“LET PEOPLE HAVE THEIR PEOPLE”: EXPLORING DEATH AND GRIEVING DURING COVID-19

by

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Abstract

Background: The Covid-19 pandemic had a profound impact on the landscape of bereavement. The effects have been acute and far-reaching, especially as they pertain to impacts on the grief process.

Method: A qualitative approach, known as Interpretive Description, was used to explore the experiences of individuals who lost a loved one to death during the highest restrictive period of the Covid 19 pandemic. This restrictive period was inclusive of March 18, 2020 to June 30, 2021 (Faye et al., 2022). Eight participants across northern British Columbia (BC) participated in semi-structured interviews and shared their experiences around the death of a loved one during the noted restrictive period. Braun and Clarke's (2006) six phases of thematic analysis were used to analyse the data which generated the findings.

Results: There were five overarching themes that emerged from the data with 15 subthemes. The five overarching themes followed by the subthemes included— family dynamics (amplified family dynamics and difficult decisions), individual impacts (death rituals, isolation, and complex grief), societal impacts (exacerbated social conditions, accountability, distrust of systems and fear), coping (spirituality, technology, creative expressions, gratitude and forgiveness), and hope for the future (seeking solutions and information sharing).

Conclusion: The resounding experiences of those who encountered the death of a loved one during the highest restrictive period of the Covid-19 pandemic were fraught with difficulties, in addition to the death. A call for improved solutions in the future was a strong narrative throughout the experiences provided.

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Glossary

Bereavement. Bereavement is unique to grief and mourning, in that it encompasses the experience associated with loss (Shear, 2012).

Covid-19 pandemic. Covid-19 is a new type of coronavirus that was deemed to have created a pandemic on March 11, 2020 by the World Health Organization (WHO) and spread globally (What is COVID-19? 2020; World Health Organization, 2022).

Grief. The internal and psychological response to bereavement (Shear, 2012).

Highest restrictive period of the Covid-19 pandemic in northern British Columbia (BC). Inclusive of the period of March 18, 2020 to June 30, 2021 when restrictions were at their peak in British Columbia (Faye et al., 2022)

Mourning. Integrating grief into life and reorienting to a world without the loved one (Shear, 2012).

Northern British Columbia (Northern BC). For this research, and to provide context, Northern British Columbia will constitute communities north of Williams Lake to the Yukon border, stretching east to the Alberta border, and stretching west to Haida Gwaii. Please see "Appendix D: Map of Sample Population" (BC Touring Council, 2022).

Pandemic Grief. A developing term used to describe the unique grief experience of those living through loss in the Covid-19 pandemic (Ummel et al., 2021).

Persistent Complex Bereavement Disorder. The diagnosis replaced Prolonged Grief Disorder in the 5th edition of the Diagnostic and Statistical Manual (DSM-5) (Boelen & Lenferink, 2020; Eisma et al., 2020).

Post-Traumatic Growth. Transformative alterations in individuals, after having had experienced trauma (Tedeschi, 2018).

Prolonged Grief Disorder. Described as “distressing and disabling yearning for the deceased and/or preoccupation with the deceased accompanied by anger, guilt, and other symptoms indicative of intense emotional pain experienced for at least 6 months after the loss” and a new diagnosis included in the International Classification of Diseases 11th edition (ICD-11) (Boelen & Lenferink, 2020; Eisma et al., 2020, p. 1).

Resilient Grieving. A range of positive actions focused on supporting healthy adaption to loss that have the potential to nurture post-traumatic growth (Hone, 2020).

Spirituality. “Spirituality includes one’s search for meaning and life purpose, connection with self, others, the universe, and a higher power that is self-defined, either within or without a particular faith orientation” (Graham et al., 2012, p. 2). Spirituality is not relegated to the individual, as evidenced by Margolin and Sen (2022) who attest to “a world view of unity, where the ultimate reality is spiritual” where “unity” does not imply “union” but “it is one” (p. 155).

Acknowledgement

I would like to extend my sincere gratitude to the participants of this project; without your participation this study was not possible—I sincerely thank you for your bravery and courage in sharing your experiences. I would like to acknowledge Dr. Tammy Pearson who encouraged me to keep moving forward, one step at a time, despite life's adversities. In addition, Dr. Indrani Margolin, Dr. Jacqueline Holler, and Dr. Joanna Pierce—thank you for your expertise and contributions—I have arrived here because of your support.

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Dedication

To all who passed away during Covid-19, and the loved ones who felt the sting of loss during this unprecedented time—may we learn from their experiences. To my little brother, William Struke, who passed away much too soon at the age of 19 in 2015, and my grandmother, Loretta Edens, who joined him, in September 2022. I hold you both in my heart and hope this research brings some aspects of healing to those who know loss.

Chapter 1: Introduction

Research Question

“Let people have their people” was a participant’s quote from this research that adequately captured the sentiment of several participants. My stark awakening occurred while walking alongside bereaved individuals as a mental health clinician during the Covid-19 pandemic, where I witnessed a distinct impact on the grieving process. It became abundantly clear that the landscape of bereavement had shifted from previous ways of mourning the death of a loved one. As the pandemic and my exposure to the grieving population continued, a persistent question was at the forefront of my mind. In what ways has Covid-19 altered the landscape of bereavement? This curiosity birthed the research question—what are the experiences of individuals who encountered the death of a loved one during the highest restrictive period of the Covid-19 pandemic in northern British Columbia (BC)?

Research Significance

This research provides a contribution to the academic literature relating to the experiences of bereavement during an unprecedented period—the Covid-19 pandemic. The landscape of bereavement was drastically shifted for individuals who lost loved ones during this difficult period in history. It is of utmost importance to be reflective, so that practical considerations and lessons can be learned from this unexpected crisis and can inform future events of this nature.

Purpose of the Research

Covid-19 was declared a global pandemic by the World Health Organization (WHO) on March 11, 2020 (What is Covid-19?, 2020; World Health Organization, 2022). This research retrospectively explored the experiences of the death of a loved one during Covid-19, at the height of the mandatory health restrictions in northern British Columbia. Restrictions were at their peak in British Columbia between March 18, 2020 to June 30, 2021 (Faye et al., 2022). The intent of the research is to provide practical considerations that support individuals who face bereavement during unprecedented events and may need to explore alternative ways of grieving. Furthermore, this research adds to the body of knowledge pertaining to individuals who experienced the death of a loved one during a pandemic. It is hoped that this knowledge may benefit individuals who encounter similar circumstances in the future.

Chapter 2: Literature Review

The Landscape of Literature and the Covid-19 Pandemic

The global Covid-19 pandemic, declared on March 11, 2020, by the World Health Organization (2022), forever changed lives. It has been estimated that for every Covid-19 death, there were nine mourners in the wake of the loss (Fernandez-Pena, 2022). This does not include deaths resulting from peripheral Covid-19 complications. Katz et al. (2020) illustrate the unprecedented nature of experience related to Covid-19 in the following quote: “death and bereavement are a natural part of life, but for most of our generation, global pandemics are not” (p. 433). Furthermore, Jordan et al. (2022) categorize the effects of Covid-19 as impacting grief, interments, the death process, and funerals in unprecedented ways.

At the early onset of the pandemic, the related research findings discussed the unknowns associated with the impact of Covid-19 (Katz et al., 2020; Maryland et al., 2020). When information referred to the effects of the pandemic, there was minimal evidence because of the recent timeline of events, and scholars openly discussed the need for further research. However, as time passed, the literature and research have not only expanded, but exploded. After continuous review of the literature, from 2020 to 2024, it is evident that researchers have conducted and published a plethora of studies regarding the concrete impacts of Covid-19, which will be further outlined below.

The Struggle to Define Grief During Covid-19

A topic area on this subject that appears to hold some ambivalence is how to encapsulate a definition of grief itself. The inconsistency within the literature in defining grief spans years. However, contemporary considerations on the definition of grief have surfaced within the last several years (Boelen & Lenferinik, 2020; Lobb et al., 2010). As grief theory evolved, it culminated in an increased acknowledgement of prolonged grief requiring a more substantial label. The literature questions and cautions against the degree of benefit in attempting to confine the complex human experience of grief. This may help to explain why there is still a struggle to encapsulate a concept that has existed since the beginning of humanity.

There are many means through which grief has been pathologized and prescribed labels. Inclusion of Persistent Complex Bereavement Disorder into the 5th edition of the Diagnostic and Statistical Manual (DSM-5) and of Prolonged Grief Disorder in the 11th edition of the International Classification of Diseases (ICD-11) attest to attempts to label grief (Boelen & Lenferinik, 2020). Killikelly and Maercker (2017) assert that the new diagnosis of PGD provided in the ICD-11 is harmonized with the recommendations provided by the World Health Organization (WHO), which allows for a broader contextual spectrum and usefulness. The anticipated rise in Prolonged Grief Disorder (PGD) or complicated grief, resulting from the Covid-19 pandemic is additionally presented (Eisma et al., 2020; Jordan,et al., 2022).

Others assert that labels, timelines, or prescribed stages of grief can do more harm than good (Stroebe et al., 2017). Diagnosis implies a timeline and a pathology of the griever in response to the loss of a loved one. However, a prescribed approach to defining a complex human response, such as grief, comes with implications. Hirsch (2019) outlines a model by which an attachment to the deceased is not considered to be maladaptive or pathological. Rather, the mourner feels validated in moving through their grief without feeling a need to adhere to a timeline or let go of their loved one.

Hirsch (2019) attests to how a collective response to grief, inclusive of the deceased, is counterintuitive to the normalized and individualized model society currently embraces. Hirsch (2019) further asserts that grief is a very natural and justified response, especially in cases where the griever lived an entire life with a solid attachment to the deceased. A "we" griever is able to simultaneously "hold in mind two complex realities, that is, the reality that my loved one is now 'absent from me' and the reality that my loved one is irrevocably 'present in me'" (Hirsch, 2019, p. 597). Society seeks to diagnose, but Hirsch (2019) contests, a symbiotic response to loss is human and should be normalized, not pathologized. That is, an ongoing connection to the deceased is not something to be pathologized.

Ummel et al. (2021) take these assertions a step further in claiming that neither diagnosis nor non-diagnosis validates what should be appropriately described as a whole separate term referred to as "pandemic grief" (p. 1). We are facing unprecedented grief, amidst a contemporary global event. As such, there is a continuously evolving process of refinement for how to adequately capture the nature of the phenomenon being experienced around the world. Moore (2020) echoes that what we have known to be complicated grief or persistent complex bereavement no longer serves justice in describing something that has become entirely unbearable with the wake of Covid-19. Therefore, research within this area is vital to provide a working comprehension of the uncharted experiences of grief amid a contemporary pandemic.

The Changing Landscape of Mourning

"Funerals are one of the most ancient known tangible signs of human social ritual" (O'Rourke et al., 2011, p. 743). Funerals serve as an important function of negotiating meaning in life and death. The position of the "death worker" in early American history was typically occupied on a part-time basis by trades or occupational groups outside of a designated industry and was known as “undertaking” (Stillion & Attig, 2015, p. 194). Additionally, family members and/or friends would typically carry out many of the activities following a death. Mourning rituals, purchasing coffins from a local cabinetmaker or carpenter, and the digging of the grave also rested with family and/or friends (Stillion & Attig, 2015).

Mourning was a communal process. Following World War II in the early 1950s, the National Funeral Directors Association (NFDA) acknowledged the “social-psychological importance of death and the value of the funeral” (Stillion & Attig, 2015, p. 196). Howard Raether, executive director of the NFDA, observed how funeral practices were much more complex than “embalming” and “undertaking” (Stillion & Attig, 2015, p. 196). This prompted a growing industry around funerals. This recognition reinforced how funerals serve to provide a platform to give and receive social support.

On a more recent note, Gordon (2015) attests to the contemporary medicalization of the dying process, whereby technology has come to replace important death rites and rituals. Further to this, Gordon (2015) sheds light on the often chaotic and disorienting environment the dying and bereaved find themselves in, when it comes to dying within a system. Gordon (2015) unpacks how death can be unnecessarily prolonged, to the detriment of the dying, but eased conscience of the family. These points are skillfully summarized by Gordon (2015) within the following quote:

> Until the advent of modern medicine with all its complex technologies, these activities were primarily focused on what family members and designated religious or cultural leaders brought into the process to assist and guide the dying person and his

> family and community through the dying process and through many defined activities to celebrate the person's life after death had occurred. Modern medicine has in many ways replaced the personal rites and rituals, the songs, chants, music, and appeal to the guiding spirits with complex medical interventions. (p. 6)

In light of the outcomes of Covid-19, it is important to consider how death within the medical system came with consequences for both the dying and bereaved. These ramifications were amplified under the weight imposed on the medical system by a global pandemic (Mellins et al., 2022).

Additionally, Covid-19 impacted death rituals. Moore (2020) illustrates the experiences of individuals being prevented from attending funerals, holding one another, crying in the presence of each other at a time when this is exactly what is needed more than ever. Moore (2020) presents the idea of grief in isolation as being nothing more than an oxymoron due to many cultures sharing in the very social practice of mourning. Becker et al. (2022) found that funeral rituals can significantly improve health outcomes in the aftermath of a loss. It was found that although there was a greater degree of grief in participating in funeral rituals, there was also a decreased cost regarding medical and pharmaceutical costs or access to social services after the fact (Becker et al., 2022). Furthermore, there are devastating effects on a loved one dying alone and for the family members and friends who are not able to be present during the passing of a significant other (Duolong, 2021; Katz et al., 2020).

Much of the research highlights the significant impact Covid-19 had on the process of bereavement (Eisma et al., 2020; Mayland et al., 2020; Ummel et al., 2021). Social isolation was one of the significant factors noted in the literature (Mayland et al., 2020; Ummel et al., 2021). Additionally, the impact on one’s inability to grieve within the context of culture, tradition, and rituals that one normally relied upon was another prominent theme (Eisma et al., 2020; Ummel et al., 2021). Ummel et al. (2021) identified the impact of abstract losses, whereby the individual struggles to fully integrate the loss based on an inability to be present at the time of death and/or facilitate traditional means of realizing the loss, such as seeing a body or attending a funeral.

Finally, an inability to provide family-centered care within the context of palliative care due to restrictions has consequences for bereavement (Katz et al., 2020). In other words, end-of-life care was not occurring the way it had pre-pandemic, which is having impacts on the process of bereavement. Katz et al. (2020) report “although there is much about the COVID-19 pandemic that we cannot control, as clinicians we have a responsibility to arm ourselves with knowledge and courage to focus on the things we can” (p. 434). Moore (2020) hopes that the changes experienced to mourning practices resulting from Covid-19 will assist in perpetuating opportunities for the reconsideration of how individuals conceptualize end-of-life as a society.

Social Impacts of Covid-19

Covid-19 generated an unusual climate in relation to the human need for connection. Levine and Heller (2010) illustrate how “dependency is a fact; it is not a choice or a preference” (p. 26). We are social beings who crave human connection and attachment to others. In reflecting upon the pandemic, it is abundantly apparent how a disconnection occurred amongst human beings. In doing so, a natural human need was interrupted. When we consider this within the context of dying and grief, the implications become increasingly stark. Van der Kolk (2014) and Mate and Mate (2022) echo the implications of disconnection, especially within individuals who have already experienced trauma at some point in their lives. Additionally, they emphasize the need for human connection as an agent for coping, healing, and flourishing.

The research available on social impacts to individuals during Covid-19 reports an increase in rates of anxiety, depression, and alcohol use (Hansel et al., 2022). It was noted that the pandemic "exacerbated prior problems" (Hansel et al., 2022). These factors led to decreased quality of life for those impacted by poor behavioral health. Malcolmson (2022) acknowledges the pandemic's role in the growth of a toxic drug supply, which has added fuel to an already deadly drug crisis. These impacts have the potential to create complex bereavement, as the loss of a loved one is, in and of itself, a difficult path. Society has had to adapt and cope with a global pandemic that witnessed numerous individuals dying alone and fostered an environment ripe with fear and anxiety alongside grief (Chrisman, 2020; Duong 2021).

Coping emerged as another prominent theme within the literature. Sofa et al. (2020) speaks to some aspects of positive coping outcomes during the pandemic. It is noted that there was a significant correlation between coping strategies and psychological well-being. Self-improvement activities and remaining connected with technology were important factors in effective management of stressors throughout the pandemic (Sofa, et al., 2022). This study additionally attested to the "feelings of helplessness in controlling problems arising during the pandemic, such as local government policies and socioeconomic impacts," as a stressor that complicated coping (p. 1).

This brings us to the rise in negative coping, which was a subset within the literature. Negative coping strategies can appear to provide a quick-fix solution to one's pain. Within the context of Van der Kolk's (2014) and Mate and Mate's (2022) work on trauma and what is expressed about traumatic events, it becomes clear in the wake of isolating circumstances why humans, who are wired for connection, may turn to coping strategies that initially fill a need for some semblance of control but fail to deliver in the end. Gouzman et al. (2022) reviewed psychological reactions to Covid-19 on a global scale and in relation to the following: "as a stress situation, traumatic event, shared reality/shared trauma, and loss and grief situation" (p. 2875). Gouzman et al. (2022) predict that there will be long-lasting psychological implications resulting from Covid-19 and suggest that more extensive study is required but echoed other studies around the rise in negative coping and associated symptoms such as anxiety, depression, poor sleep quality, and stress.

The Systemic Impacts of Covid-19

Evidence around the changing nature of how mourning occurs assists in providing an illustration of impacts resulting from structural forces (Ummel et al., 2021). The last century has given rise to the "caring professional" whereby bereavement has been morphed into a "privatized and domesticated" state (Ummel et al., 2021, p. 5). As a result, systems were operating from a platform of scarcity, whereby they struggle to be operational and serve their functions at a basic level. This scarcity has became glaring as a result of the pandemic's toll on an already overburdened healthcare system that fractured under the weight of the demands of the pandemic (Chrisman, 2022; Duong, 2021; Fernandez-Pena, 2022).

While the impact on health professionals is an important area of research (Mellins et al., 2022), much less initial research was focused on how the general populace had been impacted by the Covid-19 pandemic. There was a significant amount of research concerning the toll on health care professionals regarding death rates during Covid-19 (Duong, 2021;

Mellins et al., 2022). Farahmandnia et al. (2020) illustrate how mental health professionals were impacted by the weight of loss incurred by death, in conjunction with pandemic restrictions. Additionally, there appears to be an expectation for professionals to labor through unprecedented complications, despite impacts to their own mental health under the weight of serving a population during a pandemic.

The pandemic is not all bleak, as solution-based outcomes to challenges presented by the pandemic have emerged. Ummel et al. (2021) provided an example of how systemic failures were used to birth a solution-based platform for those who were experiencing deaths during Covid-19 in Quebec. They utilized technology to gather individuals who were disenfranchised and isolated to share their experiences with grief. Their ground-breaking work in the wake of the pandemic sought to address some of the "overlooked" and "chronic" social problems, and "long-standing inequities regarding access to quality of care" that had developed long before the Covid-19 pandemic. These psychologists, who worked in palliative care prior to the pandemic, capitalized on human strength in the form of compassion, peer support, and the power of sharing a common experience via the use of social media to generate strength and courage amongst those who were experiencing deep sorrow resulting from pandemic-related deaths and failed systems (Ummel et al., 2021, p. 2).

In specific relation to the field of social work, there has been a focus on compiling a working comprehension of the scope of the individual within the context of a larger environment during the Covid-19 pandemic (Chigangaidze, 2020). A focal point has included application of an ecological approach to better understand the impacts of Covid-19 on both macro and micro scales. Additionally, social work subscribes to a lens of social justice. Chigangaidze (2020) provides the example of "advocacy for the provision of personal protective equipment and other essentials. It calls for resource mobilization and facilitation of clinical services even to the family members of the frontline health workers so as to reduce anxiety" (p. 12). Social work has taken on the significant task of viewing the pandemic through a multi-faceted lens. Chingangaidze (2020) attests to how this widened lens allows for an optimal fit to a globally complicated situation.

The literature on death, dying, bereavement and Covid-19 encompassed several components: the landscape of the literature, attempts to define grief amidst the pandemic, the changing landscape of mourning, as well as social, and systemic impact. There was a sharp increase in research and literature on the topic, as Covid-19 continued. Additionally, attempts to define grief have remained difficult. The impacts on the mourning process, social, and societal impacts all continue to be further studied. It is abundantly clear that Covid-19 had a profound impact on death, dying, and bereavement.

Chapter 3: Research Design and Procedures

This chapter outlines the research design that governed this study, my personal positioning, reflexivity, the theoretical framework, and the qualitative methodology known as Interpretive Description.

Personal Positioning

Creswell and Poth (2018) express the importance of qualitative researchers' ensuring they shed light on their values within a study, including a description of one's social position. I am a Caucasian settler, educated, and cisgendered female. I identify my socioeconomic status between the lower to middle class range, as I have been a single parent of two children for many years, while obtaining my post-secondary education. I am a daughter, mother, sister, and life-long learner. I started as a volunteer in 2008 in the human service sector and worked as a paraprofessional within the realm of social work prior to graduating from the College of New Caledonia in 2011. I completed my Bachelor of Social Work from the University of Northern British Columbia in 2014. Additionally, I have enjoyed continuous opportunities for learning that have occurred from living, working, and playing within northern British Columbia on the traditional territory of the Lheidli T'enneh.

I have been a resident of northern British Columbia for the past 30 years and the bulk of my professional practice has taken place here. I have held various professional roles working with children, youth, and families within northern British Columbia in urban, rural and remote settings. This part of the world is a region that is near and dear to my heart, both personally and professionally.

It is important to note my experiences as a social worker having taken place in urban, rural, and remote settings in order to paint a picture of my professional background. Collier

(2018) reports a variety of differences within the practice of social work between a rural and urban environment. Collier (2018) describes that professional social work practice in a larger centre uses approaches that are ineffective and counterproductive in rural areas. Collier (2018) claims that rural social work involves “interpreting, analyzing, and constructing” (p. 4). As such, generalist practice is not uncommon among rural social worker practice, as they navigate a plethora of terrains within the work that they perform (Collier, 2018). I have spent the last 13 years working in urban, rural, and remote communities and I can attest to the assorted nature of social work practice, which included a diverse set of roles, responsibilities, skills, interventions, and approaches.

As noted earlier, it was my lingering empathy while working with families during the pandemic that fueled my motivation to explore the experiences of individuals who encountered the death of a loved one during the pandemic. The topic of death and loss was one that had intrigued me for some time. I have experienced numerous losses throughout my life. In 2015, I experienced a profound loss—my little brother suddenly, and tragically, passed away in a head-on collision at 19 years of age. When my brother passed away, I was fortunate to access face-to-face support, and my family was at my side as we walked through this difficult period together. I processed my loss within the context of social and cultural norms that our family and society were accustomed to observing. In contrast, my grandmother and great aunt both passed away within a month of each other during the pandemic. Unfortunately, such norms and cultural practices were not available due to the health restrictions that were in effect. My experience of loss provided a first-hand account of how Covid-19 altered my own grief process. As a result of my personal and professional experience, I was left wondering what were the experiences of individuals who encountered the death of a loved one during Covid-19, across northern British Columbia, at the highest restrictive period of the pandemic?

Reflexivity

Shelton and Flint (2019) utilize the example of transcription to emphasize the important role that reflexivity plays in qualitative research. Reflexivity is embedded into the entirety of the process. It is an opportunity to consider the researcher's symbiotic existence with the research. The concept of reflexivity, in relation to this research, was present throughout the process; including transcription of the interviews, which I had the honour of completing. The section of this paper which focuses on personal positioning above briefly elaborates on the researcher's reflexivity prior to conducting the research. This section will focus on the process and outcomes of the research, in relation to the researcher.

One of the most difficult aspects of this research was maintaining neutrality in the various debates around Covid-19 – and there are a plethora of them out there. I personally and professionally witnessed the devastation of polarized debates during the pandemic. This was particularly difficult amongst hearing the hardships many experienced in relation to the death of their loved ones during the event. I worked diligently to recognize, and set aside, my own beliefs around some of the larger debates that existed within society such as vaccinations, masking, and whether governments, systems, and individuals were helpful or harmful in relation to Covid-19. I achieved this by remaining mostly silent, aside from asking the questions, and allowing participants to tell their story, without any influence from me on how I perceived death and dying during Covid-19.

I certainly have my own beliefs around Covid-19 and how it was addressed, while also recognizing the dangers of black-and-white thinking, jumping to conclusions, and assumptions. I like to consider things from all perspectives, personally and professionally, and have a difficult time drawing definite conclusions on almost anything in this world because I have come to learn that I never know the full extent of anything. I can attempt to immerse myself in a larger picture but ultimately, I may never know all there is to know on anything. I approached this work with the same attitude.

There were two comments from the interviews that, for me, are a testament to the need to do things in a different way moving forward. The first was a comment by Samantha when she said “let people have their people” and the other was from Chloe who stated “We don’t just leave people to die” and furthered this with “I mean you wouldn’t do that to your dog, but you would do it to your child”. Stories of loved ones dying alone, without adequate medical care, and/or in pain (physical and emotional) was a story I have heard many times in relation to the Covid-19 pandemic.

In the culmination of my experiences within the field over the last decade, during Covid-19, and in the aftermath of having engaged in the process of researching death and dying within that context, I strongly feel that things could have been done differently. This is not a judgement on anyone or anything – only to say that we went through a difficult global event, and I sincerely hope, as a society, we learn from it.

Theoretical Framework

My research study capitalized on different but interconnected theoretical positionings that granted the flexibility required to understand such a complex phenomenon. As such, I provided further information on the ways that social constructivism, the discipline of social work, grief theory, trauma theory, Post-Traumatic Growth, resilient grieving, and spiritual theories shaped the trajectory of this research.

Social Constructivism

Social constructivism is an applicable theoretical framework for this study as it seeks to capture “the meanings others have about the world” (Creswell & Poth, 2018, p. 24). Specifically, this study sought to capture an individual’s experience regarding the death of a loved one, as it pertained to the Covid-19 pandemic at the height of restrictions. Social constructivism permitted the participants to construct their own meaning of their experiences with the death of a loved one during that time. Patton (2015) highlights additional advantages to social constructivism, where humans come to research as an evolved species, and as such, construct their own realities. In this manner, the research typically shows a “pattern of meaning” constructed by the participants (Creswell & Poth, 2018, p. 24). The application of social constructivism unites with the narratives of the participants where patterns were identified according to their experiences.

Social constructivism ascertains that the subjective nature of humans typically adheres to a social and historical process of negotiation as a direct result of interactions, which then become cultural norms that frame experiences (Creswell and Poth, 2018). This perspective was helpful given the complex nature of human responses to death, in the context of a global pandemic. Attempting to grasp the human essence of bereavement during a global pandemic, “shared meanings and consensus among a group of people” is of importance (Patton, 2015, p. 121). With the incorporation of social constructivism, I aimed to achieve the ability to honor the individual’s reality of their experiences with death.

The Discipline of Social Work

The discipline of social work provided a firm foundation to view the experiences of the participants for several reasons. Social work is a constantly evolving field due to the fluid nature of human complexities (Heinonen & Metteri, 2005). Social work was a wholesome fit from which to navigate a multifarious experience. Additionally, the British Columbia College of Social Workers (2009) reinforces the varied nature of social work, whereby the discipline provides “a wide range of services that encompass direct and indirect practice and clinical and non-clinical interventions” (p. 6). Grief, especially within the context of Covid-19, makes for an intricate and multifaceted landscape. Social work, with its varied theories and approaches worked alongside the kaleidescopic nature of human existence, which made for an ideal foundational and guiding theoretical framework.

During the Covid-19 pandemic, individuals experienced the death of loved ones within the confines of systems. Collier (2006) poses social work as “a child of industrial society” (p. 5). Born from industrialism, social work attended “to the casualties of the system” due to the deterioration of “extended family and kinship systems” (p. 5). The overarching societal component in the context of the Covid-19 pandemic shaped the experiences of death and bereavement, which cannot be bypassed, when examined from a social work perspective. Therefore, the discipline of social work provided an excellent platform from which to practically examine the experiences of those who encountered a death during a global event. In a society that has outsourced many aspects of death to systems outside of the family, social work theory provided a platform to draw on regarding this contemporary reality and is rooted in several decades of experience pertaining to the outsourcing of human experiences to systems.

The underpinnings of the discipline of social work provided an umbrella of knowledge that served in unraveling meaning-making for participants that experienced the loss of a loved one during a global pandemic from varied and complex situations. The study of one's experience of death provides an immeasurable contribution of learning to a vast life experience. Grief is not a quantifiable event in one's life. It has the potential for far-reaching reverberations. The discipline of social work allots for the multi-faceted pairing of what it means to experience the death of a loved one under complex circumstances.

Grief Theory

It is important to consider grief theory within the context of this study because experiences pertaining to grief are what is being studied. Grief is such a small word for such a large and all-consuming concept. How does one encompass this experience within the context of a study? A quote by Cholbi (2022) provides an eloquent summary of the challenges of studying death and bereavement, especially within the context of the added layer of Covid-19:

> Grief is an admittedly challenging topic to investigate in a sober, academic way. Emotionally complex and seemingly idiosyncratic, grief seems difficult to understand. Beyond that, in order to understand grief, we must confront some of the more unsettling realities of human life: that our emotions can sometimes prove difficult to comprehend or manage, that the people who matter to us are impermanent, and that because of this impermanence, our relationships with others are both sources of, and threat to, our sense of security, safety, and predictability. There is, then, much to be feared both in grief and in investigating grief. (p. 2)

Neimeyer (2014) contends that grief theory was primarily stagnant for the better part of a century while resting on the laurels of Freud's work in *Mourning and Melancholia: The Complete Psychological Works of Sigmund Freud*, the predominant narrative being that one must perform a process of being "withdrawn from attachments" and let go (Freud et al., 1953, p. 244). Neimeyer (2014) contends that this translated into the “letting go” of deceased loved ones, to process grief, and move forward (p. 125). However, another prominent theory that shaped the landscape of grief was proposed by pioneer Kubler-Ross (1973), which asserted that grief is composed of five stages. Those stages are comprised of denial and isolation, anger, bargaining, depression, and acceptance (Kubler-Ross, 1973).

Cadell (2022) attests to the plethora of “myths and misconceptions about grief” (p.100). Furthermore, Kubler-Ross (1973) is cited by Cadell (2022) as a primary contributor to misconstrued notions of grief. Cadell (2022) asserts that Kubler-Ross’ work holds “simplistic and outdated notions… perpetuated by popular culture as well as by health professionals” (p. 100). Cadell contends “theorists in this field now work from far more complex and sophisticated models” (2022, p. 100).

Outlined examples of the models referred to by Cadell, include Rubins’ (1999) two-track model of bereavement, the oscillation model by Stroebe et al. (2005), and the theory of continuing bonds (Klass et al., 2014; Klass & Stefen, 2017). The two-track model utilizes two tracks to assist in the loss: the first being a biopsychosocial approach to interpreting functioning post-loss and the second being the sustained connection between the deceased and griever (Rubins, 1999). The oscillation model refers to just that, the process of moving back and forth between the grief and activities that allow for breaks or to mitigate the pain associated with grief (Stroebe & Schut, 1999). Lastly, the theory of continuing bonds includes the griever and the meaning making that occurs through continued bonds with the deceased, as well as those who remain living with the griever in the wake of the loss (DeGroot et al., 2019).

Neimeyer (2014) proposes that there are four helpful therapeutic approaches, inclusive of Complicated Grief Theory, Cognitive Behavioral Theory, Meaning-Making Approaches, and Family-Focused Grief Therapy (Neimeyer, 2014). The focus of Complicated Grief Theory is to "foster accommodation of the loss and promote restoration of life goals and roles" (Neimeyer, 2014, p. 128). Cognitive Behavioral Therapy seeks to provide "cognitive restructuring and sustained exposure exercises", whereas the Meaning-Making Approach strives to utilize writing about a loss to make sense of it (Neimeyer, 2014, p. 128). Finally, Family-Focused Grief Theory encompasses an assessment of how the family functions (Neimeyer, 2014). Specifically, the assessment is compiled based on "self-reported levels" of the following: "cohesiveness", "expressiveness", and the "capacity to deal with conflict" (Neimeyer, 2014, p. 128).

Trauma Theory

Gouzman et al. (2022) attest that Covid-19 was a "traumatic event". Berger proposes that trauma is rooted in perception (2015). It is important to consider the impacts of worldviews and perceptions on the meaning and weight attributed to individuals' experiences with Covid-19. Nonetheless, Covid-19 has the potential to create circumstances that Berger (2015) outlines as being traumatic in nature. Trauma is an event or series of events that "challenges the natural need of people for the world to be predictable, just, orderly, and controllable such that they anticipate the sequence of events in their life, know what will most probably happen at certain times and plan with some safety" (p. 9). Further to this, Berger (2015) makes the distinction between a "stressor event" defined as placing "a demand or pressure on an individual, a family, or a community that produces, or has the potential to produce, a major change from the previous state so that the regular responses cannot effectively address it" (p. 5). In either case, as Covid-19 is an unprecedented global event, it has the capacity to create arbitrary circumstances which may be beneficially viewed through the lens of trauma theory, while not necessarily working under the assumption that it was traumatizing.

Post-Traumatic Growth (PTG) and Resilient Grieving

It would be a disservice to not include the concepts of PTG and resilient grieving within a global event that undoubtably altered the world. Indeed, these concepts may hold the keys to healing for some within the context of bereavement, which was made abundantly clear through data analysis.

Tedeschi and Calhoun (2004) outline the concept of post-traumatic growth as being:

> positive change that occurs as a result of the struggle with highly challenging life crises. It is manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life. (p. 1)

Further to this, Tedeschi and Calhoun (2004) caution that this concept is not to be confused with invalidating traumatic experiences. Indeed, they legitimize traumatic events as damaging and horrific in nature. However, the point is that the processes undertaken to heal the trauma are also precursors for potential growth.

Boynton and Vis (2022) speak to the transformative power of post-traumatic growth, as editors of *Trauma, Spirituality, and Posttraumatic Growth in Clinical Social Work Practice*. Tedeschi (2018) describes PTG as providing transformative alterations in individuals after experiencing trauma. Hone (2020) describes resilient grieving as a range of positive actions focused on supporting healthy adaption to loss that have the potential to nurture post-traumatic growth. The concepts of post-traumatic growth and resilient grieving offer a light at the end of the Covid-19 tunnel in relation to the darkness experienced and how it can manifest in a significant degree of growth for those who have experienced complex and traumatic events. Many of the deaths experienced during the Covid-19 pandemic were unfamiliar in terms of added layers of complexity associated with pandemic protocols and mandates and presented individuals with difficult circumstances as loved ones died.

Hone (2017) provides additional research on the growth that can result from experiencing loss, termed resilient grieving. Specifically, Hone attests to the normalcy of grief, as a natural reaction to loss, helping to alleviate and validate some of the more challenging feelings that may be associated with grieving. Further to this, Hone (2017) illustrates how humans have overcome adversity through the ages and are continuously adapting.

Spirituality

The topic of spirituality is of importance within this study because many participants cited spirituality as what propelled them through a difficult period in relation to their experiences with Covid-19, isolation, and bereavement. De Vynck et al. (2023) attest to the ability of religion and spirituality to “provide possibilities for healing, resilience, meaning making, and posttraumatic growth (PTG) in the aftermath of trauma” (p. 1). Reliance on spirituality as a source of strength and resiliency, and in place of the typical social lubrication of life that would otherwise take place, was a notable theme within this study.

There exists a great deal of ambivalence in the literature, due to the vast nature of spirituality. However, commonalities through which spirituality has been captured include “a search for meaning, purpose, and connection to the deepest aspects or core of oneself, connection to others, nature, and beyond the human realm such as a higher power of one's belief, or other spiritual entities" (Boynton & Vis, 2022, p. 8). Boynton and Vis (2022) attest that spirituality is "experienced through the mind, and the body and our felt sense, and through our senses and the intuitive dimension" (p. 8). Applying the concept of spirituality is of importance while navigating and studying the topic of Covid-19 and bereavement because several participants noted that their spirituality is what ushered them through their difficult and isolating experiences with grief during the pandemic.

An additional concept that related to spirituality is presented by Nicholas and Kilmer (2022) stressing the following: "In situations usually marked by confusion and despair, much of the literature describing the spiritual coping of patients and their families in palliative or intensive care suggests spirituality as offering peace and hope" (p. 172). In contrast, De Vynck et al. (2023) cautions that the potential harms of religion and spirituality to mental health has not been extensively researched. Further to this, negative impacts of religion and spirituality on mental health are described as creating "spiritual distress". De Vynck et al. (2023) studied spiritual distress within four women of Evangelical Christian backgrounds, and findings included "tumultuous journeys appeared to pull them towards an inner compass of greater congruence and personal strength, authenticity, and expansiveness. This process can be understood through the domains of post traumatic growth" (p. 11). It is interesting to note, that although religion and spirituality may have been a source of anguish within De Vynck et al's (2023) study, it still created an outcome that aligned with post traumatic growth.

Research Design

This research explored individuals' experiences with death during the height of the Covid-19 pandemic, using a qualitative approach known as interpretive description (Thorne, 2016). This section outlines why qualitative inquiry from the perspective of interpretive description best served the research question. This will be illustrated through an exploration of a qualitative interpretive description research design.

Qualitative Inquiry

Qualitative inquiry is applicable to this study, as it seeks to denote multifaceted human experiences whose essence may not be as appropriately captured under the confines of quantitative measurements and statistical analysis. A qualitative approach can "empower individuals to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participants in a study" (Creswell and Poth, 2018, p.45). It is important that the voice of a participant's experience is sufficiently captured, which qualitative inquiry effectively achieves. This study will utilize the qualitative method of interpretive description to achieve this. Thorne (2016), who conceived of the methodology of interpretive description, alludes to the multifarious human condition which is not always adequately captured by other methods of exploration.

Interpretive Description

Interpretive description was birthed out of the nursing field by Sally Thorne (2016). As a researcher of an applied practice, Thorne found that many qualitative methods did not adequately capture the practical and messy pieces associated with studying humans. It became apparent to Thorne that a new method was needed to address the glaring outliers that existed within the context of working with and studying human beings in a way that was directed towards action. Thus, interpretive description, which provides "both empirical integrity and disciplinary utility" (Thorne, 2016, p. 15), was born.

Interpretive description progresses past major description and allows for meanings and explanations to be generated, thus enhancing an applied clinical understanding from the research (Thorne, 2016). To better illustrate the nature of this research design, Thorne (2016) outlines interpretive description as

> a strategy for excavating, illuminating, articulating, and disseminating the kind of knowledge that disciplines with an application mandate tend to need in order to enact their mandate—whether it be healing, educating, serving, or building something on behalf of society. Such work is fundamentally complex and messy, often representing the kinds of problems that defy whole or coherent theorizing and demand instead a multiplicity of insights, perspectives, and approaches, used intersectionally together within increasingly dynamic contexts. (p.11)

My hope for this study is that it will start to develop practical considerations for social workers to improve support for individuals who experience the death of a loved one under complex circumstances. Interpretive description is not only conducive to dissecting intricacies, but has a constructive application to helping professions, as it seeks to reflect on a "practically relevant knowledge gap" (Thorne, 2016, p. 27). These aforementioned factors contributed to identifying interpretive description as the guiding methodology for this research.

Sampling and Participant Recruitment

The Participants

The inclusion criteria included adults (19 years of age or older), who were residents of northern BC and experienced the death of a loved one during the Covid-19 pandemic at the highest restrictive period (which for the purposes of this research, was March 18, 2020 to June 30, 2021). There were eight participants, all of whom met the criteria for participation in the study. Six of the participants were female and two were male. At the time of the research, all the participants resided in northern BC. Seven of the eight participants lived in Prince George and surrounding area, and one participant resided in Fort Saint James. Any demographic information is a result of interacting directly with participants, not of questionnaires or surveys, as presented in Table 1 (Summary of Participant Attributes).

Table 1: Summary of Participant Attributes

Location	**Numbers**
Prince George	5
Prince George – rural	2
Fort Saint James	1
Gender	**Numbers**
Female	6
Male	2
Racial/Ethnic Background	**Numbers**
Caucasian	4
Indigenous	1
First-Generation Caucasian Immigrant	1

Second-Generation Non-Caucasian Immigrant	1

The sample population's geographic parameters included northern British Columbia, which constituted communities north of Williams Lake to the Yukon border, stretching east to the Alberta border, and stretching west to Haida Gwaii (see "Appendix D: Map for Sample Population"). The participants were 19 years of age or older and capable of providing consent. Additionally, eligible participants must have experienced the death of a loved one during the highest restrictive period of the Covid-19 pandemic, while the province of BC was in a state of emergency due to the Covid-19 pandemic. In *Covid-19 Lessons Learned Review: Final Report*, the dates for the state of emergency within British Columbia are outlined as being inclusive of the first wave, and partially into the second wave, of the Covid-19 pandemic (Faye, et al., 2022). The timeline, for the purposes of the research, was that the death of a loved one would have had to occur during the state of emergency in BC, which was inclusive of March 18, 2020 to June 30, 2021.

The rationale for this timeline is that it represents the height of restrictions during the state of emergency in British Columbia. The following overview provides key markers and events during that time, serving to provide context to this logic. The first Covid-19 death in BC was on March 9, 2020 (Faye, et al., 2022). The healthcare system in BC declared a state of emergency on March 17, 2020 (Faye, et al., 2022). On March 18, 2020, non-essential travel was suspended, and establishments were closed (Faye, et al., 2022). Health Canada authorized the Pfizer vaccine on December 9, 2020, with the vaccine arriving in BC on December 15, 2020. On February 5, 2021, BC placed a permanent ban on social gatherings and events (Faye, et al., 2022). May 6, 2021 saw 43% of British Columbians ages 18 and above vaccinated with at least one dose and 66% by May 27, 2021 (Faye, et al., 2022). Finally, on June 30, 2021 BC ended the state of emergency that had resulted from Covid-19 (Faye, et al., 2022). The impact of restrictions on grievers included: limitations on funerals, ability to be with loved ones at the time of death, and/or inadequate access to healthcare if they chose to die at home to be with their loved ones.

Participants were recruited via snowball sampling, posters, and social media. The snowball method's versatility is in the ability to gain access to those who have directly experienced what is being researched through knowledgeable sources (Creswell & Poth, 2018). This method was applicable to the research as it sought individuals who experienced the death of a loved one during the pandemic. Snowball sampling allowed for engagement with a sample that experienced the death of a loved one during the proposed timeframes of the pandemic.

I dispersed posters in public spaces which resulted in generating potential participants who fit the study criteria. Public spaces included bulletin boards at the Prince George Public Library (the Bob Harkins and Hart branches), Hart Home Essentials, the Hart Save On Foods, Second Cup, the University of Northern British Columbia, and the College of New Caledonia. I also provided the posters to professionals and others known to me, who then shared or discussed my study with potential participants. The posters were also distributed via email to those who advised that they knew of potential participants. The poster was also placed on social media platforms via Facebook and Instagram.

In terms of engaging with participants, as per the guidance of to the University of British Columbia Research Ethics Board, I ensured, prior to collection of any information, that potential participants' names and contact information were only shared with the researcher by initial contacts if the contact had received permission from the potential participant to provide the information (University of British Columbia, 2023). Prospective participants were contacted by telephone after they had reached out via email and/or by telephone or provided their permission to have their information shared with the researcher. The purpose of the telephone contact was to review informed consent, explain the purpose of the study, ensure the potential participant clearly understood the study, and ensure the eligibility criteria were met. Additionally, this time provided a platform for any questions. The consent forms were provided to the potential participant for their review through either mail or email, prior to commencing the interview, if they wished it to be sent ahead of time. Otherwise, consent forms and information letters were provided at the time of the interview. If they chose to participate, a signature was obtained at the time of the interview. There was one exception where the interview was conducted via zoom, and the participant provided verbal consent, in conjunction with the research plan outlined to the UNBC ethics review board. Ongoing and informed consent continued throughout the data collection process - please see "Appendix C: Information Letter" and "Appendix D: Consent and Withdrawal" to view what will be provided to participants in this regard.

Data Collection

Data collection was achieved by conducting semi-structured interviews with eight participants. Thorne (2016) notes that "interpretive description can be conducted on samples of almost any size… although the vast majority of studies within this approach are likely to be relatively small (including, perhaps, between five to thirty participants)" (Thorne, 2016, p. 103). In attempting to understand depth of experience, the sample size remains relatively small in order to obtain a thorough understanding of each participant's experience with loss in a meaningful, thorough, and constructive manner. Additionally, Jugessur (2022) attests to the common understanding of six to twelve being commonly recognized as the "number of qualitative interviews needed to reach saturation" (p. 34). In relation to this sample size, this would translate as anything above six to twelve participants, and the research would begin to show the same patterns again and again, thereby obviating the necessity of a larger sample size for the purposes of the research.

Upon interviewing eight participants, definite and emerging themes were apparent, and it was determined, in conjunction with my thesis supervisor, that saturation in the data had been achieved to a satisfactory degree. The eight interviews were conducted over a five-month period (July 2023 to November 2023). Five of eight interviews were conducted in the participant's home. One interview was conducted via Zoom. Two interviews were conducted in locations the participants had requested—a park and a friend's residence.

Regarding the compilation of interview questions, the research design and theoretical framework were factors in the construction of the participant questionnaire (see "Appendix B: Interview Guide"). Interpretive description and the theoretical underpinning of social constructivism provided integrity as a guiding force within the research, as both pertain to the participant's driving the description of their experience (Creswell & Poth, 2018). The questions included an open-ended format, a broad welcome, and broad questions. Questions were prepared to elicit personalized perspectives (Creswell & Poth, 2018). Interpretive frameworks by nature are guided by the researcher as an instrument for interpreting the data, as well as by theoretical orientations (Creswell & Poth, 2018; Thorne, 2016). Therefore, the questions are purposefully broad to capture the participant's voice, in absence of guiding or leading outcomes, as this is conducive to a qualitative, interpretive, and constructivist framework.

Interviews ranged from approximately 15 minutes to 1 hour and 30 minutes in duration, depending on the depth of experience a participant wished to provide. The rationale for utilizing semi-structured interviews was that it was not only conducive to the theoretical framework for the proposed research, social constructivism, but also corresponds well with the study's design, interpretive description. Thorne (2016) acknowledges that "talking is one of our better and more accessible mechanisms for gaining access to that material we call subjective knowledge" (p. 138). Additionally, "we are well aware that 'what' we talk about and 'how' we talk about it are highly influenced by our temporal, spatial, and cultural location, and therefore easily recognizable as a form of social construction" (Thorne, 2016, p. 138).

The tangible aspect of carrying out the interview was guided by several components. Thorne (2016) notes the sense of "nakedness" that can occur when conducting an interview for research purposes, after having worked within an applied discipline. Thorne (2016) cautions against the typical usage of value-laden prompts, prevalent in clinical encounters. Instead, the researcher is encouraged to not be overly directing about the interview. As I have worked within an applied discipline for many years, I was cognizant of this going into the interviews and worked diligently to ensure that I adhered to the suggestions of Thorne.

Additional aspects to note regarding the interview process included the participants' having the opportunity to select a pseudonym of their choosing for the purpose of maintaining confidentiality. Interviews were recorded in adherence with the outline for ethical collection and storage of material outlined below. Two digital recorders, single-use handheld recording devices, were utilized with in-person interviews in the event that one recorder malfunctioned. These recording devices were stored in a locked safe in the student researcher's home office when not in use. Participants were informed that the interviews would be recorded, and consent was obtained prior to the interview, both in writing and verbally in face-to-face interviews. In the case of the Zoom interview, the participant was made aware that the interview would be recorded, and consent was verbally reviewed and accepted. The Zoom account used for this purpose was a secured UNBC Zoom account. Consent remained ongoing throughout the interview and participants were made aware that they could chose to end the consent process during the interview.

Ethical Considerations

A guiding component to the research design, included ethical considerations. Ethical considerations were comprised of several components, including the completion of the TCPS2 ethics course on two occasions, and referring to the TCPS2 guidelines throughout the study (see "Appendix E: TCPS2 Certificate" for the most recent certificate of completion).

It was determined, in conjunction with the UNBC ethics review board, that the proposed research presented a moderate risk due to the death(s) a participant would be discussing. Therefore, it was important to consider the ethical implications that the topic of grief holds. Ethical considerations, as it pertains to the interview process, included:

1. All research, including the semi-structured interviews, was conducted solely by the researcher, under the guidance and supervision of my thesis supervisor, Dr. Tammy Pearson.
2. Measures for conducting in-person interviews were determined by the comfort level of the participant, and in conjunction with any public health restrictions that may

have been in place at the time of the interviews. Additionally, a Zoom interview format was available, should that be the preference of the participant. Admittance into the Zoom meeting would be via a password-protected connection, and the participant was made aware that the interview would be recorded. The interview was conducted on a secure UNBC Zoom account. Additionally, accessibility of the interview location was considered and appropriately handled, to the comfort level of the participant.

3. I was cognizant of verbal and non-verbal cues during the interview process and made participants aware that the interview could be stopped or ended at any point, should they experience any level of discomfort.
4. A list of resources was provided to participants, should they require them (see "Appendix E: Participant Resource List").

Storage and protection of information was another important ethical consideration. Steps to ensure appropriate storage and protection of information, as they pertain to this study, include recorded interviews that were transcribed by the researcher, typed into an encrypted Word document, and stored with password protection. Any hard copies of this data and/or field notes were stored in a locked safe in my home office. The interviews were transcribed in a confidential space, solely by the researcher, directly from the single use recording device that was not connected to the internet. If Zoom was used in the recording of interviews, the posted best practices, as per UNBC, were adhered to.

The use of pseudonyms, as selected by participants, and not identifiable or traceable to the participant in any way, were implemented to maintain confidentiality. Additionally, information was sorted according to the pseudonyms and stored separately from the initial forms indicating names of participants. Information, hard and electronic (contained in encrypted and password protected Word and/or Excel documents) pertaining to pseudonyms will be destroyed upon completion of the thesis project. Participants were made aware that, should they choose to leave the study up to the point of compiling the thesis document, any data which they have contributed would be destroyed. Further to this, data in hard copy will be destroyed following completion of this thesis, and electronic files with analyzed data will be stored for 5 years, at which point they will be deleted.

Any costs associated with the research rested with the researcher. These included travel expenses, single-use handheld recording devices, a personal password-protected laptop, paper, and pens.

Data Analysis

Thematic analysis was implemented as the process for data analysis. Braun and Clarke (2006) assert that thematic analysis is a constructive approach to data analysis in relation to both qualitative and applied research. This research contains both of those qualities, making thematic analysis an ideal application for identifying patterns within the data set. Braun and Clarke (2014) maintain that thematic analysis provides “a robust, systematic framework for coding qualitative data, and for then using that coding to identify patterns across the dataset in relation to the research question” (p. 2). Moreover, “The primary mission in the analysis of qualitative data is to look for patterns in the data, noting similarities and differences” (Marlow, 2015, p. 215). Thematic analysis additionally coincides with Thorne’s (2016) overarching research design of interpretive description which attests to the importance of an analytic process that honors the “inherent complexity” of the human experience.

A parallel method to data analysis is outlined via the "Dimensions of qualitative analysis" by Marlow (2015) in *Research Methods for Generalist Social Work*. These dimensions include planning or organizing analysis of data, identifying the categories within the data, interpreting data, validating the data, and reporting the data. These steps closely align with Braun and Clarke's (2006) steps for thematic analysis which include: familiarizing oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing a report (p. 87). Braun and Clarke (2014) speak to how "techniques are separate from the theoretical orientation of the research" (p. 2), which shows the importance of outlining a process in relation to qualitative thematic analysis for the proposed study.

Interpretive description was the methodology used for this study. Interviews were audio-recorded and then personally transcribed by the researcher to familiarize with the data. Braun and Clarke (2006) emphasize the importance of familiarizing oneself with the data when implementing thematic analysis. I listened to each recording multiple times to ensure accuracy in transcribing the data. Following transcription, I read the data over in its entirety. I then re-read the data with the original research question in mind—What was the experience of individuals who encountered the death of a loved one during the highest restrictive period of the Covid-19 pandemic in northern British Columbia? In the proceeding readings, I continued to evaluate congruencies to the original research question, as outlined below.

I created cluster diagrams and mind maps which led to the ability to compile and group the relevant data. Margins on hard copies were used to classify possible themes and sub-themes. To adequately account for variations in the data, sub-themes were utilized. The continuous development of themes and sub-themes occurred as the researcher became familiar with the data, engaged in reflexivity, and through the process of compiling the document.

My initial step was to familiarize myself with the data. This was achieved through several means, which included transcribing the interviews myself and involved listening to the interviews several times. I then read the transcribed interviews multiple times. The initial readings were to ensure accuracy of transcription. A number of successive readings were to begin to generate codes and pull out any emerging themes (Braune & Clarke, 2006). The use of notation was implemented in the margins of the transcribed interviews and on paper, in addition to the use of a highlighter or underlining. This process assisted with searching for emerging themes and sub-themes (Braune & Clarke, 2006).

I then turned to reviewing the themes within the data, followed by defining and naming themes (Braun & Clarke, 2006). For these steps, I utilized cluster diagrams and mind mapping, which Marlow (2015) identifies as being a useful tool to assist in identifying themes and relationships. I then continued to refine the diagrams and combine or categorize the data to form concrete themes and sub-themes.

Through this process, I was cognizant of a point made by Marlow (2015) where the researcher is cautioned that contradictory evidence is to be accounted for and never bypassed. Hence, throughout the process, rival or alternative hypotheses, whether presented within the data or the literature, must be accounted for and examined. Thematic analysis provided a framework for tangibly capturing the experiences relayed in the interviews to the researcher. Finally, the production of the qualitative report, which in this instance, is encompassing of this thesis document (Braun & Clarke, 2006; Marlow, 2015).

Distribution of Study Results

The final report will be distributed to participants through a PDF formatted copy via email or through mail depending on the requested mode of delivery. Additionally, the document can be viewed through the University of Northern British Columbia’s library theses collection, once the final thesis document has been processed.

Chapter 4: Research Findings

This section addresses the themes and sub-themes developed from the semi-structured interviews and resulting from thematic analysis. The findings were arranged in a manner that addressed the research question. The primary purpose of the research was to explore the impact that the Covid-19 pandemic had on bereavement during the highest restrictive period of the health restrictions in northern British Columbia. Additionally, I specify the method used for data analysis and how the overarching themes and sub-themes were developed. Participant excerpts were selected and included (using pseudonyms) to illustrate the experiences of individual participants and depict the emergence of themes, which generated the results. The experience of death can be challenging at any time, but in the context of a global pandemic the combined dynamics can heighten the experience of grief and loss. I sought to honor the courage it took to share one's experience and strove to reflect this notion within these research findings. I was deeply honoured, privileged, and humbled to have the opportunity to hear the experiences of the participants.

Overarching Themes

In the sections below, five overarching themes, including the 15 subthemes derived from the data, will be discussed. The five overarching themes followed by the subthemes included family dynamics (amplified family dynamics and difficult decisions), individual impacts (death rituals, isolation, and complex grief), societal impacts (exacerbated social conditions, accountability, distrust of systems and fear), coping (spirituality, technology, creative expressions, gratitude and forgiveness), and hope for the future (seeking solutions and information sharing).

Theme 1: Family Dynamics

The topic of family dynamics was prominent across several interviews with participants, making it a central theme. Although families were restricted from gatherings or attending funerals, this did not eliminate previous family dynamics that were present prior to the loss of the loved one. In fact, many participants reported that historical family fractures were amplified due to the challenging conditions they faced during the global pandemic. As noted, several participants reported that many of the family issues existed prior to Covid-19, but the friction increased amongst the family members due to the added stressors of the pandemic. As such, the health restrictions, isolation periods, and mandatory vaccinations were mentioned as some of the primary sources of conflict. Family members held different perspectives regarding adherence to health protocols. Additionally, the stress involved in making complex family decisions, compounded with the task of navigating the death of a loved one were all factors that increased friction.

Subtheme 1: Amplified Family Dynamics. Numerous participants noted that their family dynamics were exacerbated and appeared more complex during Covid-19. The intensity created situations where long-standing family challenges were amplified and resulted in further fractures within the family dynamics. The impact associated with the pandemic, coupled with the death of a loved one, placed tremendous stress and strain on the family. For example, one participant explained that a family member “wasn’t taking the masks seriously”, which intensified anxiety and created an atmosphere of blame within the family. Additional issues included the topic of family members who were or were not vaccinated, and the split between family members who followed the protocols and members who declined to follow the rules added to the friction.

Many participants noted that family members decided not to follow the provincial protocols, as they needed to be with their loved one as they were dying and felt togetherness rather than the health protocols was the priority. In addition, they felt it was important to come together following the death of their loved one to provide support. One participant explained how the family members had mixed emotions about the decision to be with their dying loved one, but also experienced guilt for breaching the health protocols. Renata noted "just feeling guilty that you're not following the rules and you're grieving and then you're feeling guilty that you are doing this". Several other participants noted a sense of helplessness as they were barred from the facilities with no choice about the ability to be with their loved at the time of their death. As such, Chloe stated, "well we were locked out of there…so you couldn't be part of it". On the other hand, Solange expressed concern for the family members who had health complications and felt that the individuals who were not following the protocols posed a risk to other members in their family. In this instance, the family members decided individually to disregard protocols, which Solange noted caused a rift within the family. Solange spoke to the amplification of family dynamics at the time of their loved one's death: "I was one of the first to get a vaccine, but I don't know if I was vaccinated at that time. So, it caused a lot of tension. And through that process he's going to pass at home. The doctor came, they gave us meds to ease the pain, and we were all there, but it created this rift". In sum, the participants cited that fractures were exacerbated by disagreements around the dying loved one and restrictions or protocols related to Covid-19 at the height of the restrictions.

Subtheme 2: Difficult Decisions. As their loved one's health failed and death approached, family members were provided minimal options at the height of the health restrictions, which created difficult decisions and presented barriers for family members. One example was identified by Chloe who expressed the difficult task of being the only person allowed to visit/be present while their loved one was dying. As a result of the health restriction, a sole family member had to be identified. Chloe stated, “I was worn out but if someone else could have been trading off, we could have all been going up. And that’s a hard thing to say to the kids. You’re not allowed to go up”. Additionally, the family had to make difficult decisions regarding the possibility of their loved one’s dying in a facility with minimal contact because of the health limitations, and in some cases no access was made available to any family members. Samantha attests to a situation where their loved one died alone in a facility. Samantha stated, “I think everyone thought the restrictions were supposed to be two weeks and then you’ll be able to see your people,” but “it was longer, and she didn’t need to die alone”. On the other hand, some families were faced with a choice to leave their loved ones in a medical facility or bring their loved one home and provide care until the individual passed. One participant described implications of having a loved one die at home, as opposed to remaining in a medical facility. Solange reported, “dying at home added pressure on the family… specifically, the struggle to provide care, but knowing if their loved one remained in a facility, they may not have access to visit with them and they were dying”. Decisions pertaining to the death of a loved one are inherently difficult, but trying to balance decisions you never imagined because of COVID-19 made it very tough on many of the participants.

Additional barriers were related to the mandatory use of masks in public. One participant indicated that their loved one who was hearing impaired was disoriented when a family member arrived to visit wearing a mask. The loved one’s ability to communicate with the family member was compromised, as the loved one relied upon the ability to read lips. Chloe said, “you’re forced to wear these masks. These masks, I’m talking to an older gentleman that wears two hearing aids. He couldn’t understand under a mask”. Renate shared that the person identified to be with their loved one encountered a language barrier because English was not their first language. Renate described feeling concerned about the language barrier and stated, “I wanted to go in with my dad to make sure he fully understands what happened with my mom. And then they would say no… only one person can go into the room and that person is the only person that can go in, like we can’t switch back and forth right”.

Theme 2: Individual Impacts

Several participants used common descriptors that highlighted the various ways that the death of their loved one during the pandemic led to individual impacts. The individual impacts were experienced by the change in death rituals, the isolation factor, and the creation of complex grief under traumatic circumstances. There were many recurring words noted throughout the experiences of participants in relation to the death of a loved one during the Covid-19 pandemic. Participants described their individual impact by referring to a cluster of certain words that highlighted their experience— “inhumane”, “heartless”, “lonely”, “hard”, “so wrong”, “sad”, “grateful”, “forgiving”, “cruel”, “alone”, “preventable”, “insanity”, “unnecessary”, and “somber”. Furthermore, numerous participants expressed feeling angry or enraged at the situation and emphasized how it cannot be undone at this point.

Subtheme 1: Impacts to Death Rituals. Several participants noted that the restrictions placed on traditional death rituals such as funerals prevented their ability to grieve and connect with others, which impacted their mourning journey. Some participants noted that dressing their loved one's deceased body and viewing their loved one post-mortem were not permitted, noting that these two important death rituals were previously practiced and played a significant role during grief. Elvis talked about experiencing multiple deaths due to Covid-19, which resulted in a multi-generational, combined funeral. Elvis noted that "we couldn't hug each other or shake hands. Every time we have a funeral, we always hug each other and shake hands… it felt weird being with family and you can't hug them or nothing, we had to keep our distance". Another participant stated, "it made it very difficult to be together so that made the grieving difficult because we could not grieve as a family". The participant exclaimed, "Isn't that what you're supposed to do when somebody dies?" On the contrary, one participant noted that the restrictions related to death rituals were beneficial. Renate reported, "you really have time to grieve and not have to go through planning things for other people, so it was really helpful". In this situation not planning a funeral was appreciated and the individual had time to grieve.

All participants reported that a traditional funeral would have occurred if restrictions had not been in place. In the cases where families had a so-called funeral, the personal distance and attendance restrictions completely changed the experience of the death ritual. Many participants missed the comfort of coming together as a family, hosting other families from out of town to attend a large funeral, where music, sharing food, and connecting with each other through physical touch and fond memories were shared about their loved one.

Subtheme 2: Isolation. Some participants described the isolation as both a positive and negative experience. Enrique and Renate described how they preferred to grieve and process their emotions on their own time. They noted that the restrictions removed the social pressure to come together, and they felt they were provided a space to grieve. Other participants noted that the isolation provided a space where they had to embrace their spiritual life to cope with the death of their loved one. In contrast, several participants cited that the isolation had a deeply negative effect on their experience with grief during Covid-19. One participant noted “we were locked up but that didn’t make me angry but made me very sad, as I felt like I was being controlled”. Enrique expressed the importance to “take care of your mental health, however that looks because there’s going to be isolation involved…if something like Covid-19 occurred again you need to be prepared”. Another participant described the “unimaginable grief” that resulted from having their loved one die in isolation. Another participant commented that Covid-19 and the health restrictions “added an unnecessary stress to an already stressful situation, because dying and death are a stressful situation and grief is best expressed in community as healing comes in community”.

Several participants felt that the isolation factor contributed to an untimely death of their loved one. One participant noted “she was not ready to go” and “I don’t know, but if it hadn’t been for the isolation of the pandemic would she have declined as fast as she did”? and prior to the isolation restrictions “she was getting much better, and she was determined to walk again…and she was doing really well and then no visitors…everybody’s scared”. Renate stated “it’s not right when people are dying alone during those last days or hours. To have a person die alone is inhumane, it’s so not right and sure they have one person there but it’s hard for the other people who want to be there. I’m never getting that time back, not in my whole life”. Samantha stated, “isolation is the worst thing you can do for people” and summarized “let people have their people”.

Subtheme 3: Complex Grief. Multiple participants compared their experiences of losing a loved one prior to and during Covid-19. They noted their emotions associated with these two time periods were very different. Multiple participants noted that prior to the pandemic, when their loved ones were dying, they were surrounded by family, with an opportunity to say goodbye. Alternatively, Chloe described the death of a loved one during Covid-19 as “Oh yeah, you’re mad and this mad phase, I don’t think it ever goes away because you can’t undo it. You can’t undo the lunacy that people had to put up with”. Samantha mentioned “she didn’t go out feeling loved—she went scared and alone”. Renate attested “I mean grief is hard enough and burying someone you love is hard enough and then you have some other things to deal with on top of it”. Chloe reported, “it’s unfinished business because you weren’t there” in reference to not being able to be present at the time of her loved one’s death. It was also noted by several participants that there were impacts to the family during and post death, as only a limited number of people were able to attend their loved one’s bedside and engage in death rituals. Some participants noted the additional factors related to the health restrictions accompanying Covid-19. There was fallout from supporting loved ones who could not be a part of traditional death rituals and feelings that came with it amidst their own grief. In another instance, family members refused to come together, which also had an impact on one participant who stated, “our grief was very difficult because we couldn’t come together as a family”. One participant noted the following in reference to the delays associated with Covid-19: “well we would have had a celebration of life a lot sooner. We had to wait for a long time”. Additionally, Solange described “my grief was quite delayed”.

Theme 3: Societal Impacts

The third overarching theme surrounded impacts at a societal level. Several participants noted their experience of Covid-19 was embedded in something much larger than themselves. They noted exacerbated social conditions, questioning who was responsible for having their loved ones die alone (in isolation) under unnecessarily stressful circumstances such as death. Other sub-themes included a distrust of systems and a noticeable increase of fear throughout society. One participant noted "I think for me and for a lot of people it added an unnecessary stress to an already stressful situation because death and dying is a stressful situation". Another participant stated, "You know what the lockdowns were…I think that was so wrong…I hope we can do it better next time". Renate further reinforced this by saying "I'm never ever going to get that time back and I'm resentful for that…so no I don't think it's right to do that, you don't keep people away from loved ones. There is never a good enough reason."

Subtheme 1: Exacerbated Social Conditions. Several participants noted other social conditions were impacted by Covid-19. Renate reported that, on top of losing a loved one during Covid-19, she lost her employment. This created a dual effect where people were grieving simultaneously the death of a loved one and the loss of employment. Samantha cited several examples of how mental health, homelessness, suicides, and a lack of medical care resulted in deaths due to isolation, restrictions, and protocols because of Covid-19. Another participant, Enrique, noted the spike in deaths of loved ones as a result substance overdoses during Covid-19.

Subtheme 2: Accountability. Participants were divided much the same way that society has appeared to be split on the restrictions during Covid-19. A common theme that many participants expressed was related to who was responsible or should be held accountable for what happened, during and following the death of their loved ones. One participant said, "you can't blame, like I'm having a hard time saying well it's the government's fault…I think it is society's fault…not being willing to love and care for each other as, as humans, right". Others felt that the root of accountability stood with the policy makers and government; one participant echoed many voices who felt that priorities were not adequately assessed during Covid-19 by policy makers. One participant stated, "Bonnie Henry and her glory holes…this is a safe way to have sex, a glory hole…you can't say goodbye to a loved one but just get a board and cut a hole in it and don't use asbestos". In contrast, some participants articulated that they felt the restrictions and protocols were important in keeping everybody safe.

Subtheme 3: Distrust of Systems. Several participants expressed that while they may have started out having trust for systems, after their experiences with a dying loved one and Covid-19, they had lost or significantly dampened their sense of trust in systems. Chloe stated, "I am very upset with the health care. I will never trust them again". One participant noted, "it might be helpful if professionals were brave enough to speak out against some of the restrictions or even just wise enough to see what was happening". Many participants expressed that it would have been better to leave decisions about protecting themselves in the face of the pandemic up to the individual and the families, as opposed to having restrictions placed on them in circumstances where it just did not make sense to the participant, such as when it came to death and dying. Several participants begged the question, was there concrete evidence to justify labelling Covid-19 as a "pandemic"? This question was also asked in conjunction with the toll that restrictive practices had with the loss of connection to others, and the potential deaths participants felt were caused due to isolation/restrictive factors.

Subtheme 4: Fear. Fear was noted as another subtheme within individuals, families, and society at large. Many acknowledged that they realized that professionals were doing their jobs, as one participant noted: “I think people were doing the best they could under the circumstances”. However, many participants expressed that they felt professionals lost sight of a human being in supporting the protocols and restrictions. One participant summarized what many other participants were echoing. Renate stated regarding their loved one’s medical care, “it was a fear-based decision and not a professional one”. Further to this it was stated, “if you’re fear-based, you’re going to be making a fear-based decision”. Additionally, fear was a factor amongst the families. If restrictions were not in place, many participants identified that fear would still be a motivating factor in families’ not gathering to grieve.

Theme 4: Coping

Coping emerged as the fourth central theme which included the sub themes of spirituality, technology, and creative expressions. Spirituality as a prominent coping measure, the use of technology to connect with loved ones, and creative expressions were noted as forms of coping, in the absence of the ability to attend to death rituals such as funerals.

Subtheme 1: Spirituality. Several participants expressed that their spirituality played a vital role in their ability to cope with the death of their loved one while faced with the pressures imposed upon them by Covid-19. Additionally, many expressed taking solace in the fact their loved ones were in heaven. One participant noted “my faith carried me through. It did… I spent so much time in prayer and... the Lord, he helped me to grieve. My faith helped me to grieve… the natural way”. Another participant noted that they were a “family of faith… that was extremely helpful”.

Subtheme 2: Technology. The use of technology was a common thread across participants' experiences, whether it was the use of their phones or engaging in video chat. Enrique expressed, "being able to use your phone to connect with people felt similar when it came to engaging with their grief. You could reach out". Other participants noted that the use of technology in the medical facilities was not organized, as healthcare professionals appeared to use their own electronic devices to connect the dying with their family members. Samantha noted the difficulties associated with technology, summarized in the following quote: "I phoned her a couple of times and talked to her. She did not like online stuff. We tried to do like facetime and stuff, and she didn't like it, she didn't get it, it was confusing to her, they never had people available really. A couple of times they helped her figure it out but it wasn't something she could just do all day every day."

Other loved ones made the difficult decision to voluntarily leave medical facilities so that they could connect in-person with family, while sacrificing the ability to have medical care and having the family provide care, which in some cases the family were, or were not, qualified to provide.

Subtheme 3: Creative Expression. Several participants shared how individuals and families channeled their grief through creative means. Helpful examples included vehicle parades for loved ones and garden or art projects. An example of creative expression included a garden project that incorporated a depiction of the deceased loved one's past activities. For confidentiality's sake, this project has not been described in detail.

Subtheme 4: Gratitude and Forgiveness. Enrique expressed how Covid-19 and all that came with it created a space for gratitude. Enrique said, "I guess now I'm not taking so much for granted after seeing, you know, so many have died whether it be Covid or other causes during the restrictions. So, yeah, just look at life a little more with um… gratitude, I guess.” Another participant stated, “I think honestly the only challenge for me there was two things: probably forgiving the whole mess, that was a bit of a thing. I was mad that my mom died that way and I feel like different choices could have been made by the government, different choices could have been made by the doctors, um so that one challenge, but I managed to do it hallelujah”. The second challenge for this participant was in how to navigate supporting other family members, who had been restricted from attending the funeral.

Theme 5: Hope for the Future

The final central theme was hope for the future. All the participants expressed hope for solutions moving forward, should a similar situation occur. The additional sub-theme in this category included information sharing, specifically, being more present as a society around information sharing and more transparency at a structural level around where the information is coming from, what the source of that information is, and why it is being shared.

Subtheme 1: Seek solutions. There was a resounding pattern where most participants felt that things could have been managed in a better manner, as it related to the death of a loved one during Covid-19 at the height of health restrictions. Most participants noted that the restrictions felt unnecessary, while others felt that the restrictions were beneficial to keeping people safe. However, there was a strong recognition to seek solutions, should anything of this nature occur in the future. These solutions focused on all levels: individual, community, systems, and globally.

Subtheme 2: Information sharing. Several participants commented on how information was shared during Covid-19, for better or worse. This was observed at multiple levels including the individual, community, systems, and global levels. Solange indicated that being able to "get counseling online a little more easily" was positive but added that "we need more education on mental health in general but really I think it's important that there is a message that grief takes different amount of time for people". It was also common for participants to note that it did not matter what another's belief was around Covid-19, only that everybody strove to respect the beliefs of those around them. Additionally, participants believed that so long as information is based on solid research it should be made available to the public. Some participants expressed feeling that the information put out to the public was biased and one-sided to support the agenda of policy makers. One participant summarized this in the following way: "as human beings let's sit down and listen to each other and listen to both sides. Don't be so dogmatic in thinking you're correct and you're right and you've got it all. Because you don't. You're not serving society".

Table 2: Themes and Sub-themes Arising from the Interviews

Themes	Sub-Themes
Family Dynamics	• Amplified family dynamics • Difficult decisions
Individual Impacts	• Impacts to death rituals • Isolation • Complex grief
Societal Impacts	• Exacerbated social conditions • Accountability • Distrust of systems • Fear
Coping	• Spirituality • Technology • Creative expression

	• Gratitude and forgiveness
Hope for the future	• Seek solutions • Information sharing

Summary of Findings

In summary, individuals who encountered the death of a loved one during the highest restrictive period of the Covid-19 pandemic reported experiences that impacted multiple levels which included the individual, family, and society, contributing to the landscape of grief during a pandemic. Many participants reported feelings of anger, grappled with forgiveness, and struggled to make-sense of a difficult situation, which compounded the experience of the death of a loved one during the highest restrictive period of Covid-19. A common thread throughout the participants' experiences was a resounding pattern of hope that a future pandemic ought to be managed in a different manner. Samantha accurately and concisely summarized the experience conveyed by many when she said, "let people have their people".

Chapter 5: Discussion

The purpose of this study was to explore the experiences of individuals who encountered the death of a loved one during the period of highest health restrictions of the Covid-19 pandemic in northern BC. This chapter provides further insights into the findings and how they pertain to related academic literature and clinical practice in the context of death, dying, and bereavement during a global event. Two practice considerations with reflections were developed: 1) improve support to individuals and families (reflections: isolation kills, trauma, supports, respect for the dying, spirituality, creative outlets) and 2) hope for the future (reflections: respectful problem solving and information sharing). In addition, this chapter contains possible benefits and limitations of the study.

Improved Outcomes for Individuals and Families

The first practice consideration in conjunction with the five reflection terms were noted in a manner that may improve outcomes for individuals and families in a similar event. "Isolation kills" was one of the five reflection terms described. As noted in the results chapter Samantha stated, "Let people have their people". This statement was not unique to this participant; it was echoed by many other participants. Removing family members from a loved one during the process of dying had an extremely negative impact on the participants. Van der Kolk (2014) attests to the impact this has on an individual and reports on the state the body goes into when connection with others and safety are removed. Humans will shift into their reptilian brains, or "the ultimate emergency system" and, as a last resort, will check out of awareness (Van der Kolk, 2014, pp. 100-101). This may assist in providing an explanation as to why a couple of participants were unable to recall details related to their experiences with the death of a loved one during Covid-19 and categorized it as being "just a horrible experience", amongst other emotionally laden terms outlined in the findings chapter. This second reflection term occurred during conversations about trauma in relation to Covid-19 and the experience of a loved one dying in isolation, or under increasingly complex and novel circumstances. That said, trauma and post-traumatic growth were woven throughout the experiences, as many participants described outright that their experiences with death and bereavement during Covid-19 were traumatic and other participants noted as time passed and they reflected on the experience there was evidence of post-traumatic growth. Bray (2014) asserts that "in the aftermath of loss, it is not uncommon for individuals to disclose psycho-spiritual experiences that lead to personal changes and psychological growth" (p. 890). Many participants reported the impact of the isolation and restrictions during the pandemic both on an individual and family level; these factors created a landscape that made it difficult to cope. One area of support that was relied upon during the period of isolation was technology. Multiple participants described technology as a supportive tool in the face of isolating circumstances. The global pandemic not only changed the way participants grieved but the use of online technology skyrocketed and shifted communication between service providers and clients. Mishna et al. (2021) observed some of the benefits and challenges that were involved when social workers had to rapidly shift from in-person contact with clients to communication technology. In this study, the support of technology was beneficial in the face of a pandemic.

Seven out of eight participants echoed the phrase "respect for the dying and bereaved". One participant stated, "People deserve dignity in their last days". Participants characterized their experience as a lack of dignity and respect and extended this experience to their deceased loved ones. Providing respect for the dying and the bereaved in the event of a future pandemic, one can explore the concept of medical ethics and examine the role of autonomy provided to individuals and families. “Ethics is a philosophically disciplined reflective search for the best ways to determine the right thing to do” (Attig, 2015, p. 76). According to several of the study’s participants, keeping loved ones away from the dying in their last days, or placing loved ones in precarious positions to be with their loved ones in their last moments was, as several participants put it is, “inhumane”. As Chloe explained: “We don’t just leave people to die” and furthered this with “I mean you wouldn’t do that to your dog, but you would do it to your child”. In sum, reviewing the ways medical ethics can be implemented may provide respect for the dying and bereaved.

Spirituality was noted in the findings as a form of coping during the Covid-19 pandemic, which aligns with the findings of Nicholas and Kilmer (2022) that “spirituality and faith are important contributors to wellbeing despite or amid adversity” (p. 166). Le Roux et al. (2022) speak about the term “spiritual coping” which is defined as being: “an individual's ability to utilise faith in God combined with certain Christian beliefs and religious practices to appraise, understand, and effectively cope with stress” (p. 1). Despite the known benefits of spirituality, Boynton and Vis (2022) contend there is “evidence that social work research, education, and training have not kept up to date with the importance of spirituality in practice and developed a thorough theoretical framework for practice” (p. 9). Given that several participants attested to spirituality’s being, in some cases, their sole source of strength in navigating Covid-19 and the death of a loved one, it is imperative that the curriculum within social work is updated. The findings noted within the theoretical portion of this thesis document around spiritual distress are significant in relation to this study because even if religion or spirituality is a negative force in one’s life throughout a trying time, the connection to post traumatic growth emphasizes the importance of how a constructive outcome can still be achieved (DeVynck et al, 2023).

Several participants noted that creative outlets and projects were helpful in being able to express their grief that was otherwise stifled due to the restrictions associated with Covid-19. This finding is congruent with Van der Kolk (2014) who speaks about the importance of creative outlets as a healing component to trauma. Van der Kolk (2014) presents the powerful connection of mind and body in relation to trauma. In the absence or the ability to attend traditional death rituals due to the health restrictions, it is logical to learn that participants turned to a means of creative outlets to manage their grief. An example of the healing derived from creative outlets is presented by Gray (2017) using the concept of polyvagal-informed Dance/Movement Therapy (DMT):

> For many years, psychotherapy and behavioral science privileged long-term behavioral changes through process work, and this is important work. However, this work lacks the power of DMT and its ability to promote immediate state-shifts, inside the body. These state-shifts, even if only momentary, can be metaphorically perceived as momentary ‘‘threads’’ that can weave a tapestry of restoration, healing, and reconnection. Music, movement, dance, and rhythm, are activities that provide an immediate resource to shift physiological states. Polyvagal-informed DMT also recognizes the safety-trust-relationship continuum as fundamental to humanity and to dignity. Trust is built on safety, and relationships are built on trust. Safety begins in the body.

This quote from Gray (2017) attests to the importance of providing outlets for human beings when traumatic events occur. Gray (2017) speaks about attending a natural disaster and expresses gratitude for the tools for healing provided through polyvagal-informed DMT. Another example of a creative outlet is presented by Margolin and Sen (2022) within the context of Mahavakyam Meditation to heal adverse events within one's life. Margolin and Sen (2022) describe:

> like in other expressive arts or integrative therapies that engage the body, mind, and spirit, the emotional content can be digested and integrated indirectly. We have witnessed individuals transform their self-narrative over time from identifying wholly with overwhelming suffering to identifying with inner silence and stillness. From that metamorphosed state, individuals set larger life goals that enable them to further transcend the traumas they endured. As long as they are overcome by intrusive, automatic rumination of the trauma, larger aspirational goal setting cannot occur. (p. 160)

As such, the participants within this study relied upon the use of arts, crafts, and creative expressions to cope with the demands of a global event in conjunction with the death of a loved one.

The second practice consideration was hope for the future. In essence, participants hope that respectful problem solving would occur in the future to ensure effective planning and improve information sharing during global events. Anandhika et al. (2020) assert that the "Covid-19 pandemic has driven many governments to discover solutions for various problems faced during the pandemic" (p. 1). Furthermore, Anandhika et al. (2020) outline how Covid-19 created global challenges on several fronts and forced countries to creatively problem-solve. The authors allude to a model based on collaboration at all levels that was implemented in Jarkarta, which promoted problem-solving during Covid-19. The study found that an analysis of needs, then targeting those who were in need, and finally collaboration were needed to successfully face the challenges that the city was facing. This suggests an important question of what occurred in northern BC within the context of problem solving during the start and height of health restrictions re: Covid-19? Several participants discussed how the government and larger systems appeared to make all the decisions. Many participants questioned whether Covid 19 could have been handled differently and wondered if more autonomy could have been provided in relation to the death of loved ones during Covid-19, in particular, with regard to the mandates around restrictions that impacted participants from being with their loved ones as they died and being able to attend gatherings in the aftermath of the death. Many of the participants questioned whether it was necessary for the government to control the ability of individuals to be with their loved ones and influence death rituals to the degree that it occurred. In other words, were measures removing the ability to be with dying loved ones and being left to grieve in isolation worth it or necessary? It is important to dissect how the government justified removing people's ability to be with the dying and comfort one another, despite the occurrence of a global event. A report published by the BC Centre for Disease Control (2020) under the BC Ministry of Health articulates the concept of the "harm principle" which states:

> Society should protect itself from harm. To protect the public from harm, real or imminent, especially from risk of infection and serious illness or death, those responsible for the health and safety of the population are justified in intervening and impinging on individual autonomy and choice, if necessary. (p. 4)

This concept implies that individuals should be content in sacrificing for the greater good. However, within the context of death and bereavement, the vast majority of those who participated in this study attested to feeling as though the sacrifice did not outweigh the benefits when it came to restriction and protocols; especially when it came to having a loved one die, or having to grieve, in isolation. Further to this exploration of why the government felt it was necessary to remove autonomy over ushering their mothers, fathers, brothers, sisters, children, and other loved ones out of this world, it may be helpful to analyze how problem solving occurred within the context of BC. The "Covid-19 Lessons Learned Review: Final Report" by Faye et al. (2022) is a document completed by the BC provincial government outlining how BC problem-solved throughout the pandemic. Within this document, the following is asserted: despite being unprepared for a province-wide emergency, the Government of British Columbia's response to the COVID-19 pandemic was strong, showing resilience, balance, and nimbleness that should give British Columbians confidence in the government's ability to respond to future province-wide emergencies. (p. 1) However, those ideals listed following the statement about open acknowledgement that BC was not prepared, do not hold true to the voices of the participants within this study. There was nothing strong, resilient, balanced, or nimble about having to know that your loved one was dying alone or without appropriate medical care. In terms of problem-solving during Covid-19, and as we look to the future, the report on "Lessons Learned" during Covid-19 has this to say about how and why decisions were made:

> [S]cience cannot drive public policy decisions alone. Scientific evidence is very helpful in assessing the risks and harms associated with a disease and the effectiveness of the available public health measures. But other important considerations, like social and economic implications of public health measures, as well as their health effects for different groups within the population, all bear on the

> choice of measures put in place at a given time. In B.C., the COVID-19 Ethical Decision-Making Framework describes the process and considerations for making public health emergency response decision-making. (Faye et al., 2022, pp. 20-21)

It would be helpful for governments to consider the implications mentioned while also judging the science from multiple perspectives. In sum, were all perspectives and knowledge considered during Covid-19 at the highest restrictive period? It is evident that societies, governments, professionals, and individuals have room to grow and hopefully consider the time necessary to respectfully problem-solve prior to the next global event. Cordasco et al. (2007) refer to Hurricane Katrina and the mistrust of the public as being a barrier to effective problem-solving throughout the event. It is emphasized that authorities should not turn a blind eye to distrust from the public and should actively work to build capacity around trust and information sharing. How and why information was shared was another common reflection participants mentioned. In fact, several participants felt there was a distortion in priorities regarding information sharing and the health restrictions. Other participants noted a lack of consistency in the manner in which information was shared and different interpretations of the enforcement of protocols. It was noted that the information being shared appeared one-sided. As previously noted, one participant commented on how they felt that certain components of information were dismissed, despite there being valid research on a topic.

One concept to note, which reinforces the opinions expressed by several participants pertaining to information sharing during the pandemic, is the idea of health literacy. Szasz (2023) states that “having adequate literacy skills means being able to understand, evaluate, use, and engage with written texts” (p. 1). So how does Canada measure up when it comes to health literacy? According to Szasz (2023), poorly: many Canadians remain illiterate when it comes to health care. Additionally, Canada does not appear to have the same caliberof efforts directed towards altering the issue, as evidenced by an example from the United States (U.S). According to the U.S. Department of Health and Human Services (2021), health literacy is about ensuring that people have access to information, so that they can make informed decisions pertaining to their health. This website outlines a "National Action Plan to Improve Health Literacy", complete with a model and actionable steps that professionals and organizations can take to ensure that people are adequately informed and able to understand the implications of the health care being provided. Further to this, the U.S Department of Health and Human Services (2021) claims: "By focusing on health literacy issues and working together, we can improve the accessibility, quality, and safety of health care; reduce costs; and improve the health and quality of life of millions of people in the United States." The pandemic appears to have alerted several academics, as well as the public, to the issue of health literacy. Koh et al. (2013) were calling for reform in this area prior to the existence of the pandemic. They outline a model whereby a guiding value of health care is to ensure that individuals understand the health care they are receiving. Koh et al. (2013) then outline a method to achieve this model. Another example of how health literacy has been studied within the context of the pandemic is by Wong et al. (2020), who conducted a study in China, where they found that information sharing was linked to socioeconomic status. They found that those with a lower socioeconomic status were most at risk of being health illiterate. Additionally, a connection was made between individuals and information sharing within families. Wong et al.'s (2020) study suggests that a means of overcoming this socioeconomic disadvantage is to educate a member of a family, who then shares information with the rest of the family. I would argue that the concept of health literacy may be of benefit to individuals, families, and society at large based on what has been relayed here from the research.

Table 3: Practice Consideration and reflection phrases

Core Practice Considerations	**Reflection Phrases**
Improved Outcomes for Individuals and Families	➢ Isolation Kills ➢ Trauma theory and PTG ➢ Supports ➢ Respect for the Dying and Bereaved ➢ Spirituality ➢ Creative Outlets
Hope for the Future	➢ Respectful Problem Solving ➢ Information Sharing

Table 4: Practice Recommendations for Death and Bereavement during Pandemics

Recommendation	**Practical Applications**
Policy	➢ Trauma-informed policy creation for the next pandemic ➢ Trauma-informed applications in policy for supporting people in the aftermath of pandemics. ➢ Creating emergency clauses, whereby the implications of working with human beings in complex situations are considered and space is created, as opposed to strict adherence to policy. ➢ Pause and reflect, as opposed to fear-based policy responses. ➢ Promotion of health literacy – factual information provided in a tangible and accessible way with consideration to barriers of all types. ➢ The development of specific positions within systems that are dedicated to pandemic-specific supports.

	➢ Capitalizing on technology to provide support. ➢ Further research and innovation on how to implement creative solutions for loved ones to remain with the dying
Practitioners	➢ Holistic treatment modalities that are trauma-informed ➢ Treatment modalities that encompass the possibility for spirituality to be incorporated as an intervention tool. ➢ Implement practice approaches that create a safe space for intentional responses, rather than fear-based reactions that prioritize the needs of the individuals, rather than structures and systems controlling the response. ➢ Interdisciplinary collaboration that leans on the strengths of each profession to create viable solution-based outcomes for families experiencing the death of a loved one during pandemics.

Implications for Practice

The Covid-19 pandemic presented several contemporary unprecedented challenges to death, dying, and bereavement. This is an important area of study to continue to explore, as it is apparent that society fell below an acceptable standard for those who had to experience loved ones' suffering and dying alone. In addition, family members were made to grieve in isolation, which is flirting with disaster in consideration of the fact that we are social creatures who have participated in death rituals within the context of community dating back to ancient times (Gordon, 2015). It would be important to further evaluate whether the risks associated with isolation, mandatory restrictions, and protocols outweighed the costs, especially within the context of death, dying, and bereavement.

Additionally, consideration for implications is important. Examples of barriers cited by participants in this study—regarding loved ones whose first language is not that of the system in which they are obtaining medical care or who are hearing impaired—arose because of failed attempts to consider implications. Within the context of the "harm principle" outlined by the BC Centre for Disease Control (2020), it would make good sense to skillfully evaluate and assess the meaning of harm within multiple facets, as opposed to a laser focus on Covid-19 as an infectious disease. The hope is that as more research rolls out in the wake of the pandemic that tangible models pertaining to problem solving will be developed. Additionally, it is hoped that these models will be developed from a place of open-mindedness, a widened lens in terms of consideration for implications, and a willingness to do better.

Limitations

It was important to allow the participants' experiences and the research findings to dictate the outcomes of the study. An additional assumption is that this research could potentially provide a platform for future intervention. This may, or may not, be the case. The sample was comprised of eight participants, making it inappropriate to generalize findings to a wider context, especially considering the diversity encompassed within northern BC. Although saturation of data was satisfied within the context of the research, it does not necessarily mean that it could be generalized to the masses. However, the strength of a small sample size is the degree of depth achieved, which allows for a solid footing from which to derive what one’s experience may have been with death and dying within the context of northern BC during the highest restrictive period of Covid-19.

Areas for Future Research

This study has only scratched the surface when it comes to comprehending the experiences of those who encountered the death of a loved one during the most restrictive period of Covid-19. The explosion of research and literature pertaining to this topic is hopeful. Many participants expressed the desire that we would learn from this global event and that more autonomy would be made available to individuals, as it pertains to death and dying, should something of this nature occur again. Future research may benefit from further exploration from a mixed-methods perspective, and on a larger scale to continue to develop what the experiences of those who lost loved ones during the highest restrictive period of Covid-19 have been.

Conclusion

This study sought to better understand the experiences of those who encountered the death of a loved one during the most restrictive period of the Covid-19 pandemic within the context of northern BC. In total, eight individuals participated in the study and bravely shared their experiences with the death of a loved one during Covid-19. Both the literature and this study have reinforced the need for further exploration of how to move forward in an improved way, should another global event of this nature take place. The experiences of participants relayed here portray a picture that indicates our difficulties as a society to support a natural process that we will all experience within our lifespans. It is a topic worth exploring, creatively problem-solving around, and implementing improved solutions so that individuals, families, and the dying do not have to replicate the difficulties outlined within this study.

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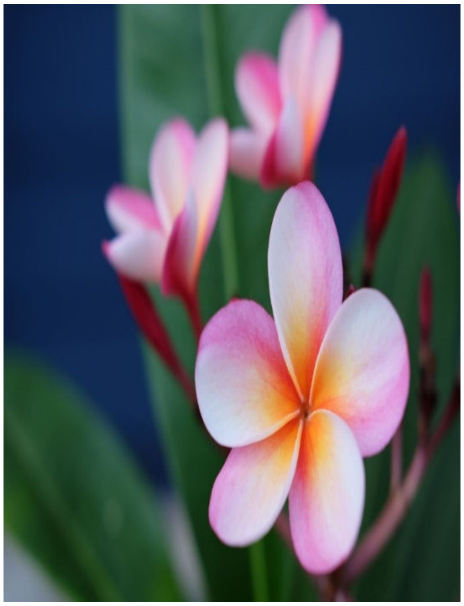
Appendices

Appendix A: Recruitment Poster

Would you be willing to share your experience about the death of a loved one during the highest restrictive period of the Covid-19 pandemic, for the purpose of research?



Seeking participants who are:

- **19 years of age or older and reside in northern British Columbia.**
- **Experienced the death of a loved one during the highest restrictive period (between March 18, 2020 to June 30, 2021)**
- **Willing to voluntarily provide up to 2 hours of your time for a recorded interview with the student researcher.**

Please be advised that although this poster may be posted on social media and disabling comments or likes assists in maintaining confidentiality, it is important to familiarize yourself with the Terms of Service of a particular social media platform. We accept no responsibility for damages or liability arising from publishing of information or content, nor the removal or complaint processes arising from such information or content.

Please contact UNBC student researcher, **Sondra Struke**, at **250-961-5490** (text or call) or via email at **sstruke@unbc.ca** with any questions and/or if you wish to participate in the study.

This study is under the supervision of Dr. Tammy Pearson, UNBC School of Social Work (Phone: 250-960-5110, email: tammy.pearson@unbc.ca)

While willingness to participate is appreciated, potential participants will only be accepted until September 30, 2023.

CONTACT FOR CONCERNS OR COMPLAINTS

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the UNBC Office of Research at 250-960-6735 or by e-mail at reb@unbc.ca.

Please feel free to take one of the slips below with information for contacting the researcher:

Sondra **250-961-5490** **sstruke@unbc.ca**	**Sondra** **250-961-5490** **sstruke@unbc.ca**	**Sondra** **250-961-5490** **sstruke@unbc.ca**	**Sondra** **250-961-5490** **sstruke@unbc.ca**

Appendix B: Interview Guide

1. Can you please describe your experience related to the death of your loved one during the Covid-19 pandemic?
2. What were your experiences with death and dying before the pandemic?
3. Can you please explain related death practices/rituals that your family/friends would have participated in, had restrictions not been in place?
4. Can you describe specific ways that the restrictions may have impacted your practices/rituals around the death of your loved one?
5. In what ways, if any, do you feel that your experiences with death, dying, and grief have been impacted by the highest restrictive period of the Covid-19 pandemic?
6. Can you please describe any challenges you may have experienced in relation to the death of your loved one during the Covid-19 pandemic?
7. Can you please describe anything you found to be helpful in relation to the death of your loved one during the Covid-19 pandemic?
8. In what ways, if any, did the pandemic encourage you to engage with your grief in a different manner?
9. What feedback can you provide to others that would be helpful during the grieving process in the context of an unexpected event such as a pandemic? In other words, if this type of event was to occur in the future what can you share that may be helpful for professionals when supporting a grieving individual in the event of mandatory restrictions.
10. If you could describe your experience regarding the death of a loved one during the highest restrictive period of the Covid-19 pandemic in three words, what would they be?
11. Is there anything you feel I missed, or that you would like to add?

Appendix C: Information Letter

UNIVERSITY OF
NORTHERN BRITISH COLUMBIA

Information Letter

Date: July 12, 2023

Project Title: “Exploring the Death of a Loved One During the Highest Restrictive Period of the Covid-19 Pandemic.”

Who is conducting the study?

Student Researcher: My name is Sondra Struke, and I am a student at the University of Northern British Columbia (UNBC) in Prince George, British Columbia (BC). I am pursuing a Master of Social Work degree. I can be reached at sstruke@unbc.ca; cell number: 250-961-5490.

Faculty Supervisor: Dr. Tammy Pearson, Assistant Professor, School of Social Work, University of Northern British Columbia, tammy.pearson@unbc.ca; office phone: 250-960-5110.

Purpose of Project:

Thank you for your interest in participating in my research. This research is being conducted as part of the requirements for a Master of Social Work degree at the University of Northern British Columbia. The research will be published as a thesis and made available to the public. The general purpose of my study is to explore people’s experiences related to the death of a loved one during the highest restrictive period of the Covid-19 pandemic in northern British Columbia. If you experienced the death of a loved one during this period (March 18, 2020 to June 30, 2021), I invite you to take part in this study.

What will happen during the project?

If you agree to participate in the study, I will provide you with the interview questions prior to our interview. The questions will pertain to your experience regarding the death of a loved one during the highest restrictive period of the Covid-19 pandemic. The interview can be held virtually or in-person depending on your comfort. The interview will range from 60 minutes to two hours, depending on what you share during the interview.

Participant Consent and Withdrawal

Participation in this research is voluntary, and you can refuse to answer any questions that make you feel uncomfortable. Participants also have the right to withdraw from the study at any point in time without penalty. Any information provided up to the point of withdrawal will be securely destroyed unless you explicitly consent to your information being retained and analyzed.

Risks or benefits to participating in the project:

There are no guaranteed benefits for your participation in the research study. The potential benefits of participating in this research include sharing and exploring your experiences related to the loss of a loved one during a pandemic. I do not anticipate any risk to you during this study. During the interview, you may feel emotional as you recall the death of your loved one. At the end of the interview, if you require debriefing, as a result of reflecting upon your experiences with the loss of your loved one or participation in this study, you are encouraged to contact a mental health professional. Please find a list of resources below.

- Brazzoni & Associates: 301-1705 3rd Avenue, Prince George, 250-614-2261. There are costs associated with using this service.

- First Nations and Inuit Hope for Wellness Helpline: Toll free 1-855-242-3310
  This is a free 24-hour service, 7 days a week, 365 days a year.
  There is an online chat available as well through www.hopeforwellness.ca

- Community Care Center: #206, 1811 Victoria Street, Prince George, 250-562-6690. This service is free.

- Northern BC 24 Hour Crisis Line: 250-562-1214 (or toll-free at 1-888-562-1214 if outside Prince George). This is a free 24-hour service, 7 days a week, 365 days a year. There is an online chat available as well through www.northernyouthonline.ca

- University of Northern British Columbia Hospital: 1475 Edmonton Street, Prince George, 250-565-2000 (during business hours). For immediate assistance, contact an ambulance by dialing 911 at any hour. Free service.

Confidentiality, Anonymity, and Data Storage:

The final document (thesis) will be submitted to an online database where a wider audience including the public will have access to review the document. Please know that all information, including your name, will be kept confidential. To protect your privacy, your transcript or any quotes from your interview will be assigned a pseudonym (fictitious name/a name of your choosing that will not identify you) and no identifying information will accompany your information. Every effort will be taken to ensure your identity is not disclosed. Any records or information will be stored with password protection and/or in a secure and locked location with the researcher. Electronic records will be stored in an encrypted file on a password protected laptop. The only individual (other than myself) who may have access to your name is my Faculty Supervisor, Dr. Tammy Pearson. This is to ensure that your voice/narrative reaches the maximized potential for contribution to this important topic.

Analyzed data, in digital format, will be retained for up to five years post-conclusion of the research project and then securely destroyed (digital record deleted). All other data, outside of the processed and analyzed data, will be destroyed upon completion of the thesis project (paper files shredded and digital records deleted).

Limits to confidentiality include:

If at any point in the study, you reveal that there has been an incident that involves abuse and/or neglect of a child (or that there is a risk of such occurring) please be advised that the researcher must, by law, report this information to the appropriate authorities. Additionally, if you reveal that somebody could be hurt, or you disclose you have an intent to hurt yourself, the researcher must also report this information to the appropriate authorities to ensure assistance is obtained.

Study results:

The results of this study will be reported in a graduate thesis document and may also be published in journal articles and books. Additionally, results may be used for distribution via presentations, brochures, and handouts for the purposes of providing suggestions to the public and professionals. The researcher can provide the participant with the results of the study by providing a copy of the findings by mail, or the final thesis document can be located at the University of Northern British Columbia library website.

Questions, concerns, or complaints about the research:
If you have any questions about this study, please contact the student researcher, Sondra Struke or the student's thesis supervisor, Dr. Tammy Pearson.

UNBC Student Researcher
Sondra Struke, BSW
Prince George, BC V2N 4Z9
sstruke@unbc.ca
250-961-5490 (cell)

Faculty Advisor
Dr. Tammy Pearson, Assistant Professor, School of Social Work
250-960-5110
tammy.pearson@unbc.ca

CONTACT FOR CONCERNS OR COMPLAINTS
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the UNBC Office of Research at 250-960-6735 or by e-mail at reb@unbc.ca.

CONSENT

I have read or been described the information presented in the information letter about the project:

YES NO

I have had the opportunity to ask questions about my involvement in this project and to receive additional details I requested.

YES NO

I understand that if I agree to participate in this project, I may withdraw from the project at any time up until the report completion, with no consequences of any kind.

YES NO

I have been given a copy of this form.

YES NO

I agree to be recorded

YES NO

At my request, a final copy of the thesis document can be sent to me at the following e-mail or mailing address:

YES NO

Email address: ____

Mailing address:

____

____

____

Please be advised participation in this research project is entirely voluntary. You have the right to refuse to participate in this study. If you decide to take part, you may choose to remove yourself and your information from the study at any time without giving a reason and without any negative impact on you [for example, employment, class standing, access to further services from the community center, day care, etc.]".

Your signature indicates that you consent to participate in this study.

Signature of participant: ______________________________________

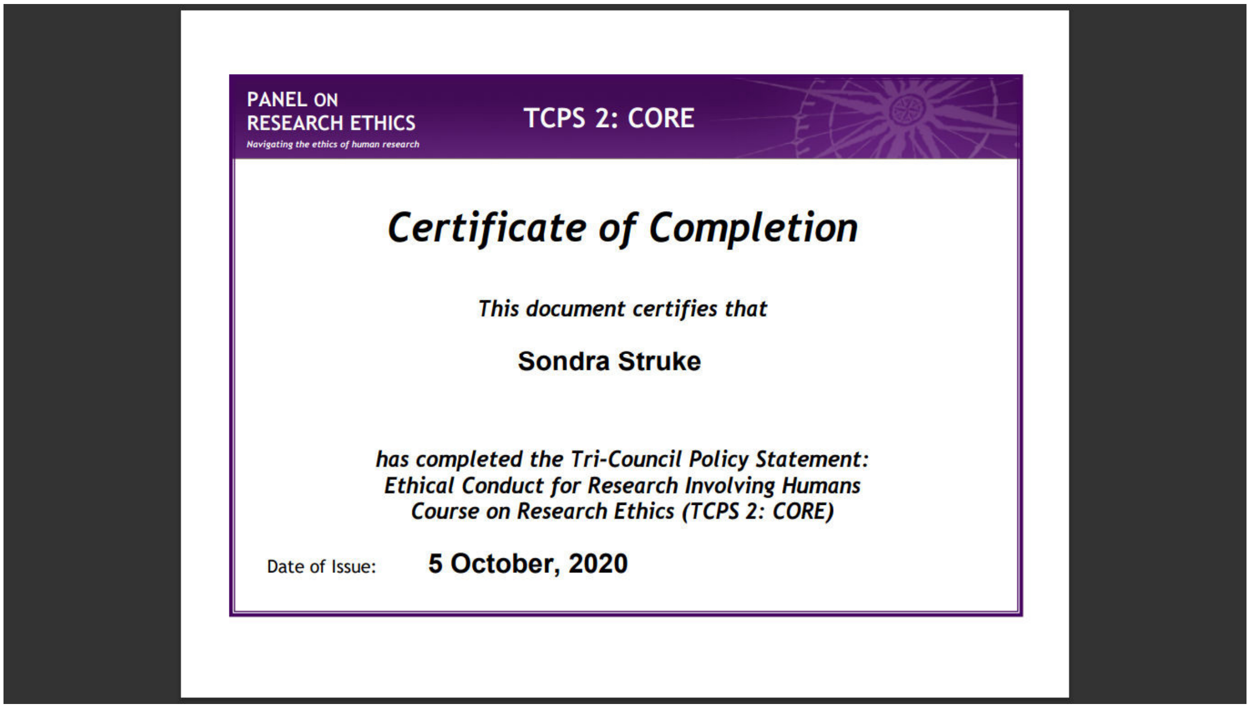
Name of Participant (Printed): ______________________________________

Date: ______________________________________

Appendix D: Map for Sample Population

(BC Touring Council, 2022)

Appendix E: TCPS2 Certificate



PANEL ON
RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Sondra Struke

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **5 October, 2020**

Appendix F: Confidentiality and Non-Disclosure Agreement

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

Confidentiality and Non-Disclosure Agreement

This study explores the Death of a Loved One During the Highest Restrictive Period of the Covid-19 Pandemic, which is being undertaken by Sondra Struke (the "Principal Investigator(s)") at the University of Northern British Columbia ("UNBC"). The study has one objective:

1. To gain an understanding of individuals who experienced the death of a loved one during the Covid-19 pandemic.

Data from this study will be used for the purpose of research:

a) Improved comprehension of the experience of bereavement during the Covid-19 pandemic, with the intent to generate practical applicable knowledge and
b) the fulfillment of requirements for a graduate degree—Master of Social Work.

I, ________________________________ (the "Recipient"), agree as follows:

1. To keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. disks, tapes, transcripts) with anyone other than the Principal Investigator(s);

2. To keep all research information in any form or format secure while it is in my possession;

3. I will not use the research information for any purpose other than the specified research project.

4. To return all research information in any form or format to the Principal Investigator(s) when I have completed the research tasks;

5. After consulting with the Principal Investigator(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Principal Investigator(s) (e.g. information stored on computer hard drive).

Recipient

(Print name)	(Signature)	(Date)

Principal Investigator:

(Print name) (Signature) (Date)

If you have any questions or concerns about this study, please contact:
Dr. Tammy Pearson
Phone: 250-960-5110
Email: tammy.pearson@unbc.ca