belief system allows these patients to actively engage in treatment planning while understanding that a patient's desires may not correspond with medical recommendations (Masters et al., 2019). Patients feeling understood tends to lead to an increase in trust which can evolve into a more therapeutic relationship (Masters et al., 2019). Self-reflection is the life long process of continuing to examine and evaluate our thoughts, feeling, and actions (Foronda et al., 2016).

Working in an oncology setting requires the ability to work with individuals from a variety of different backgrounds during a very vulnerable time of their life. Overt and implicit biases from health care providers can impact treatment decisions and quality of care. Therefore, reflecting and practicing ways to address these biases are needed to provide effective person-centred care (Masters et al., 2019). Although typically referring to racial and ethnic differences, cultural humility can be used in other contexts including but not limited to sexual orientation, gender orientation, socio-economic status, gender, disability, interprofessional roles, and health care provider-patient relationships (Fisher-Borne et al., 2015; Foronda et al., 2016).

Cultural humility differs from the cultural competency as there is no assumption of the clinician having expertise in regards to social groups or belief systems (Masters et al., 2019). Critiques of the cultural competency framework include the lack of self-reflection particularly in regards to power differentials and a primary focus on exposing the clinician to various cultures without examining historical context or inequalities (Fisher-Borne et al., 2015). In addition,

cultural competency endorses the strategy of combating inequality by clinicians learning about non-dominant cultures which typically meant individuals that identified as being members of communities that are not White, male, cisgendered, and heterosexual instead of challenging system inequalities (Fisher-Borne et al., 2015). This shift from knowledge acquisition and mastery to clinician accountability to behave in a humble, respectful, and reflective manner results in a practice that is more consistent with social work guidelines (Foronda et al., 2016).

Sex Differences and Cancer

Next, I describe the impact of an individual's biological sex on cancer development; access to care; treatment outcomes/side effects; and clinical trial representation. Male will be defined as an individual with the chromosomes XY and female will be defined as an individual with the chromosomes XX. It should be noted that sex differences in healthcare are amplified when the patient is part of a marginalised racial group, low income, not heterosexual and/or not cisgendered (Heise et al., 2019).

Physiological differences between the sexes and cancer development is well documented in the literature with males having a higher cancer prevalence than females, as well as, an increased likelihood to die as a result (Rubin et al., 2020). In particular, males are more likely to develop cancers of the bladder, colon, skin, liver, and brain (Rubin et al., 2020). While males and females are similar in many ways there are documented differences in hormone levels, growth rates, myelination, immune system, metabolism, cardiovascular ability, and the aging process (Rubin et al., 2020). These factors in combination with other determinants that have yet to be identified can influence an individual's chances to develop cancer, their prognosis, and treatment outcomes. For example, estrogen, the sex hormone that plays a role in the regulation of the reproductive system and the development of secondary sex traits for females, counteracts the

formation of tumors for liver and colon cancer while encouraging the formation of tumors for meningiomas and thyroid cancer (Rubin et al., 2020). As a result, liver and colon cancers are more prevalent in males while meningiomas and thyroid cancer are more prevalent in females (Rubin et al., 2020).

Sex differences can also influence the effectiveness and side effects of certain cancer treatments. Immunotherapy, for instance, appears to have a greater effectiveness for males across all cancer types with the exception of small cell lung cancer which did not appear to be impacted by the sex of the individual (Tsiouda et al., 2020). Immunotherapy utilizes the body's own immune system to fight cancer cells (Cancer Care Ontario, 2019). While the side effects of immunotherapy are considered to be generally mild, in most circumstances females tend to have more adverse effects (Tsiouda et al., 2020). The immune system of females is more sensitive than male immune systems making females more susceptible to developing autoimmune disorders (Rubin et al., 2020; Tsiouda et al., 2020). It is hypothesized that this sensitivity also contributes to their increased likelihood of experiencing negative side effects when undergoing immunotherapy (Tsiouda et al., 2020). In general, women have been documented to have more adverse drug reactions than men or the reactions differ between the sexes (Loikas et al., 2015).

While females are more likely to experience adverse reactions from cancer treatments and medications, they historically have been underrepresented in clinical trials (Heise et al., 2019). Recent attempts have been made to include more female participants in clinical trials; however, there continues to be a discrepancy (Dymanus et al., 2021; Heise et al., 2019). A systematic review of gender representation in clinical trials leading to the US Food and Drug Administration cancer drug approvals conducted by Dymanus et al. (2021), revealed that out of the 149 clinical trials reviewed, 60.3% of the participants were male and 39.7% were female.

Clinical trials are part of the necessary process to approve new cancer drugs as these trials help determine the effectiveness and toxicity of these therapies (Dymanus et al., 2021). Having a sample that does not accurately reflect the population being studied could result in the differences of clinical outcomes and/or adverse drug effects being missed (Dymanus et al., 2021). While there are physiological differences that can impact cancer trajectory and treatment there are also numerous social factors that may impede access to care.

Sexism and gender-based stereotypes can influence an individual's likelihood of seeking medical assistance. Males are stereotypically depicted as "strong" and being sick or receiving a cancer diagnosis conflicts with this misleading description of masculinity and what it means to be "a real man" (Heise et al., 2019). On the other hand, a harmful stereotype of "a good woman" is depicted as a female who puts the health needs of the partner and children above their own (Heise et al., 2019). In the medical field, females are considered more fragile and their health-related complaints are more likely to be treated as an emotional exaggeration or attributed to being a psychosomatic response instead of having a physical cause (Heise et al., 2019). Shame, stigma, vulnerability, and embarrassment surrounding female reproduction and sexuality can also result in many females avoiding accessing healthcare in order to prevent negative experiences and judgment from healthcare professional (Heise et al., 2019). In situations where females are not financially independent, the cost of transportation and treatment can also become barriers to accessing care (Heise et al., 2019).

Sex differences should be considered throughout cancer research, as well as during the treatment process whether it be chemotherapy, radiation therapy, immunotherapy, metabolic therapy, or targeted agents (Rubin et al., 2020). Clinical standards are required to ensure the

biology of the sex is incorporated into treatment decisions and that there is accurate representation of both males and females in clinical trials (Rubin et al., 2020).

Person-Centred Care

Western medicine tends to neglect the psychological and social factors of the human experience and focus primarily on the biological factors. Hospitalization itself is a dehumanizing experience as the person is removed from their home and placed in a cold, sterile environment under the authority of strangers and is frequently referred to by their ailment or bed number. This experience is linked to an increase of psychosocial problems including loss of self-esteem, fear, and dependency (Parry, 2001). A study by Ocloo et al. (2020) stated that 21 out of 33 patients reported feeling lonely and isolated during their time as an inpatient, as well as, not feeling listened to by doctors and nurses as they were not provided sufficient opportunities to discuss their concerns and treatment plan.

As previously mentioned, medical institutions consist of a hierarchical structure that views hospital staff as “experts” and patients as passive recipients of care. This power imbalance creates a patriarchal system where the profession-based knowledge is held at a higher regard than the patient’s expertise (Griscti et al., 2017). In some instances, hospital staff act as gate keepers to information as they assume that the patient will not understand the information or that the information may upset the patient. This obscurantism is one of the main barriers to integrating patient engagement and patient centered care which impedes the ability to deliver high quality care plans (Tzeng, 2015).

Some patients may welcome the model of care where hospital staff act as experts and take charge in their care, however, other patients would prefer to be more involved in their own care and treatment decision making (Griscti, 2017). It is important for hospital staff to be aware

of the power dynamics at play within medical institutions and how their interactions can impact patient care.

Person-Centred Care (PCC) is a partnership between healthcare providers and the patient that promotes patient autonomy by respecting the patient's values, needs, and preferences (Mitchell et al., 2020; Santana et al., 2018). The term person-centred care will be used in this paper instead of patient-centred care to emphasize that the individual receiving care should be treated as a person first and not be reduced to their role as patient or ailment (Cancer Care Ontario, n.d.b; Santana et al., 2018). This provides a more holistic implementation of healthcare services and includes the engagement of significant family members/caregivers (Santana et al., 2018). The intended outcomes for PCC are improved health outcomes, effective allocation of resources, increased quality of care, and an overall better patient and caregiver experience (Cancer Care Ontario, n.d.b).

Cancer Care Ontario (CCO), which is an organization that acts as a cancer care advisor to the Ontario government, provides a PCC guideline listing the following five sections needed to meet patient care standards: knowing the patient as an individual; essential requirements of care; tailoring healthcare services for each patient; continuity of care and relationships; and enabling patients to actively participate in their care (Cancer Care Ontario, n.d.a).

Requirements for Patient-Centred Care

Knowing the patient as an individual draws attention to seeing the individual as a person first and not solely a patient with a list of symptoms, as well as, recognizing that each individual has unique factors associated with their situation (Cancer Care Ontario, n.d.a). A systemic review of qualitative studies from Mitchell et al (2020) examined the values identified by adults as being important during their cancer treatment. The themes that emerged from this study

included autonomy, being involved, family, hope, normality, and sincerity. Many patients value the ability to be involved in care discussions and providing approval for treatment decisions (Mitchell et al., 2020). Family welfare, hope, and returning to what the individual considers normal were values that appeared connected to patient's coping and motivation while sincerity impacted the level of trust towards healthcare providers (Mitchell et al., 2020). All of these themes would be unique to the patient's situations and require discussion in order for the healthcare provider to have a more holistic understanding of the individual. Social work involvement could provide patients with the opportunity to describe these values leading to improved advocacy efforts. Having an understanding of the patient's values can help healthcare providers better address a patient's needs and preferences resulting in an improvement in patient care (Mitchell et al., 2020).

Essential requirements of care involves healthcare workers not only providing care for the disease but also include emotional support (Cancer Care Ontario, n.d.a; Mitchell et al., 2020). This can be accomplished by listening to a patient's concerns; demonstrating respect; helping patient's maintain their independence; and addressing other aspects of patient care such as pain management, nutrition needs, and psychosocial resources (Cancer Care Ontario, n.d.a). In Mitchell et al. (2020)'s systemic review, cancer patients reported that healthcare workers could provide emotional support through developing a therapeutic relationship by "checking on" the patient and exhibiting a friendly disposition. In addition, when doctors and nurses are engaged with their patients, the likelihood of medical errors are reduced, therefore, increasing patient safety (Santana et al., 2018).

Where possible, healthcare services should be adapted and tailored to meet the unique needs of the individual patient and patients should be encouraged to express their individualized

preferences (Cancer Care Ontario, n.d.a). For example, some patients prefer to be very involved in their care and consider being included in treatment decision making conversations pertinent while other patients prefer to have minimal involvement (Mitchell et al., 2020).

Having open communication between all of the professionals involved in an individual's care both within a medical institution and in the community can establish a continuity of care which can improve a patient's experience (Cancer Care Ontario, n.d.a). The instances of communication breakdown that I observed during my practicum occurred between NECC departments, as well as, with NECC staff and community agencies upon discharge. Consequences included delays in the implementation of services, duplication of resources, confusion for the patient, and an overall reduction in the quality of care being received.

The four areas identified by the CCO guidelines to encourage the involvement of patients in their own care are communication, information, shared-decision making, and education programs. Patients have preferences in what format is used to communicate information. Some patients prefer telephone consults or e-visits as it reduces the need to travel for appointments while others prefer in-person appointments (Mitchell et al., 2020). Effective communication strategies that includes listening to the patient's needs, tends to increase the patient's satisfaction, improve patient understanding and retention of information, as well as, increase treatment adherence (Santana et al., 2018).

Barriers to Person-Centred Care

While the concepts of PCC are certainly goals that healthcare providers should strive for, in reality there are Health Sciences North hospital policies and situational factors that make providing PCC difficult. One example is how the COVID-19 pandemic has altered the hospital family presence and visitor policy. Unless a patient has a communication, physical or cognitive

impairment or is experiencing a mental health crisis, they are not permitted to have a family member or support person enter the NECC (Health Sciences North Hospital, 2021). Exceptions to this policy include when it is the patient's first day of radiation or chemotherapy treatment, in-person appointments with their oncologist, and when discussing important care decisions/ the disclosure of potentially traumatic information (Health Sciences North Hospital, 2021). During these situations the patient is able to have one designated care partner present meaning that for the majority of their cancer trajectory the patient will have to endure alone without having a support person present. Navigating the healthcare system without the help of care partners has proved to be challenging for many patients (Hill et al., 2021). In addition, the designated care partner has to be the same individual throughout the patient's treatment experience which prevents additional family members from providing in-person support. I have observed this situation numerous times and it seemed to particularly impact patients who live out of town as one sole individual may have to take substantial time off work to be available for appointments and be responsible for relaying health information to other loved ones. In addition, many patients find it difficult to communicate effectively with healthcare staff through personal protective equipment (Hill et al., 2021). Since the beginning of the pandemic, the NECC has acquired face masks with a clear plastic panel to be used with individuals who read lips.

PCC requires taking a genuine interest, active listening, sincerity, as well as, treating a patient with respect and dignity which all takes time and compassion. Unfortunately, healthcare providers can become desensitized to empathetic processing as they continue to work in the medical field resulting in a decrease in compassion (Santana et al., 2018). Kakeman et al. (2021) described a relationship between Iranian nurses reporting high levels of emotional exhaustion, high rates of depersonalization, and low levels of personal accomplishment having a negative

impact on the quality of patient care. The factors experienced by the nurses in this study are also associated with an increased likelihood of developing burnout (Kakemam et al., 2021). Increased depersonalization increased the number of adverse events while, in contrast, nurses with higher levels of personal accomplishment made fewer medication errors and had a reduced risk of experiencing verbal abuse from patients and their family members (Kakeman et al., 2021). It is worthwhile to address burnout within an organization as it improves the patient's experience and safety while reducing the occurrence of costly errors (Kakemam et al., 2021).

Strategies to Improve Person-Centred Care

There has always been a need to address burnout in the workplace, however, this need has increased during the COVID-19 pandemic as employees are experiencing burnout professionally, personally, as well as societally (Peinado et al., 2020). Clinical managers can help combat staff burnout by fostering a positive work environment that encourages personal development, increasing access to psychosocial supports, and promoting staff prioritizing their own mental health by utilizing self-care techniques (Kakemam et al., 2021; Peinado et al., 2020).

Frequent complaints from patients of the NECC included the lack of communication and the difficulty of keeping track of their appointments between the different specialists. One way to improve communication and access to information would be through an electronic patient portal which could provide patient's access to their medical records and appointment information directly (Santana et al., 2018). Larger institutions in southern Ontario, such as the University Health Network (UHN) in Toronto, already have a patient portal in place. There were a few instances where patients who received treatment in southern Ontario expressed their frustrations regarding the delays, and at times staff resistance, to gaining access to their medical information

once receiving treatment at the NECC. I will add from personal observations that what patients may be experiencing as staff resistance might be a lack of knowledge from the healthcare provider on how a patient can properly access their medical information through Health Information Services.

Conclusion

Colonization, racism, and sex differences are just some of the systemic concerns that can have a negative impact on the quality of care received by individuals accessing the Canadian healthcare system. Individuals impacted by these systemic concerns may experience care that is below industry standards or encounter instances of discrimination or lack of compassion from healthcare professionals. Having negative experiences with the healthcare system in the past can result in these individuals delaying or avoiding accessing services when needed in the future. It is important for social workers to be aware of these systemic concerns; endorse person-centred care; and use their advocacy skills in order to support patients and promote positive productive change. In the next chapter, I will describe my practicum at the NECC and the completion of my learning goals.

Chapter 3 – The Practicum Setting and Learning Activities

The purpose of this chapter is to describe the advanced practicum experience and to reflect on the progress made towards the completion of my learning goals that were established with my field supervisor and readers at onset of the practicum. I will further explain the structure of the Supportive Care Program, as well as, describe in detail the learning activities; experiences; barriers; and accomplishments that comprised each practicum goal. My advanced practicum spanned from October 29, 2020 to March 26, 2021 and took place at the Northeast Cancer Centre with the Supportive Care Program located in Sudbury, Ontario. The NECC has a wide catchment area of northern communities including Algoma, Cochrane, Manitoulin-Sudbury, Nipissing, Parry Sound, Temiskaming, as well as, the James Bay and Hudson Bay Coasts (Cancer Care Ontario, 2020). Patients are treated on an outpatient basis unless medical complications require them to be admitted to Health Sciences North Hospital at which point the social worker situated on the assigned hospital floor will typically assume care.

The SCP involves multiple disciplines including social workers, dietitians, speech-language pathologists, an Indigenous patient navigator, a psychiatrist, and physiotherapists. The social work department currently consists of three full-time social workers. The role of the social workers is to provide assistance to individuals with a cancer diagnosis and their family members. The two broad areas of assistance provided by the social workers involve practical concerns, such as applying for income replacement programs, exploring funding options, and organizing travel arrangements, as well as, providing emotional support which includes advanced care planning, developing coping strategies, managing difficult emotions, and discussing grief and bereavement. As a social service worker working within the NECC, my role strictly involved the

practical concerns. My advanced practicum experience provided the opportunity for a dramatic expansion of this role to include emotional care.

Considering the large catchment area of the NECC, telephone and videoconferencing services were available to patients, however, with the current threat of COVID-19 the use of remote counselling services has increased. This safety precaution resulted in minimal face-to-face interaction with patients with the exception of “urgent referrals” which occurred when the patient needed to be seen immediately and was already at the NECC for treatment. In these situations, masking, eye protection, and social distancing protocols were adhered to in order to minimize risk.

The Ontario COVID-19 lockdown that began on December 26, 2020, resulted in a reduction to the number of staff members and learners that could be on-site and working from the office. I was asked by the clinic manager to continue fulfilling my practicum hours from home. Fortunately, I had remote access to the NECC electronic charting system and was able to engage with my field supervisor and patients over telephone. This did, however, eliminate the opportunity for face-to-face urgent referrals. Counselling sessions were conducted via telephone or the Direct-To-Patient videoconferencing program. Providing virtual care to patients increased the opportunity for the NECC to adhere to social distancing guidelines in order to attempt to reduce the transmission of COVID-19 as there were less individuals present within the centre. A systematic review conducted by Singh et al.(2021) suggests that, while studies with cancer patients are limited, in-person and virtual counselling have similar effectiveness when treating anxiety, depression, adjustment issues, and stress. It should be noted that visual observation of non-verbal communication cues (body language, facial expression) are important for in-depth counselling, therefore videoconferencing has more advantages than telephone counselling (Singh

et al., 2021). Some patients preferred the virtual care format for some of their appointments as it allowed for multiple family members to attend which in turn allowed for the patient to receive additional support and promoted shared decision making (Fassas et al., 2021). Patients also reported that the reduced travel time and cost made attending appointments more convenient and lessened the financial strain. While some individuals preferred virtual care, a study by Fassas et al. (2021) found that only 32% of head and neck cancer patients preferred a virtual visit with their medical team during the COVID-19 pandemic. Fear of reoccurrence of their cancer was a motivator for the in-person meeting as the oncologist could conduct a cancer surveillance physical exam which is not possible virtually.

While this change from face-to-face interactions allowed for some patients to access services from the comfort of their homes, others were faced with a barrier to service for numerous reasons. Some individuals had health concerns that made communication via telephone difficult (hard of hearing) and many did not have the ability to access the technology needed to utilize this change in format. While videoconferencing was the preferred counselling method based on the literature, the majority of the counselling sessions were performed via telephone as many patients did not have the technology or did not feel comfortable navigating the technology for counselling purposes (Fassas et al., 2021). Also, privacy became a greater concern as shared living spaces made it difficult to have an open and thorough conversation regarding sensitive topics as the risk of family members overhearing increased.

Supervision

The first reader for this practicum was Sandra Hoy, PhD, MSW. Sandra is a professor at Laurentian University. She received her Master of Social Work and PhD from Wilfrid Laurier University. Her specialties/areas of interest include community-based scholarship, program

evaluation, and maternal health. The second reader was Diana Coholic, PhD, MSW. Diana is also a professor at Laurentian University, as well as, the BSW and MSW program coordinator. She received her Master of Social Work from the University of Toronto and her PhD from the University of New South Wales in Sydney, Australia. Diana and her team have developed a 12-week arts-based mindfulness group program called Holistic Arts-Based Program (HAP) focused on the helping youth improve mood, self-esteem, relationships, and develop positive coping skills.

Field supervision was conducted by Jillian Romanko, who is a registered social worker with the Supportive Care Program. Jillian has a Baccalaureate en Service Sociale (BSS), as well as a Master of Social Work from Laurentian University, and has worked at the Supportive Care Program for 13 years. Jillian specializes in oncology and her areas of interest include death and dying in the context of palliative care, women's issues in oncology, and mental health in oncology. Jillian has received additional training through the Hincks Dellcrest Centre on Narrative Therapy, as well as training and certification in neurorehabilitation within the context of brain injury. In addition to providing informal direction and guidance, one-hour supervision meetings occurred every second Thursday. Each meeting began with a review of the agenda items, followed by a summary of recent progress/challenges, and ended with identifying goals for the following two weeks. Debriefing opportunities were also provided throughout the day as needed.

Meetings were arranged with the field supervisor, practicum readers, and learner via videoconference at the beginning, middle, and end of the advanced practicum. The meetings provided the opportunity to discuss progress towards learning goals and clinical skill acquisition, as well as to provide feedback.

Completion of Learning Goals

The practicum began with a focus on knowledge acquisition and observation. While I have previous work experience helping patients with travel logistics and connecting to community resources, I have not had the opportunity to provide supportive counselling for the wide array of emotional concerns that could present when an individual has been diagnosed with cancer.

At the end of the practicum a final evaluation form was completed by myself and Jillian Romanko, field supervisor, to review the progress made towards completing the learning goals that were established at the onset of the MSW advanced practicum. This form was used to help facilitate discussion during the final practicum meeting and to help recognize areas of growth, as well as areas that require additional development. To reiterate, my learning goals involved improving direct practice skills, increasing overall knowledge regarding the cancer trajectory; becoming proficient in providing support to patients through telephone and videoconferencing services; increasing advocacy skills; and self-reflection. The following section will describe the learning goal progress within the context of the practicum. Self-reflection will be incorporated into each goal description instead of being a standalone section.

Improving Direct Practice Skills

With consent from the NECC patients, I was able to join telephone counselling sessions led by my field supervisor, Jillian Romanko. After observing several sessions, I was able to lead supervised sessions and eventually transitioned to meeting with patients independently. The patients I met with initially predominantly wished to discuss Advance Care Planning (ACP). Speak Up Ontario, a website initiative of Hospice Palliative Care Ontario (2021b), provides the following description of ACP:

In Ontario, Advance Care Planning (ACP) is confirming your Substitute Decision Maker(s) (SDMs) and communicating your wishes, values and beliefs about care to help your SDM(s) make health and personal care decisions for you if you become mentally incapable of doing so for yourself.

In Ontario, an SDM is the term used for the person who makes health care decisions for another individual if they are incapable to do so themselves (Hospice Palliative Care Ontario, 2021a). This can be determined automatically using the Health Care Consent Act's SDM Hierarchy or an alternative individual(s) can be appointed by completing a Power of Attorney (POA) document (Hospice Palliative Care Ontario, 2021a). It is important that information regarding POA(s), SDM(s), and ACP is Ontario specific in order to comply with Ontario law (Hospice Palliative Care Ontario, 2021a).

In preparation to assist these patients, the Hospice Palliative Care Ontario's Advanced Care Planning, Goals of Care, and Health Care Consent e-learning modules were completed (see Appendix A) to gain a better understanding of the importance of ACP and how to have this conversation with individuals at different health care states. As a general guideline, it is encouraged for health care professionals to have ACP conversations with patients regardless of state of health. The ACP conversations I had with patients followed the semi-structured guideline provided by HPCO (see Appendix B) and included the following six areas of discussion: patient's understanding of their current state of health and prognosis; is there additional information that the patient would like to know about their current state of health and prognosis/ is there information they would not want to know; the patient's values, beliefs and what brings quality/meaning to their life, patient's worries and fears about having a critical illness or nearing end of life; tradeoffs - what states are acceptable/unacceptable to live in, for example, requiring

life support with no foreseeable cure; and what aspects are important for end of life? While these patient interactions began with ACP, it frequently provided the opportunity for patients to discuss other concerns such as death anxiety, fear of the unknown, relationship concerns, depression, and symptom concerns as rapport was established.

In order to address these other concerns a variety of other interventions were used. For instance, existential therapies were particularly beneficial to individuals who had an increased awareness of their mortality and had a willingness to self-reflect (Randal, 2016). Existential therapies can utilize either a direct or indirect method to explore an individual's death concerns (Randal, 2016). Randall (2016) provides an example of a potential question a clinician using an existential intervention may ask during a session, "If I continue on a similar course throughout my life, will I end consumed by guilt over my own unrealized potentialities?" (p.321). During my advanced practicum, I observed and utilized this strategy often with palliative patients who were isolating from their support network and withdrawing from the activities that previously made their life meaningful and enjoyable increasing their reported symptoms of depression, as well as, feelings of loneliness. Through conversation, patients were better able to identify what aspects bring meaning to their lives and raise awareness of their internal values which allowed for the exploration on how we could incorporate these aspects back into their daily activities. Another common intervention used during counselling sessions with patients to help identify pleasurable activities or events was behavioural activation. Behavioural activation is based on cognitive behaviour theories that entails encouraging patients to engage in enjoyable activities in order to increase instances of positive reinforcers and offset punishers (Cobb, 2016).

I had a superficial understanding of Dialectical Behaviour Therapy (DBT) prior to my practicum experience but was able to attend several webinars that helped increase my knowledge

base. These webinars included *Introduction to Dialectical Behaviour Therapy* hosted by the Ontario Association of Social Workers, *Radically Open – DBT study sessions* hosted by the HSN Mental Health & Addictions program, and *Coping with Cancer: DBT Skills to Manage Your Emotions and Balance Uncertainty with Hope* a webinar hosted by Elizabeth Cohn Stuntz. These strategies, while applicable to an oncology setting, can be generalized for clientele with other concerns.

Increasing Knowledge of the Cancer Trajectory

A good portion of the beginning of my practicum was dedicated to research, readings, and talking to health care professionals in order to have a better understanding of the cancer trajectory. *Everyone's Guide to Cancer Therapy* by Dollinger, Rosenbaum, Tempero, and Mulvihil (2002) provided both general information about cancer therapy, as well as chapters dedicated to specific disease sites. Taking some time to read about a patient's specific cancer trajectory provided the opportunity to connect medical knowledge with lived experience which in turn would allow me to validate and normalize common cancer experiences which can be comforting to patients. A frequent example of this was discussing the hot flashes, mood swings, fatigue, nausea etc. that can be experienced by breast cancer patients taking Tamoxifen. Tamoxifen is a hormone therapy drug commonly used to reduce the risk of certain breast cancers such as ductal carcinoma in situ or lobular carcinoma in situ, developing into invasive breast cancer (Canadian Cancer Society, 2022).

I also had the opportunity to attend the weekly stem cells rounds which is a digital conference that occurs between the NECC and Ottawa Hospital. Some individuals with certain cancers such as lymphoma, leukemia, myeloma, and other blood disorders may require a stem cell transplant as part of their treatment regime (Cancer Care Ontario, n.d.c.). There are two

major types of stem cell transplant options: autologous transplants where the patient's own stem cells are harvested for use and allogeneic transplants where the stem cells from a relative or doner are used (Cancer Care Ontario, n.d.c.). Autologous stem cell transplants can be performed at the NECC while patients will need to travel to Ottawa if an allogeneic transplant is required. The biweekly stem cell rounds allowed the professionals involved in the care of allogeneic transplant recipients to discuss relevant patient information and to coordinate treatment plans. Throughout these conferences, I was able to observe the importance of communication and collaboration amongst care providers as a crucial component in order to ensure continuity of care when the patient was transferred to the Ottawa cancer centre for their allogeneic stem cell transplant, and when the patient returned to Northern Ontario and their care with the NECC resumed.

While I feel that I've obtained a great deal of knowledge during the length of my practicum, I recognize that there is tremendous room for growth as remaining current is a continual professional pursuit.

Providing Support through Telephone and Videoconferencing

As the amount of active COVID-19 cases increased in the Greater City of Sudbury and Northern Ontario, the use of telephone and videoconferencing counselling sessions became the norm. In order to ensure that the social work skills that I possess were transferable with the use of telephone and video counselling I completed the *Virtual Care and Mental Health* video series by the Centre for Addictions and Mental Health (CAMH) which helped me develop a better understanding of digital health equity, digital fatigue, and self-care.

As the use of communication technology during clinical appointments increased, the lack of digital health equity became more apparent. Many of the patients I counselled expressed that

they did not have the technical skills nor the income to afford the devices needed to access videoconferencing. Others reported that their rural northern community did not have the internet quality needed to maintain a connection. Ontario Telemedicine Network (OTN) sites, which enable patients to have videoconferences with their medical team, are available at numerous healthcare clinics, however, transportation and health concerns were still limiting factors for some individuals.

I also found that the increased use of technology had an effect on myself as a practitioner. While working from home had benefits, it also impacted my mental and physical health. I realized partway through my practicum that the increased time spent sitting in front of a monitor was causing eye strain, as well as pain in my back, neck and shoulders. This in turn had a negative impact on my mood. To counteract these concerns, I began incorporating stretch breaks and going for brisk walks outside during the lunch hour.

While the majority of my patient interaction involved individual counselling sessions, I was provided the opportunity to facilitate the monthly Fighting Cancer Related Fatigue patient education class. This class is a collaborative effort between the different disciplines of the SCP with a social worker, dietician, and physiotherapist each leading a section to provide different strategies to combat cancer related fatigue. The social work section consisted of facilitating group conversation about one's individual experience with cancer related fatigue, as well as reviewing strategies such as progressive muscle relaxation, deep breathing, healthy sleep hygiene, delegating tasks, and scheduling the individual's day to take advantage of times when energy levels are highest. While I have taught psychoeducational classes in the past, I have never done so virtually. Patients were able to attend throughout Northeastern Ontario from the comfort of their homes which increased accessibility for some individuals. However, it was important to

establish class rules and etiquette at the very beginning in order to cultivate an environment of respect and to avoid interruptions and distractions. In adherence to the Ontario College of Social Workers and Social Service Workers (OCSWSSW) professional and ethical guidelines, the limits of confidentiality was also discussed at the beginning of the class (Van Sickle, 2014). In addition, the participants were made aware of the potential lack of privacy as this is a virtual class with several participants and many listening to the audio using their computer or phone's speakers. Participants were asked to use the chat function to excuse themselves if they had to leave, otherwise, a staff member would provide a follow up phone call to ensure that they were not in crisis. The participants were also made aware that there was additional time at the end of the class allocated to provide additional support to individuals who required additional time and resources.

Increasing Advocacy Skills

I had a limited view regarding advocacy at the start of my practicum and focused my social work practice solely on patient advocacy. Attending webinars such as *How Government Works in Canada* hosted by the Canadian Cancer Survivor Network, and *Speaking Up Versus Silence: Navigating Power, Prejudice, and Hierarchy in Medicine* hosted by the Department of Psychiatry Schulich School of Medicine & Dentistry Western University increased my understanding of how to advocate for systemic changes. Reading the *Oncology Social Work Toolbox: Building Advocacy Skills* by The Association of Oncology Social Work helped me incorporate these tactics into a social work framework. I have since expanded my definition of advocacy to not only include patient advocacy but also professional self-advocacy, organizational advocacy, institutional advocacy, community advocacy, and political/legislative advocacy.

I have had the experience of advocating to hospital staff, community agencies, home care services, etc. to improve patient care. Some frequent examples include advocating for increased home care services for a patient whose health had deteriorated and the current services they were receiving were insufficient, and helping patients who felt intimidated by the health care system express their need for symptom management to their oncologist. However, in terms of career growth, I would like to engage in larger systemic changes within the Canadian Healthcare System. This could involve attending committees to address hospital policies and other organizational concerns, as well as petitioning local Federal Members of Parliament (MPs) and Members of Provincial Parliament (MPPs) for change on a provincial level. On an organizational level, I would like to be involved in policies that encourage patient autonomy, reduce discriminatory acts, and create positive work environments by reducing hierarchical practices between disciplines and increasing respectful communication. On a provincial level, I believe it is important to advocate for accessible services for those living in rural settings which would partially consist of discussing incentives for professionals to relocate their practices to northern communities. I would like to clarify that these are not areas where it is easy to make change but I believe that progressive change is needed and I would like to be part of that process.

Two organizational meetings I was able to attend on a monthly basis were the Ethics Committee meetings where topics were discussed such as the new policies surrounding medical assistance in dying (MAiD), and the Patient Education meetings where individuals from different departments discussed and implemented strategies to make information accessible to patients and their families. On a personal level, I value transparency and feel that there is power in knowledge acquisition, therefore, I was pleased to have the opportunity to work with the social media and web specialist to update resource information on the NECC website.

Practicum Project Request - Managing Cancer Related Physical Changes Virtual Class

In addition to improving direct practice clinical skills, the Supportive Care Program requested that I begin the preliminary work on a virtual class during times when patients did not attend their appointments or if they were too ill to participate and needed to be rescheduled. The purpose of the virtual class is to help educate and support patients who are experiencing cancer related physical changes utilizing a cognitive behavioural therapy perspective. The class was not completely designed before the end of the practicum, however, the work that was completed was provided to the SCP.

The class was designed to include an hour-long PowerPoint presentation that could be presented via Microsoft Teams on a monthly basis. Patients would register with the Supportive Care Program receptionist who would email the patients a link to the class, as well as any relevant handouts. The class would not focus heavily on specific cancer types and be gender inclusive in order to not alienate any individuals seeking support. It is designed to be led by a SCP social worker. The learning goals include: being able to describe how our sense of body image develops over time; identifying cancer related physical changes and the potential impacts; recognizing unhelpful thinking patterns and ways to be kinder to ourselves; and identifying helpful resources and strategies for managing cancer related physical changes. The class was not meant to replace ongoing counselling or psychiatric services, instead it was meant as an introduction to cancer related physical changes and basic coping strategies.

I started this project by completing an environmental scan to determine what information was already available to patients in order to avoid a duplication of services. A review of the literature was also conducted for my own educational development and to be incorporated into digestible class content. While the majority of the research involves breast cancer patients, a

wide diversity of cancer patients can experience body image disturbances. However, patients with certain cancer sites are at higher risk for experiencing body image disturbances (Fingeret et al., 2014). Studies have shown that up to 75% of head and neck cancer patients who are receiving surgery have reported concerns about changes in their body (Fingeret et al., 2014). In addition, patients who receive mastectomies and ostomy placements also tend to be more likely to report body image disturbances (Fingeret et al., 2014).

Cancer and the Body

Cancer and cancer treatment can not only impact the way an individual's body looks physically but also how the body feels and functions (Fingeret et al., 2014). Visual changes to the body can include hair loss, scars, rashes, weight loss/gain, and mastectomies. Sensory changes can impact the way an individual feels within their body. Examples of these cancer related changes include numbness, particularly to the hands and feet, as well as pain/discomfort. Functional changes that can occur from cancer and cancer treatment can involve mobility/range of motion (the removal of a limb, lymphedema/swelling), and the requirement of medical devices (ostomy bags, feeding tubes).

Some cancer related physical changes might be invisible to others but still have a profound impact on the patient. Patients with cancers that affect sexual organs experience functional decline, as well as challenges surrounding perceptions of masculinity/femininity (Fingeret et al., 2014). Infertility, erectile dysfunction, and the onset of early menopause/andropause are just some of the potential concerns patients may experience.

Emotional Outcomes

A patient's reaction may not reflect the severity of the body change but the resulting discomfort may result in other psychosocial concerns such as isolation, shame, and low self-

esteem (Fingeret et al., 2014; Rhoten, 2016). Throughout my time at the NECC, I listened to many individuals minimize how they felt about the body changes they experienced due to embarrassment, guilt, or they were worried that they did not sound grateful when their life span had been extended by the same procedures that are causing them distress. Some questioned if they were being vain if they brought up concerns about their appearance. However, it is not uncommon for people to become concerned about their body image right after surgery or after completing treatment (Fingeret et al., 2014). Thoughts about how they would be perceived by others interfered with relationships and intimacy. Being afraid of scaring their grandchildren or appearing unattractive to their partner were two examples where patients withdrew from pre-existing relationships, others struggled with the thought of dating and meeting new people. In either circumstance it was not uncommon for individuals to withdraw from their social supports which increased feelings of loneliness and isolation.

While there were many concerns expressed regarding cancer related physical changes, it was not uncommon to hear patients report constructive outcomes as well. Some reported having more respect for their bodies and making lifestyle changes that included eating healthier foods, increasing physical activity, and quitting smoking. A scoping review of qualitative research from Menger et al. (2021) indicated that approximately 60% of cancer survivors experience positive change as a result of their cancer experience. Some examples of the areas of growth described in this study included: relating to others as they were able to prioritize the important individuals in their life and reported increased empathy; being open to new possibilities by re-evaluating their career choice and spending more time with family; increased personal strength and resilience; a greater appreciation for life and gratitude for small everyday things; and spiritual change as many individuals reported their faith deepening (Menger et al., 2021).

It is important to stress that positive and negative changes were not mutually exclusive and patients typically experienced both types of change as a result of cancer (Schroewers et al., 2011). While both positive and negative changes are possible, a person's affect, coping strategies, and goal reengagement influence the amount of each type of change experienced (Schroewers et al., 2011). Individuals who had a positive affect and utilized active coping strategies such as reframing and acceptance lead to higher instances of positive change (Schroewers et al., 2011). On the other hand, individuals who had a negative affect and utilized avoidant coping strategies such as self-distraction and trying not to think about their concerns lead to higher instances of negative change (Schroewers et al., 2011). In addition, cancer and cancer treatment can interfere with patients pursuing their personal goals, therefore, reengaging in old goals or participating in new, attainable goals that are meaningful can also lead to an increase in positive change (Schroewers et al., 2011).

Self-Talk and Unhelpful Thoughts

The next portion of the class that I helped to develop described basic concepts of Cognitive Behaviour Therapy (CBT) with a focus on defining self-talk and unhelpful thinking patterns with examples that applied these concepts to cancer and cancer treatment related body concerns. The goal of this section was to help create patient awareness of when their thought process is counterproductive and hurtful. Once a thought is identified as unhelpful there is the opportunity to practice reframing the thought to one that is more realistic and less harmful. Evidence supports the use of CBT interventions to support women with breast cancer who have body image concerns, however, further research is needed to determine the effectiveness for other patient populations (Fingeret et al., 2014).

Future Considerations

At the end of my practicum, I was in the beginning stages of coordinating with the Indigenous Patient Navigator to connect with an elder in order to include an Indigenous perspective. Some of the concepts we discussed were Anishnabemowin concepts surrounding self-forgiveness (BOON GIDET WISHIN), self-care (NAA DAWEN MISHIN), as well as communicating with the creator. Recognizing my social location as a Caucasian settler, it is not appropriate for me to provide these Indigenous teachings. There is the potential of incorporating a video of the Elder's teaching but that is a work in progress.

Conclusion

Whether it be improving clinical skills, examining systemic concerns within healthcare, or improving person-centred care, this practicum provided a strong foundation for me to continue developing my social work practice. The impacts of the practicum on my social work practice will be further explored in the following chapter.

Chapter 4 - Critical Reflection and Implications for Social Work Practice

In order to be an effective social worker, a clinician must engage in reflective practices that acknowledge how their life experiences, biases, and demographics may influence their perspective, and how these will impact the relationships and interactions with the individuals seeking services (Burr et al., 2016; Constable, 2016). The deeper the reflection, the greater the increase in awareness and self-evaluation (Yip, 2006). In addition, the process of framing and reframing their thinking may lead social workers to develop new insights and perspectives which can result in alternative problem-solving strategies for challenging situations (Yip, 2006).

In this chapter, I will use critical self-reflection to review what I learned during my advanced practicum with the Supportive Care Program (SCP) and how this learning can help me support cancer patients on an individual level, as well as, a systemic level. This will involve examining common themes that appeared in my daily journaling; an analysis of my own positionality and how this impacts interactions with patients; future professional development; and implications for the social work profession.

Journaling

While self-reflection can yield numerous benefits, it can be counterproductive if conducted in a way that is unstructured and uninformed by theory. Social workers who have a negative self-image may misinterpret the purpose of self-reflection and ruminate on their weakness resulting in a fixation on negative experiences that can lead to increased anxiety, as well as, the individual questioning their suitability to work in the social work profession (Constable 2016; Yip, 2006). Structured exercises can assist by encouraging productive reflection that yields deeper insight and helps increase self-awareness (Burr et al., 2016; Constable, 2016).

Approximately 10 to 20 minutes at the end of the day each day was allocated to the self-reflection journal. In order to resist unhealthy self-criticism/rumination, I applied a semi-structured framework to my daily journal entries. A journal template was developed applying reflective questions posed by Constable (2016) which used a Cognitive Behaviour Therapy (CBT) theoretical approach to analyze situations and reoccurring themes. The journal prompts utilized the ABC (Antecedent Belief Consequence) model which involves identifying the event/stimulus that triggers the individual's belief system followed by the individual's cognitive, emotional, or behavioural response (Cobb, 2016). The goal of this style of journaling is to help identify unhelpful thinking patterns or biases followed by restructuring these thoughts to reflect a more constructive perspective. For instance, my journal entry would begin with a description of an issue, concern, or challenging experience that occurred that day followed by a reflection of any underlying biases, beliefs, or assumptions that may be present in my thought process, as well as how I responded to the situation at the time. Afterwards, possible next steps for growth were identified. This included a range of possibilities such as conducting additional research to increase my knowledge regarding the specific situation, exploring alternative perspectives, as well as addressing my negative thought process directed at myself as a clinician.

Throughout the journaling process, themes began to emerge which identified mental barriers that slowed progress of developing my clinical skills. When meeting new patients, I was concerned that I would "say the wrong thing" and open up a topic that was distressing to the patient and cause more psychological harm. This prevented the opportunity for deeper emotional discussions which may be helpful to patients. In addition, I also became aware of some perfectionistic tendencies that involved comparing my clinical skill level to individuals with much more professional experience resulting in self-doubt and discouragement. To cope with

these thoughts, and the anxiety they invoked, I would overanalyze and excessively prepare before meeting with a patient which led to a disproportionate amount of time planning that could be better utilized.

There was a moment during the discussion portion of a depression and anxiety webinar where a young professional asked the speaker about how to avoid “opening pandora’s box” when having emotionally charged conversations with patients that was particularly insightful. In essence she was afraid that certain conversation topics would cause a patient additional and unnecessary stress and that she was not skilled enough as a clinician to shift the conversation back to more positive/pleasant topics. The speaker expressed that when we only address the practical issues and not the emotional, we ignore that there’s more to the patient’s life than just cancer. He then encouraged clinicians to provide patients space to talk about things that are already on their mind, even if they are challenging. Denying patients the opportunity to discuss emotionally charged topics can limit the positive benefits linked to receiving psychosocial interventions such as increasing one’s ability to cope and reducing anxiety and depression levels (Daem et al., 2019; Hoon et al., 2013; Nekolaichuk et al., 2013). Jillian Romanko and I discussed these topics at length during our field supervision meetings, and together we were able to determine that my thoughts of being unable to manage the emotional needs of the patients were unrealistic and anxiety-based as she was able to observe the majority of my counselling sessions and felt that I was developing the direct practice skills necessary to provide psychosocial support to NECC patients.

A CBT framework was utilized as I was overemphasizing the likelihood of a negative event occurring during a counselling session, and therefore, I was avoiding topics that were emotional in nature (Greer et al., 2010). As my thoughts were unrealistic and unhelpful,

cognitive restructuring was utilized to formulate more constructive and realistic thoughts. This perspective shift from seeing myself as an inexperienced clinician causing negative thoughts and emotions to a clinician that would provide the opportunity for patients to discuss negative thoughts and emotions in a supportive environment dramatically changed the way I approached clinical situations. As a result, I was encouraged to continue to provide the opportunity for patients to delve deeper into their emotional selves while utilizing their goals to help shape the session. In addition, this situation was a powerful example of how the theories and interventions used to support patients can also be applied to my own personal and professional growth. Likewise, having experience with applying interventions to my personal and professional life will improve my ability to explain and demonstrate strategies to others.

Positionality Analysis

As previously mentioned in Chapter 2, many individuals experience oppression from medical institutions through discriminatory practices spawned from sexism, racism and colonization. As I strive to incorporate reflection into my social work practice it is important for me to analyze how my social location as a 6th generation English speaking Canadian citizen who is white, cisgendered, heterosexual and appears female impacts the power relations between myself and individuals seeking support. However, I've learned from conducting research for my advanced practicum thesis that simply identifying my social roles and being aware of the privilege I experience is not sufficient as it does not address the power differential in relationships nor does it advocate for societal change. An article by Heron (2005) describes how only identifying one's social location is problematic:

The acknowledgment of privilege seems to strike a chord for racially-aware members of the dominant group, but I would propose that admitting one's privilege does not necessarily unsettle its operation. For this is a concept that has the potential to leave those who name it in

a place of double comfort: the comfort of demonstrating that one is critically aware, and the comfort of *not* needing to act to undo privilege. (p. 344)

I'm embarrassed to admit that, as a member of the dominant group in many areas of my life, I have experienced the "double comfort" of feeling critically aware of my privilege while also not advocating or encouraging any necessary social change. I can recognize my past naivety while also recognizing that I continue to be naïve to the discrimination endured by those with lived experiences. I feel that this area requires lifelong learning and reflection utilizing the concepts of cultural humility including openness, self-awareness, and self-critique (Foronda et al., 2016). I am taking steps to address this area by analyzing my positionality and exploring how this impacts the relations of power that operate during social interactions.

Examining one's positionality involves analyzing how the social roles I previously identified impact how I respond to the world through personal interpretations and how the world responds to me in return (Jacobson & Mustafa, 2019). The Social Identity Map developed by Jacobson and Mustafa (2019) was utilized to initiate critical thinking and foster awareness. Although the Social Identity Map is categorical by design, it is only meant to be the starting point of the reflection process. The first tier involved identifying the different social identities that I fulfill while the subsequent tiers explored how these identities impact my life and any emotions that are connected to these experiences. It is important to recognize that the factors that comprise an individual's positionality are not fixed constructs but are fluid and can change over time or shift according to the context, such as an individual's income level (Jacobson & Mustafa, 2019). A person may earn different income amounts throughout their life due to changes in salary, periods of unemployment, or retirement. The household income needed to live comfortably can also vary depending on changes in the economy, like inflation, or the cost of living in a particular area. Gender identity is another example of a factor of one's positionality

that at one time was considered fixed but is now considered a fluid construct that may change (Jacobson & Mustafa, 2019).

In regards to exploring the power relationships between my myself and patients, it is uncomfortable to acknowledge, but quite frankly as a visibly Caucasian person, I benefit from the domination of other racial groups. As it currently stands, I am becoming more aware of my bias blind spots. As previously mentioned in Chapter 2, a hospital is an institution and due to colonization and racial discrimination, many individuals have had traumatic experiences. Therefore, when working with patients, particularly those belonging to a racialized minority, it is important to be aware that behaviours that I might deem as being “troublesome” or “noncompliant” might actually be the individual resisting further marginalization (Kondrat, 1999). For example, an Indigenous patient having more visitors in their room at one time than what is outlined in the hospitals policy could be viewed as noncompliant and unmanageable. However, when we consider certain factors such as the history of colonization and discrimination towards Indigenous people; the disregard of the importance of Indigenous healing practices; and the cultural significance of family and community then we can view this same situation as a way for these individuals to keep their loved one safe from mistreatment while continuing to practice their cultural values during a time when their loved one is vulnerable and in need of emotional support (Hole et al., 2015). Changing how I view these behaviours would likely change how I would respond to a given situation.

Kondrat (1999) describes a list of questions social workers can use to critically reflect on “the world”, “my world”, and the contradictions between those worlds. Questions that are related to the reflection of “the world” entail exploring the social constructs that are in place, who benefits from these constructs, and how my beliefs or behaviours contribute to maintaining these

structures (Kondrat, 1999). Questions involving “my world” require an honest reflection on my beliefs and assumptions regarding individuals who belong to a different demographic categories and what social constructs I have internalized and are woven into my self-narrative (Kondrat, 1999). The final set of questions suggested by Kondrat (1999) involve exploring the contradictions between one’s intentions, values, and actions. By using the reflective questions as a guide, I am trying to identify my internalized racism and recognize when I have failed to uphold an anti-oppressive stance and have been racist in my work with certain patients (Heron, 2005).

In addition, I would like to read more literature in both my personal life and professional practice by authors from a variety of different backgrounds (Indigenous, people with disabilities, immigration stories, etc.) as a way to further develop my understanding through the voices of people with lived experiences.

Future Professional Development

My time completing my advanced practicum with the Supportive Care Program (SCP) at the Northeast Cancer Centre (NECC) provided the opportunity to learn about systemic concerns and improve my skills as a clinician. While I can acknowledge progress in the development of my direct practice skills, this continues to be an area that I will continue to nurture. I plan to continue using a generalist-eclectic approach during counselling sessions as it incorporates a holistic perspective and allows the flexibility to utilize a wide range of theories depending on the patient’s situation and what they found helpful. While my focus during the advanced practicum was on cognitive behaviour theory (CBT), dialectical behaviour theory (DBT), mindfulness, meaning making, strengths perspective, existentialism, and embodiment theory, I look forward to

expanding my knowledge and skills to include other theories that could be beneficial to individuals experiencing medical concerns.

Since my advanced practicum hours, I have accepted a role within the hospital that is split between inpatient and outpatient settings. Based on suggestions from the department's clinical lead, I will be pursuing the possibility of enrolling in an online course that teaches Focused Acceptance and Commitment Therapy (FACT) to medical professionals. Unfortunately, there are time constraints in an inpatient setting limiting the amount of attention a medical professional can provide to an individual. FACT involves utilizing Acceptance and Commitment Therapy as a brief intervention that can be used when there may be limited time available to spend with a patient before discharge.

Further development will also include continuing to use self-reflection to address how my own anxieties, insecurities, and perfectionistic tendencies can become a barrier to deeper emotional exploration during counselling sessions. As previously described, I found CBT's cognitive restructuring intervention to be useful when attempting to overcome a professional barrier, however, further development is needed in order to be successful in a demanding career such as social work. People who demonstrate maladaptive perfectionism, such as having unrealistically high standards, fear of failure, being overly critical, and the inability to accept making a mistake, are more likely to experience workaholism and professional burnout (Chang, 2012; Stoeber & Damian, 2016). There are different approaches that could be used to better manage my anxieties and perfectionistic tendencies, but the approach that I am interested in approaching in the future is emotion-focused therapy (EFT). Studies have indicated the effectiveness of EFT in the treatment of anxiety disorders and focuses on the development of self-compassion and self-acceptance, two areas which are in need of improvement when I am in

a professional setting (Watson et al., 2019). Ideally, I would like to obtain this knowledge through a workshop or webinar as I find that I retain more information and have a deeper understanding when guided by a professional.

Another personal professional development goal that I am interested in achieving is improving my ability to speak French as a second language. According to the 2016 census, 27.5 percent of the population of the Greater City of Sudbury speak French as their first language while 38.7 percent of the population are bilingual speaking both French and English. I already have some knowledge of the French language and this additional education would allow me to provide services and communicate to more individuals in the language that they feel the most comfortable using (Statistics Canada, 2017b).

Implications for the Social Work Profession

As discussed throughout this advanced practicum thesis paper, social workers have a crucial role within an oncology setting such as supporting patients on an individual level by protecting patients from the abuse of power, encouraging patient engagement in decision making, and advocating for patient autonomy. Social workers also encourage the treatment of the patient as a whole person by not reducing the individual to their diagnosis and symptoms which can improve overall quality of life. The dominance of the medical model can create challenges to uphold these practices, therefore, developing assertiveness in order to effectively advocate for patients, families, and the expertise of the social work profession is necessary in order to excel as an oncology social worker and ensure person centred care.

While social work serves an important role within medical institutions, there can be challenges effectively integrating social work services within an interdisciplinary team (Ashcroft et al., 2018). Lack of role clarity, strained professional relationships, and inappropriate utilization

of social work skills are examples of some of the barriers social workers in collaborative medical settings experience (Ashcroft et al., 2018). Recommendations to improve social work integration within interdisciplinary teams include providing education to colleagues outlining a social worker's role, skills, and competencies; highlighting the positive impact of social work involvement on patient care; and social work participation on organizational decision-making discussions (Ashcroft et al., 2018).

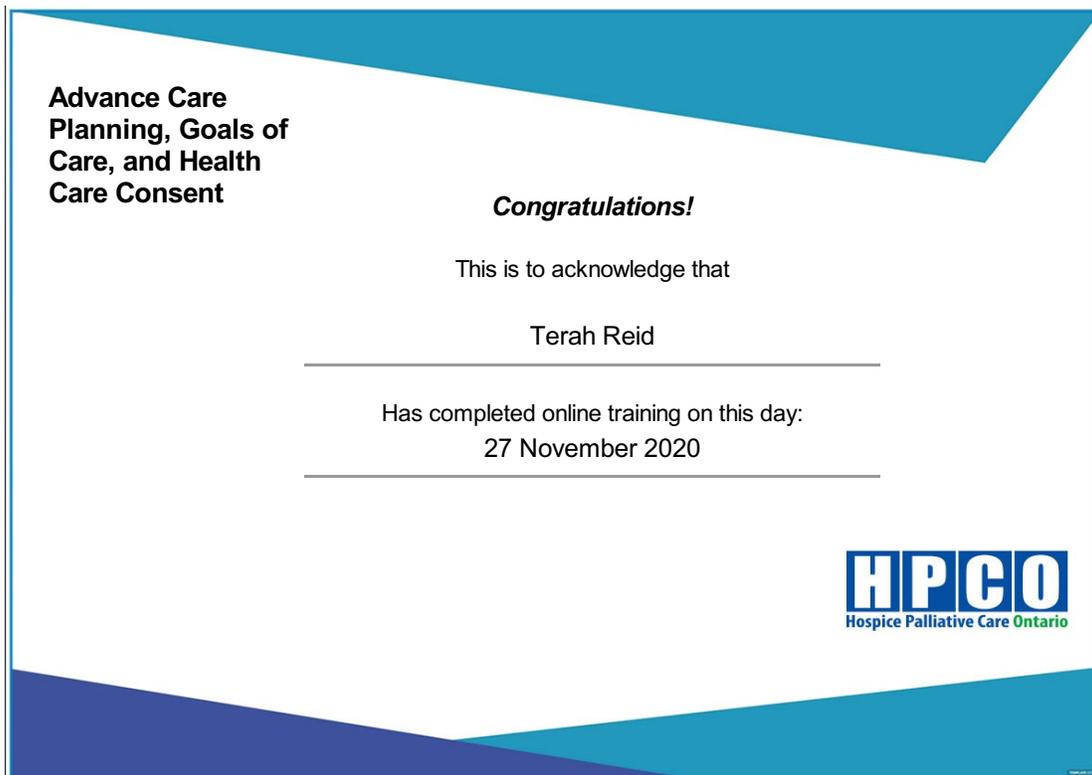
In addition, social workers should advocate for structural changes within the Canadian healthcare system. According to the literature and reports from lived experiences, racist and discriminatory behaviour exhibited by healthcare professionals result in inadequate/harmful care and unmet healthcare needs. In order to do this effectively social workers must have an understanding of the historical systemic concerns present within our healthcare institutions informed by the core concepts of cultural humility. Recommendations to better address these disparities include, but are not limited to, increasing the amount of leadership positions held by individuals of marginalized groups; receiving feedback regarding interventions/education/policies from individuals with lived experiences; and increased availability of cultural and language services (Hassen et al., 2021; Tuyisenge & Goldenberg, 2021; Vhabi et al., 2016).

In summary, while working in an oncology setting is challenging, social workers have a profound impact on the lives of the people impacted by cancer on an individual level by providing psychosocial support; education; and advocacy for patient care needs, as well as, on a systemic level by promoting systemic change through organizational and political advocacy; decolonization; and addressing discrimination.

Appendix A

Hospice Palliative Care Ontario's Advanced Care Planning, Goals of Care, and Health Care

Consent Certificate of Completion



Appendix B

Hospice Palliative Care Ontario’s Advanced Care Planning Conversation Guide

Advance Care Planning Conversation Guide – For Ontarians

Name: _____ **Today’s Date:** _____
MM DD YYYY

This document serves to record wishes, values and beliefs for future healthcare. It is NOT consent for treatment. It will be viewed as a representation of your thoughts and reflections therefore please use their own words.

1. UNDERSTANDING

What do you understand about your current health or if you have any illnesses what have you been told by your healthcare providers? What do you expect to happen over time?
 (E.g. Do you expect to get better, be cured, or is your illness expected to get worse over time? Might you develop difficulty with memory, swallowing, walking or other things that are important to you?)

2. INFORMATION

If you have illnesses and are unsure about what might happen over time, what information about the illness and treatments would be helpful to you? Is there information that you don’t want to know?

3. VALUES, BELIEFS & QUALITY OF LIFE

What brings quality to your life? What is important and gives your life meaning?
 (E.g. being able to live independently, being able to recognize important people in your life, being able to communicate, being able to eat and taste food, spending time with friends and family etc.)



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NOTE: The structure and organization of the six domains of ACP Conversation Guide questions were influenced by several sources and resources. Among these include the FIFE communication model and the Serious Illness Conversation Guide by Ariadne Labs.

Advance Care Planning Conversation Guide – For Ontarians

The remainder of the questions ask you to think about future situations. They are meant for you to consider what might be important to you in the event of a sudden critical illness (e.g. an accident) or as you are nearing the end of your life from a serious illness. This is a chance to tell your SDM about what is important to you and how you would like them to make decisions.

4. WORRIES & FEARS

Think about the care you might need if you have a critical illness or if you are near the end of your life. What might you worry about or what fears come to mind? (E.g. struggling to breathe, being in pain, being alone, losing your dignity, depending entirely on others or being a burden to your family and friends, being given up on too soon etc.)

5. TRADE OFFS

If you became critically ill, life support or life extending treatments might be offered. Describe for your SDM the state you would consider unacceptable to keep living in.

6. NEAR THE END

If you were near the end of your life, what would be important to you?
(E.g. family and friends nearby, dying at home, having spiritual rituals performed, listening to music etc.)



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NOTE: The structure and organization of the six domains of *ACP Conversation Guide* questions were influenced by several sources and resources. Among these include the FIFE communication model and the *Serious Illness Conversation Guide* by Ariadne Labs.

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