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Problem Solving Interventions: An Opportunity for Hospice Social Workers to Better Meet Caregiver Needs

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Explaining the role of social work has been a traditional challenge for the profession. Social workers are often solicited by patients, clients, and even colleagues to define and explain their role. “What is a social worker?”, “how could I use one?”, “why do I need one?”, and “what can you do for me?” are all questions frequently asked of social workers, regardless of setting. Hospice social workers are no different. The role of the social worker on the hospice interdisciplinary team and the role with patients are often confused and blurred with nurses and chaplains (MacDonald, 1991; Reese & Brown, 1997). In hospice, collaboration among team members often requires disciplinary responsibilities to overlap, making the challenge of defining social work perhaps even greater.

The ambiguous nature of the role of social work in hospice care is due in part to the lack of standardized assessment across the hospice setting. Initial assessments with patients and families vary greatly among hospice programs and sometimes among practitioners within the same hospice. While all social workers are required by Medicare Conditions of Participation (Center for Medicare and Medicaid Services, 2008) to conduct an initial assessment of patients and families, the components of that assessment are not specified (Reese & Raymer, 2004). Reliable and valid standardized instruments, such as the geriatric depression scale, are not commonly used by hospice social workers (Parker Oliver, Wittenberg-Lyles, Washington, & Sehrawat, 2009). Unlike the numeric pain scale or other tools for pain assessment supporting the nurses, hospice social workers have not agreed upon ways to measure the psychosocial issues facing their clients. While some within the hospice social work community have developed standardized assessment tools --the Social Work Assessment Tool (Reese et al., 2006) is one example--their adoption has been limited.

The lack of standardized assessment often results in an unfocused intervention (Parker Oliver, et al., 2009). Unfocused interventions can leave hospice social workers with an ambiguous identity on the team, unable to articulate their role in terms understood by the medical team members, and unable to determine the effectiveness of their work.

The purpose of this essay is to describe one common social work intervention and discuss its applicability for hospice social workers. We suggest a problem solving intervention (PSI), coupled with the use of standardized instruments to aid in assessment and evaluation of outcomes. This intervention provides a standardized practice approach for hospice social workers and should be further investigated.

Problem Solving Theory

Problem solving can be defined as a self-directed process aimed at identifying solutions for specific problems encountered in daily life (D'Zurilla & Nezu, 2007). The premise of this approach is that problems, identified by an individual, can be addressed with an active cognitive process to find a solution. PSI combines this premise with a rational model of stress as outlined by Lazarus (R. S. Lazarus, Kanner, & Folkman, 1980). Lazarus contends that stress is influenced by an individual's cognitive appraisal of a situation and his or her ability to effectively cope with the challenges it presents (R. Lazarus, 1999). PSI assesses individuals' problem solving tendencies and teaches behavioral change thereby influencing both cognitive appraisal and coping.

D'Zurilla and Nezu (2007) propose a problem solving approach that encourages individuals to modify their thinking about stressors and address problems using four related steps. This approach has been summarized by the acronym ADAPT (Attitude, Define, Alternatives, Predict, and Try out). Before embarking on the four steps, individuals are encouraged to adopt an optimistic attitude toward their ability to effectively problem solve. Then, they are guided through a problem solving process in which they clearly define the problem(s) they are facing, generate a list of alternative solutions, weigh the pros and cons of each alternative, and implement the solution most likely to be effective. This structured approach teaches individuals a skill set that can carry over to future problems.

Researchers have tested PSI with a variety of individuals facing different problems. In a recent randomized controlled trial in the home health care setting, PSI was used as a standardized intervention with home care clients to address depression (Gellis et al., 2008). To address the common problem of depression in home health caregivers, social workers systematically assessed caregivers for depression and used structured PSI as an intervention. The data showed that augmenting traditional home care with six weeks of PSI significantly lessened depression and increased problem solving ability in caregivers. In addition to finding significant improvement in depression, the home care caregivers perceived the intervention positively. Research showing the positive effect of PSI includes work with caregivers of physically and cognitively impaired older adults (Gallagher-Thompson et al., 2000), caregivers of dementia patients (Roberts et al., 1999), and caregivers of children with traumatic brain injury (Wade, Wolfe, & Brown, 2005). This research suggests PSI is also applicable in the hospice setting.

This research team has applied PSI to hospice caregivers (Demiris et al., 2010). In a pilot study we used brief PSI in hospice caregivers and found the therapy assisted in lowering anxiety, improving problem solving abilities, and improving quality of life. Likewise, PSI was satisfying for caregivers and feasible to deliver in a home care setting. In this case, PSI was delivered by four different interventionists, two nurses and two social workers. The interventionist made an initial visit to consent the caregiver into the study, administer the assessment instruments, and ask the caregiver to identify a problem to work through from a

standard problem list. For example, one caregiver chose to work on finding ways to keep the patient from wandering in the night, and another identified her exhaustion as a problem. During following 4–6 weeks the interventionist made two additional visits to the caregiver's home to teach the problem solving process, using the identified problem as an exemplar to teach the ADAPT skills. During a final visit to measure outcomes, the interventionist also interviewed the caregivers about their experience. Without intentional protocol design to address the role of social workers, seven caregivers made comments pertaining specifically to the role of social workers. These caregiver comments are worthy of discussion and attention, as they provide additional evidence of the need for focused social work interventions and a clear, recognized social work role on the hospice team. Caregiver comments were a result of the interventionist asking a general question about the communication between the caregiver and the hospice.

Confirming the confusion about the social worker role and involvement in care, one caregiver stated, “The social worker, she doesn't come every week, she comes maybe once a month”. Similarly, another responded:

I suppose I could call the social worker, I haven't done that, but the nurse, she calls me about every week, and in a way I think she might be an alarmist or something, truly she has her own issues. Her father is elderly in [remote city] or somewhere and she is dealing with that, so I don't know, maybe I would recommend that the social worker make contact with me on a regular basis so she can kind of oversee everything.

This caregiver went on to note confusion with many different hospice staff, including the social worker. Additionally, she is indicating that perhaps the weekly calls from the nurse are too frequent.

Yes, one time, let me see, it's so confusing there was a lot of different people, there was a nurse and an intake social worker and then there was going to be the real social worker that was going to come every week or every two weeks ... and the nurse was going to come every week. I've never even met them, I don't think, because there are so many people involved, I don't believe I've even ever met the regular social worker, I've only met the intake social worker and the intake nurse, and I was there when the nurse made her first visit, so she's stayed in contact with me.

Likewise, yet another caregiver was struggling with how to respond to the social worker stating:

Well, they always ask how you are doing, so I say fine. They want to find out how you are doing emotionally. I wonder how many people ... the hospital releases people to hospice and things don't go well, ...I don't know, I've never looked it up or the statistics or anything like that, but I wonder because every single person says, “how are you guys doing?”. I say, “oh we're good, how should we be doing?” I wondered about that you know.

Throughout the study, caregivers expressed surprise that they, rather than the patients, were the focus of our study. This surprise was apparent in the exit interview. In contrast, two caregivers noted that their understanding of the role of the social worker was that he or she would be more focused on the patient than on them. When asked about the communication between the caregiver and the hospice, two caregivers stated:

I'd say that's not so good in the sense that I mean our whole focus is on Judy [the patient] and they are real nice, it's not that, but I think the social worker is of the group the most concerned with the aspects of hospice and caregiving. I'd say the

nurse much less, but not inappropriate, I'd say it's not a criticism as much as an observation.

The social worker spends more time with us about the needs of the patient, so you see what I'm saying, even the social worker spends more time with us than the nurse, but it is still focused on the patient. Basically they give us things to do, you know call us if you need something, but then you're still kind of left, every time you meet somebody new or something, you don't know. You think does this meet the level of bother you criteria, so you don't know. So even though they are trying to be nice and they leave at that, you know here's the 24 hour number and we are always staffed.

Finally, two caregivers discussed the benefits of the PSI with the interventionists, comparing that experience to their social work visits. One caregiver noted that the PSI accomplished her problem solving quickly, while the social work visit was less efficient,

Yeah, I mean, you know, we took like three hours to come and accomplish what we've done, or four but, I mean, the amount of payback and comfort I got from this, you know, it was kind of peak intervention. It was a big bang for a buck.

In yet another interview the final caregiver noted:

Caregiver: Yes, maybe it was my fault, because I'm always so Mom-orientated that I never brought up my needs to ... the social worker about needing more respite help and she's been really good at trying to help me with some of these issues, but I don't think I could have gone as far with her help as I have with this program you've given me, in fact we just kept talking the problem over you know we weren't really getting going here.

Interviewer: Getting through it?

Caregiver: Yes, getting through it.

In summary, these comments suggest that the PSI delivered by the interventionist provided a regular, focused intervention which was understandable and helpful in contrast to the less regular and less focused social work visit. Given the potential benefit of PSI, the delivery of this brief structured intervention with caregivers is worthy of consideration for use in hospice.

Implications for Policy, Practice, and Research

While this paper is not meant to be a presentation of research, one outcome of our study is the indication that the regular structured use of a PSI should be investigated more thoroughly for use by hospice social workers. The use of PSI holds promise as a social work intervention with hospice patients and caregivers, and can add to the overall effectiveness of the team. It also offers the opportunity for formal assessment and documentation of caregiver concerns and for reassessment and measurement of the outcome. By embracing the clinical roots of the profession and the problem based assessments which are a part of clinical training, social workers have an opportunity to better articulate their identity and role on the team, which in turn will be embraced and better understood by patients and families. Social workers are the appropriate team members to focus on caregivers, and this brief structured intervention has the potential to accomplish this work.

Further research is needed to build the evidence of the effectiveness of PSI in hospice as well as to understand the impact of its use on social workers. Randomized clinical trials of PSI in hospice are feasible and specific evaluation of the impact of PSI on the role and understanding to social workers is also an important component of that research. As policy

makers create regulations for social workers, the need to more clearly require social workers to move from an ambiguous role as team member and care provider, to an integrated and understood member of the team is critical. Social workers have a responsibility to provide valid and reliable assessment, develop and communicate their interventions, and respond regularly to the needs of not only hospice patients, but also, and perhaps especially hospice caregivers.

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