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## **The *Caring* Artist**

Exploring the Role of an Arts-Health Practitioner in a Nursing Home and a Model of Arts-Health Practice

Michael Thaddeus Koon Boon, Tan

## Abstract

The priorities many nursing homes give to physical care often supersede consideration for leisure arrangements and resources with the effect that the range of activities and engagement opportunities for residents are limited. An inactive lifestyle in nursing homes can compromise the residents' quality of life and their psychosocial wellness through boredom, diminished morale and reinforced dependency. A low level of engagement also exposes residents to a greater risk of developing cognitive impairment and accentuates feelings of loneliness and isolation. Given the demographic trend of an ageing population together with a growing demand for nursing homes in Singapore, this research addresses the current lack of research on lifestyles of nursing home residents and arrangements to promote their personal well-being.

In this thesis, I investigate the effect of a participatory visual arts programme on the personal well-being of residents in a Singapore nursing home. The study explores the ways in which well-being is afforded through participatory arts activities and the role an artist can take in relation to human caring. To facilitate evaluation and reflection on my arts-health practice, I brought my arts-health practice into a novel dialogue methodologically with the action-research case study approach of social science. I refer to this hybrid approach as 'critical arts-health practice'.

The empirical data of the study prompted exploration of the link between vitality and participatory arts activities. Participatory arts activities are found to revitalise the sensory, physical, cognitive, emotional, social capacities of older adults and promote self-actualisation. Drawing on Gilles Deleuze's assemblage theory, I conceptualised the Arts-Health assemblage as a way of understanding the processes through which participatory arts activities contribute to the participants' well-being, as both dynamic and as involving multiple interrelated elements. I argue that the broad concerns of arts-health practice can be defined as combining individualised attention to the participant, well-being outcome, and ensuring the quality of the environment and activities for participatory arts. I argue that attentiveness to these dimensions will promote a more effective and caring arts-health practice. Lastly, the central importance of these dimensions within an arts-health practice emphasises that the arts-health practitioner is first and foremost a *caring* artist.

## **The *Caring* Artist**

Exploring the Role of an Arts-Health Practitioner in a Nursing Home and a Model of Arts-Health Practice

Michael Thaddeus Koon Boon, Tan

Thesis submitted for the degree of  
Doctor of Philosophy (PhD)  
(Human Geography and Health Studies Interdisciplinary Doctorate)

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**List of Abbreviations**

AIC – Agency for Integrated Care

INT – Interviewer

PVA – Participatory Visual Arts

**Declaration**

This thesis is the result of my own work. The material included has not previously been submitted for a degree at this or any other university.

**Statement of Copyright**

The copyright of this thesis rests with the author. No quotation from it should be published without the author's prior written consent and information derived from it should be acknowledged.

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## **Dedication**

To *Papa* (1948 – 2014) and Ma

# **1 The Greying Little Red Dot: Population Ageing, State of Nursing Home Development and Research in Singapore**

This research was motivated by a genuine personal concern for a possible future. It is inevitable that I will grow old and add to the statistic for population ageing in Singapore. However, should I require care in a nursing home, it is my hope that it will be a place where I can age optimally and have the opportunity to live an enriching life until the end of life. As an island nation, the landmass of Singapore is not large enough to be significant on the world map. Thus, the country is often denoted by a little red dot. The frequent reference to Singapore as the little red dot by the country's media, politicians and citizens has popularised the term and made it synonymous with the country. The little red dot is fast turning grey. Indeed, Singapore has one of the fastest ageing population in the Asia Pacific region (Mehta and Vasoo, 2002).

## **1.1 Population Ageing and its Challenges in Singapore: A Brief Overview**

The elderly population in Singapore is defined as persons aged 65 years and above (MSF, 2009). Over the next two decades or so, Singapore will witness a significant age shift. The proportion of elderly is expected to increase from 11.1% in 2012 to reach 18.7% in 2030. By 2030, 1 in 5 Singaporean residents will be aged 65 and above (MSF, 2009). A declining fertility rate, increased life expectancy and migration are identified by the Ministry of Social and Family Development as factors contributing to population ageing in Singapore (MSF, 2009). Population ageing is understood as a phenomenon where a society is showing an increased the proportion of older person in the population (United Nations, 2012).

As an Asian society, provision of care and support for elders has traditionally been the task of family members, but the changing demographic and social trends among younger Singaporeans are likely to challenge this status quo. While there are no strong data showing that young Singaporeans are unable or unwilling to assume the traditional filial responsibilities, several trends, including a growing preference for dual income nuclear families, changing social values and an increasing number of young Singaporean expatriates, are expected to influence future living arrangements for

older populations groups in Singapore (Mehta and Vasoo, 2000). Although the Singapore government strongly favours a community-based long-term care delivery system that encourages the elderly to remain in the community (Mehta and Vasoo, 2000), it is inevitable that a portion of the elderly will need to engage the services of nursing homes. Such arrangements may arise due to the unavailability of family members or the inability of caregivers to provide appropriate care when a more intensive and specialised level of care is required and which does not permit them to be cared for at home.

Although only a small proportion of the elderly population in Singapore is reported currently to be living in nursing homes, data show an upward trend. The number of residents in nursing homes has risen from 5203 persons in 1997 to 9278 persons in 2008 (MSF, 2009). This figure is expected to grow as the number of elderly in Singapore is estimated to reach 960,000 persons in 2030 (MOH, 2012). In anticipation of the growing demands for nursing homes, ten new nursing homes will be added by 2016 to boost the current supply of places (MOH, 2012). An estimated supply of 15,600 nursing home places is expected by 2030 (Gan, 2012).

## **1.2 A Glance at Nursing Home Development in Singapore**

Under the Singapore healthcare regulation, nursing homes are considered as healthcare facilities alongside hospitals and other medical or clinical facilities, and are categorised as Intermediate and Long Term Care (ILTC) Services by the Ministry of Health (MOH, 2015b). The Ministry of Health (MOH) and its statutory boards are the regulatory bodies for both public and private healthcare service providers. Licensing for nursing homes took effect as of 1 January 1994. Nursing home Licenses are valid for 24 months and have to be renewed two months before expiry. According to the Private Hospitals & Medical Clinics (PHMC) Act, chapter 248, revised edition 1999, nursing home refers to 'any premise other than a maternity home used or intended to be used for the reception of, and the provision of nursing for persons suffering or convalescing from any sickness, injury or infirmity' (SSO, 2016). All nursing homes in Singapore are required to comply with the standard of medical/clinical services specified under PHMC Act and are audited regularly by the Licensing, Inspection and Audit Branch of MOH.

Typically, nursing homes in Singapore provide basic nursing care, rehabilitation services and assist residents in their activities of daily living such as feeding, toileting and personal grooming. The range of services provided by nursing homes differs as they vary in size and capacity. Some nursing homes may offer more specialized services to provide care for persons with special needs like dementia and persons with stabilised psychiatric conditions. Despite the variety, nursing homes remain as facilities that provide elderly persons some short-term care or inpatient convalescent, rehabilitative care, or long-term nursing/ medical care.

Nursing homes in Singapore are operated by Voluntary Welfare Organizations (VWOs) and Private Operators. Based on their operation funding resources, nursing homes in Singapore are categorised into four categories:

1. MOH subsidised VWO Nursing Homes,
2. Non-MOH subsidised VWO Nursing Homes,
3. Private Nursing Homes under MOH portable subsidy scheme, and
4. Private Nursing Homes that are not under the MOH portable subsidy scheme.

According to figures reported in 2014, there are currently 66 nursing homes in Singapore (MOH, 2015a). The number of places in VWOs nursing homes can vary from 40 to 400 beds while the privately-run homes may vary from 20 to 270 beds. VWOs nursing homes are supplying about 6,000 places while privately-run nursing homes are offering about 3,500 places. In 2003, MOH experimented with tapping into private sector nursing home capacity by introducing the portable subsidies scheme, where subsidised patients can be cared for in privately-operated nursing homes. As of August 2012, 21 private nursing homes are registered under the MOH Portable Subsidies Scheme, offering a total of 1,859 beds.

Placement eligibility for nursing homes is dependent on the type of operation funding into which the individual nursing homes subscribe. There is no eligibility criterion for placements in non-MOH subsidised nursing homes. Thus, providers are allowed to accept anyone as long as there is a vacancy. In contrast, applications to MOH subsidised VWOs or private nursing homes are subjected to a pre-placement assessment, via the Resident Assessment Form (RAF), of the applicant's level of needs

to ascertain their eligibility (see Table 1). MOH subsidised nursing homes can only admit RAF Categories 3 and 4 applicants.

Cat 1	Physical and mentally independent. May or may not use walking aids. No need or minimal assistance in Activities of Daily Living (ADL).
Cat 2	Ambulant with minimal assistance from 1 person. May be mildly demented. Require some supervision in ADL such as transfer, feeding, toileting, personal grooming.
Cat 3	Wheelchair/bed bound with moderate assistance from 1 to 2 persons. Need supervision most of the time and require help in ADL.
Cat 4	Bed ridden. Require total assistance and supervision for every aspect of ADL.

Table 1. Resident Assessment Form (RAF) for Nursing Home Admission

Residents living in MOH subsidised nursing homes would pay reduced fees if they are eligible for financial and social assistance. However, residents living in non-MOH subsidised nursing homes are not entitled to any subsidy and are required to pay full fees.

The staffing and structural organisation of nursing homes varies according to the individual organisation's preference in so far as the Ministry of Health has no mandatory requirements. The structural organisation in a VWO nursing home usually comprises a Board of directors, a Chief Executive Officer or Director supported by Administrative staff, Nursing Staff and Allied Health Staff. Each of these areas usually has a manager leading the team. Nursing and Allied health staff mostly comprises foreign nationals from countries around the region such as The Philippines, Sri Lanka and Myanmar.

### **1.3 State of Nursing Home Research in Singapore**

While research in Singapore related to nursing homes is growing, there is a lack of knowledge of lifestyle arrangements and their impact on the personal well-being of residents. Topics addressed by existing studies include: 1) the state of nursing home development and usage (Yap et al., 2003b, Sitoh, 2003, Mehta and Vasoo, 2002), 2) health and risk assessment (Yap et al., 2003a, Leong and Nuo, 2007), and 3) care ethics (Mamun and Lim, 2005). One study that comes close to assessing the well-being of

nursing home residents documents the prevalence of depression amongst nursing home residents (Tiong et al., 2013). This study indicated that the prevalence of depression amongst nursing home residents is higher than elderly people living in the community in Singapore. While length of stay, history of depression, pain and lack of social contact were identified as risk factors, the study did not recommend any strategies for nursing homes to ameliorate the occurrence of depression. Furthermore the voices and views of the residents were not captured in the quantitative approach. It is also noteworthy to mention that most literature on nursing home research comes from the western context and contributions from the South-East Asian context have been limited (Chen et al., 2012). The limited contribution can be linked to the continued preference towards co-residence as living arrangement for the elderly in many Asian societies (Asis et al., 1995). Under such an arrangement, elderly parents live with their children in a household setting. Such a preference is understood to be influenced by traditional Asian values such as filial piety where the adult child is expected to care for their parent (Knodel et al., 1995, Asis et al., 1995, Mehta et al., 1995). While there is a lack of research and literature on the attitude of people towards nursing homes in South-East Asia, the resistance shown by residents towards a plan for the construction of a nursing home in their neighbourhood in Singapore (AsiaOne, 2012) suggests that negative perception still exists among people towards nursing homes. Living in a nursing home is regarded by many as a last resort when there is a lack of carer or ability of the carer to provide care (Yap et al., 2003b). However, in Singapore, due to population ageing, migration and a shift in preference among the younger generation toward a nuclear family (Mehta et al., 1995), demand for nursing homes has shown signs of increase in recent years (Gan, 2012).

Although healthy ageing is widely promoted in public health policy (HPB, 2012), the group of older adults resident in nursing homes appears to have limited access to such a prospect. Despite numerous studies evidencing the benefits of an active and engaged lifestyle in promoting the well-being and health of the elderly (Erickson et al., 2013, Nimrod, 2011, Schreiner et al., 2005), research into the lifestyle arrangements for nursing home residents in Singapore is currently under developed and particularly research exploring the effects for residents' wellbeing of different potential strategies. Thus, this research will address this gap.

The research aim is: to explore how an arts-health practitioner contributes to promoting the personal well-being of nursing home residents through participatory arts programmes. In doing so, I not only investigate the effect of the PVA programme on the participants but also explore the manner in which well-being is afforded through the encounter between residents, the artist and participatory visual art activities. In addition to evaluating and reflecting on the role of the artist and the effect of the PVA programme on the participants well-being, I also aim to identify the broad concerns of arts-health practice and develop a practice framework which I hope will be useful to guide and promote a more effective and caring arts-health practice. Such a framework is currently under developed.

Stemming from my research aim, the project will address several specific research questions:

1. What are the current lifestyle arrangements and well-being strategies for the residents in a Singapore nursing home?
2. How might Arts-Health practice promote the personal well-being of nursing home residents?
  - How is well-being afforded through the encounter between residents, artists and Participatory Visual Art activities (PVA)?
  - How might participatory arts engagement foster vitality?
3. What does a 'critical' Arts-Health practice look like?
  - What methods and approaches can be use to facilitate evaluation, analysis and reflection on the impact of participatory arts by an arts-health practitioner?
  - What does a practice framework to guide and promote a more effective Arts-Health practice look like?
  - What does it mean to be a 'caring artist'?

#### **1.4 Defining Terms**

Before I proceed to introduce the layout this thesis, for clarity purpose, I wish to provide the definition of several terms that are frequently mentioned in this thesis.

*Arts-Health Practice.* Arts-health practice is also widely known as arts-in-health, arts for health, arts in healthcare (Macnaughton et al., 2005, White, 2009, Dileo and Bradt, 2009). I am proposing the use of a simplified term Arts-Health practice to connote the relation and synergy arising from the connection between arts and health. Unlike art therapy or other form of creative therapy practices where art making process is intended primarily for healing and emotional release, arts-health practice is a non-therapy oriented art practice that focuses on artistic product and seeks to support the development of artistic competence, skill and knowledge. An arts-health practitioner often is a person with formal artistic training and an interest in using participatory arts programmes or activities as a pathway to amend and foster the health and well-being of individuals. Arts-health practice is understood to be therapeutic because it provides a supportive social environment that encourages communication, expression of ideas and self development (Secker et al., 2011, Staricoff et al., 2002). Although arts-health practice may have overlapping benefits with other forms of creative therapies, arts-health activities are focused on creative collaborative exchanges rather than supporting functional performance, assessment and treatment planning (Brown, 2006, Swindells et al., 2013, van der Venet, 2011). I see arts-health practice, as a form of socially engaged art practice that focuses on addressing health inequality and the promotion of health through the use of participatory arts activities. I argue that the intention of an arts-health practitioner is to connect people to, and use participatory arts programme as, a pathway to mitigate the unfavourable effect of circumstances or places on personal well-being and to promote flourishing.

*Participatory Arts programmes or activities* refer to creative arts engagement sessions created and led by one or several arts practitioners. The art forms involved can include, but are not limited to, the visual arts, music and performing; in the intervention for this study, I focused on the visual arts. Participatory arts programmes are workshop-like sessions where the arts practitioner shares and imparts their artistic skills and knowledge to participants. In doing so, under the support of the arts practitioner the participants become acquainted with artistic knowledge and develop a capability to realise an original artwork. Participatory Arts programmes or activities are distinguished from Participatory Arts (Bishop, 2005, Almenberg, 2010) which refer to a

form of art practice that elicits, relies on or involves audience interaction, participation or collaboration to contribute to the conceptual aims of an artwork that was originally conceived by the artist. In contrast, participatory arts programmes or activities involve the arts practitioner actively leading the participants to create their own original artwork.

The concept of *optimal ageing* explores how psychosocial well-being can be gained, optimised and secured despite age-related physical loss (Aldwin et al., 2001). It shifts focus away from the notion of successful ageing (Baltes and Baltes, 1993) which relates wellness in late life to being free of ill-health. Optimal ageing furthers our understanding of ageing by drawing attention to age-related potential under ideal conditions. Optimal ageing can also be linked to the principles of 'selective optimization with compensation' (Baltes and Baltes, 1993). Selective optimisation with compensation acknowledges that there are many latent reserves in ageing bodies; 'old people, like young people, possess sizable reserves that can be activated via learning, exercise or training' (Baltes and Baltes, 1993, p.9). It maintains a view that despite the increased biological vulnerability and reduced reserve capacity as a result of ageing, self-efficacy and growth continue to be a possibility. However, for an individual to realise such possibility, 'development-enhancing' (Baltes and Baltes, 1993, p.20) societal resources, opportunities and support need to be available.

*Health* in this thesis is understood and in agreement with the definition provided by the World Health Organisation which regard health as:

a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living, and is a positive concept emphasizing social and personal resources as well as physical capabilities. (WHO, 2016)

*Well-being* has been conceptualised and interpreted in many ways (Atkinson et al., 2012). This research is focused on mobilising personal, subjective well-being. Subjective well-being is concerned with people's emotional responses and judgement on satisfaction and fulfilment to events (Diener, 2000). Well-being has typically been considered through two perspectives: hedonic and eudaimonic (Ryan and Deci, 2001). The hedonic perspective focuses on happiness and links well-being to attainment of pleasure. In this regard, well-being is supported by positive affects afforded by

material or experiential gain and possession (Deci and Ryan, 2008). In contrast, the eudemonic approach emphasises meaning and self-realisation, and links well-being with capacity that contributes to personal growth and development. A eudaimonic perspective also recognizes the qualities and potential of human being to respond to challenging circumstances and to benefit from them through a realisation of personal potential (Ryan and Deci, 2001). When considering well-being in this research, I draw on both perspectives as they operate in tandem, in a synergistic fashion to shape wellbeing (Kashdan et al., 2008). Indeed, an integrated conceptualisation of well-being that captures both the nature of well-being, as well as the potential pathways to the attainment of well-being, can provide a comprehensive understanding of well-being and facilitate the optimisation of well-being (Huta and Ryan, 2010). Flourishing (Seligman, 2011) is now often used to describe the state whereby hedonic and eudaimonic aspects of well-being exist concurrently (Henderson and Knight, 2012).

To facilitate navigation through this thesis, the next section offers an overview of the structural logic. In doing so, I outline the contents of the various chapters that comprise the thesis.

## **1.5 Layout of Thesis**

This thesis is organised into three parts. In Part One, I present the context for the research and the approach taken to achieve my aims. To situate this research, the next chapter presents a literature review of the relevant conceptual aspects (Chapter 2). The topics highlighted and discussed relate to the influence of place on ageing and well-being, the importance of an active lifestyle in late life, and the known benefits of participatory arts activities in late life. Chapter 3 presents and discusses the methodology and methods mobilised to address my research aims.

Part Two of the thesis presents and discusses the empirical findings of the research, drawing on ethnographic description and verbatim accounts of participants. In Chapter 4, I offer a glimpse of the little known lifeworld of the residents of a Singapore Nursing home including vignettes of their daily life. In doing so, I also highlight the challenges and issues related to the lifestyle arrangements in the nursing home and their impact on the well-being of the residents. Chapter 5 introduces the Participatory Visual Arts (PVA) programme that I designed and implemented at the

nursing home, *I Made Magic With Art*. The chapter then documents and discusses the experience of the participants in the PVA programme. Chapter 6 provides an account of staff views of the effects of the PVA programme for participating residents.

In Part Three, I explore the link between participatory arts activities and vitality (Chapter 7). The analysis draws on assemblage theory (Deleuze and Guattari, 1988, DeLanda, 2006) to conceptualise an arts-health assemblage in order to elucidate the dynamic process through which the well-being of participants is afforded by the PVA programme. In Chapter 8, I reflect on the caring role of the artist in a nursing home and identify broad concerns of arts-health practice for use in a practice framework that aims to promote efficacy in arts-health practice. Lastly, in Chapter 9, draws together the conclusions of the thesis and suggests recommendations for practice and further research.

## **2 Contextualising the Research**

### **2.1 Introduction**

This chapter embeds and positions the study within the contemporary debates around its key conceptual components. As this study is an interdisciplinary research situated at the intersection of arts, well-being and ageing, I drew knowledge from geography, arts, sociology, gerontology, psychology, and philosophy to inform and guide my empirical work and the analysis of my findings. The chapter is organised into three thematic sections: Place and Well-being in Late Life; Arts and Health; Assemblage Theory for Health and Well-being Research. In Ageing, Place and well-being in late life, I begin by presenting key perspectives and issues confronting ageing and the aged body. The discussion will proceed to highlight the effect of place on the experience of ageing and the personal well-being of older adults. It will turn to focus on the impact of lifestyle arrangements in nursing homes on the personal well-being of residents. I will highlight some of the key issues and challenges confronting residents in nursing homes that affect their well-being. The section on Arts and Health first offers an overview of this burgeoning area of multidisciplinary practice and research before turning to look more specifically on issues concerning the current practice and state of development of non-therapy based arts-health practice. The section on assemblage theory will introduce some of the key ideas developed by French philosopher, Gilles Deleuze to present the theoretical concept that underpinned and guided my imagination and thinking about the way well-being emerges as participatory arts activities and the aged bodies intermingle. Lastly, building on these understandings, I conclude the chapter by identifying the gaps that this research aims to fill and its principal arguments.

### **2.2 Place and Well-being in Late Life**

The ways in which the aged body is interpreted, conceptualised, understood and portrayed, can influence the way the aged body is treated and cared for (Twigg, 2006, Baars et al., 2013, Biggs, 1993). The experience of ageing is thus highly situated in that it is dependent on the particular time and place within which an older person is

relationally and historically embedded. As such, place has implications on the experience of aging of older adults (Andrews, 2005, Andrews et al., 2012, Hopkins and Pain, 2007, Cutchin, 2005, Atwell et al., 2007). The locale where individuals live, socialise, are cared for, and the resources and experience afforded by place also shape and influence well-being outcomes (Poland et al., 2005, Fleuret and Atkinson, 2007). The beliefs, attitudes and opinions held by long term care institutions can affect the life of people in their care. In this sense, experience of ageing is attributed relationally by flow of multiple elements varying from social to physical characteristics of place (Andrews et al., 2012). In the following section, I will highlight the various perspectives on ageing and go in some way to discuss how the aged body has been framed by nursing homes and its implications on the residents' well-being.

### **2.2.1 Ageing and the Aged Body: Perspectives and Issues**

Ageing can be approached and understood from a number of different angles. It is both process and state, biological and social, chronological and experiential. Ageing, when considered as a biological phenomenon, is a natural and entropic process whereby an organism undergoes a developmental pattern of physiological change associated with observable changes in the features and function of that organism (Phillipson, 2013). The rates at which such physiological changes occur vary hugely and respond to a vast range of factors such as wear and tear, physical environment, occupational activities, genetics (Whitbourne, 2012). Similarly, the way in which such changes are experienced, perceived, valued or hidden varies with time, place and social milieu.

The concept of ageing as a human construction indicates the various ways in which understanding and attitudes towards ageing are shaped socially and culturally (Powell, 2006, Katz, 1996, Faircloth, 2003, Gullette, 1997). The ways in which we imagine what old age is and the characteristics of being old are influenced by an array of political, economic and social attitudes as well as cultural and social histories (Hughes, 1995). This may lead to a stereotypical portrayal of older persons that can generate negative consequences and reinforce a fear of ageing which in turn may result in access to opportunities for older people becoming limited and constrained. The aged body, as Twigg (2006, p.52) points out, 'no matter how healthy or alive, was

conceptualised in terms of the signs of senescence that distinguished it from the healthy bodies of the young.'. Old age, in many societies, is often associated with disability and illness (Ory et al., 2003). Aged bodies are also looked upon as 'damaged goods' or as 'incapable of growth' (Gutmann, 1994). With such a perspective, the aged body is frequently ascribed notions of decline, dependency, decay, abnormality and deterioration (Powell, 2002, Powell and Biggs, 2000, Biggs and Powell, 2001).

Ageing stereotypes, particularly negative ones, can impinge, also negatively, on the experiences of ageing, late life development and the care provided them (Twigg, 2006, Phillipson, 1998). The attribution of this negative perception of the aged body is argued to be a corollary of the biomedical paradigm (Powell, 2006, Katz, 1996) in which the changes associated with ageing are deemed pathological problems (Powell, 2006). Ageist stereotypes often associate older adults with decline, poor body image, and loss of function (Hurd, 2000). Ageing stereotypes are found to have adverse effects on subjective well-being and health among older adults (Coudin and Alexopoulos, 2010, Aldwin et al., 2007, Golub and Langer, 2007, Barber and Mather, 2014). Coudin and Alexopoulos (2010), for example, in their study on the effect of positive and negative ageing stereotypes found that exposure to negative stereotypes on older adults can activate feeling of loneliness, and enhance sense of helplessness. Age related stereotypes are also found to threaten and affect memory in older adults (Barber and Mather, 2014). Golub and Langer (2007) pointed out that the dominance and circulation of negative ageing stereotypes can result in interpretive biases with respect to the repertoire of behaviours of older adults, and, as such, impinge on the possibilities considered for their development and health outcomes. The authors argued that negative stereotypes of ageing increase psychological vulnerability and pose direct or indirect health risks to older adults. They identified discrimination, internalisation and environmental influences as forms through which negative stereotypes might be manifested, enacted and reinforced. Concerned with the proliferation of negative stereotypes of ageing and their strong association with ageing experiences, the authors argued for a move away from the current focus on loss and decline and towards a focus on the developmental possibilities in ageing. Drawing on these understandings of how social construction of the aged body can shape the way ageing is experienced by older adults and their well-being, I will next turn to explore

the way the aged body is framed in nursing homes, and its implications on the residents' experience of ageing and their well-being.

### **2.2.2 Ageing and Well-being of Older Adults in Nursing Homes: Issues and Challenges**

The residents of nursing homes are mostly those needing care during the later stages of their life. A decision to seek admission is usually prompted by factors that include an inability to cope with deteriorating physical and mental states associated with the ageing process, the lack of suitable accommodation and a lack of carer (Fiveash, 1998). Residents of nursing homes often are dependent on others to attend to their needs, but these will be only part of the multiple demands and activities that make up the care worker's schedule. As such, residents often have to wait for care to be provided for their particular needs (Harper Ice, 2002). Residents' daily living activities, such as toileting, grooming, taking meals and participating in activities, become subject to a rationed sequence (Tuckett, 2007, Gubrium, 1997, Willcocks et al., 1987).

In most developed countries today, nursing homes offer a form of elder care that falls between, and combines, elements of the formal provision of care through large institutional hospitals and the informal provision of care within the private, domestic setting of the family home (Andersson et al., 2007, Forbes, 2001, Harper Ice, 2002). Although very little health care is provided in nursing homes, they continue to be thought of as health care facilities, and adopt health professional hierarchies. Created under the shadow of hospitals, nursing homes have historically been concerned with medical and custodial care (Kane, 2005) and, as such, their outlook towards care has largely been informed by the medical model (Henderson, 1995). Life quality and development of nursing home residents are determined and affected by resources and technologies (Poland et al., 2005). The ruling practices, knowledge authorities and moral imperatives in circulation amongst staff can optimise (Cox et al., 2004, Fortune and Whyte, 2011), limit, deny, or constrict (Pelletier, 2005, Mamun and Lim, 2005) the life quality outcome of residents. The medical model has also been criticised for the archaic view it imposes on ageing and chronic illness (Ronch, 2004). The continued adoption of the medical model as the defining core of the philosophical

and operational blue print by many nursing homes, helped preserve the power of the biomedical gaze over the ageing body. The patriarchal, subordinating culture that the acute care medical model exercises over people can result in a batch treatment, group homogeneity and loss of individuality (Henderson, 1995).

The biomedical model of care is found to compromise the well-being of nursing home residents (Meyer and Owen, 2008, Vladeck, 1980, Vladeck, 2003, Kane, 2001, Ronch, 2004, Gerritsen et al., 2004, Glass, 1991, Ryvicker, 2009). Henderson (1995) critiqued that the 'medical value of time' observed by nursing homes, which put a premium on physical health, disease and curing, have led to a neglect on psychosocial aspect of care. He also added that the minimal emphasis on psychosocial issues in inspection surveys, which are still largely tied to basic physical care, further devalue psychosocial care thus resulting nursing home to provide 'suboptimal psychosocial care' (Henderson, 1995, p. 43). The priority on physical care often resulted in an oversight on the residents' need for activities and engagement, thus compromising the life quality of residents (Berdes, 1987, Donnenwerth and Petersen, 1992, Fiveash, 1998, Voelkl, 1986). Resident engagement in the nursing home is also influenced a number of factors:

Residents who displayed agitation and/or apathy were more likely to be excluded from activity programs. Newly admitted nursing home residents with depression were found to have low social engagement, independent of other risk factors. Cognitive impairment and deficits in physical function, as well as visual and hearing deficits, also predicted low engagement. Psychoactive drug use often causes sedation and has been associated with withdrawal behaviour in nursing home residents. Finally, the availability and quality of activity programs contributed to resident engagement. (Kolanowski et al., 2006, p. 15)

The view of ageing bodies as dependent and incapable long held by care institutions has resulted in learned helplessness and instrumental passivity (Voelkl, 1986). Such views have also given rise to what Baltes and Wahl (1992) referred to as dependence-script. This script, as Coudin and Alexopoulos (2010, p.517) explains:

describes systematic pattern of interactions between older people and others (e.g., staff members) where dependent behaviours on activities of daily living such as being dressed or fed are generally attended to and treated as adequate (or expected) behaviours by staff members whereas independent behaviours such as using the toilet or eating are ignored or even discouraged. Therefore, even if an institution's goal or a family's wish is to maintain autonomy, the actual environmental contingencies tend to enhance dependent behaviours. Such a

consistent mapping of social supportive actions upon dependent behaviours is driven by staff members' beliefs that older people are weak and in need of help.

Dependent adults are found to be susceptible to lower motivation, elicit feelings of helplessness and loneliness (Coudin and Alexopoulos, 2010), lower self-esteem (Koch and Webb, 1996) and increase risk of developing cognitive deficits (Rabbitt, 1988).

The biomedical model of care can also engender ageist attitudes and behaviours among staff in care institutions (Lookinland and Anson, 1995, Ryvicker, 2009, Ronch, 2004, Gallagher et al., 2006, Eymard and Douglas, 2012). Ageist attitudes refer to unfair or insensitive treatment inflicted on others due to their age (Tinker, 1995). Ageist attitudes and beliefs have implications for how staff treat and interact with residents, as well as how care is conceptualised, envisioned and delivered. For example, ageist communication by staff towards residents takes the form of patronising and controlling talk and has been shown to diminish both the dignity and the self-esteem of residents (Giles and Gasiorek, 2011). In another instance, Band-Winterstein (2013) revealed how staff's perception of older patients as senile and incompetent, and their paternalistic behaviour has result in physical and emotional neglect (Grant, 1996, Angus and Reeve, 2006, Band-Winterstein, 2013).

The discussions so far have highlighted the unfavourable impact that the biomedical construct of ageing can have on the well-being of nursing home residents. It is also learnt that the focus on the ageing deficit through the biomedical model have resulted in an oversight on the psychosocial aspect of care. The next section will explore the impact of such an oversight on the personal well-being of nursing home residents.

### **2.2.3 The Impact of a Leisure-Impoverished Environment on Personal Well-being of Nursing Home Residents**

Although multi-sensory stimulation is known to benefit residents' physical and cognitive wellness (Cox et al., 2004, Edvardsson, 2008, de Macedo et al., 2015, De Oliveira et al., 2014), many nursing homes continue to be impoverished environments with limited range of leisure choices and opportunities (Volkers and Scherder, 2011, Clark and Bowling, 1990, Timonen and O'Dwyer, 2009, Nolan et al., 1995, Harper Ice,

2002). Life in nursing homes is often perceived to be uneventful by the residents (Tuckett, 2007, Henderson and Vesperi, 1995). Residents were found to be spending a large proportion of their day sitting around, waiting and having little to do, while staff are preoccupied with obligations to fulfil other tasks such as preparing and dispensing medication, attending to administrative work, changing of wound dressing (Gubrium, 1997). Harper Ice (2002), in a study carried out in the US found that little has changed in the amount of time spent by nursing homes residents doing little or nothing as she compared her findings to a similar study performed by Gottesman and Bourestom (1974) twenty-five years earlier. Similarly, another study in North Wales UK, described residents as 'busy doing nothing' given the high level of passivity and lack of interaction among nursing home residents (Nolan et al., 1995, p.528).

With little to do, residents reported feeling nervous and perceiving a need to fill the void (Gubrium, 1997). Gubrium observed residents had several ways of dealing with their nervousness: they may vocalise their boredom by whining or groaning, develop compulsive actions such as wringing their hands, walking around aimlessly, or seeking attention from staff. With little or no 'time-related obligations' (Gubrium, 1997, p. 169) residents also reported losing their orientation of time's passage:

I lose track of time. I don't know the date. I don't remember the dates. I have no calendar and I don't remember things. I got my watch here. So I try to wind it and look at it, but sometimes I get confused too. It doesn't matter anyway [...] Many times I forgot what day it is. Even this morning I didn't know what day it was. It doesn't make a difference because I don't go out any place.' (Gubrium, 1997, p.171)

The low activity and lack of engagement opportunity is found to engender unfavourable emotional outcomes. Reports of boredom, lethargy, lowered self-esteem and depressive symptoms are common and framed as a result of the passive lifestyle in the nursing home (Harper Ice, 2002, Katz, 2000, Nolan et al., 1995, Choi et al., 2008, Fiveash, 1998). The lack of activity would also imply that opportunities to interact with others are limited resulting in isolation and loneliness (Organ, 2011) which, in some cases, may contribute to poor physical and mental health.

Studies have found that the probability of cognitive decline in older people living in institutional settings is greater than persons living in the community (Winocur and Moscovitch, 1990, Harmand et al., 2014). This unfavourable impact has been

linked to both physical and psychological effects of institutionalisation (Harmand et al., 2014) and the impoverished environment of the nursing home (Choi et al., 2008, Harper Ice, 2002). The progressive decline of everyday function experienced by older adults living in long term residential care put them at risk of developing cognitive impairment, depression and sleep disorders (Martin et al., 2006). Low levels of engagement and inactivity are also associated with loss of physical function and behavioural symptoms (Kolanowski et al., 2006).

A growing body of research has highlighted the limitations of technical care in nursing homes and has called for a need to enhance the lived experience of residents and for nursing homes to address this (Kane, 2001, Kane, 2005, Henderson, 1995, Meyer and Owen, 2008). Such arguments seems to concur with an understanding that although residents may be living with illnesses or disabilities in nursing homes, it does not mean that they are incapable of growth and development and thus not needing continued opportunities and resources to lead more enriched and fulfilled lives. In fact, Bowling (2005, p.3) contends that old age 'also contains many opportunities for positive change and productive functioning, and should not be confused with illness'. When considered through such a perspective, ageing thus may be regarded as an adaptive process with potential opportunity for development and enjoyment regardless of health status. It has also been argued that disability in late life should not be automatically associated with the lack of prospect for living optimally (Brown, 1989, Putnam, 2002, Burke, 2013). Similarly, Barbic et al. (2013) have argued, that regardless of disability or chronic illness, optimal ageing should not be defined solely in terms of the freedom from physical or cognitive decline, but rather in terms of opportunities that enable older adults to secure satisfactory psychological functioning.

In his call for a change in approach to long-term care (LTC) for older persons in the U.S., Kane (2005) provocatively declared that long-term care for older people has been based on the wrong foundation. He remarked that the curative tasks that nursing homes adopted from hospitals have led to the clinical concerns of residents to be prioritised over concern for their quality of life through meaningful activity and social interaction. In doing so, he pressed for nursing homes to maximize the personal goals of residents. In noting the dominance of acute care medical model in the philosophical and operational blueprint of nursing homes, Ronch (2004) questioned its compatibility

and criticised the model for its lack of concern for human development. To that he contends,

This model also represents an equally archaic view of aging and chronic illness as being passively experienced conditions, and subordinates the individual needs of older people (and younger people with chronic illness) to the acute care model of treatment by diagnosis. Such a system is (perhaps unwittingly) predicated on ageist stereotypes of group homogeneity and loss of individuality with advancing years, but more critically the system and its processes are essentially mismatched to the myriad day-to-day needs and years-long length of stay common to most nursing home residents. (Ronch, 2004, p.66)

Bergland and Kirkevold (2001) argue that in order for residents to experience optimal well-being, both physical and psychosocial needs of nursing home residents must be met. Kane (2005, p.14) contends, 'LTC [long-term care] must move from being simply a socially necessary supportive service to one that can enable frailer persons to live out their lives with dignity and comfort, sustaining their abilities as long as feasible.' Noelker and Harel (2001) have pressed for a conceptual shift in long-term care services as necessary for us to humanize long-term care in nursing homes. For them, nursing homes are not simply places that help with maintenance of the self but should also allow and offer possibilities for enhancement.

In their study on the everyday life of residents, Clark and Bowling (1990) highlighted that despite potential negative consequences of life within what Goffman called a total institution (Goffman, 1968), having access to and the resource for recreation, activity and interaction can have positive effects on residents. Nursing home residents who are able to maintain or acquire a sense of control through activities or therapeutic recreations were reported to have improved physical ability, mental alertness and life satisfaction (Voelkl and Nicholson, 1992). Given the residents' needs for a more active lifestyle where they can be physically, cognitively and socially engaged and the limit of nursing homes to provide engagement opportunities, it seems that the multi-sensorial attribute of participatory arts programme might help attend to this gap. What are the benefits of sustaining participation in activity in later life? The next section will briefly explore the implications of sustained activity in old age before turning to focus on the effect of participatory arts engagement on the well-being of older adults.

### **2.3 The Benefits of an Engaged Lifestyle in Late Life**

There are various ideas and models of growing old which affect the way we think about old age, shape our attitude and inform our approach towards people in later life. Amongst the various models, we find deficit and activity models (Reed, 2004). The former emphasise on loss of ability, decline and disengagement while the latter cast ageing in a positive way and encourage sustained activity in old age.

Activity in old age, as Katz (2000, p.2) posits, 'appears to be a universal "good"'. Activity theory in relation to ageing postulates that an engaged lifestyle in later life helps create roles and purpose, and reinforces identity (Litwin and Shiovitz-Ezra, 2006). Studies have indicated that a greater number of activity occurrences can contribute to maintaining or even enhancing the well-being of people in later life by offering opportunities and resources for personal growth and development, self-discovery and finding meaning, regardless of impairment level (Johnson et al., 2013) and health status (Nimrod and Hutchinson, 2010, Hutchinson and Nimrod, 2012). Participation in activity is more than a time-filler for people in late life; it contributes to the well-being by engendering positive emotion, optimism, autonomy, competence in people in later life (Adams et al., 2011).

Leisure activity is known to be a source of stimulation, coping and promotion for well-being among people in late life (Kelly et al., 1986, Nolan et al., 1995). According to Kelly et al. (1986, p.531) 'leisure has a place in the existential development of life's meanings as well as in coping with changes required by external events'. Leisure activity encourages the pursuit of meaningful goals and promotes positive emotions and a changed sense of self (Hood and Carruthers, 2007). A host of gerontological studies has convincingly demonstrated the benefits leisure activities offer to older adults who must cope with illness, loneliness, disability, and trauma (Kleiber et al., 2007, Hood and Carruthers, 2013). Having an engaged lifestyle in late life has found to promote adjustment, resilience and boost morale to cope with life challenging events such as death (Patterson and Carpenter, 1994). Continued engagement in life through leisure helps promote positive outcomes and contributes to enhancing the physical, cognitive, psychological and social well-being of older adults (Cox et al., 2004, Dupuis and Alzheimer, 2008, Patterson and Carpenter, 1994, Vittersø, 2011, Kleiber et al., 2007). An engaged lifestyle enables individuals to maintain skills

and enhance life satisfaction (MacNeil and Teague, 1987, Nimrod, 2011). This in turn sustains health, identity and quality of life (Caldwell, 2005). Indeed, Harper Ice points out that 'activity level in general contributes to life satisfaction, maintenance of cognitive function, physical health, and functional performances' (Harper Ice, 2002, p.346).

Although an engaged lifestyle is known to benefit the well-being and life quality of people in late life, leisure may not be easily attained due to cultural, environmental and personal factors (McGuire and Wade, 1985). As much as health and disability can impinge on leisure behaviour, environment and access to the facilities and resources of leisure also play a key role in determining choice and access. In addition, prejudices, physiological limitations, resources are also influencing factors. The unevenness in the distribution of opportunity and access to leisure resources and technologies has implications for well-being, as well as health outcomes among older adults (Iwasaki, 2007, Hutchinson and Nimrod, 2012).

#### **2.4 Impact of Participatory Arts Activities on Well-being in Late Life**

This section highlights the link between participatory arts and well-being in late life and contextualizes this research within the multidisciplinary field of arts and health research. I begin first by highlighting various favourable contributions participatory arts affords to the well-being of older adults before turning to examine some of the current debates, concerns and limitations surrounding non-therapy based, arts-health practice. In doing so, I identify the areas where my research aims to contribute.

There is an accumulating body of research supporting the positive impact of participatory arts on the well-being of older adults (Castora-Binkley et al., 2010, Flood and Scharer, 2006, Fraser et al., 2014, McLean et al., 2011, Noice et al., 2013). Participatory arts refers to arts initiatives set up by arts practitioners that aim to engage and lead participants to create artwork individually or collaboratively with other participants or with the artist (Almenberg, 2010, Kester, 1985). In doing so, the arts practitioner shares their creative expertise, imparts artistic skills and knowledge to participants and guide participants to realise their creation. Participatory arts is concerned with active involvement in art making rather than observing (Noice et al.,

2013). Participatory arts can exist in a variety of art forms and range from visual arts, performing arts, music and literary (Lally, 2009, Castora-Binkley et al., 2010).

Research to evaluate the impacts of participatory arts have been conducted using qualitative, quantitative and mixed method approaches (Fraser et al., 2014, Bungay and Vella-Burrows, 2013). Given its ability to provide understandings and insights through the meanings that individuals give to the phenomena occurring in their everyday setting (Creswell, 1998), qualitative methods are increasingly being mobilized and appreciated in health-related research (Todres et al., 2009, Morse, 2012). Some of the qualitative methodologies used to evaluate the impact of participatory arts include case study (Atkinson and Robson, 2012, Atkinson and Scott, 2015), participatory action research (Vogelpoel, 2012), ethnography (Raw, 2014) and Interpretive Phenomenological Analysis (Lawson et al., 2014). The research methods commonly used by researchers include observations, interviews and focus groups. Although existing literatures have shaped understanding on the benefits of participatory arts, the majority of existing studies were conducted by researchers from non artistic field such as humanities, social sciences (Cohen et al., 2006a, Matarasso, 1997, Atkinson and Robson, 2012) with the exception of art therapy (Slayton et al., 2010). Research contributions from art practitioners to evaluate the impact of participatory arts and to provide critical reflection on the practice are currently limited (Vogelpoel, 2012). The limited contributions by arts practitioners can be linked to the lack of established methodology and knowledge to conduct systematic research within the artistic field. Thus, a part of this research aims to develop a methodology that will enable an art practitioner to systematically gather data for use to evaluate the impact of participatory arts on participants, as well as to critically reflect on the manner through which well-being emerges from participatory arts engagements.

Participation in the arts is found to promote learning, personal growth and development, and sociability (Matarasso, 1997). Participating in the arts in old age is found to promote brain plasticity, foster social engagement, offer sense of control, and even have positive impact on the immunity of older adults (Cohen, 2006). In a longitudinal multi-site research on creativity and ageing, Cohen et al. (2006a) examined the impact of a professionally conducted community-based cultural programme on 166 adults aged 65 and older living in communities in three

geographical locations in the US. The participatory arts programme involved a range of activities such as painting, writing, poetry, choral singing. The study reported several health benefits to older adults from the creative engagement in the arts: enhanced mental health and lower depressive symptoms through diminishing loneliness and enhancing the morale of participants; a lower rate of doctor visits, reduced medication usage and fewer falls through the promotion of physical health.

The benefits of engaging in creative art activities is not only limited to healthy older adults, but is also capable of empowering the elderly at the end of life (La Cour et al., 2007, Walter, 2012). Creative art activities have enabled those seniors who are terminally ill to establish alternative ways to remain engaged in life and activity, and are found to ease life in proximity to death (La Cour et al., 2007). Creative art activities also offer those terminally ill momentary respite from their sick role and lead them to see, discover and realise latent capacities and potential despite their ailment (Walter, 2012) thereby energizing the sick, alleviating pain, promoting positive emotions, presenting opportunities for the expression of feelings and enhancing a sense of self-identity (Reynolds and Prior, 2006, Heywood, 2003, Bailey, 1997).

The growing body of evidence surrounding the benefits and positive impact of arts engagement among older adults (Cohen, 2009, McLean et al., 2011, Carr et al., 2009, Castora-Binkley et al., 2010, Cutler, 2009, Noice et al., 2013, Patteson, 2013, Cohen, 2006, Cohen et al., 2006a) has inspired and encouraged the implementation of arts programmes in nursing homes (Cutler et al., 2011, Fraser et al., 2014, Martin et al., 2004, Fritsch et al., 2009, Rollins, 2013). While a growing body of research has demonstrated the benefits and positive impact of participatory arts engagement on older people living in institutional care settings (Carruth, 1997, Rydholm, 2011, Rafidi, 2009, Ferguson and Goosman, 1991, Cour et al., 2005, Doric-Henry, 1997), most research conducted stems from therapy-orientated practice such as art therapy, music therapy and occupational therapy that often draw on a psychological perspective. Consideration for the transformation process, that is, how such impacts arise and are afforded through non-therapy oriented practice such as arts-health practice, has received little attention or exploration in the nursing home.

## 2.5 Current Understandings of the Impact of the Arts on Health and its Gaps

Most of the current exploration and knowledge on the benefits of participatory arts activity largely look inwards, and have a strong focus on evaluating the psychological or physiological processes and impact. Participation in the creative arts may momentarily consume the consciousness of individuals, freeing them from self-consciousness and displacing them from their present reality; this state, as induced by arts engagement has been called the flow state in the influential work of Csikszentmihalyi (1997). The feeling of contented absorption in an activity experienced in a flow state is found to be beneficial to break patterns of thinking or introduce new possibilities such as diverting mental focus from negative thoughts and promote a feeling of aliveness (Reynolds and Prior, 2006). From a positive psychology perspective, making art in itself can engender a sense of accomplishment and fulfilment gained from experiencing personal growth, thus, arts participation can be seen as potentially health promoting (Swindells et al., 2013). Lastly, from a biopsychological perspective, art making is found to stimulate the brain by means of cortical arousal through which pleasure is derived (Runco, 2014).

While these understandings enable us to advance understanding about psychological health impact engendered by participatory arts, observers of arts and health have noted a general lack of theorisation and limited explanatory framework for the well-being fostering process engendered by participatory arts particularly among non-therapy oriented arts engagement where health and well-being benefits is found to be equally available (Brodzinski and Munt, 2009, Daykin et al., 2007, Raw et al., 2011). Atkinson and Robson (2012) argued that the focus on psychological processes and impact have resulted in a neglect of consideration for social processes and spatial dimensions involved in enabling and shaping a therapeutic experience. Among the limited explorations, Kilroy et al. (2007) developed the 'Model of Transformation Change' to elucidate that transformation of well-being among participants in a participatory arts programme is dependent on several interconnected modalities. The elements include the participants' experience of the art activity and artwork, the relationship between participants and the practitioner, and the atmosphere of the art activity. The flow state induced by the interaction of these elements is understood to have potential to encourage personal development and

create positive qualities of confidence and self-esteem, which in return support the emergence of well-being. Atkinson and Robson (2012) have engaged the concept of liminality (Turner et al., 1983, Van Gennep, 2011) to suggest that well-being is engendered by capacity of art interventions to disrupt habits and routines of the everyday social order by providing an alternative social encounter that destabilises existing structures of thought, action and identity. This is achieved through the introduction of new activities involving different materials and requires different set of actions. The notion of liminality was also engaged by Raw (2013) to explain the process through which well-being emerges from the community based arts activities. The diversionary quality afforded by liminal space is similar to displacing quality found in flow state (Csikszentmihalyi, 1997) as one is absorbed in an activity.

## **2.6 Assemblage as Conceptual and Analytical Tool in Health and Well-being Research**

The concept of assemblage has recently impacted and inspired new understanding of health and well-being (Fox, 2002, Mol, 2002, Fox, 1998, Atkinson, 2013, Duff, 2014, Andrews, 2014). The notion of assemblage emerged from the philosophical work of Deleuze and Guattari (1988) where life and its events are considered as a 'constellation of singularities and traits deducted from the flow-selected, organised and stratified – in such a way as to converge (consistency) artificially and naturally' (Deleuze and Guattari, 1988, p.406). Our experience of the world and aspects of living is afforded and affected by assemblages – encounters with a collection of things (Deleuze and Guattari, 1988). Subjectivity, as Marks (1998, p.1) explained, 'is not a stable given; it is rather a 'collective' subjectivity which is to be produced'. It is composed, shaped and affected by the contingent connections, intermingling and disconnections of elements that may involve human, objects, ideas and practices.

Assemblages are not static or stable; they are constantly evolving and never arriving (Wise, 2005), in process of territorialising and deterritorialising, making and unmaking, intersecting, transforming and creating new trajectories of possibilities (DeLanda, 2006). Contingent encounters engender potential change and, as such, constitute the source for the invention of life and its possibilities. However, the notion

of assemblage emphasises the gathering and dispersion of things, the elements that comprise the assemblage are not random. An assemblage has an identity, expresses a particular characteristic, presents a particular function, affect and effectivity (Wise, 2005); the elements of an assemblage are not merely things, but are things that possess qualities and potentials to invent, endure, change or disrupt lines of flight (DeLanda, 2006). A line of flight is a term developed by Giles Deleuze and Felix Guattari (1988) that refers to an imperceptible possibility of escape from established routines into uncharted space with the possibilities for the emergence of new social and personal states of being. It also alludes to an instant of change when 'a threshold of two paradigms is crossed' (Fournier, 2014, p.121). The original term in French is 'ligne de fuite', where "fuite" connotes the sense of something fleeting, flowing or leaking (Deleuze and Guattari, 1988, p.xvii). Lines of flight are positioned as having the capacity to deterritorialise in that they can disrupt the consistency of power apparatus (Fournier, 2014), 'to undo, to free up, to break out of a system or situation of control, fixity, or repression' (Malatino, 2014, p.138). The sense of getting out of the groove indicated in the notion of lines of flight shares similarity to diversionary attribute of flow state (Csikszentmihalyi, 1997).

Moving beyond understanding health and well-being as states found and bounded within the body, scholars have drawn on the concept of assemblage to offer a more inclusive and fluid understanding through which to elucidate the mechanisms affecting subjective health and well-being and thereby re-approaching it as relational (Williams, 2003, Andrews, 2014, Duff, 2014, Fox, 2002, Atkinson, 2013, Andrews et al., 2014, Mol, 2002). A relational approach views health and well-being as momentary states that are 'situated' (Atkinson, 2013) and constantly 'taking place' (Andrews et al., 2014), co-evolving and co-created (Andrews, 2014). From such a perspective, health and well-being are understood as ever-changing states, interdependent, constituted, afforded and amendable by a network involving the body's relation and its interaction with other bodies, materialities and processes. In this sense, the gain or depletion of subjective health and well-being is understood to be affected by encounters, networks and associations according to the availability of enabling resources (Duff, 2011, Fox, 2002, Fox, 1998). In other words, as much as an assemblage affords the body its capacities, it is also capable of delimiting its capacity for action, feeling and desire.

Capacity of what the body can do shapes and influences health and well-being outcome (Fox, 2012).

A relational and assemblage approach towards health and well-being has also offered scholars in arts and health a tool to elucidate the link between arts and health. Participation in creative activity is recognised for its ability to create lines of flight – escape and change – for people experiencing ill-health by affecting the body's capacity to act, feel or desire (Fox, 2013). When considered through such a perspective, participation in creative activity is understood to have a potential to enable the participant to break away from existing states of ill-health by forging new pathways that enable and engage the individual in new action, movement that could enhance sense of self and the capacity and thereby contribute to their health. This is achieved by activating the body's potential and capacities to act through the connection and interaction of bodies and art material. This health transforming phenomenon has been called the 'Creativity-Assemblage' by Fox (2013, p.498). Given the capability of creative art engagement to augment health, Fox (2013, p.507) argued that '[c]reative production is no longer simply an adjunct to the processes of health care but is an integral component of health and ill-health assemblages'. While Fox's creativity-assemblage theory has usefully draw attention to the network of things such as the art practitioner, participants, art materials, involved in amending the participants' well-being, he had not considered the role of the art practitioner in shaping well-being. The manner which an arts practitioner manages, challenges and negotiates tension inherent in participatory arts activities is understood to have the potential to influence the transformative potential of participatory arts activities (Atkinson and Robson, 2012, Raw, 2013). While the significance of the role of the art practitioner has been raised, there is a current lack of practice framework to guide practitioners in their practice. The lack of practice framework also means that practitioners, like myself, navigate and learn by feeling and figuring things out along the way. Given the proliferation of arts-health practitioner in health care and community settings, there is also an urgent need for a practice framework to better inform arts-health practice (Moss and O'Neill, 2009). What are the global concerns of arts-health practice? What concept might be useful to illustrate the dynamic and contingent process occurring in a participatory art sessions through which well-being emerged? What values might an

arts-health practitioner have that facilitate the emergence of well-being? This research wants to go some way to articulate these concerns.

## **2.7 Towards Critical Arts-Health Practice**

Most arts-health practice is practice-based and lacks a research component. In contrast to the creative therapists who have a formalised approach and established research methodology to evaluate and reflect on the impact of their practice, non-therapy oriented arts-health practice currently lacks a systematic approach (Raw et al., 2011, Castora-Binkley et al., 2010). Apart from addressing the need and importance of training an artist to work comfortably and safely in a health care setting (Moss and O'Neill, 2009), as a arts-health practitioner, I feel what is of equal importance is also the need to formulate and establish a systematic approach in arts-health practice that can facilitate an arts-health practitioner to analyse, reflect and evaluate the implication of a participatory arts-health programme on the participants and/or the settings where such programme occurs.

In comparison to research contributions by researchers from the humanities, social sciences, health sciences and art therapies (Noice et al., 2013, Fraser and al Sayah, 2011, Boydell et al., 2012), contributions by arts-health practitioners to knowledge, debates and discussions in the field of arts and Health to date has been limited and rare (Broderick, 2011, Vogelpoel and Gattenhof, 2013). This scarce contribution can be linked to a lack of knowledge about how to conduct systematic study as the training arts practitioners receive is usually focused on the development of artistic skills. However, this situation is changing. Vogelpoel (2012) as an arts health practitioner, embedded Participatory Action Research (PAR) within a case study. The incorporation of systematic research within an arts-health practice was useful at enabling the arts-health practitioner to evaluate the effect of his creative performing arts programme for youth with disability and reflect on the processes contributing to shaping well-being. Embedding research within arts practices is appreciated for its ability to provide insight, enhance knowledge about the effect of arts practices on people's lives, policies or organisation, and develop practice (Fox and Macpherson, 2015, Leavy, 2009). Following these examples, this study explores a mode of practice-led research (Sullivan, 2009, Smith and Dean, 2009) for arts-health practice to facilitate

systematic study on the effect and processes of arts on health. I wish to term arts-health practice equipped with a systematic approach as critical arts-health practice.

With the increased mobilisation and engagement with non therapy, non-clinically trained artists in varied settings, observers of arts and health have called for a need to establish clearer guidelines and ethics of practice for such a group (Moss and O'Neill, 2009, Jensen, 2014). I want to suggest that critical arts-health practice could contribute to such a need not only to practice, but also expand the practice that enable the arts-health practitioner to carry out research independently, to contribute to embodied practitioners' perspective. In response to the current climate that calls for critical practice among artists engaged in arts-health practice, I wish to propose the emergence of arts-health practice as research, in recognition of the need for rigour, an ethical approach, reflexivity, and to develop a systematic way of inquiry and building 'evidence' by drawing from empirical academic tradition. Such a move, I argue will build criticality among arts-health practitioner and develop 'insider' view and professionalization.

## **2.8 Summary**

This chapter presents the intellectual basis underpinning this research, which examines the ways by which an arts-health practitioner contributes to promote personal well-being of older adults living in a nursing home. Building on a geographical assertion that place matters to physical and emotional health and well-being of older adults, I presented the issues and challenges confronting nursing home residents engendered by a medical model of care. I identified general inactivity and the passive lifestyle a key cause of the unfavourable health and well-being among residents and argued for a need to improve the level of activity for residents. I drew on activity theory of ageing to support my claim for the health and well-being benefit an active lifestyle offer to people in late life.

In considering participatory arts as a mode of intervention to promote health and well-being of residents, I identified the benefit as well as the lack of theorisation on understanding on the health promoting process attributed by participatory arts. In doing so, I also highlighted a lack in conceptual practice framework in Arts-Health

practice and the limitation in current theoretical work on the contribution of the arts on health and well-being.

What are the global concerns of arts-health practice? What concepts might be useful to illustrate the dynamic and contingent process occurring in a participatory art sessions through which well-being emerged? What values might an arts-health practitioner have that facilitate the emergence of well-being? This research aims to attend to these inquiries. The next chapter will present the methods and research design considered to facilitate the intervention and the data gathering process required to gain insight on the way which an arts-health practitioner contribute to amend and foster the personal well-being of older adults in a nursing home.

### 3 Formulating a Critical Arts-Health Practice Methodology

#### 3.1 Research Objectives

The research aim is: to explore how an arts-health practitioner contributes to promoting the personal well-being of nursing home residents through participatory arts programmes. In doing so, I not only investigate the effect of the PVA programme on the participants but am also interested to reflect on the manner in which well-being is afforded through the participatory visual art activities and to identify the broad concerns of arts-health practice that helps promote a more effective and caring arts-health practice. A unique aspect of this research lies in its endeavour to devise a methodology that integrates my participatory arts practice with a systematic research approach. Thus, alongside the delivery of a 12 Week Participatory Visual Arts (PVA) Programme, this research has also embedded an action research approach within a case study design to facilitate the analysis and reflection on my practice.

Week	Activities in the PVA Programme
Exploring Two-Dimensional Art	
1	<b>Fun with Shapes, dots and lines</b> A project using wax-resist technique and word play to explore mark making using a variety of art materials e.g. Water colour, pencil, oil pastels.
2	<b>Spring Time</b> An introductory printing project using everyday objects e.g. rubber stool caps, drinking straws to create artwork based on the theme of blossoming flowers.
3	<b>My Aquarium</b> An introductory foam printing project to create artwork based on the theme of a personal aquarium.
4	<b>Bird Park</b> Continued exploration on foam printing project to create artwork based on the theme of a bird park.
5	<b>Leave Painting – Creating Fishes</b> Project to transform dried leaves into ‘fishes’ using acrylic paints.
Exploring Three-Dimensional Art Medium	
6 - 7	<b>Clay work: Harvesting Mangosteen</b> Introductory project to air-dry clay. Project invited the participants to create small sculptural pieces that resembled the tropical fruit mangosteens.
8 - 9	<b>Clay work: My pet Cat (Making and Painting)</b> Continued exploration on air-dry clay. Project challenged the participants to create more complex shape and form based on the theme of my pet cat.
10 - 11	<b>Clay work: My Aquarium</b> Continued exploration on air-dry clay. Project challenged the participants to create more complex shape and form based on the theme of my aquarium using relief sculpture.
12	<b>Exhibition, End of programme celebration and Presentation of Certificate</b> A mini exhibition was set up at Evercare with an end of programme celebration with staff and residents. Participants of the PVA were presented with a certificate for their participation.

Table 2: Outline of Activities for the 12-Week PVA Programme

*Let's Make Magic with Art Today!* was a PVA programme I designed and conducted for the residents at Evercare. The purpose of the programme was to offer residents access to the arts so as to foster opportunities for growth and development through the acquisition and expression of artistic skill and knowledge. Over 12 weeks, participating residents were introduced to a total of eight creative visual arts projects involving a variety of two-dimensional and three-dimensional medium (see Table 2).

To facilitate the action research aspect of this research, I relied on digital video as a reflexive tool to provide data about my practice (e.g. my actions and the manner in which I interacted with the participants), and also reflection notes that I made after each session to aid analysis and reflection on my practice. Participant observation, interviews, focus groups, a colouring chart and the participants' art work were research methods used to evaluate the impact of my PVA programme on the participants. To detail the decisions taken to arrive at the research design underpinning the project and the specific methods mobilised, this chapter is organised into the following topical subsections: Arts-Health Practice and Research Sensibility, Research Design, Ways of Sensing, Handling and Making Sense of the Data, and Summary.

### **3.2 Arts-Health Practice and Research Sensibility: Ethics, Confidentiality, and Health and Safety**

When undertaking this research, I am aware that ethical issues and challenges may present themselves throughout all stages of research from its design, ethnographic and analytic phase (Hennink et al., 2011). As a researcher, I also need to anticipate potential ethical challenges or circumstances that the research process could pose to my research participants (Flick, 2009). Morse (2012) pointed out that 'Risk assessment, avoidance and alleviation' (Morse, 2012, p. 90-91) are ongoing responsibilities of the researcher throughout the duration of the research. Thus, to avoid causing any harm to the participants in this research, I have taken several measures to ensure their safety, rights, and dignity as persons were not compromised by any action of my research.

Firstly, I attended a one-day Ethics, Health and Safety and training offered by the Geography Department at Durham University to familiarise myself with the

institutional ethical code of conduct for the protection of human subjects of research established by the Belmont Report (United States, 1979). As part of the university adherence to the code of ethics for research on human subjects, a formal research proposal was submitted together with a Health and Safety checklist to the ethic committee of the Geography Department at Durham University for review and approval. My fieldwork commenced following the approval from the ethics committee (see Appendix 1).

Secondly, mindful of the unique setting – a nursing home – that I was entering to implement a PVA programme and to conduct my research, I further prepared myself by consulting specific literature on conducting research in long-term care for advice on ethical concerns (Cleary, 2003, Luff et al., 2011, Cassel, 1988). Through these literatures, I learnt the importance of privacy, informed consent, and the need to pay attention to physical and cognitive fragility while operating in a nursing home. In addition to health and safety matters, the researcher needs to be aware and anticipate potential emotional shifts amongst participants (Morse, 2012). At the same time, there is a need to care and attend to the researcher's own emotional vulnerability to the circumstance and conditions of the participants.

Risk is emergent and on-going in research, including my arts practice, in a care setting (Morse, 2012). Thus as an additional precaution, upon entering the field, I consulted the nursing manager, who was the gatekeeper and an authoritative member of staff in the nursing home, to familiarise myself with the ethical protocol at the nursing home. This initial discussion also enabled me to establish a working protocol with the nursing manager, where I was free to seek clarification and advice when circumstances necessitated. At the outset of the project, I also checked with the nursing manager whether I needed to file a separate ethical clearance through the nursing home. I was informed that this procedure was not required as long as I had approval from my home institution.

It is unorthodox for the methodology section of a thesis to include a discussion on health and safety matters. However, taking into consideration the unique role I am playing in this research, where I am simultaneously a facilitator as well as a researcher, it was key that my present and activities should not compromise the participants' health and safety. Thus, some of the health and safety measures I have taken include:

- 1) Ensuring that I am in good physical health prior to facilitating each session to avoid possibility of cross infection.
- 2) I have ensured that the environment for the art activity is well-lit and well ventilated to provide optimal visibility and circulation and prevent unnecessary strain on the eyes.
- 3) To avoid risk of fall, I have ensured that there is ample space for the participants to move around easily, particularly those who are wheel chair bound or who use walking aids. I also ensured that the activity space is kept tidy and clean. I would check the floor area regularly to ensure that it is free from hazard such as spillage, loose art material. Priority is given to clear any potential fall hazard. I would assist participants to dispose of scrap materials to ensure that they had ample workspace. Unused art materials were also regularly stowed away in portable drawers.
- 4) When the art session was in progress, I would regularly check and also ensure that participants adopted a comfortable position while making their work. This was to avoid any pressure sores or aches as a result of bad posture.
- 5) At the end of each art session, I would wash and wipe down all tools and working surfaces.

Lastly, my previous experience of working with the older adults as an artist in a nursing home also contributed to my aim to adopt a continual situated awareness and reflexivity in both my practice and my research.

### **3.2.1 Anonymity and Confidentiality**

To ensure that my participants' identity and safety were not compromised as a result of their involvement in my research, an anonymisation procedure was established at the start of the data collection phase. This involved the creation of a master code list to facilitate the assignment of codes to all the research participants, to anonymise them, as they come through the research. As a protection measure, pseudonyms were created using an online pseudonym generator and assigned to all participants. The participants' codes on the master code list were subsequently

referenced and included when transcribing interviews, naming of files and in writing this thesis. All names of people, except mine, and name of places appearing in this thesis have been anonymised.

Care was also exercised to maintain confidentiality when handling and processing the research data. Access to the research data was strictly restricted to myself; however, when the need for triangulation and validity arose, limited relevant data were disclosed to my two supervisors to gather their inputs. The master code list was stored on a password protected personal laptop dedicated to this research.

I avoided labelling my research folders and journals with obvious names such as research notes or research documents. When those materials were not in use I would ensure that they were kept in a lockable cabinet designated for use to store these materials. In addition to the empirical data, the artwork by participants also constituted a part of the data corpus. To ensure that confidentiality of those artworks was not overlooked, an arrangement was made with the physiotherapist to allocate a shelf in the secured recreation unit to temporarily store the art pieces before they were photographed at the end of the 12-Week PVA programme. As a protection measure, the digital files of the participants' artworks were anonymised according to the codes assigned to the participants on the master list. Those digital copies of the artworks were kept in my password secured personal laptop. The original artworks were released and returned to the participants at the end of this research.

### **3.3 Research Design**

To address my research aim to explore the ways in which arts-health practitioners contribute to the personal well-being of residents in a nursing home through participatory visual arts programme, the research design needs to provide detailed documentation of the processes occurring within an arts programme, the daily routines of the nursing home, and the first-hand accounts of those directly involved with the programme. In effect, the research design needs to allow the documentation of the assemblage of the arts health programme and its emergent features. The case study design allows for the thick description necessary to build the necessary data-set to address the aim and the research questions. However, given the research aim's focus on the role of the arts-health practitioner, this particular case

study is also an action-research case study based on a visual arts programme run by the arts-health practitioner-researcher in one nursing home in Singapore. Action research aims to fuse ‘action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concerns to people, and more generally the flourishing of individual persons and their communities’ (Reason and Bradbury, 2001, p.1).

A case study is concerned with examining the phenomenon of interest as it occurs within a real-world setting and the contextual conditions and complexity evolving between the phenomenon and the setting of the case (Yin, 2003). A case study is particularly well suited to study unusual events or interventions occurring in a bounded system (Yin, 2003). The bounded system – otherwise also known as the case – could refer to ‘a person, organization, behavioural condition, event, or other social phenomenon’ (Yin, 2003) and could be bounded by any or all of physical, social, historical or economic criteria (Creswell, 1998). Thus, the case is bounded by time and place, and forms the main unit of analysis (Creswell, 1998). As such, the case study enables attention to be focussed on all of the following: the interactions of the arts-health practitioner, the arts programme, the participants, the participants’ well-being and the setting of the nursing home as conceived of as an assemblage. A case study enables answers to research that attends to descriptive or explanatory questions such as what is happening or has happened, or how or why did something happen (Yin, 2003). The data collected through a case study design aim to provide in-depth understanding which is often achieved by using an array of information gathered from multiple research methods (Creswell, 1998) and which are described for this research project in later sections of this chapter.

The approach of the case study offers researchers a degree of flexibility in the form of the research. It can be applied to study a single case unit of analysis – *the holistic case*, or multiple units of analysis – *the embedded subcases*, occurring at a single or at multiple sites (Yin, 2013). This research is designed as an explanatory, single-site, embedded case study of a visual arts programme in one Singaporean nursing home, through which to explore in detail the multiple interactions of the arts-health practice assemblage. However, unusually my study comprises two units of analysis: 1) The role of the arts-health practitioner in prompting the processes that

enhance well-being, and 2) The effect of a participatory visual arts programme on participants (see Figure 1). The data collected within this action-research case study are qualitative in nature. In particular, the research accords value to the experiences, impressions, and opinions of individuals who were involved with my participatory visual arts activities in the nursing home, which can shape our understanding of phenomena.

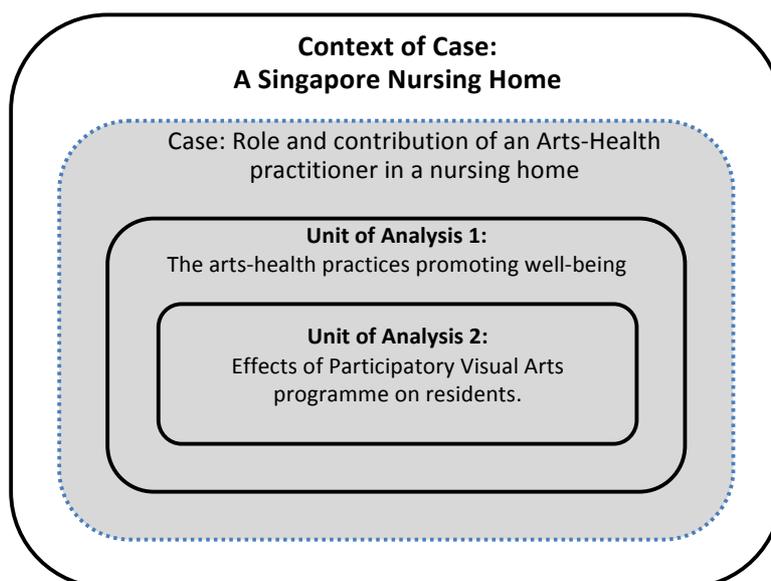


Figure 1. Research Design of current Case Study

When undertaken carefully, qualitative research can effectively give voice, create visibility or even influence changes to the life and lived experience of people in specific locales and situations which are interconnected to structural resources, constraints and rules (Hay, 2000). Through an ‘interpretive, naturalistic approach’ (Denzin and Lincoln, 2000, p.2), qualitative research brings understandings and insights through the meanings that individuals give to the phenomena occurring in their everyday setting (Creswell, 1998).

Qualitative research has been used to identify and understand the complex relations, underlying tensions and conflicting circumstances linked to health and its inequity including care needs in nursing homes (Schenk et al., 2013), experiences of illness and care in nursing homes (Nolan et al., 1996) or evidence-based practice for end of life care (Pleschberger et al., 2011). Given the attention to the first-hand

accounts of experience, qualitative methods are increasingly being mobilized and appreciated in health-related research (Todres et al., 2009, Morse, 2012). Qualitative research has been used to describe experiences, identify concepts, construct theory, examine therapeutic relationships, improve the administration of care and evaluate care outcomes (Morse, 2012). For Morse (2012), the sensitivity and attention to the human dimension of illness and caring through a qualitative health inquiry asserts a social and moral imperative to humanise health care.

The following section will explain the process I undertook to access the case study site. This will be followed by a description of the research participants and my recruitment strategy. Various research methods were employed to gather data from the different informants, which are presented in Section 3.8, 'Ways of Sensing'. My approaches to data analysis are presented in Section 3.12, 'Making Sense of the Data'.

### **3.4 Accessing the Case Study Site**

The context of this case study was a nursing home in Singapore operated by a Non-Profit Voluntary Welfare Organization (VWO). I shall use 'the facility', 'the home' or 'the field' interchangeably when referring to the nursing home throughout this thesis. The journey to identify and secure a nursing home to participate in this research was one with several turns. The Agency for Integrated Care (AIC) is the prime organisation overseeing development of the Long-Term Care sector in Singapore and, as such, was a key resource to find and shortlist potential nursing homes for participation in this research. I began by approaching AIC in January 2014 to seek their recommendation for a lead to prospective participating nursing homes. However, progress to secure a prospective lead through this channel became a concern when subsequent discussions with AIC grew intermittent. To avoid deviation from the original project milestone to secure access to the field within the first quarter of the year, I sought alternative routes to make contact.

In a serendipitous and yet timely manner, a close friend who is a hospital nurse, happened to ask if I was still looking for a nursing home to participate in the research. Through her contacts, she identified a lead to a prospective nursing home. Initial contact with the prospective nursing home via a phone call to Agnes, the nursing manager, resulted in an introductory meeting within a week at which I presented my

research and intended work plan. To my surprise, Agnes did not require any persuasion; on the contrary, she was receptive and appreciative of my research endeavour. Thus, access to the field was granted immediately at the end of our meeting and I came to appreciate how, when undertaking research, serendipity can be absolutely crucial.

Phases of Research and Purpose	Period	Activities and Participants
<p><b>Phase One</b> Pre-Implementation of Participatory Visual Arts Programme.</p> <p><b>Purpose:</b> To understand daily life and activities in nursing home.</p>	<p>Apr – May 2014</p>	<p><b>Activities:</b> Participant observation as a volunteer in the recreation unit, interviewing staff and residents on their opinions and views of daily life in the nursing home.</p> <p><b>Participants:</b> Residents and Staff who are highly involved in the provision and delivering of daily recreational activity and care to the residents.</p>
<p><b>Phase Two</b> Implementation of Participatory Visual Arts Programme.</p> <p><b>Purpose:</b> Delivery of 12-Week Participatory Visual Arts Programme.</p>	<p>Jun – Aug 2014</p>	<p><b>Activities:</b> Facilitate weekly Participatory Visual Arts-Health sessions, Field note taking, Video of participatory visual arts session.</p> <p><b>Participants:</b> Selected Nursing home residents for Participatory Visual Arts programme.</p>
<p><b>Phase Three</b> Post-Implementation of Participatory Visual Arts Programme.</p> <p><b>Purpose:</b> To understand contribution of Arts-Health practitioner.</p>	<p>Aug – Dec 2014</p>	<p><b>Activities:</b> Semi-structured Interviews and focus group discussion.</p> <p><b>Participants:</b> Selected Nursing home residents for Participatory Visual Arts programme and staff who are highly involved in the provision and delivering of daily recreational activity and care to the residents.</p>

Table 3. Three Phases of Research

### 3.5 Recruitment of Participants for the Research

The fieldwork proper commenced at the end of March 2014 after I received a formal letter of agreement from the nursing home. The research took place over nine months starting from April 2014 to December 2014. It was organised into three phases: i) Pre-Implementation of a Participatory Visual Arts Programme (Phase One), ii) Implementation of a Participatory Visual Arts Programme (Phase Two), and iii) Post-Implementation of a Participatory Visual Arts Programme (Phase Three) (see Table 3).

Although the purposes, types of activities, and informants were distinct in the three phases, data from those phases were interrelated and jointly contributed to address the research aim.

### 3.6 Research Participants

The different constituencies of people involved with the arts-health action research in the nursing home were the arts-health programme participants, staff who were highly involved in the provision and delivering of daily recreational activities and care and other residents of the home not participating in the arts programme (see Table 4).

Research Participants	
a.	Residents participating in the 12-Week Participatory Arts Programme (n=10)
b.	Care staff at the Nursing Home (Nursing Manager (n=1), physiotherapist (n=1), therapist aides (n=5), and care staff in wards (n=7))
c.	Residents who did not participate in the Participatory Arts Programme (n=4)
d.	The arts-health Practitioner (n=1)

Table 4. Research Participants

The staff involved in recreational activities and care were relevant in providing a rounded understanding on the effect of my participatory art activities and actions and its contribution towards the personal well-being of participants. The nursing manager, the physiotherapist (PT), therapy aides and care staff in the residents' wards were identified as meaningful participants based on a selection criteria that considered the frequency of the staff's contact and their familiarity with the residents. While the primary aim of the research was to study how arts-health practice promotes the well-being of nursing home residents, it was essential to obtain a wider understanding of the experiences of daily life in the nursing home within which the participatory visual arts programme was implemented. With this in mind, residents at the nursing home who were not participants in my programme were also recruited to elicit their experiences and opinions about their daily lives. Lastly, I recognised that as a practitioner-researcher, I am also a participant in the world that I am researching; the researcher 'is included in, rather than outside, the body of their own research' (Steier,

1991, p.2). Given this embodied circumstance, I am also a participant in the research and part of the data triangulation matrix.

In this discussion, I have identified participants of my Participatory Visual Arts programme, the nursing manager, the physiotherapist, therapy Aides, care staff in the residents' wards and non-participating residents as informants of the research. I will next proceed to discuss the recruitment procedure my informants for the research in the preceding section.

### **3.6.1 Sampling and Recruitment**

Various sampling strategies are available for a researcher to consider whilst conducting research in a long term care setting (Cleary, 2003). Due to my initial lack of familiarity and knowledge about the research setting, I felt it was useful for me to consult with the nursing manager on recruiting procedures while planning for recruitment of research participants. This measure served two purposes. Firstly, I wanted to minimise any inconveniences and avoid unnecessary disruptions to the work routine of my gatekeeper. Secondly, and more importantly, I wanted to ensure that the sampling approach I had in mind did not compromise the personal safety of participants or infringe ethical practice. While doing this, I am also mindful of the prospect of obtaining corroborated evidence (Yin, 2003) where the informants may be asked to provide a scripted response. However, gathering from our agreement on the recruitment procedure and the data obtained, corroborated evidence did not appear to be a matter of concern to this research. Several sampling techniques were used in different phases of the study to facilitate my data gathering. Snowball (Marshall, 1996) and convenience (Miles and Huberman, 1984) sampling were used in Phase one, while purposive sampling was used in Phase Two and Three. The following sections will elaborate on these techniques and discuss the recruitment procedure undertaken in the three research phases.

### **3.6.2 Recruitment of Participants for Phase One**

Phase One of this research sought to understand the daily activities and life of residents at the participating nursing home. In appreciating their embodied experience of life in the nursing home, the staff in charge of daily recreational activities and the

residents were identified as the most relevant and meaningful data source for this research phase. Staff were recruited using a snowball strategy (Marshall, 1996) with assistance from Agnes, the nursing manager, while the nursing home residents were recruited by means of convenience sampling as explained below (Miles and Huberman, 1984).

The recreation unit at the nursing home is managed by physiotherapy and occupational therapy staff who conduct physical exercises and cognitive stimulating activities for residents. On my first visit, Agnes, the nursing manager advised that the most efficient way to obtain an overview of the recreational schedule and activities of the residents would be to station myself at the recreation unit. I took her recommendation and, on my second visit, she introduced me to Susie, the physiotherapist, and I joined the recreation unit as a volunteer. During all introductions to staff, I identified myself as an arts-health practitioner and researcher and explained the purpose of my presence in the nursing home. Through Susie, I met therapist aides, Matthew, Tracy, Jess and Alvin, who were full-time staff, and Lucy, the Occupational Therapist, who was a contract staff employed by the nursing home through a third party service provider. She visits the facility for three days a week to conduct rehabilitative activities with the residents.

As a volunteer in the recreation unit, my responsibility involved receiving residents, keeping the residents company by chatting and motivating the residents while they performed their prescribed physical exercises and assisting staff to transfer residents to various exercising stations. The daily recreational sessions at the recreation unit offered me an opportunity to be acquainted with residents. I would identify myself as an arts-health practitioner and researcher to the residents during our initial meetings. After a few occasions, I approached the group of residents to seek their interest in participating in a formal interview to share their views on their daily activity and life in the nursing home. The selection criteria for participants were their willingness to share their views and their ability to communicate in languages in which I am competent, which are English, Chinese, Teochew or Hokkien (the latter two are Chinese dialects). This opportunity to interact with the residents also allowed me to publicise my participatory visual arts programme and identify potential participants for Phase Two of the research. The interaction was also useful for me to gain a sense of

the general physical profile of residents and to ensure that the planned creative activities were suitably designed for the residents.

### **3.6.3 Recruitment of Participants for Phase Two**

As the research aimed to understand how an arts-health practitioner shapes the personal well-being of nursing home residents, participants of the Participatory Visual Arts (PVA) programme were identified as a key group of informants. Phase Two of this research involved conducting a 12-Week PVA programme for a group of residents at the facility. The participants were recruited through purposive sampling (Patton, 2005) assisted by the nursing manager. Due to limited human resource and time constraints, the PVA programme was only able to cater to interested residents who were ambulant. As part of the selection criteria, participants need to be willing to participate in an interview and able to converse in one of the research languages (English, Mandarin, Teochew or Hokkien). They need not have previous experience in visual art making.

Participants for the programme were recruited via two routes. First, I nominated a list of residents who had expressed interest to attend the PVA programme to the nursing manager for her to assess their suitability for participation. Secondly, the nursing manager helped recruitment of participants based on the criteria I provided, which she shared with the ward staff and asked for their recommendations. Due to limited financial, human and time resources, the PVA programme was only able to accommodate 12 participants. However, keeping in mind that my participants are susceptible to ill-health and the normal drop-out rate, 17 residents were recruited to participate in the participatory visual arts programme initially. The number of participants later fell and stabilised at ten participants on the third week of the programme (see Table 5). Reasons for attrition include poor health and lack of interest.

I also requested staff support to be present during the programme to support me. The role of the staff was to ensure safety and comfort of the participants throughout the sessions. I was hoping to recruit three to five staff for this purpose, however, staff were unable to commit to the programme due to their heavy workload.

No.	Participants of the PVA Programme	Gender	Ethnicity	Health Status/ Ability	Language of Interview
1	Alice	F	Chinese	Ambulant but required walking stick. Generally in good health.	Teochew (A Chinese dialect)
2	Betty	F	Chinese	Non-ambulant; Wheel-chair user. Generally in good health. Living with Achondroplasia.	English
3	Clare	F	Chinese	Non-ambulant; Wheel-chair user. Stroke; loss mobility of her.	Mandarin
4	Janice	F	Chinese	Ambulant but required walking stick. Generally in good health.	English
5	Elaine	F	Chinese	Ambulant. Mild mental disability. Generally in good health.	Chinese
6	Julie	F	Chinese	Ambulant. Generally in good health.	Chinese
7	Peter	M	Chinese	Non-ambulant; Wheel-chair user. Generally in good health.	English
8	Joe	M	Chinese	Ambulant but required walking stick. Generally in good health but has weak right arm due to stroke.	Mandarin
9	Freddy	M	Chinese	Non-ambulant. Wheel-chair user. Generally in good health.	Mandarin
10	Charlie	M	Chinese	Non-ambulant. Wheel-chair user. Mild mental disability. Generally in good health.	Hokkien (A Chinese dialect)

Table 5: Participants of the PVA Programme

### 3.6.4 Recruitment of Participants for Phase Three

Phase Three of this research sought to gather experiences and opinions of participants of the PVA programme. Inputs from staff in charge of recreational activity were also sought to triangulate findings about my contribution to promote the personal well-being of residents. To address the need of this research aim, I relied on and approached the participants of the PVA programme and staff that were recruited in Phase One and Two of this research.

### 3.7 Principles of Triangulation

The reality that emerges from a research study is shaped by the types of information obtained by the researcher from participants of the research, as well as the ways the researcher uses to build and interpret the research data (Creswell, 1998). As a arts-health researcher, I am mindful of the assumptions I might possibly make about the field, my prospective research participants and the justifications for our claims to knowledge from our research (Dyson and Brown, 2006). I might have expectations about the benefits of the arts on health, and preconceptions about the daily life and capability of the residents. Similarly, this subjectivity in perspectives and assumptions exists amongst participants of the research. In understanding such dynamics of the embedded issues at play, I considered the principle of Triangulation (Denzin, 1978) by incorporating the use of data triangulation and methodological triangulation (Dyson and Brown, 2006) to enhance robustness, confidence and reliability of the research (Creswell, 1998, Yin, 2013).

For the purpose of fostering an accurate and rounded depiction and understanding of the residents' perceptions of daily life at the nursing home and the impact of my art programme on their well-being, I used multiple sources of data. The multiple sources of data involved in this research were the participants of my art programme, staff who were highly involved in the provision and delivering of daily recreational activities and care, other residents of the home not participating in the art programme and myself. Besides enabling me to validate the impact of daily life at the nursing home and my art programme on the participants' well-being, the opinions I obtained from the multiple sources of data also allowed me to discover relations and gain insights and meanings of events and interactions occurred.

I am aware that my presence in the research setting may result in the Hawthorne effect (Mays and Pope, 1995), which may cause the residents or staff to modify their behaviour and activity in relation to the aims of the research. Yin (2003) for example, cautioned about corroborated evidence that may result from triangulation as research participants echo 'the same institutional "mantra," developed over time for speaking with outsiders (such as researchers or media representatives)' (Yin, 2003, p.13). I am mindful of possible dressed-up routine and customised responses by research participants, which can result inaccurate

impressions. For example, staff may 'step up' on their attitude when interacting with residents or add activities as a result of my presence in the nursing home.

To minimise inaccuracy, I relied on methodological triangulation to build my research data. For example, the convergence of different data and perspectives I obtained from various methods such as interviews with residents, focus groups with staff and my personal observations helped validate, verify and provided a balanced understanding about daily life at the nursing home and the impact of my art programme. The use of multiple methods also helped enhance the sensitivity and reliability of the research. For example, video recordings of the participants' experience of the creative art process can corroborate with participants' opinions gathered from interviews to provide detailed video sequences of the participants' actions and responses.

Besides providing resources for validating purposes, the use of several data collection methods also helped to supplement and broaden information, and lent insights to the meanings of events, offered details and lent understanding to the reactions to interactions among people, materials and processes that occurred during research. For example, the video recordings of the atmosphere and processes of the art sessions offered insight and helped unpick the complex and dynamic relations at play during an art session. The ability of video to capture fleeting moments and the unfolding of events led me to take notice of the assemblages of material and processes at play and provided insights into how well-being emerges from an art session. This phenomenon may not be made apparent or succinctly captured by interview for instance.

### **3.8 Ways of Sensing**

The choice of research methods was determined by their relevance to provide meaningful data or 'purposive data making' (Richards, 2009, p.47) with regard to addressing the research questions. Thus to obtain a rounded understanding of how my arts-health practice contributed to promoting the personal well-being of the participants, the research methods employed in this research include: participant observation, semi-structured interviews, focus groups and research journaling. In addition, I also considered and integrated several visual methods (see Table 6).

Research Methods Used in the Study	
a.	Participant Observation
b.	Field notes
c.	Semi-Structured Interviews
d.	Focus Groups
e.	<i>Colour of My Life</i> Colouring Chart
f.	Digital Video
g.	Participants' Artwork

Table 6: List of Research Methods Used in the Study

### 3.8.1 Participant Observation

Relevant data in this research come from my learning about the daily activities and life at the nursing home. This contextual understanding was useful for evaluating my contribution as an arts-health practitioner in the nursing home. For this purpose, I utilised participant observation. Participant observation is a research method that allows researchers to learn about phenomena through observing events and by participating in the daily activities undertaken by people in the research setting (Emerson et al., 2011). While carrying out participant observation, I served as a volunteer at the recreation unit for two months in Phase One of the research. I would spend about seven hours at the nursing home during each observation and was fully involved in the two daily sessions of recreational activities. A total of 17 visits were conducted over two months. My role was to support the recreation staff in receiving and assisting the residents through their daily recreational activities. When I was actively assisting the staff, I observed and made mental notes on the kind of activities that occurred at the recreation unit, the way in which staff conducted activities, and the residents' reaction to the activities. Each activity session lasts for approximately 90 minutes where staff would place and rotate residents around various activity stations such as exercise equipment and puzzles, and would be followed by a group activity to end the session.

As a volunteer, I also had the opportunity to interact with the residents by chatting with them to learn about their opinion of daily life in the nursing home.

During moments when residents have settled into their activities and do not need any assistance, I would take a step back from my participant role to observe the operation of the recreation unit. To minimise the loss of impressions, I would make use of break time between the sessions to jot down points of observation and my thoughts in a pocket-size notepad that I kept by my side. As a volunteer, I also had the opportunity to perform the duty of fetching residents from their ward and tidying up the activity area after each session as the staff did. Besides allowing me to realise the hectic and laborious nature of the staff's duties, the participant observation process also enabled me to obtain impressions of residents' recreation choices and their opinion of life in the nursing home.

At the end of each observation session, I would take time to write my field notes (Ponterotto, 2006) at the lobby to record my observations, feelings and reflection in form of 'Thick description'. Thick descriptions (Geertz, 1994) are 'truth like statements that produce for readers the feeling that they have experienced, or could experience, the events being described' (Denzin, 2001, p. 83-84). When writing my field notes and research journal, I took care to ensure that identifiable names were not recorded in the memo. When required, names of informants were initially abbreviated according to the first letter of their first names and their role e.g. Irene - a resident would be abbreviated as IR and Charles – a staff would be connoted by CS. These abbreviations were further assigned with codes based on a master code list.

### **3.8.2 Semi-Structured Interviews**

As a research tool, the interview is appreciated for its ability to gather data on experiences and viewpoints of individuals in their everyday settings; Its strength lies in its sensitivity to provide factual, descriptive information, as well as, disclosing nuances of the meanings participants attached to particular situations in their lived, everyday world (Kvale, 2007). When conducted carefully, data from interviews can provide thick and rich data (Creswell, 1998) that lends insight into people's beliefs, motivations, emotions and perceptions of their situated circumstance (Hennink et al., 2011). Interviews are often integrated into research to supplement information with data to which other methods might not be able to access (Turner III, 2010). The unique set of information attained through interviews can help a researcher to establish a well-

rounded data-set and enrich analysis by offering embodied perspectives, details and depths. Informed by these benefits, interviewing was regarded as a relevant data collection tool that could lend understanding of the contribution my activities and actions as an arts-health practitioner might contribute to promote personal well-being of residents in a nursing home. Among the various interviewing techniques (Flick, 2009), I have chosen to use semi-structured interviews to gather responses from my participants. This particular technique was chosen for its ability to help streamline and develop explicit knowledge from the presuppositions I held prior to interaction with my participants (Flick, 2009). Those interviewed using this method include participants of the PVA programme, the nursing manager and residents who did not participate in the programme. The interview questions are critical to research in a way that they can influence and/or dictate how the interviewees respond and what information is captured (Turner III, 2010). Learning from Hennink et al. (2011), I adopted an iterative approach in designing my interview guides. This iterative process provided useful opportunities for me to reflect, clarify and revise my interview questions and to ensure their coherence and effectiveness in gaining understanding in relation to the research questions and the conceptual framework of the study. The design of the interview questions can have a major impact on the research analysis and its findings and, thus, the researcher needs to constantly be reflective to ensure a process of 'purposive data making' (Richards, 2009). The content, clarity, quality and level of detail of what will or was captured can consequentially affect subsequent analysis and interpretation.

Interview guides (Burgess, 1991) were devised and used to facilitate the interviews. The interview guides aimed to facilitate the collection of data on the following topics of concern to this study:

1. Residents' outlook on their way of life in nursing home.
2. Residents' opinion and impressions of my activities and action as an arts-health practitioner.
3. Staff opinions and impressions of my activities and actions as an arts-health practitioner at the nursing home.

To ensure the effectiveness of my interview questions, I considered several recommendations by Hennink et al. (2011). First, open-ended questions were largely used to encourage my informants to fully express their experiences and opinions. Where possible, I would avoid the use of close-ended questions, which usually limit the breadth of information. Secondly, care was taken to avoid formulating leading questions. Questions were checked to ensure their neutrality by avoiding the use of evocative or judgemental words that could influence and direct interviewees in a particular direction. Thirdly, keeping in mind the age of the residents and the busy schedule for staff, I ran the interview questions by my supervisors and a few elderly relatives to ensure that they were worded simply and clearly.

To maintain an ethical research practice, I had, prior to all interviews, taken time to explain to all my informants the purpose of my research and their involvement. This process was observed to ensure that my informants understood their role and rights while participating in the interview. In addition, I made explicit to them that they could, at any point in the interview, decline participation with no further questions asked, or seek clarification on any uncertainty. Regardless of the informants' background, data collection commenced only after consent was given. For participating staff, consent was sought using a printed consent form, which they signed to indicate their consent to participate. However, for the participating residents, a more elaborate process was required.

Mindful of the potentially vulnerable position of nursing home residents (Cleary, 2003), additional measures were taken to seek clarification with Agnes, the nursing manager, regarding an ethics protocol for the researcher in the nursing home. When I learnt that there was no existing ethics protocol, Agnes and I undertook several steps of review and consent to ensure that the dignity, rights and safety of the participating residents were not compromised. First, a copy of my interview questions for residents was sent to the nursing manager for review and approval. Second, upon reviewing and approval, the nursing manager offered to be a proxy for the residents. This decision was made by the nursing manager to avoid any unnecessary anxiety to the resident caused by requiring them to sign documents. Lastly, to ensure that fully-informed consent is obtained, I proposed and established with the nursing manager that I would seek verbal consent with the participating residents prior to all interviews.

All the interviews were recorded on an SD Card via a digital audio recorder. The raw recordings of the interviews were reviewed at the end of each data collection session to ensure that the interviews were clearly recorded and captured in its entirety. Besides enabling me to obtain a general impression of themes emerging from my data, the review lent opportunity for me to adjust my interview questions and fine-tune my interviews technique. Reviews were carried out after the original audio files were transferred, stored and organised on a password access laptop. Research and data collection is a circular interlinking and spiral process (Creswell, 1998, Glaser and Strauss, 1999, Flick, 2009, Hennink et al., 2011) thus I adopted and maintained a reflexive approach when engaging and thinking about the data collected. The review processes were useful in several ways. First, when necessary, they allowed me to adjust my interview questions to develop more effective topical probes for subsequent interviews with other informants. Secondly, as an inductive and reflexive exercise, listening to the interviews enabled me take notice of the gaps, emerging themes and insights, to help me assess and check the direction of my research. Lastly, the review of the original recording of the interview also provided a reflexive space for me to reflect, refine and improve my interview technique and strategy. The process of transcribing the interview data will be dealt with in more detail in section 3.11.2 'Transcribing audio recordings.'

### **3.8.3 Focus Groups**

In addition to semi-structured interviews, I also held focus group discussions with staff. To minimise inconvenience and avoid any unnecessary disruption to the tight routine and heavy work schedule of staff, focus group discussions offered a practical approach to gather their views on the effects of the PVA programme for the participants. Besides optimising the limited time I had with staff, focus group discussions enable a range of viewpoints and explore the attitudes and issues that are of importance to people. The dynamic evolving from the discussion has the ability to reveal information that may lend new insights not anticipated by the researcher (Kitzinger, 1995). This was carried out in Phase Three following the completion of the 12-Week PVA programme.

### 3.9 Visual Methods

This research also acknowledged the richness and uniqueness that visual material can contribute to our understanding of phenomena (Emmison and Smith, 2000, Leavy, 2009, Stanczak, 2007, Banks, 2001, Cloke et al., 2004, Liamputtong and Rumbold, 2008). Visual artefacts such as drawings (Guillemin, 2004), photographs (Hurworth et al., 2005), and the processes of producing them (Dennis et al., 2009, Baker and Wang, 2006), have been used in qualitative research for varied reasons and in innovative ways. The visual method involved in this research includes: colouring charts, video and the artwork produced by the participants on the PVA programme.

#### 3.9.1 Colouring Charts

An innovative visual method, *Colour of my life* colouring chart (see Figure 2) was devised as one of the data collection strategies. The chart served various purposes.

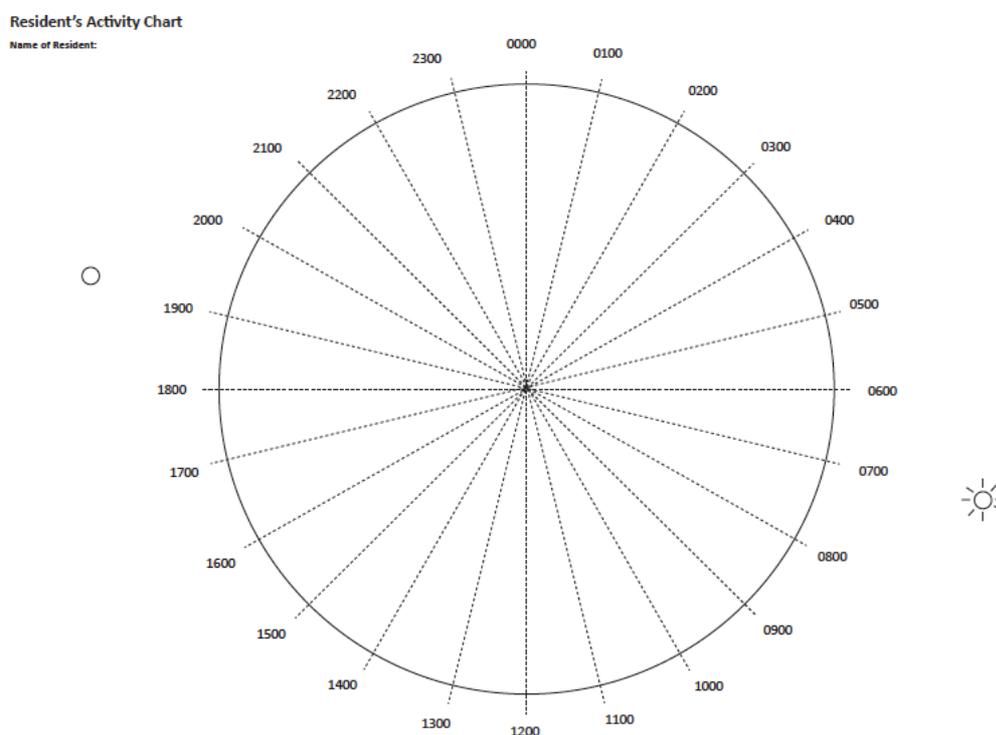


Figure 2. *Colour of My Life* Colouring Chart

First, it was an effective ice-breaker that eased the residents into sharing with me their daily life at the nursing home. At the start of each interview, I would present a blank

chart and a set of colour pencils and invite them to indicate the various activities they were occupied with on a 24-hour schedule. Secondly, it served as a reference point in the interview for me to revisit and follow up on questions and ideas that surfaced during the interview. Lastly, the coloured charts of the residents offered convenient and immediate access to the general pattern constituting the daily life of the residents. A more detailed discussion of this method will be presented in Chapter 4.4 to exemplify how the method helped facilitate empirical findings about the residents' daily life.

### **3.9.2 Digital Video**

A key concern in this research was to address how I would manage the simultaneous role I undertook in Phase Two of this research as an art facilitator and a researcher. On the one hand, as an art facilitator, there were multiple matters that required my attention when delivering a session to ensure its success. Some of the key tasks required of me included: Providing participants my undivided attention when instructing them to ensure that they grasped the project learning and creative objective; When leading the participants through a session, I was also required to constantly attune, assess and respond to the needs and demands emerging from the contingent events unfolding during a sessions to ensure that participants felt supported during the learning and creating process. From time to time, I was required to assist participants in replenishing their supply of art materials; explain or demonstrate techniques and assist participants to resolve technical or conceptual concerns regarding their work.

On the other hand, as a researcher, I was keen to observe the atmosphere of the art sessions, the dynamics and affects emerging from interactions among people, particularly the interactions between the participants and myself as the art facilitator, the interactions between participants, and the participants' reactions and responses to the creating process and materiality. Besides relying on note taking to capture key observations during each session and reflecting on each art session, I also considered the use of video recording as a strategy to minimise potential distractions that could affect my facilitation work.

Video recording is capable of capturing fleeting moments of social life and human interactions to provide a corpus of data for use in relation to a range of analytical interests and theoretical commitments (Heath et al., 2010). A unique feature of video that distinguishes it from other methods lies in its ability to capture visible conduct such as 'gaze, gesture, facial expression or bodily comportment. In addition, it enables the researcher to consider how the ecology of objects, artefact, text, tools and technologies feature in and impact on the action and activity under scrutiny' (Heath et al., 2010, p.7). Video data can be archived, retrieved, and analysed repeatedly.

In appreciating these qualities, video is increasingly used as a research tool to support research that examines situated activities, conduct of individuals and interaction among people (Heath et al., 2010) including in various health-related studies (Forsyth et al., 2009, Pearce et al., 2010, Asan and Montague, 2014, Heath et al., 2010, Iedema et al., 2006, Downing and Tenney, 2008). Through video, observable phenomena can be subject to close and repeated scrutiny; it also offers a varying 'level of granularity' (Haw and Hadfield, 2011, p. 26) by providing macro and micro levels of data that can account for a whole event by microseconds of happening. In this research, digital video was used as an extractive and reflective tool (Haw and Hadfield, 2011) to aid the study of the affectual phenomena resulting from my activities and actions during the PVA programme. These emerged from the complex relations and interactions involving the participants, myself as the arts-health practitioner and the materiality of both the setting and the PVA programme.

Like any other research method, the use of video in research has its own set of ethical, practical and analytical considerations and challenges (Heath et al., 2010). In this research, ethical issues concerning access and consent to use video as part of the PVA programme in the research setting was not a challenge. Approval for the use of video during all participatory visual arts sessions was obtained from the nursing manager prior to the start of the research. To further observe ethical practice, verbal consent was sought from participants as they arrived to attend the weekly programme.

In this research, the main challenges I encountered while using video were practical and methodological ones. Equipped with only one digital video camera, some of the challenges I faced concerned the placement of the device, the area of focus and

duration of recordings. The initial video strategy used was based on 'the fixed camera' (Heath et al., 2010) technique. In this technique the camera was placed in a fixed position capturing a single view-point. This strategy provided a consistent view of the stream of actions occurring in the most 'natural' manner possible during the art sessions. However, I found that the technique was not effective in offering a rounded view. Thus to optimise and obtain a 'rounded' data collection, I self-devised a time-based fixed camera approach where the camera was rotated around various spots in the venue where the PVA session took place on a 30 minutes basis. To minimise missed opportunities to capture data rich moments, I also devised another strategy that I called action-led video recording, where the video was moved in response to emerging actions. Finally, I also paid attention to the sitting arrangements of the participants to optimise the view while using the camera.

### **3.9.3 Participants' Artwork**

The incorporation of visual artwork as data in qualitative research is not new (Cloke et al., 2004). In this research, the visual art pieces produced by the participants from the 12-Week PVA programme were regarded as a data source. In considering the participants art pieces as data sources, I do not intend to conduct any psychoanalytical examination or interpretation of the residents' artwork. Such intents are the concern of trained professionals in the field of therapy or counselling such as an art therapist or a psychiatrist. This perhaps is an appropriate juncture to refresh our understanding of arts-health practice. Arts-health practice is not therapy; it does not aim to 'treat' but, rather, it endeavours to, in an equal and complementing manner, mobilise participatory arts programme for purpose of promoting health and wellbeing of its participants alongside development of artistic competence, knowledge and skills (Vogelpoel and Gattenhof, 2013). The focus of arts-health practice is on artistic production. In addition, I would like to think that in creating access to participatory art in care settings, the arts-health practice is engaged with the politics and rhetoric of care. It is concerned with the assemblages, technology and power in the manner bodies are cared for and the possibility of places what shapes care. In doing so, it also critically interrogates the assumptions and expectations of ageing and marginalised bodies. Thus, I was interested to use the imaginative and formal qualities of the

participants' artwork to attest the latent creative potential among nursing home residents and their capacity to develop when opportunities arise, in this case, the PVA programme. I hoped participants' artwork, would create agency for nursing home residents to challenge assumptions and expectations about their ability and current care approaches.

### **3.10 Data Saturation and Handling of Data**

The corpus of data produced from this research can be loosely categorised into two formats: physical and digital. The former is comprised of research journal, colouring charts, participants' artwork, while the latter refers to audio recordings, interview transcripts, and video recordings. Informed by principles of data saturation (Guest et al., 2006, Bowen, 2008), data collection for this research was discontinued when no new information or themes emerged from subsequent triangulation of my empirical data. Knowledge from qualitative research resembles 'an intricate fabric' (Creswell, 1998, p. 13) which the researcher constructs from the threads of data gathered, analysed, interpreted and woven together. To help me manage the accumulating data efficiently, I heeded the advice of Coffey and Atkinson (1996) and assumed analysis as an ongoing activity throughout this research. Through an iterative (Flick, 2009) and inductive approach (Hennink et al., 2011), I allowed myself to be immersed in a constant mode of sensing, reflecting and coding/categorizing while going through different phases – Design, Empirical and Analytic cycles – of this research.

Qualitative research is a reflexive exercise (Hennink et al., 2011). Besides promoting efficiency in data handling, this iterative and reflective analytical process also lent and developed my critical sensibility towards the research. This enabled a process of data reduction (Richards, 2009) to occur throughout the research, that is, to decipher the relevant threads of data the research needed and reflect on the most appropriate strategies to adopt in order to build data to support my contribution as an arts-health practitioner towards the personal well-being of the residents. In addition, to help develop my confidence and foster validity of the research, I would periodically update my two supervisors on my research progress via a restricted access online blog, and sought their feedback and advise using Dropbox to facilitate reviews of

documents. Conscientious about ethical considerations, I exercised care to maintain confidentiality in all the data. Efforts were taken to keep physical data in a secured location by keeping them in lockable storage. In addition, I also avoided labelling physical research items such as research folders and journal with obvious names.

### **3.10.1 Handling Of Digital Data**

The second body of data in this research existed in a digital format and also required attention in terms of confidentiality. Digital data produced from the research, such as audio recordings of interviews and audio-visual recording of the PVA sessions, were processed and organised according to the master code list. All audio and audio-visual recordings from the research were recorded on a dedicated 16 GB SD Card. Following each data collection session, the audio or audio-visual data were promptly transferred from the SD card to the two dedicated portable research hard drives. The files were named according to the codes assigned on the master code list. All recordings on the SD Card were deleted as soon as the transferred contents were checked to ensure that they were retrievable and playable from the two portable research hard drives. The hard drives were kept in a lockable cabinet when they were not in use.

Similar to physical data format, digital data are subject to various risks such as loss and damage. As a precaution to minimise the risk of losing data, damage or accidental deletion of files, a back-up routine was established from the start of the research. As a good housekeeping practice, a back-up was performed at least once every fortnight, or more frequently, after a substantial amount of work had been compiled. Copies of data were backed up periodically on two portable hard drives and on a password accessed cloud database in Dropbox. As mentioned above, the two portable hard drives were locked in a cabinet when they were not in use.

### **3.11 Preparation of Data for Analysis**

Before embarking on the analytical phase of this research, several procedures were required to be in place to 'prepare' the raw data to facilitate a more in-depth analysis.

### **3.11.1 Digitizing And Consolidating Raw Data**

Non-digital raw data, such as hand-written field notes and research notes were digitized by scanning and storing them as Adobe PDF files. Research journal entries on my restricted online research blogs were copied and stored as Microsoft Word documents. Lastly, in addition to research notes, the daily activity charts were scanned into digital copies and stored as PDF files on my password secured personal laptop. To maintain confidentiality, the digitized charts were assigned codes established on a master list.

### **3.11.2 Transcribing Audio Recordings**

Another set of data that required preparation for further analysis and study were the raw audio recordings of Interviews and focus group discussions conducted with residents and staff. I personally transcribed all audio recordings from the interviews and focus groups. QuickTime player was used to play back the audio recordings and the transcripts were typed up and stored as Microsoft Word documents. To ensure accuracy when transcribing, each sampling process was repeated at least twice when I was transcribing. On occasions, when the original interviews were conducted in Chinese, Teochew or Hokkien, I would also translate them into English. To check the accuracy of my translation, sections of transcripts and its original audio recordings were presented to a fellow Singaporean PhD student at Durham to provide a check on the translation quality.

Transcribing is an interpretive act involving a complex process of reduction, interpretation and representation (Bailey, 2008). To ensure that the transcripts are readable and meaningful for use in my analysis and interpretation, I have given thought to the level of detail required from the audible data and the manner in which they are represented in written form. According to Sarangi and Roberts (1999), utterances can be crucial and useful when interpreting data. They cue us to the informant's attitude, feelings and emotions and enrich interpretation of the data. Therefore, besides transcribing what was being said in the recorded conversations, attention was also given to note occasions of emphasis, speed, tone of voice, timing and pauses in the conversations (Bailey, 2008).

To facilitate the retrieval and further analysis, time codes were assigned those of these significant moments. I would also annotate on the transcripts using the 'Insert Comment' function on word to note down my impressions and questions. When transcribing, I also took note of contextual details such as the environment where the conversations and the occasion when it occurred. The inclusion of such information in the transcripts greatly facilitated the ease in retrieving contextual information for reference and data triangulation in subsequent interpretation and analysis. The decision to personally transcribe the interviews served several purposes: my familiarity and understanding of the language and its nuances; the mnemonic recollection of the situated circumstance; the immediate access to triangulation with other data.

### **3.12 Making Sense of the Data**

Although data analysis was an ongoing activity in this research, an analytical phase was set aside to permit a more comprehensive analysis and interpretation of the data. To aid my analysis, I purchased and installed the data analysis software NVivo for Mac for use on my personal laptop. The software was useful in assisting me to code and categorise the data. Through this process, Nvivo also lent visibility to emerging themes and shifting trends developing from the research. It also assisted in data reduction.

In analysing and interpreting the data, I took a two cycle approach (Saldaña, 2009) to the coding process and worked inductively, bearing in that making sense of data is a cyclical act (Hennink et al., 2011). I first drew on the strategies devised by Richards (2009) to allow myself to enter and open up the data. The data were skimmed through to obtain a general impression. While listening to participants' responses, I would take note of their tone of voice, speed and emphasis to sense their feelings and conjure ideas about their views on the daily life, recreational choices, and their experience of my art programme. Based on initial impressions of the data, I would assign descriptive coding on Nvivo. Coding refers to 'a word or short phrase that symbolically assign a summative, salient, essence-capturing, and/ or evocative attribute for a portion of language-based or visual data' (Saldaña, 2009). Coding provides the researcher handles to sort, distil and compare data (Charmaz, 2006). As a way to help validate the data, I approached my participants to share with them my

initial interpretation of the data. This process was useful to enable me to ascertain the accuracy of my initial interpretative work and seek further clarification where needed. In addition, I also engaged my two supervisors to review my interpretations and findings.

To enrich the data, memos were created on either Nvivo or in a journal dedicated to record my responses and reflections to the emerging themes. To enable myself to move off the text and engage in a more focused analysis, principles in grounded theory (Strauss and Corbin, 1990, Charmaz, 2006) were drawn on to help me move beyond descriptive learning towards conceptual and analytical interpretation. While doing so, open coding (Strauss and Corbin, 1990) was performed to generate and assign descriptive and topical codes that reflect meanings and interpretive understanding emerging from the data. When coding, I took notice of the types of events and activities, actions, behaviour and words and reflected on what those actions and statements implied, shape or challenge our perceptions (Charmaz, 2006). To facilitate the formulation of concepts from the descriptive codes, I subsequently used Hierarchical Axial coding (Strauss and Corbin, 1990). Hierarchical axial coding involves exploring of the relation between the existing codes and aide formulation of concepts or themes through sorting, categorising and linking descriptive codes. To assure the reliability of coding, selected sections of the code were shared and discussed with my two supervisors.

The unique role that I had as a practitioner-researcher in this study did present some challenges, as well as benefits. First, to address and manage the simultaneous need to conduct my art programme and as well as research, I made use digital video recording as a data capturing strategy to capture the activities and action during the art session. As my participants turn up for the session, I would inform and seek their consent for their participation to be captured by the video. The use of digital video recording was found to be useful in helping me strike a balance and manage the demands of the research as well as the art aspect of the study. With its ability to capture live action, video recording allowed me to fully concentrate on the delivery of my art session and give my undivided attention to my participants. The video recording from each session also usefully provided me the critical distant needed to observe myself in actions during the art session and reflection. Alongside the use of video, the

reflection notes written at the end of each session to aid recollection of my thoughts and feeling about the interaction I had while facilitating a session or interacting with the participants. An advantage of being a practitioner-researcher can be found in my ability to provide first hand account of the attitude, opinions, and the manner I managed the art sessions and participants. However, I am also aware of the unexpected bias that I might have towards my interpretation and analysis of data such as having expectation that my participants will find the PVA programme enjoyable. To minimise such biases, and maintain objectivity, I relied on different data sources and research methods to triangulate and verify my findings for their accuracy. Data sources gathered from the participants of my PVA programme, the staff's opinions and my field notes, through various methods such as participant observation, semi-structured interviews enabled me to compare, determine and validate my interpretation of my findings. In addition, I also engaged my two supervisors to review and comment on my interpretations and findings. Second, as a practitioner–researcher, I was also required to ensure that the logistic requirements for the research and art aspect of the study were met during each session. To manage the logistic demands of the research, I created a checklist for the equipment and materials to aid my preparation for each session. I also made a point to arrive at Evercare early, usually an hour before the session, to set up the equipment and materials required for the research and art aspect of my session.

### **3.12.1 Meeting and Making Sense of Visual Data**

The visual data of this research comprised daily activity charts, the participants' artwork and video recordings. The *Colour of my life* colouring chart and artwork were examined using content analysis (Prosser, 1998). Analysis of the video recordings of the art programme was a little more complex. I undertook a preliminary review of the raw footage as recommended by (Heath et al., 2010) to catalogue a simple description and classification of the material. This was followed by a substantive review to 'find further instances of events and phenomena, so as to enable comparison and to delineate aspects of interactional organisation' (Heath et al., 2010) and an analytic review that 'will involve the review of related data sets in order to find examples of action that appears to reflect similar characteristics ' (Heath et al., 2010). Some of the

questions used to inform the way the videos were assessed were: What did the arts-health practitioner do? How did the participants react or respond to the activity? Was there any interpersonal interaction and if so of what nature?

### **3.12.2 Navigating the Sea of Data**

To help me maintain sight of the unfolding themes and keep track of different threads of thought, I would periodically generate flowcharts and diagrams. I found them useful for two reasons. First, they help lend visibility to unfolding trends in my thoughts and themes emerging from the data. Secondly, they were useful in mapping the turns and shifts occurring as the research developed. Another strategy I used to manage the sea of data was to adopt a file-naming convention when handling and storing digital data. The file names of all the digital data would include, where applicable, information on the Year, Month, Last Name of Author, Activity/ Title. File names would follow the following format and order: YYYY\_MM\_Last Name of Author, Activity/ Title. The use of this file naming convention, to some extent, can be regarded as a coding activity where I had to consider and create a theme for the folders. The digital data were further categorised and stored into folders that were thematically named. For example, audio interviews of participant opinions of the arts-health programme followed the file naming convention and were stored in a folder named 'Interviews\_Opinion on Art Programme\_Participants'.

### **3.13 Summary**

In this chapter, I have deliberated and discussed my research strategy, choice of methods for data collection, ethical and safety considerations, and approaches towards handling and making sense of the data, to weave a methodology for Critical Arts-Health practice that facilitates a systematic exploration on how an arts-health practitioner contributes to promoting the personal well-being of nursing home residents through participatory visual arts programmes.

To facilitate evaluation and reflection on my arts-health practice, I brought my arts-health practice into a novel dialogue methodologically with an action case study approach of social science. To obtain the thick description necessary to build the necessary data-set to address the aim and the research questions, research methods

such as participant observations, semi-structured interviews, focus groups, colouring charts and video were used to provide detailed documentation of the processes taking place within an arts programme, the daily routines of the setting in which the programme takes place and the first-hand accounts of those directly involved with the programme various.

Data collection ceased when no new information or themes emerged from subsequent triangulation of my empirical data. To analyse my data, I took a two cycle coding approach (Saldaña, 2009) following the necessary transcribing process. Based on initial impressions of the data, I would assign descriptive coding on Nvivo. To enable myself to move off the text and engage in a more focused analysis, principles in grounded theory (Strauss and Corbin, 1990, Charmaz, 2006) were drawn on to help me move beyond descriptive learning towards conceptual and analytical interpretation. To facilitate the formulation of concepts from the descriptive codes, I subsequently used Hierarchical Axial coding (Strauss and Corbin, 1990). To assure the reliability of coding, selected sections of the code were shared and discussed with my two supervisors.

In doing so, I also addressed the current lack of systematised research frameworks within arts-health practice that has hindered arts-health practitioners in undertaking independent research that can provide insights into the processes and effect of arts-health practice. I wish to refer to this systematic approach as 'critical arts-health practice'. A systematic approach can offer various advantages for the arts-health practitioner. First, a systematised research framework within arts-health practice can help promote rigour and enhance credibility. The structure rendered by established research design and data collection methods can help generate greater consistency among arts-health practice and facilitate comparison and synthesis across studies.

Secondly, the structure afforded by a systematic approach to arts-health practice can offer the practitioner a consistent set of tools for use to analyse, reflect and evaluate on practice. A systematic approach would also enable arts-health practitioners to capture and demonstrate the impact and value of non-therapy oriented participatory arts engagement for the well-being of participants. The knowledge gained from those processes, can help guide and inform the practice as well as theoretical concepts for arts-health practice. This accumulated knowledge can

also be used to facilitate and inform further comparison and analysis. Thirdly, a systematic approach could help address the growing appetite for knowledge and ways of understanding arts-health practice among arts-health practitioners to advance their practice. A systematic approach also helps foster learning about strength and weakness of collaboration and help partners communicate and grow (Cameron et al., 2013).

I do not intend this approach to be a prescriptive but wish to regard this set of principles and practices as one of the many ways an arts-health practitioner can undertake research. More importantly, moving beyond studying the contribution of the arts-health practitioner in a nursing home through a participatory visual arts programme, this study will also go in some way to reflect on global concerns in arts-health practice and develop a conceptual framework to guide arts-health practice.

## **4 The Colours of My Life – Perception of Daily Life among Residents in a Singapore Nursing Home**

'The way a society structures its long-term care system reflects a variety of beliefs and assumptions.' (Kane, 2005, p.2)

### **4.1 Introduction**

Although research on nursing homes in Singapore is growing, existing studies lack insight into the lived experiences of residents and the implications of current lifestyle arrangements on their personal well-being. The purpose of this chapter is twofold. First, drawing on empirical findings, it offers insight into the little-known lifeworld of residents in a Singapore nursing home. Secondly, through the residents' accounts of their daily life, it highlights the tensions and limitations in lifestyle options offered by the nursing home to residents. In doing so, it discusses how these might constrain the prospects for growth and self-efficacy and impact personal well-being among residents in the nursing home.

What does the environment of a Singapore nursing home look like? What do residents do on a typical day? How do residents feel about the lifestyle of the nursing home? What do those feelings tell us about their life quality in the nursing home? What might be some of the tensions and limitations at play that impinge on residents' prospects of optimal ageing while living in a nursing home? The forthcoming sections attends to these questions by taking the reader through the gates of *Evercare*, a Singapore nursing home, to become acquainted with the daily life of the residents.

### **4.2 Beyond the Gates: The Lifeworld in a Singapore Nursing Home**

Evercare was initially set up as a welfare rest home for the aged sick and destitute. It is managed by a non-profit organisation and relies on funding from the Singapore Ministry of Health and donations from private donors to support its operations. To date, Evercare has undergone several expansions to meet the growing demands for admission. It currently supplies approximately 400 beds; this is a

considerable increase over the 16 beds the home offered when it first opened a few decades ago.

Situated at the periphery of a populated residential estate, the home is a high-rise facility consisting of a two multi-storey buildings where residents reside. The nursing home is equipped with several passenger lifts to assist movement between different floors. There are also covered passageways connecting the two buildings. Besides the resident wards, the facility also houses the following: administrative offices, a main kitchen, a multi-purpose hall, a Physio/Occupational therapy room, storage rooms and several staff dormitories which are located near the residents' wards on each level.

Evercare sits within a fully fenced compound. Access to the compound is mainly through two adjacent gates - a large sliding gate, and a small swing gate - which are located at the side of the compound closest to a street. The entrances are monitored and controlled by two reception staff who work alternate shifts. The gates of Evercare are usually shut. However, they would open occasionally to allow visitors, staff or vehicles to enter or leave the compound.

The profile of staff at Evercare is a culturally diverse one. Apart from the multi-ethnic mix of Chinese, Malay and Indian among the Singaporean staff, Evercare also employs staff from Myanmar, Sri Lanka, the Philippines and China. The care staff are predominantly female and the number of foreign care staff is noticeably higher than the local Singaporeans. Residents are taken care of by the teams of nurses and care aides in their wards. In addition to the care staff in the ward, Evercare has a team of administrators, managers, social workers, cleaners, logistics personnel, drivers and cooks to support its operations. In addition, it also has a Physiotherapy team comprising of one physiotherapist and four therapy aides who see to the recreational needs of the residents.

The health profile of residents at Evercare is mixed. Most residents are non-ambulant persons who require varying degrees of assistance from care staff to attend to their daily needs such as toileting, showering and feeding, while a minority of ambulant residents are entrusted to provide their own self-care. The majority of residents at Evercare are Chinese; there are a few Indians and one Malay resident. Most residents are dressed in the in-house pyjamas. The standardised garment seems

to be useful at enabling staff to spot and distinguish residents in the compound from visitors and staff.

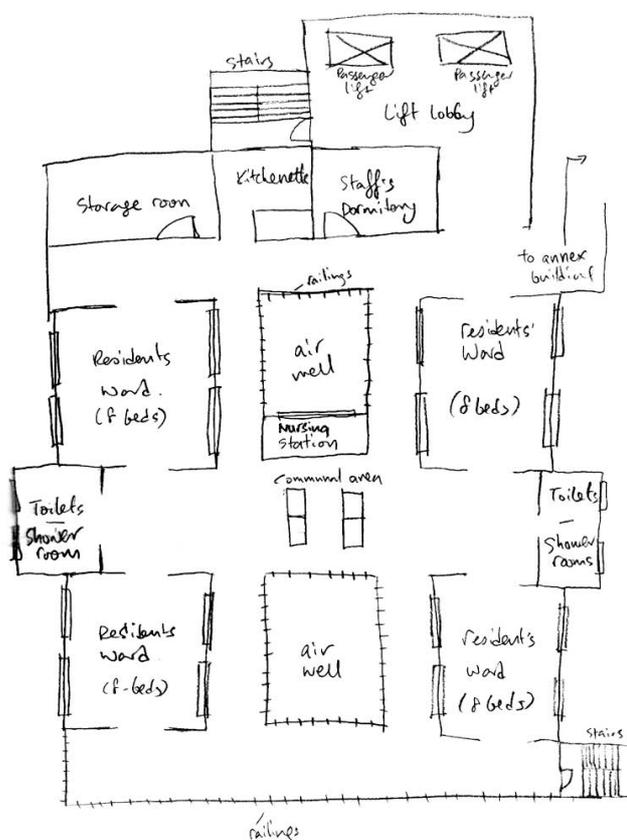


Figure 3. Diagram of Layout for the Residents' Accommodation at Evercare

At Evercare, the residents' accommodation on each level of the multi-storey building comprises of four residents' wards, two toileting and shower areas, a kitchenette, a storage room and a staff dormitory (see Figure 3). There are two air wells that run through the building to help promote ventilation and allow natural light into the residents' living area. The nursing station located at the centre of the accommodation is used by staff to monitor activities in the ward, perform administrative duties, and to prepare medication. The area in front of the nursing station is a communal area furnished with several tables and chairs. The residents would usually sit at the communal area for a change of scene from their ward or to receive their visitors. During meal times, the communal area is double up as a dining area. The corridor along the southern end of the facility looks out at a row of trees and the surrounding residential estate.

The living space for residents at Evercare resembles a general hospital ward. This feature is typical of most, if not all, nursing homes in Singapore. At Evercare, residents reside in a naturally ventilated, 8-bed ward (see Figure 4). Male and female residents occupy different floors in the two multi-storey buildings. The furnishings for the wards are basic. In each ward, one finds eight hospital beds, each accompanied by a waist-high storage cabinet for residents to store their possessions. The personal space for residents is defined informally by the perimeter of their bed frame and storage cabinet.

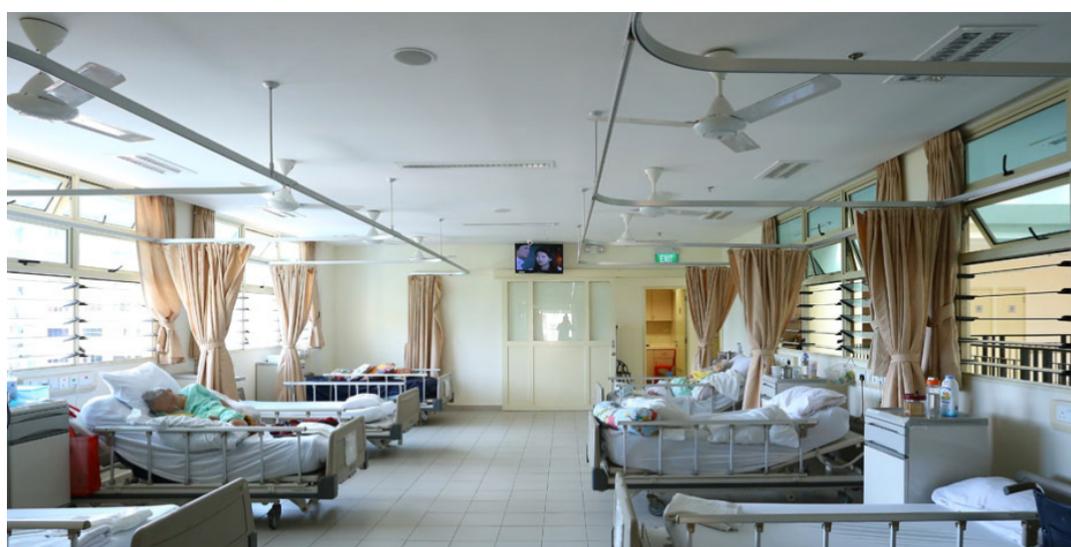


Figure 4. View of a Ward at Evercare

Each ward is equipped with several rotating blade fans to optimise air circulation and to keep the residents cool in the hot and humid Singapore weather. I was particularly struck in the wards at Evercare by the quality of the light, air and the spotless floors. The cream-coloured walls and large panels of lever windows made the place feel bright and airy. In comparison to other nursing homes that I had visited, the lack of smell of urine and disinfectant at Evercare was noteworthy.

Privacy barely exists for residents in this setting. When circumstance necessitates, privacy is temporarily bestowed upon a resident by drawing the set of curtains by their bedside. The curtains are usually drawn when residents require assistance to be changed or to ease themselves, to change their clothing; or when staff need to perform clinical procedures on residents, or when the death of a resident

occurs. Otherwise, the curtains are drawn to one side of the bed, leaving the resident exposed. Although the curtains can enable residents to temporarily reclaim their privacy, they have no means to shield themselves against noise and smells. Despite the high levels of cleanliness at Evercare, the smell of faeces or urine inevitably travels when a resident needs changing by staff.

#### **4.2.1 Challenges of Institutional Living**

From the interviews, residents had in common various daily challenges posed by the environment of Evercare. Noise was a major complaint as the environment of Evercare is far from quiet. The air at Evercare is filled with the drone of the rotating ceiling fans, echoes of sounds from the TV sets in the wards, the intermittent rattling of trolleys, and random episodes of bantering among staff. Occasionally, shouts and wails from residents will punctuate the air and persist for a while until the staff are able to soothe those residents. Snoring, coughing and moaning from ailing residents were also highlighted as sources of disturbance. Some residents commented that the environment of Evercare resembles a zoo or a mental hospital. The uncontrollable noises do affect the residents' ability and quality of rest and also their mood. Joe for example, expressed his frustration towards his fellow residents in his ward:

There are people who disturb others in the middle of the night. The person will sneeze loudly, so loud that the whole ward hears him. That is appalling. He does that day and night, and he will shout whenever he wants with all his might. A lot of people will hear them, not just people in the room. But why? If he is fed up with living, isn't it better that he leave [dies] sooner?

Residents also have to deal with the inconsiderate behaviour of fellow residents. Clare described incidences when her fellow resident would turn off the TV when Clare was watching a programme. In another example, Magdalene spoke about an inconsiderate resident who would turn on the TV in the middle of the night. Besides complaints about fellow residents, residents have also expressed their annoyance at rowdy behaviour by some staff. This would usually occur when staff change shifts, or at night when staff who live in the dormitories have their leisure time. Evercare has staff dormitories in its facility to house some of its foreign staff. As staff dormitories are

located near the residents' wards, the noise of their merry-making has resulted in some resident-staff disputes.

Residents of Evercare spend a substantial amount time within its compound. From the interviews, it appears that having the opportunity to travel out of Evercare is a much desired and prized activity for many residents; however, the prospect for travel out of Evercare is often hard to come by for most. Following admission, the residents are not permitted to leave the compound, unless an arrangement has been made and approved by the management staff. Nonetheless, opportunities for residents to venture out do exist. It appears that their probability of travelling out of Evercare is variably linked to their state of health, individual social resources and institution resources. Ambulant residents seem to enjoy the prospect of travelling out of Evercare more than their non-ambulant counterparts. In addition, a resident's opportunity to travel out also seems to depend on the availability and quality of their relationship with their kin or friends. Residents' accounts suggest that ambulant residents with good social resources are those who most enjoy the prospect of taking time out from life in Evercare. Joe and Alice, for example, are residents who seem to have maintained good social capital.

Joe: I have a lot of friends who visit me frequently. They would take me out for tea on Sundays.

Alice: My younger sister will visit me. She will bring me out on either Saturdays or Sundays.

Apart from these circumstances, other opportunities that enable residents to leave Evercare are limited to staff-organised outings, attending a medical appointment, hospitalisation, requests for transfer or their death.

A feeling of having lost one's freedom is not uncommon in among residents when commenting on their confined lifestyles. The sense of isolation that develops following admission seems to have far-reaching effects on residents' outlook on life. The confined lifestyle seems to smother hope among residents as it exacerbates their sense of debilitation and intensifies a sense of powerlessness. Francis, a non-ambulant resident shares his experience:

Int: Prior to your move to a nursing home, did you have a similar view about it?

Francis: No. I never thought it would be like this.

Int: Hmm...So what was life like prior to your stay in the nursing home?

Francis: Before I came in here, my life was very good outside. I was working. I had my own fun[Mumbles]...my own food.[...] I get to eat whatever I wish. But most importantly, I had money.

Int: Ah...Wealth...ok.

Francis: [Mumbles]...in here, it is useless to have money.

Int: Why is money useless here?

Francis: I can't buy things and I can't go out.

Int: I see.

Francis: It feels like being in a prison...

Int: What makes you feel that way?

Francis: Being in a prison is better than this place. It is very tough.

Int: Why do you feel that this place feels like a prison?

Francis: There is no place to go. It is different when we were living outside. If I wish to go out, go shopping...if I feel like going to the cinema, I go. When I wish to look for friends, I can go look for my friends. In here, everything is not permissible.

Int: In here everything is not permissible? So this makes you feel like being in a prison?

Francis: Yeah...

Int: So are you agreeable that nursing home should feel like a prison? You previously mentioned that life here feels like life in a prison

Francis: What is there to agree to? I don't have a solution to my situation. I resign to life.

Int: Resign to life. Hmm...So let's assume that you are developing a nursing home, what idea might you have for the place to enable elderly to have a better living experience?

Francis: ...Hmm...there is nothing much. Some times, it is like making friends, if one doesn't share commonality on a topic of conversation, it is useless to speak another word.... you see, now we speak in different language...

Int: So imagine if there is an opportunity for you to establish a nursing home, what would you provide for the residents.

Francis: ...I can't think of anything. This is an impossible matter.

Int: An impossible matter? Well, let's assume that there is a possibility. What do you hope for?

Francis: That would not be possible.

Francis's opinion of his life in the nursing home is far from being encouraging. His comments offer us a glimpse of one possible impact of life in a nursing home. His feelings resonate with results found in existing studies that showed that residents feel disenfranchised and acquiescent (Voelkl, 1986, Lieberman, 1969) as a consequence of institutionalisation.

Feelings of loneliness are commonly felt among residents. It could be said that residents are alone in the crowd. The concept of 'alone in the crowd' was first used by Cacioppo et al. (2009) to illustrate the pervading solitude brought on as the result of society's preoccupation with social media. For Turkle (2012), 'alone together' was used instead to describe a similar phenomenon. Although both authors were commenting

on the effect of social media on western society, their analysis on loneliness makes the term useful and appropriate for use to describe the collective loneliness of residents at Evercare. Having said that, I did find a few exceptional cases where residents connect well with each other.

### **4.3 Recreational Opportunities at Evercare**

Recreational activities are occasions when residents have opportunities to meet other residents out of their wards. Recreational activities are mostly provided by the physiotherapy (PT) and the occupational therapy (OT) team. This usually happens from 8.30 am to 10 am or 2 pm to 4 pm on weekdays, and 9 am to 11 am on Saturdays. During these periods, residents are scheduled to attend exercise and activities led by the PT and OT staff. Besides exercising, a handful of residents would hang out at the recreation station to work on puzzles or on colouring sheets. Apart from these formalised activities, Evercare also relied on voluntary groups who occasionally visit to provide one-off cultural performance or recreational activities such as a sing-along session or craft with residents.

At the time of this study, Evercare had engaged an external occupational therapist who visits twice or three times a week to supplement residents' need for recreation. However, I observed that visits by the occupational therapist were irregular and there were days when the occupational therapist did not turn up as planned. Although the occupational therapist informed me that reminiscence activity, bingo sessions, art and crafts and cooking sessions were offered to residents, those sessions were held irregularly. Thus, there seems to be a lack of variety and consistency in the programme offered by the occupational therapist.

Prior to the implementation of my 12-Week participatory visual arts programme, Evercare did offer residents some form of art activity. However, those sessions were often informal, impromptu or one-off sessions. During the observational phase of the research, I observed that staff would occasionally provide a couple of residents colouring sheets to work on during their visit to the recreation unit. Since colouring is not a formalised activity, not many residents were seen engaging with it. For residents who wished to do so, they often carried out the activity alone at a table. Prior to the implementation of my art programme, there was only one bingo session

and a batik colouring session and there was a gap of several weeks between those two activities.

The chapter so far has led us through the gates of a Singapore nursing home and offered snapshots of its physical environment. It has also revealed several characteristics and affects, the physical environment and infrastructure of the nursing home. The characteristics displayed by Evercare in the empirical data hitherto, are similar to the characteristics identified in numerous studies on life in nursing homes including the sense of severance and isolation (Porter et al., 1992, Rowles, 1979) brought on by the confined lifestyle, disenfranchisement (Shin, 2015, Voelkl, 1986, Hersch et al., 2003), lack of privacy (Schenk et al., 2013), low level of social engagement and interaction (Andersson et al., 2007, Tuckett, 2007) and loneliness (Wilson, 1997). This situation roused my curiosity about the daily life of residents in Evercare and prompted a provocative question that is similar to the one Harper Ice (2002) posed in her study of the daily life of nursing home residents in the U.S.: Has anything changed? What is the daily life for residents in a Singapore nursing home? How do residents feel about the lifestyle of the nursing home? What do those feelings tell us about their life quality in the nursing home? To find out, the next section will provide accounts of the lived experience of several residents and their outlook on life in a nursing home.

#### **4.4 Colours of My Life: Accounts and Outlook of Residents' Daily Life at Evercare**

As a way to learn about residents' lived experiences, I used the *Colours of My Life* chart (see Figure 5) that I developed to engage residents to visualise as well as to account their typical day at Evercare. The *Colour of my life* chart depicts a 24-hour cycle that helps visualise the duration and the types of activities a resident engages on a typical day at Evercare. The advantage of this participatory visual method had been discussed briefly in my methodology chapter (see Section 3.9.1). I will now explain in detail how it was used.



through the fixed and two-dimensional surface of the coloured chart, an array of experiences and untold stories were revealed. I am now going onto to explore in more details the colourful lifeworlds of some residents to learn about their daily life and the impact their current lifestyle has on their outlook on life in a nursing home.

#### **4.4.1 The Colours of Joe's Lifeworld: Waiting to get into the *Goal***

Joe is a bespectacled gentleman with a set slightly crooked teeth and greying hair, which is thinning out around the top portion of his head. He comes across as an amicable and outspoken person who is unafraid to speak his mind. His bowed legs gave him a distinctive gait. Prior to his admission, he was staying at a community hospital for over a year following a motor accident that damaged his spinal cord. It left him temporarily incapacitated. He has since been rehabilitated and is able to perform most of his activities for daily living independently except for showering. He has a weak right arm and limps a little. He uses a walking stick to support himself when moving around.

A typical day for Joe at Evercare begins at 6 am. Upon waking, he will meditate while waiting for his turn to be showered by staff. Depending on the efficiency of staff, Joe usually gets his shower within an hour of waiting. According to Joe, showering is a brief and hurried affair that normally lasts no more than 5 minutes. Joe's annoyance about the indelicate showering experience is noticeable as he describes this in a raised voice:

Showers are carried out very quickly...in a slapdash manner. For non-communicative residents, showers may last less than two minutes while for the verbal will take about 5 minutes...they are able to complain. Things are done haphazardly after a shower. They will powder you while you are still wet. Looking at the rate of them using the powder in such manner, I wouldn't be surprised that the powder will run out within a week. They dust the powder on you wildly. And if you need to have cream applied on you, they will squeeze a liberal amount of cream on you; the cream will run out in three days.

Breakfast at Evercare is usually served around 8 am. Joe prefers to take his breakfast at his bed; he does not join his fellow residents for breakfast at the common area outside his ward. The common area is located in front of a nursing station and can sit about 20 residents. Outside mealtimes, the common area becomes a space where residents sit around and a workspace for staff to prepare medication or sort out laundry and other

sundries. The occupational therapist also uses the common area to conduct occasional leisure activities with residents, such as bingo and crafts.

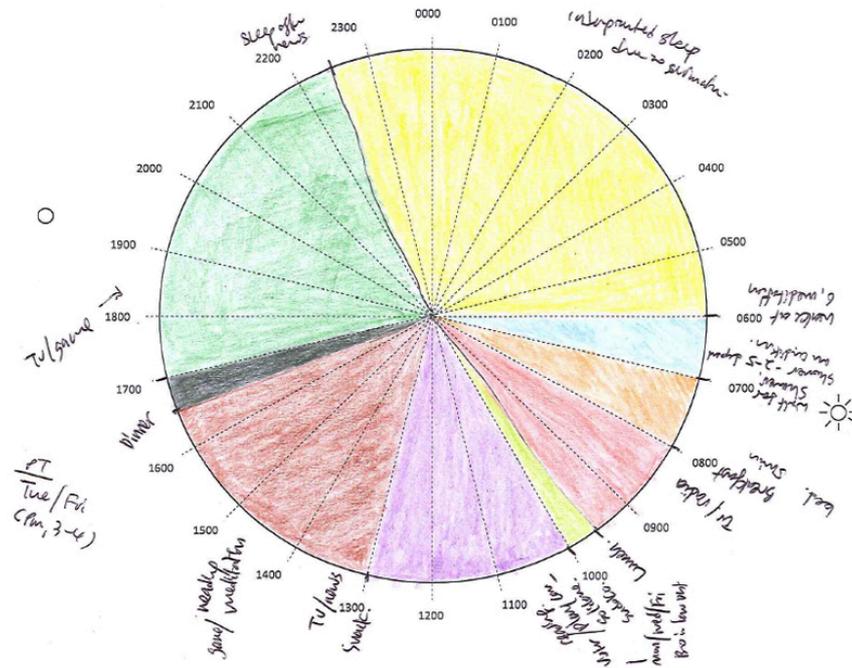


Figure 6. Joe's Colour of My life Chart

Following breakfast, Joe keeps himself occupied by watching TV, listening to the radio, reading and solving Sudoku puzzles. In addition, he will occasionally play computer games on his laptop. I must say, when I first met Joe at his ward, the sight of a laptop on his tray table bewildered me. I had a perception that elderly people of Joe's age tended to have limited exposure to technology, and, indeed, the laptop was an uncommon sight in the nursing home belonging as it did to a resident. I am impressed by Joe's effort and drive to remain up-to-date with the digital world we now inhabit. However, tech-savvy Joe is a rarity among the population of residents at Evercare.

At Evercare, it is not hard to find residents sitting around, gazing into space or lying on their beds with nothing much to do. Joe is one of the few residents, I found, who has devised some personal pursuits to keep themselves occupied and engaged. For a handful who are mobile or are able to wheel themselves around, they may take trips to no-where by roaming around the compound. Most residents remained at their

bed and spent a large amount of their time at their ward. Lunch is usually served at around 10.30 am. Staff would serve residents who require feeding first before proceeding to serve the rest. Once again, Joe takes his lunch at his bed. The lunch period is also a time when Joe receives his visitors. His kin and friends visit him three times a week. They would usually bring food for Joe and eat together. On certain occasions, Joe gets to enjoy a day trip out of Evercare with them. Staff activities around the wards start to slow down slightly after lunch. The atmosphere also felt more relaxed as residents were wheeled back to their wards from the common area. After lunch, most residents would nap upon returning to their wards. Staff also make use of the period after lunch to make their round in the wards to clean the area, change residents, follow-up on administrative work, prepare medication or take care of sundries. The physiotherapy staff would also visit the ward to perform physical therapy for bed-bound residents. While all these are going on, the TV plays in the background. Residents receive a light snack at 1pm.

Besides waiting for mealtimes and for staff to attend to their daily physical needs, scheduled physical exercise is the other activity that residents are certain about and are guaranteed to receive (when their health condition permits). The physical exercise sessions are meant to maintain and promote physical wellness. For two days a week, Joe would head to the physiotherapy department for his exercise. During each visit, Joe usually spends approximately an hour to work on stationary bikes, arm-peddalling machines and arm pulleys. Residents are usually directed to their exercise stations without any general greeting by staff. However, I observed that staff do occasionally exchange pleasantries with a few residents who seem to have good rapport with them.

The physical activity feels almost mechanical. Residents are plugged to various exercise stations and thereafter left alone to carry out their exercise. It was mostly a solitary activity. There was not a main facilitator who would lead them through their exercise programme. Staff would occasionally go up to a resident to prompt them to move. Unlike his non-ambulant counterparts who need to rely on staff to rotate them among the various exercise stations, Joe is free to roam freely. Besides convenience, his mobility also grants him the liberty to exit the programme whenever he feels like. He usually does not stay on for the full programme, which last approximately 90

minutes. He skips the ball tossing and passing activity that staff do with residents in a group at the end of each session. Having made several observations of the exercise sessions, the finale, in my opinion, is rather uninspiring. Residents and staff appear to go through the motions during those sessions. There was hardly any eye contact among residents nor do they seem interested in others. The ball was literally passed from one arm to another. The staleness of the techno tunes that get repeated like a broken record at each session seems to weigh down further the already deadened atmosphere.

As far as participation in institutionally organised activity is concerned, Joe only participates in physiotherapy sessions. He takes no interest in other activities and is critical of residents' motivations and interest to participate in other staff-organised activities such as the occasional cultural events or outings, which are often accompanied by treats. He feels that residents can be ravenous and he does not want to be associated with such behaviour.

- Int: Do you think there is ample activity here for the residents?  
 Joe: If you ask me. Well, I do not participate in their karaoke session. When there are, visitors bring in an event, I too do not participate. When they go for outing, I do not join them.  
 Int: So you do not participate?  
 Joe: So I can't answer your question. As I don't participate so I wouldn't not know if there is enough. But I can tell you that for those who attended, they would complain about the lack of red packet, the lack of gifts. Even if gifts were distributed, you get people complaining about the quality of the gift. They will also complain that the food is not tasty when visiting places. If the food is tasty, they will complain that red packets are not provided.  
 Int: Why are you disinterested in the activity?  
 Joe: Because I do not want to spoil myself.  
 Int: Ah...I see  
 Joe: I will be like them over time. Criticising others.

On afternoons when he is not at the physiotherapy sessions, Joe keeps himself occupied by watching TV, listening to radio programmes, playing computer games and meditation. He hardly naps. These activities would usually be sufficient to keep him occupied till dinner time, which is served daily at 4.30 pm. With the exception of bed-bound residents or those who feel unwell, residents at Evercare gather in its multipurpose hall for dinner. But as usual, Joe prefers to dine alone at his bed and is

allowed to do so. After dinner, Joe usually spends the evening watching TV or playing games on his laptop.

By 5 pm, the environment of Evercare feels very calm as the formal activities of staff finish. As staff and visitors leave the compound of Evercare, the air of Evercare quiets down further but is hardly silent. The murmuring of TVs continues and the wailing of some residents occasionally punctuates the air. Joe normally goes to bed at 10.30 pm after catching the late night news. His sleep does not go undisturbed. He revealed that the condition of his prostate cancer has resulted in a weakened bladder; he wakes a few times to ease himself in the night. And occasionally, he is kept awake by the noise of merry-making emitting from the staff dormitories near his ward.

Joe sees the nursing home as 'a holding place for the elderly to wait for their time to be up, and help them to wrap up the journey.' However, he specifies, one needs to receive a *door gift* from heaven to qualify for entry. Here, he lends an interesting point of view on old age and the finitude of life:

Regardless how strong, fierce or capable one is, every elderly [person] will receive a *door gift* from heaven. The process resembles a lucky draw at a party. Everyone has a lot in the draw; however, the gift remains unknown until one gets picked for us. If the *gift* turns out to be kidney disease, we would suffer from it. Otherwise, it might be other ailments such as Diabetes or Stroke. Those are the door gifts. Once we received them, we await our moment to be sent into the goal. It is inevitable.

Joe's observation of life in Evercare has also led him to realise that dying is rarely a straightforward affair; it is a situation where one has little control over. The wrestle between life and death towards the end of life is often indeterminate. Over the course of his stay, Joe witnessed numerous struggles among fellow residents. He humorously associated the life-death struggle to a game of soccer:

All are waiting for it to happen. If the ball gets into the goal, the person is in [dies]. But if the ball misses the goal, ends up at a hospital for a few days. This process of going back and forth the hospital can drag on for a while until the ball eventually gets sent into the goal. Then it is bye-bye.

Although residents may appear to be doing nothing most of the time, some of them are not entirely passive. Lucid residents are quasi-ethnographers in that they are keen observers of events at the nursing home. Besides surveillance by the CCTV, the

watchful eyes of lucid residents offer another layer of surveillance to monitor staff behaviour. Joe and some other residents disclosed incidents where residents were handed roughly by care staff, although, fortunately, such incidents are infrequent.

Joe is generally satisfied with the quality of Evercare's physical environment. In comparison to other homes he had visited, the quality of Evercare's environment, in his opinion, is of a respectable standard. He described the other homes as being 'very dark and dirty'. Having said that, he felt that there was room for improvement at Evercare. Given the opportunity, he would like to make Evercare and other nursing homes 'more heaven-like'. Some of his suggestions included: introducing more flowering plants, creating more 'shady and cool' outdoor areas for residents to relax in. Spirituality appeared to be a matter of particular interest and significance to Joe; he wished nursing homes could offer spiritual guidance for residents.

Although Joe did point out that the variety of activities at Evercare is limited, he felt that this is a characteristic of nursing homes since the majority of residents are non-ambulant or are likely to be in a vegetative state. For Joe, the need to enliven the experiences of daily living of residents was not necessary; he sees the nursing home as a place of suffering:

In actuality, those bed-ridden residents are simply left with a mouthful of breath. Have you seen those who are in that state? Their eyes are always closed and they just kept breathing. Their eyes may open when you nudge them but will close shortly after. What can you expect from those residents? What do you want them to do? For those, you can criticize me for saying this. In my view, I think it is better for them to go. Don't stay on here. They live to suffer.

He does not expect nursing homes to make exceptional arrangements to accommodate to the needs of the small number of ambulant residents nor those who are still lucid despite other disabilities. The priority of nursing homes for Joe, is to simply ensure that a person receives sufficient care to be kept alive. He expressed:

nursing home is for families who no longer have the capability to take care [of] the person, [...] a place to house them, so that someone can keep watch of the person, they do not fall, if the person is immobile, they can sit on a wheelchair, to prevent him from fall, if they need a shower they get it. These are normal needs, anything more than this is not available. [...Its aim is] to maintain normalcy, as long as residents don't die that is fine. As long as they don't suffer from fall, don't die that is ok. But if they do pass away as a result of old age, then that is alright.

Even though Joe felt that having more activity does more good than harm to residents, he remained sceptical about the participation rate and is doubtful that the package of activities at Evercare would change much in the perceivable future.

#### 4.4.2 The Colours of Magdalene's Lifeworld: Rooted to my Bed

Magdalene, or Mag as I would affectionately call her, is a chubby lady in her late eighties. Her body frame is noticeably larger than most female residents at Evercare. She cheekily compares herself to a 'tortoise'. She keeps a shaved hairdo and exudes an aura of a benevolent grandmother. Unlike Joe, Mag is a non-ambulant resident who has a high level of dependency on staff. Apart from eating, she requires assistance in all aspect of her activities for daily living, including showering, toileting, transferring and grooming. As such, her life is intimately tied to the routine of staff and she is confined to her bed most of the time.

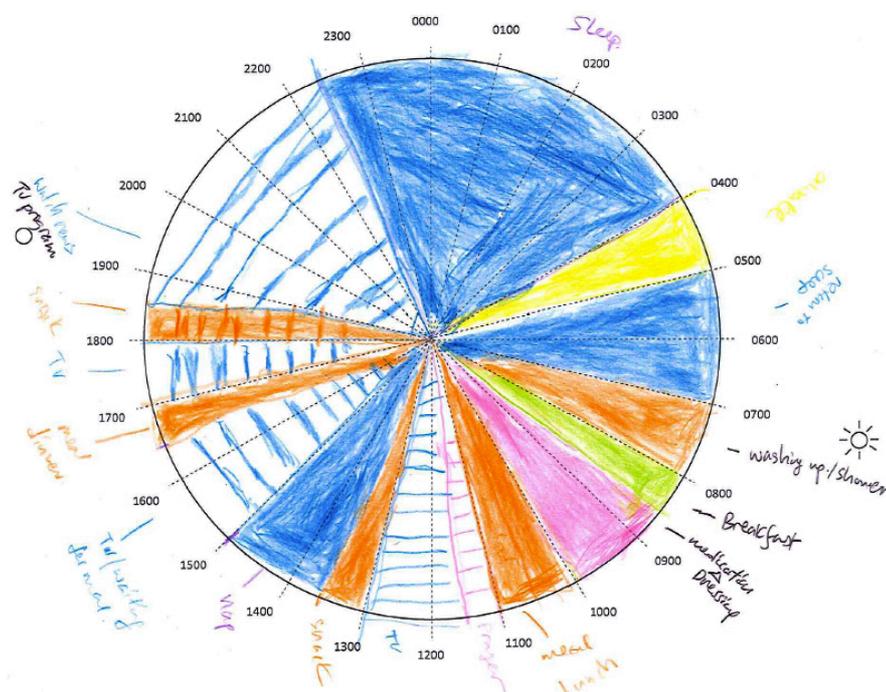


Figure 7. Mag's Colour of My Life Chart

Mag's day usually starts at 4 am. She is normally woken by the pain in her legs or by thirst. She would request for some painkillers from staff to ease her discomfort so that she can continue to sleep further before waking at around 7 am. Like others who

require showering assistance, Mag waits for her turn to be wheeled into the showering area. Mag receives her breakfast with a set of medications at her bed after her shower. During the period when I interviewed Mag, she had a pressure sore on her buttock. Thus, her morning routine includes dressing the wound by care staff. Mag would wait for her turn as care staff go on their rounds. She uses the waiting time to catch up on current affairs by watching the morning TV talk show. Upon completing their nursing tasks, care staff proceed to prepare lunch for residents. Like others, Mag received her lunch at around 10.30 am. When she is awake, Mag spends a considerable amount of time watching TV. She enjoys following the drama series and variety programmes which she finds educational and enriching. Other than that, Mag also allocates some time in the day for prayer and will take naps when she feels tired. However, her naps are often interrupted by staff noises when they change shifts in the afternoon.

Mag is scheduled for a physiotherapy session every Thursday afternoon. It is also an occasion for Mag to leave her bed and venture out of her ward. She usually spends about two hours in the recreation unit, working out at various exercise stations under the supervision of the physiotherapy team. Mag enjoys her visit as it offers her an opportunity to socialise with staff and residents outside her ward. She is well liked among the physiotherapy staff. Staff are attracted to her amicable personality and do spend some time chatting with Mag as she exercises. Not all residents receive the same level of attention from staff as Mag. Staff-resident interactions are observed to be limited during the exercise sessions. Unless special attention is required, staff would usually let residents work out alone at exercise station while they keep a close watch on them.

The high resident to staff ratio appears to prevent staff from giving more personal attention. On average, the five-person physiotherapy team usually receives around 16 residents at each session. There is a lot to accomplish for the five-person team within two hours. Firstly, they need to fetch residents from their wards before each session. Secondly, during the exercise session, staff have to rotate wheelchair bound residents around various exercise stations, perform one-to-one rehabilitation work with selected residents and assist weaker residents to ensure their safety. Lastly, at the end of each session, the physiotherapy staff have to send the residents back to their respective wards. These tasks have to be performed by the team twice a day on

weekdays and once on Saturdays. Signs of exhaustion from the substantially laborious tasks are noticeable at the end of each session. Staff often heaved a sigh of relief after completing each session.

Apart from those two hours on Thursdays, Mag hardly gets to venture out of her ward. It seems that non-ambulant residents are often dependent on staff availability and their attitude. In Mag's case, her opportunity to participate in activities relies heavily on not just on the availability but also the willingness of staff to transfer her. An example of such an incident was revealed during our conversation on participating in possible recreational activities. Mag recalls:

How to sing...I can't go. There is singing activity on Level Two that they always asked me to join. But no one pushes me there. Whenever I request the ward staff to bring me, they would brush me off, telling me that I don't know how to sing, that I don't know the song. So I didn't go. They don't want to bring me there. The people conducting sings well, they will teach me how to sing.

In this case, it seems that availability of staff may not necessarily be the only issue that determines a resident's opportunity to participate. It appears that staff's outlook and opinion are powerful determinants dictating the resident's opportunity and access to participate in activities. The perception of staff in this example, dissuaded and disqualified her from an opportunity to at least try. Although it is not the intention of staff to create negative experiences, such encounters can lead to less affirming feelings such as dejection and a sense of powerlessness. This in itself could have implications for the residents' self-esteem and well-being. In our conversation, Mag expressed her disappointment, 'I will be on my bed. They don't want to bring me [to] what can I do; I have no choice. I can't walk by myself.' Mag suspects her weight might also be a deterrent to staff as transferring a large person would require quite a bit of effort from staff. Given the tight and busy schedule of ward staff, getting residents to 'non-official' activities may not receive much priority over their need to accomplish their duties. This lack of flexibility among staff suggests a possible shortage of human resources. It seems that staff would transfer her when the occasion necessitated. Those occasions would usually be for purpose of attending to her daily physical care needs and the prescribed physical exercise session at the physiotherapy department. Otherwise, she

is rooted to her bed. Mag's day usually end at 10 pm after she finishes watching her TV series.

The manner in which the care staff treat residents can be affected by the staff's mood. Magdalene hints, 'If they are in a good mood, they will perform their task well. But when they are not in a good mood...'. Her comment made me wonder what might staff do to residents when they are not in a good mood? When I probed further, she revealed that residents occasionally experience rough handling by staff.

Communal living is challenging particularly in this setting where privacy is sorely lacking. Besides having to deal with the attitude of staff, residents are also constantly challenged by the behaviour of fellow residents. In Mag's case, she has to deal with the inconsiderate behaviour of a fellow resident who would occasionally turn on the TV during resting hour.

Despite these pitfalls, there are rosy moments for Mag at Evercare. She finds joy and looks forward to having visitors. Her children visit her at least once a week and bring her goodies. She requests a few food items to satisfy her craving. She finds comfort and contentment in their company and of course, the food they bring. There are occasions when they were unable to visit; she expresses her disappointment when that happens.

The popular impression of the nursing home among the Singaporean public appears to be of a bleak existence. Although there has not been any formal study on Singaporean perceptions of nursing homes, the public outcry over a proposed nursing home development project in a residential neighbourhood suggests the existence of a stigmatised view (AsiaOne, 2012). The recent case of resident abuse reported in the news does nothing but perpetuate an already grim view the public has about nursing homes in Singapore (Chong, 2012). Prior to their admission, residents at Evercare also had similar impressions themselves. Mag confessed that she found the elderly in nursing homes scary. The episodic crying and shouting of the elderly intimidated her; but once she herself became a resident, she had no choice but to embrace and develop a tolerance for those phenomena. In fact, she had now assumed a different point of view and developed an empathy towards the plight of the elderly in nursing homes, 'Seeing them is rather pitiful. It is better to be dead. [Laughs]...better to be

dead. It is really pitiful.’ She feels that the regulated life can be tormenting to elderly and lacks autonomy.

While it is the duty of staff to take care of residents, Mag feels that she is also a burden to staff. The inconvenience she experienced as a result of her disability seems to affect her morale and also reduced her enthusiasm to participate in activities outside the ward. Even though she thinks that the range of activity for residents at Evercare is limited, she is doubtful about her prospect of participating in them. For Mag, it seems like a case of a willing but disfranchised resident.

- Int: Are you satisfied with the variety of activities? Do you think there are enough activities?
- Mag: No not enough. I am not satisfied If they don't get me involved. Or bring me to attend.
- Int: Do you wish to see more activity?
- Mag: No
- Int: Why not?
- Mag: Too many activities are troublesome. The staff will not be willing to bring me often. I can't expect them to move me frequently.
- Int: Let's say if the activity is easily accessible or by your bed?
- Mag: Unless they can bring me then that it is good.
- Int: So you think it is good to have activities?
- Mag: Yes. It is a pity that they don't want to move me. Even Matthew knows [Matthew is a staff from another department that Mag periodically socialises with].

**4.4.3 The Colours of Francis' Lifeworld: The Despondent Resident**

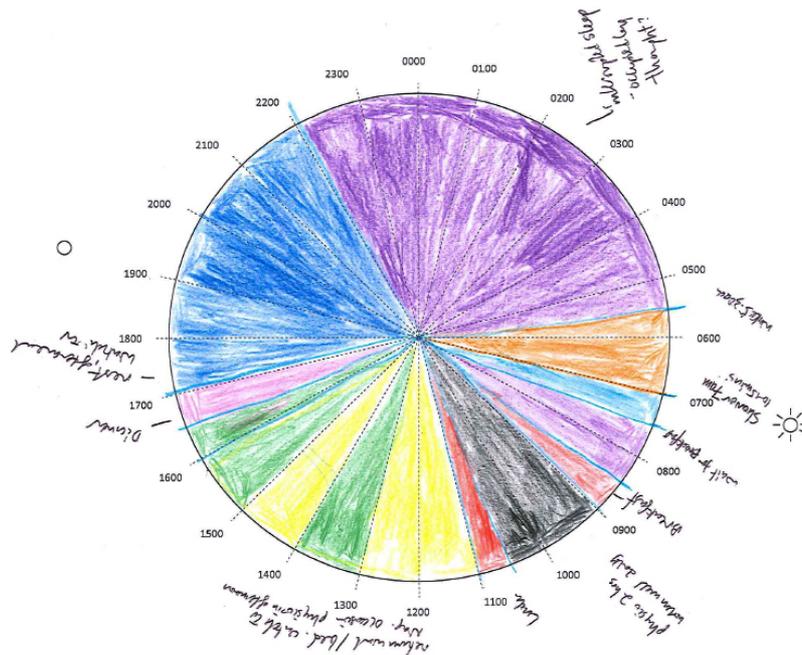


Figure 8. Francis's Colour of My Life Chart

Francis is a lanky resident in his late sixties. Like Mag, he needs to rely on staff for most of his daily activities for living except for eating. Despite needing to use a wheelchair, his ability to transfer himself independently from his bed to his wheelchair is an asset and an advantage he has over Mag. He has the freedom to roam at will. Francis comes across as an amicable but reserved gentleman. Evercare is the second nursing home Francis has lived in. He was relocated as a result of a subsidy arrangement.

A typical day for Francis begins at 5.30 am. He is frequently bothered by thoughts about his disability and that have affected his quality of sleep and his outlook to life at Evercare. Francis's perception of his debility has generated feelings of meaninglessness and pessimism in him.

Francis: Yes I do wake up at midnight.

Int: Why are you awake at midnight?

Francis: I can't sleep.

Int: Why can't you sleep?

Francis: Lots of thoughts going through my mind.

Int: What do you think about? [long pause] what do you think about? Would you like to share with me?

Francis: To share...I am useless, I tell you, when one gets here, people say 'one awaits death'.

Int: Do you feel so?

Francis: I feel so. You get fed and wait for your death.

Int: Hmm...one gets fed and wait for death. Do you think this is a reality?

Francis: It is meaningless.

Int: You feel that life is meaningless. So how can life become meaningful?

Francis: One needs to be physically healthy. Now I am disabled. One of my arms and one of my legs no longer move. This is similar to a handicap.

Int: But do you think a handicapped person can also live life meaningfully?

Francis: No opinion.

Francis spends most of the day in his ward watching TV. Apart from that, he would nap when nothing interests him on the TV or when he feels tired. On days when Francis feels well physically, he will visit the physiotherapy department for his therapy session that lasts about two hours. During the period of the interview, staff were rehabilitating him to walk. Francis is one of the few residents with whom the physiotherapy team has established a good rapport.

Francis joins his fellow residents for meals in the designated dining area, but he hardly converses with others during mealtime. I observed that a majority of residents keep to themselves at mealtimes. While seated at the table waiting for their meals,

residents look blankly into space, observe others or keep to themselves. Residents interviewed expressed difficulty striking up conversations with fellow residents. On the rare occasions when conversations happen, they are often limited to nothing more than a brief exchange of pleasantries. The continued lack of reciprocity from others appears to diminish residents' zeal for engaging others.

From the residents' point of view, it is rare to develop a sustainable relationship with fellow residents. Francis is one of the rare cases. He managed to establish a good talking relationship with another resident that resides next to him. However, at the time of the interview, Francis had lost his companion who had been hospitalised for treatment of kidney failure. Francis's disappointment with this unexpected circumstance could be sensed from his droopy expression as he talked about his situation. In an environment where human to human interaction seems deficient, it is interesting to notice the compensatory strategies residents use to find themselves company with non-human forms. Betty, a resident, for example, keeps a handful of stuffed soft toys that she names to keep her company. She has a favourite among them and would bring it along wherever she goes. For another resident, Peter, his transistor radio is his consistent companion. Perhaps the voice of the DJ over the airwaves is a reassuring sound to him.

Francis usually retires for bed at 10 pm after a day of doing nothing much. Francis feels indifferent when he was asked for his opinion about the level of activity at Evercare. His indifference seems largely linked to the perception he has about his disability, 'Look at me, I only have a functioning arm and leg, I can't move much, so there isn't much option.' Although Francis showed reservation in his comment about the level of activity, he did indicate the positive affect he experienced when attending activities in Evercare. When watching a performance, Francis finds temporarily release from his meandering thoughts. External arts groups would visit and perform for residents. However, such visits are infrequent; they are often limited to festive occasions. In Francis' opinion, having recreational activity is 'definitely good'. He feels that participating in activity offers a sense of focus and distracts him from his wandering thoughts. He also thinks that participating in an activity can enable the development of interest and help stimulate the brain.

Int: Do you find it important to have things to do?  
 Francis: Yes it is important. It can help develop a person's interest.  
 Int: So you feel that having things to do is important. But why is it important?  
 Francis: The mind doesn't wonder too much. I find myself using my brain.

The uneventful and passive lifestyle at Evercare appears to be a concern amongst its residents. Residents have expressed boredom and worries about their brain turning 'rusty' as a result of reduced activity. Residents are concerned that reduced activity may expose them to greater risk of loss in cognitive strength, becoming senile, or developing dementia. Another threat that the uneventful and aimless lifestyle posed to residents is depression. The empirical data indicated the high tendency for residents to ruminate and be preoccupied with thoughts about their personal circumstances during their free time. This dwelling on their ailing health and their personal situation seems to have a downward spiralling effect on their self-esteem and morale. The extent of the crippling effect resulting from the low level of activity at Evercare could be found in the example of Francis:

Int: Do you think you have an enriching life here?  
 Francis: Well time passes without much expectation.  
 Int: If you have a choice, would you prefer life to be lived without expectation or you wish to be able to live life to its fullest?  
 Francis: If there is a possibility, life should be lived to its best. But I don't have the ability.  
 Int: Why do you say that?  
 Francis: It is not up to me to determine.

In the eyes of residents, activities are not merely resources to alleviate their boredom. Participating in activity can have physical as well as positive psychological effects on residents that enhance their sense of self-image, self-worth and autonomy. In the eyes of some residents, losing one's ability to participate in activities is a sign of being 'useless', while others relate not being able to do anything to 'failure'. In addition, the inactive lifestyle resulting from a limited offering of recreational activities at Evercare drew comments such as 'feels like a sick person' and 'feels like a vegetable' from residents. While watching TV is a baseline activity for residents, its passive nature is barely sufficient to appease residents' desire to want to do more.

#### 4.4.4 The Colours of Betty's Lifeworld: More Activities besides the Television

Betty, a resident living with Achondroplasia - a cause of dwarfism, offers example of a resident's desire to be engaged and active.

Int: So you watch a lot of tv...?  
 Betty: Yeah....  
 Int: Do you enjoy watching tv?  
 Betty: No choice...just pass the time.  
 Int: You watch tv to...?  
 Betty: Pass the time.  
 Int: To pass the time...are you happy with it?  
 Betty: No choice what.  
 Int: No choice ah...if let's say there is a choice, what would you like to do?  
 Betty: Some hand work  
 Int: You like to do some hand work any other things besides handwork?  
 Betty: Don't know what to do.  
 Int: Don't know what to do. But you think it is good to have things to do? What does doing things help you with?  
 Betty: Keep us occupied [in] our mind.  
 Int: Keep you occupied your mind. So when you don't do things what do you feel  
 Betty: Very boring...  
 Int: You feel very bored? Any other feelings for not doing  
 Betty: Like a sick person...  
 Int: You feel like a sick person because you can't do anything. So you feel that you feel that doing things can actually make you feel...  
 Betty: Good.

Activities are important for Betty, however, she feels that there are insufficient activities and lack of variety to keep her occupied. She expressed concern about developing dementia from her lack of activity and she feels a need to combat the doldrums of nursing home life. Activity helps her stay alert and makes her feel less isolated. It promotes a better mood; she considered that she felt happier when she is engaged in an activity and by being able to move, she feels less like a sick person. Although she tries to occupy herself by watching TV, she revealed that most of the time she 'uses her ears to watch TV'. It seems that she was not really engaged and going through the motions; at the same time, she has no particular ideas as to what else she might like to do to keep her occupied.

Her disability and dependence on staff also greatly reduced Betty's sense of autonomy. She feels rather powerless and lacks control over her life as she is dependent on others to do most things for her. In her view, being in a nursing home makes people lazy and she blames this on the dependency residents develop on staff

care. Betty made it clear that she does not like the lifestyle of the home; she wished for more autonomy to be able to do the things she wants to do.

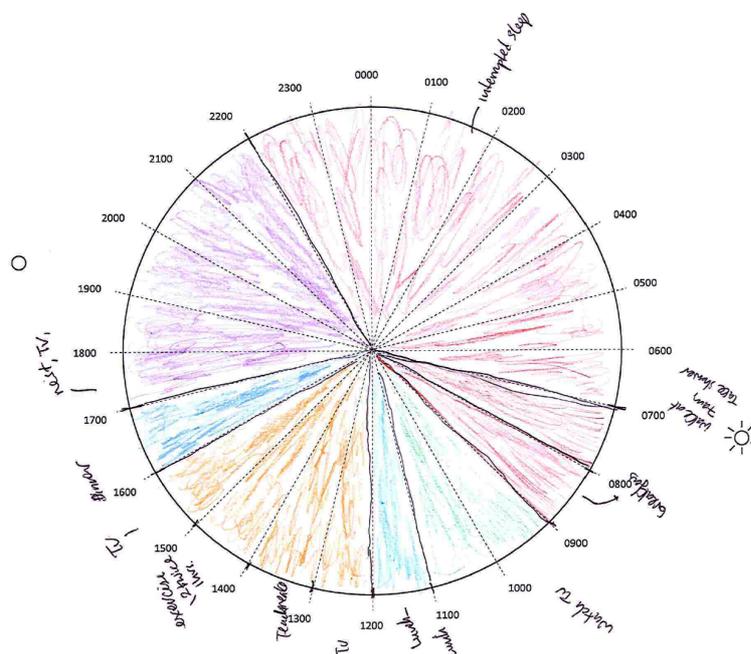


Figure 9. Betty's *Colour of My Life* Chart

While having nothing much to do appears to be the status quo of daily life for the residents at Evercare, it is interesting to find several residents trying to resist the passive lifestyle. In their refusal to accept a sedentary lifestyle, they have devised personal strategies to counter their activity deficient life at Evercare. Besides tech-savvy Joe, who supplements himself with computer games, reading and engaging in spiritual exercises, Alice is another case that is worthy of mention.

#### 4.4.5 The Colours of Alice's Lifeworld: The Thriving Body

Alice is in her late eighties. She is small in build, standing at just around about 1.3 meters. She comes across as a good spirited lady with a zest for life. Although she uses a walking stick, her ability to move independently suggests that her physical health and fitness are still in good shape. A typical day for Alice starts out at about six in the morning. Upon waking, she would wash and make herself a cup of hot drink and have a slice of bread with her favourite spread as a light bite before breakfast.



Through my interview with Alice, I gathered that engaging in activity provides her with various health and wellbeing promoting qualities which include: alertness, a sense of achievement, comfort, assurance, security and worthiness. Perception of time changes when a resident is occupied with activity. Alice explained that 'Being occupied makes the day go by more easily. It is better to have things to do.' Alice ridiculed the lethargic behaviour by some of her fellow residents, 'I can't sleep easily like others; there are some who can really sleep. I think it is remarkable that they can sleep both day and night (chuckle).'

By speaking to Alice, I also learnt that the quality of a programme can affect a resident's motivation to participate. Alice's comments raised an issue about the need for age-appropriate activity which I believe is not commonly discussed when examining and assessing programmes for residents in a nursing home. It seems that the quality of a programme can affect the self-esteem of residents. Alice finds the exercise activity infantilising.

Alice: The exercise activity...feel like a kid...reminds me of child play, we pass [an item] to each other (laughs heartily). It's amusing...

Int: But do you enjoy yourself

Alice: I say, old age feels like a kid...they get us to move our arms. Elderly like us have stiff arms and legs, so the passing item activity encourages us to move our arms and legs. So it will be 10 plus when we are done. Thereafter, we will disperse back to our respective wards.

Thus, while activity can yield benefits to participants, there are dimensions to consider and one of those is the age-appropriateness of the activity. In a similar vein, it might be worthwhile assessing the appropriateness of an activity also in terms of health-appropriateness, that is the suitability of the activity based on the health condition of the resident.

Apart from these self-initiated activities, Alice makes an effort to attend the physical exercise programme at least two to three times a week. During each of her visits, she will take her time to go through the various exercise stations. This is an advantage Alice has over most residents; she does not have to be reliant on the staff and has the freedom to move as she desires. Attending the physical exercise programme is also an opportunity for her to be in the company of others. Although conversation rarely happens, she enjoys the feeling of being surrounded by people.

Besides working out at the physiotherapy department, she would also take trips to nowhere by roaming around the compound of Evercare. She would occasionally hang out around the multipurpose hall area to observe people or would turn to the TV to pass the time. While Alice is proactive in keeping herself occupied, she still finds there is a lack of variety of activities and events that residents can look forward to daily. For Alice, activities help her to pass time. With little to do, Alice usually retires to bed at around 9.30 pm.

#### **4.5 Summary**

The discussions so far have led us through the gates of Evercare to offer an overview of the environment in a Singapore nursing home and its infrastructures. The various characteristics displayed by Evercare in the empirical data suggest that Singapore nursing homes possess characteristics that are similar to many nursing homes overseas. My learning from my interaction with residents suggests that they are generally well taken care of by staff. Apart from a handful of complaints about the attitude of staff, and isolated incidences of rough handling by staff, residents expressed that they are generally happy with the quality of physical care. The basic care that they are receiving also offered them a sense of security and confidence that even though their condition may deteriorate in the future, they are re-assured that they will receive good care. However, the disengaged and inactive lifestyle appears to be a concern for residents.

With plenty of time at hand and little to do or look forward to, residents have expressed concerns about their uneventful lifestyle. Besides, boredom, the empirical data indicate the likelihood that residents dwell in their debilitation which can provoke a more depressive mood. The lack of involvement accentuates their sense of uselessness and failure, reinforcing the sick role, thus affecting self-esteem and self-worth. The lack of activity also reduces the availability of social life and interaction, increasing the sense of loneliness. This lack of social life and social relationships in nursing homes suggests that the nursing home might be thought of as a 'non-place' (Augé, 1995), a term referring to a phenomenon of a place that lacks intimate social relationship despite being saturated by people. In contrast to home-place, the anonymity engendered by the uniformity of the physical environment, the lack of

biographical connections and distinguishing personal features in nursing homes has been linked to experience of stress, loss of identity and displacement which can diminish the well-being of residents (Milligan, 2003). This phenomenon of the residential home as non-place is also observed by Fitzgerald and Robertson (2006) where the lack of historical connection with others appears to accentuate a solitary life for residents.

Residents have also expressed concerns about the limited stimulation they received from the lack of activities at Evercare and the potentially detrimental effects it poses to their cognitive and mental wellness. Contrary to popular belief that ageing bodies in nursing homes are unproductive, empirical data revealed an elderly population which desires to do more and to thrive. While they may be a minority among the resident population, what does *living* mean in a nursing home? Do residents have a sense of a future while waiting for death? What can be done to promote optimal ageing for elderly in nursing homes?

What the empirical data suggest is that the unresolved existence of a tension between the quality of long term care and the quality of life (Kane, 2005, Harel, 2001, Noelker et al., 2001, Kane, 2001) seems to continue to decrease the prospects for optimal ageing for residents in Singapore's nursing homes. While physical care has been found to be sufficient, the psychosocial aspects of care appear to be deficient at Evercare and the residents recognise this.

## 5 Fostering Space of Leisure: Participatory Arts Activities and Thriving

*It is the eighth art session at Evercare. The residents will be embarking on their second creative paperclay project today where they will learn to create cat sculptures. Paperclay is a non-firing, white clay medium that hardens gradually upon exposure to the air. As they arrive and settle in at the art activity venue (a temporary space that pops up weekly at the common area outside the physiotherapy department), I presented them with their finished artwork, a sculpture of the tropical fruit Mangosteen, from their first paperclay project which they have been working on in the past couple of weeks. The residents greeted their 'harvest' with delight. A chorus of chatter and chuckles ensued. As the residents examined their art pieces, some faces beamed with glee, while others were astonished by the quality their own creation. 'Is this mine?... Woah! Doesn't it look beautiful?', exclaimed Freddy as he inspected his work. Despite the initial doubts that some residents had about their creativity, seeing their finished artwork seems to enable them to dispel their apprehension about their creative skills. In fact, I think some residents are rather captivated by their creative potential.*



Figure 11. Mangosteen Paperclay Artworks by Participants. Joe (Left) and Freddy (Right)

*As I had not previously worked with the group using the medium, the mangosteen paperclay project was an adventure to me as well as it had been for the participants. I suppose the tinge of nervousness and anticipation was natural even though my instinct assured me that the residents will do fine. Seeing what the residents accomplished in*

*their first attempt at paperclay, I was thrilled and also felt relieved. I was glad their artworks attest the initial belief I had about the residents. There is still something in them – that sparkle of life and imagination. I also felt encouraged that residents with physical and mental disability in the group were undeterred by the creative challenge. That being said, the project did not go by without challenges for them. For a few residents who are physically disabled or weaker, manipulating and shaping the paperclay can be a challenging task initially. A few lack strength to press the clay, while some lack dexterity to finesse details in their work. When encountering those circumstances, it helps to support those residents by devising a strategy to enable them to overcome their challenges and to progress with their work as independently as possible. For example, if I see a participant struggling to manipulate a lump of clay, I would approach the person and ask if there is any concern that I can assist them with. Upon learning about their lack of strength to manipulate the initial portion of clay, I would suggest that the participant break the clay into smaller portions so that it would be more manageable. I would assist them in reducing the portion of clay should they need further assistance. To ensure that they are coping fine during the session, I would monitor their progress and check in with them periodically. When necessary, further adjustment would be made.*

*Although these initial disadvantages and challenges may demand more effort and time from residents who are physically or mentally disabled; their disability did not seem to dampen their drive to complete. The interest shown by participants to respond to the creative task got me thinking about where did their impulse to create come from? Is it an innate capacity? The spurt of creativity, imagination and motivation released by the residents fascinates me. These ageing bodies are like dormant volcanoes; brewing silently, waiting for moments of connection like this to release their cumulated forces of latent potential. I felt inspired by the participants' tenacity and imaginative responses.*

*The release of creative impetus by these ageing bodies challenged the current benchmark I have about ageing bodies in nursing homes. They seemed to tell me that I can afford to be bolder with my imagination and expectation of ageing bodies. It appears that I was not the only person who is experiencing the affective quality of the residents' artworks. The staff who visited us today felt it too. They were astounded by the residents' creative 'harvest'. The art pieces revealed an aspect and an ability of the residents that they have not previously encountered, imagined or envisioned. These ageing bodies are still teeming with life. They are back for more today.*

*(Field notes, Session 8 of Art programme, 08/08/2014)*

## **5.1 Introduction**

In contrast to popular stereotypes that associate ageing bodies in nursing homes with decline and dependency, empirical findings from the previous chapter revealed that while ill-health and disability may be prominent among the resident population at a Singapore nursing home, some desire to remain active, and to grow and develop themselves. However, the lack of variation in their routine and the limited recreation choices at Evercare made life bland. Boredom is widely reported by residents who expressed their concerns about the potential threats and complications arising from boredom. Fear of losing cognitive function or developing dementia were some of the most common anxieties along with feelings of loneliness, aimlessness and low spirits. Residents also expressed their desire have a more active and engaged lifestyle rather than sitting around with nothing much to do. This view may represent and be applicable to only a minority of the nursing home population, however, given the implications for the residents' well-being, this is an important request that should not be overlooked or taken lightly.

## **5.2 The Nursing Home as a Leisure-Scarce Place**

The health and well-being of people can be affected by an individual's social position and social mobility (Wilkinson, 2005, Wilkinson, 2002). Provision and choice of leisure activities are important not only for satisfaction with leisure but also for satisfaction with life throughout the lifespan, including in late life (McGuire and Wade, 1985). An active and engaged lifestyle is found to benefit the health and well-being of people in late life (Son et al., 2007, Wang et al., 2002, Lennartsson and Silverstein, 2001) however, as McGuire and Wade (1985) pointed out, marked leisure inequality exists in late life. The unevenness in the distribution of opportunities and access to resources and technologies has implications for health and well-being outcomes among older adults (Iwasaki, 2007, Hutchinson and Nimrod, 2012). While health and disability may impinge on leisure opportunities, the provision of, environment of and access to leisure facilities and resources also affects choice and uptake by older adults. Dupuis and Alzheimer (2008), in highlighting how not all people in late life have equal access to leisure, identified the following population groups where choice and access to leisure might be particularly constrained:

more marginalised older adults such as those from different ethnic groups and cultures, those living in poverty, those living with sudden or lifelong illness or disability, those with alternative sexual orientations, those living in long-term care settings (e.g., nursing homes, homes for the aged), and those living in less developed areas of the world. (Dupuis and Alzheimer, 2008, p.99)

The term *leisure-scarce* serves to capture the limited leisure opportunities in the environment of Evercare and other similar nursing homes. Leisure-scarce places may lack resources to enable leisure care that can attend to the needs of people who desire to thrive and this can impinge on the prospects for individuals to live optimally. Conversely, one could apply the term *leisure-enriched* to describe situations or places where access to and option for leisure activities have been enhanced. These terms can be useful to assess and describe the opportunities for leisure in particular places, as well as to indicate any inequality or unevenness in the distribution in leisure.

Empirical findings on the daily life of residents at Evercare in the previous chapter strongly indicated that the leisure-scarce situation is a concern for the residents at Evercare. The leisure-scarce situation at Evercare, as observed, could be linked to several factors. Firstly, the scarcity of human resources for leisure at Evercare appears to be a key contributing factor to the limited leisure choice and access. Although Evercare has physiotherapy staff to conduct exercise programmes and physical activities for its residents, this is the only choice of leisure activity for residents, is limited to specific time slots and appears to be under strain. To cope with the needs of the resident population at Evercare, which, at the time of the study, numbered around 400; the five-person physiotherapy team have to schedule physical activities on a rotation basis. As a result, access to leisure is constrained. This is particularly so for non-ambulant residents who are dependent on staff assistance for transfer to and from the session. The team runs a 90 minute session twice daily on weekdays and once on Saturdays and which can accommodate no more than 20 residents in a session, most of whom are wheelchair bound. During these sessions, residents may not necessarily be fully engaged in the activity. Some might stop or refuse to participate. Furthermore, the physical activities largely focus on the physical needs of residents that will enable them to maintain or rehabilitate their level of physical function. Psychosocial needs of residents appear to take a back seat. Health,

as Petersen and Waddell (1998, p.3) argue, 'is not purely a matter of individual physiology, and health care does not simply equate with medical care undertaken in hospitals. The biomedical model of health [...] views the body as machine, disconnected from social environments...'. This point suggests there is a need to expand the caring services, to ensure that the biopsychosocial needs of residents are addressed and receive equal attention alongside clinical and physiological care.

Given these commentaries, it is evident that the provision, choice and access to leisure at Evercare is clearly inadequate for the resident population. The occupational therapy service that Evercare has contracted in to the home is also very limited in providing residents access to leisure. Although the occupational therapist visits Evercare three times a week, the range of activities offered has been limited and irregular.

Secondly, the material resources for leisure appears to be limited at Evercare. Apart from television and the sporadic scheduled visits by voluntary groups to entertain residents, there is very little for residents to look forward to. In this circumstance, what seems a mundane activity for most of us, like a hair-cut, becomes a significant event for residents. While volunteering in the therapy department, I found a collection of leisure supplies including puzzles, building blocks, colouring sheets and a bingo set, that were under-utilised by staff. Although these supplies may help staff to counter residents' boredom, I have a suspicion that repetitive exposure to the same set of materials might also become stale and uninspiring for residents. Given the limited options, residents had to simply make do with what is available to them. Residents were observed stacking building blocks or arranging puzzles by themselves, while staff occasionally go on their rounds and interact briefly with them. In addition, I question the age appropriateness of some of those materials, many of which, such as building blocks or colouring pages, are associated with activities in childhood. There appears to be an unquestioned low expectation of the capability of the residents; the study thus offers an alternative set of activities as a leisure option for residents in the nursing home.

Lastly, I want to suggest that the lack of leisure is also probably a consequence of the orientation Evercare adopts to drive its care planning. Residents' views on staff responsibility at Evercare suggested that the care model adopted by Evercare is still

intrinsically informed by the medical model, in which physical care remains the predominant concern. Residents saw Evercare staff as people who are responsible for handling administrative matters, are a source of support for their physical well-being and are a source of assistance for their physical needs and care. Clare illustrates this perception:

- Clare: The nurses are responsible to give us advice, call you guys and manage the staff, they pass instruction on the things to be carried out by the staff.  
 Int: So what is the job scope of nurses here? What is their role?  
 Clare: They feed us, they change our diapers, and clean the floor.

That did not mean that residents were dissatisfied with the quality of care that Evercare provides. In fact, they expressed gratitude towards the physical care work that the staff provide, as evidenced by Betty:

- Betty: They only do cleaning for us.  
 Int: Cleaning of what?  
 Betty: Like changing pampers, all this [laughs].  
 Int: Ok...like body care  
 Betty: What they do is very good work. Without them their help we are also in trouble.  
 Int: Yes, yes...so that is an aspect of their work.  
 Betty: They also play a part.

However, the empirical findings revealed that more attention is required to address the leisure-scarce situation at Evercare as there are those who resist the imposition of a passive lifestyle. So, how might an arts-health practitioner help address the leisure-scarce situation? How might residents benefit from encountering and engaging an arts-health practitioner? What is unique about the contributions an arts-health practitioner makes to a nursing home? What purpose might an arts-health practitioner serve in a nursing home? The next section will introduce the Participatory Visual Arts programme that I implemented at Evercare and examine its effects for the residents who participated in the programme.

### **5.3 Fostering a Place for Leisure in a Nursing Home: ‘Let’s Make Magic with Art Today!’ a Participatory Visual Arts Programme**

As an effort to alleviate the leisure-scarce situation and to enhance the caring services at Evercare, I implemented a Participatory Visual Arts (PVA) programme as the action part of my action-research case study. While doing so, I investigated the role and manner an arts-health practitioner contributes to promote the personal well-being of residents. The participatory visual arts programme, *Let’s Make Magic with Art Today!*, was a 12-Week programme I designed and conducted at Evercare between June and September, 2014. Rather than a form of therapy that aims to heal or ameliorate the effect of disease or disability, the purpose of the programme was to offer residents access to the arts so as to foster opportunities for growth and development through the acquisition and expression of artistic skill and knowledge. Through these processes, the programme endeavoured simultaneously to promote the well-being of its participants.

Over 12 weeks, participating residents were introduced to a variety of two-dimensional and three-dimensional art. A total of eight creative visual arts projects were set for the participants to accomplish. The arts sessions were held every Friday afternoon and lasted for approximately 90 minutes each. I had two art assistants to support me during the sessions. The responsibility of my assistants included overseeing the logistics, ensuring that participants have ample material to work with and attending to the participants’ queries when required.

Evercare did not have a designated room or area that caters to leisure activities. Thus, I had to discuss and negotiate with the nursing manager to locate a suitable space in Evercare for my to the nursing manager. As a start, I was offered the multipurpose hall, however, the venue proved unsuitable for several reasons. First, the large space of the hall posed some communication challenges. The participants were sitting too far apart and had difficulty hearing my instructions. Secondly, the lighting and ventilation were not ideal; the intensity of the lighting in the hall was poor and even though I tried to improve the situation by locating the activity space near to the entrances to allow more natural light and air flow, the lighting remained dim and the air stuffy. Lastly, my session overlapped with the routines of that space. It appeared that I was taking up the dining space and staff would start preparing for the next meal

at around 3pm. During that period, the hall becomes quite distracting for myself as well as for the participants, as other residents were brought to the hall to wait for their meal. The increasing meal preparation activity in the hall during the session, also created pressure for me and the participants to clear the space and make room for the meal activity as quickly as possible. Following the first session, I had a discussion with the nursing manager and requested that the programme venue to be relocated. After exploring various options, the communal passageway outside the recreation unit was identified as a suitable venue. The communal passageway was much brighter and has better ventilation than the multipurpose hall. The size of the space was more controllable and conducive for communication and facilitation. Apart from the first session, the remaining 11 weeks of the programme were held in this space.



Figure 12. Weekly Participatory Arts session at the Communal Passage Way

As an intervention, the 12-Week PVA programme was a new event at Evercare that took staff a while to understand. I must admit the programme did place additional demands on the ward staff who had to be reminded to prepare and send their residents for the art session. Timely attendance by participants following the first session was a challenge and in the first few weeks, participants were often late for the sessions. I learnt from the physiotherapy team that the ward staff had not gotten used

to the new schedule for their residents thus might have overlooked the schedule while they were preoccupied by their work routine. This challenge was resolved with help from the physiotherapy team. They kindly offered to help me remind their colleagues in the ward prior to the start time of my session to remind them to send the participants. In addition, I also took the initiative and visited participants in their ward before the start of each session to check in with them. I would also personally go and pick them up on the occasions when staff had failed to note the schedule and had not sent them for the programme.

### 5.3.1 Participatory Visual Arts Session as a Therapeutic Landscape

Attending the PVA sessions offered participants the opportunity to ‘travel’ out of their ward and residents seemed to appreciate the momentary respite from their life in the ward that the art sessions offered them. This time out can be framed a form of retreat where the change of scene and participation in a different set of activities appears to refresh and invigorate them.

Clare: Because every week, I get to go down there to move my body. It is not advisable to sit on the bed daily. Other wise I sit here every day.

Besides offering a change of physical environment, the art sessions were appreciated by some participants as an outlet for emotional release. Betty, for example, shared her cathartic experience. It seemed that the process of art making allowed her to wander into an imaginative landscape that was liberating and relaxing.

Betty: Some times we are not in the mood, we can express out.[...]Very relaxing.

Int: The programme...You find the programme relaxing? Why is it relaxing?

Betty: Can forget everything. I feel so free!

Int: You feel very free?

Betty: Yeah. Like...umm...no burden at all.

Many participants indicated that they found pleasure in colouring. Colouring is also a way to exercise choice, sense of control and autonomy. Colour has expressive and affective values of aesthetics that can uplift mood. The repetitive motion, the focus and attention give rise to a sense of absorption into the process.

Joe: I think it is ok. This suppose is ok. Enjoy. When you spend time doing things, you don't think about things. You focus on making.

In these ways, the PVA session can be regarded as a form of therapeutic landscape. The concept of the therapeutic landscape has provided a tool for scholars to assess the 'healing' and 'therapeutic' efficacy of places. A therapeutic landscape experience can be understood as 'a positive physiological and psychological outcome deriving from a person's imbrication within a particular socio-natural-material setting' (Conradson, 2005, p.339). It has been widely adopted for use in various circumstances since its conception by Wilbert M. Gesler (1993) who used the concept to analyse the nature of places that had come to hold a reputation for healing and recuperation. Moving beyond initial focus to explore the therapeutic properties associated with natural environment, Williams (1998) made arguments to broaden the concept to include spaces, processes and human agency that promoted and maintained health through notions of therapeutic and caring environment. Smyth (2005) offered several new iterations of the therapeutic landscape concept in order to expand the manner which the concepts may be considered. The notion of therapeutic spaces draws attention to constructed environment such as institutional spaces, and is attentive to the interplay between the physical, social and symbolic organisation of built spaces in shaping health. Lastly, therapeutic network explores the implication of support and care arrangements outside the biomedical setting through informal setting such as the home and the garden (Milligan, 2009, Milligan et al., 2004).

In the case of the PVA, the therapeutic landscape, instead of being a physical location, exists as a temporal event and contingent space constituted through a gathering of the participants, myself, the art material and the creative projects that territorialise and transform the communal passage way. In this sense, the therapeutic landscape may not necessarily be a physical location but a situated event or therapeutic space.

### 5.3.2 Desires to Thrive

The art sessions do not merely serve as time fillers; the impact of the creative art sessions seems to go far beyond being an occupational and pacifying tool. The population in the nursing home is diverse and varied and, despite the fact that the majority of residents are living with declining health, this does not necessarily equate to a lack of desire to develop themselves or to optimise their life quality. There are residents who particularly resist succumbing to the inactive lifestyle, and showed desires to thrive. Thriving is understood as an emotional state of satisfaction or psychological well-being resulting from discovering or developing an ability to master or overcome adversity from a physical or psychological stressful event in a positive manner that leads to growth and development (Bergland and Kirkevold, 2001). Through the description of their reasons to participate in the art programme, these thriving bodies revealed their aspirations to develop, challenge and even improve themselves despite their failing health.

Peter: Every week I look forward to the session. [...] Ah...at least at least have something to learn from it. No doubt, no doubt I myself am not be capable in art, it is good for me to learn something new.

Elaine: You let us learn and find things for us to learn. I will learn where possible. That is good.

The PVA sessions also provided some residents with an opportunity to reconnect to a creative potential that they recognise from engagements in the early stages of their life but which potential has lain dormant until given this opportunity to revive it:

Freddy: In my younger days, when I was in school, I did have some experience with art.

Int: Ah so you had experience with art in your younger days, can you share what did you do?

Freddy: Drawing.

Int: I see, you previously did drawing. How long has it been since you last drew?

Freddy: It has been a while, a few decades

Int: I see, do you think about continuing your drawing?

Freddy: Thinking about continuing...well only if there is opportunity and time.

Clare: In my younger days while in school, I like art. That is why I said, oh well!, it is ok to be single arm, I shouldn't be too concerned about things turning out to be

ugly. It is not as if they are going to be displayed. That's when I convinced myself.

For others, the art sessions led them to discover and realise an unknown creative potential within them. For Betty, the art session had not only enabled her to realise her interest in art making but also, it seems, ignited a zeal in her to challenge herself to create more.

Betty: You taught us how to draw, how to create ah. To appreciate the point of creation, the expression of it. [...] This is something we don't know at all previously. It was from you that we learn and know what to do.

Int: So do you feel that you have developed over the 12 weeks?

Betty: Still want to learn some more.

Int: Still want to learn some more? Do you think the programme offer you a sense of goal? Like gives you goal?

Betty: Yeah.

Int: Gives you a sense of goal. You think that it challenges you?

Betty: Yes.

Int: You feel challenged? In a good way or a bad way?

Betty: Good way.

Int: In a good way arh? Ok, ermm, is there anything you enjoyed about the programme? Anything that you like in particular?

Betty: Each time can learn more. Arh. Learn more, learn more different topics.

Int: hm. So you do enjoy having different topic, exploring different topic.

Betty: Yeah.

Int: Why, why is that an enjoyment?

Betty: Not so moody lah! It is a good break from my daily life, every time the same old thing [raised voice]

Int: ah, so you think the change give variation, variety that you think is good. Ok so besides having varieties in projects, are there anything else that you enjoy? That makes you like the programme?

Betty: See how far our work.



Figure 13. A Selection of Artworks by Betty

The sense of growth in knowledge, skills, confidence and reorganisation of the self gathered from the participants' responses accords with the known indicators for thriving (Carver, 1998).

### 5.3.3 Art as Goal Setting and as Motivational Resource

There is a correlation between goal orientation and subjective well-being (Ebner et al., 2006). Older adults were found to benefit from having stronger personal goal orientation, although their goals may focus on the maintenance of function rather than growth in a strategy to maximise, adapt or counter loss-related processes. The creative activity appeared to have a goal setting purpose for participants. Each project was taken as a challenge by the participants and they would use the outputs as a means to assess and monitor their skills and ability and to set further objective for themselves.

Many indicated that they looked forward to the sessions because they got to learn something, create something new and look forward to improving their skills. This sense of purpose among residents seems to come from having an opportunity to develop oneself. Alice's comment highlights this purpose-shaping characteristic of the arts session,

- Int: Why do you want to come down?  
 Alice: I am curious about what you will be doing, and teaching us to do. Or else what, sit there? When you are here to teach, I will go, but if you are not teaching, there is not point of us coming down. When you guys are here, I come to draw at my own will. Like these, I create them arbitrarily. Right? How can I draw?  
 Int: Well in the past, you feel that you do not know how to do this but..  
 Alice: I have never meddled with such thing. I have never done this at home. When I was home, I would do house chore, colour some stuff and do random stuff.  
 Int: So you have not thought that you can do this?  
 Alice: Never...I never imagined myself to be creating this, it is all arbitrary and they do look adorable. [Laughs]  
 Int: So you feel that they are adorable despite it done arbitrarily. Is this an aspect of yourself that you have not seen before?  
 Alice: Never.., I have never created work of such quality. I am amazed how I managed to produce this.  
 Int: So are you impressed?  
 Alice: Yes think I am quite capable. Even if it was an arbitrary effort, they come out to be quite adorable. [Chuckled]  
 Int: So you have not imagined yourself to be doing this in the past.  
 Alice: Yeah, in the past I have no idea of this so how can I do this? It is quite amusing, how the arbitrary effort can produce things that look quite realistic.

- Int: We feel that you create very well, not bad, very pretty. The things you made are very neat.
- Alice: Looking at this myself, I think they are adorable. It is a fact that I have not done any of these before. Looking at them I think they look rather nice. [Chuckle]

The curiosity and anticipation that participants demonstrated in relation to the creative projects seem to engender a sense of futurity and to elicit a sense of aspiration. The projects ignited enthusiasm and gave residents something to look forward to through exploring, creating and learning. Thus, the PVA programme, to a certain degree, has successfully injected zest and hope into the lives of residents that has helped them break the otherwise bland routine.

#### 5.3.4 Promoting Cognitive Well-being with Creative Art Making

Participation in the art sessions offered participants an opportunity to engage in a meaningful activity that stimulated their mind as opposed to being sedentary in their ward and they themselves appreciated the PVA programme as a form of cognitive exercise. Active cognitive engagement is deemed important by participants; it is perceived as a preventive activity that can help reduce the risk of becoming senile. Participants reported a heightened sense of alertness when participating in the PVA programme, a sensation that they evidently appreciated. They found learning about art techniques, exploring the art materials and creating art stimulating:

- Int: Do you find the art session important for the elderly?
- Alice: Of course.
- Int: Why is it important?
- Alice: When you teach us things to do, we are alert.
- Int: You find yourself feeling more alert.
- Alice: Ya...it is better that someone teaches us something. Otherwise people will keep sleeping. These people..
- Int: How do you think residents might benefit from the art programme.
- Betty: [Raised voice] This can keep their mind going, instead of spending most of our time sleeping. I am afraid I will be come demented. At least this is something that keeps the mind running.
- Peter: First thing, this thing will make my mind more active. Not so...not so...inactive.
- Int: So you think doing art can keep your mind active?
- Peter: Ah...that's right. Some times, some times you doesn't use your brain also no good.

The creative processes involved decision-making that is part of how the programme engaged the participants mentally. Participants had to decide on the colours, the composition and form of their artwork and then how to shape their work to achieve their desired form. In doing so, the process also demanded a degree of focus from the participants. The realisation of artwork often elicited a sense of mastery and helped boost confidence and self-esteem. In addition, the art session is also appreciated for its multi-sensorial quality of engagement. It seems that participants not only enjoyed the cognitive stimulation offered by the art activity but also appreciated physical stimulation of the senses that was part of making art. Clare pointed out, 'Yes, it exercises our hands and our brains. Eyes, and the eyes.'

### 5.3.5 Fostering a Socialising Space

In the leisure-scare environment, social interaction was observed to be limited at Evercare. Against a backdrop of the hectic staff routines, the residents were often found idle and kept to themselves in their wards. Residents spoke about the limited opportunity to interact with other residents or the lack of activities that could promote a sense of community. In creating a space for leisure at Evercare, my participatory arts programme also fostered a socialising space as a further benefit that the programme contributed to residents. The art sessions fostered a communal occasion that facilitated encounters between residents, and between residents and staff. The creative activities also created conversational opportunities for residents. They would chat about some current affairs or exchange comments on the art pieces that they are creating. This opportunity for the residents to socialise with their peers proved valuable to some of the participants. Having the opportunity to be with others and to do something together appeared to lift the mood of residents:

Betty: Can meet you all nice people!

Int: So prior to my visit, you have not seen the other residents?

Alice: Not at all. It is only through your session that we sat together, I became acquainted with them, conversations developed from the initial nodding of head.

Int: So the session offered you an opportunity to meet others?

Alice: Yes. I get to meet people from the activity on Friday. I know people from the Friday activity. If you don't participate in activity, how would you get to know people. [...] When you guys come and teach us thing to do, our spirits are better. I shared with them, since you stopped coming, we have nothing to do. When the session is on, the others will gather around to chitchat, that is good. But when you stop coming, the

residents no longer come together. They don't come up. When the session was on, we at least get to nod to each other.

Int: How do you feel when you were with your fellow resident? Do you enjoy that?

Charlie: Yes.

Int: Do you enjoy mixing around with the ladies and gentlemen every Friday? Do you enjoy being with others?

Charlie: I like.

Although the atmosphere of the art sessions was non-competitive, residents paid attention to the quality of artwork produced by their peers and participants expressed pleasure from viewing the work of others. The vibrant colours and the attractiveness of the unique and varied art pieces created by their fellow participants offered aesthetic pleasure and perhaps brought about a sense of curiosity. I suppose the art programme was an opportunity for residents to discover and be acquainted with a hidden aspect of their fellow residents, that is their imagination and creativity. In some ways, this release of creative and imaginative energy could be regarded as a manifestation of life, an expression of vitality in ageing bodies, an indication that vitality is not lost but needing a leisure opportunity to be enabled and expressed. The social environment also functions as a motivational space that inspired residents themselves. This opportunity to be together and to make things together served as a goal setting opportunity for residents to benchmark themselves. The works by their peers presented a driving force that motivated participants to set their own goals towards excelling themselves:

Betty: Besides making our own work, we can learn something from other people also by looking at their work.

Int: So you get to see the creation of other people?

Betty: Some...some creations are better than mine.

Int: I see. Do you have a particular piece in mind?

Betty: I don't know their name but see them.

Int: I see that you do pay attention to the work of others, so how does that make you feel, when you see the work of others?

Betty: I hope to improve more!

Int: You want to improve more, looking at people's work give you some sort of a...

Betty: Challenge.

Clare: We can use our brain to think how we are going to accomplish the work. It can also train our eyes. That is very good. You have see as you create.

- Int: Any other things you enjoyed?  
 Clare: And I can make friends.  
 Int: So you find it offers you opportunity to be in contact with people.  
 Clare: Have opportunity to interaction with other. Have opportunity to observe how other approach their work. We can learn from the way they work.  
 Int: So besides this programme, do you have an opportunity to interact with others?  
 Clare: No. Very Seldom.  
 Int: Very seldom  
 Clare: I will simply sit here. I sit from the moment I wake at 7...6 in the morning. I will sit until 12pm. Watching TV.

The discussions so far have offered several understandings of the perceived benefits that the art intervention offers residents at Evercare. What might be seen as a time-filler for residents is revealed as providing cognitive and socialising benefits. Residents appreciated the art programme for the zest it brings to an otherwise sedentary lifestyle. It appeared to offer and enable some of those ageing bodies to fulfil their desires and aspirations to develop themselves, to connect and to release their latent potential.

### 5.3.6 Art as a Source of Enjoyment

Enjoyment or aesthetic pleasure gained by looking at their personal creations and those of others, by appreciating the colours and forms, was an experience commonly reported by participants:

- Betty: After doing one piece we make, we look at our own work, we enjoy it.  
 Int: Did you like did you expect yourself to be creating all these works before joining this programme?  
 Betty: No.  
 Int: Did you imagine yourself to be doing all this work?  
 Betty: No...I prefer this one.  
 Int: You prefer this one. So this is your favourite. Can you tell me what is in this picture?  
 Betty: Like got birds, flower...  
 Int: A bird a flower...  
 Betty: Look at it you feel very bright la.

Pleasure was also derived from having the opportunity to explore and develop oneself. Residents have associated uselessness to their inability to perform or participate in activities. Being able to complete a creative assignment offered participants a sense of accomplishment, which has boosted their self-esteem and self-image:

Int: Did you previously think you can do all these?  
 Elaine: Never  
 Int: Never...so now looking at your work how do you feel?  
 Elaine: I feel very happy.  
 Int: So you think being able to learn is a good thing.  
 Elaine: It is a good thing

Peter: By coming here, discuss with me about the art.  
 Int: What benefit do you think I bring to the home?  
 Peter: What benefit you give to me? Some benefit of joy. Like that, like that.  
 Int: How do you feel when you are interacting with me? When you are making artwork?  
 Peter: Very good!  
 Int: Why is it good?  
 Peter: At least you pass some knowledge to me.

Freddy: Woah!...not bad.  
 Int: So do you feel proud?  
 Freddy: No...  
 Int: You don't feel proud? But do you feel delight?  
 Freddy: I feel enlightened.  
 Int: You have not imagined yourself to do this?  
 Freddy: No [looking through the artwork, seems to admire his creation] these are my creations?  
 Int: Do you feel you have gained anything from the art activity?  
 Freddy: I can realise my imagination. Didn't think I what I was going to create. I simply drew.

Surprise, fascination and disbelief were also among the reactions reported by participants as the session led them to release and discover the latent creative potential within them. The arts-health practitioner can be regarded as a person who led and connected the participants to their latent potential, making them realise an aspect of themselves that they have not previously known or acknowledged. Many did not expect or foresee themselves accomplishing in their lifetime what they accomplished in the 12-Week programme. Alice, a resident in her eighties says:

Int: Well, how do you feel about your ability to create these in your 80s? years old, you are still capable of doing these...how do you feel?  
 Alice: [Laugh] I feel...I am amazed.  
 Int: Has it occurred to you that you can do this?  
 Alice: Not at all.  
 Int: You have not imagined that even when you are 80, you are still able to do this.  
 Alice: I did not expect myself to splashed so much. I have not expected. I didn't not expect that I would know how to splashed these. [Burst of laughter]  
 Int: Now looking at your creation, what is your view about yourself?  
 Alice: I see that I am quite clever. [Bursting in laughter, chuckles]  
 Int: You find that you are quite clever. Now that you are learning things

- Alice: I find that I am quite clever, I am able to splash things till they look quite realistic.
- Int: Did you, in the past expect yourself to be doing this?
- Alice: Not at all.
- Int: So it is through the 12 Week Sessions that you are able to do a lot of things.
- Alice: Yeah...Other wise, I wont know. I am clueless. I didn't expect myself to accomplish this.
- Int: You didn't expect yourself to achieve this.
- Alice: Yeah...I didn't expect I can achieve this.
- Int: I think you are very capable
- Alice: [laugh].



Figure 14: A Selection of Artworks by Alice

The art activities appeared to offer residents a sense of positive future development and enabled them to discover, build and release their capability. While at the same time, it also kindled a desire within participants to want to increase their own potential. Most participants, if not feeling amazed, were pleasantly surprised by their ability to create with a sense of disbelief about their capability was commonly reported. This also appears to trigger the release of other positive emotions, such as fulfilment, achievement and feeling happy. These emotions in turn boost their morale and invigorate their sense and expectation of self and a positive outlook on life. The sense of achievement and pride also emerged from the art programme for participants. These realisations seemed to have a vitalising and invigorating quality. Participants appeared motivated and reported that they aspired to do more and better work,

- Staff: What is this? [a Chinese lady care staff was passing interjected interview. Stop by the table, looked the art pieces, asking]

Int: Art pieces.  
 Staff: Done by her? Ah...  
 Betty: Ya...My art la. See how high...how high I can go.  
 Int: How high you can go? So you feel that this activity allow you to see how much you can achieve?  
 Betty: hm. How far [simultaneous reply]  
 Int: Yah? So do you think you did well?  
 Betty: Hope to [whisper and giggle]

#### 5.4 Doing a Different Kind of Dance with Residents: Fostering a Nurturing Space

The unique role I played at Evercare as an arts-health practitioner was noticeable to the residents. To residents and care staff, the arts-health practitioner clearly possessed different skill sets and could attend to different aspects of their needs and serve different purposes. Residents indicated that they benefited differently from these respective skills. Thus, residents saw care staff as people who attended to their physical sustenance and body care, while they associated me, the arts-health practitioner, as a resource that helped alleviate their current inactive lifestyle by providing leisure, sensory and cognitive stimulation, and personal development.

Joe: You guys are the other way round. It is another aspect. Another dimension of life.  
 Int: What dimension?  
 Joe: Some might have the talent but may not have the opportunity to encounter art, will make use of this opportunity to use. To nurture this interest in them.

Alice: Your responsibility is to teach us how to do things, while the nurses take care of us.  
 Int: What do they take care of?  
 Alice: They take care of our meals...they would walk around, ask us if we are doing alright. Nothing much. They don't offer us colouring, nothing.  
 Int: And my responsibility?  
 Alice: Yours is better, you teach us do to things. You teach us how to make art, teach us to colour.

Peter: You ah, as an artist, at least, at least you pass some knowledge to me, the value of the art.

Clare: The nurse doesn't. They attend to things that concern our body. They don't take care of the ability of our mind and vision acuity. They don't.  
 Int: So when you interact with me, what aspect of need do you think I attend to?  
 Clare: What aspect?...The first time when I attended your programme, Miss Agnes asked me to attend, I went and saw you guys painting, I think to myself that is good that there is another activity. This is why I will attend every week. I will get the staff to send me to the activity area at 1330. They don't have to call me, I go there by myself.  
 Int: So you find what we are able to provide...take care of...?

- Clare: You can take care of our mental/ psychological needs, the ability of our mind, our eyes.
- Int: In what way did we take care of your mental/ psychological needs?
- Clare: Because we remember the event, Friday is for art session. Now that there isn't any more art on Friday, I feel so bored. I exercise on Friday then I will be back here sitting like a block of wood. When I exercise on Friday, after having tea at 1300, I wash and clean my face, Clean up my body, I will get the to push me to T5.
- Int: So you feel that I offered you...
- Clare: A lot of things.

Residents also recognised and pointed out that my activities dealt with another dimension of their life and addressed aspects of their needs for which the current care culture did not cater:

- Int: You never thought you would be able to make art previously?
- Elaine: No. In here, nobody teaches me.
- Int: The nurses don't teach you?
- Elaine: How can the nurse teach me this?
- Int: What does the nurse do?
- Elaine: They distribute medicine.
- Betty: You know how to create things. They seem to lack an ability that is comparable to yours.
- Int: What do you mean? Can you explain a little more?
- Betty: Like drawing and the art your conduct, they do not seem to know.
- Int: So you feel that the staff are not able to do this?
- Betty: Yeah

Residents welcomed the disruption that the art programme brought into their monotonous lifestyle. An immediate benefit perceived by residents was the ability of the programme to engage them, keep them stimulated and the opportunity to develop themselves. The art session also alleviated their boredom:

- Freddy: Help us to pass time.
- Peter: Very interesting, an also have some hobby. At least some hobby to occupy my time. Or else...always here, nothing to do very dull.
- Janice: Also good. Pass our time. If not we all very boring! Nothing to do.
- Joe: You help residents them pass time, provide some interest, for them to play. We don't get this from the nurses. They help out in taking care of our daily need, such as meals, medication. They are concerned about our safety, to ensure that you don't fall. They look after patients.

It was interesting to note how the art sessions affected their experience and perception of time. Time seemed to speed up, or passed by easily while they were occupied with the creative art activities:

Int: No burden at all? so how would you regard your experience? How did time feel for you?

Betty: It passed very fast ah!

Int: It passed very fast? Too fast?

Betty: [Chuckle] No la I enjoy that is why I feel it pass very fast.

Int: So you think doing art activity is good way of passing time?

Betty: Yeah certainly.

Elaine: It passes very easily.

The activities I provided as an arts-health practitioner seemed to invigorate the residents' senses. In addition to being regarded as a leisure resource, the arts-health practitioner could also be seen as a source of stimulation and enrichment for residents. My presence and activities supplemented opportunities for social and cognitive engagements that residents felt was lacking in the current services at Evercare.

Clare: Different. You teach us how to do art.

Int: So do you think we offer something else in addition to what the nurse provides?

Clare: Yes additional. You are also able to chat with us. You can help us improve our memory. You can also pass us knowledge. Otherwise, over here, there is not much knowledge. Beside reading newspapers and watching TV to gain knowledge, no one has the mean.

Freddy: You allow art making, you instruct and guide us.

Int: Is there a different responsibility between the artist and nurse play?

Freddy: You explain to us how to do things but the nurses don't.

In addition, the artist is also seen as a bridge to the outside world:

Betty: Arh. From you we learn from outside what is going on. Like you are the bridge! [Chuckle] [...] Because we cannot go outside so you come and teach us, we learn something lor. [Raised voice]

Contrary to the stereotypical assumptions that often link aged bodies in nursing homes to decline and disengagement, my empirical findings so far have conveyed that there are still bodies that desire to develop themselves.

The art session appears to be a nurturing space I held for the participants encouraged and liberated them to explore, adapt and play as part of the creative process. Alice's comment reflect this impression:

Alice: I have never meddled with such thing [art making]. I have never done this at home. When I was home, I would do house chore, and do random stuff. [...] I never imagined myself to be creating this, it is all arbitrary work and they do look adorable [laughs]. I can go on splashing as I please [laugh]. I splashed the flower, the birds and a bunch of other stuff. I find them rather adorable. Yes I have not splashed so much.

While the art session was a free flowing activity, there were also moments where it required analysis and problem solving. For example, while creating the cat sculptures, participants had to engage in visualisation skills to translate the two-dimensional reference images of cats into three-dimensional forms, which can be challenging. However, participants remained committed to the project and persevered to complete their assignment. I supported participants by making them aware of the possibilities that they can consider when they faced uncertainty in the process of creating. I encouraged them to try things out and assess the quality of their creation. The art session was maintained as a space of discovery where I would lead and support participants to enable them to achieve the eventual art pieces they desired. The sympathetic and nurturing space resulted in eclectic pieces of work that drew out distinctive personalities and fostered the release of imagination and creativity in a spurt of life from the ageing body.



Figure 15. Paperclay Sculptures of Cats by Participants. (Left to Right): Betty, Clare and Alice

The nurturing space also fostered positive affect among participants. While attention was paid to ensure that projects were appropriate and manageable for

participants, it was inevitable that some participants faced particular individual challenges, due to lack of experience, physical fitness or dexterity. Peter, Freddy, and Joe for example, expressed their initial uncertainties,

- Peter: At the beginning yes. Gradually as the course goes on...beginning very very hard to...to grasp the whole idea.
- Peter: First thing for me is this subject, first and foremost is...art is ...first of all the art is not to my interest.
- Int: Did you grow to love it?
- Peter: Yeah.
- Int: Over time begin to love what you do?
- Peter: Yeah yeah. Gradually, gradually then get used to it.
- Int: What did you have to get used to?
- Peter: Got used to the idea on how to create something, then so and so la.
- Int: So that was the challenge initially. You find the session hard initially.
- Peter: Ya very hard. Then as the course goes on ah, then at least, at least, I know something.
- Int: know what? What did you learn?
- Peter: At least I learn something about art.
- 
- Freddy: Clay is messy and dirty, it is very hard to wash and clean my hands after use.
- Int: You feel that it dirty your hand. Do you find clay more challenging?
- Freddy: Yes difficult
- Int: Why is it challenging? Besides being messy
- Freddy: Drawing is better. I don't like clay.
- Int: Can you share with me why you don't like clay?
- Freddy: Drawing is easier, while clay is more difficult.
- Int: Why is clay difficult.
- Freddy: Because I have little experience with clay. When I was in school I only had experience with drawing. I have not dealt with clay.
- Int: But now that you give clay a go, how do you feel? Do you think you succeeded?
- Freddy: Passable
- Int: You made cat, mangosteens, do you feel that you succeeded?
- Freddy: Well I don't know, it depends on how other views it. Their comment and criticism.
- Int: I feel that you have accomplished a lot and did well. Have you imagined yourself to accomplish this?
- Freddy: I never imagined.
- Int: How do you feel looking at your work?
- Freddy: I feel I like it [satisfied].
- 
- Joe: Because our hands are not nimble, so it can be difficult when it comes to manipulating the thing. Frankly speaking, that thing is very difficult to manipulate, very hard to manipulate. For the others, they may not feel that way as they have good functioning hands.

However, the nurturing space I generated and held, by being attentive and responsive, was successful in leading them to develop their confidence and to assist them in

overcoming initial challenges. I see this supportive role as an indispensable part of arts-health practice, which enables the participants to overcome self-doubt, build self-belief and renew their sense of self through discovering what they are capable of attaining. The confidence and pride gained by some participants also led to their desire to show their work to others. Clare for example, enthusiastically summoned all the staff at her ward to come and look when I visited her ward with the photos and a selection of her original art pieces:

- Int: So working with an arm was difficult? But you...
- Clare: I persevered and wanted to overcome that. I must overcome that. I dare not, I cannot lose to others so I persevered till the end. Otherwise, how do you think I can stand with one leg. I amputated this leg, but this leg has the strength to stand when get off the bed. I can help while others are assisting me. I need to overcome myself. Rose! [she called out to a staff passing by] come and take a look at the things I have done.
- Rose: Oh...drawing ah?
- Clare: Yeah. You see I do the work. Drawing...drawing [Calling call out to another female Malay staff who was passing by].
- Rose: Look realistic.

Peter expressed a desire for his work to be displayed publicly as he wanted to dispel the public's misconception that nursing home residents are unproductive. This can be seen as, in some ways, an assertion on one's dignity,

- Peter: Very nice. All these were done by us? Will it be sold for exhibition? [...] it is good to let the people outside ah know that the patient here have...done something ah.

#### 5.4.1 Overcoming the Hill of Self-Doubt

Clare, a resident with physical disability, described her initial uncertainty, self-doubt and the apprehension she had about herself in relation to her disability. A stroke and her diabetic condition had caused her to lose function in one of her arms and to have one leg amputated:

- Int: Have you previously participated in any art programme?
- Clare: No, no, no.
- Int: So would this be your first time attending an art programme?

- Clare: This the first time....It is my first time. I think to myself, if it would be possible for me to do so with one hand. But I said to myself, what the heck! I shall give it a try.
- Int: I see, so you previously doubted your own ability to participate.
- Clare: I doubted because I only have an arm, I doubted myself...
- Int: You doubted...
- Clare: I wondered how am I going to do it with one arm. Well I told myself let's take instruction from them, with one hand I might also be able to produce something, why care so much, shall see if I like it at the end.
- Int: So you were previously concerned if you are able to participate with one arm?
- Clare: If it is possible to work with one arm. But I insisted that I will succeed. I insist that I want to succeed. I wondered, can I work with one arm, and told myself, it is possible with one arm. It is possible. I say, as long as we have confidence, we will be able to finish. When you guys are here, Miss Agnes came to call me, they encouraged me to participate so I decided to give it a shot.
- Int: So how do you feel looking at your artwork?
- Clare: Very Good. Didn't think that I can produce such things.
- Int: Ah, ok. So you have never imagined yourself to produce such work?
- Clare: I didn't...I didn't dare imagine. I thought, what can this one arm of mine do other than some weird looking things. [...] very happy, Very excited that I can produce thing of such standard, I consider that that is not bad an achievement. For a disabled person to be doing this. [...] It was challenging creating the gold fish piece. Because it was hard to manipulate the form of fish.



Figure 16. A Selection of Artworks by Clare

I see the artwork that Clare produced as a testimony that provided witness to her innate ability but which had had no opportunity previously to be explored or expressed and this experience was empowering for Clare. The ability to create something from nothing can serve as an indicator for the vitality within. It is perhaps this release of energy that can generate hope, purpose and a sense of a future which in turn are all related to the promotion of self-esteem and reinforced self-belief.

Seeing helps one confirm and to be convinced about the vitality that resides in us. In Clare's case, it also continued to build her resilience and enable her to overcome her self-doubt.

#### 5.4.2 A Gift to Those at Home: Peter's Special Request

The art programme also provided an opportunity for some participants to express their personal desires. As much as participants enjoyed creating their work, for some, the artwork served a further purpose besides being a pleasing looking piece of work. In Peter's case, the artwork became an heirloom that he requested be passed onto his family.

Int: These are all your fish. Remember this? The fish with the bubble.  
 Peter: Especially this one ah, among these two ah, this is the one I like best.  
 [comparing two pieces of his work – aquarium theme and birds and flower theme, he pointed that he like the aquarium piece]  
 Int: You like the fish best?  
 Peter: Ah.  
 Int: Why do you enjoy the fish?  
 Peter: [pause] Ah...[clears throat]...by the way ah, can I ask you...to frame one for me?  
 Int: Of course. I will frame and get back to you.  
 Peter: Frame one for me as a...as a remembrance. Frame one for me, so that when my family member comes, I will ask them to bring home, bring back home, and display on our...our house, our main hall.

As our conversation moved along, Peter reminded me again of his wishes.

Peter: Don't mind you...you frame the fish for me.  
 Int: Yes I will do that, I will do that.  
 Peter: Thank you ah.  
 Int: Ya no problem.  
 Peter: how much is the cost, I will...I will reimburse you. When my family member come, I will tell them how much, then I will ask them to pay.  
 Int: Ok sure sure sure. Have they seen your art work before?  
 [Pause]  
 Peter: Ah they? No. because why, because why, they come once...once a month only. So very hard for them to see it. But that artwork on aquarium...  
 Int: You like it?  
 Peter: Then the second one is er...that one, that one, the trees flower that one.  
 Int: Ah the trees and the flower. Ok can.  
 Peter: Then also the mangosteen.  
 Int: Hmm..and the mangosteen.  
 Peter: Yeah.

Int: Ok and you would like your family to have them?  
 Peter: Ya ya.  
 Int: Ok I will. I will let Miss Agnes know. Then she will help you take care of it also.  
 Peter: Thank you ah!  
 Int: No...problem.  
 Peter: Trouble you.  
 Int: So your family have not seen your artwork before?  
 Peter: Har? Who?  
 Int: Your family members, they have not seen your artwork before?  
 Peter: No...not one of us is an artist.  
 Int: So this is a little surprise for them?  
 Peter: Not one of us.  
 Int: So this is a surprise?  
 Peter: They are not keen on art. They are keen on other courses. Especially arts...  
 Int: So would this be a surprise for them?..  
 Peter: Har?  
 Int: Would this be a little surprise for them?  
 Peter: Er...I hope so. I hope so. I hope so [fading voice]



Figure 17. Artwork by Peter that he requested be presented to his Family

Towards the end of the 12-Week programme, Peter fell and was out of action for a couple of weeks. At one point he appeared delirious and became hospitalised and staff were uncertain about his prospects. Weeks later, I was glad to find Peter back in his bed looking in a better shape when I took the opportunity to visit him in his ward. Even though the 12-Week programme was over, I went back to let him finish his last project while he was recuperating and thereafter, brought him the newly framed piece of artwork for which he had requested my help.

### 5.4.3 From the Silent World of Julie

Julie is a deaf and mute participant in my programme. I was not informed of her disability until the second week of the programme. When Julie was not participating in the art sessions, she spent most of her day in her bed either sleeping or idling. She was always enthusiastic to follow me when I checked in with her weekly for the session. Working with Julie was interesting. She does not sign and neither was I able to, so I had to devise and improvise ways to communicate with her. I gestured, demonstrated and prompted while instructing her. She was highly capable of working independently. If it were not for the programme, Julie would have remained a marginalised deaf and mute resident with whom few could communicate under the current care regime. Through the art programme, her latent creative potential for communication through these colourful imaginative worlds could be expressed.



Figure 18: A Selection of Artworks by Julie

#### 5.4.4 Desiring More

Following the 12-Week PVA programme, feedback from the participants indicated that they felt they had benefitted from the programme and enjoyed the enriching opportunities it offered. Besides being a leisure resource, the PVA programme also sparked interest among participants to develop themselves further. I was also regarded as a motivator and a source of cognitive stimulation:

Clare: It was very good. I am not the only person who likes it; there are many others who like it too.

Peter: Happy. Happy. (that is about it) that is why I...that is why I longing for another course.

Alice: Well...it is right to get them to be active. Else they will be sleeping. You should come when you can, to teach us how to do things, otherwise they would keep sleeping. Right?! When you are free, come by on Friday to teach the elderly to do art, otherwise, they will be sleeping after meal. They don't...so if you get them to do they will do it. But when you are not here, they won't be doing it.

Several residents felt that holding the sessions once a week session was inadequate. They felt they would benefit even further with increased frequency and recommended that the frequency of the sessions be increased in any future programme. Fearing that their memory might fail them or that they would be unable to keep up with learning, some participants felt that a more frequent programme could help reinforce knowledge and skill retention. In addition, they would also be reassured of a leisure option to keep themselves active:

Alice: Yeah. Once a week is too long. Twice a week will be good for them to express themselves. So that they will be more alert. If you get them to participate, they will participate. Otherwise they will be sitting around or sleep.

Betty: At least twice [directive tone][...]A week like very long like that.

Clare: Twice at least [...] Because it will be easier for us to retain what you have taught us otherwise we might forget. Because we are old, we have aged, might turn senile. We might forget so you need to help us.

Peter: This programme, from my point, at least ah one week twice.

Peter: Because why, one ah nothing to learn. One day One time ah a lot of thing learn. You see because for us, not only one time only you can learn so many thing now.

Int: So by having twice a week, what benefit do you think you will get form it?

Peter: Because more classes, I myself have a lot to learn.

Elaine: Thrice is will be good.

However, not all participants shared this view. Freddy, for example, felt that the once a week session was sufficient for him.

Int: How do you feel about having one session a week is enough?

Freddy: Yeah, that is good enough.

Joe offered a pragmatic opinion about the participation rate as a reminder to me to manage my expectations of the ageing bodies in nursing homes, which I appreciated. The lack of access to reading material that Joe pointed out perhaps also indicates the institution's lack of a predisposition towards building the capability and needs of residents and their recreational opportunities.

Joe: Ok...I think it is good if you can do this. It is good to let them play. But in a nursing home, the number of participants, those who can participate may not be a lot. May be less than 10%. Because there is not even newspaper here. They are thinking that all the people here are already incapable. These things are not required. Daily leisure needs are not required.

In contrast to the empirical data that indicated participants' motivation for more, Joe remains suspicious and doubtful and felt that his fellow participants were looking for other benefits. However, drawing on the experiences of most participants and their facial expression during my interviews, they seemed genuinely interested in the programme:

Joe: Let me tell you why I think they keep going back. Because they think they will get some benefit. Which is why some of the guys here want to go for meal at level 2. Why do you think they want to be there? A lot of people may not be aware of, things gets distributed there during meal times. So they are the one who knows that, there could be benefits there. Hence they visit. But for myself, I don't want to go down, because I don't want these things. But for those people who do not know, it is ok. There are people from level 2, 3, 4, 5 who are not able to move, they won't be receiving. Unless the donor knows, they will come up to distribute. If they don't, it doesn't matter. This is the reason why some people would go down.

## **5.5 Falling Back into the Leisure-Scarce Mode**

When the 12-Week art programme ended, Evercare fell back into its leisure-scarce mode once more and this effect is apparent to participants in that life became

uneventful once more for them. There was little for them to look forward to and little reason and opportunity for them to meet. They retreated back to their wards:

Betty: Very boring ah[...]sitting down here [snigger].

Alice: They do not have art. When you are here, we can draw freely with the supply of paper. But now that to stop coming, there is nothing for us to do. Yeah when you were around, we came out to paint, to colour, we get to move.

The return to this situation perhaps reinforces the observations I made in the earlier discussion where I pointed out that the leisure-scarce situation is a constraint imposed by inadequate human resource, limited leisure resource and, most importantly, the model of care in nursing homes which is infused the view of the elderly as 'failing' humans. This phenomenon in particular provides a clear indication of the unique contribution that an arts-health practitioner can make and that is distinct from the orientation of the care staff. The arts-health practitioner supplemented and attended to another dimension and need of residents, which is lacking in the current configuration of staff concerns at Evercare. There is a need to explore what might be needed to set in place opportunities and possibilities for arts-health practitioners to expand the nursing home's caring ability.

Int: Since you have been living here, have you been able to participate in a regular art session?

Alice: Nobody offers.

Int: So is this the first time?

Alice: Art session? There hasn't been any.

Int: So this is the first where a regular session has been conducted.

Alice: Yes. It is because you came, we are doing, otherwise we don't. That is about it.

Int: Is this the first time you created so many things?

Alice: Yes it is the first. Because you came, I get to do this.

## 5.6 Summary

Informed by an understanding that a leisure-scarce environment can impact unfavourably on the quality of life and well-being of older adults, this chapter set out to examine the potential contributions of an arts-health practitioner to the care provided in a nursing home. I conceptualised the term leisure-scarce to refer to places

where leisure resources are limited which included the environment of Evercare. Empirical findings through interviews with residents identified the arts-health practitioner to be a source of leisure and also a resource for enrichment, personal discovery and development for residents. This capacity depends on qualities and skills that are unique to the arts-health practitioner and distinguish their role from that of the care staff who focus primarily on physical body care.

Contrary to the stereotypical assumptions that often link aged bodies in nursing home to decline and disengagement, the empirical findings so far indicate that there do exist elderly bodies that still desire to thrive. From empirical data, I also found individuals who resist the inactivity of the care home passive lifestyle. These thriving bodies revealed an aspiration to learn, develop and even improve themselves. They challenge the stereotypical views of the ageing body in nursing homes by demonstrating their desire and ability to explore, experiment and develop despite physical frailty and various health problems.

The creative activities I offered have exemplified various benefits and positive emotional outcomes. Going beyond being a tool to occupy residents and pass the time, the leisure space I fostered with my PVA programme claimed and situated a pro-socialising space that encourages and enables interaction among residents. It also generated a sympathetic and nurturing space that enables participants to discover, realise and release their innate creative potential. This, in return, generated various positive affects such as enjoyment, purpose, confidence and a reinvigorated self-image, all of which can boost the mood and outlook of residents. The activities I provided offered them a sense of hope, purpose and a future and a desire to want to further develop themselves. It encouraged the residents to thrive.

The varied and vibrant creations of participants force us to recognise the liveliness that still remains within the ageing body. The original art pieces by the participants clued us to the energy and potential lying dormant and waiting for a moment of opportunity and nurturing to be released and expressed. Residents appear to have found such a moment in the arts programme and through the practice of the arts-health practitioner and clearly want the provision of more moments of this kind.

## 6 'You Can See Them Blooming': Emancipating the Aged Body through Art

'The ageing body is thus not natural, not pre-discursive, but fashioned by and within culture' (Twigg, 2006, p.42)

### 6.1 Introduction

In the previous chapter, I presented the opinions and experiences of participants in the 12-Week Participatory Visual Arts Programme (PVA), which I introduced at Evercare. The physical, sensory, cognitive and social stimulation afforded by the PVA programme were found to enliven the participants. The sense of self discovery, development and enrichment experienced by the participants also fostered positive emotions such as confidence, fulfilment that helped promote personal well-being. Contrary to assumptions that aged bodies in a nursing home are lethargic, disengaged and incompetent, my findings revealed aged bodies with desire, aspiration and capacities for learning, developing and improving themselves as they connect and engage the PVA programme. What are staff's reactions to the *becomings* of residents through the Participatory Visual Arts Programme? How might the *becomings* of the participants affect staff assumptions of nursing home residents? What are staff views on the contributions of the arts-health practitioner and the prospect of the arts-health practitioner contributing to caring? The following sections will examine staff's observations of the participants' journey through the PVA programme and the effect it had on them. The themes and content of this chapter derived from a semi-structured interview with Agnes, the nursing manager, Selma, a care assistant in the ward; and a focus group with five staff from the physiotherapy team. The team is made up of Susie, the physiotherapist and Jess, Alvin, Tracy and Matt who are therapist aides.

### 6.2 Caring Constraints and the Becoming of Aged Bodies

The body is often largely viewed and understood as a closed biological and physiological entity. However, in recent decades, developments in the sociology of the

body and body theory (Fox, 2012, Rose, 1996, Massumi, 2002, Blackman, 2008) have formulated and diverted our view from seeing and thinking about the body being a bounded entity, a singular organism, a bounded stable substance, towards the 'body multiples' (Mol, 2002). Our bodies, as Blackman (2008, p.1) posits, is not a container for the self but rather 'always extend and connect to other bodies, human and non-human, to practices, techniques, technologies and objects which produce different kinds of bodies and different ways, arguably, of enacting what it means to be human.' Every relation that the body encounter with has the capacity to affect the body with varying intensity (Fox, 2012). With this understanding, the body is recast 'as process' (Blackman, 2012, p.3), a system that is open and dynamic – not defined and bounded by an outer skin-envelope or other surface boundary but by their potential to reciprocate or co-participate in the passage of affect' (Seigworth and Gregg, 2010, p.2) The body is not a static being but always becoming by 'affective energies and creative motions' (Blackman, 2012, p.1). Through this formulation, the body is no longer what it has or is: it calls attention to the 'imperceptible dynamism of matter' (Clough, 2010); it opens up questions and imaginings related to what bodies can *do* and what bodies could *become* (Deleuze and Guattari (1983) as it encounters, interact and disengaged with human, non-human, material or immaterial.

Becoming, as Blackman (2012, p.106) argued, can be affected by 'crystallization of systems of intensity that delimit becomings and prevent or block the possibility of movement'. The focus on physical care at Evercare has led to an operation where human, material and immaterial resources are mainly allocated to ensure that physical need and wellness of residents were attended to. Such arrangement, as I discovered, has resulted in an oversight on leisure choices for residents. Although staff noted the need to help residents occupy their time and recognised the potential benefits leisure activities could offer, Evercare appears to face a constant challenge in its ability to provide leisure activities for residents in a consistent manner. During the period of research, Evercare did not have a department or a dedicated coordinator for lifestyle and activity. Agnes, the nursing manger, had responsibility for overseeing all operations at Evercare, including leisure programming. Leisure activities for residents were arranged and provided through several routes. First, the five-person physiotherapy team conducted the scheduled routine physical exercises. Although the

team runs the programme daily, residents' participation is usually from scheduled visits. Secondly, a contractual occupational therapist visits Evercare about two to three times a week to offer activities. Thirdly, various volunteer groups visit on ad hoc basis to provide entertainment or conduct recreational activities for residents, although these were usually one-off events, which were infrequent and had no continuity. Agnes was aware that Evercare has struggled with the regularity of leisure activity choices and access for residents, 'there was some student activities going on but on a very ad hoc basis ermm, and they sort of left and then the programme die on its own kind of thing.'

From the focus group discussion with staff, staff expressed their concerns about the unfavourable consequences the leisure-scarce situation might have on the residents' mental well-being. The lack of leisure choices and resources has also encouraged the emergence of a particular kind of aged bodies. Staff thus acknowledged implicitly that the current care arrangement at Evercare has induced lethargy more than vitality. Staff felt that the likelihood of residents developing negative feelings and thoughts increases when they are inactive.

Matt: To make them more active, they don't stay in bed all day long, thinking of those negative thoughts all these things. Something occupied them positively...

Jess: Positive things, positive thinking [simultaneous conversation].

Tracy: Occupy their mind ...[simultaneous conversation]

The leisure-scarce situation was not entirely neglected; Agnes had previously attempted to alleviate the situation by encouraging her care staff to be more involved in providing activities and engaging the residents. However, her efforts were met with several obstacles. First, despite knowing that some of her staff might be artistically inclined, she had difficulty in getting them to initiate programmes for the residents. Agnes felt her staff lacked the necessary ability to inspire and lead residents to discover and develop their ability:

Agnes: In terms of activities, it is also related to the function of the nursing home as well. Errmm...if we look at health care assistance, I got very artistic health care assistants around, but they somehow lack the ability to lead and inspire the residents in art. Because that is a skill in

itself to facilitate the group in the art session. They don't have the kind of skills to facilitate the residents in to the art session kind of thing.

Secondly, the shortage of human resources is often cited by staff as reason to justify their lack of ability to provide leisure activity programmes. Although the nursing manager has previously encouraged her staff to provide activities, the staff are unable to execute and sustain such activities. Coordinating operations and synchronising schedules can sometimes be a challenge for staff working across different departments in Evercare. Considering the amount of tasks care staff have to undertake, the physical work can be both physically and emotionally exhausting leaving them with very little extra physical or emotional capital to offer residents. Thirdly, It appears that the lack of motivation, willingness and initiative among care staff have posed an obstacle to ensure a consistent leisure activity programme. There have been previous attempts and initiatives to cajole staff to implement activities but without much success and this may also be an economic issue but also one of capacity and ability in that staff are unwilling to take on more tasks when they are barely coping with those they already have:

Agnes: Generally, to some extent yes. Because the health care staff will say that, 'we don't have enough staff, how to carry out activities.' That is the general consensus among all the wards if you go and speak to all the wards. [Chuckles]. I actually tried to implement games inside the hall ah...since uhmm...close to five years ago, ermm... usually there is staff assigned to the hall, and whether they keep the activities going or not, that is another issue. Some of the staff who are very 'on' will kick, get the ball rolling and things like that but there are times when they are all stationary, residents sit in a big circle, they do nothing there. Waiting for things to happen but nothing happens that kind of thing [chuckle]. Yeah so again ah...how much the staff want to participate in the activity is also a concern.

Jess, the therapy aide who assists both the physiotherapist and the occupational therapist, noted the challenge of continuity that the occupational therapy team faced in trying to provide leisure activities for residents. Such provision is often disrupted by the periodic intake of new residents at Evercare when staff experience a surge in administrative tasks. As a consequence, the occupational therapy team's leisure activities would become a lower priority and come to a halt at Evercare:

Jess: So far no one from outside, nobody conduct any programme. For occupational therapy, they did. Because they did a lot of art creative. They do different kinds of hands on. They got a lot of different. But from outside there is nobody. From occupational therapist there is. Every month, they do different creative art work. Even recycle items, and then painting, they did for each an every level. But now currently we can't do cause, there are a lot of new cases, we stopped that for a while. Once all back to normal, we will start back again.

The limited human resource was evident when I commenced the 12-Week programme and, to a certain degree, affected residents' participation. Since the participants were brought to the activity by staff on the first session, I assumed that ward staff would continue to bring their residents for subsequent sessions, but this was not the case. There were several occasions when I had to pick up participants proactively from their ward as the ward staff had overlooked or not registered the transfer to the art programme into their routine. Having noticed my predicament, the physiotherapy team, with whom I developed a good working relationship, stepped up to assist me by helping me make calls to remind their colleagues on the wards about the programme and to make arrangements to help the non-ambulant residents be brought to the programme. Jess spoke about some of the difficulties and challenges:

Jess: Not mean not enough, there is but there is er time management due to the maintenance situation we have, we also have to communicate with the maintenance people, because, we are back clashing by time, Patients must be ready, ready to do this programme. Because we are also facing a lot the time we got clash. Here the job is heavy duty. The problem is the time. Because patients are not ready yet, we are ready, patients not ready, we have to consider their medical terms also, they have to take medication also, we have we are addressing a lot already, for the nursing side, for them, how much we can able to bring them. But some patients they are willing to come everyday, but we can't bring them every day because, we have to cover each and every level.

Susie: Each and every level

Jess: But, some patients one time they do, they forget it about that. But some they want more, they come every day. We would love to bring them, but we have to give others, for timing also to bring them. If we never bring them, they will, why you never bring me today? They will ask. If you miss one session, we also got problem. But we also, we are helping them and we are also fighting back with them also to make them come, to make them their lives better. This one-hour session for them to give them therapeutic exercise, to make them to mobile, to move their arms and leg so that they can function them. I know some they want to do certain things, but there is nobody to give them

because each patient they need to. Every body want to have a personal person to encourage them. But here not everyone can because they have to take care of everybody. Because don't have enough people to. From outside we managed to help them, to bring them some happiness, for this one hour for them. The same thing for the art also, they are so happy.

Agnes considered that it has always been difficult for nursing homes to attract suitable staff willing to care for the elderly and with an appropriate skill set and ability, never mind finding staff with the skills to run leisure activities.

Agnes: I suppose cost is an issue [hesitant, concerned tone, spoken with a bit of a resignation], bringing in the right people to lead the programme is also an issue. Ermm...not all people have the heart for the elderly. Not in the local scene definitely, because you can advertise and things like that, but you don't get many respondents that kind of thing. And...ermm plus, the staff numbers, we are very lean in numbers. Ermm...once you are lean in numbers, how you are going to get the programme started is very tough. It is very tough.

Agnes' comments probably suggest that Evercare has reached a limit in its ability to provide residents with leisure activity options and access. Taking into consideration the challenges of financial constraint and difficulty in finding suitable human resources faced by Evercare, what might be a useful way to enable Evercare to better address the leisure and life quality needs of residents. The following section therefore explores the views of staff on how my Participatory Visual Arts (PVA) programme and the artist has helped address the limit of leisure faced by Evercare and its effect on the participants' well-being.

### **6.3 Invigorating the Lethargic Body with Participatory Visual Arts Programme**

'So, currently with what you have actually implemented here, I have spoken to ah...the occupational therapist as well as her team, and...they are saying that there are positive impact on the patients.' Agnes, Nursing Manager, Evercare

During the recruitment period for my PVA programme, it was common for Agnes and her colleagues to encounter what I am terming as the lethargic body – residents who felt hesitant, reluctant and doubtful about participating in the 12-Week

PVA programme. Agnes indicated that a few residents needed more persuading than others. Julie was a case that Agnes highlighted:

- Int: Did you have resident participants that you recommended for the programme that didn't want to participate initially, or just like a bit shy, or not eager but then stayed on with the programme?
- Agnes: The mute lady. [Referring to Julie]
- Int: Ok.
- Agnes: Initially she wasn't keen. But we sort of dragged her along sort of thing. I think she turned out to be very well at the end.

Despite her initial hesitation, Julie's interest in the programme developed more and more over the weeks. Both Agnes and Jess noticed the change in Julie's mood and her perceptible expressiveness over the time that she participated in the programme. Staff reported that prior to participating in the programme, Julie often had a stoic appearance. However, they noted that she became more expressive during the art sessions. Julie was observed to smile during the art sessions, when staff or I interacted with her to view her creations. For the staff, Julie's smile was clearly significant; I was told she had not been seen smiling for a while. They both also noted Julie's animated mood.

- Agnes: For some of them, I would say that it has created a very positive impact. There is this mute lady who has never smiled in her life before, and I used to have one resident who look after her but this patient has passed away, so she is sort of left alone. Ermm...and whenever you talk, you have actions with her, she usually frowns, she won't smile. But in this art lesson, she is smiling. And that is wonderful. [Chuckle]

Jess who works with Julie regularly during occupational therapy sessions also regarded Julie's smile as a breakthrough as she had not experienced this response in any of the sessions she had run with Julie:

- Jess: Ah most of the time. She love that thing so she if you put anything in front of her, She knows what she is going to do. She immediately...I will be moving around and when I come back, She will be done with the necklace beads. So we know that she is interest on this bead. But so far I have never seen her smile, or anything. She just keeps quiet. This is the first time when she does this, she smile at the art piece a lot. ah ya, she smiles. I went near her and I saw she was doing and I talked, was trying to communicate with her, you happy with this? She can't talk you know, but she smiled so the biggest difference on her

face. Others I know that they know they love to do this also. This case different seeing from her face, smiling, then she enjoyed it.

The transformation of Julie's attitude was also evident through the willingness and enthusiasm she showed when I picked her up at her ward on several occasions. She would greet me with a smile when I woke her from her nap and she would jump out of her bed and follow me to the activity area. Clare, a resident with disability due to stroke who we already met earlier, was another example of the hesitant body. In Clare's case, she was concerned that, given her disability, she would not be able to participate fully in the PVA programme. To some extent, these apprehensions are usual when embarking on something new; an initial hesitation can be attributed to a lack of experience with the art, a lack of confidence in one's ability or perhaps a lack of initial interest. In the case of the care home, the lack of choices and access to leisure activities also constrained opportunities for the hesitant body to discover its potential and realise its capabilities and, through such opportunities, to overcome these initial hesitations and doubts.

Staff saw the PVA programme as a resource that is useful to engage and invigorate the residents. They welcomed the stimulation, the art programme injects to help diversify help a seemingly bland routine. The PVA programme was valued as an outlet for expression the stimulation it offered residents. They perceived its potential to modify and supplement an otherwise dull lifestyle:

Selma: For them personally, it is a kind of, what you call that er...er what do you call that? Away from their, their daily activity. Their daily activity is eat, sleep, take medicine, shower, exercise and then just roll again. So if you put in something else, you know making art, they can express themselves. There is something else la you know.

Chin: Open their mind. Their life can be rather dull. Doing things like this is quite good. Besides, they have time. They have time.

Jess: It is better for them to have this programme so they can also change their mind also. If not they will not get fed up with one thing and they never focus.

Int: So giving them purpose?

Agnes: Yes a sense of purpose.

Int: Hmm..so you thinking having a art, regular artist led programme could also give them a sense of purpose?

Agnes: Yes. To say that I have this thing to do. I look forward to doing it. So it is different from the daily things where nothing happening. Ooo...Got

volunteer, ok lah, let's go and sit around to see what the volunteers are doing that kind of thing. So again, different dimension I guess.

While it was obvious that the programme allowed Evercare to expand the choice of active leisure activity for residents, it was not to simply serve as a time-filler for the participants to keep them occupied. Earlier findings from the participants indicated that they enjoyed the therapeutic qualities (see Section 5.3.1) and personal enrichment (see Section 5.3.2) afforded by the PVA programme. Besides offering the participant a change of scene from their ward, the art session was appreciated as a resource for sensory and cognitive stimulation. In doing so, the PVA programme also stirred desires to develop their skills, encouraged new ambitions and to discover new skills, helped overcome self-doubt. The staff were found to share similar opinion on the benefit of the programme, in particular, staff saw the potential of the programme to stimulate and maintain the cognitive wellbeing of residents. Susie explicitly described the creative activity as an opportunity to 'stimulate the cognitive function' of residents, informed through her observations of how the programme engaged the participants and demanded of them a continual process of decision in designing their artwork. During the focus group, a member of her team also expressed a similar viewpoint about the cognitive stimulating quality that the programme offered:

Alvin: Brain Stimulation.  
 Int: How do you think that is brain stimulating?  
 Alvin: Because if the residents put their hands on, their mind will also work together hand in hand. And that's when they can actually have the feel...  
 Matt: I think it is more of the coordination of hand and minds. As they think they work it out. Occupied, to stimulate their mind, to think to create. Very healthy for them.  
 Int: So you think that when they are creating their artwork, they are actually...  
 Matt: Thinking.  
 Int: Thinking about putting pieces together?  
 Matt: Correct.

For Agnes, the programme was an opportunity for residents to be exposed to new experiences and offered them a sense of purpose. She also appreciated that the programme offered challenge and stimulation to residents: 'So that is something which is erm, some thing wonderful about your art programme, it draws them out from that little cocoon they were in.' The programme effectively created a distinct

space and time that was characterised by play and quest in order to enable participants to explore their own journey of discovery. The benefits to residents observed by staff suggest that the realisation of one's ability to create, to make something out of nothing, can be an empowering experience and that this realisation and the journey of discovery it entails can be affirming of one's sense of being alive. This journey where one produced something out of nothing can elicit a sense of fulfilment and accomplishment.

Agnes: It gives them a purpose. A purpose of forming something out of nothing. And when they created something out of nothing, they are quite happy with what they have done. Ermm the product that have come out of the whole thing. Erm, even they themselves also knew that it wasn't perfectly, perfect art it was, but yet they were proud of what they have done. I think it is fantastic.

A particularly important observation was that staff also noted a growing ambition developing and a desire among participants to discover the kind of art work what they are able to realise and interest to improve their skills and the quality of their art pieces. This quality of the programme to foster purpose again seems to promote benefits to the participants' well-being:

Matt: Because they start the programme, they want their job to be finished so that they can see how much they can do. How well they can do. And that is very important.

Jess: The first session they came and do this, I saw them, oh must do an art piece, they just do like a job and they done the job and then they went back. After I think ermm two to three weeks, then they saw, oh my art piece getting better, so I must come and do better...more so that I can be better in my life. First two weeks, I noticed that they were not so engaged, and they didn't respond properly. They told me to do art piece, that why it feel like a homework just fill in and go. But after a few weeks, then I noticed that they engaged well. Oh my piece is getting perfect, so I must, eh next time, I will do better than that. Then I see from the beginning to now, went up, their perseverance went up. Their interest first was low. Why should I do this? This one not necessary at all. just for showcase some of them say. Then after that, it went up, the improvement, wah, my talent is showing off already so I must do better than my partner who is doing beside me. I noticed that also, they didn't tell out. I can see from their face expression, they so the art piece, oh, must better then him. Yes I noticed that. They did they want to challenge. Before he do, the better I must finish faster must do the piece well.

Another benefit achieved by the participatory visual arts programme as perceived by staff is the sense of ownership that accompanied the participants' art creation. Staff felt that the act of bringing something into existence is, in itself, empowering for participants. As much as creation is life giving, it is also an affirmation and sign to oneself of the continued existence of vitality within. The discovery and unfolding of this capacity seems to have a morale-boosting effect as staff noted a shift in the participants' state of emotion. Agnes observed the display of pride among participants:

Agnes: I mean for them to feel proud of their work, I think it is fantastic. Ermm, rarely do they urm, the problem with the patient here is, they don't have the chance to gain ownership to an item very much. In this art programme, you can feel that, hey I made this, this is mine. Let me present it to you all. So it gives them a sense of ownership. This is my own work. I created this. It's just like what Peter has done, I created it. I am proud of what I have done. You don't see that urmm...very much in the patients until this art session arrived.

The display of pride is an expression that she had never seen from her residents while caring from them and she is pleased that the programme is able to draw out this quality among participants:

Agnes: Thank you for bring such joy to the patients. I have never seen them, erm...so proud in their life before. Yes until that day, I was scared I was [not] around that day, because towards the last few weeks, I was not around kind of thing. I was away, somewhere, but not in that session itself. On the last week itself, I can see the happiness on the patients faces, which is wonderful. Wonderful. Yup. Thank you for bringing such joy to them.

### **6.3.1 Shifting Residents' Attitude and Behaviour: Ambition, Vigour and Hope**

Besides supplementing cognitive stimulation, the ability of the PVA programme to modify attitudes and behaviour among residents was also apparent to the staff. Over the course of the programme, staff also noticed the gradual change in behaviour and mood among some of the participants who were reputed of being difficult or withdrawn. This change can possibly be encouraged by the ability of the art session to provide an outlet for expression and the calming effects the creating process renders. Jess for example, noted this on Joe when he participated in the programme:

Jess: They release so many things, they release their mind stress, their medical terms, even their angers especially. When they, Most of the staff, a few of them they got anger this thing. Uncle Joe, is a very angry person, he always er..not communicating with his level because he will misunderstand and he will get angry. But when he do his art piece, he is very cool down, I noticed that very cool calm, he did his very perfect piece, he needs to show his talent. And we noticed that, we know him is a very hot tempered man, and he is very hard to make, certain things he will not be very understanding. He wants his own way, He will go his own way. When he came to this programme, I see a lot bigger different. He engage with this piece, he came up, show his talent, all his wonderful, what he can do. Uncle usually come for exercise. But nowadays he didn't. Because he didn't want to come up. But when he engaged in this art piece, he did lot of different things a lot of different success. He is so different. And so his anger also a little bit went down. Compared to last time, he get hot tempered very fast, he can't communicate with you. He always fight with the workers downstairs, but when he is doing this piece, he is very cool down. I asked him uncle, are you ok or not, you today look very calm. I even ask. I think I am perfect I am very cool. Why are you asking. I am doing my art piece, please don't disturb me. I notice that. [chortle]

In another example, Susie shared about the perceived change in Clare who is known to be uncooperative.

Susie: Yah. That's why also very difficult to handle her. If she likes the person, she can listen and she follows. If she don't like this person, she won't help you anymore. So Clare also very difficult to manage her at their level. So I also try to talk to her also. And now she changed, she changed.... She wants to help new residents, and she wants to share also. So she changed a lot. Otherwise very difficult to move her. Last time I asked her to join this physiotherapy, but she don't want, but she is willing to try in your art programme. I surprised also. Clare yah I surprised also. Very difficult.

Clare's willingness to participate in the art programme can be linked to the enrichment and stimulation she enjoyed getting from the art programme. From discussion on the research findings in Section 5.4, it is learnt that she appreciated the cognitive and sensory stimulations afforded by the programme, which she does not get from the care staff. Her enthusiasm and motivation can also be linked to the confidence she gained having discover her ability to develop herself despite her disability (see Section 5.4.1). Following the 12-Week PVA programme, Agnes, the nursing manager also noted that some of the participants were more willing to explore and showed more enthusiasm to participate in programmes, 'The patients who are not actively involved, now are more actively involved in programmes which is wonderful.'

The PVA programme seems to generate a sense of future among the participants. Agnes, who is well acquainted with residents who are participating in the programme, sensed their anticipation for the weekly sessions.

Agnes: Oh Yes...It was...ermm... for some of them, I will say that it manifest more than the others. Ermm...like I can sense that they are actually looking forward to the art session itself. Perhaps it is because of the way you guide them, that they get very comfortable with you guiding them. A different artist come in, a different kind of work may not...work very well with them in that respect as well. But because of your ability to be able to guide them, they sort of enjoy working with you as well. So the artist itself also makes a lot of difference when they are leading the group.

From this quotation, I also discovered that the participants' enthusiasm towards the art session was not simply linked to being given an opportunity to participate in an activity or to the attraction of the socialising opportunity that is inherent in the programme. Whilst these are clear motivations, it appears that participants were also drawn and motivated by the quality of my interpersonal communication and facilitation skills while delivering the activities.

Over the course of 12 weeks when the programme was conducted, staff observed gradual changes in the mood and morale among some participants. Staff in the physiotherapy team who had frequent contact with the participants through their physical exercise routine shared their observations of the progressive shift in some participants' attitude as they went through the participatory visual arts programme.

Agnes: For the patients, for those who have never been exposed to art and come into the art programme and realised that they can do thing that they were not able to do before, and...if the artist is willing to continue the programme, for a long term here, I think these residents would have presented things that they never expected in their whole life. Ermm they would know that they have done something...ermm much better than what they have first started off yeah. A sense of achievement, or people who says that...the...if you talk about the egoistic part of it, oh they are in the other higher plane now, where they felt that can perform something that is beautiful. Yeah.

Int: So you think an artist can benefit a nursing home.

Agnes: Yes! [laughs]

Jess: First at first they don't have any believe of themselves that they can do this.

Tracy: Confidence la...you mean.

Jess: Ya confidence first thing when they start this one they didn't have any belief. Joe had because I know he has the talent, but for the first beginning he started, he got the believe. But for the rest who came,

they don't have any belief in themselves. I cannot do this ah...please ah what for, call me also waste time. They have this on their mind but none of them didn't say it out. Cos they know if they say, they are hurting someone. But some elderly, they didn't say out. So once when the programme went through and you bring different, different ideas, like using clay, even the pictures of the fish, they leave that you make...ask them to colour. Then slowly they felt something believe in the trust that you can do something to change their better way for their life from the bad to become good. Most of them are very successful. That's why I see a lot of change, it makes them a lot of change on themselves. I see a lot of difference, really this programme is very great for them to have this thing. In future if they have, this programme conduct more, we also can help. The OT side we can help. But the problem is we cannot do more so we have to limit it for them. But if we have the more people to encourage to come, we can do it.

Matt: I think they are much more confident in themselves. The way they talk, the way they communicate with us also, they are more confident in the way they, they not like this one cannot that one cannot. Something like that. It makes them, ok I can do this, they are very confident lor.

Jess: One, two they have the confident 100%. The rest they didn't have the confidence, but once they started to do the first, based on this after the each level, they went on to explore different ideas, their confidence went up a lot. And the they, I have so much confidence on myself, some time they will say, I can do anything I can. I am not ah people who can't do anything. They some times they come and tell me this. We know their condition, certain things they can't do. But we don't want to let them know you cannot do this thing this. But they told us, I can do anything I can. I am not that type of person. They even they fight us also.

The programme has thus helped the participants to overcome the apprehension they had about their own capability. While at the same time, the programme also enabled them to discover, realise and connect themselves once again to a dormant creative potential within themselves. This perhaps demonstrates the plasticity that continues to exist in the aged body and its capacity to develop, to become. This also goes on to show the capability, different assembling of resources from human, non-human, material and immaterial is capable of engendering. Contrary to lethargic bodies engendered by the existing care arrangement, the PVA Programme has an enlivening effect on the participants.

Besides the unfolding of confidence among participants, staff also noted the programme has kindled ambition among participants. They recalled how some participants exude a strong desire and drive to better themselves. These energies from the aged bodies were imperceptible to staff until the implementation of the participatory visual arts programme.

Matt: And sometimes it is not after the session that they just forget about it you know. Some time eh this session I didn't do very well you know, then they go back and they will think you know. Eh! Next session what must I do to improve my...my job better.

Jess: yes I noticed as well. Because I see some of them, oh she is doing better than me, I must do better than them. Even if it is different colour never mind. I will do perfect and better than others. They could have the fight among the partners, I notice.

The display of vigour and drive from the participants has surprised the staff. They did not expect or envision their residents to have such capability. Agnes for example, expected that participants would lack motivation and might be highly dependent. However, upon observing the way the participants responded to the programme and seeing what they are capable of achieving, Agnes found the assumptions she had about the residents to be untrue. She was surprised by the vigour shown by participants as they connect and interact with me as the arts-health practitioner:

Agnes: I...I would expected a lot of prompting going on, urm...but seeing the smiles on their face from their final creation it was fantastic! One of them can even describe that can should be holding a fish, because the cat is eating a fish, and that is the imagination and it just comes out like that and it is wonderful! [Chuckle]

The sense of futurity that the programme introduced is also believed by staff to offer residents some sense of hope, which has invigorating effects on residents:

Int: Hmm. Do you think this kind of looking forward, has got an impact on their wellbeing?

Agnes: Yes...

Int: In what ways do you think it actually affects their wellbeing?

Agnes: It makes them feel more a..live!

Int: So anticipating?

Agnes: Yes...

Int: Hoping?

Agnes: Yes it helps them to feel motivated to live for another day.

The zeal displayed by some participants also took staff by surprise. Staff rarely perceived such intense displays of anticipation from residents, but the programme seems to elicit a sense of eagerness. In Clare's case, the programme acts as a form of

retreat, where she felt she could be relaxed and, as such, she would often turn up early for the sessions:

Jess: A lot of change can be expected from them. They can move on. They can move on to many things in their live and this kind of thing in next time, they can change anything. They may get anger, temper they see colour, they can change their person or may be medical side if they do this sort of things. I say so far, the work from this a lot of change I saw. They themselves, Clare, not yet ready yet, she came first. She came first and I was surprised.

Susie: One o'clock she already there.

Jess: She came first, The motivation she is engaged with this. She love it a lot that is why she want to come before. I said, not yet time, and then I tell her not yet time, and she said, never mind, I come for a while and just relax here. When they come, I go there.[laughs] she is the first person.

Staff also noted that the participants became more animated and responsive after they started participating in the programme. The enthusiasm shown by participants towards the programme was a form of energy that staff had not noticed among residents previous. Staff noted the participant's drive and interest to the next session.

Int: Are you all surprised by the responses that they are giving you towards their own creation?

Matt: Yes! [simultaneous]

Jess: Yes we are so surprised. We usually see them they don't give any response. Normally we see them, Why should I respond to you. I am not interested leave me alone they say.

Jess: when they did this piece..

Matt: They will say boring la...[laughs]

Jess: Yeah when they did this piece, they come and ask me, When is the next programme ah?I need to go up to do this piece, they come and ask me. If I pass by their wars, they will come and ask me. This coming Friday, In the few weeks when you are not around, why ah..this two weeks they never come here why never...mummy, I think they may have some problem there, so they can't come. But they, this week got or not. This week they will come or not? Can I do my art piece, definitely, they some time they come and engage and they ask me, they say, in future, they come back again, that one I don't know, but if there is, they will come back and do.

The programme, to a certain extent, thus made perceptible to the staff an important aspect of the residents that staff had not seen before, that is their creative potential

and their imaginative abilities. But more importantly, I felt the creative event permitted and encouraged the expression of vitality:

Susie: We also very wonderful...Woah! They can do such a thing. We also...we never think that they can do like this way, so I also appreciate the job also.

Matt: Ermm..no I don't think [laughs] the things come out form them is so..so good. [...] Never expected. Never expected it to be so good.

Jess: We never expected one person can do so perfection. Even the fish. I First I saw the painting, I was thinking who did this cos the fish look like real. But when I ask him, he told me that uncle Joe did this, I unexpected this from this person [tee-hee]. Because we know him that he can do exercise, we never know he has great talent on him because so far he hasn't told anything about his art piece. When the piece that you showed me I thought it was someone else who can do so professional. I thought your member did this. I thought these two are samples. I never expect that it is from the resident.

With increased confidence, staff also noted that some participants were gradually developing more independence:

Jess: When they did this piece, I noticed most of them didn't ask so much. They want they can do it, They can managed to do 70% by themselves. They didn't ask so much from your members, I need help, this they didn't. They try to make at least 70% to make themselves and the rest 30%, they did ask for help. I...notice that.

Matt: In a way they become more independent. And not always depend on others to do it for them. Sort of.

### **6.3.2 Creative Activities as Social Gel**

Staff viewed the art programme as an opportunity to promote socialising for residents. This view resonates with the understanding of leisure activity as creating a pro-socialising space that promotes opportunities for people to connect, interact and build relationships, that I identified and proposed as one of the contributing benefits that the art programme could offer to residents. Staff believed that leisure activities can facilitate opportunity for residents to establish relationships with others, whether with the facilitators or other residents. These informal relationships generate a valuable opportunity through which residents can share and express their thoughts and feelings; residents would otherwise not be unable to express themselves, according to staff, as they are largely left alone with no-one to talk to.

Susie: firstly, when ..if occupied with them, who participate in group exercise. This neighbour or staff. They make friend with them. This is the first we got. Very friendly relationship. Otherwise if you not join them, they will not be...how to say, not friend with you, can say with a stranger, they don't want to say out their feeling, like that ya really.

Residents were rarely seen interacting with each other beyond the usual exchange of pleasantries, however, Matt noted that the art sessions encouraged extended interaction amongst participants as they were seen discussing their work among themselves, from time to time.

Matt: And some times they can share among themselves also. They see each other [laughs]

Besides offering an opportunity for socialisation, the programme also fostered a feeling of inclusion for some residents who might have been marginalised or had encountered difficulty in connecting with others. Betty, who had struggled to fit in with her counterparts due to her grumpy personality, appeared much more at ease while participating in the art programme.

Agnes: [giggles] Yes! You can sense that they are looking forward to it. You...I mean in that way it was great...ermm for them to come to terms with it. Betty, this lady, short lady, was never accepted in any group, because she has personality issues. But the art people sort of take her in as part of them. Allow her to do what she needs to be done. That was wonderful. [laughs]

Being involved in the programme also generated conversation topics that participants and staff continued with one another beyond the duration of the art session. Staff observed that some participants would occasionally recall and discuss their opinion of their art pieces and experiences,

Int: Did the residents come and tell you about this?

Matt: Yah! Some of them. So it helps them to continue to think you know. How to make their product more...

Tracy: More nicer

Matt: More better, more nicer for people to view.

Int: So there are incidences where, the residents when you are working with them they tell you about..

Jess: Yah some times they will tell us also.

Matt: They will tell you not nice...not nice, next week I will do better.[laughs]

- Jess: Even when your programme has finished, they ask you, eh no more arts already? So they come and ask me, aiya, so sad, with some more days so that we can do some more things, they come and ask me. I said in future if they come back again, you can do more arts.
- Matt: I tell them, your job so nice ah, your product they so happy [chortle]. I want to do better next time.
- Jess: Sometimes they say, 'no, no, no', this time I do my piece is not nice, but it is looking nice. I some time say, it looks nice, I think it is fantastic but they themselves say, 'no no no I will do better than them'.

### 6.3.3 A Deregulating Occasion: Creative-Role, Expression of Vitality and Well-being

The art programme appears to be a unique and rare occasion that enabled participants to engage in imaginative and creative play. The sense of play and opportunity to wander afforded by the art session set it apart from other activities that felt more regimented at Evercare where residents have limited agency and felt like they were undergoing some form of treatment. In doing so, the art session also provided an opportunity for participants to put into reality their thoughts and ideas. The self-led creative exploration and sense of discovery appear to give participants a sense of freedom, fulfilment and wonderment. The agency and sense of fulfilment experienced by participants seems to foster autonomy and interest them to participate further.

Agnes: ermm...what the OT did wasn't something very dynamic. What you have done is something very different. Because, at the end of the project itself, ermm...even with the watercolour, you don't have any base, outline for them to colour. You just let them to fill the papers with colours and it itself erm.. there were some beautiful work that is being done in that sense. Ermm and you allow the elderly to express it in their own way. You don't not fixated, eh you coloured out of line already. you know, we don't do that to the patient. So, whereas your art is very free flowing in itself. It allows the patients or the resident express their own sense of art work.

- Matt: Cos they think that they are not under treatment. Art is something that they like to do. So they will do it.
- Jess: Even though not under treatment also, it is like the air going through, colours following behind you show you the perfect piece of what they want to do.
- Matt: There is no force in them, doing this thing. They can do it naturally.
- Jess: Because when they do the art piece I think it is not resistance for them that they must follow this colour this and that. Any colour can be an art piece. Any shape can be an art piece. Anything can be an art piece. Its Just what you think.
- Int: So do you think the art session also give them a sense of freedom?
- Jess: Yes! [simultaneous]

Tracy: Yah.  
 Susie: got the freedom  
 Matt: Definitely  
 Alvin: Precisely.

The art session also offered participants an opportunity to adopt a different role. Instead of the usual lethargic, sick or disabled role they usually enact in their everyday ward life, the art session encouraged them to take on a different role as the creative and productive body. Staff also regard the art activity as an alternative approach to encourage residents to move and to help them maintain or improve their functional ability and particularly for those who are reluctant to participate in physical exercise. Although art making does require the use of strength and a range of motions, residents may not necessarily associate these kinds of movement to formal exercise and therefore are more willing to participate:

Jess: Actually it is necessary...it is good to have this kind of programme, It can change their daily routine life, to see different things, they can hands on beside lying on their beds or doing this thing, they can see through colours, they can see one thing and they can see difference. I see this programme that some see different colours, they enjoy. But if you do regularly, they can have a life style difference. They know they can feel what they are doing. Then it is also like a therapy also, when hands on, their hands, also they do, if you ask them to do normal exercise, they don't. If you ask them to touch something and ask them to do something, it is also a good for them also. You can see the difference.

Matt: It is also a form of exercise for them to stretch their hands to and fro..in and out.

Int: So you feel that the art work will enable them to..

Jess: Yup!

Matt: Ya stretching do stretching at the same time

Tracy: Hand movement also..

Int: Hand movement...so you think the artwork will encourage them to have hand movement.

Matt: Hand movement.

Susie: Like the resident thinking ah, if come to lets say physio therapy or occupational therapy, they know that they have to do have to do hand exercise already. They thinking like that. So may be they have to definitely use their hand. Their upper limbs both. One hand or two hand. They thinking. But I thinking This er.. art programme ah, they never think about they have to use their hand. And they follow your programme, and they uses their hand very well.

Jess: She don't like to come exercise but she manage to come up to do her art piece. Said I don't want to do my exercise but I want to do my art

piece. But she never realise that she is using her hand more and her mobility has gotten better but she didn't realised but she wants to do more of this piece. She makes colours, she bring out my life better.

Staff appreciated the multi-sensorial stimulation the programme offered participants:

Jess: Yes they did, really they do a part help for them also. Because some time, we ask them to do therapeutic exercise, some they not going to do because they say, same colour thing, same object, same [mumbles], same things they doing. Because their mind is register. But art piece they doing different things. Even touching papers, clays, paintings, water, glue, everything they touching, something different like you are eating food how you taste. At the same time, they touching different things. And also make them also, they will think back, oh the main therapy they ask me to do this arh, I didn't use my hands at all. When I do this piece, It is like some they have shoulder problem. Especially some few residents, so I do this art piece, my shoulder problem a little bit went down. Some of them. So I think this movement, Because exercise they fix to one direction, they, for they artist, they have to move their hand tips, They have to reach, they have to paint, they have to mix, they have to colour, to use the thing, they felt that a kind of exercise. One two they realise that they doing exercise, eh what this art piece arh, is like an exercise you know, they come and told me that. I pretend that, I oh really, I know but I pretend that I really ok, but some they never realise. They never realise. But they are thinking this is art piece what, where got exercise?

Interestingly, although healing is not the primary mission and concern for arts-health practitioner, the staff understood the processes through 'artifying' of creativity, play and discovery to hold an inherent healing potential for those participating.

Agnes: Yes...I mean, my personal belief. I believe art is healing to a person to some extend where it is horrific art or good art, wonderful work or not so wonderful work, but by the fact that you are doing something, it actually heals the mind and heals the body to some extend. And...ermm, what I believe was being displayed by the patients itself and I think is beautiful.

#### **6.3.4 Art as Enrichment**

I am aware that prior to the introduction of my participatory visual arts programme, the occupational therapist (OT) occasionally conducted art sessions with residents. In the opinion of the nursing manager, the art sessions offered by the OT were a very different experience from the programme I offered. The art activities by the OT appeared to be limited in the extent of the challenge and adventure posed to residents and the outcome of the activities predictable; residents were usually

provided with a colouring template to fill with colour. The nursing manager commented,

'No. not much expectation for some of the session where the occupational therapist carry out where colouring of pictures and things like that. Urrmm...but I won't...not all the resident enjoy just playing with colour like this.'

Agnes associated the colouring activity as being a childlike activity implicitly critiquing the lack of age-appropriateness of the activity,

'and they get the residents to colour onto the pictures. It is like what children are doing you know, got the outline of the picture and they just inside kind of thing...'

From my conversation with Jess, who supports the occupational therapist, I learnt that art is used as a tool in therapy to address and treat physical functional issues:

Jess: Our main focus is on the patient's physical hand movement. Creating art piece is not our priority. We can give them different things to feel with their hands. They can use paint, colour, crayons, erm any recycling items. They do paper cutting using scissors. All these activities provide tactile stimulation and encourage them to use their hands. But your art activity is different. You lead them to discover and show their talents with using the colour, the clay, the paintings. When using art, the occupational therapist is interested in stretching and strengthening and mobilizing activity accompanying art making. With art, patient don't think about they are exercising.

This was unlike the programme I offered, in which the objective related to the intent to create access and exposure to aesthetic knowledge and skills. In doing so, I initiated an event to facilitate discovery, enrichment and the opportunity to develop capacity. The time and space of the event also served as an outlet for expression and imaginative play. Matt, the therapy aide noted that the lack of association of the artist with the institution could be motivating for participants as they relate to the artist differently. The artist is seen as a dynamic and stimulating figure that can enrich participants with skills, knowledge while taking the participant on an adventure of discovery and play. Thus, the artist seems to provide a space for development rather than treatment.

Matt: Different kind of concept lah. May be for occupational therapy they think that they need to exercise, so that everyday they are doing the same thing. Whereas for you all the artist, they feel that oh I am doing something different. You know. Trained by a professional, so they put in more effort to produce their own product hor, I mean that is the

difference lah. They got different kind of concepts. They will lean towards the professional artist way of doing things. They ask them to create things, more challenging kind of work. Because occupational therapy may be asking them to do the same thing all over again, and again ever day, so they would think that ah, professional artist can make me do certain things that I never see before, It is a kind of challenge

#### 6.4 Unfolding the Flourishing-Aged Body

Staff observations of the participants' response to the art programme and their reaction in turn towards the participants' creativity have potentially notable impacts on staff assumptions of the aged body in nursing homes. Prior to the programme, staff had no perception of the aged body as potentially a body of vigour with a capacity to create, imagine and thrive. As such, their role was to maintain the aged body were maintained rather than encouraging it to thrive. Although the residents were kept alive, their aliveness was nonetheless elusive. However, the unexpected display of vigour and capability by participants and through the participatory visual arts programme debunked these assumptions held by staff. The participatory visual arts programme was perceived to enliven the supposedly lethargic body, in an unfolding of a flourishing body. In doing so, it seems to shift staff perceptions of the aged body away from one that lacks vigour to one that is capable of 'blooming', as Agnes puts it,

Int: So through through..so the art work, seeing all these creation by the residents , so for the first time, it also allow you, did it kind of like allow you to look at the person in a new way?

Agnes: Oh yes! [snigger]

Int: Were you surprised by some of them in terms of their ability?

Agnes: Oh yes! Definitely. Ermm...i..i didn't know that ermm, some of them can create beautiful things, beautiful cat...who can stand up on four legs! Ermm...I didn't know that he was so artistic till this and he was a new patient actually, erm..has been here for close to a year or so, and I didn't know that he was so artistic in...inclined until such a way. And it was beautiful! I would say it was beautiful. Even the objects that may not seem to be beautiful to other people, I still think that to the patients themselves, it's a beauty in itself. I mean It may not be something of professional level that you know that you are expecting it, but it is something that the residents has created and they are proud of it and I am happy with it. That they are proud of what they have done actually. Yes.

Int: So you feel that the art work also give us an insight to...

Agnes: The patients themselves.

Int: To the potential of the patients themselves?

Agnes: Yes!

Int: Hmm...

- Agnes: In fact, we could draw out some of the ability from them. You can see them blooming in that sense.
- Int: So blooming in that sense, so you like feel that nursing home still can be place where people can blossom?
- Agnes: Yes.

#### 6.4.1 'They Want to Fight Back': A Display of Resilience

Staff felt that, as an arts-health practitioner, I have enabled participants, through their encounters with me, to tap into and connect with a potential that otherwise they might not have been aware of. The gain in motivation upon discovering their ability through the art programme is seen by staff as an affirming attribute of my practice. The unfolding of the flourishing body has at the same time disclosed a sense of resilience among the aged body. Having observed how the encounter through the art programme drew out the participants' capacity to create, staff regarded this capacity as a sign of resistance by the aged body. Through making, participants displayed the vigour of a life force characterised by imagination and creativity that continues to exist within them. Thus, they resist being relegated to an ageist stereotype of the aged body as incompetent and lacking vigour:

- Int: What do you think is positive that could come out from all these things that they are doing? How do you think all this make them feel?
- Matt: Because it is their achievement, Wah...they never expect that they can do so well right [laughs],
- Int: Ah.. so you think.
- Alvin: Mission accomplished.
- Matt: Yah.
- Int: Mission accomplished.
- Matt: Ya...! It is an achievement to them la.
- Int: Ok so you think that sense of achievement contributes.
- Matt: Ya Make them more confidence in themselves. they want to do more, they want to be better. They are showing off.
- Jess: and then they will say, I want to come out of my sickness.
- Matt: Yah...
- Jess: [giggle] Come out and do. Challenge that I can beat anybody and themselves. Because I know some people they want to come out from.
- Matt: I think it helps in their medical condition, definitely. [simultaneous conversation]
- Jess: Then the patient also know what their condition is but they want to fight back to do something success to come out from their life. But they know some time their body internal body cannot due to their medical condition but they want to fight back. Here a lot of patients they want to fight back, but I don't think that I am a sick person, I am an old man or what, I can do what I can do. Until when my life ends, I go through what can I do. That is why I can see each and every body, who participate in this programme because they want to fight back

and do something different. Beside than I am staying in my room, then looking at the TV and nothing else to communicates, so might then do something with hands, something with something difference, I can pass thorough it. Then Same time they can think about positive things than negative, I can't do anything this and that. It is also a motivation for them.

Staff felt the goal-setting quality of the programme ignited and drew out a sense of determination among participants. The drive that participants displayed was perceived by staff to be a positive affect generated through the programme, which led participants to look beyond their immediate personal predicament. Staff also noted that meeting the challenges posed by the creative process brings a quality of fulfilment from participants realising their ability to accomplish the task through conceptualising and physically realising their work and, along the way, problem solving and adjusting to the demands of the various creative techniques to which they were introduced to and with which they had to become familiar.

Jess: They fighting back also...I must do this successfully, and you can see that they give their full support in the things they want to do. They give their full. I go time some times I see the programme there, I see that they give their full support on what they need to do on their art piece, I see that they are trying to fight back. They even they, some time event they are able to do certain things due to medical but they fight back to do the piece they need to do. Is nice or not nice, I need the piece to be done to show that I can do it. Even if nice ugly or never mind. I don't care, I just need to finish the piece I need to show. Even what kind of shape also never mind, Like some time they want to show the perfect piece, challenge I need to do it, I know I can do everything. I know that other people cant able to do it. I could see each an everybody they do they show, even they show a little bit talent, They show their full power I can do it, I can do anything. Other people can do this and this and that. Even the clay they touched it ah,The first time they touched, Some they, especially Charlie don't like to touch the clay and use gloves, he managed to go through the other session without the gloves any more. He also show his full power, to show that no need the gloves, I can do it with my hands, you can see he tried that, the first time, I ask if he want to use, after that, he doesn't use the gloves at all. I saw he fight back, never mind, clear already what for am I scared about that, I can do it with this, then he also never mind and agreed. He showed his talent her also. I see this art piece make them fight back also. Really they did full power to show that I can do anything. I will not be bargain, even if nice or not nice, I can do it. I see the difference from them. Compared to the first programme, painting of course require this, you guys use this blow this, When it comes to this part it is the main challenge for them. This is the first time they touching with clay. And they never come across clay with white colours. Because lots of patients asked me what kind of clay is this. They ask me. Just a normal paper clay. They say, I have never seen clay

like this. You know in those time they see clay, clay is usually brown. They used to make pots this things. How can this thing can make this type of things meh? Some ask, if you have the talent, you can do anything in your life.

The programme also led staff to recognising the flourishing potential among the aged body. The unfolding of the flourishing body also staff to see the possibility and benefit a nurturing and encouraging attitude bring to aged body in nursing home, in this instance how my practice shifted participants expectation of themselves and led them to discover their ability:

Matt: Don't under estimate them lah actually right? [Laughs] because some time they can do really impossible thing for us to see. Right so, continue to give the encouragement, I believe they can do even more for us to know. [...] I think nothing is impossible lah. I think by nurturing, they can be much better. Then hopefully in future, they will participate more in this art.

Tracy: Don't always think of their sickness la, like always think of having sickness, or like er...I old already cannot do anything.

Jess: Yes! There is a lot of space. They can do it each and everybody. Not only particular thing that is need. Even any patient they can do it. They can blossom their life better than that. Sticking to one think, think that I am unable person, I can't do anything, they can blossom, just need the motivation and encouragement for them each and everybody they can come out from their lives.

However, staff also acknowledged that time and opportunity are required to allow the flourishing body to be unfolded.

Matt: Only if we can give them time, give them opportunity, I believe they can do it definitely.

#### **6.4.2 Flourishing-Aged Body as Inspiration**

This release of capacities by the residents appears to affect the staff's perceptions of their own potential and their sense of self-belief. Staff were inspired by the persistence showed by residents while undertaking the art session:

Int: Do you think you are inspired by what you saw?

Matt: Yah! Yah! Of course.

Int: What kind of inspiration did you get from them?

Matt: We must not be so er..so er so..

Tracy: Negative thinking.  
 Matt: Negative thinking and nothing is impossible that we can do also. They can do we also can do also right. [laugh]  
 Int: So they have showed you something?  
 Matt: Yah! It helps.  
 Int: What did it show you?  
 Matt: Show that by..by what ah? By perseverance, they still can complete the art right?  
 Int: So you see perseverance?  
 Matt: Yes correct. Actually in fact it also helped us in our own thinking also. Some times we as a normal person we also think that we cannot do this, cannot do that. But you can see that you are so old, they are so sick, yet they can do things, those impossible thing that they can do. Isn't that wonderful? [laugh]  
 Int: What about you Susie?  
 Susie: I also feel like that, I cannot do this art work. So later..yah correct,  
 Int: I think to every body that what they are trying to tell you.  
 Susie: so at first I am also thinking I am drawing some anatomy also, I think cannot be drawn you know this. Now I have to try myself out so I also can draw. So everybody have to try out. Must try out.  
 Int: So from the resident's work you, they fight back and tell you that if I can..why..  
 Jess: why I myself cannot do it.  
 Susie: Why I cannot do it right?  
 Int: Ok interesting. What about you?  
 Alvin: Err..well I mean for residents, again it is not end of the world you know. It is like, they can try and what he put the word is perseverance, so then upon completion, or even in the midst of them doing something, they know that they have started doing and they feel good about themselves. So and the next step is to keep trying. And go for better options.

The participants' perseverance have also encouraged the staff to overcome their own self limiting attitude they have about their personal creative ability and opened up their willingness to try.

### **6.5 Participant's Art as Agency: De-Stigmatising Aged Body**

Selma saw the potential of the residents' artwork to help initiate change to impressions about nursing home residents. She thinks it will be good if there is an opportunity to display the residents' artwork around the lobby of Evercare for visitors and family to view. She considers that an encounter with the work of the residents could challenge and dispel the stereotypical view and educate people to a different view of those ageing bodies that are resident in nursing homes.

Selma: This one shows their enthusiasms. Ahh...this also shows although they are dementia, because the taboo ah, the idea of people, they say oh dementia ah, they will say that.

Gone case very trouble some, very, you know annoying. But if you show, show and focus, everybody will come in and they will see this is work done by the residents here. Although they are dementia cases, but they, they are not, not that annoying kind [raised voice], of, of, arh, personality you know. But they are still, still productive. They still can...

In addition, Selma also felt that the artwork of residents would be useful as an educational tool for staff, and particularly for new staff, to shift the perception of residents by those who will be taking care of them. Selma thinks the display of artwork can be educational not only in debunking certain negative constructions of residents held by new staff but also in allaying their anxieties in coming to work in the nursing home.

Selma: At least, at least, for those, for those who are new here, especially new workers who they come in, arh.. just like, I reflect on my own experience. When I come here, they were telling that oh you will be handling a lot of dementia cases, arh, very ar, ,a little bit troubled personality.

Despite seeing the benefits of the art, Selma also acknowledged her own lack of ability and patience to conduct enrichment programme for residents,

Selma: Challenging ah. Challenging bad reputation. I was not the image that I played in my mind. So must be very annoying, it is kind of encouragement when you go in, especially for new staff you know, oh this is done by the resident you know. At least although they are dementia, if you give them a little bit encouragement, a little bit of love, a bit of... of care you know. They can do something. I don't think I have the patience to do all this. But If you can give them encouragement, I think they can. They can do something. So in the way that The concept that people say that dementia patients they are annoying, old people, they are a..nnooy...ing that one is all, actually is not, not applicable.

Nonetheless, Selma thinks that nursing home should be a place where ageing bodies can still flourish,

Selma: Yessss! Why not? why not? You know some time, you can never tell you know. Some times their art, to you or me are , just is like arh nothing la you know. But some times it can be a piece of art work. It is different, it show case their perseverance, their patience, their need, their want to do something. It is good you know. I like it. I like it! I like it very much. Especially if you want to showcase.

Selma also saw the potential of the artwork to be conversational pieces that staff can use to encourage residents to engage in social interaction. However, although Selma is impressed and inspired by the residents' artwork, she remains uncertain and a little hesitant about the prospect of having an artist in a nursing home.

## 6.6 Contributions of Arts-Health Practitioner in a Nursing home

The idea of having an artist involved to serve in a nursing home was not something any of the staff had ever considered. Staff had the impression that artists are a group of people that are highly specialised and have specific concerns in expressing themselves and their talent; artists were seen as not having an investment in others. Furthermore, in the existing paradigm of care which often adopts a medicalised assembly of staff such as nurses, care aides and allied health professionals, the artist is a remote choice or consideration:

Agnes: I have never imagined an artist coming to a nursing home [Chuckle] [...] Because a lot of artists are in their own world. They are immersed in their own art itself. Not many would like to engage with other person with the art that they are doing. And when you came knocking on my door, I say yes why not? Think different. And it was, I was glad of the way, you actually led them into the programme itself. And you sort of encourage them to do what they can with what they have. You know. That is itself turned out something that is unexpected but it was something, that I would say, some thing wonderful came out of it. Ya.

While this notion of artist as egocentric holds a degree of truth, it does not reflect the wider potential and practice of the arts. What this view suggests is also a further need for staff to be made aware of the broader spectrum of artistic practice, such as this kind of arts-health endeavour; exposing staff at the nursing home to the potential contributions that an artist, in this case an arts-health practitioner, can make in terms of improving care is an important part of the intervention informing this research. Staff lack of awareness of the potential of the artist for a nursing home, indicated a gap between the arts sector and the care sector. Artists are perceived to be not only egotistical, but also unapproachable individuals that need to be invited to contribute to the nursing home. Given this situation, this exploratory effort to connect the arts with care can be seen as a pilot and a step towards better mutual understanding, a

demystification of each others' assumptions and an open collaboration to generate the synergies that could inform a better quality of life for residents in nursing homes:

Agnes: The kind of people who would come in to a nursing home, I have never had an artist come in to a nursing home ermm...to volunteer their time here before. I never had that kind of chance. The performance yes. The people who perform arts, ermm, were engaged by certain organization to come and perform. Not because they come in on their own. I realised that artist themselves need an invitation to invite them in. You don't get the flowing in on their own as per se. If I have big event, it is the organization themselves that invite the groups to come in, to create a platform for the resident to respond kind of thing.

In addition to expanding the range of activities for the residents, Staff also felt that there was a need for an avenue to showcase the participants' artwork. The public display of the participants' artwork is seen as a form of affirmation and encouragement that can inspire the participants further. The showcase of work is also regarded by staff as an advocacy to attest the capability and potential of residents to continue to develop themselves and to demystify stereotypical assumption of nursing home residents. The desire and enthusiasm of participants to showcase their work was expressed in earlier findings (see Section 5.4). The display and sharing of artwork seemed to elicit a sense of accomplishment and pride.

Selma: Artist...[uncertainty, suspicious tone] in the way that arh... does not interfere with their daily life. You come, you encourage them, hmm! You encourage them. But if you encourage them just like this, and then after that finished already put in the locker...nothing, nobody see. Nobody knows. Arh? I think it is a waste of time for you being here also right. It will at least let people know that, yes they are old, they are sick but if you care enough, you show them your patience, they can be productive in a way you know. They can show you the other side of their...something like that.

I agree to the staff's view on the need to display the participants' artwork and took active effort to find ways to create such opportunity. For example, I would put up the artwork of the participants for display at the venue of the art session. The colourful and imaginative display of artwork not only created excitement among the participants, where they are able to see, enjoy and be inspired by the work of their counterparts. It also attracted staff and non-participating residents to view the work. In 2015, a selection of the participants' artwork was invited to be displayed at the

Agency for Integrated Care Community Care Seminar in Singapore as an advocacy for art and wellness in nursing homes.

### 6.6.1 Arts-Health Practitioner as a Life Quality Resource

Agnes acknowledged explicitly that the current staffing at Evercare posed some limits on the level of psychosocial care, an area that she considers is inadequately addressed in Evercare. She also conveyed a desire to address the situation and claimed that the organisation has taken steps towards improving its leisure-scarce situation. Through observing the programme, she felt the participatory arts programme had demonstrated its potential by attending well to the psychosocial aspect of care at Evercare.

Int: So how might artist complement caring in a nursing home? What kind of care do you think we attend to?

Agnes: The psycho dynamic. Psychosocial care.

Int: So you think art, this work that is done by the artist can compliment the psychosocial side of caring in nursing home.

Agnes: Yes...

Int: Can you share with me, I am not familiar with psychosocial.

Agnes: urm...the interaction urmm, in the art itself, helps to present the art to the people in public to say that, hey, this is how I look at things, Ermm, it also create this psychosocial wellness in them to say hey I can do this, I never thought I can do this before. Ah so that is the psychosocial aspect of the care that comes out.

Int: So do you think the psychosocial aspect of care is also important to the fundamentals of care...

Agnes: Oh Yes!

Int: In the nursing home?

Agnes: Yes, Yes...it is important. Ermm, what I have been drawing out some of them in the past is all on the psychosocial aspect. Not so, I don't do so much direct caring but I engage them in talking, engage them in sensing the place around for me kind of thing. It is all psychosocial aspect that I dealt with ermm, with interaction with them that kind of thing. And...that itself, Some times can be not, can, it can create a sense where it is not too healthy as well. Because they can be too over dependent on me. That is the reason why I also wanted to break a little bit rather than...

Int: To have a variety also..

Agnes: Yes..not just myself engaging them.

Int: So you feel that, an artist, having a programme run by an artist can actually compliment the pys...psychosocial.

Agnes: The psychosocial aspect

Int: Of care.

Agnes: Yes.

Besides attending to the need to create a pro-social space that could facilitate socialising, staff saw the stimulation that the social occasion prompted. The activities were perceived to have the ability to engage, activate and even modify participants' attitudes and outlook on life:

- Int: So what do you think an artist gives?
- Alvin: The impression the mind-set, the impression, er... the holistic picture, and er...delivering the end product to er.. residents.
- Int: So you think that the artist would be beneficial for the residents.
- Alvin: Yes.
- Int: What about you?
- Tracy: Same thing also la. Er..can coordinate their mind, and then ah creative, creative, because artist normally need to be creative. So make their mind more creative.
- Jess: And make their mind working moments. Here they think one thing and they jam and stuck. One they move their mind, this not only hand, and also communicating their mind also. Cos the mind tell you what you need to do. So you hand is functioning. Without your mind you can function your hands. Even if you function with you hands ah, you mind never move on. Never register anything. Means the mind can see through oh, I am looking at this picture, Oh but the can must be in this design, So they register themselves, oh I need to shift, the mind is telling you that you need to do this, this you need to create, you need to do colouring, you need to create an art piece, they mind is telling you and also sometimes your mind is moving, your hands also moving, both of them moving together. How they register with this pieces. And they also see from your members, how you all giving them the motivations, can display. Oh if you do this, art is a free thinker, you can do anything. It doesn't mean you must stick to one item, you can create any kind of art piece, what kind of environment, or what kind of medical condition, what kind of piece. You can do it anywhere, any place, even can do it at the parks, or any nature, any places. You can do art piece. Not necessary must be fixed to one area. It can be anything they can do. This is to feel, and make their mind move, and make their hand movement.
- Susie: And you can change their behaviour also...we difficult here, we very difficult to manage behaviour, if like that they change their mind their mind with this art programme. And can change their mind set right. And can change their relationship with other staff and the room-mate also.

### 6.6.2 Enthusiasm for the Arts-Health Practitioner

Upon witnessing the various positive affects that the programme generated, staff developed an enthusiasm towards the arts-health practitioner. Despite no previous experience and some misgivings as described above, they expressed growing interest in the prospect of having an artist in the nursing home and are keen to see more residents involved in the programme:

Int: So what is your view of having a regular artist led programme in a nursing home?

Agnes: It will be wonderful if it happens.[giggles and laugh]

Matt: so hopefully it can be made into a regular kind of activity for them la. I mean ultimately, they will gain in a long run.

Jess: I hope ah more of this programme will come in any, all in Singapore, there is lots of nursing home, can come with this type of programme, and able to change the physical and mental side.

Susie: We need to engage them more through this programme so they can try their life, I think so, we can change their mind set, we can change their behaviour, we facing a lot, not this side, that side the nurses side very stressful. So some times they throw here, ya...I can say out from them also. But here we also, difficult to manage because of the manpower. Then I am also some interest in the art but some time no choice, I cannot manage my physiotherapy side, I bring this to the occupational therapist side. I also thinking how to manage how to keep this thing going. So we need you, we need you.

Jess: To make them improve and can develop well. Cos we know that how this is how important for the patients for life to come out. Things stick to one environment. It is a very great start from this place, because we have started already, but right now we can do, because we have a lot of patients coming in. but your side you have started really it was very successful. We never expected from uncle who do a perfect piece, we just thought the end part will be a simple piece. We never expected, I never expected, this piece become like this. One patient is able to make the standard of the art. Really I think it is a great challenge for you oh...for seeing one place a fantastic piece, it is very hard to get from the patients, It is very hard, but for this nursing home, I think you are surprise that uncle did the.

Staff noted that, following the completion of the PVA programme participants also expressed a continued interest to participate in any future programmes.

Matt: I think basically they are very keen on it lah. And one of the resident Clare, she told me that in future ah, this kind of activity can be started again arh. So that they can enjoy while doing so that they don't feel so boring. Rather they stay on the bed all day long. They can have their creations all these things.

Jess: Even some of them, even Clare, if I pass by there she will ask me, I did my art piece, very nice, next time ah, would you all do art piece some more, can come more frequent because I feel very boring at my room. Because I am stay in. when I go up to your level, I see the art piece I do I feel happy. A lot of change.

## 6.7 Challenges of Integrating an Arts-Health Practitioner

Although the 12-Week Participatory Visual Arts programme has demonstrated positive impact on life quality of residents and their well-being, it seems that the nursing home may not be ready to adopt the artist in to its care assemblage now or in the foreseeable future. The provision of leisure seems to be associated with traditional allied health care professionals who have an established work relation with the care institutions:

Matt: Not at all la. I thought that the occupational therapist will take over all this kind of jobs. So it never crossed my mine before.

Tracy: Same La..

Susie: I agree with Matthew...Mostly occupational therapist conduct the class.

Tracy: same la

Jess: If the nursing home they have the occupational therapist, they can engage with them this art piece. If the some place that they don't have, there is a need for someone to come to conduct this programme, to make engage with the patients, and fix to do this activity. If not, it should be ok. what Matthew say is time management is one part is ok. But if the home have occupational therapy, to do this type of pieces, no problem for patients, they can be able to come out in the life. If some centre, if they don't have, they need someone to come out with this art piece, to conduct programme, to make their patients, what kind of patients the life better, and bring them their pass, and enjoyment days, even if they are very old, They can get back their past.

The difficulty of integrating an artist into the health care sector is also noted in the work of Eades and Ager (2008) where they recommended that further studies need to be carried out on cost-benefit, cash-efficiency, and quantified health-gain analysis. Conventional allied health care professions appear to be the obvious choice and thus management's preference, often based on a sense of familiarity with the professions and relationships established by these professions with nursing homes. While there is nothing wrong with that view but it is important for us to be aware that although allied health care staff such as the occupational therapist and arts therapists were established to address and attend to specific activities that care settings require, the artist, particularly the arts-health practitioner, have gone on to demonstrate that they are equally effective in contributing to caring by working with diverse population

groups and communities (Staricoff et al., 2002, Daykin et al., 2010, Murcia and Kreutz, 2012).

What perhaps would put an arts-health practitioner at a disadvantage is the current lack of ethos and theoretical frameworks to guide practice. The allied health professions have an established body of knowledge with principles and objectives, while this is largely not established for arts-health practitioners.

Another setback and challenge to integrating an arts-health practitioner into the care team was a cost issue. When I inquired of Agnes about the prospect to have a regular participatory programme, she revealed her concern on the matter:

Agnes: [let out a breathe] Cost?! Will be an issue. Ermm...But having said that of course, I have to look for finances to fund the programme itself. Especially the material cost. Let's say if I have an artist that comes in and on a volunteer basis, then of course, I need to fund the project the work being done. I cannot be expecting the artist to come out with money, that kind of thing. That in itself then I have to look for funding. Ermm to create the projects.

Int: Do you think it is fair for artist to be paid for this kind of job? [laugh]

Agnes: Ermm...

Int: Eventually lah let's say you know there are more artist coming in to...

Agnes: Then we will need to see how much it benefits the patient in totality as number per se. If a group too small, than it will may not be, very beneficial to pay the artist to do that. Ermm, it has to be a group that is substantial enough, you know kind of thing, so that, we could actually, ermm ya, then the artist pay could be involved...yup but again, if the hourly rate is too high, we may have issue la.

However, Agnes is willing to partner an external party able to fund and support the programme. For her, the prospect of integrating an arts-health practitioner would be more attainable if funding resources can be established with external partners to support such leisure enriching initiative.

Int: Would you be open to partnering with partnering agency who may be able to support the artist payment and collaborating with nursing home?

Agnes: Yes.

Int: Ok..so you think that could be a way forward also?

Agnes: [nods]

## 6.8 Summary

The aged body is frequently associated with decline, poor health, dependency and incompetence. Ageing, when considered and envisioned through such a perspective, often resulted in an oversight of the potential of growth and development in late life. As such, the archaic, patriarchal, subordinating culture that nursing home has long adopted from the acute care model have unfavourable consequences on prospects of leisure, life quality, and opportunity to age successfully for residents. As an effort to alleviate the challenges of nursing homes, I implemented a participatory visual arts programme as an exploratory effort to reflect and gain insight of the role and contribution an arts-health practitioner might lend to alleviate its caring predicaments.

This chapter presented the staff's attitude and opinion and explored my role and contribution as an arts-health practitioner to the leisure-scarce situation. In asking what staff reactions to the *becomings* of the aged bodies through the creative encounters, I learnt that staff felt that the participatory visual arts programme has benefited the participant in varied ways. Besides serving a function to keep residents occupied, the programme was perceived to have far reaching effects that appears to enhance the participants' sense of wellbeing. The creative events has engaged the lethargic aged body and yielded positive emotions. The PVA programme has stirred up ambition, kindled sense of hope and even boost morale of participants. Through this process, the lethargic body is invigorated to make perceptible the flourishing-aged body. Through encountering and entangling with an arts-health programme, the *becoming* of the aged body, drew out, released and made visible the liveliness that can persist in the aged body through the participants' capacity to create and imagine.

The visibility of the flourishing body, brought on by the connection and interaction that the arts-health practitioner made with the aged body, in return challenged the view staff had about the aged body. The becoming of bodies, as Deleuze indicates, create visibility to repressive social structure while at the same time offer escape (Blackman, 2012, p.103); it also exposed the limits the current care assemblage imposed. While staff generally looked at the arts-health practitioner favourably, I also learnt about some of the challenges and uphill task for nursing home to adopt and integrate an arts-health practitioner. Financial resources to support life-

enriching activity for resident are deemed as a key concern by the nursing home. I also realised that despite the perceived benefit of having an arts-health practitioner in a nursing home, further work is required to build and develop familiarity with the activities and purpose. What this suggests is also an ongoing need for arts-health practitioners to establish and articulate their ethos, ethics and conceptual understandings in order to gain credibility and to ground the practice.

## **7 Arts-Health Assemblage: Art Making as Lines of Flight for Vitality in a Nursing Home**

### **7.1 Introduction**

In the preceding empirical chapters, I first began by providing an overview of the environment in a Singapore nursing home and the lifeworlds of residents in Chapter 4. Findings revealed that while physical care was found to be sufficient, attention towards leisure choices and range of activities opportunities were lacking at Evercare. The leisure-scarce situation appears to compromise the residents' quality of life and their personal well-being. With little to do or look forward to, the inactive lifestyle has engendered boredom, reinforced dependency, and accentuated the feeling of loneliness among residents. Residents also expressed concern about the adverse risk the inactive lifestyle can have on their cognitive and mental wellness. Findings from the chapter suggest a need to enhance the personal well-being of residents at Evercare by improving their leisure choices.

In Chapter 5, I examined the effect of my Participatory Visual Arts (PVA) programme on the personal well-being of residents at Evercare. Findings from interviews with the participants revealed that besides providing residents a change of scene from their ward, the PVA programme also fostered a nurturing space that encouraged play, self-expression, and personal growth. The PVA Programme can be framed as a therapeutic landscape that invigorates and inspires the participants. The process of creating an artwork also stimulated the participants' senses and mind as they explored a variety of art materials, ideas, and made decisions. In doing so, the PVA Programme elicited positive emotions such as enjoyment, fulfilment, inculcated self-belief and confidence, and ignited ambitions among the participants. These experiences afforded by the PVA programme were found to enhance the personal well-being of participants. Findings in the chapter also revealed that the care offered by an arts-health practitioner differs from that of care staff. According to the participants, these invigorating qualities found in the artist are not usually available in the care routine of care staff. Given these understandings, the arts-health practitioner

can be regarded as a resource for social, cognitive and sensorial stimulations, as well as a nurturing figure that encourages personal development.

Lastly, In Chapter 6, I explored the staffs' observations of the effect of the PVA programme on the participants and their opinions on the contributions an arts-health practitioner brings to Evercare. Over the 12 weeks, staff observed improved mood, enthusiasm, and gain in confidence among the participants. The arts-health practitioner is found to activate, invigorate and inspire the residents in ways that care staff have not observed among the residents in their care routine. The participants' ability to create, and their zeal to develop themselves have also changed staff's assumption about aged bodies in a nursing home. The release of this potential among the residents seems to be encouraged by the different configuration of intention, abilities, material and processes afforded by the arts-health practitioner. Upon experiencing the ability of the arts-health practitioner to provide sensory and cognitive stimulations, encourage personal development and interaction among participants, the artist is found to complement and enhance the psychosocial aspect of care at Evercare that is currently limited.

Arts-health practice, as I have come to a deeper realisation through this study, goes beyond the act of creating access to the arts and providing art activity to individuals. Findings in this study have indicated the unique identity and capacity of participatory arts activities to amend and foster the personal well-being of participants. This seems to be affected and achieved through a network of elements managed but not controlled by the arts-health practitioner, including space, materials, bodies (of participants and other staff), mood (Carey and Sutton, 2004, Tolia-Kelly, 2007, Askins and Pain, 2011). It was clear I needed to move beyond understanding health and well-being as states found and bounded within the body. Therefore, this chapter will use notions of assemblages (Deleuze and Guattari, 1988) to analyse how personal well-being emerges from a participatory visual arts programme with nursing home residents. In doing so, I am also interested to identify the various elements involved in the process and investigate what further concepts can be developed to expand understanding of the benefit of participatory visual arts on residents in a nursing home.

## **7.2 Health and Well-being as Assemblages**

The concept of assemblage (Deleuze and Guattari, 1988) has inspired a turn towards a relational approach to health and well-being. According to Deleuze and Guattari (1988), our experience of the world and aspects of living is afforded and affected by assemblages – encounters with a collection of animate and inanimate things. When considered in this perspective, life and its events are framed as a ‘constellation of singularities and traits deducted from the flow- selected, organised and stratified – in such a way as to converge (consistency) artificially and naturally’ (Deleuze and Guattari, 1988, p.406). Similarly, a relational approach views health and well-being as states constituted, afforded and amendable by a network involving the body’s relation and its interaction with other bodies, materialities, and processes (Williams, 2003, Andrews, 2014, Duff, 2014, Fox, 2002, Atkinson, 2013, Andrews et al., 2014, Mol, 2002). From a relational approach, health and well-being are also understood as momentary states that are ‘situated’ and ‘emergent’ ‘effects’ (Atkinson, 2013), constantly ‘taking place’ (Andrews et al., 2014) or co-evolving and co-created (Andrews, 2014). In this sense, the gain or depletion of subjective health and well-being is understood to be affected and effected by encounters, networks and associations according to the availability of enabling resources (Duff, 2011, Fox, 2002, Fox, 1998). In other words, as much as an assemblage affords the body its capacities, it is also capable of delimiting its capacity for action, feeling and desire. Given such understanding on how health and well-being can be shaped and influenced by assemblages - networks and encounters with human, materials and processes, I will next explore how notions of assemblages have been approached and considered in the field of arts and health.

## **7.3 Recent Exploration on Assemblages in the field of Arts and Health**

There have been limited application of assemblage theories to the field of arts and health (Raw, 2013, Fox, 2013, Atkinson and Scott, 2015). Moreover, the interest has to a large extent focussed on the processes of becoming and emergence through an assemblage and on the nature of health or wellbeing seen as relational effects of the assemblage (see Atkinson and Scott 2015 and Fox, 2013). Research attention to

the arts practitioner or the artist as part of the assemblage and the nature of an assemblage-based practice is negligible (see Raw, 2013).

Fox (2013) examines the health-transforming potential available in creative production and reception in a broad context that encompasses art therapy and non-therapy based creative activities. He explicitly treats such contexts as assemblages and connects this to creativity in a hybrid concept of the *Creativity-Assemblage*. Within the creativity-assemblage, creativity is a flow of affect between bodies, things and ideas rather than being an attribute of the body. The new capacities engendered and the affective power of creative activities and products is understood to affect health as the body engages with the creativity-assemblage. Atkinson and Scott (2015) draw on the concept of assemblage to unpick the processes through which well-being, when seen as relational, may be stabilised, disrupted or changed. The arts intervention, in this case a dance and movement intervention in a primary school, disrupts the routines of the classroom through reorganising space, materials and conduct. The authors also draw on Deleuze and Guattari's lines of flight to describe how arts participation not only disrupts but throws those involved into new encounters and relations. It is, then, within the disrupted assemblage that a space emerges that is yet to be contoured or marked with pre-scripted habits, and that enables new possibilities including for identity and well-being to be explored.

These analyses by Fox (2013) and by Atkinson and Scott (2015) bring insight to the gentler transitions, and the disruptive, creative or inventive characteristics, of assemblage through which well-being emerges, stabilises and is amended. However, their study focus is primarily on the transforming processes of and for health and well-being and give only limited attention to the concerns, experiences and practices of the artists involved in these processes. An exception is found in the work of Raw (2013) who, in examining the processes of community-based art, identified six recurring and interrelated elements in participatory art practice: intuition, personal commitment, framework of value, spatial framework, relational framework and creative. She coined the term of a *Practice Assemblage*, which not only emphasises the interrelatedness of elements that shape and affect participatory art outcomes but also draws analytical attention to the centrality of 'practice'.

While current explorations on assemblage in the field of arts and health have acknowledged the network of human, material and process at play in shaping health and well-being outcomes with art activities, existing considerations have not actively considered the conduct of the arts-health practitioner and the quality of the immediate physical environment as elements of the assemblage and their influence on well-being. Findings from my study suggest that the manner in which I conducted the art sessions will have an effect on the participants' experience. Participants perceived certain characteristics of how I worked, which I am capturing by the terms 'adaptable' and 'patience' as forms of support exhibited during my sessions. This put the person at ease and encouraged them in their exploration and creative making.

Int: What do you think is important for artist to observe when working with you in an art session?

Alice: You are not fussy when you are working. That is good. You take your time to guide me. You are patient.

Reflecting on the manner with which I facilitated the art sessions in this study, the arts-health practitioner, in my view, is at best analogous to a bee tending to a field of flowers (see Figure 18). The line in the diagram illustrates a typical movement and

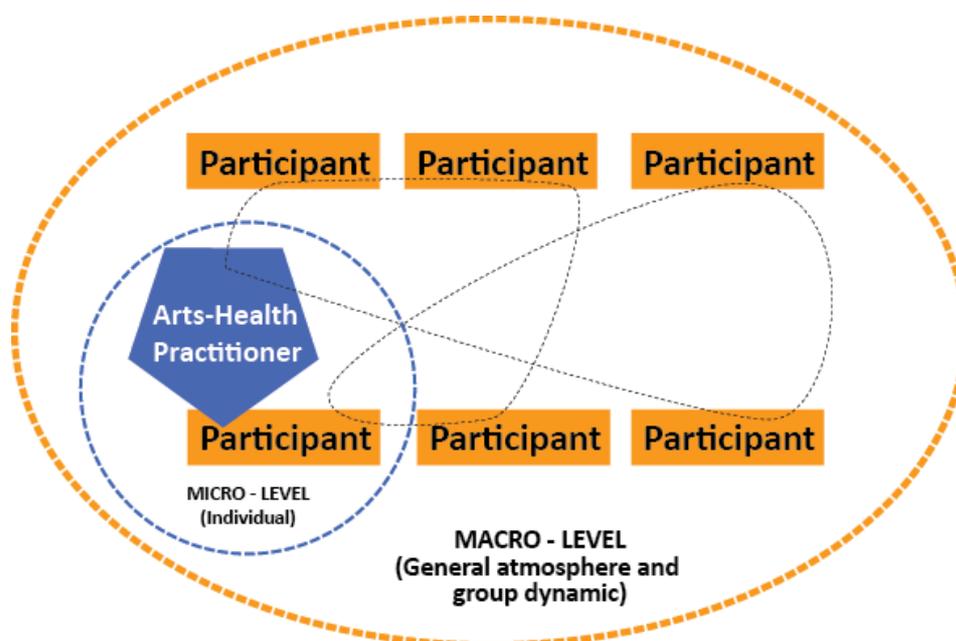


Figure 19. Perceived Dynamics of Arts-Health Practice

interaction that is required of me when leading a participatory arts session. When an art session was in progress, I found myself having to simultaneously manage interactions on two levels: the micro- (my interaction with individual participants) as well as the macro (the atmosphere and dynamic of the art session). As an arts-health practitioner, I found myself constantly attuned to the flux of needs, responses and reactions of participants, as well as to elements of the environmental context. As such, my role was, in part, to 'hold the space' for participants in terms of ensuring that the ambience is conducive, supportive, nurturing and affirming. I noticed how my attention and the salience of the participants' needs and concerns would shift and vary dynamically according to the demands of tasks and activities emerging in an art session. For example, while supporting disabled participants, such as Clare, to ensure that she did not encounter much difficulty while working with a single arm (see Section 5.4.1), I also had to stay attuned to other participants who might require my assistance.

The dynamic and contingent flow I experienced as an arts-health practitioner when conducting the art sessions for this study seem to differ from the linear progression of interaction among elements suggested by Raw (2013)'s practice assemblage. In addition, although Raw offered insights to the commonality found in participatory arts practice, the elements identified: intuition, personal commitment, framework of value, relational framework and creative key provided little clarity on the conduct expected of the arts-health practitioner. Furthermore, while the practice assemblage draws attention to the interrelatedness of elements, the term does not readily connote the health and well-being transforming potential of the arts. Thus, I am interested to explore more explicitly the nature of an assemblage involved in participatory arts and offer a term that better clarifies where practice and the arts practitioner fit within the health and well-being amending capability of the arts.

While Fox (2013)'s creativity-assemblage and Atkinson and Scott (2015)'s destabilisations draw us to be aware of the health and well-being promoting capability of creative engagements afforded by a network of human, materials and activities, neither considers the effect on the well-being of participants of the immediate external environment where the art session takes place. The environment of my art programme had an effect on both the participants' experience and their

concentration. For example, the multi-purpose hall where the programme was initially held did not have good ventilation, and the stuffy environment made the participants warm and distracted. The overlapping schedule between my art programme and the staff's preparation for dining activities in the multi-purpose hall distracted the participants and put pressure on them to finish their work (see Section 5.3). In contrast, when the art programme was relocated to the communal passageway outside the physiotherapy room, the cool and airy environment offered participants a more comfortable and conducive environment in which to work. Without the pressure of needing to complete their work, participants found the passageway more relaxing and less distracting. The setting of the arts participation is a critical element in an assemblage.

In the next section, I will follow in the tradition of this work and also draw on Deleuze and Guattari (1988)'s concept of assemblage to identify the various elements involved in a PVA Programme and how the gathering and interaction of elements in a PVA programme amend and foster the personal well-being of the participants. In doing so, I will extend existing work to capture the capacity of the network of elements to amend health and well-being with an emphasis on how this is fostered by an arts-health practitioner.

#### **7.4 Arts-Health Assemblage**

My findings about the lifeworld of residents (Chapter 4) and the effect of the PVA programme (Chapter 5 and 6) suggest that the network of elements engaged by care staff and the arts-health practitioner have engendered different experiences and opportunities for residents. Although the care staff attended satisfactorily to the residents' physical needs, the materials and activities involved lacked the capacity to provide engagement opportunities for residents and to foster their personal development. This is apparent from findings presented in Chapter 4 where residents were found to have limited physical, cognitive and social stimulation in their daily life while care staff got on with their routine tasks at Evercare. This reflects an established care home assemblage in which a passive lifestyle has compromised the personal well-being of residents through reinforcing the sick role, eliciting boredom, and diminishing self-esteem. However, the assemblage fostered by the arts-health practitioner, as

evident from discussion in Chapter 5, whilst only constituting a temporary alternative space, was found to have an animating quality that was not apparent in the everyday spaces of the home or the interactions with the care staff. As such, the assemblage of the PVA was itself infused through a very different kind of care offered by the arts-health practitioner compared with the assemblages of care entrenched in the 'care' home and in the practices of the staff. The new relations that residents had with art materials, art making activities and myself, through the PVA programme have not only deregulated their routine (see Chapter 6.3.3) but it also led to new possibilities that supported personal development and engendered their positive emotions such as fulfilment and improved confidence. In this sense, the disruption to routine and new possibilities fostered by the collection and interplay of elements brought on by an arts-health practitioner offered a 'line of flight' (Deleuze and Guattari, 1988) that amended the mood and invigorated the participants. A 'line of flight' (Deleuze and Guattari, 1988) refers to an imperceptible possibility of escape from established routines into uncharted space with the possibilities for the emergence of new social and personal states of being. Given the limited attention to the concerns of the artist involved in the assemblage, which I argue to have influence on well-being outcome, I will next explore the elements involved in the assemblage of the arts-health practitioner. In addition, I will also discuss the manner, in which I managed and negotiated the challenges and tensions arising from the encounters and interactions between these elements that have implications for the atmosphere and the participants' experience, to support the emergence of personal well-being among the participants.

The venue for my PVA programme at Evercare was a passageway outside the physiotherapy room. The passageway had no specific function other than to facilitate movement of people and objects in and out of the physiotherapy room. However, following my arrival at Evercare, the passageway was repurposed weekly by my intention and presence to amend the lifestyle and well-being of the residents through a participatory visual art programme. My intention guided how I arranged the furniture at the venue and the choice of art materials and art activities to be introduced to the participants. The gathering and collecting of things in the activity venue did not only physically occupy the physical space of the communal passageway, but it also give rise to an opportunity and experience that destabilised the routine of

the residents at Evercare by engaging their bodies and minds with a different set of actions. The network of elements that I engaged also provided residents with a time and space to escape from established routines into uncharted space with the possibilities for the emergence of new social and personal states of being as suggested by Atkinson and Scott (2015) (in turn drawing on Deleuze and Guattari (1988)'s concept of assemblage and the emerging lines of flight). As the participants arrive and engage with the art material, and the art activities, the transitory and fleeting non-place (Augé, 1995) characteristic of the communal passageway is transformed into a therapeutic landscape. The different set of actions that engaged the residents through the art programme, such as creating forms with the art materials or exploration of texture and colour, led them into a journey of play that taps into their creativity.



Figure 20. A View of a Participatory Art Session at Evercare

Besides invigorating the sense of the participant with a change of scene from their ward life and engaging residents in new sets of action (see Section 5.3.1), the assemblage of the arts-health practitioner appears to have an animating quality that stimulated the residents physically, cognitively, and socially, and even inspired them. While participating in the art making session, participants were engaged in an assortment of movements such as pinching, rolling, turning, extending their arms as they manipulated the art material to create their artwork. Movements of the

participants' arms filled empty sheets of with a myriad of colours, turning them into various landscapes. Blobs of clay were enlivened and transformed to mimic a fruit or a creature.

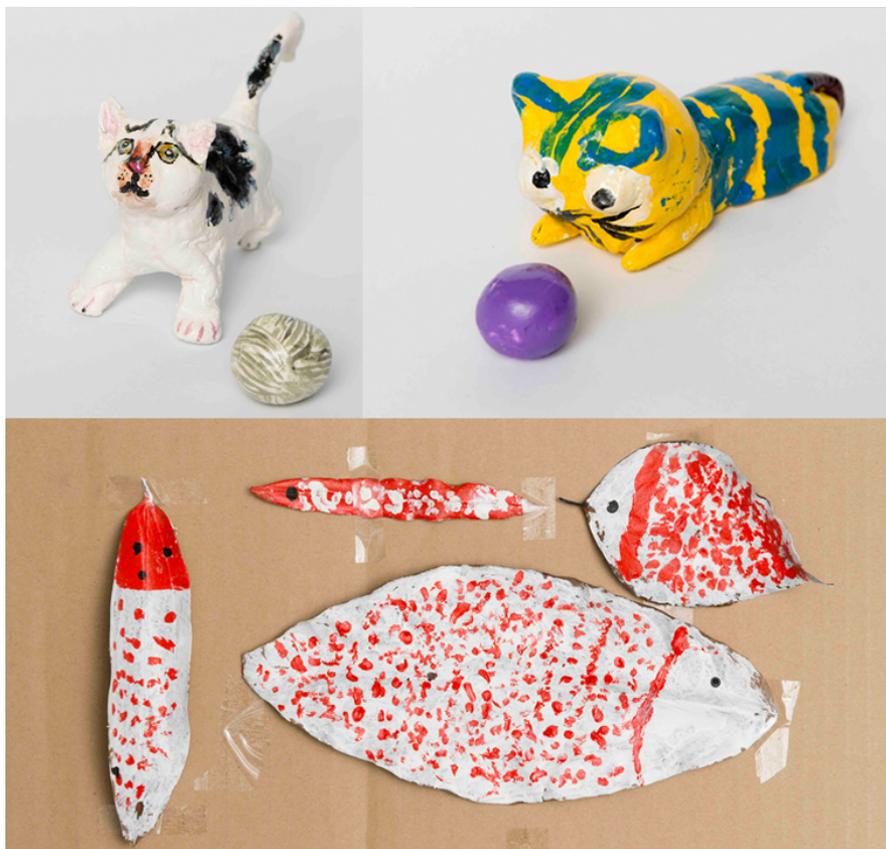


Figure 21: A Selection of Artworks by the Participants

Besides inducing physical actions, the art materials, and activities present in the assemblage of the arts-health practitioner also engaged the participants cognitively. While creating their work, participants had to conjure ideas for their artwork. They are also required to make decisions on the compositional and aesthetic choices such as colour, form and proportion of their piece, to shape their work to achieve the impression they anticipate for their work. In their pursuit of realising their artwork, the wandering and preoccupation that participants experienced while manipulating the art also presented a capacity to shift the participants' focus and amend their mood. Betty, for example, in the discussion in Chapter 5.3.1, spoke of how the art making process gave her a sense of release and an outlet for her to vent her moodiness. She

appreciated how the act of fiddling with the art material and the concentration she needed to give to realise her idea in physical form could move her into a more relaxed state where she felt free and unburdened. This distractive capacity of art making can also be found in Joe's experience. As Joe's concentration for his creative pursuit deepened, it diverted his attention away from his meandering thoughts. In other words, the challenge and creative pursuit initiated by the presence of the art material, art activities and myself, seems to have also created a sense of purpose. The interplay of art material, activities also inspired new self-images. For instance, Clare's discovery of her ability to create artwork led her to overcome the initial self-doubt she had and gave her confidence and inculcated self-belief. These shifts emerging from the art programme have helped demonstrate the positive impact art making can have on the personal well-being of participants.

The artworks produced by participants are affective. The colour field resulting from the participants' work injected a touch of vibrancy to the otherwise stark environment of the nursing home. Participants would occasionally be delighted or express admiration of their own creations. The creations would also spark conversations amongst participants where they would exchange words of admiration with each other, fostering socialisation. This opportunity, and witness of one's ability to turn imperceptible vision and imagination in to tangible artwork, also inspired the participants to further develop themselves. This can be found in the desire and aspiration expressed by participants. We can see, for example, the sparking of desire and curiosity about new skills to be learnt from each art session expressed by Elaine and Peter and how Betty avowed that she would challenge herself to further improve (Chapter 5.3.2). Participants have spoken about how they appreciate having opportunities to enrich themselves by developing new skills and gaining new knowledge. Through this process, the art material and activities have led participants to discover through experience their capabilities, reconnecting them back to the earlier days of their lives. Besides enabling the participants to flourish, the assemblage of the arts-health practitioner also made visible the untapped and disregarded capabilities and energy of ageing bodies and their vibrant imagination and creative impulse.

The atmosphere of participatory arts sessions often felt relaxed, light-hearted and animated by the intermittent socialising and the unique creations by the participants. It was not hard to spot episodes of enjoyment, deep concentration, and conscientiousness while the participants were making their work. Staff passing by the art activity area would occasionally be drawn into the assemblage and become part of it. They would interact with participants by engaging them in a brief exchange of conversation revolving around their creation. Impressed or surprised by the residents' abilities, their encouraging comments would elicit smiles from participants.

However, it appears that the art material, activities and immediate physical environment involved can also present participants with difficulties and issues that can elicit unfavourable experiences and feelings. For example, the feeling of self-doubt experienced by Clare due to her disability (see Chapter 5.4.1) did create some anxiety and affected her self-belief during the initial phase of the programme. Similarly Betty's lack of reach and strength due to her short physique also created some frustration and challenges when making art. However, it is part of the artists practice in facilitating the creative space to maintain an observant attitude in order to be able to address the problems and assist the participants in overcoming their constraints. I would respond by learning from the participants themselves what the matter was before proposing adjustment and improvisation. For example, when Betty encountered difficulties in manipulating a lump of clay due to a lack of strength, I suggested she try to work with a smaller portion and assisted her in breaking the initial lump of clay into smaller portions. In another instance, when Joe found it challenging to stabilise his hand to join different clay pieces, the little adjustment I suggested to him to rest his arm on the table enabled him to have more control.

Joe: Because our hands are not nimble, so it can be difficult when it comes to manipulating the thing. Frankly speaking, that thing is very difficult to manipulate, very hard to manipulate. For the others, they may not feel that way as they have good functioning hands.

Besides being observant, I aimed to maintain an approachable attitude, which also encouraged participants to voice their concerns and difficulties to me. In this sense, it

is important to consider that human, material and process may not necessarily be the only elements present in the assemblage of arts-health practitioner. It seems that the conduct of humans can also shape and shift the experience for participating individuals and their well-being.

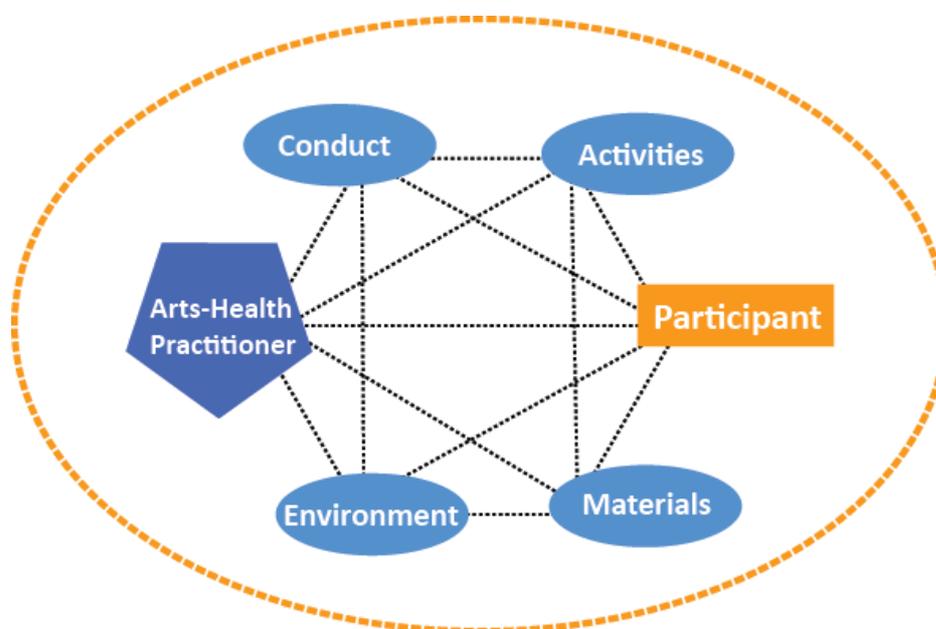


Figure 22. Components of an Arts-Health Assemblage

I have used the notion of assemblage to explain the conduct of a PVA session because my research suggested that successful sessions depended on the manner an arts-health practitioner manages a range of elements coming together often in unexpected ways. The notion of 'line of flight' expressed for me the inventive capacity of a PVA session to disrupt routine, creating new possibilities that led to amending the participants' well-being. The section has extended this understanding of the relations between arts participation and wellbeing by stressing the centrality of the arts practitioner as the architect and manager of the assemblage. The arts-health practitioner needs to be constantly attentive and responsive to differentiated experiences of the participants in relation to the material, spatial, social and atmospheric elements of the assemblage. Having described the elements of the assemblage that made up the PVA sessions, the next section will extend existing work

on the arts-health/wellbeing assemblage further again by extending and complementing the notion of creativity with that of vitality.

## **7.5 Looking Beyond Creativity: Participatory Arts Activities And Vitality**

The association that creativity has with participatory arts activities is well established and the benefits of creativity for health and well-being is well explored by many studies (Flood and Scharer, 2006, Daykin et al., 2007, Cameron et al., 2013, Cohen, 2006). Creativity has been examined for its ability to promote mental health and social inclusion (Secker et al., 2011), eudaemonic well-being (Swindells et al., 2013), enhanced brain plasticity (Cohen et al., 2006a, Cohen, 2009, Cohen, 2006) and resilience (McFadden and Basting, 2010). However, the animating and energising attribute – the sense of liveliness emerging and experienced from participatory arts, appears to have received little exploration in existing studies on arts, health and well-being. From the participants' experience of the PVA programme presented in Chapter 5, the sense of alertness that Alice gained while participating in the PVA programme, the motivation that the art sessions sparked among participants such as Elaine, Peter and Betty who expressed having desire to learn more and improve themselves seems to offer clues to the animating attribute and energising potential of participatory art programme. Similarly, the energising potential of the PVA programme was also noticed by staff (Chapter 6) through the shifts in mood and inculcating of self-belief that they observed among the participants as they undertook the PVA programme. The actions induced by the arts-health assemblage while engaging the body and mind of the residents also displaced their lethargy. This energizing potential has prompted me to explore the link between vitality and participatory arts activities. In doing so, I propose that the following exploration of the link between vitality and participatory art activities can expand current understanding of the benefits of participatory arts activities by drawing attention and giving insight to its animating attribute and energising potential.

### **7.5.1 What Is Vitality?**

Feeling alive differs from being alive. As much as human existence is dependent on physiological functions and physical needs, it is also, in part, sustained and fuelled

by what Bergson termed *élan vital* (Bergson, 1983) or others have called a vital element (Stern, 2010, Fraser et al., 2005). Vitality is a term commonly used to describe such experiences of aliveness. Vitality is understood as having and being aware of the availability of physical and mental energy to the self (Ryan and Deci, 2008). The experience of vitality is a 'mental creation, as a product of the mind's integration of many internal and external events, as a subjective experience, and as a phenomenal reality' (Stern, 2010, p.4). In order for vitality to be experienced, our body and mind need to be subjected to a constant process of change when we are awake (Stern, 2010). 'The experience of vitality is inherent in the act of movement. Movement, and its proprioception is the primary manifestation of being animate and provide the primary sense of aliveness' (Stern, 2010, p.9), in other words, 'vitality must have a basis in physical action and traceable mental operations' (Stern, 2010, p.9).

The experience of vitality as proposed by Stern (2010) is engendered by five elements: movement, time, force, space and intentionality. The emergence of vitality relies on the flow and connections among these elements. Experiencing positive affect, vigour and having a sense of pursuit in life are known to engender vitality (Greenglass, 2006). Vitality is known to diminish when social contacts generate feelings of not being effective, disconnection or reduced autonomy; vitality reflects experience of volition, being effectual and integration of the self (Greenglass, 2006). While vitality is linked to a positive sense of aliveness and energy, it refers to more than merely being active or aroused. Rather, as Ryan and Frederick (1997, p.530) suggests, 'it concerns a specific psychological experience of possessing enthusiasm and spirit'. Vitality has been associated with the experience of a sense of enthusiasm, aliveness and awareness of the availability of energy to the self (Ryan and Frederick, 1997). Vitality contrasts low positive affect characterised by lethargy and unpleasant emotional states with positive affect expressed as having enthusiasm, full concentration, a zest for life, experience of pleasurable engagement, high energy, active and alert (Greenglass, 2006). It has been associated with feelings of vigour (Camic et al., 2014), activated positive affect (Watson and Tellegen, 1985) and calm energy (Thayer, 2003). Experiencing vitality also offers a sense of 'going somewhere' (Stern, 2010, p.8).

Drawing from these existing understandings, vitality could be understood as an energised state and experience that is animated and thrives on the availability of

movement, experience of positive affect and having ambition – a sense of pursuit in life. It is a felt-awareness of the availability and presence of vigour.

### **7.5.2 Vitality, Health and Well-being**

Vitality is not merely an experiential concern but is found to have a robust association with behavioural and health outcomes (Kubzansky and Thurston, 2007, Ryan et al., 2010). There are different definitions of vitality in different studies. For Ryan and Deci (2008), vitality is regarded as an essential and functionally important indicator of health and motivation. In this perspective, energy is vitality differentiated from positive well-being. Their view has been corroborated by a growing body of evidence that suggests that positive affect associated with vitality can enable individuals to gain resilience to physical and viral stressors, and reduces vulnerability to illness (Benyamini et al., 2000, Cohen et al., 2006b, Polk et al., 2005). Individuals in vital states are found to cope better with stress and challenges and have greater mental health as they are more productive and active. In their study of older women with disability, Penninx et al. (2000) found that vitality is capable of protecting older persons from adverse health outcomes by preventing the development of new disabilities and even lower risk of mortality. Kubzansky and Thurston (2007) found emotional vitality, which is characterised by a sense of energy and positive well-being, protects adults from coronary heart disease. In addition, vitality is also found to help individuals cope with life challenges, facilitate regulation of negative emotions, reduce stressors and improve immunological functioning (Rozanski et al., 2005).

From another perspective, it is understood that vitality is linked to positive well-being and can be shaped by activity. Activities that satisfy basic psychological needs for relatedness, competence, and autonomy were found to enhance vitality, while those that do not drain vitality (Ryan and Deci, 2008). Having a sense of personal mastery, happiness, reduced experience of depressive and anxious symptoms are also indicators of vitality (Penninx et al., 2000). It is also argued that vitality is enhanced by lifestyles that support autonomy and encourage building of relationships, personal growth and community (Ryan and Deci, 2008). Recreational tasks can foster vitality; the pursuit of meaningful activities, especially those related to intrinsic goals, can maintain or enhance vitality (Ryan and Frederick, 1997). Not only can meaningful

activities satisfy the basic psychological need for relatedness, competence and autonomy, they also are capable of restoring depleted energies. These studies imply, as a corollary, that deprivation of movement and action in body and mind may delimit and diminish the security of vitality, or sense of aliveness, which consequentially has implications for individual well-being.

## **7.6 Vitalising Attributes of Participatory Arts Activities**

From my earlier discussion on the arts-health assemblage, it is understood that the network of elements engaged by the arts-health practitioner gave residents an experience that differs from the routine assemblage of the care home. In comparison with the limited engagement and passive states produced by the care home assemblage, the actions initiated and induced by the arts-health assemblage were found to activate and stimulate the body and mind of the residents. Drawing on an understanding that vitality can be initiated and encouraged by subjecting the body and mind to a constant process of change through physical action and movement (Stern, 2010), I will explore the various actions and movements induced by participatory art activities that appear to animate vitality.

### **7.6.1 Animating Physical and Emotional Vitality**

The opportunity to move one's body is a quality of the PVA programme that many participants appreciate. Magdalene, Clare, Alice, Betty and Peter spoke about how the routine of spending too much time on their beds and the inactive lifestyle have made them feel tired and lethargic.

Clare: Because every week, I get to go down there to move my body. It is not advisable to sit on the bed daily. Otherwise I sit here every day [...] like a block of wood.

Alice: Well...it is right to get them to be active. Else they will be sleeping. You should come when you can, to teach us how to do things, otherwise they would keep sleeping. Right?! When you are free, come by on Friday to teach the elderly to do art, otherwise, they will be sleeping after meal. They don't...so if you get them to do they will do it. But when you are not here, they won't be doing it.



Figure 23. A Participant working on an Art Piece

The PVA programme puts the body in action by engaging participants to use their arms, hands and fingers as they paint, manipulate and shape the art material to create their artwork. The art-making sessions were found to be a useful resource to promote physical wellness of residents. The physical action and movement required of participant during art-making were appreciated by staff who saw it as an alternate way to engage the residents to be physically active besides the routine physical exercise (Chapter 6.3.3). Staff noted that residents showed more willingness and enthusiasm to participate in the arts programme than the scheduled physical exercise. Jess the therapy aide highlighted the physical stimulation the art sessions provide.

Jess: Because some time, we asked residents to do therapeutic exercise, some were reluctant to participate. They say, they keep doing the same things. But when they attended the art programme, they get to do different things. Even touching papers, clays, paintings, water, glue, everything they touched offered something different like you are eating food how you taste. Because while exercising they had to repetitively perform an action. But for the art, they have to move their fingers to pick things, move their arms to reach for things and paint, to mix, they have to colour, to use the thing, it is a kind of exercise. One two they realise that they doing exercise, eh what this art piece arh, is like an exercise you know, they come and told me that. I pretend that, I oh really, I know but I pretend that I really ok, but some they never realise. They never realise. But they are thinking this is art piece what, where got exercise?

The actions and movement required from participants in the art-making process were seen as a good alternative approach to stimulate and help the residents to maintain or improve their physical wellness. Clare, a resident also took notice of the physical stimulation she gained from making art.

Clare: It exercises our hands and our brains. Eyes, and the eyes. It very good.  
I like it.

In doing so, the physical movement also created a forward momentum that activated and animated the emotions, mind, senses and determination among residents.

The actions required in art-making activities displaced moodiness, lethargy, and meandering thoughts among residents and elicited positive affect. The concentration and effort that the art-making process demand of participants in the process of realising their work seems to have the capacity to divert attention and focus of the participants. In doing so, it has offered participants a sense of relief. Betty spoke about feeling less burdened and free when participating in the programme.

Betty: I feel so free.  
Int: You feel very free?  
Betty: Yeah...like... no burden at all.  
Int: No burden at all? So how would you regard your experience? How did time feel for you?  
Betty: It passed very fast ah!  
Int: It passed very fast? Too fast?  
Betty: [Chuckle] No la I enjoy that is why I feel it pass very fast.  
Int: So you think doing art activity is a good way of passing time?  
Betty: Yeah.  
Int: What do you think you gained?  
Betty: Experience how I can creation the ar..art. [...] Very relaxing.  
Int: You find the program relaxing? Why is it relaxing?  
Betty: can forget everything.  
Int: You forgot everything?  
Betty: Free la..  
Int: Ah the program make you feel free. But what is it about it that makes you feel free? The art making process?  
Betty: ah...  
Int: Is it the people?  
Betty: The art.

The sense of play that the PVA programme encouraged not only offers participants an opportunity to express their personality, but also offers a space where the participants can rejuvenate themselves and feel liberated.

Alice: [Laughs] They look adorable. I can go on splashing as I please [laugh]. I splashed the flower, the birds and a bunch of other stuff. I find them rather adorable. Yes, I have not splashed so much before.

The completed artworks achieved from the physical action of manipulating and shaping art material shifted the emotions and views of self among participants. For example the sense of amazement felt by Betty, Alice, Clare, Peter and Freddy reflects their surprise and how impressed they are with their capability to create colourful pieces that they originally created out of their own hands despite their lack of experience. Many did not imagine themselves accomplishing what they did. The pleasure and satisfaction that participants derived from seeing their completed artwork lifted their spirits and mood. Cultivation of positive emotion is argued to optimise health and well-being (Fredrickson, 2000).

### **7.6.2 Animating Cognitive Vitality**

Art activities can be mentally demanding and can also induce a certain degree of cognitive action and movement. The process of creating often would require participants to envision ideas in response to the project brief. When making their work, participants also needed to, from time to time, make decisions on colour choice, the position and placement of elements on their pieces. Such cognitive engagement can be found in Francis's comment on his art making process:

Int: How do you feel when you were colouring? Were you thinking of any things?

Francis: I find myself using my brain, you make a decision about choice of colour.

At times, participants may also encounter circumstances where they felt challenged by a new technique and need to problem solve. Such occasions would also spur social connectivity where they would approach myself or my assistants for assistance to help them resolve certain aesthetic or technical challenges, such as the mixing of paints to achieve the desired colour, or figuring out ways to join and shape their clay pieces.

Joe: Well because I have not done that before, I have never tried working with this. And this thing is hard to stick. Did you see that this little piece of clay is out of position? If it was discovered earlier, I would have fixed it. The problem is that it is hard to stick, it is hard to join them. At the beginning I thought it will be done by covering it, it should take care of itself upon drying, [mumble]. This problem arose from us not trying this before. Didn't expect that it can be difficult, one has to mould and press it, It will change shape when you pressed on it.

The cognitive stimulations that the participants received through learning art techniques and creation of their artwork have given rise to a sense of alertness as reported by Alice (Chapter 5.3.4).

Int: Do you find the art session important for the elderly?  
 Alice: Of Course.  
 Int: Why is it important?  
 Alice: When you teach us things to do, we are alert.  
 Int: You find yourself feeling more alert?  
 Alice: Ya...it is better that someone teaches us something. Otherwise, people will keep sleeping. These people... [...] It is better that you are here to teach us. Our mind will be more active as we need to decide and think how to get things done. When you are not here to teach, we keep sleeping. [laughs]

Besides feeling alert, participants also expressed appreciation for the opportunity to be exposed to something new and the intellectual gain afforded through the PVA programme. Peter's comment provides an example of such intellectual developing capacity he found from his participation in the PVA programme.

Peter: First thing, this thing will make my mind more active. Not so...not so...inactive.  
 Int: So you think doing art can keep your mind active?  
 Peter: Ah...that's right. Some times, some times you don't use your brain also no good. [...] at least have something to learn from it. No doubt, no doubt I myself is...is not capable of art ah, in a way good for me to learn something new. At least I have tried something new for myself.

The cognitive engagement and action induced by PVA programme also engendered a sense of curiosity and adventure for participants. The varied themes of the creative projects that participants were introduced to weekly kept them on their feet and stirred their curiosity and anticipation. In a sense, it created a sense of futurity, giving

participants a sense of going somewhere. This sense of going somewhere or anticipation has been associated with vitality (Stern, 2010).

- Alice: I am curious about what you will be doing, and teaching us to do. Or else what, sit there? When you are here to teach, I will go, but if you are not teaching, there is not point of us coming down. When you are here, I come to draw at my own will. Like these, I create them arbitrarily. Right? How can I draw?
- Int: Well in the past, you feel that you do not know how to do this but...
- Alice: I have never meddled with such thing. I have never done this at home. When I was home, I would do house chore, colour some stuff and do random stuff.
- Int: So you have not thought that you can do this.
- Alice: Never...I never imagined myself to be creating this, it is all arbitrary work and they do look adorable. [laughs]
- Int: So you feel that they are adorable despite it was done arbitrarily. Is this an aspect of yourself that you have not seen before?
- Alice: Never...I have never created work of such quality. I am amazed how I managed to produce this.

The art making session also presented cognitive challenges which participants had to resolve in the process of realising their artwork. For example, Peter and Freddy spoke about the learning curve they encountered during the initial period of the art programme. Their ability to overcome that learning curve led to a new realisation of their own capability and self-belief. In addition, they also experienced joy, pleasure and fulfilment through their ability to resolve their challenges. This empowering capacity of the art programme initiated by the act of creating, which result in a shift in self-belief was also observed in Clare (Chapter 5.4.1) as she realised despite living with disability, she can still develop her creative potential and find enjoyment and fulfilment from the process.

### **7.6.3 Animating Sensory Vitality**

Interview data from Chapter 5.3.1 revealed that residents who participated in the art programme welcomed and indeed looked forward to the change of scene afforded by the participatory art session weekly. Not only did the programme enable participants to take time out from their ward, it also introduced variety and offered them an opportunity to partake in a different activity. Alice, a resident expressed her appreciation:

Alice: There is nothing much to do daily other than watching TV. There is nothing much besides watching TV. It is good that we are brought to art session to create something...that is not bad.

The art venue is a sensory-rich and stimulating environment. Besides affording the participants a momentary respite from the routine life of their ward, the participatory arts sessions were found to refresh residents' senses and stimulated them. This finding concurred with the disruptive quality found in participatory arts activities to create extraordinary out of the routine space (Raw, 2013, Atkinson and Robson, 2012). From the video data, participants appeared to be curious about the variety of material present at each session. They would survey the art materials laid out in the venue with a sweeping glance as they enter the space. Their curiosity would lead them to fiddle with the materials, speculate among themselves about the project, or prompt them to ask me, or my assistants about the project for the session. From Clare, it is understood that this sensory animating capacity found in art-making was not available in the assemblage of the care home.

Clare: It's not the same. Your activity engages the mind and eyes. But the nurses don't do that. [...] They attend to things that concern our body. They don't take care of the ability of our mind and vision acuity. You attend to our brain and our eyes. You take care of our mental wellness, our vision acuity, and the ability to make discerning judgments.

The art material also offered different visual, tactile and olfactory sensation for the participants. In creating their work, they would make contact with the coolness of the water or clay, dripping off paints, feeling a drift of breeze, captivated by particular hue. These sensations were found to be therapeutic for residents. The emotional response emerged from admiring their creation or that of others could also be interpreted as an on-flow of sensory vitality. The art activity appeared to heighten the senses of the participants while at the same time it accentuated their sense of awareness, involvement and connectedness with their surroundings. This notion of connectedness and alertness are known to be indicators of vitality. In contrast to the mundane and lacklustre atmosphere of the ward, the art venue is a sensory-rich environment charged by the myriad of colours, textures and sounds of chatters and

banter. The reception the participants have on the sensory animating quality afforded by the environment of the art programme and the art activity seems to be in agreement with findings on the health and well-being benefits of a multisensory environment. Sensory enriched environment and activities are known to benefit older adults as the stimulation they received help promote physical and cognitive wellness (Cox et al., 2004, de Macedo et al., 2015, De Oliveira et al., 2014, Volkers and Scherder, 2011, Heyn, 2003).

#### **7.6.4 Animating Ambition as Vitality**

The PVA programme also induced a sense of pursuit and created a forward momentum among participants. The actions introduced by the art programme led to the discovery of personal creative potential and shifted views of self. Although the art programme did initially raise a degree of uncertainty and self-doubt among participants who are physically impaired, the PVA programme offered a space that enabled and encouraged participants to flourish, by encouraging participants to look beyond their own doubt and impairment. The available support from myself and my art assistants enabled them to overcome their personal challenges. This led them to realise their latent potential. It seemed that risk taking itself, being challenged to move beyond their comfort zone, can be a vitalising experience through overcoming self-doubt, experiencing growth as they learn new skills and knowledge, and realising potential for development. These developments and realisations are qualities that the lifestyle arrangements of the nursing home have not enabled residents to access or experience prior to the introduction of the PVA programme. Clare's case provides an example of the invigorated sense of self-belief and identity gained from participating in the PVA programme .

Int: Have you previously participated in any art program?

Clare: No, no, no.

Int: So would this be your first time attending an art program?

Clare: This the first time...It is my first time. I think to myself, if it would be possible for me to do so with one hand. But I said to myself, hack care! I shall give it a try.

Int: I see, so you previously doubted your own ability to participate.

Clare: I doubted because I only have an arm, I doubted myself...

Int: You doubted...

- Clare: I wondered how am I going to do it with one arm. Well I told myself let's take instruction from them, with one hand I might also be able to produce something, why care so much, shall see if I like it at the end.
- Int: So you were previously concerned if you are able to participate with one arm?
- Clare: If it is possible to work with one arm. But I insisted that I will succeed. I insist that I want to succeed. I wondered, can I work with one arm, and told myself, it is possible with one arm. It is possible. I say, as long as we have confidence, we will be able to finish. When you guys are here, Miss Agnes came to call me, (slurred speech), (they came to call me to go participate, then I go).
- Int: So how do you feel looking at your artwork?
- Clare: Very Good. Didn't think that I can produce such things.[...]
- Int: Ah, ok. So you have never imagined yourself to produce such work?
- Clare: I didn't...I didn't dare imagine. I thought, what can this one arm of mine do other than some weird looking things. [...] very happy, Very excited that I can produce thing of such standard, I consider that that is not bad an achievement. For a disabled person to be doing this.

The pride gained from realising their ability had even elicited desire to showcase their work to the public. Peter, a resident who was inspired by the body of creations, enthusiastically suggested that there should be an exhibition to showcase the works so that the general public can learn about the things that residents do in nursing homes. His comment seems to suggest an intention to shift social imagination and debunk stereotypical perception of the ageing body in nursing home as incapable.

- Peter: Ah better...Let the people outside know that the patients here done something.

The PVA programme also fostered growth and development that allowed them to connect with their latent potential from which they were able to gain a new perspective about their own ability and kindled new ambitions.

- Int: So do you feel that you have developed over the 12 weeks?
- Betty: Still want to learn some more
- Int: Still want to learn some more. Do you think the program offer you a sense of goal? Like gives you goal?
- Betty: Um.
- Int: Gives you a sense of goal. You think that it challenges you?
- Betty: Um.
- Int: You feel challenged? In a good way or a bad way?
- Betty: good way.
- Int: In a good way arh? Ok, ermm, is there anything you enjoyed about the programme? Anything that you like particularly?
- Betty: Each time can learn more. Learn more, learn more different topics.

- Int: Hm. So you do enjoy having different topic, exploring different topic.
- Betty: Hm.
- Int: Why, why is that an enjoyment?
- Betty: Not so moody lah! every time the same old thing [raised voice]
- Int: Ah, so you think the change give variation, variety that you think is good. Ok so beside having varieties in projects, are there anything else that you enjoy? That makes you like the programme?
- Betty: See how far our work, our work will go.

During an interview with Betty, the display of her artwork at her bed attracted the attention of the care staff in her ward. When the staff inquired if she had made them, she did not hesitate to respond with delight and pride in her work.

The art activities also afforded residents a sense of ownership, agency and autonomy. In creating their artwork, they were observed to exercise care about their creation. Occasionally they would reveal a look of approval or break a smile of satisfaction at their work. These attitudes exercised by participants seemed to inculcate a sense of focus. Clare comments offer us the sense of conscientious and autonomy exercise by a participant.

- Clare: Yours we can print things by ourselves, we create using our own hands, and colour. Yours is better.
- Int: What is the difference when you colour and create with your own hands?
- Clare: It is not the same. That you have to use your eyes, your mind, to figure out how to do thing, how to pursue, how to do things to avoid damaging it. Colouring [sheets given by staff] is different. You simply colour, even when it is not good they [staff] will still say it is good. That is not good.
- Int: Why do you think it is not good?
- Clare: Where do you need to use your brain. You simply doodle. Even when it is bad they will still tell you it is good. Where do you have to use the brain? For yours it is different. You need to use you brain and focus.
- Int: You feel that our program demand you to be focused?
- Clare: Of course you have to be focused.

### **7.6.5 Animating Social Vitality**

Lastly, the findings of this study also suggest the potential of participatory arts activities to animate sociability. The concept of sociability (Simmel and Hughes, 1949) refers to the pleasurable, joyful and delightful experience emerging from being present with others and having an opportunity to partake in the play-form of social life. Such positive emotions and affect are believed to emerge when the play-form

afforded by social circumstance lead us to momentarily depart from our status and burden in 'real' life to enjoy the presence of others and the moments. Sociability can also be regarded as a form of social capital, which is found to be a vital well-being resource (Helliwell and Putnam, 2004, Yip et al., 2007, Kawachi et al., 2008). Sociability is found to have the therapeutic effect quality on identity. Play impulse promoted by engagement in imaginative and creative activity such as participatory arts session momentarily extract the participants from their everyday reality and joins individuals.

The participatory arts sessions are resources and opportunities for participants to connect themselves and interact with their counterparts. The contingent space engendered by the Arts-Health assemblage fostered an atmosphere that encourages interaction between residents. This can be attributed by the informal set up that the Arts-Health assemblage offers where it encourages play and exploration. Unlike the clearly demarcated boundaries of beds in the ward, the art venue was set up in a manner where participants shared tables and are in closer proximity to each other. The play action involved in the art sessions and the light-hearted atmosphere had also secured a space that encouraged interpersonal communication.

Alice: When you come and teach us thing to do, our spirit are better. I shared with them [staff], since they no longer come, we have nothing to do. When the session is on, the others will gather around to chit chat, that is good. But when you stop coming, the residents no longer come together. They don't come up. when the session was on, we at least get to nod to each other. No that you stop coming, we stopped knowing each other.

Over the period of the intervention, a sense of camaraderie also began to develop among participants. And residents expressed enjoying the companionship and interaction opportunity they have with fellow residents.

Alice: Through your programme residents will also have the opportunity to gather and talk, meet each other. When you are not here, we go our separate way. Who do I chat with? Like when you were running your session, the few of us would gather.

Although the main focus of the PVA Programme is on participants, it remains porous and influences its surrounding environment. Occasionally, the curiosity of staff

passing by the session would draw them into visit the session and spark conversations between staff and the participants. The residents' creation offered staff a different aspect of the residents, showing their capability and imagination. Their artwork offered staff a conversation piece for staff to initiate conversation with them. And at times, the conversation would spark a group chatter that where it would attract contributions from other participants and staff. Such socially enlivening occasions can be noted in the video data from one of the art sessions where participants were painting on dried leave to turn them into 'fishes'. While chatting with a visiting staff member, a participant playfully imagined that the fish originate from Myanmar, calling it Myanmar fish. This sparked an imaginative conversation about ways of cooking and eating this imaginary fish and its taste. The conversation was extended to other a few participants who began to chip in, speculating and suggesting ways to prepare and consume the fish. The sudden surge of playful conversation and imaginative, tickled those around and injected laughter and enlivened the atmosphere, leaving participants, myself and staff delighted.

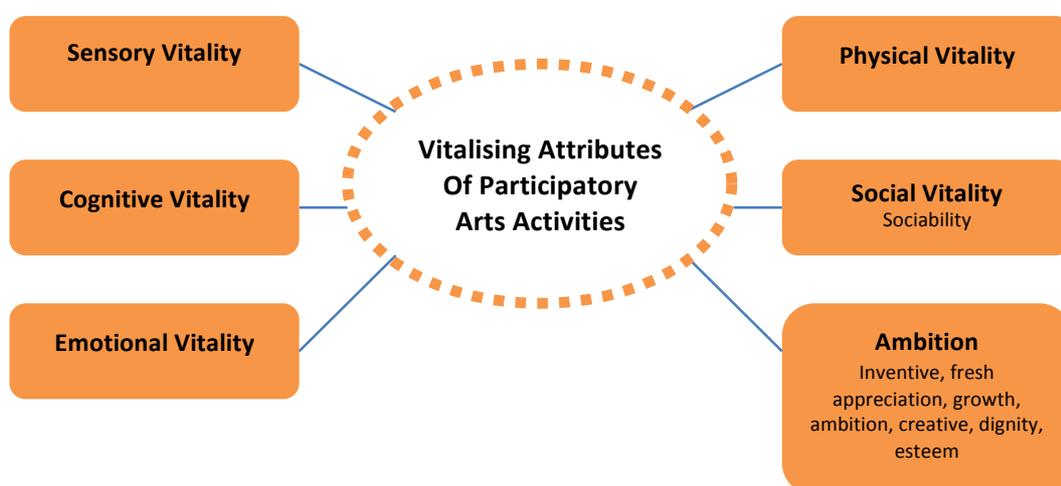


Figure 24. Vitalising Attributes of Participatory Arts Activities

The discussions so far have attempted to establish the link between vitality and participatory art activities. Drawing from understanding that vitality can potentially be initiated and engendered by positive affect, zeal and sense of pursuit gained from by

physical action and movement (Greenglass, 2006), I traced how actions and movement induced by the PVA programme engender energising and animating quality. The vitalising attributes of participatory arts activities found include sensory vitality, cognitive vitality, physical vitality, emotional vitality, social vitality and ambition.

## 7.7 Summary

This discussion began by highlighting that although nursing homes provide care for persons, it seems that in its preoccupation with caring for residents' physical needs and health, to *keep* residents alive, nursing homes have overlooked residents' need to *feel* alive. As a result, the quality of life for residents is often compromised. The lack of attention to residents' quality of life has inevitably engendered a passive and inactive lifestyle and affected the prospect and security for individuals to age optimally in nursing home. Although multi-sensory stimulation is known to benefit residents' physical and cognitive wellness, many nursing homes continue to be impoverished environments with low physical and social activities.

In exploring how a participatory visual arts programme might ameliorate the inactive lifestyle and enhance residents' subjective well-being, the discussion has paid attention to considering the transformation process occurring in participatory arts activities through which well-being gain might arise. To facilitate exploration on the health and well-being fostering role of the arts-health practitioner, I have drawn on Deleuze and Guattari (1988)'s ontological work on assemblage to develop the arts-health assemblage, a theoretical concept that not only helps explicate the health fostering process of non-therapy oriented participatory arts activities but also helps to identify the various factors at play that engender health and well-being. The arts-health assemblage is a contingent encounter and coalescence of multiple elements initiated by the arts-health practitioner. The key components in an arts-health assemblage would comprise of the arts-health practitioner, participants, conduct, art materials, art activities, and environment. As these elements connect, intermingle and disconnect, it creates affectivity that amends and fosters the personal well-being of nursing home residents.

In this discussion, I have also ventured to explore the link between vitality and participatory arts activities. Through further analysis of my empirical findings, I

interpreted and identified six vitalising attributes of participatory arts activities that contributed to augment the subjective well-being of participants. The six vitalising attributes identified were: sensory vitality, physical vitality, cognitive vitality, emotional vitality, social vitality and ambition. I hope my proposition of Arts-Health assemblage had not only explicated the health affording process and quality of non-therapy based participatory arts but also through the consideration of vitality, drawn attention to the importance and implication of vitality on the health and well-being of residents in nursing homes to support further engagement and implementation of the arts in nursing home so that residents can become and feel alive instead of simply being kept alive.

## 8 The *Caring Artist*: Considerations for Effective Arts-Health Practice

While attending to a patient, other skills, the softer skills, needs to be involved as well, because the patient has many dimension of needs, one do not just perform procedure, you need to look at the person as per se.

Agnes, Nursing Manager, Transcript from interview 08/10/2014

### 8.1 Introduction

The previous chapter drew on a relational understanding of health and well-being to theorise the manner which personal well-being emerges through a PVA programme. I expanded on Deleuze and Guattari (1988)'s notion of assemblage by developing an *arts-health assemblage* to highlight that well-being outcomes emerging from participatory arts activities, in part, is dependent on the dynamic interplay of various elements that include the arts-health practitioner, the participants, art materials, activities and environment. While framing the arts-health practitioner as a part of the assemblage, I also called attention to the manner in which an arts-health practitioner manages and negotiates the challenges and tensions arising from the interactions between these elements, which in part, also shape well-being outcomes (Chapter 7.3). Given an understanding that the conduct of an arts-health practitioner is an integral element of the arts-health assemblage (Chapter 7.4), and the limited attention on the conduct of the arts-health practitioner in existing literature, this final discussion chapter will go in some way to reflect and describe a way of thinking about the modes of arts-health approaches, and to articulate the attribute of the arts-health practitioner I hope can help facilitate the emergence well-being.

It is interesting to learn from the empirical findings that the participants and staff have considered the work of the arts-health practitioner as a form of caring. From discussions about the role of the arts-health practitioner with residents in Chapter 5.4, Joe regarded the arts-health practitioner as a person who gave attention and attended to 'another dimension of life' other than their physical needs; the arts-health practitioner as one who led residents to nurture their creative potential. Similarly,

Clare, Alice, Elaine, Peter and Betty regarded the arts-health practitioner as a person who gave attention and attended to their needs and desire for their body and mind to remain active and engaged. These qualities experienced by the participants were found to supplement the psychosocial needs of residents at Evercare. The capacity of an arts-health practice to attend to the psychosocial aspect of care among residents was observed by Agnes, the nursing manager (Chapter 6.6.1). The possibilities for interpersonal interaction, cognitive stimulation and personal development are qualities that Agnes identified in the work of the arts-health practitioner which she felt helped promote the psychosocial wellness of the residents. Given the capacity of an arts-health practice to promote psychosocial wellness of the residents, it can be argued that in the process of conducting and delivery the art programme, the arts-health practitioner is also partaking in caring work. This realisation thus prompts me to go in some way to explore the link between caring and arts-health practice. What is unique about arts-health practice? What does it mean to be a 'caring artist'? What does a practice framework to guide and promote a more effective arts-health practice look like? In doing so, I hope the discussions in this chapter can offer further articulation on the modes of arts-health approaches and the attributes of the arts-health practitioner so as to build a knowledge of good practice in arts-health field (Moss and O'Neill, 2009, White, 2010).

## **8.2 Arts-Health Practice: A Modality of Human Caring**

Existing studies have largely focused on evaluating the impact of participatory arts activities (Fraser et al., 2014, Castora-Binkley et al., 2010, Cohen et al., 2006a, Patteson, 2013) and explicate the processes through which health and well-being emerges from participatory arts activities (Atkinson and Robson, 2012, Fox, 2013, Atkinson and Scott, 2015). However, there is a current lack of discussion on the modes of arts-health practice and the attributes of an arts-health practitioner.

What is unique about arts-health practice? Given the interest of arts-health practice to engage and work with people, it could be argued that without the human participants, arts-health practice has no purpose. In this way, arts-health practice is distinguished from the work of an artist whose practice is focused on a pursuit of creating their personal artwork. Given the interest of arts-health practice to engage

people, the practice can be framed as a form of human-centred art practice distinguished by its intention to amend and foster the health and well-being of participants through creative art engagement. Although arts-health practices have displayed qualities that support, nurture and encourage individuals (Cutler et al., 2011, Fraser et al., 2014, Organ, 2011), the link between caring and arts-health practice have received very little attention and exploration in current framing of arts-health practice. The capacity of the arts-health practitioner to care for the psychosocial needs of residents revealed in Chapter 5 & 6, and the compassionate quality that Joe perceived in my own arts-health practice have prompted me to reflect and explore notions of care in arts-health practice.

Joe: You need to have compassion, if you don't have a compassionate heart how do you think you think you will be here?

What is Care? To care is to recognize the lived experience of others as worthy of our attention; care suggests that we respond in ways that are helpful and which perhaps facilitate positive change and new ways of being together (Conradson, 2011). Caring and care involve time, material resources, knowledge and skill, social relationships and feeling (Phillips, 2007). Care, as Tronto (1993, p.104) argues 'is not simply a cerebral concern, or a character trait, but the concern of living, active humans engaged in the process of everyday living'. Care involves actions that help fulfil the need of others. Caring is described by Tronto (1993) as comprising four aspects:

- Caring about – heeding the presence of a need and recognising a necessity to address the need.
- Caring for – undertaking responsibility for the identified need and determining how one's action can address those needs.
- Caregiving – acting in situations where a carer is in contact with the object of care through the 'direct meeting of needs for care'.
- Care-receiving – evaluating the efficacy of care exchange; how 'object of care' respond to the care it receives.

As I reflected on the process that I have undertaken as an arts-health practitioner in this study, the parallel that my practice had with these four aspects of caring became apparent. Firstly, as an arts-health practitioner, I am aware of the leisure-scarce condition in the nursing home and am concerned about the unfavourable impact the inactive lifestyle has on the quality of life and well-being of residents. The growing demand for nursing homes as a result of population ageing and the changing trend in living arrangements for older adults in Singapore also prompted me to recognise the necessity to address the need to improve the quality of life and well-being among residents in nursing homes. Secondly, my awareness and mental concern for the leisure-scarce situation moved me to take on the responsibility to care for the leisure-scarce situation by considering and developing actions to meet the need of the residents. In this case, I explored how the PVA can amend their lifestyle and help promote the personal well-being. Thirdly, I partake in caregiving, through the delivery of my PVA programme. I responded to residents' need and desire to develop and be active by providing attention, time, material, activities to engage and stimulate the residents. Through this process, I found that my actions have amended and fostered the personal well-being of residents. Lastly, my practice also involved learning about the effectiveness of my actions to address their need.

Care does not only entail attending to the practical needs of the other; an emotional aspect is also involved and is expected through care. The time bound up in these care exchanges and relationships also affects the 'embodied temporalities on care exchanges and experiences' (Bowlby, 2012, p. 2017). Milligan and Wiles (2010, p.738) drew attention to the fact that, 'care-givers do not simply do things for people; they also support them with encouragement, personal attention, and communication in ways that endorse a mutual sense of identity and self-worth.' These responsive and encouraging qualities of care and caring were observed in my practice by Agnes, the nursing manager:

How you led the group [of residents] made a big difference to the patients' art and their experience. The freedom they had in their creations, your encouragement, and prompting to get them to try different approaches when things didn't work. You showed a different aspect of the artist, your versatility to work with different patients. Because every patient is different and has different abilities and needs. You were sensitive to the

residents' need. You responded and adjusted according to the resident's need. For you, you actually presented it very well with the patients. And not all artists are like that...

Agnes' observation of how the conduct of the arts-health practitioner can influence and shape the participant's experience also reinforced the significance of the conduct of the arts-health practitioner that I highlighted and argued for in my discussion on the arts-health assemblage in Chapter 7.4. The analysis and findings have gone on to show that the work of an arts-health practitioner does not only involve the imparting of artistic knowledge and skills but the arts-health practitioner is also required to create and hold spaces for individuals, to support their growth, and the social and emotional transactions that unfold in the process. This is evident in the need for me to be sensitive to the initial apprehensions and uncertainties that participants had about their creative ability such as the learning curve experienced by Peter (see Chapter 5.4) or the initial doubt that Clare had due to disability (see Chapter 5.4.1). My capacity to lead and enable participants to find alternatives to overcome their challenges inspired new ambitions, as is evident in the participants' desire to further develop themselves (see Chapter 5.3.2). Alongside the provision of creative art activities, the demand of arts-health practice also requires the arts-health practitioner to attend and respond to the emotional needs and shifts emerging from an art session. Taking into consideration the concerns that an arts-health practitioner has towards the situation of others, and the attention and effort that the practitioner offers to amend and foster the personal well-being of individuals, it is perhaps useful to consider these attentions and actions of arts-health practice as a modality of human caring. Given the care exchange involved and required in arts-health practice, it may be useful to articulate an awareness of this caring characteristic and, thereby, demand of arts-health practice an explicit understanding of the arts-health practitioner as a *caring* artist.

### **8.3 Arts-Health Practitioner as a *Caring* Artist**

Taking into consideration how social relations and social practices enacted in caring can have positive and negative consequences on human well-being (Atkinson et al., 2012, Milligan, 2005, Kearns and Gesler, 1998, Gesler, 2009, Gesler and Kearns, 2002), it can be argued that the attitude and manner in which the arts-health

practitioner interacts and responds to participants can have implications on well-being outcome through a participatory arts activity. The significance of the conduct of an arts-health practitioner was also indicated in my discussion on arts-health assemblage (Chapter 7.4). Given the significance of the conduct of an arts-health practitioner and the current lack of articulation of the attributes of an arts-health practitioner, I will now draw on my experience as an arts-health practitioner in this study to reflect on what it means to be a *caring* artist. I hope this consideration on the attitude and conduct that I observed in my practice can provide a way of thinking about the modes of arts-health approaches that can be useful to guide and promote a more effective arts-health practice that support care and encouraged the emergence of well-being among the participants.

The *caring* artist, first and foremost is compassionate. The caring artist takes notice of the situation of their fellow human and is interested to take on the responsibility to create positive change to their situation through a creative art engagement. The motivation to undertake this study was led by my awareness of the leisure-scarce condition in nursing home and the unfavourable impact the inactive lifestyle have on the quality of life and well-being of residents. As a response, I took on the responsibility to develop and conduct a 12-week participatory visual art programme, to explore the change that my intentions and actions can facilitate. In doing so, I created opportunities that led and enabled the participants to discover their creative potential.

In this sense, the caring artist is also hopeful and sees potential in others to grow. The hopeful attribute of the arts-health practitioner is reflected in the different opportunities, expectations and challenges that Clare experienced from my PVA programme versus the art activity that she received from care staff.

Clare: It is not the same. That you have to use your eyes, your mind, to figure out how to do thing, how to pursue, how to do things to avoid damaging it. Colouring [sheets given by staff] is different. You simply colour, even when it is not good they [staff] will still say it is good. That is not good.

The amazement shown by staff upon seeing the residents' artworks as indicated in Chapter 6, has also suggested the different expectations and aspirations the care staff and the caring artist had for the participants. The multiple artworks produced have also led the staff to realise the untapped potential of the residents and act to counter assumptions of the limited capabilities of the residents and the limited expectations of what they can become (see Chapter 6.4). This hopeful outlook and belief that the caring artist has toward the potential of the ageing bodies in a nursing home engenders a space that promotes play and expression. Agnes's observation on the art programme also suggests that the hopeful outlook I had about the potential of nursing home residents had encouraged risk taking and fostered imagination among participants that was not found in other activities provided by staff.

Agnes: Ermm...what the OT did wasn't something very dynamic. What you have done is something very different. Because, at the end of the project itself, ermm...even with the watercolour, you don't have any base, outline for them to colour. You just let them to fill the papers with colours and it itself erm...there were some beautiful work that is being done in that sense. Ermm and you allow the elderly to express it in their own way. You don't not fixated, eh you coloured out of line already. you know, we don't do that to the patient. So, whereas your art is very free flowing in itself. It allows the patients or the resident express their own sense of art work.

Empirical findings also indicated the implication of the quality of participatory arts activities on well-being outcome. For example, Clare felt stimulated because the art projects in the PVA were regarded as more challenging compared with the colouring sheets that care staff would provide (see Chapter 5.4.1). In addition, the sense of fulfilment she experienced from her ability to respond to the creative brief empowered her and inculcated self-belief. The participants' efforts to respond to the challenges of the creative projects in the PVA fostered and encouraged imaginative play and expression also elicited a renewed sense of amazement, pride and confidence.

Besides being empathetic toward the situation of others and feeling hopeful, there seems to be several other attributes that are at play in the process that contribute towards the emergence of positive well-being among the participants. Empirical findings have also gone on to highlight the high level of interpersonal

engagement, demand and support involved in the process of amending and fostering well-being of participants. While delivering an art activity, the potential needs and challenges encountered by participants also require the arts-health practitioner to give attention and respond to. When considered in this sense, the work in arts-health practice have been linked to caring and was framed as a modality of human caring.

In my discussion on the participants' experience of the PVA programme (Chapter 5) and the arts-health assemblage (Chapter 7), I have highlighted that the emerging and shifting needs and emotions among participants. For example, the learning curve experienced by Peter and the challenges face by Joe when manipulating clay (Chapter 5.4), or Clare's initial self-doubt about her ability (Chapter 5.4.1). These situations arising from the PVA sessions have go to show the emotional demands in arts-health practice that require the arts-health practitioner to respond and attend to. In this sense, the fluctuating demands and emotional reaction arising in an art session call for a need for arts-health practitioner to be sensitive and responsive. These attitudes can be regarded as another attribute of the caring artist.

Given the aim and intention of arts-health practice to animate health and well-being, it also seems useful and important for the practitioner to pay attention to elements involved in ones' practice that could potentially limit or inhibit the emergence positive well-being. When undertaking this study, I took precautionary measures to eliminate or minimise any risks to the physical health and safety of participants that could potentially arise from the art activities or the venue. I also ensured that all art materials used were non-toxic and would not present any threat to the health or well-being of participants. For example, I consulted staff to determine the most suitable tools for the participants to use. Understanding that my participants may not have good muscular control or good eyesight, I substituted the use of pen-knives with safety scissors to eliminate potential physical injuries. When conducting the programme, I also aimed to eliminate or minimise the potential risk of cross infection. Thus, art materials were either washed or wiped down with disinfecting products after each session. I also diligently observed good personal hygiene by washing my hands prior and after each session.

From discussion on the implementation of the PVA programme in Chapter 5.3, it is apparent that the quality of the environment where programme is held can shape

the participants experience and perceived quality of the art programme. Besides paying attention to the ambience such as quality of lighting, airflow, temperature, and noise when I was conducting the PVA programme, I also paid attention prior to the start of each session to ensure that the venue was free from potential risk or hazard that could subject the participants to unnecessary harm. For example, by understanding that some residents were at risk or more prone to fall, I arranged the furniture to ensure ample space for participants to move comfortably round the space without any obstacle. Lastly, I would also constantly monitor and maintain the general atmosphere of the participatory arts session to ensure that participants remained motivated, engaged and interested.

In addition to physical safety, I also exercised sensitivity to avoid subjecting participants to emotional risks. To do so, I made an effort constantly to observe and take note of the participants' reactions and responses throughout the arts sessions. To facilitate my monitoring, I ensured that my participants were seated within my peripheral vision to provide me to a good vantage point. When conducting my art session at Evercare, I constantly paid attention to the actions and reactions of my participants by observing their movement, gestures and expression. I would monitor and periodically check in with the participants to find out how they were managing with the activity and provide support when the need arose to enable participants to resolve their concerns and challenges while undertaking a creative task.

The caring artist is also responsive to the participants' needs and challenges during an art session. Working with an arm for Clare can create some inconvenience for her when creating her work. For example, she was not able to press down on the paper to prevent it from moving while painting on it. This did initially annoy her. In response to her challenge, I offered to stick down her paper with masking tape to stop it from slipping away from her that helped resolve her problem and allowed her to focus on the creation of her work. In another instance, to help Betty overcome her lack of strength to manipulate a lump of clay, I assisted by breaking her clay down to smaller manageable portion. I make an effort to keep smiling which can help make me approachable which, in turn, helps put the participants at ease and makes them comfortable approaching me with any difficulty or query while making their artwork. Making oneself approachable is also an attribute of a caring artist.

Int: Is there anything that an artist needs to be mindful of while working with the residents?

Betty: Put on a smiling face! [chuckle]

The attention to the shifting action and reaction also call for a need for the arts-health practitioner to be present and attentive; to have an ability to be present to self and others that is focused on an intentionality to care for and foster positive experience for participants in an art session. In other words, a caring artist needs to be committed to lead and support the participants to discover their capabilities to grow. Besides being sensitive to the shifting action and reaction of the participants during an art session, a caring artist is also required to exercise sensitivity by not imposing on the participants but allowing the participant to guide and help determine for what and how it is most appropriate to help. For example, there was a session when I saw that Peter was not feeling well, but had still decided to attend my art session. During the session, I could see him struggling with his concentration to paint. After checking with him, I found that he wanted his work surface to be elevated so that he did not have to exert so much energy. I met his request by propping his work up with two packs of clay. He persisted for a while before deciding that the art activity was too much for him that day and decided to leave the session. I respected his decision and arranged for one of the care staff to assist him back to his ward. In this sense, a caring artist establishes and maintains good communication with participants and is respectful. Being respectful was also a quality that Agnes, the nursing manager felt to be essential when interacting with residents.

Agnes: An open attitude for the elderly. Ermm to accept their disability, and to allow them to express in their own way. I think that is good enough and when we talk to them we do not belittle them. Ermm I think that is very important. And even if art did not turn out very well for them, we do not say that this is wrong, you should not do it this way, erm, that is also important. To allow the elderly to express in their own way of expression, I think these qualities are good to have.

Given high degree of interpersonal interactions involved in arts-health practice, respect is a quality that applies in any setting where arts-health practice takes place. A sense of respect, as I came to know through my practice, can be fostered through the manner in which the arts practitioner communicates with the participants. For

example, it is useful to adjust and lower one's height to the eye level of the participant to minimise impression of talking down to them. I would usually stoop down across or beside my participants when guiding them. Respect can also be exercised by showing a willingness to be a good listener.

The caring artist is also one who encourages and nurtures. Such attributes were suggested in Joe's and Betty's opinions about the role of an arts-health practitioner. Joe sees the arts-health practitioner as one who attends to 'another dimension of life' and encouraged development of his interests and capabilities.

- Joe: You guys are the other way round. It is another aspect. Another dimension of life.
- Int: What dimension?
- Joe: Some might have the talent but may not have the opportunity to encounter art, will make use of this opportunity to use. To nurture this interest in them.
- Betty: You taught us how to draw, how to create ah. To appreciate the point of creation, the expression of it. [...] This is something we don't know at all previously. It was from you that we learn and know what to do.

This nurturing capacity of the arts-health practitioner was also observed by staff:

- Agnes: For the patients, for those who have never been exposed to art and come into the art programme and realised that they can do thing that they were not able to do before, and... if the artist is willing to continue the programme, for a long term here, I think these residents would have presented things that they never expected in their whole life. Ermm they would know that they have done something...ermm much better than what they have first started off yeah. A sense of achievement, or people who says that...the...if you talk about the egoistic part of it, oh they are in the other higher plane now, where they felt that can perform something that is beautiful. Yeah.
- Int: So you think an artist can benefit a nursing home.
- Agnes: Yes! [laughs]

When leading participants, patience also appears to be a crucial attribute of a caring artist. The opinions of participants and staff have indicated the importance of an ability to tolerate and accept the limitations participants might experience. This can make for a laborious process in building the creative journey and the arts-health practitioner needs to remain willingness to lead and support participants through the process.

Agnes: Ah! That is very important. [gasp] The patience that the artist can portray to the elderly is very important. Because it is through patience that you can draw the elderly out. If you do not have the kind of patience with the elderly then you will give up eventually. [laughs]

Betty: Because we are elderly already. We can be slow with our work. So you need to be to guide us.

By reflecting on my practice in this study, I realise that to engage and motivate residents to participate in the creative process, it is important for the practitioner to ascertain the suitability of the kind of arts activities and level of difficulty of the creative task that are appropriate for the participants. This will not only help ease participants into the creative work, which is likely to be a new venture for many, but can also help them build confidence through tasks that are manageable. It is important, then, throughout the process to pay attention to and monitor the comfort and ease of the participants while engaging in the creative task. The practitioner may also be required to make modifications to the creative task or activity in response to the participant's needs and to support and encourage them. Thus, it may be helpful for the practitioner to be familiar with some of the potential challenges that may confront a particular group of participant and devise alternative supportive strategy or mechanism that can support participants to realise their creative task.

When undertaking this study, I took time to speak to the nursing manager to obtain general information about the participants such as their age, gender, experience with the arts, and general health and well-being condition or circumstances. Access to this information offers various benefits. First, it allowed me to assess and identify the potential risks and challenges that the participants may be susceptible to. This process also allowed me to anticipate the necessary measures required to support participants as they partake in the participatory arts programme. Second, it has helped me to determine, plan, and design the creative activities, logistical materials and the optimal environment required for the activities. Lastly, this process has enabled me to establish rapport with relevant personnel who would be a point of contact to seek support or clarification when circumstances require them to do so during the participatory arts session.

Lastly, taking into consideration how the arts-health practitioner managed to activate and energise the body and mind of residents, the caring artist is also one who invigorates and inspires.

Int: So how do you feel looking at your artwork?  
 Clare: Very Good. Didn't think that I can produce such things.  
 Int: Ah, ok. So you have never imagined yourself to produce such work?  
 Clare: I didn't...I didn't dare imagine. I thought, what can this one arm of mine do other than some weird looking things. [...] very happy, Very excited that I can produce thing of such standard, I consider that that is not bad an achievement. For a disabled person to be doing this. [...] It was challenging creating the gold fish piece. Because it was hard to manipulate the form of fish.

Int: Well, how do you feel about your ability to create these in your 80s? You are still capable of doing these...how do you feel?  
 Alice: [Laugh] I feel...I am amazed.  
 Int: Has it occurred to you that you can do this?  
 Alice: Not at all.  
 Int: You have not imagined that even when you are 80, you are still able to do this.  
 Alice: I did not expect myself to splashed so much. I have not expected. I didn't not expect that I would know how to splashed these. [Burst of laughter]  
 Int: Now looking at your creation, what is your view about yourself?  
 Alice: I see that I am quite clever. [Bursting in laughter, chuckles]  
 Int: You find that you are quite clever. Now that you are learning things  
 Alice: I find that I am quite clever, I am able to splash things till they look quite realistic.

In this reflection on what it means to be a caring artist, I have identified several attributes that have suggested its significance to in the process of amending and fostering the personal well-being of participants. Stemming from having a compassionate and hopeful outlook on the situation of others, the caring artist is also respectful, attentive, sensitive and responsive to the needs and challenges of participants. The caring artist understands that the creative journey can be potentially laborious and challenging for themselves and the participant but is willing to exercise patience and is committed to lead and support the participants to discover their capabilities and grow. In other words, the caring artist encourages, nurtures, invigorates and inspires. Through this reflection on what it means to be a caring artist, four elements have emerged and suggested its salience to the concerns of arts-health practice. They include participant, well-being outcomes, environment and quality of activities. Taking into consideration the current lack of clarity on the concepts that are

of concern to arts-health practice (White, 2010, Raw, 2013, Jensen, 2014), the final section of this chapter will draw on the four concepts to develop a conceptual model that I hope will provide useful reference to facilitate decision making, actions and reflection on arts-health practice to advance understanding and build knowledge of good practice. Conceptual models articulate the purpose and scope of a practice by identifying global perspectives and concepts that are considered to be of importance to it; such knowledge in return facilitates reasoning processes, facilitate decision-making, evaluation and reflection that can further advance practice and its effectiveness (Masters, 2014).

The unique role I had as a practitioner-researcher in this study did demand me to ensure that the quality of my art programme and the rigour of my research were not compromised. Through this, I realised the importance and benefit of good organisation and planning. The time allocated to the preparation of logistical materials prior to each session was useful at enabling me to ensure that the smooth running of my art session and research activities which occurred concurrently. However, it was inevitable for unexpected situations to arise at times in an art session where the flow of planned activities were disrupted such as the spillage of paint by a participant, which required me to respond spontaneously. While being organised is useful at streamlining the flow of activities, I learnt that it is equally important for me to be responsive and adaptable to the situation to ensure that the participants' safety was not compromised.

As a practitioner-researcher undertaking a research to evaluate the effect of my participatory art practice on the participants, I am aware of the possibility that I might have some biases, preconceived expectations and assumption about the anticipated impact and benefits. The data and method triangular procedures I engaged in this study has been useful in providing me the much needed critical distance to validate the accuracy of my findings by comparing the data from my research participants (both residents and staff) through various methods e.g. interviews and focus groups with my personal observation notes. The on going review and discussions I had with my two supervisors, were also beneficial at lending objective feedbacks that enable me to clarify and articulate my analysis and findings.

#### **8.4 The Metaparadigm of Arts-Health Practice**

Although there has been a growing interest for arts-health practitioners to establish modes of approaches to facilitate better experiences for participants and well-being outcome (Raw, 2013, Dileo and Bradt, 2009, Jensen, 2014, White, 2009, White, 2010), there have been limited conceptual models of arts-health practice that identify elements that are of importance to the practice that practitioners need to consider and manage in order to provide a pleasant and enriching experience that contributes to amend and foster the well-being of participants.

Although existing works have gone some way to highlight the various components that could guide and promote the effectiveness of arts-health practice (White, 2010, White, 2009, Jensen, 2014), the current frameworks have yet to identify the global concerns of arts-health practice. Arts-health practice is conceptualised and framed as a 'social tonic' by White (2009, p.104). He regarded arts-health practice as a gift and a resource that the practitioner offers participants for the purpose of 'character-building for the individual, and it can also increase morale in the social group' (White, 2009, p.104 - 105). He offered a framework comprising several principles, which he deemed important to ensure an effective arts-health practice. The principles include the need for the arts-health practitioner to: 1) create a vibrant atmosphere; 2) be responsive and affirming to participants; 3) ensure participants experience a sense of well-being and control. Sensitivity to context and the quality of interaction with participants were also highlighted as a key elements in an effective practice (White, 2010). In addition, he also emphasised the importance of self-care, that is for the arts-health practitioners to ensure that their own personal health and well-being are not compromised as a result of their practice. Although White identified several elements, his work did not explore or attempt to identify the global concerns of arts-health practice. Furthermore, he also did not offer a checklist for practitioners that could act as a reference guide to inform their decision-making.

More recently, Jensen (2014) considered the medical code of the ethical principle of 'first, do no harm', and recommended it as a code of practice for application in arts-health. The principle of 'first, do no harm' highlights the responsibility and caution an arts-health practitioner must. It draws attention to the potential harm that might arise from participatory arts engagement if the practitioner

fails to observe confidentiality, beneficence or autonomy or fails to be respectful or have adequate facilitation skills. Jensen's proposal recommended that practitioners should observe an ethical code of conduct, assess the suitability of participants, and ensure informed consent for participation. It also proposed a need for a mentoring and feedback system. While the 'first, do no harm' code is useful for drawing practitioner attention to the need for awareness of the person and for prudence in the activities in order to protect participants from potential harm, it does not acknowledge other phenomena that have emerged as important to arts-health practice from this study in relation to amending and fostering well-being outcomes. The arts-health assemblage described in the previous chapter highlighted the relational characteristic of arts-health practice and called attention to the network of elements involved in arts-health practice. Although Raw (2013) offered insights to the commonality found in participatory arts practice, the elements identified: intuition, personal commitment, framework of value, relational framework and creative key to the practice assemblage provided little clarity on the conduct expected of the arts-health practitioner. Thus, in this final section, I will identify the 'metaparadigm' of arts-health practice and offer a framework of practice that calls attention to the various elements involved in arts-health practice that required the attention and care of the arts-health practitioner. A metaparadigm spells out the global concerns of a practice; it can be regarded as the cornerstones of practice from which more restricted structures develop (Eckberg and Hill Jr, 1979). It defines the boundary of a practice, its interests and summarises the intellectual endeavour, social mission and recurring themes that are of interests to a practice (Fawcett and Desanto-Madeya, 2012). A metaparadigm creates a focus for a practice, which promotes its unity and facilitates communication between its practitioners. It also helps members of a practice explain to others outside the area of practice who they are and what is their special interest and contribution.

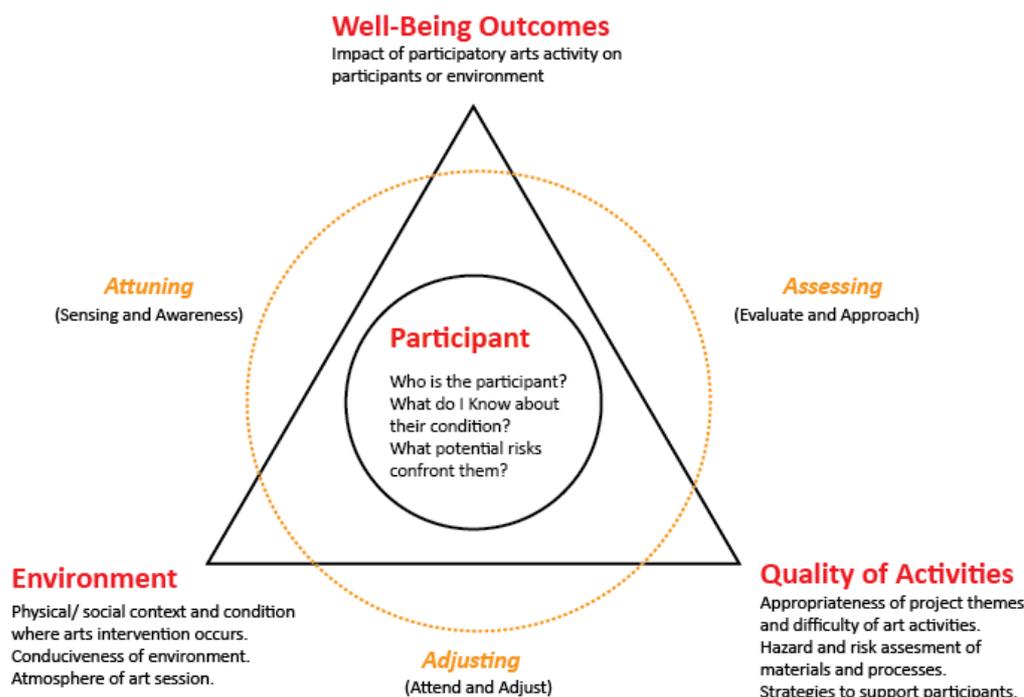


Figure 25. Metaparadigm of Arts-Health Practice

Drawing on my empirical study, reflections on my practice and the elements that I have discussed and highlighted relating to the practice and disposition of the caring artist, I have identified four governing concepts of a caring arts-health practice: the participant; well-being outcomes; the environment; the quality of the activities. Participant refers to an individual participating in the participatory arts programme whose health and well-being circumstance are of interest to the arts-health practitioner. The emergence of well-being, as indicated in preceding discussions, in part is depended on the arts-health practitioner attentiveness and responsiveness to the shifting needs and challenges of the participants. Well-being Outcomes indicate the aim of arts-health practice to amend and foster health and well-being of participants. Having a consciousness about this intend about arts-health practice can offer the practitioner a sense of focus and steer emerging outcomes towards this objective. Environment refers to the context where the arts-health practice and activities occur. It also draws attention to the meaning of the place and the implication of the arts to the participants in that particular context. Environment also refers to the ambience and dynamic atmosphere unfolding alongside the art session. And finally,

quality of activities draw attention to the positive affectivity (Watson et al., 1988) such as enthusiasm, alertness, excitement resulting from the creative processes, materials, and interpersonal transactions occurring in a participatory arts session.

<b>Participant</b>	<ul style="list-style-type: none"> <li>• Who are the participants? (E.g. age, gender, experience with arts)</li> <li>• What are the health and well-being concerns or conditions affecting the participants?</li> <li>• What potential risks or challenges might the participant face while participating in the arts session?</li> <li>• What vulnerability might they face? What action is required to ensure that participant is treated with respect, dignity and care?</li> </ul>
<b>Well-being Outcomes</b>	<ul style="list-style-type: none"> <li>• What measures need to be taken to eliminate or minimise physical health and safety risks of participants? (E.g. Potential Hazard spot and injuries, Infection)</li> <li>• What measures need to be taken to eliminate or avoid subjecting participants to emotional risks?</li> <li>• How are participants reacting to the participatory art activities?</li> <li>• Who can the arts-health practitioner turn to for further assistance in when a participant are experiencing physical or emotional risk?</li> </ul>
<b>Environment</b>	<ul style="list-style-type: none"> <li>• What is the setting and its operation protocol? (E.g. Care institution, community centre, learning institution)</li> <li>• Is the physical environment safe for participants?</li> <li>• Is the physical environment conducive for participants?</li> <li>• What considerations need to be given to foster a vibrant atmosphere during the participatory arts session?</li> </ul>
<b>Quality Activities</b>	<ul style="list-style-type: none"> <li>• Is the creative task set at an appropriate level of difficulty for participants?</li> <li>• Does material and process possess any hazard to participants?</li> <li>• How are participants managing and responding to the creative task?</li> <li>• Are participants feeling comfortable and at ease during the session?</li> <li>• What alternative support strategy or mechanism is available to support participant through the creative task?</li> </ul>

Table 7. Practice Framework for a Caring Arts-health Practice

The quality of art activities is also concern with the appropriateness of themes and level of difficulty of creative brief, the suitability of material and process used in the art activities for participants, and anticipating strategies to support participants. These conceptual elements are brought together through the dynamics of a caring practice which I am capturing through three terms, attuning, assessing and responding which I elaborate further below. Together these governing concepts and dynamic practices constitute a metaparadigm of arts-health practice as represented here in Figure 25. The four governing concepts of arts-health practice have also usefully helped to generate a list of considerations and offered a practice framework (see Table

7) that I found useful to guide me in my practice through the planning, designing and facilitating phases.

While the four concepts are central and important to arts-Health practice, the demand from each component can fluctuate during the participatory arts session. Thus in a way, a caring arts-health practice demands that the practitioner is attentive and responsive to the shifting and unpredictable dynamics as they unfold in a participatory arts session. To manage the challenges of the task to allocate attention to the four central concerns, I approached my practice using an iterative mode of action comprising of *Attuning, Assessing, and Responding*.

Attuning calls the practitioner to be present constantly and pay attention to the event unfolding. The concept of situation awareness (Endsley, 2000) lends a useful description of the various actions involved in attuning. Situation awareness involves a process of perception, comprehension and projection. Perception involves monitoring, detecting cues leading to awareness of multiple elements such as people, objects, events and their current states such as condition, action, and locations. Comprehension involves a process of recognition and interpretation and of integrating information gathered to assess the potential impact on actions and views. Projection refers to the anticipated course of action. Assessing requires the practitioner to evaluate the circumstances encountered or presented by participants and to understand and clarify their needs. Lastly, responding refers to the course of action required of the practitioner to attend and assist participants to resolve their concerns by making the necessary adjustments or to introduce alternative approaches. Thereafter, the practitioner reverts to assessing their response. This practice of maintaining a sense of equilibrium so as to foster a supportive and nurturing environment, I am calling a practice of *holding space*.

## **8.5 Summary**

Unlike other professions affiliated with the field of arts and health such as art therapy, occupational therapy, arts-health practice currently lacks conceptual models to orient practitioner and guide practice. Thus, this chapter sets out to explore and identify the various phenomena of interest to develop a conceptual model for use to guide and promote the effectiveness of arts-health practice. Through my empirical

findings, I have proposed a metaparadigm or framework, of a caring arts-health practice. This comprises four global concerns, or governing concepts in arts-health practice: the participant; well-being outcomes; the environment; the quality of the activities. To manage the challenges of the task to allocate attention to the four central concerns, I suggested an iterative mode of action comprising of Attuning, Assessing, and Responding, which encourages the practitioner to be present and be sensitive to the reaction and needs of participants and respond in a supportive and nurturing manner. In addition, I also went in some way to reflect on the mode of arts-health approach. Although arts-health practitioners have displayed supportive and nurturing qualities through their practices, care and caring have received very little attention and exploration in current framing of arts-health practice. Thus, a part of this chapter explored the link between arts-health practice and caring. In doing so, I drew out the caring characteristic I found in my arts-health practice and highlighted the various caring attitude, which involves qualities of interpersonal exchange that an arts-health practitioner should be mindful of when leading the participants. Given the interest and attention that an arts-health practitioner takes in the situation of others, and the actions undertaken to foster positive well-being through participatory arts activities, the arts-health practitioner is also framed as a caring artist.

## **9 Conclusion**

### **9.1 Introduction**

This concluding chapter will offer a reprise of the research background and its aims before summarising the key findings from this study, and the contribution of this research to the literature. Finally, it considers the limitations of the project, and identifies potential areas for future research and policy implications.

### **9.2 Summary of Research Background and Process**

The priorities many nursing homes give to physical care often supersede consideration for leisure arrangements and resources. Such care arrangements have limited the range of activities and engagement opportunities for residents. Besides, boredom, the lack of activity can reinforce the sick role, diminish morale, engender a depressive mood and lethargy that compromise the personal well-being of residents. The low level of engagement also exposes residents to greater risk of developing cognitive impairment and accentuates feelings of loneliness and isolation. In the light of population ageing and an increased in demand for nursing homes in Singapore, this research addressed the current lack of research on lifestyle arrangement to explore potential strategies that might help promote the personal well-being of nursing home residents. In doing so, I implemented a 12-Week participatory visual arts programme and explored how it can promote the personal well-being of residents. To facilitate the evaluation and reflection on my arts-health practice, I devised a novel approach that amalgamates arts-health practice with a social scientific qualitative action-research case study. I refer to this systematic approach as 'critical arts-health practice'. In addition to investigating how might arts-health practice promote the personal well-being of nursing home residents, this study also explored the manner which well-being emerges from a PVA programme and the elements involved. Drawing on my empirical data and reflection on the practice and disposition of the caring artist, I also developed a practice framework that I hope can be useful to promote a caring arts-health practice.

### 9.3 Summary of Key Findings

The 12-Week PVA Programme was found to promote the personal well-being of nursing home residents. The PVA Programme elicited positive emotions such as enjoyment and fulfilment, inculcated self-belief and confidence, and ignited ambitions among the participants. According to the participants, these invigorating qualities found in the artist are not usually available in the care routines of care staff. Given these understandings, the arts-health practitioner can be regarded as a resource for social, cognitive and sensorial stimulations, as well as a nurturing figure that encourages personal development. Similarly, staff observed improved mood, enthusiasm, and gains in confidence among the participants. The arts-health practitioner is found to activate, invigorate and inspire the residents in ways that care staff have not observed among the residents in their care routine.

It also became apparent to me from this study that the capacity for arts-health practice to amend and foster personal well-being is affected and achieved through a network of elements that require the attention and management by the arts-health practitioner, including space, materials, bodies (of participants and other staff), mood. This realisation prompted a need to move beyond understanding health and well-being as states found and bounded within the body. Drawing on the notion of assemblage (Deleuze and Guattari, 1988) I developed an arts-health assemblage to extend this understanding of the relations between arts participation and wellbeing by stressing the centrality of the arts practitioner as the architect and manager of the assemblage. The arts-health practitioner needs to be constantly attentive and responsive to differentiated experiences of the participants in relation to the material, spatial, social and atmospheric elements of the assemblage.

Alongside the provision of creative arts activities, the demand of arts-health practice also requires the arts-health practitioner to attend and respond to the emotional needs and shifts emerging from an art session. Although arts-health practitioners have displayed supportive and nurturing qualities through their practices, the link between caring and arts-health practice has received little attention and exploration. Taking into consideration the concerns that an arts-health practitioner has towards the situations of others, and the attention and effort that the practitioner offers to amend and foster the personal well-being of individuals, I have also framed

the arts-health practitioner as a caring artist. Drawing on the findings and my reflections from this study, four elements have emerged as salient to arts-health practice. They are: the participant; well-being outcomes; the environment; the quality of the activities. Given the prominence of those elements indicated in my empirical findings and my reflection on the practice and disposition of the caring artist, I have proposed a metaparadigm for a caring arts-health practice that considers and puts forward the four elements as the governing concepts for arts-health practice. In doing so, I hope the model will offer fellow arts-health practitioners a point of reference that can guide and promote more effective arts-health practice.

## **9.4 Contribution to the Literature and Future Research**

### **9.4.1 Contribution to the Literature**

In contrast to other professions affiliated with the field of arts and health, such as art therapy or occupational therapy, who have a formalised approach and established research methodology to evaluate and reflect on the impact of their practice, arts-health practice currently lacks a systematic approach to facilitate evaluation and reflection of the practice (Raw et al., 2011, Castora-Binkley et al., 2010). Thus, a major contribution of this research to the literature is to provide an innovative arts-health methodology that amalgamates arts-health practice with a social scientific qualitative action-research case study to enable myself, an arts-health practitioner, to systematically evaluate and reflect on the effect of my practice and the manner in which health and well-being is fostered through participatory arts activities. I refer to this systematic approach as 'critical arts-health practice'.

Secondly, the research also offers insight to the little known lifeworld of residents in a Singapore nursing home by highlighting their inactive lifestyles and the effect of this on them. The findings attend to the current gap in the knowledge about the lifestyles of residents in Singapore nursing homes. In doing so, nursing homes are framed as leisure-scarce places, and I also present and investigate a strategy to ameliorate the situation by implementing a participatory visual arts programme.

Thirdly, besides demonstrating the benefits of the participatory visual arts programme on the residents, I have also gone some way to develop our

understandings of the social processes and spatial dimensions that are involved in how a non-therapy based art engagement can enable and shape health and well-being, processes that have had relatively little attention to-date (Atkinson and Robson, 2012). Expanding on notions of assemblages (Deleuze and Guattari, 1988), I conceptualise arts-health assemblage to show that the emergence of well-being among the participants is dependent on the manner which an arts-health practitioner manages (conduct) the dynamic interplay between elements that includes the participants, activities, materials and environment.

Fourthly, my study drew attention to the link between the concept of vitality and participatory arts activities, which expands the current framing of the purpose of participatory arts-health activities. I interpret and identify six vitalising attributes of participatory arts activities that help augment the subjective well-being of participants. These six vitalising attributes are: sensory vitality; physical vitality; cognitive vitality; emotional vitality; social vitality; ambition. In addition to exploring the concept of vitality as an additional benefit to health and well-being afforded by participatory arts activities, I also propose that vitality might be an indicator of wellbeing for a practitioner to strive for in their practice. Given vitality's focus on inducing movement, eliciting positive emotion and animating ambition, I feel that it provides a more perceptible reference point for practitioner to strive for while foster health and well-being.

Lastly, this research has gone some way to reflect on the modes of arts-health approaches and the attributes of the arts-health practitioner and developed a model that identified: the participant; well-being outcomes; the environment; the quality of the activities as governing concepts to guide and promote a more effective and caring arts-health practice.

#### **9.4.2 Limits of the Study and Possible Future Research**

Although the innovative action-research case study approach was effective at enabling me to gather the data necessary to examine and interpret the effect of the participatory visual arts programme on the residents, the research had several limitations. Firstly, due to time, human and financial resources constraints, I was not able to offer a more extensive arts programme that could have reached more

residents beyond the group of 10 that I engaged. As a recommendation for future research, it will be ideal, if resources were available, to expand the weekly session in the home to two or three sessions per week to cover more of the resident population. In addition, I would also have preferred to be able to extend the length of the participatory arts programme to 24 weeks to enable better a longitudinal study. This approach would increase the number of participants and enhance the validity and significance of the study. A more extensive research period might also enable a more comprehensive understanding on the lifestyle arrangements of residents of nursing homes in Singapore by involving more homes in future studies.

Secondly, the dual role that I undertake as a researcher and arts-health practitioner did impose certain limitation to my ability to observe the sessions. As the facilitating artist, I found myself often absorbed by the work required to guide and ensure that the participants felt well supported during the art session. In doing so, I was not able to commit myself fully to observing the session in progress. However, I chose to use video to compensate this limitation. While video as a method was useful to capture the flow of events occurring during the participatory arts activities for analysis, the single camera used did pose some limitations in providing a more comprehensive overview. Despite devising various strategies to compensate any possible inadequacy, such as a time-based fixed camera approach where the camera was rotated on a 30 minutes basis around the venue and an action-led video recording, where the video is moved in respond to emerging actions, the availability of more video recording devices would be useful to offer a more rounded view. I would also recommend the arts-health practitioner to consider the use of a wearable GoPro camera that can be attached to the practitioner to capture the interpersonal interactions with the participants to offer an embodied perspective of the practice.

Lastly, this research had focused on visual arts and so the findings only reveal and present the well-being benefits found from visual arts activities. Although visual arts engagement is found to promote the personal well-being of the participants, it may not be a form of art that appeals to all residents. There are many art forms available for exploration in a long-term care setting and it would be worthwhile to expand the study to look into other art form such as dance and movement, music,

writing and so forth to broaden the range of recreational activities in a nursing home and the cultural nuances involved.

### **9.5 Implications and Suggestions for Eldercare**

Arts and health is a developing field in Singapore. Thus, it is important to make an effort to promote the integration of participatory arts programmes in a variety of health and social care settings. Under the invitation of the Agency For Integrated Care, Singapore, a selection of artworks created by participants in this research was featured at its Community Care Forum in 2015. The forum brought together stakeholders from allied healthcare professionals, physicians, nurses, social care professionals, health administrators from Singapore and the Asia-Pacific region to explore ways to improve services and quality of care in the intermediate and long term care sector. The display of artwork provided examples to stakeholders of the abilities of ageing bodies and invited them to consider expanding their current range of programming to include the use of arts and arts-health practitioners. In addition, preliminary findings of this study and the developing practice framework were also presented at the Arts for Eldercare Seminar 2016, Singapore organised by the Singapore National Arts Council, the 5<sup>th</sup> International Health Humanities Conference, Seville, Spain and Working with Person-centred processes: Art, Education and Cross-Sector Collaboration Conference, Bangkok to discuss about the capacity of participatory arts to foster well-being and also to call attention to the centrality of the arts-health practitioner in managing the arts-health assemblage.

While undertaking this research study, I am also aware of the hope and expectations my intervention might raise amongst the participants. It was heartening to learn from the nursing manager that the enthusiasm, capability and socialisation she observed from the residents through the PVA programme have inspired and convinced her to send several of her care staff to an art training programme which will enable the home to transit towards providing continuity to the PVA following the completion of my study.

In addition, the research also demonstrated the role arts-health practitioners play in developing a more inclusive and caring society by fostering flourishing opportunities through the arts for people regardless of their age and health status.

Thus, this research recommends further interaction between arts-health practitioners and the health and social care sector, to expand their current services and capability to care.

## **9.6 Final Remarks**

This thesis explored the effect a participatory visual arts programme on the personal well-being of residents in a Singapore nursing home through an innovative qualitative action-research case study method. In doing so, the 12-Week PVA Programme was found to promote the personal well-being of nursing home residents. Participation in the PVA programme is found to activate lethargic bodies, foster opportunities for discovery, and encouraged self-development and expression. As such, the assemblage of the PVA was itself infused through a very different kind of care offered by the arts-health practitioner compared with the assemblages of care entrenched in the 'care' home and in the practices of the staff. Given the capacity of the arts-health practitioner to invigorate the body and mind of the residents, the arts-health practitioner, as a caring artist, can be a useful resource for nursing home to ensure that residents to have access to an enriched and engaged life.

**APPENDIX**

## Appendix 1: Ethic Approval Letter For Research



Durham  
University

Department of Geography

Shaped by the past, creating the future

3<sup>rd</sup> October, 2014

To Whom It May Concern,

I am writing to confirm that our Departmental Research Ethics Committee has received and reviewed a copy of Mr Michael Tan's project proposal, entitled "Room to Flourish? : Exploring the Intersection of Care, Artist and Time in a Nursing Home". No ethical or data protection issues were identified, and as such the Chair has authorised this research to take place within our Department.

Mr Tan has been made aware that any changes to the methodology or reporting strategy of the project will require submission to the Committee for re-approval.

If any further information is required, please do not hesitate to contact us.

Yours Faithfully,

A handwritten signature in black ink, appearing to read 'P Harrison'.

Dr. Paul Harrison,  
Chair of Research Ethics Geography Sub-Committee

p.p. Ms. Freya Copley-Mills  
Secretary to the Committee

## Appendix 2: Research Ethics And Monitoring Form

### Research Ethics and Data Protection Monitoring Form Research Ethics Geography Sub-Committee (REGS)

Research activities, funded or otherwise, by all academic and related staff, postgraduate and undergraduate students are subject to the University requirements for ethics and data protection review. The Research Ethics Geography Sub-Committee (REGS) will review research proposals against the guidelines provided by the Economic and Social Research Council, the Natural Environment Research Council and the University's own guidelines interpreting the law on Data Protection and research with vulnerable persons.

It is a requirement that prior to the commencement of all research that this form be completed and submitted to the Research Ethics Geography Sub-Committee. The Sub-Committee will be responsible for issuing certification that the research meets acceptable ethical standards and will, if necessary, require changes to the research methodology or reporting strategy.

A copy of the research proposal detailing methods and reporting strategies is attached x

Name of applicant:	Michael Thaddeus Koon Boon <u>TAN</u>
If appropriate, name of Supervisor or Research Methods Tutor	Sarah Atkinson (Geography)
Title of research project:	Room To Flourish?: Exploring the Intersection of Care, Artist and Time in A Nursing Home

<b>A: FILTER QUESTIONS</b>			
1.	Will REGS be the primary route for ethical review ?	Yes	No
	IF NO please provide information on the committee and institution to be the primary route		
2.	Is this a proposal to the ESRC ?	Yes	No

3.	Does your research involve living human subjects ?	Yes	No
	IF NO proceed to Section D		
4.	Does your research involve only the analysis of large secondary and already anonymised datasets?	Yes	No
	IF YES proceed to Section C		

**FOR REGS USE ONLY**

Full ethical review now	
Full ethical review if funded	
Light touch review	

**B: RESEARCH ON LIVING SUBJECTS**

1a.	Will you give your informants a written summary of your research and its uses?	Yes	No
	IF NO please provide further details and go to 1b		
1b.	Will you give your informants a verbal summary of your research and its uses?	Yes	No
	If NO, please provide further details		
2.	Will you request signed consent from all informants ?	Yes	No
	IF YES, please append the consent form Is the consent form appended ?	Yes	No
	IF NO, please provide further details  Informants might not be literate and may feel anxious or comfortable in signing a form. However, I shall ensure that at all initial contact with informants, I will introduce myself as the researcher. Potential informant will be briefed on the purpose of the research and be informed that all data collected will be anonymous and treated with confidentiality. It will be made known to them that their participation is absolutely voluntary and they have a choice to not participate or withdraw their participation at any point of the research. Verbal consent will be seek before proceeding with any further formal interaction.		
3.	Does your research involve long-term engagement over the course of which participants might forget your role as researcher? (for example, participant observation, ethnography, participatory approaches)?	Yes	No
	If YES, please provide further details on ensuring continued informed consent  Prior to any activities that may result in collecting data from participants, I remind participants my role as the researcher, reiterate the purpose of the project and seek their verbal consent before proceeding with any further questioning.		
4.	Does your research involve covert research (ie your purposes are not disclosed) ?	Yes	No

	IF YES, please provide further details		
5a.	Will your research participants be from any groups that may be considered vulnerable (children under 18; people with learning disabilities; people with other forms of mental illness or mental incapacity; people in emergency situations; prisoners or young offenders; anyone who might have a particularly dependent relationship with the research team such as other staff or students; other)	Yes	No
	IF YES please specify here and continue to 5b  Informants of project may involve ambulant and non-ambulant elder persons who are residents of nursing home who may have varied physical and cognitive health status eg Dementia.		
5b.	Do you have Criminal Records Bureau clearance sourced through Durham University ?	Yes	No
6.	Will your information <i>automatically</i> be anonymised in your research?	Yes	No
	IF NO Will you explicitly give <i>all</i> your informants the right to remain anonymous?	Yes	No
7.	Will monitoring devices be used openly and only with the permission of informants?	Yes	No
8.	Will your informants be provided with a summary of your research findings?	Yes	No
9.	Have you considered the implications of your research intervention on your informants?	Yes	No
	Please provide further details in all cases  To my best ability, I understand that the research intervention will not compromise the personal safety or put persons in a disadvantaged position where their professional or personal life can be affected. Prior to carrying out any work, purpose of the work will be made known to all informants. Consent will be seek before commencing any session to ensure that consent is granted.		
10.	Please provide details of any other ethical considerations arising from your research  The research will engage older persons who may be vulnerable. Best effort will be taken to learn and familiarize myself with the protocol about interaction with residents from staff of nursing home, to consult with staff when uncertainty arises, to ensure that my approach is most appropriate to residents.		



3.	<p>What measures have you undertaken to support the University Policy on environmental sustainability (<a href="http://www.dur.ac.uk/greenspace/policies/strategic-plan/">http://www.dur.ac.uk/greenspace/policies/strategic-plan/</a>) Please provide details</p> <p>The research is largely observation and interview-based with staff and resident of nursing home. Although direct environmental impact is a remote concern to the objectives of this research, it will be mindful of the environmental impact that resources such as energy and materials used in the process of the work to minimize wastage.</p>
4.	<p>If there are any other ethical issues arising from your project related to environmental impact, please provide details</p> <p>NA</p>

<b>E: WORKING OVERSEAS</b>			
1.	Does the research involve research conducted overseas or an international collaborator?	Yes	No
IF NO proceed to Section F			
2.	Have you checked whether there are ethical review procedures with which you will need to comply in the country/countries involved in your research ?	Yes	No
3.	<p>IF YES, please either state that none exist or specify the procedures and the measures you have taken to comply with these.</p> <p>Non-exist. However, I will seek further advise from staff at the Agency for Integrated Care before starting my actual fieldwork.</p>		
4.	Have you checked whether there are legal requirements with which you will need to comply in the country/countries involved in your research? (eg employment of research assistants, exportation of samples etc.)	Yes	No
<p>IF YES, please either state that none exist or specify the legal requirements and the measures you have taken to comply with these.</p> <p>Non-exist for this particular occasion. All work will be done personally.</p>			

<b>F: CONFLICTS OF INTEREST</b>			
1.	Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above normal salary or the costs of undertaking the research?	Yes	No
IF YES, indicate how much and on what basis that has been decided.			
2.	Does the research involve external funding?	Yes	No
IF YES, what is the source of the funding?			

3.	Will the research funder or sponsor have the right to impose restrictions on publication and other forms of dissemination of the research findings?	Yes	No
	IF YES, please give details		
4.	Are there any other potential conflicts of interest involved in this research project?	Yes	No
	IF YES, please give details		

### ***Declaration***

1. The information provided on this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the University's ethical guidelines and the ethical principles underlying good practice provided in the guidelines appropriate to my field.
3. If the research is approved, I undertake to adhere to the study protocol, the terms of this application and any conditions set out by REGS.
4. I undertake to seek an ethical opinion from REGS before implementing substantial amendments to the protocol.
5. I undertake to submit progress reports if required.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
7. I understand that my research records/data may be subject to inspection for audit purposes if required in future.
8. I understand that the REGS may choose to audit this project at any point after approval.



Signed

Date 16/10/13

**Submissions without a copy of the research proposal will not be considered.**

## **Appendix 3: Participant Information Sheet**

### **CONSENT FORM FOR PARTICIPATION**

#### **UNDERSTANDING RESIDENTS' EXPERIENCE OF A PARTICIPATORY VISUAL ARTS PROGRAMME IN A SINGAPORE NURSING HOME**

**Principal Investigator: Michael Tan Koon Boon**, Visual Artist and PhD Student

Department of Geography, Durham University, UK

[m.t.tan@dur.ac.uk](mailto:m.t.tan@dur.ac.uk), +6597902455

#### **Faculty Supervisors:**

**Professor Sarah Atkinson**

Department of Geography

[s.j.atkinson@durham.ac.uk](mailto:s.j.atkinson@durham.ac.uk), +44 (0) 191 33 41871

**Professor Jane Macnaughton**

School of Medicine, Pharmacy and Health

[jane.macnaughton@durham.ac.uk](mailto:jane.macnaughton@durham.ac.uk)

+44 (0) 191 33 48164

#### **Description Of The Research And Your Participation**

My name is Michael Tan Koon Boon. I am a visual artist and PhD student at Durham University in the UK. As part of the research for my study, I would to understand your view on lifestyle arrangement in Singapore nursing home and the effect of a participatory visual arts programme on the residents.

I am hoping that the answers will help understand the benefits of art engagement as leisure activity for resident's, particularly how it might promote their wellbeing. In addition, the research also explores the significant contribution an artist offers to nursing home to complement caring practice.

Your participation will involve:

1. Participating in an interview with questions asking about your opinions about leisure time and activities in the nursing home, and the pilot artist led art programme that the residents have participated in.
2. A digital sound recorder will be used at all interviews.

**Risks And Discomforts**

There are no known risks associated with this research. All activities involved are conversational and physically non-exerting.

**Potential Benefits**

Findings from this research may be useful to make recommendation for future inclusion of professionally led participatory art as a form of leisure activity in nursing home, as a pathway to promote residents' wellbeing. To build understandings that will better inform artists of their role and attitude when working in care settings; to enhance practice.

**Protection Of Confidentiality**

Protecting your privacy is a priority. The research will do its very best to maintain the confidentiality of your identity and all information shared. All information is only accessible to the researcher. All data collected will be securely stored in a locked cabinet or in a password secured laptop. The result of the study will be anonymous and your identity will be not be revealed in any form of communication related to the research.

**Voluntary Participation**

Your participation in this research study is voluntary. You may choose not to participate and you may withdraw your consent to participate at any time. You will not be penalized in any way should you decide not to participate or to withdraw from this study.

**Questions And Further Information**

If you have any questions or concerns about this study or if any problems arise, please contact Mr Michael Tan at +6597902455.

**Concerns And Complaints**

If you have any concerns or complaints about the ethical conduct of the project please do not hesitate to contact my supervisors, Professor Sarah Atkinson ([s.j.atkinson@durham.ac.uk](mailto:s.j.atkinson@durham.ac.uk), +44 (0) 191 33 41871) or Professor Jane Macnaughton ([jane.macnaughton@durham.ac.uk](mailto:jane.macnaughton@durham.ac.uk), +44 (0) 191 33 48164).

**Consent**

**I have read this consent form and have been given the opportunity to ask questions. I give my consent to participate in this study.**

Participant's Name and signature

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Date:

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A copy of this consent form should be given to you.

## **Appendix 4: Typical Interview Schedule For Residents To Understand Their Daily Life**

Present resident with a copy of the *Colour of my life* Chart and a set of colour pencil

1. What is a typical day like for you in the nursing home?
2. What is your expectation of nursing homes?
3. How do you feel about your life in the nursing home?
4. What types of leisure activities are available to residents in the nursing home?
5. What is your view on the current recreational arrangement at the nursing home?
6. How frequently do you participate in those leisure activities?
7. What is your view on the importance to remain active in late life?
8. What might be some of the reasons that have prevented you from leading an active life in the nursing home?
9. What is the benefit of participating in leisure activity?
10. What other kinds of activities would you like nursing homes to offer the residents?

**Appendix 5: Typical Interview Schedule For Residents To**  
**Understand The Effect Of The Participatory Visual Arts**  
**Programme**

1. Can you share about your past experience with the arts prior to joining the 12-Week art programme?
2. How do you feel about your ability in the arts prior to joining in the 12-Week art programme?
3. How would you describe your experience of the 12-Week art programme?
4. What are some of the difficulties or challenges you faced while participating in the art programme?
5. How did you overcome or resolved them?
6. What might some of the memorable moments in the art programme for you?
7. How do you feel looking at your artwork?
8. How do you feel about your ability in the arts at the end of the programme?
9. What is your view of having a regular art programme in a nursing home?
10. What are your views about having artist in nursing home?
11. How does interacting with the artist make you feel?
12. How might the role of an artist differ from care staff?
13. What attitudes do you think is useful for an artist to have when working with residents in a nursing home?

## **Appendix 6: Typical Interview Schedule For Staff To Understand**

### **The Effect Of The Participatory Visual Arts Programme**

1. Prior to this 12 Week art programme, was there any artist-led art programme offered to residents at the nursing home on a regular basis? If so, what have been doing previously?
2. What might be the reasons for the nursing home to not have a regular art programme?
3. How do you feel looking at the collection of artwork created by the residents?
4. How might the residents' artwork affect your perception about them?
5. How might seeing their artwork affect your expectation what a nursing home can be?
6. Did any of the participant spoke or shared with you their experience of the weekly art programme?
7. Did you notice anything significant shift in the attitude of participating residents? (Mood, level of engagement and interaction)
8. Based on your observation of the participants' response to the 12-week art programme, what is your opinion of having an artist in nursing home?
9. What aspect of care can artist attend to?
10. What skills might be unique to the artist that you is beneficial to complement caring in nursing home?
11. Do you think it is important for residents to remain active?
12. What might be some of the challenges to enable resident to be active?
13. What skill and knowledge might be necessary and useful for artist to know while working in nursing home?

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