Interdisciplinary Team Strategies for Terminally Ill Clients and Families Experiencing anticipatory grief In Home-Based Care In Kenyan low-Income communities: A Systematic Review

Dr. Wanjiru Jane J. Mugai
Chuka University, Kenya

Abstract: **The study evaluated the effectiveness of interdisciplinary team strategies for helping terminally clients and families experiencing anticipatory grief in home-based care. Interdisciplinary teams represent the collaborative working between professionals from various disciplines including physicians, psychiatrists, psychologists, nurses, social workers, and other trained volunteers as well as spiritual leaders with the aim of addressing various needs of patients or clients with terminal illnesses and their families. Most patients diagnosed with life-limiting illnesses such as cancer, Alzheimer's disease among other life threatening illnesses may have multiple and complex needs. Facing end of life due to advanced severe illness can result in psychological pain and distress associated with anticipatory grief. Such clients and their families require integration of interdisciplinary team strategies to their care regimen so as to help them cope with psychosocial issues and complex multi-morbidity. Sustained levels of anticipatory grief can result in serious health risks including serious mental health disorders like clinical depression in patients faced with end-of-life and members of their families. Although little evidence exists regarding the risk factors of anticipatory grief, some empirical evidence point to a serious state of emotional suffering that may require integration of support from an interdisciplinary approach. However, the approaches aimed at addressing the end-of-life psychosocial issues in Africa and Kenya in particular may not be similar with those utilized in the western world and many of them are not well documented. There was need to assess the effectiveness of strategies being implemented by interdisciplinary teams to address issues related to anticipatory grief in terminally ill clients and families in home-based programmes in Kenyan communities. To establish the effectiveness of the strategies used, a systematic literature review was conducted through identification of relevant published articles in various databases including Clinical trials, MEDLINE, PubMed, and PsycINFO, in addition to a hand search on relevant journals, dating from 2000 to 2020. To ensure quality of the findings, only articles and studies published in reputable journals and databases were included in the synthesis. The selection criteria focused on studies using qualitative methods or mixed methods so as to ensure consistency of study designs. The search identified 15 articles, which were assessed to establish quality for inclusion, after which 7 that met the criteria were included in the synthesis. All the included articles represented a population of 290 respondents drawn from various regions in Kenya, and focused on various themes, including communication, dignity therapy, spiritual care, and psychosocial support. The results from the reviewed articles indicated that communication, dignity therapy and general structured counselling as well as spiritual support were helpful in end-of-life care, thus establishing a level of effectiveness in addressing anticipatory grief in clients with terminal illnesses and their families. The study recommended that extensive training on grief counselling methods was required on communication proficiency of care providers. More research was recommended on effectiveness of other interventions that were not evaluated in this review.**

Keywords: **Anticipatory Grief, Interdisciplinary Strategies, Communication, Dignity Therapy, Counselling, Spiritual Support**

I. INTRODUCTION

Interdisciplinary approach entails working collaboratively between professionals from different disciplines through sharing of responsibilities while promoting role interdependence and respecting each member's autonomy and experience (Department of Human Services, 2008). An interdisciplinary approach relies on health professionals from different disciplines, along with the patient/client, working collaboratively as a team, (Wikipedia Google 2020). The most effective teams share responsibilities and promote role interdependence while respecting individual members' experience and autonomy.There is substantial scientific research pointing to potential benefits of interdisciplinary approaches in caring for clients with life-limiting illnesses and family caregivers in home-based care programmes.

A report by The National Hospice and Palliative Care organization (NHPCO) (2018) in United explains that interdisciplinary team members basically comprising of physicians, social workers, nurses, spiritual or religious counselors or therapists, occupational therapists, have been helpful in management of anticipatory grief and end-of-life care in clients and caregivers both prior and after death. Such bereavement services are preceded by assessment protocols, which may include evaluation of risk factors, for complicated grief, concurrent life stressors, social support, and relationship with the deceased among other relevant factors.

Research shows that adopting a family-centered approach allows professionals to easily facilitate bereavement care to patients and their families by helping them come to terms with the dying process. The approach may benefit the surviving family members by providing them with a sense of comfort and predictability. Ideally interdisciplinary teams' (IDTs) approach focuses on creating a competent workforce from clinical and non-clinical, as well as government and nongovernmental services through integration of major services, including psychiatry, nursing, psychology, social work and occupational therapy (Schultz, Walker, Bessarab, McMillan, & Marriott, (2014). Collaboration is acknowledged as an important component of team processes. A concept analysis undertaken by Henneman *et al*. identified that collaboration "requires competence, confidence and commitment on the part of all parties. Respect and trust, both for oneself and others, is key to collaboration. As such, patience, nurturance and time are required to build a relationship so that collaboration can occur.

In interdisciplinary team approaches emphasizes are mostly done to empower the clients and the family.Interdisciplinary team strategies' involvements in end-of-life care focus on the biopsychosocial and spiritual dimensions of human experience and facilitate growth and development in the last phase of life. In spite of its great promise for improving clients care, the interdisciplinary model is notwidely implemented in today's health care system and mostly in Kenya. The contributions of interdisciplinary teams to terminally ill clients in home based care can be enhanced through the development of interdisciplinary team training programs, the creation of payment structures that support the interdisciplinary team model, and continuing research assessing the dynamics of team functioning and the benefits that interdisciplinary team care provides to client and families in the terminal illness phase.

However, teams providing support ought to understand the risk factors resulting from morbid bereavement, distinguish various presentations of grief, and know how to manage such outcomes, or make referrals if clinical interventions are required (Lichtenthal et al., 2011). Several theoretical works have looked into the benefits and effectiveness of interdisciplinary teams' approach in supporting patients at end-of-life stage and their families cope with anticipatory grief. Potential benefits of IDTs on anticipatory grief or the sorrowfulness occurring before deaths of patients with terminal illnesses have been established, not only for patients and home caregivers, but also for organizations that provide care as well as practitioners.

While anticipatory grief may have some similarities with grief after death, the former is distinguished by its unique indications, such as increased anger, intense loss of emotional control, anxiety, lower quality of life, and uncharacteristic grief responses (Al-Gamal, 2013). Other indications include lower level of well-being among terminally ill clients and increased caregiver burden, which necessitates care services such those provided through interdisciplinary teams (Garand et al., 2012). Studies have highlighted some difficulties in provision of interdisciplinary approaches during anticipatory grief process for the terminally ill clients. Coordinated interdisciplinary teamwork is difficult and improving communication skills with all interdisciplinary team members does not always occur. In an empirical study by Mazor et al. (2012), "breakdowns" in care were found to be fairly common with patients during cancer treatment.

Effective interdisciplinary team characteristics are competence, communication, and organization (Klarare et al., 2013), including leadership, clear vision, quality of care, respect for team roles, respect for the clients/patient and individual characteristics (e.g., listening skills, desire to achieve group goals, and interdisciplinary team experience; Nancarrow et al., 2013).

Increased levels of AG have also been associated with poor decision making of caregivers. This was reported by Fowler, Hansen, Garand and Barnato (2013) from University of Pittsburg, in a study involving 73 families and caregivers of terminally ill patients/ clients. The study found that intense levels of anticipatory grief strongly correlated with decreased levels of positive problem solving, such as seeing problems as challenges; and having heightened levels of negative problem solving, like maladaptive cognitive emotional tendencies. These multiplicities of responses require different diagnosis through a multifaceted, consultative approach, implying that care services through interdisciplinary approach may be important.

Studies have also shown that anticipatory grief for the terminally ill clients in the home based care can be more psychologically distressful than the common grief after death. Indeed Johansson and Grimby (2012), in a study examining the experiences of anticipatory grief in family members of patients in palliative care and hospices in Sweden found that 40 per cent of women who had lost a husband reported pre-loss stage to have been more stressful compared to post-loss stage. In AG, patients and family members faced with the reality of terminal illness have an elongated grieving process. While this form of grieving may benefit the families of patients with terminal illness by preparing them for imminent death and helping them develop coping skills after death, there is need for monitoring in order to get necessary support.

Reviewed research indicates that families experiencing AG may have wide ranging emotional responses such as existential loneliness, disappointment, sadness, anxiety, separation, resentment, anger, guilt, desperation, loss of identity, exhaustion and denial among others (Garand, et al., 2012). Such persons may benefit from interdisciplinary teams strategies, which prioritizes on mental health, physical, emotional and social well-being of patients and families.

Despite the growing tide of many life-threatening illnesses such as cancer and the ongoing Covid-19 pandemic, there is paucity of research regarding the effectiveness of

interdisciplinary approach in managing anticipatory grief at the end-of-life. However, some researchers such as Muhammed (2020) and NNadi (2019) in Nigeria have shown that home-based and respite care, psychosocial support provided by professional counsellors as well as spiritual support and various community based interventions may benefit patients and families experiencing grief due to impeding loss.

Selman, Higginson, Agupio, Dinat and Downing (2009) in Uganda and South Africa found that poor coordination and intermittent supply of information about symptoms management by care teams only increased distress among clients with terminal illness and family cares and recommended more training in counselling and communication proficiency for care providers. In Kenya, Weru, Gatehi and Musibi (2020) showed that use of inter-professional approaches such as dignity therapy may help patients and families cope with grief, improve wellbeing. Other studies showed that approaches utilized by IDTs including caring for clients through integrating various competencies may be effective in reducing physical and emotional distress in patients and families (Grant, Brown, Leng, Bettega, & Murray, 2011; Githaiga & Swartz, 2017).

Interdisciplinary team work is a complex process in which different types of staff work together to share expertise, knowledge, and skills to impact on patient care. Despite increasing emphasis on interdisciplinary team work over the past decade, in particular the growth of interdisciplinary education as note by Hammick, Freeth, Koppel, Reeves,& Barr (2007), there is little evidence as to the most effective way or strategies of delivering interdisciplinary team work (Ravet 2012);

This difficulty is compounded by the multifactorial nature of team work, which comprises the skill mix, setting of care, service organisation, individual relationships and management structures, (Nancarrow, Booth, Ariss, Smith, Enderby, and Roots 2013).

II. LITERATURE REVIEW

Interdisciplinary treatment strategies denote the collaborative approach between various professionals, including physicians, nurses, social workers, counselors, therapists, chaplains or spiritual leaders, and home health aides as well as other trained volunteers to address multifaceted needs of terminally ill patients (Wittenberg-Lyles, Parker, Demiris & Regehr). Characterized by nonhierarchical formation, interdisciplinary teams (IDTs) work together with each of the team members taking responsibility for effective workings of the team towards caring for the terminally ill patients. Strong IDTs depend on good interdisciplinary education, careful selection of members and quality team training in key skills such as communication proficiency, stress management as well as having good institutional support (Judith, 2011).

The term anticipatory grief (AG) on the other hand entails a state of sorrowfulness associated with an expected loss that is common in terminally ill patients and families staring at end of life of their loved ones (Johnson, Lodhi, Cheema, Stifter & Dunn-Lopez). Most of very old patients and those diagnosed with cancer, Alzheimer's disease and other terminal illnesses may as well have multiple and complex needs, and facing end of life due to advanced age or severe illness can result in pain and psychological distress associated with anticipatory grief. Such patients and their families may require integration of interdisciplinary team strategies to their care regimen so as to help them cope with psychosocial issues and complex multi-morbidity (Daem, Verbrugghe, Leroux, Hecke, & Grypdonck, 2018).

Research indicates that availability of care services tailored for the terminally ill and their families can be helpful in improving the quality of life for such patients and families as they stare at the reality of death due to a life threatening illness (BLeclerc, Blanchard, Cantinotti, Couturier & Gervais, 2014). Studies have shown that sustained levels of AG can lead to serious health risks both in terminally ill patients and members of their families. Lichtenthal, Clark and Prigerson (2011) in their work *Supportive Oncology* argue that intense anticipatory grief can result in serious mental health disorders such as clinical depression, which may end up causing substantial impairment in the daily lives of the patient and family members.

Although little evidence exists regarding the risk factors of anticipatory grief, some empirical evidence point to a serious state of emotional suffering that may require integration of support and care strategies with an interdisciplinary approach. Burke, Clark, Ali, Gibson and Smigel sky (2015) in a study carried out in Tennessee, United States reported that anticipatory grief is associated with serious risk factors and should therefore be closely monitored in order to provide necessary interventions to the affected patients and families. The study assessed the effects of anticipatory grief in 57 family members of terminally ill veterans and reported that anticipatory grief was part of a group of factors and related distress that necessitate early monitoring in order to provide intervention where possible.

Psychological effects of AG are evidenced through studies such as one reported by Garand, Lingler, Deardorf, DeKosky, Schulz and Reynolds (2012) in Pennsylvania, United States, which established a correlation between high depression levels and anticipatory grief in family caregivers of patients with Alzheimer's disease. Other studies have also shown correlation between anticipatory grief and psychological distress, including hopelessness and intrusive thoughts in advanced cancer patients and their families (Mystakidou, Parpa, Tsilika, Athanasouli& Vlahos, 2008).

D'Antonio(2014) in New York, United States underlined some of the most common strategies employed by interdisciplinary teams. These include giving information about AG, seeking to

normalize the experiences and dealing with somatic concerns. Studies have shown that once those experiencing AG are identified, IDT providers use approaches like identifying psychological and physical responses, and addressing them by providing information or education to patients, caregivers and families, as well as making use of empathetic communication strategies (Back, Arnold & Tulsky, 2010).

In support of the above findings, Metcalf (2013) at St. Catherine University in Minnesota found that strategies such as education and communication with patients and families, empathetic listening and reminiscing or life review were effective in supporting patients and families experiencing AG. In particular, participants in this study reckoned that the end-of-life moment calls for quality listening, and empathetic communication skills so as to offer a listening ear and companionship on the journey. This creates an impression that providers of this intervention actually care, making the patients and families to feel even more empowered towards expressing their emotions (Klunder, 2011).

However, most of the available literature focuses on interventions for managing chronic pain, anxiety and depression, which are also common in terminally ill patients and families. Moreover, intervention strategies for AG remain largely untested and cannot be generalized for Kenyan situation. Additionally various methods may have different results on each individual's needs (Hultman, 2008). There is some empirical evidence supporting the implementation of other intervention strategies, such as dignity therapy, individual and group psychotherapy, grief therapy, and meaning centered therapy (Metcalf, 2013).

Martínez, Arantzamendi, Belar, Carrasco and Centeno (2017) in a systematic review of 28 studies reported that dignity therapy (DT) is helpful in controlling psychological distress and relieving existential distress in terminally ill patients. The study's results were categorized into various forms, including effectiveness, suitability, feasibility, satisfaction and adaptability to various illnesses and cultures. One of the randomized studies pointed to statistically significant reduction of anxiety and depression scores of patients experiencing high levels of baseline psychological distress at end-of-life. However, further research is needed to assess the effectiveness of DT in families and home-based caregivers of patients with terminal illness.

Conversely, Mai, Goebel and Jentschke (2018) in a mixed methods study carried out in two German palliative care units established that DT is helpful and feasible for German palliative care units. The study involved 30 patients and 26 relatives and found out that out of the 19 patients who completed the questionnaire, 18 rated DT as helpful, same as 24 out of 26 relatives who answered all the questions. However, more evidence is required to compare and assess the effectiveness of strategies such as DT in patients and families experiencing AG in other countries and backgrounds.

In many African countries, a growing tide of chronic illnesses including cancers and the ongoing HIV/AIDS and currently Covid-19 crisis presents a legitimate need for effective home-based care programmes for the purpose of addressing end of life grief in patients and their families. There is still very little research regarding the strategies utilized by interdisciplinary teams to respond to anticipatory grief in this region. Further, there is lack of service appraisal and measurable outcomes on the efficacy and effectiveness of intervention strategies used on patients, families and caregivers in home-based programmes on the continent (Gysels, Pell, & Straus 2011).

In Nigeria, Nnadi (2019) notes that the approach for addressing the end-of-life psychosocial issues is different from what takes place in the western world. He observed that strategies utilized for the terminally ill and grieving relatives include home-based and respite care as well as emotional and spiritual support. This was consistent with Muhammed (2020) in yet another Nigerian based research, which recommended relevant community based intervention programmes that could address varying needs of clients and families experiencing grief during the end-of-life.

Agom, Ominyi, Onyeka and Anyigor(2020), in an exploratory study involving physicians, nurses, patients, and their family members sought to find the effectiveness of collaboration of interdisciplinary teams in Nigerian context. The study established that clients with life-limiting illnesses benefitted from strategies such as psychosocial support and pain management provided by interdisciplinary teams. The IDTs would occasionally visit clients and their relatives at home, and also made routine virtual contact through mobile phones to offer care and support to improve the quality of clients and relatives. Patients /clients and families sampled in this study acknowledged that the inter-professional teams offered services such as medication advice, bed bathing, wound dressing, counselling and emotional support.

Studies about interdisciplinary strategies offered through home-based programmes are still scarce and there is paucity of solid evidence-base regarding the effectiveness of such approaches in helping clients and their relatives facing end of life related grief. This is consistent with Selman, Higginson, Agupio, Dinat and Downing (2009) study focused on addressing information needs of patients with incurable diseases and their relatives in South Africa and Uganda. The study found that information needs regarding treatment and symptom management were rarely met due to poor supply of information by inter-professional teams, leading to increased distress among clients and their caregivers. The study recommended further training in the areas of communication and counselling skills for the personnel offering care services at end of life stage.

In Kenya, despite paucity of research regarding management of anticipatory grief in terminally ill patients and families, some studies have shown promising results in some of the intervention strategies. For instance, Weru, Gatehi and Musibi

(2020) conducted a randomized trial on the effect of dignity of therapy in helping advanced cancer patients achieve quality of life. The results showed that dignity therapy had some positive effect on lowering anxiety and even a greater statistical in appetite improvement and wellbeing. The results however showed that DT had no statistical change in patients' overall quality of life.

III. THEORETICAL FRAMEWORK

The systematic review was anchored on five stages of death model by Elisabeth Kubler-Ross (1967) as outlined in her work, On Death and Dying. Kubler-Ross illustrated the process of death as comprising five main stages identified as denial, bargaining, depression and lastly acceptance (Kübler-Ross & Kessler, 2005; Bregman, 2017). In the first stage, *denial*, Kubler-Ross observed that individuals react in refutation of negative information or upsetting reality as a defense mechanism against hardship. At this stage patients diagnosed with terminal illness as well as their relatives may at first deny and object to the reality of such information. Kubler-Ross opines that such news should be delivered with skillfulness and clarity.

The next stage is *anger*. In this stage, Kubler-Ross finds that patients experience anger as they process and accept the reality of a life-threatening illness. In going through the process, patients may lay the blame on various individuals such as physicians for failing to treat or prevent the disease, relatives for not being as supportive as expected, or other persons such as providers of spiritual support certain injustices and so on. In this stage, inter-professional care providers such as nurses and physicians as well as family caregivers ought to be able to discern that the anger being experienced by the patient is a natural response and be able to tolerate it.

The third stage is identified as *bargaining*, which Kubler-Ross noted might be characterized with seeking certain measures of control over illness. This may include medical, religious or social help or even adhering to recommended form of treatment. While some bargaining or negotiations may even appear irrational, care providers do not have to be too hard on patients in correcting their negotiations but need to be considerate and provide necessary care without being too hearty so as not to distort patients' ultimate understanding.

The fourth stage is identified as *depression*. In this stage, Kubler-Ross notes that a patient may experience various responses such as fatigue, sadness and anhedonia, ideally describing the deep state of emotional pain and distress that may also be transferred to caregivers, including family and relatives. This stage demands that care providers be conscious in restoration of compassion that may have been lost in the previous stages. The last stage, which is identified as *acceptance* is illustrated as the period when an individual comes into terms with the reality and does not have to object or struggle against it any more. During this stage an individual may out of acceptance even begin to prepare for death, enjoy the remaining time or even contribute towards the wellbeing of their loved ones. The last stage of Kubler-Ross is the ultimate goal of grieving or dying process.

IV. METHODS

The systematic review was conducted through identification of relevant literature by conducting an intensive search on various databases, including Clinicaltrials, MEDLINE, PubMed, and PsycINFO, in addition to a hand search on relevant journals, dating from 2000 to 2020. To ensure quality of the findings, only articles and studies published in reputable journals and databases were included. The selection criteria focused on studies using qualitative methods or mixed methods. The process was important to ensure there was consistency in selection and proper consideration of study designs.

Articles that were not related to anticipatory grief, interdisciplinary team strategies, terminally ill clients and family caregivers were excluded. Similarly, articles that were not based on research carried out in Kenya were not included. The titles and abstracts identified through database searches were read to establish the suitability of the article. If the basis for suitability was established, then the source article was retrieved and read in full. The quality of the articles included in the synthesis was established through assessment of each title, abstract, purpose, research design and data analyses procedures, possibility of biases, ethics, implications and generalizability.

V. RESULTS AND DISCUSSION

The initial comprehensive search identified 15 articles, out of which 7 were eventually included following quality assessment for inclusion in the synthesis. All the articles included in the synthesis had a population of 290 total participants. Out of those included, 3 focused on communication around end of life care, 2 focused on dignity therapy while the other 2 were centered on general counseling, spiritual care/ counselling, psychosocial and emotional support as strategies used by interdisciplinary teams in home-based programmes to support terminally ill patients and relatives experiencing anticipatory grief as shown in Table 1.1.

Table 1.1: Summary of Synthesis and Effectiveness of Interdisciplinary Team Strategies for Anticipatory Grief

Author	Participants	N	Location	Strategy/ Intervention	Effectiveness
Selman, 2018	caregivers & Patients	21	Nairobi	Spiritual care	Effective
Murray, 2003	Cancer patients & relatives	24	Meru	General counseling, psychosocial, emotional, spiritual support	Psychosocial and spiritual needs are met
Kimani, 2018	Heart patients	18	Western Kenya	Communication about illness,	Poorly executed
Caren, 2020	Patients & caregivers	16	Uasin Gishu	Communication about illness,	Communication is therapeutic and effective
Githaiga, 2017	Family caregivers	13	Nairobi	End-of-life care communication	Communication is helpful. Family caregivers influence end of life preparedness
Grant, 2011	Patients, family carers,nursing staff, community leaders, volunteers	54	Nairobi	Dignity therapy, social support i.e. bathing, feeding instruction enhanced dignity, facilitate good death	Patients valued being treated with dignity & respect. Home based social support reduced physical, emotional and financial burden
Weru, 2020	Patients	144	Nairobi	Dignity therapy	Dignity therapy is helpful in lowering anxiety, improving wellbeing

Communication in end-of-life Care

Most of the studies showed that good communication is a fundamental component in end-of-life care as it creates connectedness between patients with life-threatening illnesses, families and caregivers. Meaningful end-of-life conversations between patients and physicians, nurses and family members enhanced preparedness about death and dealing with issues surrounding the end of life. Good communication by interdisciplinary teams was effective as a psychosocial intervention for patients and relatives in coping with anticipatory grief (Githaiga, 2017). Communication influenced adaptation to illness, adherence to treatment, patient disclosure and treatment outcomes and was found to be therapeutic to both patients and carers (Caren, 2020). However, one study showed that communication was counterproductive due to poor execution (Kimani, 2018). These findings were consistent with Judith (2011) observation in her work *Interdisciplinary Team, Palliative Care,* in which she claimed that strong interdisciplinary teams are based on quality training in fundamental skills, such as communication proficiency and stress management.

Dignity Therapy Enhanced Quality of Life

Reviewed studies indicated that dignity therapy and treating terminally ill patients with dignity and respect enhanced quality of life for patients and lowered distress in families. In one study dignity therapy was found to be helpful in lowering anxiety, improving appetite and wellbeing (Weru, 2020). Showing dignity and respect to patients, being supported at home through practical support strategies such as providing directions on bathing and feeding in home-based programmes enhanced good deaths. Home-based social support also reduced physical, emotional and financial burden to patients and families (Grant, 2011). This implies that dignity therapy and treating clients with respect in home-based care averted avoidable suffering and distress for patients, caregivers and families, thus helping in coping with anticipatory grief. The findings are consistent with Martínez et al. (2017) systematic review that reported dignity therapy as being helpful in lowering psychological and existential distress in patients with terminal illness. The findings also support Mai et al. (2018) in a German based mixed methods research that found dignity therapy to have been effective in helping patients in palliative units, as well as relatives experiencing pain and grief related to a lie-limiting illness.

General Counselling and Spiritual Support Advanced Human Connectedness

Other reviewed studies showed that providing general counselling, spiritual support, emotional support were helpful in addressing patients, caregivers and family members' psychosocial and spiritual needs (Selman, 2018; Murray, 2003). These findings corroborate (Garand, et al., 2012) study, which reported that prioritizing on social wellbeing, mental health, and emotional support can be helpful to patients and families experiencing grief related to life-limiting illness, noting that AG is associated with diverse emotional responses including sadness, disappointments, anxiety, resentment, separation, anger, identity loss, denial and exhaustion among others.

VI. CONCLUSION

The study sought to establish the effectiveness of interdisciplinary team strategies for terminally ill clients and families experiencing anticipatory grief in home-based care programmes within Kenyan communities. The following conclusions were reached based on the findings:

The study concluded that quality communication was effective in managing anticipatory grief in terminally ill clients and families in home a fundamental component in providing end-of-life care to patients and families experiencing anticipatory grief. Meaningful conversation

between nurses, physicians and patients and their families were effective in enhancing preparedness about death and dealing with psychosocial issues associated with anticipatory grief.

The study concluded that dignity therapy was effective in managing anticipatory grief in terminally ill clients and their families. Dignity therapy enhanced quality of life amongst clients with life-limiting illnesses, caregivers and relatives. Treating terminally ill patients with dignity and respect, offering practical social supports at home, such as providing directions on feeding and bathing reduced suffering, enhanced good deaths and lowered distress in patients, families and caregivers.

The study concluded that general counselling and spiritual support was effective in supporting terminally ill clients and families experiencing anticipatory grief. Psychosocial counselling and spiritual care delivered to patients at home was helpful in meeting the psychosocial needs of patients and families experiencing anticipatory grief.

VII. RECOMMENDATIONS

Based on the findings, the study made the following recommendations:

- The study recommended that there was need for implementation of more appropriate and robust strategies that are sensitive to culture and varying needs of local communities.
- The study recommended that extensive training on communication skills be offered to care providers for effective collaboration and clarity within care teams, patients and families.
- The study recommended that more research was needed on effectiveness of other intervention strategies that that were not evaluated in this review.

REFERENCES

[1] Agom, D., Ominyi, J., Onyeka, T., &Anyigor, C. (2020). Exploring Organizational Culture Regarding Provision and Utilization of Palliative Care in a Nigerian Context: An Interpretive Descriptive Study. *Indian journal of palliative care*, *26*(3), 358–364. https://doi.org/10.4103/IJPC.IJPC_39_20

[2] Al-Gamal, E. (2013). Quality of life and anticipatory grieving among parents livingwith a child with cerebral palsy. *International Journal of Nursing Practice*,19(3), 288–294.doi: 10.1111=ijn.12075

[3] Ashford, J. &LeCroy, C. (2013). *Human behavior in the social environment: A multidimensional perspective.* Belmont, California: Brooks/Cole.

[4] Back A., Arnold, R., &Tulsky, J. (2010). *Mastering Communication with Seriously Ill Patients: Balancing Honesty with Empathy and Hope*. New York: Cambridge University Press; 2010.

[5] BLeclerc, B., Blanchard, L., Cantinotti, M., Couturier, Y., Gervais, D., Lessard, & S. Mongeau, S. (2018). The effectiveness of interdisciplinary teams in end-of-life palliative care: A systematic review of comparative studies *Journal of Palliative Care* Volume 30 Issue 1 pages 44-54 https://doi.org/10.1177/082585971403000107

[6] Bregman L. Kübler-Ross (2019). The Re-visioning of Death as Loss: Religious Appropriation and Responses. *J Pastoral Care Counsel*. 73(1):4-8. [PubMed]

[7] Burke, L., Clark, L., Ali, K, Gibson, B. Smigelsky, M &Neimeyer, R. (2015). Risk Factors for Anticipatory Grief in Family Members of Terminally Ill Veterans Receiving Palliative Care Services, *Journal of Social Work in End-of-Life and Palliative Care*, 11:3-4, 244-266, DOI: 10.1080/15524256.2015.1110071

[8] Daem, M., Verbrugghe, M., Schrauwen, W., Leroux, S., Hecke, A. &Grypdonck, M. (2018). How Interdisciplinary Teamwork Contributes to Psychosocial Cancer Support. Cancer Nursing. 42. 1. 10.1097/NCC.0000000000000588

[9] D'Antonio, J. (2014). Caregiver grief and anticipatory mourning. *J Hosp PalliatNurs*. 2014; 16(2): 99-104.

[10] Department of Human Services (2008). *Health independence programs guidelines*, State Government, Melbourne.

[11] Eldrige, L. (2019). How anticipatory grief differs from grief after death. Very Well Health. https://www.verywellhealth.com/understanding-anticipatory-grief-and-symptoms-2248855

[12] Fowler, N., Hansen, A., Barnato, A. & Garand, L. (2013). Association between anticipatory grief and problem solving among family caregivers of persons with cognitive impairment. *Journal of aging and health*, *25*(3), 493–509. https://doi.org/10.1177/0898264313477133

[13] Garand, L., Lingler, J., Deardorf, K., DeKosky, S., Schulz, R., Reynolds, C. (2012). Anticipatory grief in new family caregivers of persons with mild cognitive impairment and dementia. *Alzheimer disease and associated disorders*, *26*(2), 159–165. https://doi.org/10.1097/WAD.0b013e31822f9051

[14] Githaiga, J., Swartz, L. (2017). Socio-cultural contexts of end- of-life conversations and decisions: bereaved family cancer caregivers' retrospective co-constructions. *BMC Palliat Care***16,** 40 (2017). https://doi.org/10.1186/s12904-017-0222-z

[15] Goldsmith, J., Wittenberg-Lyles, E., Rodriguez, D., & Sanchez-Reilly, S. (2010). Interdisciplinary geriatric and palliative care team narratives: collaboration practices and barriers. *Qualitative health research*, *20*(1), 93–104. https://doi.org/10.1177/1049732309355287

[16] Grant, L., Brown, J., Leng, M., Bettega, N., & Murray, S. (2011). Palliative care making a difference in rural Uganda, Kenya and Malawi: three rapid evaluation field studies. *BMC palliative care*, *10*, 8. https://doi.org/10.1186/1472-684X-10-8

[17] Gysels, M., Pell, C. & Straus, L. (2011). End of life care in sub-Saharan Africa: a systematic review of the qualitative literature. *BMC Palliat Care***10,** 6 (2011). https://doi.org/10.1186/1472-684X-10-6

[18] Hottensen, D. (2010). Anticipatory grief in patients with cancer. *Clin J Oncol Nurs*. 14(1): 106-107

[19] Hultman, T., Keene R, & Dahlin, C. (2008). Improving psychological and psychiatric aspects of palliative care: The national consensus project and the national quality forum preferred practices for palliative and hospice care. OMEGA, 57(4), 323-339. doi: 10.2190/OM.57.4.a

[20] Johnson, J., Lodhi, M., Cheema, U., Stifter, J., Dunn-Lopez, K. Yao, Y., Johnson, A., Keenan, G., Ansari, R., Khokhar, A. &Wilkie, D. (2017). Outcomes for end-of-life patients with anticipatory grieving, *Journal of Hospice & Palliative Nursing*: June 2017 - Volume 19 - Issue 3 - p 223-231 https://doi:10.1097/NJH.0000000000000333

[21] Judith A. (2011). The *Interdisciplinary Team, Palliative Care* (Second Edition), Pages 540-551, https://doi.org/10.1016/B978-1-4377-1619-1.00038-X

[22] Klunder, K. (2011). The complex maze called hospice social work. Denver, Colorado: Outskirts Press, Inc.

[23] Kübler-Ross, E., Kessler, D. (2005). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. New York, NY: Scribner. Google Scholar

[24] Lichtenthal, W., Clark, M. &Prigerson, H. (2011). Bereavement care in Mellar P. Davis, P., Feyer, P., Camilla Z., *Supportive Oncology*, Pages 624-634 https://doi.org/10.1016/B978-1-4377-1015-1.00059-X

[25] Mai, S., Goebel, S., &Jentschke, E. (2018). Feasibility, acceptability and adaption of dignity therapy: a mixed methods study achieving 360 feedback. *BMC Palliat Care***17,** 73 (2018). https://doi.org/10.1186/s12904-018-0326-0

[26] Martínez, M., Arantzamendi, M., Belar, A., Carrasco, J., Carvajal, A., Rullán, M., & Centeno, C. (2017). 'Dignity therapy', a promising intervention in palliative care: A comprehensive systematic literature review. *Palliative medicine*, *31*(6), 492–509. https://doi.org/10.1177/0269216316665562

[27] Metcalf, J. (2013). Hospice Social Work Methods and Interventions for Terminally Ill Patients Experiencing Anticipatory Grief. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/232

[28] Muhammed, S. (2020). Psychosocial Needs of Bereaved Spouses in Nigeria: Implications for Grief Counselling Intervention. *Canadian Journal of Family and Youth* / Le Journal Canadien de Famille et de la Jeunesse. 12. 78-97. 10.29173/cjfy29551.

[29] Mystakidou, K., Parpa, E., Tsilika, E., Athanasouli, P., Pathiaki, M., Galanos, A., Pagoropoulou, A., & Vlahos, L. (2008). Preparatory grief, psychological distress and hopelessness in advanced cancer patients. *European journal of cancer care*, *17*(2), 145–151. https://doi.org/10.1111/j.1365-2354.2007.00825.x

[30] NHS (2013). Optimising the role and value of the interdisciplinary team: providing person-centred end of life care. National End of Life Care Programme, Leeds (UK): Retrieved from: http://capcsd.org/interpro-fessional/EoLC.pdfGoogle Scholar

[31] Nnadi, D. (September 4th 2019). Palliative Care: The Nigerian Perspective, Palliative Care, MukadderMollaoğlu, IntechOpen, DOI: 10.5772/intechopen.85235. Available from: https://www.intechopen.com/books/palliative-care/palliative-care-the-nigerian-perspective

[32] O'Connor, M., Fisher, C., & Guilfoyle, A. (2006). Interdisciplinary teams in palliative care: a critical reflection. *International journal of palliative nursing*, *12*(3), 132–137. https://doi.org/10.12968/ijpn.2006.12.3.20698

[33] Schultz, C., Walker, R., Bessarab, D., McMillan, F., MacLeod, J., & Marriott, R. (2014). Interdisciplinary care to enhance mental health and social and emotional wellbeing. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed., pp. 221-242). AUSMED Publications.

[34] Selman, L., Higginson, I., Agupio, G., Dinat, N., Downing, J., Gwyther, L., Mashao, T., Mmoledi, K., Moll, A. &Sebuyira L. (2009). Meeting information needs of patients with incurable progressive disease and their families in South Africa and Uganda: Multicentre qualitative study. *British Medical Journal*. 2009, 338: b1326-10.1136/bmj.b1326.

[35] Weru, J., Gatehi, M. &Musibi, A. (2020). Randomized control trial of advanced cancer patients at a private hospital in Kenya and the impact of dignity therapy on quality of life. *BMC Palliat Care***19,** 114 https://doi.org/10.1186/s12904-020-00614-0

[36] Wittenberg-Lyles, E., Parker, D., Demiris, G. &Regehr, K. (2010). Interdisciplinary collaboration in hospice team meetings. *Journal of interprofessional care*, *24*(3), 264–273. https://doi.org/10.3109/13561820903163421.