Holistic Arts-Based Mindfulness Program with Older Adults at a Slow-Paced Rehabilitation Hospital: Deepening Skills of Working with Older Adults

by

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Advanced Practicum Thesis Report

presented at

Laurentian University

as a partial requirement

of the Master of Social Work Program

The Office of Graduate Studies
Laurentian University
Sudbury, Ontario, Canada

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Thesis Defence Committee/Comité de soutenance de thèse

Laurentian Université/Université Laurentienne

Faculty of Graduate Studies/Faculté des études supérieures

Title of Thesis Titre de la thèse	Holistic Arts-Based Mindfulness Program with Older Adults at a Slow-Paced Rehabilitation Hospital
Name of Candidate Nom du candidat	Brooke Davies
Degree Diplôme	Master of Social Work
Department/Program Département/Programme	Social Work

ACCESSIBILITY CLAUSE AND PERMISSION TO USE

Abstract

Older adults have historically been excluded from research (Jacelon, 2007). This issue is highly problematic as the current rate of growth for the older adult population is the highest in recorded history (UN, 2022). Older adults have unique experiences with mental and physical health, yet those who work with this population are repeatedly shown in the literature to have inadequate professional training and knowledge of best practices (Buttigieg et al., 2018). Perceptions of older adults from the vantage point of both health care professionals and older adults themselves are immensely impacted by the pervasiveness of ageism, resulting in misinformation, stereotypes, and the implementation of inappropriate interventions. Impacts of ageism can include low self-esteem, depression, and anxiety, resulting in lower quality of life. The Holistic Arts-Based Mindfulness Program (HAP) was introduced to older adults at St. Joseph's Continuing Care Centre (slow-paced physical rehabilitation hospital) as an anti-ageist, non-pharmacological intervention to positively affect mood and overall sense of wellbeing. HAP proved to be more challenging to implement than anticipated due to scheduling, COVID-19 restrictions, and internalized ageism on the part of patients. The program was adapted to a 1:1 delivery method to address these challenges. The results of this 1:1 delivery had benefits for patients, including the active resistance of the Foucauldian notion (Foucault, 1995) of docile bodies in an institutional setting, thus leading to a more patient-centred approach. HAP allowed space for patients to recognize their strengths and explore their feelings while rehabilitating. Social workers should consider the use of 1:1 arts-based mindfulness interventions when working with patients in a slow-paced physical rehabilitation hospital setting as an integral tool in the healing process.

Résumé

Les adultes plus âgés ont historiquement été exclus de la recherche (Jacelon, 2007). Cette question est très problématique car le taux de croissance actuel de la population des personnes âgées est le plus élevé de l'histoire (ONU, 2022). Les personnes âgées ont des expériences uniques en matière de santé mentale et physique, et pourtant, la littérature montre à plusieurs reprises que ceux qui travaillent avec cette population ont une formation professionnelle et une connaissance des meilleures pratiques inadéquates (Buttigieg et al., 2018). Les perceptions des personnes âgées, tant du point de vue des professionnels de la santé que des personnes âgées elles-mêmes, sont immensément affectées par l'omniprésence de l'âgisme, ce qui entraîne une désinformation, des stéréotypes et la mise en œuvre d'interventions inappropriées. Les conséquences de l'âgisme peuvent inclure une faible estime de soi, la dépression et l'anxiété, ce qui entraîne une baisse de la qualité de vie. Joseph's Continuing Care Centre (hôpital de réadaptation physique à rythme lent) comme une intervention anti-âgiste et non pharmacologique visant à influencer positivement l'humeur et le sentiment général de bien-être. Le programme HAP s'est avéré plus difficile à mettre en œuvre que prévu en raison des horaires, des restrictions COVID-19 et de l'âgisme intériorisé de la part des patients. Le programme a été adapté à une méthode de prestation 1:1 afin de relever ces défis. Les résultats de cette prestation 1:1 ont eu des avantages pour les patients, notamment la résistance active à la notion foucaldienne (Foucault, 1995) de corps dociles dans un cadre institutionnel, conduisant ainsi à une approche plus centrée sur le patient. Le HAP a permis aux patients de reconnaître leurs forces et d'explorer leurs sentiments pendant leur réadaptation. Les travailleurs sociaux devraient envisager l'utilisation d'interventions de pleine conscience basées sur les arts lors de leur travail avec les patients dans

un hôpital de réadaptation physique à rythme lent, en tant qu'outil intégral du processus de guérison.

Acknowledgments

There are several people whose support and guidance throughout my Master of Social Work must be acknowledged. I would like to begin by thanking my first and second readers, Dr. Diana Coholic and Dr. Leigh MacEwan for encouraging the introduction of HAP to the community at St. Joseph's Continuing Care Centre in Sudbury and for carefully facilitating the thesis writing process.

I would like to acknowledge my Laurentian University social work professors, specifically Dr. Sandra Hoy, Dr. Tanya Shute, and Dr. Elizabeth Carlson-Manathara and my truly one-of-a-kind MSW cohort, for reinforcing my passion for working with older adults. I would not have come to this advanced practicum and thesis report without the collaboration and nurturing of this amazing group of professors and students.

I would like to thank the community at St. Joseph's Continuing Care Centre for providing me with a supportive learning environment where I felt safe to ask questions and learn from my mistakes. I started at this organization as a volunteer, became a practicum student, and am thrilled to be joining the team as a full-time member of staff in the Fall.

Next, I must thank my extraordinary clinical supervisor Sonia Meerai, who went above and beyond her duties to enhance my learning and encourage my abilities.

Finally, I must thank my husband, family, and friends. I am grateful for their unwavering confidence in my abilities, especially at times when I struggled to believe in myself. Thank you to everyone who made this goal a reality.

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Acronyms

Alternate Level of Care (ALC)

Anti-Oppressive Practice (AOP)

Bachelor of Social Work (BSW)

Black Indigenous People of Colour (BIPOC)

Cognitive Behavioural Therapy (CBT)

Emotional Freedom Technique (EFT)

Holistic Arts-Based Mindfulness Program (HAP)

Long-Term Complex Medical Management (LTCMM)

Master of Social Work (MSW)

Mindfulness-Based Intervention (MBI)

Mindfulness-Based Stress Reduction (MBSR)

Potentially Inappropriate Medications (PIMs)

Qualifying Year (QY)

St. Joseph's Continuing Care Centre (SJCCC)

Strengths-Based Approach (SBA)

Introduction

The percentage of Canadians 65 years of age and older is expected to increase significantly in the coming years. Currently, 18% of the country's population is comprised of those aged 65 years and over (Statistics Canada, 2020). According to the Government of Ontario, there are currently approximately three million (Government of Ontario, 2022) older adults living in the province of Ontario. Northern Ontario is seeing the number of older adults rise at a faster rate than the rest of the province; "by 2036, individuals aged 65 and older will make up almost 30% of the total population in Northern Ontario, compared with about 24% in Ontario" (Northern Policy Institute, 2021, para. 2).

Due to the aging population, injuries and life-changing physical maladies are increasing. For example, injuries due to falling are detrimental for older adults. As stated by the Public Health Agency of Canada (2014), "[falls] remain the leading cause of injury-related hospitalizations among Canadian seniors, and between 20% and 30% of seniors fall each year" (p. 3). As a result of such injuries and physical changes as well as other psychosocial factors, older adults are at an increased risk of experiencing mental health issues such as depression and anxiety (Iaboni & Flint, 2013).

Conceptualization of the Advanced Practicum

In 2019, I moved to Sudbury, Ontario and began volunteering with St. Joseph's Health Centres. During my Master of Social Work Qualifying Year (QY) at Laurentian University, I became interested in social work with older adults. For my 450-hour QY placement, I worked with Jennifer Gosselin, BSW, RSW, at St. Joseph's Continuing Care Centre (SJCCC) and was immersed in the responsibilities and realities of social work in this setting. SJCCC is a slow-paced physical rehabilitation hospital that predominantly treats older adults using an

interdisciplinary approach consisting of nursing, social work, physical and occupational therapy, and optional chaplaincy support.

During my placement at SJCCC, I saw patients benefit from the physical support they were provided daily by a team of physiotherapists, occupational therapists, nurses, and rehab assistants. However, I also observed the overwhelming need for mental health support; a skill that lies primarily with the facility's social workers. Two social workers service this facility that supports 64 patients, and they work very hard to do so. Many of the patients who come to SJCCC have existing mental health issues. Hospitalization and physical limitations can exacerbate depression and anxiety in those who have a history of these problems. For those who have not experienced such mental health concerns, hospitalization can increase the risk factors (see Saeed et al., 2016).

In concert with the usual concerns around hospitalization for an extended period, there is the added factor of the ongoing COVID-19 global pandemic. During the last 2+ years of the pandemic, many of the patients who arrive at SJCCC (usually a minimum of 6-week stays) have already experienced isolation at home, followed by a period of acute care hospitalization before beginning their slow-paced rehab journey. There is no doubt that the pandemic has increased the need for mental health support across Canada (CAMH, 2021) and the world; for the patients at SJCCC, this is no different.

Having seen firsthand the need for additional mental health support for patients, I decided to complete my 450-hour advanced Master of Social Work (MSW) practicum at SJCCC. During this advanced practicum, I introduced the Holistic Arts-Based Mindfulness Program (HAP) where patients were able to express their experiences through art while learning the skills and concepts of mindfulness. Mindfulness can be defined as "a holistic philosophy and way of being

in the world, and it can be both a state (an experience) and a trait (a personality characteristic or disposition)" (Kabat-Zinn, 1990). Mindfulness has been proven to help reduce symptoms of anxiety and depression (see Blanck et al., 2018; Coholic et al., 2018). The literature also documents that it may help improve other aspects important to the quality of life of patients at SJCCC such as positively influencing one's gait (see Hoang et al., 2020).

Bringing HAP to SJCCC interested me as this program has the potential to provide an added level of support for patients. HAP aligns itself well with the values and mission of SJCCC. This organization's mission is to heal patients in body, mind, and soul; a holistic approach also found in HAP. SJCCC places innovation as a pillar of its values, keeping an open mind to novel programming focused on improving patient care (SJCCC, 2021). While arts-based mindfulness is not necessarily a new concept, it had not been employed at SJCCC before I piloted the program during this practicum. As this practicum brought about many challenges and unexpected changes to my original intended programming, I utilized the skills of reflexivity and staying connected to patient-centred care to adapt as required.

In Chapter One, I will explore the literature related to Mindfulness-Based Interventions, Arts-Based Methods, and the implications when working with an older adult population. Before delving into the literature, however, I will first disclose my social location, as one's personal background shapes the perspective held when approaching a body of research and influences interpretation of the literature (Jacobson & Mustafa, 2019).

Chapter 1- Literature Review

This review will look at Mindfulness-Based Intervention (MBI) and arts-based methods research as a whole and will more specifically focus on the literature written about these interventions with the older adult population. This review will consider a holistic approach and a strengths-based perspective concerning mindfulness research and implementation. Due to the institutional context of this advanced practicum in which all participants dealt with physical issues and for many, mental and emotional problems as well, the literature explored in this review will by and large focus on MBIs implemented with older adults where a presenting problem exists. Before delving into the literature, I feel it is important to address the social location from which I am approaching the research, so this section will precede the literature review.

Social Location

One's social location is a crucial element of meaningful practices of self-reflection and reflexivity. With regards to social work and research, the absence of acknowledging one's place and privilege in the world creates blind spots in the interpretation of the literature and gaps in the production of studies. One's social location provides context regarding the perspective from which the literature is being approached and interpreted. It is for this reason I feel it necessary to address my social location prior to exploring the literature. Some social work scholars have been critical of the way the discipline often looks to issues of oppression without paying close enough attention to the role that social worker privilege plays in its negative perpetuation (Mullaly & West, 2018). It has been the belief and message of some academics that social workers must actively address, critically evaluate, and deconstruct the privilege they hold as it can not only have adverse effects on the client experience but can also inhibit growth and reflexivity on the

part of the practitioner (Greene, 2010; Jones, 2010; Mullaly & West, 2018). Several authors have written on the importance of identifying one's social location/social identity through self-reflection (see Hunter, 2003), however, it is in the work of Jacobson and Mustafa (2019) that a practical guide and template are provided in the form of the Social Identity Map. Implementing the elements of this map, I will explore my social identity concerning research about MBIs with older adults.

I identify as part of the middle class and have done so my whole life. I have always had shelter, food, and access to transportation. Living my life in the middle class means I have been relatively free to make life choices and monetary decisions without significant worry, including the choice to return to university in my 30s to pursue my MSW Degree. Having grown up in Canada, I have been privileged in terms of my overall safety, access to health care, and my ability to participate in a democratic system. It is my racial identity as a White person, my heterosexuality, and my cisgender experience that further elevates the privileges encountered living in Canada and being part of the middle class. I am aware, for example, that if I were not White, my interactions with my Canadian identity may have been drastically different in my upbringing. As I learn and reflect, I can see the flaws in the idea of Canada, or Turtle Island as it is called by some Indigenous Peoples living in North America (Michaud-Turgeon et al., 2012), as being a place of acceptance and equity that embraces multiculturalism, when considered through an anti-colonial lens. One example of how this idealized vision of Canada is flawed is the racist treatment Indigenous Peoples are exposed to in the Canadian healthcare system. In 2020, Joyce Echaquan, 37-year-old Atikamekw women from Manawan First Nation, recorded her final moments before dying in a hospital in Montreal. Echaquan's recording captured hospital staff making racial slurs toward her, calling her names, and ignoring her cries for help

(CBC, 2021). The government launched an inquiry into treatment of Indigenous Peoples in Canadian health care concluding that Echaquan's death was in part, due to systemtic racism in Canadian health care. Echaquan's death is not, however, the first to spark an investigation (College of Family Physicians of Canada, 2016) and the research on Indigenous disparities in the Canadian health care system are well evidenced in research (Fraser et al., 2021; NewsRx, 2021). It is in this way for example, that I recognize my experiences as a White person in Canada, are vastly different from others living in the same country.

Finally, I acknowledge my experiences as an able-bodied person at the age of 33 years old. My ability is for the most part taken for granted and is not something about which I often think. I can gain physical access to places I want to go; I can drive myself around with ease and freedom, and I enjoy a level of safety in not having to rely on service providers for assistance with my activities of daily living. My age influences the way I am viewed in society as well, as younger people are often viewed as productive and full of life, whereas older adults must constantly face unfair assumptions based on ageism.

It is through an awareness of the intersectionality of my privileges that I acknowledge and reflect upon my place in the world. In terms of working with and researching the experiences of older adults, I recognize that being young and not having faced the realities of this population places me in a position of privilege. Furthermore, in being able to work with this population, listening and trying to facilitate helpful assistance to alleviate challenges being experienced, I also understand my position of great privilege having one foot in the world of older adulthood while being able to remove myself from this experience when I go home at night.

My social location in relation to the literature and my practicum experience will be woven throughout the thesis report. I aim to perpetually recognize my position in relation to

those with whom I work and to the literature I reference. It is with transparency and acknowledgement of my social location that I move forward with interpreting the literature.

Overview of Mindfulness

The roots of mindfulness are in a 2500-year-old Eastern Buddhist traditional practice (Blanck et al., 2018), however, its power was made popular in the Western medical community through the work of Jon Kabat-Zinn (1990) and the creation of Mindfulness-Based Stress Reduction (MBSR) in 1979. MBSR was originally implemented to aid those living with chronic pain (Brandel et al., 2022). The application of Mindfulness-Based Interventions (MBIs) has now grown to a plethora of topics from cognition (Dunning et al., 2019), obsessive-compulsive disorder (Hawley et al., 2021), emotion regulation (Guendelman et al., 2017), stress experienced by cancer patients (Lei Chui et al., 2021), and many others. MBI research has focused on group settings as mindfulness lends itself well to this context, it is cost-effective and can reach a wider group of people dealing with similar issues.

MBIs are becoming increasingly studied and implemented as a non-pharmacological option (MacLeod et al., 2018; Lestoquoy et al., 2017) for treating physical and mental illnesses and ailments. This holistic option is of particular interest for older adults and those who work with and care for them. Mindfulness research pertaining specifically to older adults is still in its infancy in Western, English language academia, however, the preliminary research shows promising results (see Hazlett-Stevens et al., 2019).

Mindfulness has been found to stimulate various benefits including but not limited to cognitive, emotional, and interpersonal improvements through changing brain functioning, increasing compassion and self-esteem, and stabilizing emotion regulation (Brown et al., 2016). Over the past decade, systematic reviews and meta-analyses have explored and exhibited the

considerable effects of MBIs on stress, depression, and anxiety when compared to waitlist and active control groups (Blanck et al., 2018; Han, 2021; Khoury et al., 2013; Nissen et al., 2020; Vollestad et al., 2012). It is from the data collected on younger and mixed-age samples that MBIs are gaining popularity and attention for combating issues faced by the older adult population. Older adults face similar problems as younger people (for example, anxiety and depression), however, their relationship and risk factors attached to these problems differ in unique ways (National Institute on Aging, 2021).

Themes Throughout the Literature

In reviewing the literature on MBIs with older adults dealing with physical or mental/emotional illness and ailments from 2015 to 2022, three main themes emerged: (1) the importance of mindfulness as a non-pharmacological option for older adults, (2) the influence of mindfulness on quality of life in older adults, and (3) the utilization of various forms of mindfulness to meet the needs of the group. These themes will be further explored and discussed in the next section.

Mindfulness as a Non-Pharmacological Option for Older Adults

When delving into the research on mindfulness with older adults living with a malady or illness the theme of medications and overprescribing quickly came to the fore. Several authors (Black et al., 2015; Franco et al., 2017; Labbé et al., 2016; Ng et al., 2020; Wong et al., 2017) explicitly spoke about the need to reduce the number of medications taken by older adults and herald mindfulness as a promising non-pharmacological tool in treating various ailments facing this population. Although there are some authors (Helmes & Ward, 2017; Hoang et al., 2020; Kovach et al., 2018; Ng et al., 2020) who do not explicitly use the term “non-pharmacological” or directly discuss the overmedication of older adults, this theme is implicit in their work. The

fact that mindfulness (a natural and holistic intervention) is being implemented as a tool in treating participants demonstrates the value of non-pharmacological treatment.

As expressed by Zhang et al. (2015), exploring mindfulness to treat insomnia in older adults over the age of 75 years, "…due to their convenience, doctors have preferred pharmacotherapies, while patients prefer behavioral therapies" (p.181). This sentiment is reflected throughout the literature in the discussion of preventative measures for common psychological issues such as anxiety and depression (Rawtaer, 2015), to the dangers of medications contained in the Beers list (named after Dr. Mark Beers) to a list of Potentially Inappropriate Medications (PIMs) for adults over the age of 65 years (Luiggi-Hernandez et al., 2018). The articles explored in this review all deal with older adults who had current mental and/or physical health issues, rather than studying older adults described as "healthy." In the studies, mindfulness was implemented as a holistic and non-pharmacological option for issues including diagnosed and undiagnosed anxiety, depression, and stress (Franco et al., 2017; Labbé et al., 2016; Rawtaer et al., 2015; Wetherell et al., 2017), insomnia and sleep disturbances (Black et al., 2015; Zhang et al., 2020), falls prevention (Hoang et al., 2020), dementia and mild cognitive impairment (Kovach et al., 2018; Ng et al., 2020; Wong et al., 2017), and finally, chronic low back pain (Luiggi-Hernandez et al., 2018). The fact that older adults are willing to participate in various mindfulness programs to help combat their ailments proves that there is a need for non-pharmacological approaches. This feature of the literature further supports Zhang et al. (2015) in their finding that older adults are interested in exploring behavioural and more holistic therapies.

The Influence of Mindfulness on Quality of Life in Older Adults

Another prominent theme that emerged from the literature involved the improvement of quality of life (QOL). Helmes and Ward (2017) used this term more than any other paper reviewed (20 times) and used a tool to capture the QOL of the participants; "quality of life of participants was measured using the WHOQOL-OLD, a measure specifically developed to assess the construct in older adults" (p. 278). Across the literature, QOL seems to fall within the World Health Organization's (WHO) definition of QOL which is at the basis of their tool (WHOQOL-OLD); "WHO defines Quality of Life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHO, 2021, p.1). Helmes and Ward (2017) found their mindfulness intervention to have significant impacts on the QOL of participants. Other studies did not implement the WHOQOL-OLD tool, however, their research uncovered elements of QOL that are observed in the WHOQOL-OLD. In the work of Luiggi-Hernandez et al. (2018) for example, they uncovered the following themes: (1) Overcoming Fear of Pain, (2) Pain Awareness (assessing and understanding pain), and (3) Pain Significance. These themes confront one's ability to participate in activities they enjoy, and address feelings of fear of pain and death, and feeling out of control, which are all part of the WHOQOL-OLD and QOL more generally speaking.

Although a handful of studies did not explicitly talk about QOL (Labbé et al., 2016; Ng et al., 2020; Wetherell et al., 2017; Zhang et al., 2017) these articles were implementing mindfulness to alleviate the pain and suffering of symptoms experienced by older adults to help improve their day-to-day life; an endeavour that can easily be understood as contributing to improved QOL.

While the QOL theme is more explicitly written about than the theme of non-pharmaceuticals, it is obvious that the two are connected. For example, Kovach et al. (2018) spoke about the brain changes that can be achieved through mindfulness that in turn have effects on issues related to blood pressure, heart rate, and emotional regulation. When improved, these effects contributed to an improvement in the perception of one's daily functioning and QOL. As previously explained in this review, older adults are at a higher risk of experiencing adverse effects of pharmaceuticals, and in this way, it is clear to see the connection between QOL and being able to engage in helpful and effective drug alternatives such as mindfulness.

Utilization of Various Forms of Mindfulness to Meet the Needs of the Group

Mindfulness practice can come in many forms. One final theme of the literature is that different groups require different styles of mindfulness to be applied. Various styles of intervention appeared throughout the literature and for different reasons. Examples of mindfulness programs utilized in the literature included Mindfulness Meditation (Black et al., 2015), Mindfulness-Based Cognitive Therapy (Franco et al., 2017; Helmes & Ward, 2017; Labbé et al., 2016), Mindfulness-Based Stress Reduction (Franco et al., 2017; Wetherell, 2017; Zhang et al., 2015), Present in the Now (PIN) Mindfulness (Kovach et al., 2018), Flow Meditation (Franco et al., 2017), and Mindful Awareness Program (Ng et al., 2020; Rawtaer et al., 2015). There are however some articles that are outside the norm in terms of mindfulness applications. Hoang et al. (2020) simply incorporated various mindfulness activities (such as having participants complete mindful body scans) into a pre-existing falls-prevention course. While they referred to MBSR in the literature at large, Luiggi-Hernandez et al. (2018) did not disclose what specific type of mindfulness intervention was implemented in their study. Perhaps this is because Luiggi-Hernandez et al. (2018) were performing a qualitative study meant to

establish themes participants spoke about when reflecting upon their mindfulness training experience, rather than the details of the program itself. Finally, Wong et al. (2017) explained in their work that they used "an eight-week Mindfulness for Mild Cognitive Impairment (MCI) program intervention that was developed at Monash University as a part of this study" (p.183). The last three studies described are good examples of researchers using mindfulness in a way that was appropriate and made sense for the participants involved. As researchers suggested, mindfulness interventions should be adapted and implemented according to the needs of the group receiving the program. This attention to the relevance of adjusting and tailoring MBIs to the participants' needs reflects a strengths-based perspective by setting participants up for success and encouraging their abilities.

HAP is the specific MBI that was implemented during the advanced practicum. This specific approach to facilitating mindfulness satisfies the themes that emerged from the literature on MBIs. HAP is non-pharmacological, seeks to improve the quality of life of participants (Coholic, 2019), and adopts multiple forms of mindfulness (tai chi, guided imagery, artistic creations) to best support participants. Since HAP intertwines mindfulness-based intervention with arts-based methods, it is also important to address the literature on arts-based methods. This area of research regarding older adults is in its infancy, however, the findings for this population are promising.

Arts-Based Methods

The final stage of Erik Erikson's eight stages of psychosocial development (Erikson, 1950) usually comes in older adulthood and involves reflecting upon the past, present, and future to grapple with the meaning of one's life (Graves & Larkin, 2018). Arts-based methods prove to be a valuable tool in navigating this reflective process (Huss, 2015; McKay, 2020) helping older

adults to express themselves and make meaning of their experiences (McKay, 2020). Arts-Based methods allow participants a multi-modal (writing, art production, oral, body movement) option for expressing and understanding themselves (Haeyen & Noorthoorn, 2021).

An example of why multi-modal forms of expression are helpful when working with older adults relates to a lack of vocabulary around feelings and emotions. There are researchers who suggest that when older adults are asked to explain in words how they are feeling, they are limited to describing physical feelings, rather than psycho-emotional experiences (Gielkens et al., 2018). This consideration of art as a means of self-expression is not only helpful for older adults who may not feel comfortable or be well-versed in expressing their feelings, but for many others including children (Coholic, 2019), people with cognitive impairments (Fong, 2021), and newcomers for whom English is not readily accessible (Alves-Moreira & Jakobi, 2021). Arts-based methods can be an engaging and enjoyable intervention that allow the participant to feely create while having control over disclosure (Coholic, 2019). This aspect of arts-based methods differs from a situation in which one is expected to share only verbally how they are feeling. Arts-based activities allow the participant to express themself and engage in introspection without necessarily having to communicate verbally (Rodrigues et al. 2019).

The greater sense of self-expression afforded by arts-based methods is the foundational element of the many benefits that can result from engaging in artistic creation. For example, in being able to express oneself, there is a stronger ability to connect with others who may be experiencing similar situations (Rodrigues et al., 2019; Muhr, 2020). Communication through arts-based methods has also been shown to reduce feelings of isolation in both community and institutionalized older adult populations (Dadswell et al., 2017; Phinney et al., 2014; Roos & Malan, 2012). Furthermore, arts-based expression supports older adults through ameliorating

symptoms of depression and anxiety (Dunphy et al., 2019; Nan et al., 2020). The research on arts-based methods as a means of alleviating depression and anxiety is of particular interest in the context of the advanced practicum setting, as hospitalized older adults face higher risk of anxiety and depression (Lalor et al., 2015; Zisberg, 2017). The benefits attributed to the implementation of arts-based methods with older adult populations are invaluable. By helping older adults to express themselves, connect with others, and improve symptoms of anxiety and depression, arts-based methods can contribute positively to the overall well-being of older adults (Groot et al., 2021).

Most of the research on MBIs and Arts-Based Methods is done with groups. The Holistic Arts-Based Mindfulness Program (HAP) was created with the intention of being implemented with groups, and prior to facing challenges in the advanced practicum environment, it was my plan to work in a group setting. It is for these reasons that social work in groups is an important aspect of the literature that will be explored in the review.

Social Work with Groups

The literature on social work with groups suggests that this form of social work is proven to evoke various advantages for participants including mutual aid, resiliency, and human connection. Mutual aid is a process wherein group members provide support and contribute to healing and helping one another (Giacomucci, 2021). Mutual aid forms the very foundation of social work with groups (Gitterman & Shulman, 2005; Glassman & Kates, 1990; Steinberg, 2010; Northen & Kurland, 2001; Skolnik-Basulto, 2016). Some social work scholars argued that it is in this process of mutual aid that meaningful group work lives:

> "I realized that I could not speak about the contribution of mutual aid to group work because for me catalyzing mutual aid is group work, and mutual aid in motion is a sign

> that group work is taking place. I will even go so far as to propose that the mutual-aid process is evidence of group work or at least social work with groups in action. It is a process through which people (1) develop collaborative, supportive, and trustworthy relationships; (2) identify and use existing strengths and/or develop new ones; and (3) work together toward individual and/or collective psychosocial goals, which reflects the very essence of social work with groups as I understand it. Thus, in my mind to catalyze mutual aid and to engage in group work are synonymous" (Steinberg, 2010, p. 54).

Another valuable factor of social work in groups is that when facilitated from a strengths-based perspective, resiliency is encouraged among participants by drawing out their abilities and validating their positive attributes (Gitterman & Knight, 2016). Resilience can be understood as the capacity to experience and navigate hardships in a way that safeguards one's overall "health, well-being, and life satisfaction" (Kiosses & Sachs-Ericsson, 2020, p. 157). Strengths-based group work gives participants the chance to focus on the positive factors present in their lives making way for solutions rather than problem-focused conversations. When group members open up to each other, sharing and normalizing experiences, participants are able to glean power and strength from the group (Lietz, 2007).

Finally, by providing older adults with group opportunities, participants may benefit from developing new friendships, practicing their interpersonal skills, and receiving peer support. For many in this population, social connections are dwindling (Ingersoll-Dayton et al., 2009) and group opportunities provide essential human connection. Research has demonstrated that loneliness and lack of human connection can be as lethal as smoking 15 cigarettes per day (Tiwari, 2013) showcasing the importance of providing space for people to communicate and connect about their common situations.

Gaps in the Literature

It is difficult to address gaps in the literature specific to older adults, mindfulness, and arts-based methods, as the entire area of study is sparse. This dearth of material is especially apparent when studies looking at "healthy" older adults are removed from the body of literature. Based on the available information about MBIs with older adults who are presenting with physical and/or mental/emotional problem(s), it is appropriate to assume that implementing the HAP program with older adults at a physical rehabilitation hospital will be beneficial to the participants involved. This is a reasonable expectation, as HAP is an MBI, which has demonstrated benefits with various populations (Coholic, 2019). In addition, HAP utilizes an arts-based approach, shown to have beneficial impacts on older adults with respect to cognition, (Fong et al., 2021), depression, (Dunphy et al., 2019), anxiety (Nan et al., 2020), isolation (Dadswell et al., 2017; Phinney et al., 2014; Roos & Malan, 2012), and overall well-being (Groot, 2021).

Implementing HAP at SJCCC in its intended group setting during the time of the COVID-19 pandemic proved to be challenging. Ultimately, the program shifted to a 1:1 delivery the unexpected benefits of which were described earlier in this report. This 1:1 delivery did uncover a specific gap in the literature on mindfulness and arts-based methods, wherein 1:1 delivery is wholly understudied. This lack of research focused on 1:1 intervention is apparent not only in the literature that exists with older adult participants but in all age groups.

Critiques of Strengths-Based Approach and Mindfulness to Consider in Practice

Although the Strengths-Based Approach and Mindfulness I don't think mindfulness is a theory per se – people don't usually refer to it that way have many beneficial applications when working with various populations, as has been demonstrated throughout the literature review, it

is integral to my reflexive social work practice to consider possible implications of their utilization in practice. The following critiques and considerations are the product of ongoing learning through MSW course work, independent research, and lived experiences encountered in the application of HAP during practicum.

Considerations for the Implementation of Strengths-Based Approach

In their work on Strengths-Based Approaches in social work and social care, Caiels et al. (2021) explained that "Instead of starting with *problems*, a strengths-based approach starts with what is working, what makes people feel well and what people care about" (p.403). Taking a Strengths-Based Approach (SBA) can be a beneficial way to work with participants who are having difficulty acknowledging their strengths. The SBA is collaborative because the participant and practitioner can explore what each of them views as the participant's strengths. With the HAP, participants can draw on the advantages of group work. In a group work setting, members can help each other to recognize the strengths of individuals, but also of the group as a collective. While the benefits of SBA are many, including resiliency, empowerment, self-advocacy, improved sense of hope, and self-determination (Masten et al., 2009), this approach is not without critiques. Some researchers have been critical of the individual responsibility SBA places on clients (Gray, 2011; Slasberg & Beresford, 2017) and highlight the fact that SBA can ignore systemic forms of oppression (Gray, 2011). Others have considered the risk of betraying client practitioner relationship, as SBA can be perceived by some as dismissive of the "miserable situations" (Jung, 2019, p.25) in which some clients are living.

One example of the considerations involved when using SBA became evident to me in a discussion with Dr. Lea Tufford. I video recorded a simulated client interview for Dr. Tufford. I spoke with Dr. Tufford about how I had been taking an SBA with my client, but that it had

resulted in frustration on the part of the client, and I was unable to understand why. Upon watching my video, Dr. Tufford gave me the feedback that while I skillfully employed the strategies of SBA, my client was profoundly depressed. Dr. Tufford explained that simply using SBA with a client experiencing this level of mental illness is ineffective and dismissive of the client's situation. This is an example of a situation wherein the practitioner would want to meet the client where they are, be with them in their pain, and work on slowly bringing them out of a dorsal vagal state of being shut down (Porges, 2009). At this moment, I realized the sanist perspective I held. I was feeling that depression is uncomfortable, I did not want to be "dragged into this client's negative thinking", and that everyone should be able to acknowledge their strengths, especially a client such as this who was highly educated and accomplished. I was able to reflect upon my own experiences with periods of mental illness, and those of my close family. I realized that in fact, I had internalized the sanist discourse that I had personally experienced to be oppressive and dismissive of my experience. This experience highlighted the importance of being aware of sanism and how is it so embedded in mainstream North American culture. During the completion of my advanced practicum at SJCCC, I found it crucial to be aware of this limitation and to continually challenge automatic sanist thoughts as they entered my mind. Older adults are at an increased risk for depression (CDC, 2022) and through this advanced practicum, I have become more aware of the consequences and the importance of addressing and challenging sanist thoughts when working with HAP participants who are struggling with the SBA.

This experience with SBA led me to reflect upon other clients for whom approaching their experience in a predominantly strengths-based way would be inappropriate and/or ineffective, dismissing the client's reality (Slasberg & Beresford, 2017). The personal experience

explained above serves as a reminder that as a social worker, I want to embrace an informed eclectic approach, in which SBA is but one of many tools implemented in direct practice (Coady & Lehmann, 2016). Many social work scholars have argued that generalist-eclectic approaches better help practitioners serve the needs of each client. An eclectic approach allows the social worker to address each client's particular situation, while considering their needs in the moment (Greene, 2017; Huang & Fang, 2016; Langer, & Lietz, 2014).

For Black Indigenous People of Colour (BIPOC) clients facing daily acts of microaggression (Sue et al., 2007), for example, I would want to carefully consider how best to implement SBA doing so in a thoughtful and appropriately timed manner. One form of microaggression is categorized by Sue et al. (2007) as a "microinvalidation" wherein "communications exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of colour" (Sue et al., 2007, p. 274). If implemented without awareness, I could see myself having applied SBA to work with BIPOC clients and unintentionally perpetuating feelings of invalidation, similar to how this was done with my simulated client experiencing profound depressive symptoms. It is worth noting here, that while microaggressions are often considered solely about BIPOC, older adults also face microaggressions directed toward them because of ageism (Zimmerman, 2017). For older adults of colour, microaggressions faced may be a result of intersectionality (i.e., racism, ageism, sexism, ableism, etc.). Such actions are shown to have negative effects on mental health (Auguste 2021, Zimmerman 2017). My privilege as a White, young person affords me the "luxury of obliviousness" (Mullaly & Dupre, 2019, p. 278), something I actively worked to combat in my advanced practicum and will continue into my future social work practice.

In reading the anti-Black sanism work of Meerai et al. (2016) I began to understand further how the issues of sanism and racism converge. An awareness of the types of experiences that Black clients living with mental health issues are required when thinking about implementing SBA because these clients may have experienced the intersectionality of racist and sanist oppression when seeking support. This is not to say that SBA should not be used with such clients, only that social workers are responsible for carefully navigating and validating the fact that awareness and appreciation of one's strengths may not yet be accessible.

The mental health and racial considerations/critiques of SBA I have reflected upon relate to my work facilitating HAP with older adults as some of them may identify as BIPOC and/or may be experiencing mental health issues. This reflective look at SBA has opened my mind to other populations/situations where I would tread lightly or adjust how I would typically incorporate SBA into my direct practice. In a slow-paced physical rehabilitation hospital setting like SJCCC for example, all the participants of HAP will be recovering from an injury or illness. For many of these patients, considering their strengths when all they can see is what they consider to be weaknesses is a difficult and frustrating task.

Using an Anti-Oppressive Practice to Critique Mindfulness

Mindfulness and anti-oppressive social work have been lauded as complementary approaches to social work and social justice (Orr 2002, Berila 2016, Hick & Furlotte 2009). For social work practitioners, the anti-oppressive practice requires a practice of self-reflexivity, self-care, and bringing awareness to biases and assumptions (Baines, 2011), all of which can be explored through mindfulness (Vu & Burton 2020, Nilsson 2021). Research has shown that the nervous systems and brains of people who experience systemic oppression such as racism are negatively impacted by the effects (Fani et al., 2021, Harrell 2003). Research has also shown the

effects that racist thoughts have on the brains of those who hold them; particularly the way that in-group/out-group biases are processed (Cikara & Van Bavel, 2014) and how the amygdala responds to the perceived threat established in the brains of racist individuals (Chekroud et al., 2014). While mindfulness is certainly not going to single-handedly remove social injustice and the way it is experienced by people who are oppressed, it is a tool that can be used to calm one's nervous system (Tang et al., 2009) and create new neural pathways and healthy changes to the brain (Lardone et al., 2018). Both the calming of one's nervous system when activated either by racism or racist thoughts and feelings, as well as the changing of the brain's response, should not be dismissed (Weichselbaum & Banks, 2021) when it comes to establishing anti-oppression and social justice work. For many reasons, mindfulness and AOP work harmoniously together. There are, however, some issues that arise when examining the current context in which mindfulness is being touted. The results of modern-day mindfulness manipulation are in direct conflict with the concepts of AOP.

The problems illuminated when mindfulness is critiqued from AOP, are not necessarily linked to the pure theory (Seema & Säre, 2019) of mindfulness itself, but rather the way mindfulness theory has been co-opted, used for capitalistic gains, and reduced to a catch-all buzzword. In analyzing mindfulness when it is used in these ways, various social justice theories could easily be implemented to form a critique. Anti-colonialist theory, anti-capitalist theory, anti-sanism, and critical-race theory could all be used appropriately to critique aspects of the way mindfulness has come to be utilized and indeed weaponized. I feel that AOP however, fits best because the issues associated with the problematic manipulation of mindfulness are manifold and have big impacts on social justice (Baines, 2011).

Many scholars have drawn attention to the overall lack of diversity (race, age, ability, economic status, etc.) in mindfulness research (see Chin et al., 2019) and the over-representation of upper-middle-class white female mindfulness practitioners. It is integral that there be representation in the mindfulness research to better understand the subtleties and nuances (Fleming et al., 2022) involved in the implementation of mindfulness practices within oppressed and marginalized groups. It is of utmost importance that mindfulness is not thrust upon groups of people experiencing oppression in a way that implies they can breathe their way out of oppression, (Chin et al., 2019) or that it is their responsibility to simply find calm and compassion when confronted with racism, sexism, ageism, ableism, sanism, etc.

The portrayal of mindfulness as being an individualistic way for people to fix any problems or pains they may be experiencing is problematic. Mindfulness, while powerful and life-changing for some, is not a panacea (Treleaven, 2018). This panacea portrayal of mindfulness is one that capitalist powers have particularly glommed onto in recent years. One need only complete a simple internet search to observe the wide range of mindfulness programs, of varying fees, promising to alleviate and improve a plethora of problems. Additionally, big businesses such as Amazon have jumped onto the mindfulness bandwagon, while reports of inhumane working conditions in their warehouses prevail (The Guardian 2020; Marcus 2021), thus, illustrating the disconnect between the true intent behind mindfulness theory and the way it has been reduced to a public relations buzzword giving the illusion of change and genuine investment in the mental health of employees. The capitalistic spin on mindfulness as being something you must pay to learn, or that it can be used as a means to increase productivity in the workplace, is in opposition to the true roots of mindfulness theory, which is by nature anti-capitalist (Seema, & Säre, 2019). Social workers are appropriately positioned to facilitate

mindfulness, as “our interventions and research methods are often holistic, innovative, creative, and unique” (Coholic, 2019, p. 1). Social work opposes capitalist means that are sometimes applied to mindfulness (Seema, & Säre, 2019) and focuses on the encouragement and empowerment of peoples.

In Chapter One, I provided an overview of the literature pertaining to MBIs and arts-based methods and looked specifically at work being done with older adult populations. While the literature is sparse in this area, research demonstrates promising outcomes for older adults who engage in MBIs and arts-based methods. In addition to the literature on these forms of intervention, I also explored precautions and considerations when using SBA and mindfulness. I discussed the benefits of an eclectic approach to social work; choosing what is best suited to each client and their individual needs. In the following chapter, I will provide an outline of the practicum process, learning, and logistics. I will discuss the ways in which I prepared for the advanced practicum, describe the practicum environment, how HAP was implemented, the logistics of supervision, the MSW student role, and my learning goals.

Chapter 2- Practicum Process: Learning and Logistics

The Master of Social Work advanced practicum consisted of 450 hours completed at St. Joseph's Continuing Care Centre (SJCCC) which is a slow-paced physical rehabilitation (SPR) hospital in Sudbury, Ontario, Canada. The practicum was completed in January 2022-June 2022. In this chapter, I will: (1) describe the steps I took to prepare for undertaking this advanced practicum, (2) describe the practicum environment, (3) outline the implementation of HAP in this setting, (4) explain the supervision experience, and (5) describe my role as an advanced practicum student.

Preparing for the Advanced Practicum

As mindfulness was a key component of my advanced practicum, mindful preparation to take on this learning experience was integral. I have consistently held a morning mindfulness practice for the last 4 years. This daily practice consists of yoga, breathwork, and various forms of meditation, including Christian Meditation, guided meditation, silent meditation, etc. More recently, I have incorporated the Emotional Freedom Technique (Bach, et al., 2019) of therapeutic tapping. EFT Tapping combines both cognitive and somatic techniques and is brief exposure therapy wherein tapping is used to stimulate acupressure points on one's body to help lower levels of stress and anxiety (Church et al., 2013).

In addition to my mindfulness practice, I participated in an online workshop called "A Compassionate Presence" with Kathryn Anne Flynn (Master of Clinical Psychology, qualified yoga, Ayurveda, and meditation educator) via Zoom on Sunday, January 9th, 2022. This workshop included a yoga and meditation practice, EFT Tapping, journaling, and breathwork, all

of which supported my mindfulness practice and deepened my knowledge and confidence in the facilitation of HAP.

I decided to take this workshop not only for its beneficial connection to my advanced practicum but because I value physical relaxation (Zhang et al., 2021) and self-care as means to combat stress. I appreciate that self-care is a term that has become a popular buzzword (Pandve & Patil, 2020), especially during the COVID-19 Pandemic in which capitalism reigns and messaging suggests that material goods alone can satisfy self-care needs. To establish a true and meaningful approach to mindful self-care, I regularly adapt and create a self-care plan consisting of focus on physical, psychological, relational, emotional, spiritual, and workplace/academic factors (Reach Out Australia, 2020). An example of my current self-care planning is outlined below:

Physical -Yoga every morning -Make regular massage and chiropractic appointments -Walks in nature with my dog	**Psychological** -Set boundaries around schoolwork. E.g., I will not work on school assignments past 6 pm on weekends and 10 pm on weeknights. -Go for neurofeedback sessions as needed
Emotional -I will talk to my sister on Zoom once a week so we can share our feelings about our graduate school experiences and life. -I will share my needs, concerns, and hopes with my husband.	**Spiritual** -I will meditate after yoga every morning -I will attend church in person when it is safe/watch mass online during lockdowns.
Relationships -I will prioritize people who matter to me and will reach out to family and friends through writing cards and letters.	**Workplace** -I will consult with faculty and friends when I am feeling confused or anxious. -I will take advantage of professional development opportunities.

Overall Balance: By setting boundaries about schoolwork, I will be able to achieve a more

healthy relationship with my feelings of inadequacy. Recognizing the parts of life that are more important than academic achievements and the perceptions of others will help me to detach from this fixation and worry.
What might get in the way? When I encounter a task for school which is making me feel particularly doubtful of my abilities, I tend to get either hyper-focused and agitated, or frustrated and avoidant. When I am hyper-focused on an assignment or task for school sometimes aspects of this self-care plan may face the threat of non-compliance.
What negative strategies do you need to avoid? When I am feeling like an imposter or when I am feeling anxious sometimes, I cope by avoiding my feelings through distractions like sleeping or watching tv for hours. Sometimes this strategy is helpful in smaller doses but becomes detrimental when I rely upon them in excess.
If you implement your plan, how might you feel? I know that if I implement this plan I will feel better overall. Any time I have implemented aspects of this plan, I notice a marked difference in my ability to respond to situations and understand my feelings.

Practicum Environment

Figure 1

Map of Northeastern Ontario

St. Joseph's Continuing Care Centre is recognized as a class E (rehabilitation) and class G (chronic pain) slow-paced physical rehabilitation hospital that opened on June 1, 2009. This site was the first stand-alone continuing care facility in Northeastern Ontario and serves patients from across the region. SJCCC is part of the broader organization of St. Joseph's Health Centres. Included in this organization are St. Joseph's Villa in Sudbury and St. Gabriel's Villa in Chelmsford (long-term care homes), as well as two St. Joseph's Continuing Care Centre (SJCCC) locations; one (the main site), is located alongside St. Joseph's Villa on South Bay Road in Sudbury, while the other is currently located on the 2 top floors of the Clarion Hotel on

Elm Street in downtown Sudbury. The organization is guided by the values of "dignity, excellence, service and integrity with a focus on a culture of caring" (SJSudbury, 2022). This advanced practicum took place on the first floor of the SJCCC main site which consists of 32 beds.

St. Joseph's Health Centres is a Catholic non-profit organization and registered charity under the St. Joseph's Foundation of Sudbury. This foundation was established in 1998 to provide financial support to the work being accomplished by the Sisters of St. Joseph of Sault Ste. Marie within Greater Sudbury. All money raised in Greater Sudbury is utilized to support St. Joseph's Health Centre projects and programs in the district. The foundation played an integral role in raising funds that contributed significantly to the construction costs when St. Joseph's Villa and St. Joseph's Continuing Care Centre were built. The foundation provides ongoing financial support to these sites in terms of helping to purchase equipment and to implement new programming (SJSudbury, 2022).

Patients who come to SJCCC are all given an automatic 6-week admission. Depending upon the progress and circumstances of each patient, however, their admission may result in an early discharge or an extension of their admission. In addition to the typical admissions of patients, SJCCC also accommodates patients who fall under Long Term Complex Medical Management (LTCMM) formerly known as Medically Complex Unit (MCU). LTCMM usually includes patients who require more care than could be provided in a Long-Term Care Home, but less care than would be provided in an acute care hospital. Additionally, some patients are waiting to be discharged into Long-Term Care; these patients live at SJCCC and are categorized as Alternate Level of Care (ALC). Another form of admission is referred to as Short-Term Medical Hold (STMH) and patients who would typically fall under this category are those who

for one reason or another require an indeterminant length of admission. An example of this may be a patient who has restorative potential but requires medical stabilization and improvement before the full rehabilitation program can be applied.

When SJCCC is fully staffed, each floor consists of two Registered Nurses who are the clinical leads for each hallway, a team of Registered Practical Nurses, two physio therapists, two rehabilitation assistants, two occupational therapists, two doctors (who visit patients weekly), one chaplain, one dietitian, and one social worker. St. Joseph's Health Centres requires social work staff to hold a BSW, RSW. As I was completing an MSW advanced practicum and none of the social workers in the organization held an MSW, I was responsible for arranging clinical supervision outside of the organization. The details of my clinical supervision will be outlined in further detail later in this chapter in the section on supervision.

Implementation of HAP

The original format planned for the implementation of HAP was meant to have eligible and interested participants from the first floor meet twice weekly on Mondays and Wednesdays from 10:30 am-12:00 pm for three weeks. This anticipated format aimed to provide participants with a total of six HAP group opportunities. The group size was expected to range between a minimum of three participants and a maximum of six participants. The six meetings held over three-week sessions were intended to work around the incoming and outgoing patients on a timeline that would maintain consistent group members. This intended scheduling was coordinated in a manner conducive to the general six-week stay at SJCCC and was in line with my practicum schedule of 7:30am-3:30 pm, Monday to Wednesday, from January-June. Within my first week at SJCCC, I began to realize that for several reasons, this plan was not going to work in the immediate future.

The first major roadblock to running HAP in groups was that when I came to SJCCC the first floor was under a COVID-19 outbreak, meaning that no group programs were allowed to run. Due to the ongoing COVID-19 pandemic, HAP would have to be delivered to patients 1:1 in the patients' rooms. As this was not my intended implementation strategy, I decided to hold off the start date of programming, in hopes that the outbreak would end and programming in groups would again be allowed to resume. Within a couple of weeks, the outbreak was over.

The second roadblock to running HAP in groups came when the outbreak had been declared over and groups were allowed to congregate. When I attempted to book a consistent meeting room in which HAP could be run on Monday and Wednesday mornings from 10:30 am-12:00 pm, I found that it was impossible to obtain a consistent room. Different rooms had to be booked for Mondays and Wednesdays, a situation that was made less ideal by the fact that rooms were not consistently available at the same time on both days. The new plan was for HAP participants to meet in one meeting room on the second floor on Mondays from 10:30am-12:00 pm and on Wednesdays, we would have to meet on the ground floor from 1:30pm-3:00 pm. I created flyers that included calendars clearly outlining the days, times, and locations where the program would be run each week and provided them to interested potential participants. On the morning of the first week that sessions were meant to run, I was scheduled for an N95 mask fitting and realized that the room in which the fitting was taking place was the second-floor meeting room that had been booked for HAP. The mask-fitting technician informed me that she would be using this space indefinitely. Moments after my mask fitting was complete, staff were notified that the building was undergoing a "precautionary outbreak" meaning that yet again, patients would not be allowed to participate in group activities. In realizing that finding a private, accommodating space in which to facilitate HAP was going to be more difficult than initially

expected with the added layer of unpredictable COVID-19 restrictions, I began to reflect upon what options were available.

A third concern that arose was the drastically changing circumstances of SJCCC patients and an unprecedented turnover in staff. Between my QY placement (which concluded in July 2021) and the advanced practicum (commencing January 2022), SJCCC saw an increase in patients experiencing significant cognitive impairment and an increase in LTCMM and ALC cases. This impacted HAP as it greatly reduced the pool of patients from which I could recruit, as HAP would be offered only to patients who were cognitively intact to a degree that benefits of HAP could be reaped. The staff turnover resulted in a substantial loss of staff in terms of both nursing and allied health. This loss of staff impacted HAP as I no longer had enough staff to assist patients in ambulating to the meeting room. This may seem to be a negligible impact, however, due to the lack of therapy staff, few patients were able to ambulate independently. The result of this would have left me to singlehandedly porter patients to another floor, thus, creating issues of patients being left unattended in the meeting room while waiting for the remaining group members to arrive.

Upon discussions with Dr. Coholic and the staff at SJCCC, it was determined that 1:1 HAP activities in patients' rooms would be the best way to move ahead that aligned with current COVID policies. While some patients decided not to participate in HAP due to the new format, others were enthusiastic about the change. In February, HAP began to be facilitated in a 1:1 design. The many unexpected and unintended benefits of this 1:1 delivery method inspired the permanent employment of this style. The benefits of 1:1 delivery in this setting will be further explored in Chapter 3.

Throughout the advanced practicum I worked with a total of 12 participants, averaging about four patients per month. The number of HAP sessions with each patient varied from one to five. These numbers were appropriate given patient availability and interest, combined with my daily availability and overall practicum schedule. The activities covered in 1:1 HAP sessions included (1) Thought Jar, where participants filled an empty jar with water, adding bobbles, beads, glitter, etc. Participants applied meaning to the different items representing their thoughts and feelings. Participants were asked to shake and swirl the jar around until the contents were agitated. This activity provided a visual representation of a busy mind versus a calm mind and is helpful in explaining the concept of mindfulness; (2) Guided Imagery, wherein the facilitator read from a calming guided imagery script and participants were given the option to paint, sculpt, or simply close their eyes and listen; (3) Me as a Tree, where participants were invited to draw themselves as a tree; (4) Emotion Listen and Draw, where patients listened to various pieces of music and drew or painted the emotions that arose; (5) Coat of Arms, which was adapted for 1:1 by asking the participant to create a coat of arms that illustrated themself showing what was important to them; (6) Emotion Collage, where participants flipped through magazines and cut out pictures that caught their eye or spoke to them in some way. Participants then created a collage using the clipped images; (7) Doodle Draw, where participants doodled for a short time before stopping and modifying their doodle according to what they see in the image (Coholic, 2019).

Supervision

Supervision during the advanced practicum was provided at various levels. At the agency level, I was meant to be supervised daily by Jenn Gosselin BSW, RSW, who also supervised my QY placement. During the first few weeks of the advanced practicum, however, Jenn moved into a role providing staff education. Jenn's replacement was Nadia Rainville, BSW, RSW and it was she who provided day-to-day supervision, while Jenn and I began to meet weekly. For clinical supervision, I worked with Sonia Meerai MSW, RSW who was off-site. Sonia supervised me in the form of 30-minute brief check-ins as required as well as one-hour formal supervision meetings once every three weeks. Sonia also made herself available for any issues that arose between meetings through email and text. Sonia received a BSW from Ryerson University, an MSW from York University, and is currently working on completing her Ph.D. at York University within the Gender, Feminist and Women Studies Program. Sonia teaches Research Methods in the BSW program at Wilfrid Laurier University, is a qualitative researcher at The Toronto Health Economics and Technology Assessment (THETA) Collaborative and has worked with older adults in various capacities from hospitals to research involving caring for those with dementia. Sonia was a wealth of information, helped me navigate the Research Ethics Board process, and gently guided me through issues such as working with patients in challenging situations, dealing with instances of countertransference, and challenging my experiences with ageism. At the Laurentian faculty level, supervision was provided by Dr. Diana Coholic. Dr. Coholic and I shared an occasional phone conversation, but primarily conversed through emails in which I would deliver updates regarding my work. Dr. Coholic supported my learning with patience and understanding when programming veered from the expected. Supervision was an integral part of achieving my learning goals, growth, and reflexivity.

MSW Advanced Practicum Student Role

As an advanced practicum MSW student, it was my role to work with Nadia Rainville, BSW, RSW to establish and prioritize tasks for each day, week, and month. In this role, I was able to both observe and assist Nadia to provide professional and patient-centred care. As an advanced practicum student, I was able to take on more duties and responsibilities than was the case in my QY placement. In collaborating with the allied health team, as well as my direct supervisor, I was able to work more independently with patients offering and facilitating HAP activities, but also delving into other responsibilities and tasks held by the RSW. Some of the responsibilities I was able to take on in this advanced practicum student role included providing supportive listening to patients and their families, assisting patients with various tasks such as applying for government assistance, and independently leading the initial assessment process with patients under the supervision of the RSW. More specifics regarding duties and responsibilities in terms of their connection with my learning goals will be discussed in Chapter Three.

Learning Goals

The advanced practicum learning goals were set with the intention of guiding the introduction of HAP at SJCCC, as well as helping to deepen and develop the skills obtained during my QY 450-hour placement including conducting initial assessments with patients, determining substitute decision-makers in the event patients were unable to make informed decisions regarding their care, guiding patients through setting goals for recovery, addressing any concerns or difficulties patients wanted to speak about, staying in touch with patients' families when appropriate, and assessing what community supports might be of help to the patient. It was also important for me to nurture my practice of reflexivity using embodied practice, mindfulness,

and feedback from my clinical and on-site supervisors. The goals that were set for my advanced practicum were outlined in my proposal and have served as a guidepost for my learning and practicum experience.

My first goal of advanced practicum was to deepen my understanding of ailments and issues that mindfulness has the potential to ameliorate, through reading and researching. One of the most prolific works I read during my practicum was a book by David Treleaven (2018) called Trauma-Sensitive Mindfulness. The author takes a pragmatic and practical approach to the application of mindfulness used to treat symptoms of trauma. In this work, he also touches upon the ways that mindfulness practice can negatively impact a trauma survivor, if not implemented in a trauma-sensitive manner. In addition to reading this book, I was also able to access a webinar with the author in which he further explained aspects of the book. While there were several readings regarding mindfulness and its impacts on various issues that I completed during practicum, this work by far stood out the most. Some of the primary take-aways from this book that factored into my work at SJCCC included: (1) mindfulness is not a panacea or a catch-all intervention, it must be used intentionally and carefully, (2) breath is not neutral for a person with a trauma or anxiety background, and (3) as a facilitator, be aware of dysregulated arousal in participants. In terms of how to address these three take-aways, the most pertinent suggestions offered by the author are to provide options to participants and to educate yourself about dysregulated arousal. Some of the ways participants can be supported included using anchors outside of the breath, such as sounds or bodily sensations, and when facilitating meditation or other mindfulness activities, discouraging “pushing through” or “sticking with it” if the participant is feeling over-aroused. Also, it is key to allow participants the ability to take breaks and watch for non-verbal cues of dysregulated arousal. These cues may include excessive

sweating, pale skin, muscle tone rigidity, hyperventilation, poor eye contact, difficulty focusing, slurred speech, an abrupt change in mood, increased startle response, and flat affect (Treleaven, 2018). When working with patients at SJCCC, there were several times when the lessons learned from this book proved beneficial and improved the facilitation of HAP for myself and the participants. For example, a patient who participated in HAP (further described in Chapter 3, Case Example 4) had recently undergone a traumatic surgery resulting in the implementation of a colostomy bag. This patient was working on a doodle draw when she began breathing heavily, sweating, turning pale, and repeating that she could only see images of colostomy bags and sadness in her drawing. I was able to recognize that this patient needed to take a break from this activity. I helped her to orient herself, to slow her breathing, and return to a state of calm.

The second goal of the practicum was to work within an interdisciplinary approach to better understand social work from an embodied practice perspective. This was attained by consulting with the physiotherapists, nurses, and occupational therapists, reading and being mindful of my own bodily experiences throughout this practicum. This goal was aided by the fact that during the first two weeks of practicum, SJCCC moved all the allied health team members from the floor into a common space from their isolated offices. This environmental change encouraged collaboration and consultation with the various members. I found it helpful to collaborate with the rehabilitation team to discuss ways in which to encourage HAP with patients. One finding of HAP in a rehabilitative setting with older adults was that many patients prioritized their physical health over their mental and spiritual health. This perception of mental and spiritual health as being less important, is well documented in the literature and is unfortunately common and it is noted that internalized ageism can play a role in older adults' attitudes toward mental health (Benjenk, 2019, Hancock, 2018, Jorm, 2012, Kessler, 2015,

Lyons et al., 2018), and is further exacerbated when considered in the context of a physical rehabilitation hospital. The complicated effects of ageism will be further described in Chapter Three.

By working with the rehabilitation team, I was able to find ways to modify activities based on rehabilitation needs. For example, for one patient who had limited use of his hands, I worked with the occupational therapist to improvise an adaptive paintbrush by taping a washcloth around the brush handle, thus making it easier to grasp. For other patients, validity was given to HAP by describing the relationship between mental and physical health (Kolappa et al., 2013). Conversely, there was a particular patient (the patient previously described who had grief around her colostomy) for whom the spirituality involved with HAP was of utmost importance. It was the interdisciplinary work done by the chaplain and me that helped provide this patient with a more meaningful and fruitful HAP experience. Through her HAP work, the patient would often speak about her strong Catholic Faith. The patient was at SJCCC during Holy Week (the week before Easter), so the chaplain and I worked together to provide guided Christian meditation and art activities on the theme of Holy Week. Finally, I was able to engage in an interdisciplinary approach to social work by participating actively in weekly rounds meetings with the allied health and nursing staff. These meetings involved staff discussing each patient and their progress. During this practicum, I was able to become more involved in direct patient care than was the case during my QY placement. For instance, I was able to administer the Geriatric Depression Scale (GDS) assessments with patients, lead the initial assessments with patients under the supervision of the RSW, and present concerns and barriers during these weekly rounds meetings in which collaboration with the various team members was instrumental to helping patients achieve their rehabilitation goals.

Embodied practice was essential to the interdisciplinary work completed, as psycho-social experiences are inextricably linked to how one moves through the world in their body (Marshall, 2016). For example, better understanding of the physical experiences of patients helped me to better understand how to support the patient in terms of available community programs and access to services. In considering embodied practice, I came to further understand the role of social work in a physical rehabilitation hospital from a critical disability lens. This movement grew out of the activism of people with disabilities in the 1970s (Reaume, 2014) recognizing the lived experiences of people with disabilities and challenging the discrimination, stereotyping, and pathologizing of this group of people. One example of a problematic reality for those living with disability and whose assistive devices are crucial for mobility is that washrooms in apartments and homes are often not accessible. The issue of inaccessibility contributes greatly to the increased risk of falls in the washroom, faced by older adults (Siefkas, 2022, Stevens, 2014). When integrating an interdisciplinary approach, the rehab team and social worker often had to collaborate to find solutions for patients wanting to return home, but who had washrooms that would not accommodate their wheelchair or walker.

The third goal of the practicum was to continue to enhance my daily mindfulness practice to take better care of myself and the patients of SJCCC. This goal was attained as I continued my daily practice throughout practicum, which was enhanced by incorporating the use of EFT Tapping. In reading an article entitled, “Tapping Your Way to Success: Using Emotional Freedom Techniques (EFT) to Reduce Anxiety and Improve Communication Skills in Social Work Students” (Boath et al., 2017), I decided it would be beneficial to introduce this intervention into my daily mindfulness practice. The positive result of this third goal was best proven to me by my ability to embrace the space between stimuli and response, thus improving

my communication with others. Rather than quickly reacting to situations or comments made by patients and staff, I was able to breathe, and take a moment to think and respond, rather than immediately reacting. I feel this outcome allowed me to better care for myself and patients by increasing my awareness and providing time to be thoughtful in my responses. The slowing down of my responses impacted my self-care as I found myself feeling less rushed and pressured to quickly respond. My mindfulness practice played a significant role in the successful completion of this advanced practicum.

My final goal of practicum was to deepen my reflective practice through journaling, meditation, and consultation with my supervisors and the members of the interdisciplinary team. The use of journaling was a goal of mine not only for the pragmatic purpose of remembering aspects of practicum to be written about later, but also to engage in reflective practice. In journaling about my practicum experiences, I was able to recognize patterns in my thoughts and attitudes (Utley, & Garza, 2011), and was able to address feelings of anxiety (Watson et al., 2021) I experienced about practicum. Journaling, meditation, and conversations with my supervisors were also instrumental in dealing with feelings of grief when for example, two patients with whom I had worked, died at SJCCC during my practicum. These interventions were also helpful in processing and navigating through a specific instance of countertransference, a common occurrence and one for social work students to especially be aware of (Van Breda & Feller, 2014). Finally, it was in the consultations with my on-site supervisor, faculty supervisor, and off-site clinical supervisor that I was able to reflexively navigate the changing regulations and rules around COVID-19 in Ontario, and what they meant for my practicum. If not for the thoughtful, pragmatic, and understanding conversations with my supervisors, I would not have felt confident

in my adaptations to HAP programming, which was unavoidable and, in the end, unexpectedly beneficial from both facilitation and participatory standpoints.

Conclusion

The advanced practicum at SJCCC allowed me to extend the knowledge obtained during my QY placement and provided invaluable learning opportunities both involving HAP and duties of the day-to-day social work role. The interdisciplinary aspect of the practicum helped me to consider patient care from different perspectives. I was able to gain experience collaborating with team members to bring patient-centred care to those participating in rehab at SJCCC. This chapter outlined the opportunities for learning as well as the logistics of the practicum itself. In Chapter Three, I will engage in critically reflecting upon the practicum experience. Patient case examples and photographs of artwork will be used to illustrate various findings of introducing HAP to older adults in a slow-paced physical rehabilitation hospital. I will discuss the benefits and challenges of delivering HAP in an institutional setting.

Chapter 3- Critical Reflection and the Advanced Practicum Experience

When considering an advanced practicum experience, I was excited and eager to return to SJCCC where I had previously completed my Qualifying Year placement. Returning to SJCCC provided the opportunity to introduce HAP to an older adult population and allowed me to deepen and expand upon the foundational knowledge I had previously built. Completing this advanced practicum at SJCCC presented me with many opportunities to understand the nuances and specificities of working with older adults. In adapting to COVID-19 restrictions, my perception and application of a patient-centred approach were enhanced. Additionally, this advanced practicum provided me with ample circumstances in which I was able to practice reflection and consider embodiment. In this chapter, I will discuss the relationship I have forged with reflection and how it has been applied to my advanced practicum in various ways. Finally, I will share artwork and case examples to illustrate the experience of facilitating HAP in a slow-paced physical rehabilitation hospital.

My Relationship with the Practice of Social Work Reflection

In my brief social work education, I have found the difference between reflexivity, reflective practice, reflection, and critical reflection to be somewhat confusing. In reading the work of authors like Jan Fook (2015), however, I better understand the differences and similarities between these concepts. I understand now that critical reflection can be conceptualized as a subcategory or component of reflective practice. As Fook (2015) explains, reflective practice will not always lead to critical reflection, but critical reflection cannot happen without reflective practice. Critical reflection requires the ability to have one's perspective changed and even transformed, and it applies meaning to assumptions and assesses power within

situations. Reflective practice, on the other hand, is more of an ongoing assessment of one's actions and assumptions:

> It involves thinking about what one has done after completing an activity or while one is still engaged in an activity. The usual purpose of this is to improve what one does, to develop and grow, or to find new ways of thinking or doing. (Hase, 2014, p. X)

Reflexivity differs yet again, as it involves the acknowledgement of one's impact and role in each situation, rather than assuming a position of impartiality without influence (Finlay, 1998). Reflexivity opens the researcher's mind to challenges as it demands the researcher examine themself alongside the data, scrutinizing biases and assumptions that will affect and influence how they interpret data (University of Warwick, 2021). Reflexivity as Fook explained, requires the "ability to recognize that all aspects of ourselves and our contexts influence the way we research" (Fook, 2015, p. 443).

In their work, *Reflection and* R*eflective Practice in Health Professions Education: A Systematic Review*, Mann et al. (2009) explained that many academic definitions of reflection have been proposed over the years. The authors look specifically at definitions of reflection that have been attributed to Dewey (1933), Boud et al. (1985), and Moon (1993). Of these three definitions of refection, the one with which I most connect is from Boud et al., "a generic term for those intellectual and affective activities in which individuals engage to explore their experiences to lead to a new understanding and appreciation" (p. 19). This definition of reflection is appealing to my professional and personal values and beliefs as it emphasizes the "exploration of experiences", which for me leaves space to include not only cognitive but also bodily experiences. The way I have come to conceptualize the meaning of reflection is very much in line with my mindfulness practice. Allowing for space and time in silence is a crucial

aspect of my reflective process. This process is not unique to me, however, and is thoughtfully expressed in the work of Yuk-Lin Renita Wong, who approaches critical social work from an integrated mind/body/spirit perspective. Wong (2018) suggested that discursive reflection alone does not suffice, and that critical social work is failing if it does not acknowledge and include spiritual, bodily, and emotional ways of knowing. It is with this sense of reflection that I move forward in this thesis report.

How Reflection Impacted my Social Work Practice in Advanced Practicum

Critical reflection became an ongoing, regular, and necessary aspect of my social work practice during this advanced practicum. In reflecting upon my approaches, actions, interactions, and thoughts during practicum, I was more open and receptive to taking healthy risks, adapting, and growing as a practitioner. In reflection, I can make connections and find a crossover between my past school teaching experiences and social work. Reflection upon my skills can be empowering as I often suffer from imposter syndrome. Reflections that illuminate the skills I have developed greatly diminish my feelings of insufficiency. The belief that I am an imposter in social work has been an ongoing issue I have been working to overcome. A symptom of these negative thoughts that I am an imposter, is feeling anxious and inadequate. For me, imposter syndrome presents physically in the form of an unsettled stomach, clammy cold hands, a racing mind, or sometimes a paralyzed feeling. Reflection is a meaningful and helpful tool I have been able to employ throughout the advanced practicum that empowered me as an MSW student with knowledge and value.

A reflective practice I often utilized when feeling inadequate is a method taken from Cognitive Behavioural Therapy (CBT) referred to as thought-monitoring. CBT describes different levels of cognition that strongly influence the way people view themselves, others, and

the world. The way a person interprets the world forms the way they will react to events and situations. The levels of cognition include core beliefs, intermediate beliefs, and automatic thoughts (Beck et al., 2011). Thought monitoring aids in getting to the root of one's cognitive patterns. By monitoring my thoughts and bodily reactions in situations that arose during practicum, I was better able to challenge negative thoughts and ultimately replace them with more helpful ways of thinking. Additionally, thought monitoring helped highlight not only the times I doubted myself but also times that I was impressed or proud of myself.

At the end of each day completed at SJCCC, I would go through a bit of a Pendleton Model style conversation (Hardavella et al., 2017) with myself looking at what I thought I had done well, what I thought I could improve on, and how I thought I might be able to work toward achieving my goals for practice. By reflecting in this way, I embraced my strengths and took a realistic look at what could be improved. Reflection helps me remember that while I may not have the social work experience and knowledge of others, it is an area in which I can grow and reach my goals if I keep working at it, using reflection as a key tool to get myself there.

It was my ongoing and evolving practice of reflection that allowed me to decide how best to react to the challenges associated with trying to deliver consistent group programming in an institutional setting, during the time of the COVID-19 pandemic.

Challenges of Working in a Rehabilitation Setting

Although I had completed a social work placement at SJCCC previously, I was unable to anticipate the logistical complexities, exacerbated by the ongoing COVID-19 pandemic. Within my first couple of weeks back at SJCCC, I realized that despite my best planning and consultations with staff, HAP in groups, let alone a consistent group over three-week sessions, was going to be virtually impossible. As described in Chapter Two, during my time at SJCCC

there were several outbreaks and precautionary outbreaks that halted all group gatherings. During the first outbreak I experienced, I began meeting with interested and eligible patients 1:1 in their rooms. This decision was made through a reflective and collaborative process, discussing the situation with SJCCC staff, Dr. Coholic, and my clinical supervisor. This 1:1 approach to HAP was solely intended to be a temporary solution in response to COVID-19 restrictions. As I implemented the new 1:1 HAP format, however, I understood that this design was preferable in a rehab setting.

The 1:1 HAP delivery method made meeting with patients much more flexible, an absolute necessity in a rehabilitation setting. As described in Chapter Two, booking a consistent and accessible meeting space was far more difficult than expected and made more difficult by COVID-19 restrictions. When I began working with patients 1:1, however, I realized that even if a meeting room had been easily secured and all COVID-19 restrictions lifted, there were various events and confounding issues in patients' schedules that presented obstacles to running a consistent program. My hours at SJCCC followed that of the allied health team, starting at 7:30am and ending at 3:30pm. At around 7:40am-8:00am, the team meets with the clinical leads on the floor to receive the morning report, wherein any pertinent information about patients is shared. Between 8:00am-9:00 am, patients are going through their morning routine (dressing, grooming, toileting, etc.) with the nursing and rehab staff. From 9:00am to 10:00am, patients are eating breakfast in the main dining room, or if the floor is on outbreak, meal trays are brought to each patient's room. On Tuesdays and Wednesdays, the allied health team meets from 9:00am to 10:00 am for weekly rounds, a process in which staff address progress and concerns for each patient. From 10:00am to 12:00pm, patients are doing their exercises under the supervision of the rehab team. During this two-hour window, it is possible to meet with patients who have not yet

done their exercise, or who have completed their rehab for the morning. For some patients, however, exercises can be exhausting, thus making them less likely to be interested in HAP participation. During this window of time, nurses are also visiting patients to assist with medication administration, personal care, toileting, and bathing; these processes can be quite time-consuming for some patients. There are two doctors assigned to all patients at SJCCC on the first floor, one for the north hall and one for the south. At least two days a week, these doctors come in and visit their patients in the morning presenting yet another necessary, but genuine obstacle to meeting with patients. From 12:00pm to 1:00pm, allied health staff have a lunch break and from 12:30pm to 1:30pm, it is lunchtime for the patients. From 1:30pm to 3:30pm, there is another window of time in which it is possible to visit patients. There are, however, just as many conflicts with scheduling in the afternoon as there are in the morning.

In the afternoon, when COVID-19 restrictions permitted, the recreational therapist ran group activities such as bocce ball, birdhouse making, live concerts, bingo, etc. Some patients participated in another set of rehabilitation exercises in the afternoon and nurses continued assisting with medication administration, personal care, bathing, and toileting. The afternoons are also a more common time for visitors to see patients and for patients to take naps. At any point during the day, patients may also have appointments outside of SJCCC. Since all patients at SJCCC are dealing with various health issues, it is common, for example, that patients attend appointments with specialists and surgeons at Health Sciences North (HSN). In more extreme cases, patients may be sent out to HSN for extended stays until their acute care situations have stabilized and they are able to return for rehabilitation. For SJCCC patients who are in more complicated situations and discharge is a concern, care conferences with the family are often scheduled. In a care conference meeting, the health team (including social work) meets with the

family and patient (when appropriate) to discuss discharge plans. Care conferences can take upwards of an hour depending on the situation. In addition to the array of circumstances affecting scheduling that have been outlined in this section, there is the reality of patient overturn. Throughout each week, patients are discharged and admitted to SJCCC, and it is the role of the social worker to complete an initial assessment with each patient upon admission. These assessments can take between 30-45 minutes or more depending upon the patient and the complexity of their situation. Finally, there are unexpected issues that arise throughout each day in which the social worker is asked to intervene. Due to my role as a Master of Social Work advanced practicum student, it was pertinent for me to be involved in as much direct patient work as possible, while also being committed to the delivery of HAP. Having explained the many variables at play on any given day, it is clear to understand why scheduling was by far the most challenging aspect of working in a rehabilitation setting and why the flexibility of a 1:1 design made far more sense. If a patient was busy, or an unexpected issue arose, 1:1 meetings presented themselves as a more patient-centred, adaptable, and accommodating option. Had I decided to forge ahead with group HAP meetings during times when COVID-19 restrictions were relaxed, there would have been occasions where patients would have had to miss out due to scheduling conflicts.

Patient-Centred Benefits of 1:1 Programming

Patient-centredness associated with 1:1 HAP was evident not only in terms of scheduling but also in terms of privacy. Many participants expressed to me that they appreciated being able to meet in the privacy of their room, especially when discussions became emotional. Some researchers have found evidence to suggest that older adults are more likely to describe physical concerns rather than emotions and feelings when asked how they are feeling (Gielkens et al.,

2018). I found this to be true when working with several older adults during HAP. When these participants eventually shared their emotions and feelings, they were shy and even embarrassed, making their private room a more comfortable setting for sharing. For one patient, privacy was appealing not only in terms of sharing but also for physical privacy. This patient had recently undergone a colostomy and was struggling with adjusting to having a colostomy bag and being around others. The ability to offer 1:1 HAP allowed her to speak freely with me about her feelings of embarrassment, grief, anger, and sadness related to this surgery, while also being able to have a physical reprieve from being around a group of people.

From an embodied practice and critical disability perspective, 1:1 HAP was also beneficial in terms of accessibility and adaptability for the unique needs of each participant. Patients who participated in HAP had varying physical and cognitive abilities. By meeting patients in their rooms, patients were able to have more control over the circumstances of the environment. One example of this is that some of the participants had hearing impairments and their quiet room was much more conducive to conversing with me and receiving activity instructions. Research shows that providing an opportunity for quiet in a hospital setting is not only important for those with hearing impairments but also for patients in general, as excessive hospital noise can negatively impact recovery (Jue & Nathan-Roberts, 2019). Another example of the inclusivity afforded by 1:1 is that for patients with larger bodies using bariatric wheelchairs, their rooms provided more space for us to comfortably sit and engage in the HAP activities than a small meeting room with other participants would have offered (Tandiono, 2017). This accommodation speaks to the work being done in critical fat studies (Martel et al., 2021) around discrimination of the "obese patient" that harms the health relationship in medical settings resulting in negative effects on patient outcomes (Medvedyuk et al., 2018).

For patients experiencing acute pain, 1:1 delivery allowed for re-scheduling and pauses. In more serious situations early termination of a HAP session was sometimes required. Patients experiencing pain need to pace themselves (Antcliff et al., 2022) not only physically, but mentally as well. For many patients, admission to SJCCC was preceded by time spent at home in isolation from covid and an extended stay at HSN for acute care. One of the common elements of 1:1 HAP meetings was patients' desire to visit and share stories both related and unrelated to HAP. In a 1:1 environment, participants were free to share without time restriction, whereas in a group setting, I would have had to ensure equal time for participants to share. This 1:1 visiting time proved helpful in creating positive and trusting relationships. While certain adaptations could be made whether in a group or 1:1 setting, I was able to provide care and attention more effectively to patients in a 1:1 meeting than would have been possible in a group of individuals with diverse needs.

In reflecting upon the HAP participants with whom I worked and the benefits of 1:1 programming, I was reminded of the work of Michel Foucault regarding docile bodies in his work Discipline and Punish (1975). I considered this work in concert with ideas about ageism and ableism.

Resisting Docile Bodies: A Foucauldian Reflection

In reflecting upon the patients with whom I worked during this advanced practicum, I am reminded of the section of *Discipline and Punish* (Foucault, 1975) called *Docile Bodies*. In this section, Foucault explains how religious orders, military, and prisons utilize a timetable to create order, remove individuality, and exercise power over those at the mercy of the schedule. In health care institutions like SJCCC, for example, patients have set mealtimes, bathing times, recreational activities, etc. This scheduling makes logistical sense from an employee standpoint,

but it raises concerns about patient-centred care. By setting schedules around waking up, getting dressed, eating, bathing, and activity, the patients lose independence and are subject to ways of creating docile bodies. In their work *Becoming institutional bodies: Socialization into a long-term care home,* Wiersma and Dupuis (2010) undertook a phenomenological study that examined the lived experience of older adults upon moving into a long-term care home (LTCH). In this work, the authors outlined three methods the participants noted their bodies being "managed" by staff: (1) routines, (2) waiting, and (3) risk management. Participants shared with the authors that while often they would rather sleep in, participate in activities at a different time, or eat in their rooms, eventually they fell in line with the routines because it was easier than appealing to staff to make exceptions. This finding applies to my practicum environment because, while SJCCC is not a long-term care home, there are a handful of patients who do live as residents at SJCCC. Patients who live at SJCCC do so because they have complex medical needs that could not be managed in LTCH. Other patients who live short-term at SJCCC do so because they are waitlisted for LTCH; these patients fall under the category of Alternate Level of Care (ALC). Some ALC patients at SJCCC have lived there for a year or more while waiting to be placed in LTCH. At a minimum, all patients are given an automatic admission of six weeks, so for all intents and purposes, SJCCC is their home during this time. One participant in Wiersma and Dupuis' (2010) work shared how some staff had negative reactions, such as ignoring, walking away abruptly, and using a harsh tone and body language, when told by residents that they wanted to deviate from the rigid schedule and routine. In terms of Foucault, the negative reactions by some staff members are an example of "normalizing judgement" (Foucault, 1975, p. 193). When writing about normalizing judgement Foucault said that to understand this process, we must look at how a child in school would look at punishment,

however, this understanding applies as well to people (especially older adults) in institutionalized healthcare settings: “everything that is capable of humiliating them, of confusing them: . . . a certain coldness, a certain indifference, a question, a humiliation…” (Foucault, 1975, p. 194). For the residents interviewed by Wiersma and Dupuis (2010), the types of punishment described previously were enough to have residents feel they needed to conform to the routines and expectations set out by staff.

The tailoring of docile bodies through waiting and risk management was explained by participants as factors that limited autonomy. At SJCCC the same concerns expressed in this study described above existed for patients who relied on staff for assistance with mobility and hygiene, that is, much of the day revolved around waiting. Waiting for things like toileting assistance, meals, rehabilitation exercises, scheduled recreational activities, medications, visits, appointments, etc. Risk management factors, include having patients use assistive devices, implementing roam alert devices, closing the hospital to visitors due to viral outbreaks, and initiating isolation protocols; common practices in the time of COVID-19. Wiersma and Dupuis (2010) explained that residents’ desires to be independent and have autonomy over their bodies are restricted. Older adult patients in healthcare institutions are taught that their bodies are frail and in need of constant protection, for which they alone cannot be trusted.

In presenting 1:1 HAP activities to patients, I was able to consult with individuals about what time was preferable to meet. Activities could be selected based on the needs and concerns of each patient and a sense of choice and independence was therefore obtained. Patients appreciated the flexibility I was willing to provide, and in my Foucauldian reflection, I realize that flexibility was a means of resisting the creation of docile bodies. The flexibility of program delivery allowed for individualization and returning a sense of control to the patients.

Implementing a 1:1 program design beyond the point of COVID restrictions provided patients with the dignity of accessing differentiated facilitation of HAP based on their individual needs.

Another aspect of Foucault's work that arose for me throughout my advanced practicum was his description of the ideal vision of a soldier. The image that is conjured up here is one of strength, brawn, alertness, and perfect posture. This image reminds me of the way societal norms frame the civilian experience. The typical ideal of an average citizen is economically and physically productive, independent, healthy, and able-bodied. For those living with disability and for older adults, however, the ageist and ableist tone set by society is that this person is no longer as useful; they are seen as defective, as drains on the healthcare system, and as burdens to their families (Inouye, 2021). Large rehabilitation hospitals are meant to return patients to their optimal physical ability. Certainly, there is positive, patient-centred work being done to aid patients in meeting the meaningful goals they have set for their rehabilitation, but there is also an air of internalized and overt ageism and ableism in healthcare that is undeniable. Patients must be rehabilitated so that they can return to their most productive potential because anything less is deemed undesirable by society. Arts-based mindfulness programming worked in opposition to ableism and ageism by helping patients learn to accept themselves without judgement.

Arts-Based Mindfulness: A Conversation Starter

The majority of patients at SJCCC are older adults aged 60 years and older who are dealing with a wide array of health issues including cancer, fractures, Parkinson's, stroke, and more. Research implementing mindfulness as an intervention for such ailments suggests this approach can provide advantages to patients (Grahn Kronhed et al., 2020; Mehta et al., 2019; Pickut et al., 2013; Wrapson et al., 2021). Complementary to the effects of mindfulness is participation in the creation of art, the benefits of which are many for older adults (Ilali et al.,

2018; Noice et al., 2014; Stephenson, 2016). Some of the positive impacts as noted by Noice et al. (2014) included improved psychological health, increased engagement, and an increased sense of empowerment. Evidence of the power of arts-based mindfulness was palpable when patients were able to engage in meaningful sharing, expressing their feelings and emotions as a direct result of their work. I found that conversations were able to organically grow from the activities (Stuckey & Nobel, 2010) and that patients shared things with me during HAP that otherwise likely would not have arisen. As previously described, some research has shown that older adults are more likely to describe physical health concerns when asked how they are feeling, rather than describing their emotions and feelings (Gielkens et al., 2018), however, HAP provided a platform from which to explore this territory safely and with encouragement. In this section, I will touch upon the goals of HAP and how they served as an anchor during practicum. I will display several pieces of artwork created by participants. The photographs of patient art will provide the context in which I will briefly share the insightful reflections and powerful reminiscing that transpired from these creations. When I invited patients to participate in HAP, I explained to them that I was offering 1:1 visits wherein we would used arts-based activities to help pay attention to thoughts and feelings without judgement. Depending on the patient and how well I knew their circumstances, I was able to tailor my invitation accordingly. For example, many patients experienced anxiety around their illness and recovery, so I would first speak with them about how they were feeling and then explain how HAP might be helpful in calming their anxious mind. The ability to tailor invitations helped create rapport with patients before HAP even began.

Following the Goals of HAP

Since HAP was originally intended for youth, adjustments were required for implementation in a slow-paced physical rehabilitation hospital during the time of COVID-19. As a result of restrictions, disruptions common in an institutional setting, accessibility, and age appropriateness, I found the best way I was able to implement HAP was not by using the HAP manual and adhering to session-by-session content, but rather as an invaluable tool providing multiple activities to be incorporated into my social work with patients. Activities were chosen based on many factors, including age appropriateness, feasibility in a 1:1 setting versus a group, and the physical ability of the patient. The goals of HAP are:

> (1) Teaching and facilitating mindfulness concepts in accessible, relevant, and meaningful ways,
>
> (2) Improving self-awareness and understanding/expression of feelings, thoughts, and behaviours,
>
> (3) Developing self-compassion and empathy,
>
> (4) Recognizing and shoring up strengths. (Coholic, 2019, p.7)

This set of goals served as my guidepost throughout the advanced practicum and informed all my decision-making around any modifications or adjustments to the work. For example, a patient who was shy and did not share very much asked if we could continue listening to a song that was being used for the activity Listen and Paint, rather than moving on to the next four songs. The patient shared that this first song was bringing up so many feelings for her and she wanted to have more time to paint. When I suggested that we move on to hear the other pieces, the patient expressed that she wanted to stay with the feelings this song brought up and that she wanted to talk about them more with me. By reflecting on the goals of HAP, I decided

that this request was appropriate and meaningful to the patient and to disregard her request would hurt the relationship and possibly leave her feeling discouraged about sharing and exploring her feelings when they surface. This opportunity for modification based on relevance and meaning for the individual speaks to the patient-centred benefits of working 1:1 explored earlier in this chapter. Further examples of patient-centred modifications grounded in the goals of HAP will be woven throughout the following case examples.

Artwork and Case Examples

Case Example One

Figure 1

Participant artwork created during the HAP activity called Emotion Listen and Draw

During the first session with this patient, she created a Thoughts Jar, sculpted with Play-Doh while I read guided imagery, and practiced 5 Finger Breathing. The patient had been experiencing anxiety around the fact that she would begin weaning off her oxygen machine. The breathing activity helped reduce her anxiety and for bringing her attention to her breath to keep it flowing calmly without holding or conversely, breathing too rapidly. The patient expressed that the guided imagery helped her feel calm and focused on her breath. As we developed a good relationship during our first HAP session together and subsequent social visits I made, the patient

was able to open up more during the second session in which she painted the picture in Figure 1. The patient painted this picture during the activity called Emotion Listen and Draw; she specifically asked if she could paint instead of draw because her hands were feeling stiff, and painting was more accessible. In considering the patient's needs and the goals of HAP, I determined that painting instead of colouring would be appropriate. The patient and I listened to the song *Lullaby in Birdland* by Duke Ellington, which is a big band piece of music. The patient shared with me that this song made her think of tap dancers. I asked, "what do you feel when you hear this music?" The patient shared that this type of music made her feel happy as it reminded her of her father who played numerous instruments. The patient shared that she does not often talk about her father because it makes her emotional. The patient began to cry and shared that although it is uncomfortable, connecting with memories and the feelings they evoke is something she wants to practice. As the patient shared with me many memories about her family and her childhood, I pondered the research around older adults and reminiscence therapy (Liu et al., 2021), including its proven benefits for improving overall well-being on institutionalized older adults (Gaggioli et al., 2014). As HAP has mostly been conducted with youth, I had not considered the possibility of reminiscence as an added benefit of HAP activities with older adults, however, it is an aspect of HAP that proved to be a prominent component of working with an older adult population.

Case Example 2

Figure 2

Participant HAP artwork created after completing guided imagery

This painting was done by a patient after listening to a guided imagery reading about a path leading to a safe place. I said to the patient, "I notice your path is windy", he explained to me that nothing in his life has been straightforward. This observation inspired a conversation wherein the patient shared with me various challenging aspects of his life and how he has worked through them. Together, the patient and I were able to highlight his resilience and strengths. The patient shared that he appreciated reflecting on his strengths and abilities, as his time in the hospital was making him feel discouraged. The patient also shared with me a belief in God and how his Faith helps him to make understanding of life and gives him the courage to keep going. This patient's experience with spirituality is in line with the findings of Coholic (2011) wherein young people participating in HAP often related issues of loss to spirituality. Spirituality acting as a conduit to establishing meaning in life was a common aspect of conversation with patients during the advanced practicum. This patient suffered a life-altering accident in his youth and expressed that his belief in God helps him to understand why this event occurred. The patient shared with me that through the guided imagery we did and the subsequent

painting he produced, he was able to slow down and reflect on his life. The patient shared that he was able to start creating new meaning around his current health and move toward hope for the future.

Something I learned about doing guided imagery readings with patients, is that I needed to thoughtfully consider the language being used in the scripts. For example, many readings talked about walking, however, some of the patients at SJCCC, primarily or exclusively use a wheelchair. In these instances, I would make sure to change the language to reflect the situation of the patient; "imagine you are wheeling…" Another example of using language mindfully is that I often inserted the word "safe" throughout the script. The choice to intentionally reinforce an element of safety was born out of having read the book Trauma-Sensitive Mindfulness (Treleaven, 2019). In this book, Treleaven highlights the fact that for people who have experienced trauma, and even for some who have not, allowing too much space for participants' minds to wander, can lead to very unpleasant and frightening images or flashbacks. In my experience teaching yoga and mindfulness, I received feedback on several occasions from participants that they enjoyed the way I led guided imagery because they felt the space was being held in a comforting way. Many participants shared with me that they typically dislike guided imagery because they find their minds go wandering to undesirable places, resulting in a situation full of anxiety, rather than calm. One of the most important aspects of creating a trauma-sensitive environment for participants when doing activities such as guided imagery is giving participants the cue, "if it feels safe and comfortable to do so, you may choose to close your eyes." HAP supports this trauma-sensitive approach to having eyes open and being able to move by providing the option for participants to sculpt with Play-Doh, or to create a piece of art while listening.

Case Example Three

Figure 3

Patient drawing for the HAP activity Me as a Tree

This, Me as a Tree drawing, was completed by a patient who is an artist and who had not done any artwork in approximately a year. This patient shared that he was not sure what his ability to complete a piece of art would be like since his time in hospital and the fact that he has gone so long without creating. As the patient began to draw, he shared that he has been feeling overwhelmed when he thinks about returning to his home. The patient expressed concerns about having to complete tasks like cleaning and cooking and was feeling nervous about taking care of himself in general since he lives alone. When the patient completed his drawing, I noticed how small the tree was and the fact that it was all by itself with nothing around and shared my observation with the patient; he paused to contemplate my comment. The patient reflected upon his artistic choices and considered the possibility that he drew himself as a tree in this way because he had been feeling small and overwhelmed. The patient also spoke about how the injury that brought him to SJCCC was precipitated by overconsumption of alcohol and how this experience was humbling, another probable reason behind drawing a small tree and feeling shame or embarrassment. The patient shared that his family has largely been absent from his life

and that he does not have many friends, thus aligning with his blank background to his tree. The patient shared that he had not realized how alone he had been feeling until reflecting on his drawing. He shared that he wants to start making more of an effort to connect with his family and make friends. This reflective process led to a conversation about the patient's strengths and positive personality traits that make him an enjoyable person to be around. In disclosing his struggles with alcohol, an opportunity to remind the patient about the supports available and the importance of taking things one day at a time naturally revealed itself. The patient was able to speak about himself with empathy and compassion throughout our conversation. The patient shared that the Me as a Tree activity was something he had never considered before and that he was surprised by how such a simple task drew out such meaningful and insightful perspectives on his situation.

Case Example Four

Figure 4

Patient collage entitled, "Grief"

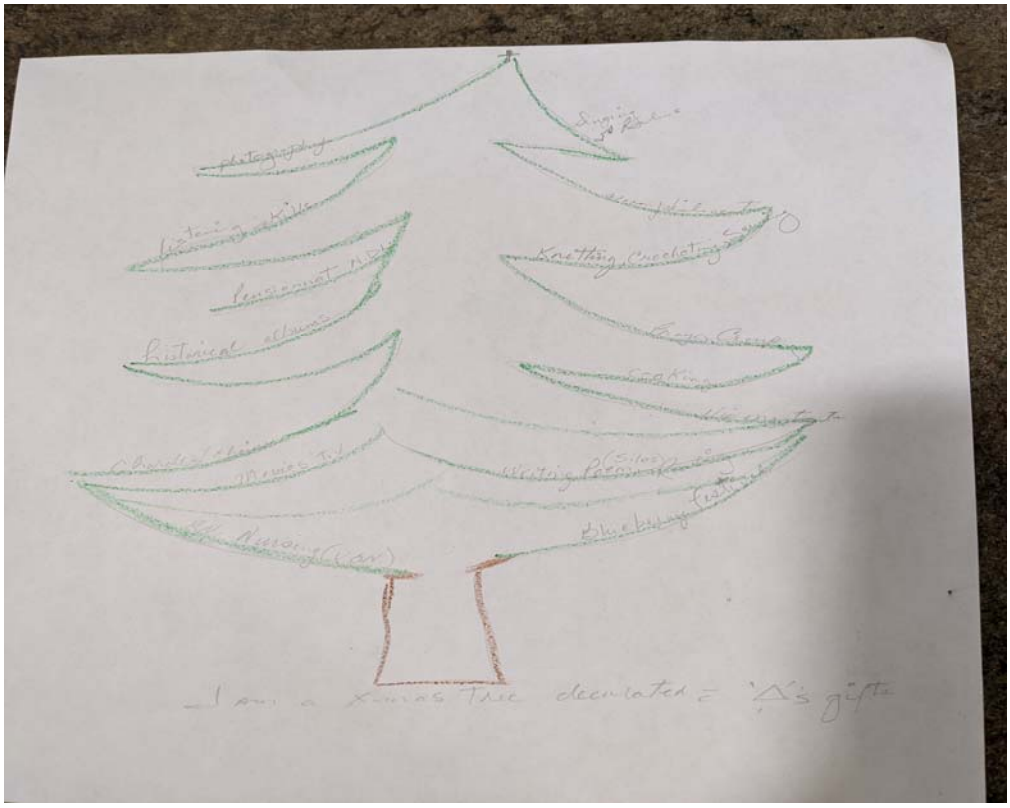
The patient who completed this collage is an Indigenous woman who shared with me that she feels it's important for her to share her knowledge and pass it down. The patient offered to teach me how to do a "life stage mandala" and I enthusiastically took her up on the offer. The patient showed me that every few months, she will look through magazines and cut out any pictures that stand out to her as indicative of the current stage in her life. The patient glues the pictures onto a piece of paper, gives this mandala a title, and writes a short description of what the mandala means to her at that moment. This mandala was called "Grief." The patient used pictures to show how she is starting to grieve the life that she had, is trying to embrace the new challenges she is being faced with, and how she feels about the struggles she is experiencing. The patient had recently been diagnosed with cancer and underwent a colostomy; a change with which she is having a challenging time. The collage the patient created allowed us

to have some talking points from which to explore her feelings. The patient expressed to me that she is not always able to find the words to describe how she is feeling, but that when she has a piece of art to refer to, the language flows more naturally.

Before this collage, the patient had a very emotional experience when we did the HAP activity called Doodle Draw. The patient shared that all she could see when she looked at the doodle was the ups and downs she's experienced with her health and that any circular shapes caused her to think of colostomy bags. The patient asked to spend some time with this doodle to see if there was anything else she could see over time. I reassured the patient that she is going through a big change and that she can take as much time as she needs. When I met with the patient the following day, she shared with me that she was able to see some positive images in her doodle, such as flowers and a smile. The patient shared that she was appreciative of having the time to reflect on her own and study her doodle in private. When this patient was only able to see negatives associated with her doodle draw, I reflected on my learning with Dr. Tufford described in Chapter 1. I resisted the urge to start pointing out the patient's strengths in this moment, as I did not want to invalidate or dismiss her low mood and difficult life circumstances with which I could not relate. I sat with this patient in her sadness and grief and trusted that the process of doing HAP activities over time would slowly help the patient to come to a vantage point where strengths could be seen and valued. At this moment, my mindfulness practice was helpful, as I was able to sit in an uncomfortable feeling without judgement or distraction. I have learned through this advanced practicum that being able to sit with patients in their pain, discomfort, sadness, and grief helps to build a strong therapeutic alliance and foundation of trust with patients, a finding consistent with the outcome of recent research done in a pain rehabilitation setting in the Netherlands (Paap et al., 2021).

Figure 5

Patient drawing for the HAP activity Me as a Tree



The final piece of art this patient was able to create before being discharged was a drawing for the activity Me as a Tree. We started our session together with the activity called, Listen for Two Minutes in which participants listen for two minutes and observe what can be noticed using their five senses. When the two minutes were up, the patient explained that instead of staying with the senses experienced in her hospital room, she transported herself to a quiet, safe, and calm forest. The patient explained to me all the sounds and feelings she had as she imagined herself surrounded by trees. I explained to the patient that this was a serendipitous image that came to her mind because the activity I had planned was called Me as a Tree; she became overwhelmed with emotion. The patient described to me all the times in her life that trees have been of great significance to her. I explained the activity to the patient, and

she said she didn't think she had the strength to complete the drawing today. I reassured her and offered to leave the materials with her so she could complete the drawing at her leisure. I went back to visit the patient about a different matter later that day and she had drawn a Christmas tree. The patient told me she realized that even though she is going through a difficult time, she has been given many gifts, and this reminded her of a Christmas tree. The tree she drew had all the gifts she feels she has received in her life written on the branches. The patient agreed to complete a program evaluation and wrote that HAP helped her, "look inside herself" (J. Lalande, personal communication, May 6, 2022). The patient shared with me that in doing HAP she realized the power of her inner strength at 88 years old, a significant shift in perspective for this patient. Throughout my social work involvement with this patient both HAP-related and otherwise, she repeatedly mentioned her age and how she felt she was not as valuable as she was in her younger age, and that she felt she was burdening her family.

This self-directed ageism was a common refrain when working with older adults at SJCCC and it presented itself in various ways; including being used as a reason to decline HAP involvement. Many patients to whom HAP was offered, shared with me that due to their age they felt they would not be adequate. Despite my anti-ageist encouragement and reassurance that one need not be, "good at art" to be involved, I heard this reason for not getting involved in HAP frequently throughout my advanced practicum. Patients under 60 years of age are in the minority at SJCCC, however, nearly half of the patients who participated in HAP were in their 40s. While I did not complete any research about the reasons behind this, I have established a set of hypotheses: (1) despite research demonstrating that older adults can learn new things (Winstead et al., 2013), many older adults have internalized a belief that *you can't teach an old dog new tricks*. Copious research exists on the detrimental effects of internalized ageism, including data to

suggest older adults are skeptical about their ability to learn (Formosa, 2021), and a common trend that internalized ageist ideas about growing older results in older adults failing to access health care when necessary (see Ouchida & Lachs, 2015, for more); (2) As a result of being in a rehabilitation hospital, some older patients may have been too overwhelmed and exhausted to be interested in HAP. Research shows that older adults are more likely to report poor sleep than younger adults (Li et al., 2018), a reality that may be exacerbated for some patients due to their ailments, medications, noise, and lighting in the hospital. For patients who are easily fatigued from their rehab exercises, it is likely that HAP just was not within their bandwidth; (3) the language of HAP as being an "arts-based mindfulness program" may not be language that resonates with an older adult population. When I explained mindfulness as being, "a way of paying attention on purpose, without judgement" or as "a way to help improve concentration on the present moment", many older adults were disinterested. I tried changing the language and attempted to frame the program as being "activities to help build self-awareness and self-compassion", however, this did not seem to garner any more attention from older adult patients. This could be related to a generational attitude of carrying on with life without complaint or introspection (Hadden, 2012). Additionally, I wondered about the stigma of mental health and how older adults face the intersectionality of this stigma and ageism (Connor et al., 2012). I wonder how this stigma coupled with identifying as female, or a person of colour may further affect the stigma and reluctance to participate in a program that supports mental health.

Case Example Five

Figure 6

Patient drawing for HAP activity Me as a Tree

The patient who completed this drawing completed four sessions of HAP facilitation. During her first session, she created a Thought Jar wherein she was able to choose from a selection of beads, gems, sparkles, and sequins, to which she assigned meaning and feeling. The patient chose one blue bead which represented sadness and two purple beads, one to represent the patient and one to represent her mother who had passed away, she then put in a small number of sparkles, which she explained had no particular meaning. When the patient shook up her jar, one of the purple beads sank and one rose to the top and just floated there. The patient shared with me that she believed this was a sign and that the bead representing her mother was the one that floated to the top because her mother is in heaven watching down on the patient. This activity prompted a conversation about feelings the patient had held onto for quite a while. A couple of days after this session, the patient shared that her roommate with dementia had been playing with the patient's Thoughts Jar and that the lid was now broken. I offered the

opportunity to make a new jar and the patient excitedly accepted. When the patient created her new jar, she chose the same beads and sparkles and explained that they still represented the same meaning as the original. Once again, one purple bead floated to the top and one to the bottom. The patient was amazed and as she talked about how she felt so happy and surprised, the blue bead (representing sadness) floated to the top and stuck to the floating purple bead. The patient shared that she believed this was her mother sending another message from heaven and that the blue bead floating to the top showed that the patient's deceased mother was trying to take away the patient's sadness. The patient opened the lid to the jar and added a pink bead, explaining that pink represented healing. The patient shared that this activity and the sign from her mother were bringing feelings of happiness and healing.

The next activity this patient did was Me as a Tree (Figure Six) in which the patient drew a small sapling. I encouraged the patient to share with me a bit about her picture and what meaning she thought was behind the sapling, its roots, and the birds. The patient explained to me that she believed her tree represented a new phase in her life and that she felt like she was able to grow into the person she wants to be. She shared that the roots represented her connection to her father and that the birds represented loved ones who had died and were now watching her grow.

Case Example Six

Research that looks at mindfulness and dementia tends to focus on training that includes only the caregivers of those with dementia (Holmes et al., 2014; Collins & Kishita, 2019), or programs that include both caregiver and person living with dementia (Paller et al., 2015). Research strictly meant to examine the outcomes of mindfulness training for people living with dementia, is in its infancy (see Nagaoka et al., 2021 for more). While some studies examining the feasibility of mindfulness as an intervention for cognitive impairment suggest that mindfulness

can benefit those with dementia, (Chan et al., 2020), other authors claim that there is no difference between participants who have dementia and the control groups to whom they are compared (Nagaoka et al., 2021). Research on arts-based interventions with dementia patients is more plentiful and is generally stronger in design than studies that investigate mindfulness with this population (Fong et al., 2021). In perusing all this research, I decided that I would try to implement some of the HAP activities with a patient at SJCCC who had dementia and was interested in the program. The first activity that we tried to do together was a Thoughts Jar. While the patient enjoyed looking through the beads, sequins, and sparkles, she kept forgetting the purpose. As I would gently draw her attention back to the activity, her mind would wander, and she would start to tell me about her life. In the end, this attempt at a HAP activity resulted in a visit and an opportunity for reminiscing which the patient enjoyed, nonetheless. On another occasion, I was able to do some guided imagery with this patient. The patient was able to relax and listen for the full 5-minute script and she shared that she enjoyed listening. I learned through working with this patient that most HAP activities require a level of abstract thinking, insight, and self-reflection that may be inaccessible for people with dementia (Chan et al., 2020).

Conclusion

Chapter three focused on the critically reflective process I engaged with throughout the advanced practicum. It is apparent that there are benefits to implementing HAP in a slow-paced physical rehabilitation setting and that there are also unique challenges that must be taken into consideration. Flexibility and adaptation are key elements to be embraced to provide meaningful and relevant arts-based mindfulness opportunities to patients. The importance of activities that are tailored to the individual and the vast benefits of working 1:1 with patients were discovered during this practicum process.

Introducing arts-based mindfulness skills allowed patients to explore the feelings experienced during a time of vulnerability and healing. Partaking in HAP activities allowed time and space for patients to pay attention to their feelings and emotions on purpose while being supported by my facilitation. As was exhibited through the participant vignettes, some of the patients were able to discover and assign meaning as they considered challenging and unexpected events in their lives. HAP is not allied with any sect or denomination; however, it allows and invites spirituality (Coholic, 2011). HAP's embracing of spirituality worked particularly well in SJCCC which is a Catholic organization and where there is a chaplain available for patients. Some of the patients who explored their spirituality through HAP were then able to expand their understanding through further conversation with the chaplain. This was also true for patients who did not necessarily experience spiritual contemplation, but who needed further social work support. HAP acted as a gateway for patients to address concerns and reflections that arose through mindfulness and artistic endeavours. In the final chapter of this thesis report, I will summarize the findings of this advanced practicum and will explore the implications for my future social work practice and other social workers practicing with this

population. I learned a lot about myself during the advanced practicum experience. Primarily, I learned that although doing new things may feel uncomfortable and I may lack confidence, my mindfulness and reflective practices give me the serenity and perspective to persevere. This experience and the personal and professional learning obtained will assist me greatly as I move forward.

Chapter 4: Summary and Implications

As part of the program requirements for the MSW degree at Laurentian University, I chose to complete an advanced practicum comprising 450 hours of social work experience. I chose to participate in this practicum with St. Joseph's Continuing Care Centre (SJCCC) in Sudbury, Ontario. The advanced practicum took place from Monday to Wednesday, eight hours each day, from January 2022-June 2022. I had previously completed 450 hours of placement at SJCCC during my MSW Qualifying Year, five days a week from May 2021-July 2021. It was the objective of this additional 450-hour advanced practicum to expand and enhance the foundational skills and knowledge I had obtained, and to introduce the Holistic Arts-Based Mindfulness program to slow-paced physical rehabilitation patients. In this chapter, I will discuss the implications of this advanced practicum on my future social work practice and will offer my suggestions and concluding thoughts regarding arts-based mindfulness with older adults in a physical rehabilitation hospital setting.

During the time in which I completed this advanced practicum, I had to problem-solve ways of implementing HAP in a rehabilitation hospital setting during the ongoing COVID-19 global pandemic. The restrictions and repercussions of this reality forced me to adapt and adjust my original plans while staying true to the goals of HAP. This necessary flexibility taught me a valuable lesson about how social work is meant to meet people where they are, accommodating their specific needs rather than trying to mould people to fit my ideas. The result of deviating from the original plan was a more patient-centred, 1:1, individualized program. I learned the value of working in an allied health team which collaboratively supports patients. The allied health team at SJCCC takes an integrative approach and I was fortunate to build relationships with professionals outside of social work who were willing to work in partnership. The staff at

SJCCC were excited and intrigued by HAP and I felt very supported in my work. This experience taught me the importance of considering different perspectives. I will further discuss the implications of my learning in the following section.

Implications for Social Work Practice

This practicum thesis report contributes to the limited research on arts-based mindfulness methods with an older adult population, illustrates the benefits of arts-based mindfulness to those participating in a slow-paced physical rehabilitation program, and details the ways in which HAP supports social work practice and builds rapport with clients. Providing programs like HAP to patients in hospital is an important endeavor, as patients in hospital are at a greater risk of struggling with their mental health. By providing 1:1 programming, arts-based mindfulness is accessible to a range of patients interested in participating. For these reasons, social workers in hospital settings should strongly consider implementing programming like this with patients.

Providing rehabilitation patients with an evidence-based, holistic arts-based mindfulness program helps to support the patient and staff, as the patient's mental health is appropriately addressed. Helping patients to improve their mental health makes the jobs of the rehabilitation and nursing teams run more smoothly, as there is an undeniable connection between mental and physical health in which poor mental health effects physical health and vice versa (Sickel et al., 2019). In functioning on a flexible 1:1 schedule, HAP did not interfere with any of the other tasks or duties performed by other disciplines, thus, contributing to the ease of running this program.

There is obvious value to implementing programs such as HAP with patients in a rehabilitation hospital, however, there is also value in social workers using tools of the program themselves. Social workers can use HAP activities to aid their own self-reflective practices and

to improve their understanding of their own thoughts and feelings. HAP can be utilized in various ways by social workers and with a variety of populations.

When contemplating my future social work practice, many aspects of my practicum learning will inform the way I approach my work. Four elements that stand out include the role of continuing education, the value of collaborative approaches to social work, the importance of person-centredness, and the value of a personal mindfulness practice. These aspects of learning will be integral to the way I move forward in my social work career.

First, continuing education was a significant part of my advanced practicum experience. Patients arrive at SJCCC with various ailments and issues. Having not come from a medical model background, I constantly found myself researching characteristics of different psychological and physical diagnoses patients were living with. One of the key reasons for social workers in a hospital setting to become comfortable with medical terms is to help patients advocate for themselves. Social workers who educate themselves on medical terminology are then able to empower patients by increasing their health literacy (Mannsåker et al., 2021). While medical concerns are not always applicable to the role of a social worker, it was common that in researching different medical terms I was able to establish a basic understanding of what to expect when working with certain patients. For example, by learning about the effects of delirium on a patient I knew that confusion, agitation, and tiredness would impede accuracy when trying to complete an assessment. As a result of this learning, I was able to research strategies for working with patients in a delirium (Grover & Avasthi, 2018) and more often, saved assessments and conversations until after the delirium had cleared, unless necessary. Another example of this type of learning was recognizing that patients who had recently had a stroke were potentially going to be more emotional; even experiencing bouts of uncontrollable

crying (Andersen, 1995). This was an important characteristic to be aware of, as stroke-related tearfulness could easily be misinterpreted as low mood. During my practicum I also took part in professional development sessions on the following topics: goals of care discussions, advanced care planning, power of attorney for personal care and substitute decision-making laws in Ontario, palliative care, SJCCC's Guardian Angel end-of-life program, Huntington's Disease, and dementia care. Additionally, I educated myself through reading articles and books, listening to podcasts, and watching various webinar recordings. Topics included trauma-sensitive mindfulness, arts-based interventions with older adults, mindfulness with older adults, ageism in healthcare, and self-care strategies for social workers. Continuing education is not only a requirement of the Ontario College of Social Workers and Social Service Workers (OCSWSSW, 2022) but also a personal standard to which I hold myself.

Secondly, I have learned the value of collaboration in social work. Collaboration can be applied in several ways, including seeking advice, reflecting with others, and working together on a certain task. Collaboration served me well during the advanced practicum through supervision and working with the allied health team. Supervision was a valuable experience in which I was able problem solve, reflect, and make plans for practice (Beavis et al., 2022) with the collaboration of Sonia Meerai RSW, MSW. Supervision from a practitioner outside of the organization was helpful, as Sonia was able to take a perspective free of organizational biases, and share knowledge and experience not held by staff at SJCCC. The process of supervision proved to be a welcomed and beneficial practice. Additionally, Sonia and I collaborated on an application to the Research Ethics Board (REB) to approach the pilot use of HAP safely and ethically with this vulnerable population. This collaborative experience was productive as Sonia was able to call upon her previous REB experiences and I was able to express my intentions for

practicum more thoroughly. The REB approved a program evaluation that consisted of a consent form, demographic questionnaire, interview guide, and study script. Although there was only one patient (described in Case Example 4) who agreed to participate in the program evaluation, the experience of going through the review process was an excellent learning opportunity. The feedback provided by the patient was simple, but meaningful. The patient chose to answer the interview questions in writing. She disclosed that she is 88 years old and identifies as "French/Native." The interview consisted of two questions. When asked, "in what ways did this program impact you?" she responded, "kept me busy and made me look inside myself." When asked, "What would you change about the program?" she responded, "nothing."

The allied health team at SJCCC was another valuable group of people with whom I could collaborate. Allied health is made up of physiotherapy, occupational therapy, spiritual health/chaplaincy, and social work. This collaborative experience was helpful in that there were perspectives outside of social work upon which to draw. An example of this was when I was working with a patient who had mobility issues with his hands and the occupational therapist collaborated with me on ways to adapt the HAP activities and art materials to fit the patient's needs. Collaboration amongst the team was beneficial not only in terms of supporting patients but also in feeling backed and encouraged in my work. Conversely, sharing social work perspectives with other team members was also well received. For example, reminding other disciplines that professional ideas about what is best for the patient may not align with the patient's wishes. Several times throughout my practicum, I was able to engage in collaborative conversations where social work advocacy of patient rights helped to change the focus of care planning. For example, many patients required an ally to help advocate when they did not feel comfortable with the discharge plan. For some patients, this meant that the RSW and I would

bring concerns to the team on behalf of the patient, bringing awareness about the patient's perceived barriers and concerns. Research examining collaboration among health care professionals demonstrates that practitioners are adept at negotiating overlapping areas of their work (Schot et al., 2020). By finding appropriate ways to work together, health care staff are better able to combat burnout and serve patients, a finding consistent with my experience at SJCCC. I will unequivocally take an approach of collaboration forward into my social work career. Perhaps the most instrumental aspect of the collaborative nature at SJCCC is communication. The team meets regularly, keeps each other up to date about progress and planning, and utilizes the strengths and competencies of each professional appropriately.

Next, the learning I acquired regarding the importance of person-centredness in social work was perhaps the most impactful. While I struggled to fit SJCCC and its patients into the plans I had for HAP, I realized that HAP needed to fit into SJCCC and what was most relevant for patients. Redesigning HAP to be done with patients 1:1 illuminated a plethora of reasons this design should be maintained beyond COVID-19 restrictions. In working with patients 1:1, I learned that I could better accommodate individual needs including washroom breaks, rescheduling sessions, length of sessions, location, and allowing space for supportive listening. Person-centred approach bolsters the idea of working with patients (Washburn & Grossman, 2017) rather than coming from a prescriptive position. The goals of HAP in concert with a person-centred approach (Rock & Cross, 2020) helped ground my decision-making processes. Once I was grounded in a practice of person-centred care, the advanced practicum began to flow more smoothly and my relationship with patients grew stronger. When I completed my Qualifying Year placement at SJCCC I feel I intrinsically moved toward person-centredness. When I returned to complete my MSW advanced practicum, however, I initially allowed my task

of completing a thesis report to cloud my judgement and I resisted person-centred care and instead favoured my task-based mindset. Realizing that I needed to adapt was a good reminder that social work revolves around working with people and when I start working alone, issues arise. I am grateful for the opportunity this advanced practicum provided to re-centre my social work practice in an approach that is person-centred.

Finally, my practice of mindfulness played a significant role throughout the advanced practicum. My practice of sitting with feelings and emotions proved beneficial when I worked with patients experiencing hardship as I was able to support their feelings without wanting to deviate or distract. This skill was also helpful when my feelings of imposter syndrome, anxiety, or shame arose. In practicing mindfulness, I was able to recognize the bodily sensations and thoughts that came up for me and reflect upon their meaning and purpose without judgement. An example of this was when I distracted from a patient's sharing in an initial assessment to tell a story about a similar situation I once had. My intention was to normalize for the patient, however, the embodied experience I had at the moment (my face feeling hot, my legs feeling numb, my hands shaking) combined with later reflection, illustrated to me the importance of providing patients with a supportive silence (Sharpley et al., 2005). By learning this valuable lesson about allowing space for silence, I incorporated the mantra, "Today, I will allow for silence and choose my reactions with purpose" into my morning mindfulness practice. This advanced practicum was instrumental in growing my mindfulness practice while also facilitating the mindfulness practices of patients.

Concluding Thoughts

Implementing arts-based mindfulness with patients at a slow-paced physical rehabilitation hospital is beneficial for many reasons. Patients working to strengthen and overcome physical health challenges are often impacted by mental health challenges (Doherty & Gaughran, 2014) and HAP is an appropriate tool to help patients navigate such struggles. During a time in one's life when deficiencies and problems may be prominent, HAP encourages finding strengths and resilience (Coholic et al., 2021) to overcome various obstacles. HAP provides patients in a medical setting the opportunity to explore their feelings and emotions from a holistic approach, rather than from a medical model. HAP is an engaging and enjoyable way to broach certain topics that may otherwise feel awkward or intrusive (Day-Vines et al., 2020). HAP is also useful in giving language for patients to discuss their feelings; a task that many find incredibly difficult (Brown, 2021).

Programs such as HAP certainly have merit when facilitated in group settings (Coholic, 2011; Furman et al., 2017), however, in an institutional setting such as SJCCC, it was my experience that 1:1 programming was advantageous. Although HAP was not originally intended to be implemented in a hospital setting, its introduction was easily integrated once an appropriate mode of delivery and plan of distribution was established. I believe that slow-paced physical rehabilitation hospitals are a suitable setting for HAP activities to be introduced by social work staff. Social work staff fit specifically well with HAP as opposed to nursing or other allied health staff, as social workers have the basic supportive listening and counselling training (Booysen & Staniforth, 2017) often required to delve deeper into the artwork participants produce. In my practicum experience, it was common for patients to become emotional when working through HAP activities. To ensure proper support and encouragement of participants, I feel social

workers are best positioned to incorporate HAP into their work. I also found that HAP was a useful entry point to explore nonchalant comments made by patients in their initial assessments that posed a red flag as a social worker. HAP provides a nonthreatening and organic context for having more challenging conversations about patients' thoughts, situations, feelings, concerns, etc. Providing HAP 1:1 further allowed for that safe and confidential environment in which longer more in-depth conversations could flourish. HAP 1:1 with a social worker and patient helped to foster positive and trusting therapeutic alliances (Paap et al., 2021). Utilizing holistic interventions like HAP can bring significant value to social work practice, as evidenced by the case examples described in this report. Social workers who are interested in employing HAP in their practice should read the work of Dr. Diana Coholic and consider whether the activities are best implemented in a group or 1:1 setting, as both can be effective.

In this advanced practicum thesis report I have thoroughly explored the literature on arts-based and mindfulness interventions with older adult populations, detailed the particulars of the advanced practicum environment, used reflective practice to evaluate my role and experience as an MSW practicum student, and underscored the various challenges and benefits of using HAP in a slow-paced physical rehabilitation hospital setting. The outcome of this practicum has inspired within me a greater appreciation for the utilization of arts-based mindfulness activities when working in an institutional setting. My experience implementing HAP indicated that arts-based mindfulness is not only appropriately used with older adults (60 years and older) but also with adults in their 40s and 50s as well. I believe that continuing to offer HAP activities to patients at SJCCC will benefit not only the patients but will help to foster better therapeutic relationships between patient and social worker. The patients admitted to SJCCC are living with numerous physical and mental health challenges. Facilitating HAP activities with patients

elicited conversations about struggle, sadness, and frustration, but those discussions were ultimately balanced with realizations of strength, value, and resilience.

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