

Performing veteranhood through the creative arts:
An ethnographic study of recognition and sociality among
veterans living in a Canadian seniors' village

by

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A thesis submitted to the Faculty of Graduate and Postdoctoral Affairs in
partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in

Anthropology

Carleton University
Ottawa, Ontario

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Abstract

This research explores the performance of veteranhood through the creative arts. It investigates how music-making affects sociality and recognition of Canadian World War II and Korean War veterans living in long-term care. I draw upon phenomenology as the guiding theoretical framework to explore the embodied dimensions of sociality, recognition, and performance of veteran identity through the creative arts. This dissertation draws upon other theorists beyond phenomenology to analyze the myriad dimensions of institutional veteran care. I make the following arguments in this dissertation: First, I argue that the veteran-residents were provided with care for their physical well-being, as well as care for their social identities as veterans. I contend that the creative arts programs were a form of milieu therapy, where daily music-making and singing war songs together was a means to restore, rehearse, and perform veteranhood. Second, I argue that people entering long-term care went through a process of un-making and re-making as they were transformed into residents, and then into veteran-residents. I argue that this experience was negotiated by performances of self-authoring and expressions of resistance. Third, I argue that the biomedical and creative arts doxas of care provided for the veterans were ambivalently-related to one another and that each was constitutive of a different sense of selfhood. I explore how porters mediated the milieus and accompanied residents on these existential shifts. Fourth, I argue that the group music programs, such as the resident bands, provided a stage for veteran-residents' new forms of sociality and recognition in a milieu framed as "play" with musical materials from which to construct their identities. Finally, I argue that an ethopolitics and a politics of recognition informed social conditions around performances of veteranhood.

Acknowledgements

This doctoral dissertation was the result of sustained engagement and continuous reflection. This research took place within a constellation of social relationships. It would not have been possible without many generous and encouraging people to whom I extend my sincerest gratitude.

I thank the administrators and staff at my field site who supported my research over the years with unending confidence and enthusiasm. This research would not have been possible without the hospitality of the recreation staff, artists, musicians, and music therapists who welcomed me into their space and facilitated my work at every turn. I am humbled by their compassion, empathy, and respect for the people with whom they work, and the way they used their incredible talents for the betterment of people's lives. I am eternally grateful to the residents who opened their lives with me. Thank you for the music.

I am indebted to my supervisor, Dr. Bernhard Leistle, for guiding my intellectual development over many years and for creating an academic environment that was rigorous in focus while allowing space for my intellectual pursuits. Thank you for letting me go out on the limbs and for drawing me back to centre each time.

I am also grateful to my Thesis Committee Members, Dr. Danielle DiNovelli-Lang and Dr. Amina Mire. Your discerning intellect, mentorship, and unwavering confidence sustained me throughout this journey.

I must thank the staff at the Department of Sociology and Anthropology. In particular, I am grateful to Paula Whissell for her patience, good humour, and unending support. Her gentle reminders and quick responses smoothed out all the bumps in the road. I am grateful to my academic colleagues with whom I shared the doctoral experience, especially Dr. Sheila Rao and

Dr. Fatemeh Mohammadi for fostering a positive and cooperative atmosphere in which each of us flourished.

With eternal gratitude, I thank my mother for all that she has given me. Her brilliance has inspired me to climb to new academic heights and our dialogues at the dining room table, on road trips, and while gardening helped me sort out my thoughts while ascending the intellectual mountains. Thank you for the years of Suzuki music lessons, summer music institutes, and support in all my musical endeavours. These are at the core of my being.

To my husband, Christian, thank you for your tireless support in all ways. Your delight in my achievements were motivation to forge ahead. Thank you for always getting tickets and for building us a beautiful home. To our son, Isaac, thank you for your excellent timing, for waiting until all drafts and applications were submitted before entering the world, and for being brighter than the sun itself when you arrived.

Finally, I acknowledge the Social Sciences and Humanities Research Council for providing the funding for this research.

Table of Contents

Abstract	ii
Acknowledgments	iii
Table of Contents	v
Chapter 1: Introduction	1
The Social Contract	1
The Field site	4
The Connection between Veterans and the Arts	5
Constructing a Meaningful Life through the Arts	10
Caring Tensions	12
Positionality and Methodology	21
Chapter Outline	25
Chapter 2: Literature Review and Theoretical Framework	28
Institutional Ethnographies on Ageing	28
Canadian Veterans in Long-Term Care	32
Anthropological Engagements with Ageing	34
Critiques of Biomedicine	35
The Biomedicalization of Dementia	38
Sociality through a Phenomenological Lens	40
Intersubjectivity and the We-Relation	40
Music-making as Embodied Selfhood and Sociality	41
Creative Arts as Therapy	47
Contribution to the Field	49
Chapter 3: Restoring a Generation of Veterans	50
Treating the Biological Body	51
A Cup of Coffee and a Song	53

Treating the “Living Death”	55
Re-membering Veteran Identity	57
Re-experiencing shared pasts through song	63
The Creative Arts as Milieu Therapy	67
Conclusion	69
Chapter 4: Becoming a Resident	71
Being Acted Upon	72
The Medicalization of Life and Fragmentation of Self	72
Becoming a “Resident”	75
Day Schedules and Docile Bodies	80
Crisis and Protracted Liminality	84
Back to the Barracks: Living together as Veteran-Residents	90
Reclaiming Agency	96
Performative Struggles for Recognition through Idioms of Resistance	96
“This is my house”	98
“I’m not invited in my own home”	100
Re-possessing Selfhood	101
Conclusion	107
Chapter 5: Ambivalence and Parallel Doxas of Care	109
The Social Field of Care Staff	109
Portering between Doxas of Care	112
Invitations to Play as an Invitation to Expand the Self	117
Shifting Between Modes of Being: I’m not in the Jazz Band	124
Returning Them to What?	128
“Doing the Stats”	132
Conclusion	135
Chapter 6: Constructing New Personhoods through Group Music-Making	137
Evoking New Identities in a Musical Milieu	137

Peer Recognition	148
The Jazz Café	150
Conclusion	157
Chapter 7: The Politics of Recognition	159
“Dispensia” Reprise	159
The Ethopolitics of Veteran Care	160
A Veteran-Centred Milieu	162
Self-Presentation and Singing “In,” not “Out” of the Choir	165
Recognizing Veterans on Remembrance Day	167
The Politics of Recognition	175
A Selected Few Singing for a Generation	178
Conclusion	181
Chapter 8: Conclusion	184
Future Research Directions	189
References	192

Chapter 1

Introduction

The Social Contract

The residential care facility was built in the 1990s, largely through the support of Veterans Affairs Canada (VAC) and the Canadian Government to provide care to ageing overseas service veterans.¹ The facility was designed to be a seniors' village, with two independent living apartment buildings, a short-term stay house, and a sprawling two-story long-term care facility of three linked buildings, each with four units. From 2015 to 2017, the long-term care facility was home to veteran-residents, as well as non-veteran residents. The focus of the facility was the veteran population: caring for the veterans was the foundation of the facility's reputation. The supportive care for veterans was in fulfilment of the social contract between the Canadian government and the veterans from World War I (WWI), World War II (WWII), and the Korean War. At the time of this ethnography, there were no surviving WWI veterans. My informants were WWII and Korean War veterans whose health conditions were sufficiently advanced to require long-term care, including specialized dementia care. This care was subsidized by the Government of Canada as repayment for their service.

Feminist philosopher Carol Pateman (1988) explained that social contracts order society by placing the civil law of the state, or the government, in a position of power over individuals, whilst individuals willingly subordinate themselves to this power. According to Canadian historian Lara Campbell (2000), during the Depression years that followed the cessation of WWI, returned Canadian ex-servicemen, wounded from their time on the front lines and suffering unemployment and poverty at home, sought financial aid and greater recognition that

¹ Actual name of the field site changed for the dissertation.

they felt they were owed by the government for their wartime sacrifices. In response to veterans' pleas, the government created a social welfare policy to address veterans' economic and social security. This policy was rooted in the language of "contract, service, duty, and individual responsibility" and entwined with concepts of entitlement and citizenship (Campbell, 2000, p. 125). Pateman noted that the subject of all contracts is "the property that individuals are held to own in their persons" (1988, p. 4). In this dissertation, I suggest that the veterans' lived experiences and wartime accounts constituted personal property that was part of the reciprocal social contract with the government. Indeed, the veterans' bodies had symbolic value, particularly when they performed their veteran status and received recognition as such.

The social contract between the Canadian government and Canadian veterans included financial and moral responsibility to provide care. Feminist scholars have noted that when it comes to care, the social contract theory does not fully capture the ethical complexities associated with affective relations of dependence (Baier, 1994; Held, 1993). In this case, the veterans were made dependents of the government by agreeing to the contract. In recent years, debate has arisen about the ambiguous use of the terms "social contract" and "social covenant" (VAC, 2004), and legal battles regarding the binding terms of the government's promise have ensued (Everson, 2014; Thomson, 2014). Despite this, a national ethos of veteran care came to be inscribed in official documents. This ethos stated that returning veterans should be recognized and rewarded for their service and their benefits must "exceed the benefits afforded to non-veteran seniors" (Ives, 1998, p. 92).

In 2004, VAC remarked on the unique character of service in the armed forces. "There really is no equivalent profession to that of service in the Forces. Whatever programs we put in

place, or adjustments we make, they must clearly reflect this reality" (VAC, 2004, p. 59). In a longer statement, the VAC explained this ethos of providing care:

To put on the uniform of one's country – and this is as true today as it was in 1914 – is to make an extraordinary commitment: to put oneself at risk, as required, in the interests of the nation. It is this commitment that explains and justifies veterans' benefits and the branch of government that administers them. Wisely, Canada has understood that extraordinary sacrifice and service require extraordinary recognition.... Between those in uniform and the country they service there is an implicit social covenant that must be honoured. (2004, p. 1)

The commitment to continued long-term care of the overseas service veterans was derived from the 1945 Veterans Charter. The charter integrated all of the previous statutes and regulations under one federal effort to provide an unprecedented program of rehabilitative care for its returned soldiers (VAC, 2004). Beginning in 1915, the Government of Canada built veteran hospitals to care for returning WWI veterans because there was no universal health care available in the country. The use of veteran hospitals continued for returning WWII veterans. In 1948, provinces were funded through National Health Grants to build veteran hospitals, transferring responsibility from the federal government to the provincial ministries. An essential part of the transfer agreement was that a fixed number of immediately available beds in each facility be reserved for veterans and that the care meet the VAC standards. The Veterans Charter was extended to Korean War veterans under the *Veterans Benefits Act, 1954* (VAC, 2004). The eligibility criteria for VAC support for benefits and long-term care were stringent and based on many factors including service dates. Veterans were eligible if they served in a theatre of actual

war on or before March 31st, 1946, if they served in the Merchant Navy of WWI or WWII, or if they served in the Korean War as a member of the special forces (VAC, 2013).

A critical turning point was the institution of public hospital insurance in 1957 and Medicare in the 1960s, which gave all Canadians access to hospital care. This was a privilege that had been previously reserved for veterans. This also meant that the responsibility of regular veteran hospital services was covered by the province. At the same time, VAC realized that it would need to install long-term care services for ageing WWI veterans, and the future senior veteran population (VAC, 2004). By 2003, VAC had 171 contracts with provincial and private institutions across Canada (VAC, 2004). The facility where I did my research was responsible for carrying out one of these contracts.

The Field Site

The physical structure of the facility was impressive, perhaps designed to match the symbolic grandeur of the veteran population. Upon entering the grounds from the main road, the presence of veterans was made known by the prominent memorial monument. The centre block was inscribed with the words, “Lest We Forget,” a single red poppy, and silhouetted soldiers marching across uneven land. The monument was framed by two flagpoles flying the provincial flag and the Canadian flag. The flags were lowered to half-mast for 24 hours following the death of a veteran-resident.

The interior of the building was a tribute to the veterans. The walls were decorated with images of poppies, artwork of war scenes, war memorabilia and tapestries representing the Canadian forces. Central spaces, such as the cafeteria, the pub, the links between buildings, and the great hall, were shared by veteran- and non-veteran residents, yet were decorated with war service imagery and memorabilia. Banners representing the army, navy, and air force hung in the

links between buildings and in central spaces. From the lofty second story ceiling of the cafeteria, hung two large model aircrafts: one a spitfire and the other a Lancaster bomber. Smaller scale model war planes assembled and painted by veterans were familiar sights, as were other works of art made by veterans in the art studio. The pub adjacent to the cafeteria was panelled in dark wood, with books, pictures, and objects related to war service. The significance of the veteran population to the facility was unmistakable. The military spirit was even reflected in the almost daily painting and re-painting of walls throughout the building to keep it looking impeccable.

In the first formal introduction to the building for new staff and volunteers, the social responsibility for providing care for the veterans was made known. “We have two populations living here: the veterans and the community members,” said the orientation leader. “Our core values are resident-focused care, quality care, and we have a unique responsibility: we have the veterans.” Standards of conduct, decorum, and adherence to policies were expected to be at the highest level of professional and ethical practice at all times. The orientation leader continued, “Anyone who comes into our facility is expected to know the mission, vision, and our code of conduct. The mission is to our staff and volunteers to work with our partners and families to provide excellent long-term care to our population. We are committed to providing a safe, comfortable, and friendly environment for our residents. So, remind yourself: We work where residents live, they don’t live where we work.” The presence of the veteran-residents resulted in a high ethical standard of care that was adopted and emulated by staff and volunteers.

The Connection between Veterans and the Arts

An essential component of the facility’s veteran care program was the unique arts programming. Creative arts and recreation programs were offered multiple times a day, some of

which ran concurrently with other programs, allowing veteran-residents to choose their preferred activity. Veteran-residents were offered myriad recreation programs, such as card games, pub nights, legion bingo nights, one-to-one visits, reminiscence programs, afternoon social teas, movie nights and much more on the units and in the central areas. Recreation programs for veterans included outings to the Legion, special dinners and events for veterans, museums, sightseeing excursions, and hockey nights to honor veterans. Veterans who were able well enough to leave the facility were escorted to these events on their own bus. The bus looked like a converted school bus, painted in the facility's colours, and it was able to accommodate many residents in wheelchairs. Its ongoing maintenance was taken care of by the local legions. There were also outside bands that regularly came to play big concerts for the veterans and other residents. The facility was a destination for entertainment groups, particularly military bands and musical groups associated with the armed forces.

The most sought-after programs were those hosted by the creative arts department. At the centre of the building was the creative arts studio, known as the "Crown Jewel" of the facility. The arts studio was proudly presented to tours of legion members, government officials, and Veterans Affairs personnel. Staff brought new residents to the arts studio within the first few days of their arrival. The original architectural plan included the arts studio with two large working rooms, a central office with computers for staff, a large back storage room, and a fully operational woodshop. Floor to ceiling windows lined the back walls of the studio rooms, overlooking large trees and paved walking paths below.

The arts studio concept was a carryover from the old veterans' hospital, but it was also an expansion on the curative strategy for returned Canadian WWI soldiers. When the soldiers returned home and were unable to resume regular work, there was concern about how the

country would provide pension income to all who needed it. An engineer from Toronto, Walter Segsworth, spearheaded the idea that the soldiers recovering in hospital could be taught to be busy. “Young women hired as ‘ward aides’ at \$60 to \$75 a month would coax and prod the men into working on crafts. Once ambulatory, they would move into ‘curative workshops’ to practice woodworking, motor mechanics, or shoemaking and to revive factory disciplines and old skills” (Morton, 1998, p. 19).

The Military Hospitals Commission created ‘ward occupations’ that gave men something to do during the day, either through what were deemed handicrafts at the time, or in the “curative workshops” that were held in hospital basements and sheds. Once men were fit to be discharged from the hospital, they began serious retraining on their new job sites (Morton, 1998, p. 20). “By restoring a soldier’s will and ability to work,” wrote Morton, “real wages would soon outpace any pension income” (1998, p. 19). The government priority was to return veterans to work through postwar treatment and in so doing facilitate “civil re-establishment” (Ives, 1998, p. 86). The “returned soldier” was one who went back to work, supported his family, and resumed the responsibilities and pleasures of civil life by becoming wholly self-sufficient. Postwar Canada was poor, and the earning power of these bodies was needed to rebuild the economy.

The rehabilitative relationship between veterans and the arts continued from the first curative workshops after WWI. As stated above, the arts studio was introduced to visitors as the “Crown Jewel” and “the heart” of the facility. Although creative arts programs took place on the residents’ units, the studio was the public showpiece. Instead of “war aides” there were professional artists, musicians, and music therapists, as well as volunteers who supported the veterans’ participation in the creative arts programs. Professional artists provided resident-focused art classes, including painting, glass mosaics, pottery, and woodworking. A convoy of

rolling carts allowed artists, music therapists, and musicians to bring their programs to residents on the units. The priority was to engage veterans in activities as soon as they arrived at the facility with the expressed intention of improving overall well-being, increasing social connectedness, and reducing experiences of isolation, depression, and anxiety. This was similar to the idea of civil re-establishment noted above, but instead of helping returned soldiers returning to family life and careers, the ageing veterans were integrated into the day-to-day life of the long-term care community. Care went beyond the individual to the well-being of the collective, suggesting a program of social rehabilitation.

There was an interesting economy associated with the arts studio. The art that residents produced was made available for sale to visitors at a nominal cost. Half of the sale price went to the resident and the other half was returned to the art department to cover the cost of materials. Art objects for sale included pottery (*e.g.*, plates, mugs, vases, and figurines), woodworking projects (*e.g.*, birdhouses, airplanes, and children's toys), silk scarves, glass mosaics, and paintings. The resident artist's last name was etched on the back, adding to its authenticity. Although a person's veteran status was not indicated on the art, visitors seemed to assume it was all veteran-made. The art provided material objects that visitors purchased and took home with them or gave as gifts. Observing visitors handle and talk about the art, it seemed as though the object took on a special aura (or value-added quality) because it was made by a generation of veterans that was quickly disappearing. The creative expression of veteran-residents held symbolic capital for those who recognized it.

Music was another important medium of creative expression for veteran-residents and galvanized the community feeling among them. The creative art department included both music therapists and professional musicians who provided music programs on the units and in central

areas for residents. The music programs did not have a single designated space as the artists had with the art studio. Musicians and music therapists worked with residents in their private rooms, in common areas on the units, in the games room, the pub, and the multi-purpose great hall, outdoors in one of the courtyards when the weather was warm. Most of the time, musicians and music therapists were working in the territory of the nursing staff, visiting units with carts and instruments and borrowing space for a few hours amidst the routinized flow of care work. They were almost always visitors in someone else's space. Sometimes the upright piano in a unit's recreation room or a musician's portable keyboard provided a way to visually demarcate musical space, but there was still a feeling of overlapping care agendas. Acoustically, excellent quality microphones and speakers were used to amplify voices and instruments. The sound technology helped vocalists embody the role of lead singer and made sure residents knew their sound mattered. Particularly in group programs, musicians and music therapists expertly adjusted microphones and speaker levels, facilitating recognition within the group. Group music programs commanded audiences of visiting family members, sitters accompanying residents, nursing staff who paused to listen on their way to somewhere else, and even residents from other units who came to listen. The music was usually from the 1920s, 30s, and 40s, most from the wartime era because it was familiar to the veterans. Visitors and staff remarked that they liked hearing the veterans sing music and enjoyed seeing them engaged in music-making.

In the context of long-term care, this was a uniquely high concentration of skilled professional artists, musicians, and music therapists in one place. It was believed by staff that the arts literally breathed life back into residents. The reality of the long-term care setting was that this space was the veterans' final stop. This was their last home. Their last breaths, last relationships, and last moments of self-expression happened in this long-term care space. Early

on in my fieldwork, an administrator explained to me that residents initially came to long-term care to die, but this changed when they made new social connections: “They are moved into their rooms by family. They sit in overstuffed recliners with the blinds drawn and the lights off, feeling disengaged and unhappy. They wait to die. Then, something happens. They make a connection with someone.” Based on my experience, it was engagement with the arts that changed the course for people. So, while death did not take its leave, it took its place. Through the arts, residents living with and without dementia were vitally engaged, often defying the biomedical narrative of the deterioration of ageing bodies. The following ethnographic story illustrates how the arts were central to the everyday lives and identity of veteran-residents.

Constructing a Meaningful Life through the Arts

One afternoon, I met with a Korean War veteran named Fred Thompson². Mr. Thompson was partially paralyzed and lived with congestive heart failure and the early stages of dementia. He was unable to live at home because of his advanced health problems and his need for assistance with activities of daily living (e.g., bathing, preparing meals, etc.). He was a large man with broad shoulders, a bald head, and tattoos covering his forearms from his days as a cadet. He had a joyful disposition and a booming laugh. Everyone felt better after chatting with Mr. Thompson, and it seemed Mr. Thompson always felt better after chatting with others. His care at also included the social dimensions of life; he needed to be engaged, to participate in a community, and to have meaningful work to do. As a man without relatives or children, Mr. Thompson relied on the arts staff for social support. He was a regular participant in the arts studio and in music programs, especially the choir. He enjoyed sharing war stories as he added coats of paint to his woodworking projects and explaining the meaning an old war song held for

² Pseudonyms have been used in place of informants’ real names.

him during a music program. Engagement in the arts meant more to him than a simple pastime; it was integral to his sense of self and social existence. On a few occasions he expressed that the arts staff were like his family and they made the place feel like “home” to him.

During this visit, Mr. Thompson and I played music and practiced one the hymns that he was going to sing as a solo with the veteran choir at the end of the month. As we finished our music, I started to conclude the visit, but Mr. Thompson interrupted my exit and asked if I had time to stay so he could show me a bit about himself and his history. He invited me to sit down as he pulled out the photo album his late wife had assembled for him that contained his life’s story. “I’ll tell you who I was.” he said, opening the album and directing my attention to the first black and white photograph.

“That’s me as a sea cadet,” he said pointing to the photograph. “That was where I joined the service core with the wedgie hat and the world war uniforms we had then.” Mr. Thompson joined the service when he was 19, volunteering to go to Korea. He was assigned to the Special Forces who were trained to go to war. He learned the skills necessary to go into combat, fly airplanes, fire weapons, and received parachute training and, as he said, “do many things that I can’t tell you about now.” He could tell me about his album, though.

He continued, offering a short description of each photograph: “That’s my grandmother who lived to be 98. She was the best grandmother I ever had. I lost my parents at a young age.... There I am in uniform again.... There’s me with the hockey team....” The album also contained pictures of him during his time in Korea. “We lived in forty-man tents. We didn’t have to wear helmets all the time either. We would have lost our hair even sooner!”

“You got a little way to go there,” Mr. Thompson said, directing me to the next page. “There, want to read *Just a Common Soldier?*” It was a poem written in 1987 by A. Lawrence

Vaincourt, entitled *Just a Common Solider (A Soldier Died Today)* (Vaincourt, 2004). Aloud, I read the whole poem. “That’s my favourite verse: ‘Just a common soldier,’” said Mr. Thompson. We read the verse again in its entirety: “He was just a common soldier and his ranks are growing thin; But his presence should remind us we may need his like again. For when countries are in conflict, then we find the soldier’s part; Is to clean up all the troubles that the politicians start.” Afterwards, he continued his explanation, “I like it because it could be just an air mechanic who looks after loads of bombs or something like that or it could be anyone who has never been raised up in rank because of what he does. But our motto is, if our country is threatened we’re proud to serve.” Mr. Thompson used to pack parachutes during his time in service and had a special connection to airplanes.

In his room, models of Spitfires and C130s he had made in the art studio hung from the ceiling. “You will never know how much I enjoy doing art here,” he said looking at the planes above his bed. His daily presence in the art studio and in music programs demonstrated the meaning and value of the arts in his life.

Caring Tensions

Mr. Thompson’s experience of constructing a meaningful life through the creative arts program was shared by many veteran-residents. Over the years, stories were told and re-told about exemplar veteran-residents whose lives had been completely transformed by the arts program. Photographs, obituaries, and signature pieces of artwork made by these legendary residents were kept in the arts studio as testaments to the power of the care. Mr. Thompson’s photograph was among this collection.

The benefits of the arts programming were felt throughout the facility. There were residents at the facility who did not have veteran status. These people were called “community”

residents. The arts programming was so well known in the city that these “community” residents waited for years on waitlists to get a bed. Although programming on the non-veteran units was more limited and resources in the arts studio were preferentially allocated to veteran-residents, people still wanted to live in this environment. Occasionally, tensions arose around participation in programs when veterans were served first. Residents who were new to the facility sometimes bristled at the informal rules for participation. For example, in veteran-resident art classes or small group programs, materials were first made available to veteran-residents before being made available to community, convalescent, and respite residents. Despite frictions, people were still generally grateful for the arts programming. The sister of a community resident explained, “The other homes are small and there is no stimulation, not like here, anyway. Here, the residents come alive. There is so much going on all the time and the staff is so talented. There is just more energy here and it makes people want to live!”

The social contract between the Canadian government and the veterans promised to provide exceptional care. In the context of this facility, exceptional care meant both medical care and creative arts care. Toward the end of my fieldwork, the recreation and creative arts department was officially retitled to include the word “therapeutic.” This title change qualified the creative arts as a modality of care that was neither entirely recreational, nor biomedical. It was an interesting change because, as previously stated, the staff included artists and musicians in health care who were not formally trained in clinical therapy.

In this dissertation, music is understood as a beneficial force at the veteran-centred facility that follows a tradition of music for morale boosting and self and collective expression in song among Canadian soldiers of WWI and WWII. Before exploring this tradition, it is important to acknowledge that the relationship between wartime music and its role in soldiers’

lives has not been universally positive. Musicologists have documented the use of music during war to incite hostility, intimidate, humiliate, and torture soldiers (Bergh & Sloboda, 2010; Cusick, 2006; Pettan, 1998; Reinert, 1997). Music has also been used to galvanize community and motivate soldiers into combat: from the historic use of the Scottish bagpipes and American drum and fife that accompanied soldiers into battle, to WWII German military shortwave radio playing “Ride of the Valkyries” to motivate soldiers in the field, and to present day with the use of hard rock and metal music on portable listening devices among modern soldiers in combat zones (Botstein, 1995; McNeill, 1995; Pieslak, 2009).

During World War II, music was used among Canadian soldiers to boost morale rather than to explicitly excite the men into battle (Pieslak, 2009). Popular songs in the 1930s came from American artists and were marked by the influence of jazz, with lyrics that continued to address separation caused by war, stories of happy resolutions, reinscribing American cultural values rather than being overtly patriotic (Mohrmann & Scott, 1976; Pieslak, 2009). “The attachment to loved ones, the goodness and purity of servicemen, the righteousness of the cause...such themes were regular in the music, and they were most successful when treated with humor or when couched in forms that made them singable, danceable, or both” (Mohrmann & Scott, 1976, p. 155). The use of music as entertainment and morale improvement was so pervasive, that Mohrmann and Scott (1976) argued that “America swung rather than marched into World War II” (p. 145). In Canada, by 1942, the federal government realized that morale was at an all-time low and acknowledged that this was negatively impacting soldiers’ experiences of battle exhaustion, discipline within their units, and combat performance. To boost morale, an armed forces-wide entertainment program was established, where the Army, Navy, and Air Force each had their own set of performers (Halladay, 2002). These groups were made

up of “male and female military personnel who could sing, dance, act, juggle, play musical instruments or otherwise amuse” and their performances were intended to improve morale among troops at home and overseas, encourage recruitment, and promote the war effort (Halladay, 2002, p. 21).

Group singing was imbedded in the military cultures of both American and Canadian world war soldiers (Pieslak, 2009; Cook, 2009). In WWI, Cook (2009) noted, “Canadians sang regularly, from Toronto middle-class houses to Quebec lumber towns, from maritime folk songs to the latest Vaudeville tune hummed through downtown Winnipeg, and also in church, school, and social gatherings” (p. 225). Informal choirs and groups of soldiers, accompanied by harmonicas, violins, and pianos, sang hymns and popular songs from musical cultures in North America and England. Cook (2009) wrote, “Singing was a group activity that brought men together, forged bonds of comradeship, reinforced belonging in the group, and helped the soldiers endure the strain of unending combat and service” (p. 224). Canadian soldiers were known for writing parodies of well-known popular songs (and parodies of parodies) to reflect their experiences of war and circulating them only among their military groups (Cleveland, 1994; Cook, 2009). Parody was a way for soldiers to take ownership of the song, authoring lyrics to express discontent with the war, and share in-jokes and vulgarities that were beyond the bounds of civilian society, marking it as a unique part of the soldiers’ culture (Cook, 2009). Scholars have suggested that in the isolated life of soldiers at the front lines, singing created a shared consciousness among soldiers (Halladay, 2002; Ashworth, 1980).

The use of music at the facility described in this dissertation followed the tradition of using music to boost morale, provide soldiers with a means of personal and collective expression, and galvanize communities, as well as provide healing to recovering soldiers of in

military hospitals of both world wars (Rorke, 1996; Pieslak, 2009). Musicians and music therapists used music in individual and group programs with the intention to alleviate physical and emotional distress, facilitate remembering, and connect people with personal and collective identities. Music was also used as entertainment that would boost morale among veteran-residents.

The presence of the arts was financially connected to the presence of the veterans. As the veteran population declined, there it seemed to become more important to promote the creative arts component of care. As the years passed, people who lived at the facility expressed their own concern about the declining population. A female tenant from the senior village apartments articulated her feelings about the risk of losing the veterans. “I don’t want to imagine this place without the veterans,” she began, as we sat together at the woodshop table in the art studio. She was painting another coat of copper onto a wooden toy beaver she was making for her nephew while I was helping a veteran-resident add navy blue camouflage markings to his wooden plane that was modeled after a Spitfire used in the war. She continued, “This arts studio is the heart of the place. It is dead in the apartments. Nobody does anything. In the studio, everyone is busy and happy. There is life here. What will happen to it when all the veterans are gone?” How ironic, I thought, that the independent living apartments were perceived as more lifeless than the long-term care building where health conditions were more advanced and people were purportedly much closer to death.

There was anxiety around the coming “post-veteran era.” As time went on, the threat of extinction of the veteran population became more real. What was a projected eventuality when I began fieldwork in 2015 turned into a tangible reality by the time I completed my fieldwork in 2017. Formal town hall meetings, annual general meetings, and other assemblies held by the

administration discussed the future financial implications as the government-defined veteran population dwindled. The impending population shift was called “the veteran transition.” Veterans arrived older and frailer than they used to, in part because seniors stayed at home as long as possible before entering advanced care. Further, the veteran population was collectively much older. In 2015, the youngest WWII veteran-resident at the facility was 88 years old. Across Canada, between 2012 and 2017, the number of veterans in VAC-supported long-term care facilities was projected to decrease from 5,408 veterans to 3,591 (VAC, 2013).

The facility’s painter was acutely aware of the high mortality rate driving the veteran transition. In addition to repainting the main walls of the facility on a rotation schedule that had him painting a wall somewhere every day, he was also in charge of repairing and repainting every room after a resident passed away. In March 2017, one quarter of the rooms were vacant on one of the two veteran dementia units. Leaning against his paint cart one morning, we exchanged thoughts about the number of rooms that stood empty. “When I came back from vacation,” he explained, “there were nine names on the board for veteran rooms to be painted. The next week there were another eleven, then another nine. There have been thirty-one deaths in three months.” When my fieldwork concluded, there were whispered conversations in the hallways about the unprecedented number of veteran beds that were empty on veteran units and how there were not names on the waitlist to fill them.

For the veterans who remained, issues of recognition as veterans seemed to become increasingly important within the facility. Recognition for veterans’ service was inscribed into the national pathos for veterans. Ives (1998) remarked on the historical and present-day importance of recognition among Canadian veterans:

It is important for veterans to continue to believe in the justice of the cause for which they risked their lives, a cause in which sacrifice created a better world.... They want to believe that their sacrifice has endowed a lasting moral legacy. As they move towards the end of their lives, this recognition becomes more and more crucial. Entitlement is recognition, and recognition is key (p. 94).

The significance of being recognized as a veteran was embedded in the national and institutional discourse of veteran care. This, however, begs the question about the veterans' agreement to the terms of this sort of recognition and their possible desire to be recognized as something or someone other than a veteran at times. One might wonder if the veteran-residents were not still reciprocating or fulfilling their end of the social contract.

The institutional ethos of veteran care was ever-present in the facility; however, the focus of the veteran-residents' social roles shifted depending on the social context. For formal events and occasions where media and officials were present, veteran-residents wore their uniforms and were addressed with expressions of gratitude and reverence. In day-to-day life, veteran-residents dressed in plain clothes, sometimes donning a Legion vest, a Korean War beret, or a poppy on their lapel. Programming also varied in the focus on veteran identity, sometimes facilitating conversations and reminiscences about life in the service, while at other times focusing on entertainment in the moment without explicit emphasis on veteran identity. Depending on the social context, a veteran-resident's family role, job identity, or medical subjecthood was more relevant than veteran identity itself. At the institutional level, however, veteran status was always the dominant identity. The dissertation will explore how the institutional emphasis on veteranhood influenced creative arts programs and shaped veteran-residents' experiences of selfhood and social relationship.

A similar ambivalence was apparent toward dementia diagnoses among veteran-residents.

In the biomedical context, a veteran-resident's diagnosis of dementia was used to devise care plans, explain behaviour, make decisions about participation in programs, and so on. In the creative arts context, music therapists and clinically-oriented musicians and artists used the diagnosis as a starting point from which to provide care, while other musicians and artists relied less on the diagnosis and more on their interaction with the person. At an institutional level, dementia diagnoses were determining factors for deciding on which unit a veteran would be placed and for providing opportunities for veteran-residents to perform their identity. In this dissertation, the ambivalent treatment of veteran identity and dementia diagnosis will be explored in the context of the creative arts programs.

My fieldwork took place at a historically significant time when the cohort of WWII and Korean War veterans was rapidly declining, and along with it the stability of the institution as a designated place for veteran care. This impending loss of a generation of veterans had sociopolitical implications for the country, but also for the long-term care facility. The veterans who remained drew increased attention from the government, stakeholders, and the media, who wanted to capture these “living legends.” In 2018, a televised panel of experts discussed the consequences of losing WWI veterans (Lowman, 2018). To lose a veteran, they concurred, was to lose a piece of living history. We lose a sense of history that is only achievable in the presence of someone who saw the events first-hand. They explained that we lose the ability to honor their experiences in their lifetime, which is important given the country’s long history of loving soldiers when they go to war, but forgetting them when they come home. We also lose an appreciation of their effort and a sense of what all that effort was for. The panel emphasized the

importance of the connection to a living witness who could share their memories and stories.

One of the experts stated, “When they go, the stories go with them. Lest we forget.”

On the precipice of the extinction of another generation of veterans at the long-term care facility, there was renewed commitment to the correction of the past wrongs that echoed through the social contract, and to the capture and preservation of the images, narratives, performances, and materials produced by these veterans. Indeed, the production of veteranhood had perhaps never been more important, but it had perhaps never been more challenging. These veterans were older and in illness conditions that required long-term care, including living with advancing dementia. They did not all have the capacity to share the treasured stories and first-hand accounts of war, and many were in poor enough health that performances for government officials or the media would have been an assault on their dignity. When such performances were required, a selection process was necessary, as not all of the veterans could perform the normative role of “living legends.” Indeed, advancing dementia and illness meant that the stories were lost before the person himself.

This dissertation explores the role of the creative arts as a modality of veteran-focused care and its role in producing individual and collective veteranhood in long-term care. Veteran care was both biomedical and humanistic, where the biomedical care focused on biological life, and the creative arts focused on their memories, social relationships, and social identities. With the veteran population dwindling, not only was it important to take biological care of the veterans, but it was also important to take care of their memories, identities, and embodied historical record. The veterans’ artwork, music-making, recounted stories, and presence (particularly in uniform) provided opportunities for recognizing residents as veterans. The ethnographic approach used in this dissertation allows the reader to witness everyday practices of

care and the politics of recognition that shaped veterans' experience of ageing together in long-term care.

Positionality and Methodology

As an ethnographer, my perspective was informed through the vantage point of the creative arts. The research was approved by the university's institutional review board (IRB #102012), as well as by the field site administrators. Fieldwork took place between February 2015 and August 2017. Informed consent was obtained from informants, and family members when required. Participant observation, semi-structured interviews, and field note documentation were used for data collection. Participant-observation was arts-based (Graham, 2017a).

Participant observation is a naturalistic approach that immerses the ethnographer in the everyday life of the community, granting an insider perspective of the practices of the informants' social world. Engaging in the arts programs alongside the residents was a way to be present in the community in a helpful and welcomed way. For example, I transported equipment for programs with staff, I helped bring residents to and from programs (this was called "portering" and will be discussed in Chapter 5), I also facilitated residents' music-making during the programs by holding microphones, music books, or instruments that the residents were using. I also played music with the group as needed to support a resident's melodic line or to fill in the harmonic accompaniment. Direct participation in everyday life enhanced my awareness of, and sensitivity to, informants' aesthetic expressions of selfhood and sociality. Brief fieldnotes were made during encounters with informants, and later, detailed fieldnotes were recorded off-site.

Semi-structured interviews took place across several encounters, often repeating past conversations. The transition moments between activities were important for capturing fresh reflections about the significance of the arts in residents' past and present lives. Visits after

programs or chats during programs were also important moments where the arts facilitated residents' memory and self-expression. I learned that not only did the social context have to be congruent with the intended interview topic for interviews with people living with dementia, but I also had to be ready to let go of my agenda and go with each resident's flow. Data gathering was holistic and focused on describing the human experience of recognition and sociality through my own experience as a fieldworker.

From the beginning of my fieldwork, I was part of the creative arts team. I participated in arts central programs and in arts programs on the units, both during the day and at night. I moved with members of the creative arts department and eventually on my own. Like the rest of the creative arts department, I wore casual attire instead of nursing scrubs, and wore a lanyard with my name tag and photo around my neck. My name tag was printed with the title "Student," so my role was not mistaken at the facility. It was a lucky coincidence that a few years before I arrived, there had been a violinist on the creative arts staff whom people were used to working alongside. The in-house music library even had a collection of violin music and fiddle books. I was fortunate to step into a space that had been previously created and people wanted to have filled. Empathy, patience, and respect for the people were essential to fieldwork.

The creative arts team was called upon for everyday activities and most importantly for special events that were often closed to the general population. Being part of this department granted me access to occasions from which I would have otherwise been excluded. For example, Remembrance Day was such a large-scale event at the facility that attendance had to be controlled to prevent over-crowding. As an assistant with the resident choir, I was able to attend the Remembrance Day ceremony every year of my fieldwork.

An important aspect of my role as a musician-ethnographer was my capacity to give back to the facility, staff, and residents in a concrete way. I assisted staff and residents in music-making activities within the context of scheduled programs and concerts, and I also collaborated with staff musicians and music therapists in performances at the facility. For example, I played violin along with pianists and guitarists for the weekly Classical Coffee Hour, I played fiddle tunes for the Social in the Pub events, and I performed in seasonal performances for the whole facility (*e.g.*, Christmas Concert, St. Patrick's Day Concert, and Hallowe'en Concert).

Further, my rapport with residents was mediated and sustained by the arts. Many veteran-residents were musicians and it was a significant connection for them to share music with another musician. Playing along with the violin (or fiddle) in band rehearsals, visiting with me and talking about music, and hearing the sounds of the fiddle were meaningful for the residents. As one music therapist explained, "For a lot of the guys, the fiddle completes the picture of the band as they knew it when they used to play in bands." It was a profound experience to connect with people in their 80s, 90s, and into their 100s through music. I established positive relationships with the residents I met, and some became more central in the research than others.

The duration of my fieldwork may appear quite long, but it is important to note that the field did not remain the same throughout my presence. By this, I mean that the community of the field site changed as residents (informants) passed away, some with warning and others without warning. Though I did not leave the field, the field continuously left me. What psychological studies refer to as "participant attrition" was a routine part of my field site's evolution. By the end of my fieldwork, I had kept records of my key informants, but I had lost count of how many people I had encountered and shared time with before they passed away.

It is important to note a few limitations of the fieldwork. First, my schedule conformed to the schedule of the facility. I was present in mornings, afternoons, and evenings, but I never conducted fieldwork overnight. This would have been an interesting dimension of residents' lives to observe, but it might have been difficult to justify given that creative arts staff did not work overnight either. The mornings, afternoons, and evenings had markedly different active communities of residents – some residents were most awake in the mornings, others in the evenings.

Second, at the beginning of my fieldwork my role was similar to that of an apprentice where I accompanied staff to programs and resident visits. This role meant that my experience was partial, and I adopted the perspective of the creative arts staff over that of the nursing staff or other departments, such as physiotherapy, housekeeping, or kitchen staff. My early field experiences with residents was also filtered through an experienced staff member who acted as a mediator between myself and residents. Staff orchestrated conversations, translated resident experiences, and filled in their own perspective about what living in long-term care (with or without dementia) meant to residents. Gradually, I learned how to talk to people living with dementia and how to navigate the long-term care space without appearing out of place. Still, my work was carried out with some trepidation because of the power structures on the units. In the creative arts studio, musicians and artists were in control of the space; however, on the units, the nursing staff and personal support workers (PSWs) were in charge and it was challenging to conduct participant observation without feeling uneasy.

A final limitation of this work was that I worked predominantly with male veteran-residents. The ratio of male to female veteran-residents was 80% to 20% at the time of my fieldwork, a proportion that was opposite of most long-term care facilities. Further, many more

male than female veteran-residents attended music programs that I apprenticed. Consequently, this dissertation was informed almost entirely by male veteran-residents. As a young female ethnographer, the men approached me differently than they approached male volunteers and private sitters who were around my age. Depending on the social context, the men likened me to a daughter, a grand-daughter, a girlfriend, a wife, or simply a young woman with whom one does not share gory details of war. Had I been a male researcher, the collected data may have been different. Consequently, the interactions and accounts that were gleaned were the product of my subject position relative to these informants.

Chapter Outline

Chapter 2, “Literature Review and Theoretical Framework,” provides a selective review of the anthropological literature about ageing and approaches to care for older people. The dissertation is situated in a tradition of institutional ethnographies that captures the perspectives of the residents, care staff, and other relevant social actors. The chapter guides the reader through the theoretical framework and key phenomenological concepts that will be used to analyze the ethnographic data.

Chapter 3, the first ethnographic chapter, entitled, “Restoring a Generation of Veterans,” explores the ways in which the creative arts were mobilized as therapeutic tools in long-term care. The chapter looks at the tension between the creative arts as therapy and biomedical care, and its ambivalent relationship with the dominant biomedical discourse (Agamben, 1998; Scheper-Hughes & Lock, 1987). Creative arts staff were at different times clinical or humanistic in their approach to care. Residents’ needs were sometimes constructed as biologically-based, while other times understood as products of the social environment. Dementia was no longer an individual biomedical problem, but a collective phenomenon. This chapter argues that music as therapy sought to restore veterans’ shared memories and identities by facilitating connections

among veteran-residents through music-making. Memory, music, and collective identity are analyzed through Straus' (1970) concept of "the again," and illustrated through ethnographic stories that describe music therapy sessions with veteran-residents. Following Frank and Frank (1993), the chapter concludes with a discussion about the creative arts as a form of milieu therapy that continually reproduced the collective veteran identity.

Chapter 4, "Becoming a Resident," explores how people transitioned into the long-term care setting and became veteran-residents. Turner's (1969) concept of the liminal will be used to analyze the process of separating individuals from their former social roles and social supports, facilitating their integration into the new environment. Goffman's (1961) notion of the "total institution" is used to understand how the characteristics of the institution affect each newcomers' sense of selfhood. Paramount to this chapter is the discussion about the biomedicalization of life and of ageing in Western society, including the power of the institution to un-make and re-make individuals as they transitioned into long-term care. Following Butler and Athanasiou (2013), the transition made new residents feel estranged and dispossessed from their sense of self and from others. Ethnographic accounts will illustrate how veteran-residents negotiated alienating experiences through self-authoring practices and feelings of agency.

Chapter 5, "Ambivalence and Parallel Doxas of Care," explores the tensions between the biomedical and creative arts doxas of care (Bourdieu, 1977). Both doxas acted upon residents but constructed personhood according to different sets of beliefs and values: the biomedical milieu constructed veteran-residents as medical subjects and the creative arts milieu constructed a musical personhood. Porters were responsible for moving residents not only between physical spaces in the facility, but also for assisting residents to make the existential shift between the milieus. The moral tension that accompanied the task of returning residents to the care unit will

be considered. Finally, the chapter discusses how the creative arts doxa of care was ambivalently integrated into the biomedical doxa of care through facility-mandated documentation procedures.

Chapter 6, “Constructing New Personhoods through Group Music-Making,” shows how the framing of the social setting (Bateson, 1972), and the experience of collective music-making (Schütz, 1976), transformed how veteran-residents experienced themselves in the world (Berger & Luckmann, 1966). In the musical milieu, a new horizon of potential self-expression and social relationship emerged. Personal biographies, nicknames, and signature songs replaced a biomedical subjecthood based on diagnoses and treatment plans. Veteran-residents were recognized (Butler & Athanasiou, 2013) for their music-making, rather than for their illness. Performances in resident bands had a galvanizing effect for the group by emphasizing the group identity beyond the new individual identities.

Chapter 7, the final ethnographic chapter, entitled, “The Politics of Recognition,” discusses the ways in which engagement in the creative arts made the bodies of veteran-residents visible. The tension between un-making and re-making residents (Chapter 4) is revisited through the ethopolitics of veteran care (Rose, 2007). Ethnographic accounts illustrate the way in which participation in the choir on Remembrance Day created a “space of appearance” (Arendt, 1958) for residents who conformed to a normative image of the veteran-resident, and provided a forum for residents to express resistance against such conformity. Situated in a particular sociopolitical and economic context, the creative arts became part of a greater politics of recognition.

Chapter 8, the final chapter, will draw together key points that emerged across the chapters and outline future research directions.

Chapter 2

Literature Review and Theoretical Framework

This chapter provides a selected literature review of the anthropological research about ageing and the experience of caring for or being cared for in advanced age. The scholarly work that is discussed in this chapter is intended to situate this dissertation in the academic field of ageing research. Theoretically, the dissertation strikes two levels: on the first level, it takes up the experience of self and sociality through a phenomenological lens, focusing on the ways in which music-making shapes identity and sociality among veteran-residents in long-term care. On the second level, this dissertation extends the research into a political phenomenology, by considering how the broader institution associates participative music-making with identity, sociality, and recognition of veteran-residents.

Institutional Ethnographies of Ageing

Early institutional ethnographies in long-term care facilities followed Erving Goffman's seminal text, *Asylums* (1961). In this text, Goffman provided an account of the everyday life and relationships of residents and staff at an American mental hospital. He defined the total institution as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (p. xiii). He outlined the basic types of total institutions in society, three of which fit the characteristics of the long-term care facility. Goffman's first type of institution explicitly included homes for the aged that were established to care for people who could not care for themselves and were ultimately harmless. If the secure units for people living with dementia are taken into account, then Goffman's second type of total institution is also

applicable; that is, a place established to care for people who were deemed incapable of caring for themselves and who posed a threat to the community.

The fourth type of institution was designed for the pursuit of work-like tasks, such as army barracks. The woodworking studio at my field site was described by many veteran-residents as a place “to go to work in the morning,” and it provided purpose and routine akin to a weekday job. In this dissertation, long-term care is considered a total institution even in its hybridity, because it conforms to the following central features of a total institution outlined by Goffman: a break down of barriers separating sleep, play, and work, where residents engaged with the same co-participants under similar authorities all the time; each phase of the resident’s day was carried out in the company of other residents who were treated alike and do similar things together (*e.g.*, prearranged meal schedule, a limited number of possible scheduled recreation activities, etc.); the activities were intended to fulfill the institutional mission to provide exemplary care to the veteran-residents.

It is important to note that Goffman’s perspective on the total institution was based on his experience researching American patients and staff whose relationship to one another and to guards was more negative than what I encountered in the long-term care setting. Although some fundamental social structures and tensions may be carried over to explain the social order in long-term care, the reader should remain open to a more nuanced interpretation of veteran-residents’ experience with one another. The social structure in long-term care is complex and the quality of relationships between veteran-residents and arts staff was much more positive than in Goffman’s original description of the total institution.

The effect of environment on experience of selfhood and sociality has been explored ethnographically. One of the first critical ethnographies of long-term care was published by

sociologist, Tim Diamond, entitled *Making Gray Gold: Narratives of Nursing Home Care* (1986). As part of his research methodology, Diamond trained to become a PSW and gained employment in a nursing home. Through this insider experience, he wrote about the experience of care staff and the sociopolitical and economic pressures under which they care for their residents. Other qualitative researchers have applied ethnographic methods to glean insights into the interpersonal dynamics and sociopolitical networks of residents, care workers, and families in long-term care, some with a more critical lens than others (Foner, 1994; Gubrium, 1975; Henderson, 1979; Kayser-Jones, 1981; Lidz, Fischer and Arnold, 1992; Savishinsky, 1991; Shield, 1988; Tisdale, 1987).

Henderson and Vesperi (1995) edited a volume about ethnographic investigations of nursing homes as social worlds, entitled *The Culture of Long Term Care: Nursing Home Ethnography*. They compiled chapters written by anthropological gerontologists that considered the use of ethnographic methods in nursing home settings, as well as chapters that applied these methods to explore resident and care staff relationships. Among the latter chapters, Barbara Hornum's chapter applied van Gennep's (1960[1909]) theory of liminality as elaborated by Turner (1969) to residential settings for the elderly in the United States and the United Kingdom during the 1980s and 1990s. Here, she compared the impact of age-segregated housing to institutionalization in terms of their relative impact on people's selfhood, including feelings of belonging and autonomy. Hornum concluded that integration and life satisfaction was much higher in the Scottish nursing home, where residents did not experience a feeling of "learned helplessness" as their American counterparts did (1995, p. 163). This work lends support to the perspective that the social environment, or milieu, shapes experiences of self and other.

Further support can be drawn from the same edited volume, where Silverman and McAllister (1995) used ethnographic methods to investigate the way in which residential care either facilitates or limits the continuity of social roles and expressions of self among people living with dementia. The research looked at how both common and specialized skills and interests were continued through organized programs related to past social roles (*e.g.*, gardening, crocheting and story-telling, and meeting “clients” at the “office”). The authors made a brief reference to the mention of music program that facilitated a resident’s engagement with her Italian identity. It was noted that continuation of practical skills (both real and imagined) not only maintained a sense of self and self-worth, but also provided a social context for remembering and recounting one’s personal history. Silverman and McAllister questioned the extent to which staff mediated the social interaction between residents living with dementia as “go-betweens” (1995, p. 215), and the barriers to role continuity (*e.g.*, resident-to-resident aggression, staff time constraints, and institutional policies). This research suggests that the environment acts upon residents and shapes their personhood. These studies, however, do not address expressions of resistance to being acted upon, which this dissertation will do.

Ethnographers who studied ageing continued to challenge the status quo by revealing organizational tensions and power structures that shaped health systems and the everyday lives of care workers and residents (Baumbusch, 2011; Bland, 2005, 2007; Jervis, 2001; Lopez, 2006a, 2006b, 2007; McColgan, 2005; Powers, 2001; Rosofsky, 2009). Stafford (2003) edited an updated volume, entitled, *Gray Areas: Ethnographic Encounters with Nursing Home Culture*, that took a critical approach to the study of meaning-making and relationship-building in long-term care. Contained in this volume was Carder’s (2003) work on the social world of assisted living that responded to the question, “What difference do the assisted living values make in

daily practice?” (p. 263). Carder argued that when an institution creates a social model with an inherent and stable set of values and practice techniques, it takes on its own structure and force: “A bandwagon has been created and is now sustained by the very activities that created it in the first place” (2003, p. 281).

In Western society, long-term care facilities have become normalized settings in which people 85 years and above live and die (Stern, 2006). Despite the growing interest in the social life in long-term care facilities, there remains a lack of comparative ethnographic data about how people live and age together in institutional settings. For example, Stern (2006) noted that there was a marked absence of ethnographic data from Canadian settings in the literature. Qualitative research about Canadian long-term care facilities has been conducted predominantly by nursing researchers (Cable-Williams & Wilson, 2017), rather than by anthropologists. This dissertation addresses the absence of Canadian-based ethnographic data about the meaning and experience of ageing in long-term care, including the experience of ageing together with dementia.

Canadian Veterans in Long-Term Care

Canada’s ageing veteran population is significant for many reasons, including their special status as recipients of government health care subsidies and their symbolic power as living witnesses to the country’s military history. Research about elderly military veterans in the United States is well-established and more wide-ranging in its scope than in Canada. American researchers have investigated the projected use of long-term care services by veterans (Guhan et al, 1999; Kinoshian, Stallard, & Wieland, 2007;), care models to provide all-inclusive care to frail elderly veterans (Weaver, et al., 2008), and models to assess fall risk among elderly veterans in long-term care (French, et al, 2007). Petrovic-Poljak and Konnert (2013) were the first to publish

research documenting the experience of community among family caregivers of military veterans in long-term care. The authors noted that the caregivers of veterans were a social subgroup with unique histories and needs. It was found that family members' connection to the military community led to an enhanced sense of community in long-term care.

Health research from other disciplines has looked at mental health and well-being among Canadian veterans living in long-term care. Research has been predominantly based on intervention trials for malnutrition among veterans (Boström, Van Soest, Kolewaski, Milke, & Estabrooks, 2016), or cost reduction of infectious disease control (Evans, Kralovic, Simbartl, Freyberg, Obrosky, Roselle, & Jain, 2014). Many studies have focused on young Canadian veterans' use of mental (Mahar et al., 2017) and general medical health services (Aiken et al., 2016). Researchers have also investigated predictors of post-traumatic stress disorder (PTSD) among Canadian veterans, including senior veterans who sought outpatient mental health services (Konnert & Wong, 2014).

With regard to the use of therapeutic creative arts among older Canadian veterans, there is very little documented literature. While my fieldwork was still ongoing, I authored and co-authored papers about the use of participative creative arts in the ageing veteran population; however, these studies focused mainly on visual art projects (Graham, 2017a; Graham & Fabricius, 2017a, 2017b, 2017c). The experience of returning soldiers and their rehabilitation and care (including curative arts workshops) was documented by Desmond Morton in a chapter entitled, "The Canadian Veterans' Heritage from the Great War" (1998). This work provided important historical data about the use of the creative arts among returned veterans, in terms of both infrastructure (how, where, and by whom the arts were applied), and the intention behind the application. Whereas Morton's writing provided a window into the rehabilitation of young

returned soldiers, this dissertation explores the use of the creative arts as care for older veterans at the end of their lives.

Anthropological Engagements with Ageing

Anthropologists have looked at what it means to age in Western society (Boyles, 2016' Herskovits, 1995; Lock, 2005, 2011, 2013). Others have focused on other parts of the world, including India (Chatterji, 1998; Cohen, 1995, 1998; Lamb, 2000), Brazil (Leibing, 2002, 2006, 2008), and Japan (Danely, 2015; Traphagan, 2000). Many of these scholars have approached ageing from a perspective that is critical of biomedicine. For example, Lawrence Cohen's work has focused on the critical study of biomedicine, health, and the ageing body. In *No Aging in India: Alzheimer's, The Bad Family, and Other Modern Things* (1998), Cohen investigated the meaning of Alzheimer's disease, the body and the voice in time, and the cultural politics of senility. He suggested that, "the possibility that the experience of the body...the relationship between an ageing body and an ageing self – may be differently constituted across class and cultural and other axes of social difference needs to be explored in the move toward a political phenomenology of age" (1998, p. 152).

Author Margaret Gullette (2004) argued that people are "aged by culture" more profoundly than by nature or the body, whereby the experience of ageing is influenced by dominant social discourses with accompanying social, moral, and political implications for societies (p. 705). Following Gullette, medical anthropologist Sarah Lamb (2005), explained that, "Age is a fundamental dimension of human life and yet, interestingly, something that many in the United States find difficult to confront" (p. 705). Important dimensions of knowledge are lost when a significant portion of the life course is cut off from inquiry. Lamb (2005) continued, "Studies of age and aging provide an illuminating lens into complex and important features of

U.S. society, surrounding cultural-moral values, social relationships, and visions of personhood” (p. 708). By extension, Lamb’s insight lends itself to Canadian society as well. Older people have figured into the oral histories and cultural knowledge upon which ethnographies have been constructed, yet, as Vesperi (2009) said, “the anthropology of aging has been largely overlooked as a source for illustrating and theorizing about the full range of human cultural and biological experience” (p. 21). She argued that it is important to position older people in dynamic social processes because changes in their lives may be indicative of larger intergenerational shifts, as well as accelerating economic, political, and technological changes that are relevant to younger people (Vesperi, 2009).

In the topic of this dissertation, cross-cultural comparison is fruitful for considering alternative conceptualizations of the experience of being an older adult in society, particularly an older veteran living with or without dementia in long-term care. The Western biomedical tradition that follows the Cartesian divide between mind and body is not universal, and through comparison with alternative more holistic conceptualizations of selfhood, one can make better sense of the integrated experience of the creative arts and make space to uncover the experience of self and relationship among veteran-residents. The anthropological nuances of age and ageing as a social phenomenon underscore the following critiques of the biomedicalization of ageing.

Critiques of Biomedicine

Following Bourdieu (1977), biomedicine will be conceptualized as a doxa of care. As a doxa, this means that biomedicine comprises a set of beliefs and practices that are perceived as hegemonic by the social actors who reproduce them. A doxa can insulate its adherents who take their dominant position for granted. This characteristic of doxas makes it difficult for people outside the doxa to establish their own validity and gain access to the dominant doxa. For the

purposes of this dissertation, the biomedical doxa is contrasted with the creative arts doxa, though there were other doxas at play in the long-term care field (*e.g.*, physiotherapy, occupational therapy, etc.). These doxas were not accessible to me during my fieldwork because I was granted access through the creative arts. For this research, the biomedical doxa is conceived as the dominant doxa of care, with more institutional control over residents than the creative arts doxa of care.

Medical anthropologists have critiqued the Cartesian metaphysics that is foundational to biomedicine (Lock & Nguyen, 2010; Scheper-Hughes & Lock, 1987), particularly with regards to ageing (Fischer, 2015; Fontana & Smith, 1989; Herskovits, 1995; Wentzell, 2013). Cartesian metaphysics separated mind from body, the visible from the invisible, and the rational from the irrational. The materialistic Cartesian attitude has led biomedicine to construct the body as an individual, physiological machine, removed from social influences. Treatment of the body adheres to a disease model that locates the health problem in the individual biological body, as opposed to following an illness model that locates health problems in the broader social environment. Thus, the biomedical doxa understands both cause and treatment of sickness as biologically-based, while complementary healing doxas are more open about the cause and approach to the perceived health problem.

In the context of the veteran-residents' contract with the government, the institution had the responsibility to keep them alive through medical and therapeutic techniques, or else the institution may have been found negligent. Indeed, they had to be seen to make veterans live, lest they be charged with letting them die. Residents' health was divided among many different care professions, such as nursing, physiotherapy, occupational therapy, social work, dentistry, and a host of other specialists. Complementary health approaches included pet therapy, horticulture

therapy, and the therapeutic creative arts and recreation. Biomedicine and creative arts as therapy are the two doxas of care that will be discussed.

The power of health care professions over residents' lives, and over the practitioners who provided care to residents, can be understood through Foucault's (2003, 2008) concept of "biopolitics" (the state processes of power and control over human life), as well as Rose's (2007) concept of "vital politics." Rose (2007) referred to contemporary "vital politics" as an extension of political concern with population health and illness, to include "our growing capacities to control, manage, engineer, reshape, and modulate the very vital capacities of human beings as living creatures" (p. 3). Rose's concept "ethopolitics," which he defines as:

...attempts to shape the conduct of human beings by acting upon their sentiments, beliefs, and values – in short, by acting on ethics.... If 'discipline' individualizes and normalizes, and 'biopolitics' collectivizes and socializes, 'ethopolitics' concerns itself with the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are. (2007, p. 27)

The concepts of vital politics and ethopolitics will be used as analytical tools to explore the long-term care facilities' approach to veteran care. This includes the institutional ethos of care given by the social contract and the everyday care practices of the care practitioners who provided direct care to the veteran-residents.

The veteran care paradigm will also be explored through Butler and Athanasiou's (2013) rereading of Hegel's politics of recognition. The authors described an apparatus of recognition that conceptualizes selfhood as a facet of relational sociality. Performative efforts at self-authoring are strategies for obtaining recognition and self-recognition in an environment of continuous experiences of misrecognition and experiences of undesired recognition as something

other than how one wants to be known. Recognition is understood to be fundamentally partial, placing it in an open, but nevertheless complex, relationship to sociality and freedom. The authors asserted that the experience of recognition may be something that one “survives,” noting that there are underlying social conditions that accompany recognition, such as social normativity, heteronormativity, ethnocentrism, cultural recognition. The questions, “Who are you?” or “What are you?” become increasingly fraught with concerns about power relations, compliance with established terms of recognition, and even the viability of one’s own life.

The dialectics of recognition and practices of self-authoring are understood as performative expressions for the analysis of the present data. This dissertation will consider the performative aspects of self-authoring where the self is understood as a relational concept. In so doing, it will explore the politics of recognition and the accompanying social conditions that inform the recognition of veteran-residents in long-term care.

The Biomedicalization of Dementia

Medical anthropologists have investigated the social construction of “dementia” as a biomedical construct (Cohen, 1995; Leibing, 2002, 2006; Lock, 2005, 2011, 2013). Annette Leibing (2002, 2006) conducted research on the globalization of Alzheimer’s disease from North America to urban Brazil. She has also written extensively on the “divided gazes” of medicine and humanistic approaches to care for people living with Alzheimer’s disease. Through ethnographic research, including interviews with doctors, family members, and people living with dementia in Brazil, she found that the emerging illness category of “Alzheimer’s Disease” threatened to replace existing local Brazilian understandings of ageing, senility, and memory. The individualizing disease model of biomedicine reproduces a narrative of unidirectional loss and decline. “Death before death” or “loss of self,” she notes, are new and imported phrases that

are used to capture the experience of Alzheimer's disease. Leibing suggests that Alzheimer's is a "disease of time," "a disease of place," and a "disease of a modernity" that is preoccupied with memory (2002, p. 214). Leibing's other work has continued to critically broach processes and issues of dementia care.

Social scientists have begun looking beyond biomedical conceptions of dementia to the social worlds of people living with dementia (Cohen & Leibing, 2006; Kitwood, 1997; Lamb, 2000; Lock, 2005, 2011, 2013). Rather than a Cartesian understanding of selfhood as belonging exclusively to the rational mind, scholars have emphasized the embodied and socially-situated aspects of selfhood (Graham, 2017b; Kontos, 2005, 2006, 2011; Kontos & Martin, 2013; Taylor, 2017), including remembering, or "co-memorating," as a social phenomenon (Bassett & Graham, 2007), and music-making as a way to embody identity and sociality (Kontos, 2014).

Kontos (2005, 2006, 2011) applied Bourdieu's concept of habitus and Merleau-Ponty's concepts of being-in-the-world to explore the subjective experience people with Alzheimer's disease. Her 8-month ethnographic research took place at a long-term care facility in Toronto. Kontos has since published work on sociability and embodied selfhood in the context of bodily sources of agency, arguing for an expanded discourse on sociability in dementia (2011). Contrary to popular stereotypes of loss and isolation in long-term care, her study illustrated that people living with dementia sustained a sense of selfhood and maintained a capacity for engaging in social relationships with others. Gesture, tone of voice, and gaze were found to be important embodied ways through which people living with dementia expressed themselves in social interactions and initiated contact with one another. Kontos compelled future researchers to explore the diversity and social nuances of dementia as a social phenomenon, noting that the creative arts would be a rich domain for future investigations.

Sociality through a Phenomenological Lens

This dissertation will use a phenomenological lens to look at veteran-residents' sense of self and the relationships between veteran-residents. Specific analytic concepts include the we-relation and music-making as an experience of embodied self hood and sociality.

Intersubjectivity and the We-Relation

Following Schütz and Luckmann (1973, 1989), every person inhabits a shared life-world through which they encounter and relate to people and things. The authors explain, “The life-world is the quintessence of a reality that is lived, experienced and endured.... We must act in the everyday life-world, if we wish to keep ourselves alive. We experience everyday life essentially as the province of human practice” (1989, p. 1). The life-world has a particular structure of intersubjective relationships between other people that is taken for granted. In the “thou-orientation,” an individual shares a spatial and temporal community with other people around them, making the other person’s body and gestures intelligible. In this orientation, the other person’s thoughts, feelings, and meanings are not accessible.

Schütz and Luckmann (1973) refer to the more personal and reciprocal intersubjective social arrangement as a “we-relation.” In the “we-relation,” people meet face-to-face, and become immediately meaningful to one another such that the life-world becomes one of common experience. The authors argue that the we-relation is the fundamental relationship between human beings and the precondition for social existence. When someone enters the institution and is un-made through medicalizing processes, we-relations are more difficult to establish with other people. New residents feel estranged from people around them, trapped in an anonymous form of the thou-orientation, or a “they-relation” (Schütz & Luckmann, 1973). In this arrangement, the world is filled with contemporaries, or people who live in the same space and

time but whose thoughts, feelings, and meanings are inaccessible. The experience of dementia can, but does not always, make other people and one's own self seem inaccessible, effectively isolating and estranging the individual from social life.

Music-making as Embodied Selfhood and Sociality

According to Merleau-Ponty (2012[1945]), the body engages with the world through a variety of sensory modalities. The lived experience of the world is initially pre-objective and immediate. In the pre-objective moment, the senses are not yet differentiated into separate senses (e.g., "sight," "smell"). The experience of the world is through synesthetic perception, where all the senses are spoken to at once as a unified impression. Merleau-Ponty (2012[1945]) describes the experience of perception for the phenomenal living body:

...The sound of the flute gives rise to a blue-green colour, the sound of a metronome in the dark is expressed by gray patches, spatial intervals for vision corresponding to the temporal intervals of the sounds, the size of the patch to the intensity of the sound, and its height in space to the pitch of the sound...Everything happens as if he were seeing 'the barriers between the senses, established in the course of evolution, occasionally falling down'...The form of objects is not their geometrical shape: the form has a certain relation with their very nature and it speaks to all of our senses at the same time as it speaks to vision. (p. 238)

According to Merleau-Ponty, perception is an immediate, pre-objective and pre-reflective experience of the phenomenal body that is guided by intentionality. He argues that intentionality is how the body experiences the world before thought intervenes. Through experience, we then interpret our world and make it meaningful (Merleau-Ponty, 2012[1945]).

There is an ambiguity about being-in-the-world, in terms of the things and people that surround us, our body, and the space and time within which it operates:

The world is always already constituted, but also never completely constituted. In the first relation we are solicited, in the second we are open to an infinity of possibilities...

We exist in both ways simultaneously. Thus there is never determinism and never an absolute choice; I am never a mere thing and never a bare consciousness. (Merleau-Ponty 2012[1945], p. 480)

The structure of our social life is indeterminate. Within every interaction there are infinite possibilities for action available to us, as the world is always open to new experiential possibilities and our perception always only partial (Merleau-Ponty, 2012[1945]). The body is also open and ambiguous, simultaneously with a world of its own and belonging to a social world into which it is drawn. The paradox of the body, for Merleau-Ponty, is that it is never fully an object or a subject to itself and thus one's perception of experience is never absolute, even though we take for granted that it is complete (2012[1945], p. 242). There are always blind spots and alternative potential outcomes that one cannot foresee. The extraordinary characteristics of sound can take us by surprise and evoke unanticipated response to one's self and to other people.

Phenomenologists argue that our relationships to ourselves and the world are derived fundamentally through the body (Merleau-Ponty, 2012[1945]). Merleau-Ponty succinctly stated, “The body is our general means of having a world” (2012[1945], p. 147). Through the living body, we anchor to a certain milieu as a mode of “being in the world,” meaning that we attend to the environment that the body creates for itself and inhabits. All perception of the milieu is experienced synesthetically, where the “originary layer” of sensing is prior to any division of the senses, wherein an experienced object speaks directly to all of the senses (Merleau-Ponty,

2012[1945], p. 236). Sensations are felt pre-objectively, and through a translation into different sensory registers, they provide meaning and structure of the world. Sensory experience changes our understandings of ourselves and of other people with whom we relate.

Erwin Straus (1966[1930]) argued that each of the five differentiated senses (hearing, sight, touch, smell, and taste) has its own set of significant sociological results. For example, sound and smell are powerful because they are “pathic” senses. By “pathic” Straus means to say that the sensation is directly and immediately experienced by the body. Sound is perceived the moment one is within earshot of its source. Any distance between self and sound is dissolved. Averting one’s gaze does not affect the perception of incoming sound as it would for sight. As a pathic sense, sound fills the space, approaching everyone within its range. Sound, like smell, creates a sense of proximity that can be overwhelming to the listeners.

Sound is also powerful for its effect on temporal structure and subsequently our sense of reality. Sound, like smell, affects one’s experience of past, present, and future in a way that sight cannot. Leistle (2006) argues that in the case of ritual, smelling aromas disorder temporal dimensions of experience, blending past and future with the present. Unlike vision where the figure and ground are clearly separated from one another, the differentiation is not clear in smell. The aroma is perceived as an atmosphere that may have transformative effects on the self. Leistle (2006) wrote,

Its affective character, homogeneity and substantiality combined predicate smell as a *sense of atmosphere*. Aromas communicate what is singular and essential about a material object, a person or a social situation. To the extent that they are indissolubly bound to concrete and particular circumstances, they elude reflective objectification. On the subjective side of sensory interchange, smelling involves a corresponding

atmospherization of the self. Temporal and spatial structures of experience are loosened, distinctions between inside and outside blurred. As in sensory experience in general, a kind of ‘tuning’ between self and world occurs. (p. 60)

The blurring and loosening of experiential structures is significant for understanding the impact of sound, both remembered and heard for the first time, on veteran-residents’ experience of selfhood (biography), other people, and their care environment. This may be particularly important for those living with dementias that disorder time and sense of self in the world.

Sound may be even more powerful than smell because of its primordial connection with language and communication which signal both individual and collective identity. Sound has the power of blurring divisions within the self (in terms of biographical timeline) and dissolving borders between self and other, thereby creating a poignant “atmosphere” (Leistle’s term) of the collective veteran body. Just as music becomes a “cultural device” to realize a specific relationship between self and environment, as Leistle (2006) explains in the case of ritual trance and possession, perhaps music can also be used as a cultural device to create a relationship between veteran-residents and their relationship to themselves and others in terms of their veteran identity.³

In health care settings, scholars have studied how sound shapes the lived experience of oneself and other people (DeNora, 2000, 2016; Dewing, 2009; Gunaratnam, 2009; Kittay, 2008; MacKinnon, 2003; Rice, 2003, 2013). For example, the sound of call bells, other people’s cries for help or anxious wails, and the sounds of rolling carts remind people that they are not at their

³ Scholars have argued that the categorization of “sound,” “music,” and “noise” is an arbitrary construction with ambiguous and subjective distinctions (Brown, Rutherford, & Crawford, 2015; Kittay, 2008, Novak, 2015; Pickering & Rice, 2017; Schafer, 1977). In this dissertation, sound, music, and noise are used synonymously to refer to acoustical phenomena that are constitutive of selfhood and sociality among veteran-residents.

home, but in a shared institutional space. It has been shown that the long-term care environment evokes and shapes particular understandings of the self (Graham & Fabricius, 2017b, 2017c; Hatton, 2014). Scholars have argued that when the soundscape of the space is marked by the sounds of care work, the individual is constructed as a medicalized subject (Kittay, 2008; Rice, 2003, 2013). Intruding sounds from other people violate a sense of personal space and privacy that a person would have enjoyed when living at home. The medicalized soundscape reinforces that residents are there to be acted upon. By the same token, sounds can trigger memories and associations with biographical details that remind the person of their life and position in the world. In both cases, sound is an embodied experience with implications for selfhood and sociality.

Ethnographers, like Stephen Feld (1990) and Steven Friedson (1996), have considered the social significance of sound among community members. Feld (1990), explored the use of song among the Kaluli of Papua New Guinea, analyzing their use of poetry, metaphor, and tonalities of weeping and singing to understand how song expressed and healed people's grief. The experience of personal transformation through sound was explored by Friedson (1996) among the Tumbuka in Malawi. He argued that in spirit possession, collective music-making intensified the transformation experience for both spirit and the Tumbuka people, creating a powerful social effect.

Scholars have explored the ways in which music-making is constitutive of selfhood and social relationship (Clifton, 1983; DeNora, 2000, 2016; Schütz, 1976). The phenomenologist, Alfred Schütz (1976), argued that music is a social relationship, thus the reciprocal music-making constitutes a restoration of social communication as a face-to-face we-relation. When playing music with another person, Schütz said, there is a shared flux of experience. During the

creative process, a vivid present exists for both people who “tune in” to one another; they grow older together as long as the music lasts. The social relationship is presupposed whenever collective music-making happens. Schütz points to Western polyphonic music as possessing “the magical power of realizing by its specific musical means the possibility of living simultaneously in two or more fluxes of events” (1976, p. 173).

In a complementary argument to Schütz’s argument regarding the relational properties of music, Thomas Clifton described the association of music to social relationships. In *Music as Heard* (1983), Clifton argued that musical meaning is immediately taken up by the body, expressing things about other people and about ourselves. He defined music as a form of play, wherein everyday dualisms like stimulus and response, or spontaneity and order, are blurred and transcended. When there are lyrics to the songs, Clifton notes, they become secondary to the more important shared creative gestures of the performance itself.

DeNora (2000, 2016) argued that music is a source of social agency, providing the cultural materials from which individuals and groups of people can constitute selfhood and sociality. DeNora explains the connection between music and agency in the following way:

To be an agent, in the fullest sense, is thus to be imbued – albeit fleetingly – with forms of aesthesia.... To be aestheticized is to be capacitated, to be able to perceive or to use one’s senses, to be awake as opposed to anaestheticized, dormant or inert. It is also to be awake in a particular manner, to possess a particular calibration of consciousness, an embodied orientation and mode of energy, a particular mixture of feeling” (DeNora, 2000, p. 153).

Music is used in “identity work” that involves the social activity of remembering to create an image of who one is in relation to others in the world by actively taking up musical

properties such as rhythm, gesture, harmony, and style (DeNora, 2000, p. 63). In her recent work, *Musical Asylums* (2016), DeNora explains that singing is a whole-body activity that unifies individual “sound and sounder,” and, in addition to this individual synchrony, singing together produces an embodied synchrony as a collective (p. 83). When one sings, she adds, one is performing a musical presentation of self and in so doing furnishing the socio-musical space. DeNora contends that “If music is a device of social ordering...if it can be seen to have effects upon bodies, hearts and minds, *then* the matter of music in social space is...an aesthetic-political matter” (2000, p. 129). Together, this literature informs my approach to how veteran-residents’ individual and collective music-making was constitutive of their experiences of selfhood, as well as their experiences of recognition, sociality and veteranhood.

Creative Arts as Therapy

This dissertation takes up the purpose and meaning of “therapeutic” creative arts as it is mandated and made available to veteran-residents. In *A History of Madness* (2009[1961]), Foucault wrote that from the Middle Ages onwards, the early hospitals in the Middle East subscribed to a medical humanism that borrowed a form of spiritual therapy directed by doctors. This spiritual therapy for madness involved music, dance, theatre, and dramatic storytelling. Following the Renaissance, music was considered a powerful therapy for madness. Stories about music as a cure for profound melancholy, delirium, and frenzy, illustrated the curative powers of listening to concerts of musical instruments. Over time, the rationale for the curative properties shifted from the material reality of the sound that carried and released virtues inside the sufferer’s body, to a more movement-based explanation.

The arts were already integrated into institutional settings that provided medical or psychiatric care for people who were deemed incapable of caring for themselves. As ageing

became increasingly medicalized and old age homes became normalized, it follows that the arts would continue to exist as a form of therapy. Erikson, Erikson, and Kivnick (1986) wrote about participation in the arts as a means of vital involvement in old age. In a setting with the arts, “every sense can be stimulated - hearing, touch, taste, smell, and the kinetic sense of the entire musculature.... It should be antithetical, in every way to what one old man has described as a ‘thinning of the sense of life by loss of objects and interests.’” (p. 318). The authors espoused a milieu of active involvement, preferably in the company of younger people, so that there was “no place for commiseration, [or] for the discussion of symptoms and disabilities.” The “studio workshop” described by the Erikson, Erickson, and Kivnick (1986) constituted a milieu of engagement in stimulating, meaningful creative work. Indeed, it is akin to the creative arts studio workshop at the field site (described in Chapter 1).

Frank and Frank (1993) explained that “therapy” refers to techniques administered by professional caregivers to relieve suffering (or treat) suffering or illness. The performance of psychotherapy requires a cultural definition of an illness and the definition of an appropriate treatment, occasionally overlapping and conflicting with other doxas’ definitions of treatment (Chapter 3). Psychotherapeutic models rely dominantly on the relationship between the healer and the person seeking help, and through this personal relationship the help-seeker’s behaviour, attitudes, values, and self-image may be influenced with the intention to improve well-being. In long-term care, the therapeutic recreation and creative arts staff were the designated individuals who provided treatments to residents. The creative arts were applied as therapy to address medical conditions such as Alzheimer’s disease and dementia, to alleviate depression and grieving, and to increase social participation (Chapter 3), and to construct new identities for

individuals and groups in both a musical milieu (Chapter 6), and in a veteran-centred milieu (Chapter 7).

This dissertation will deploy Frank and Frank's (1993) concept of "milieu therapy," a humanistic, as opposed to pharmacological, form of environmental therapy, to discuss the work of creative arts as therapy and the influence of the veteran-centered environment of the facility upon resident-veterans' lives. There were several milieus that influenced the lives of veteran-residents: the medical milieu of the residential unit, the musical milieu of the music therapy program (an extension of the creative milieu of the arts studio), and the veteran milieu that was reflected throughout the facility in its material objects and ethos of care.

Contribution to the Field

The present research builds upon the existing literature by providing accounts from the ageing male veteran population in long-term care through the lens of the creative arts. Ageing research is lacking in terms of male perspectives, particularly from the Canadian veteran demographic. Further, very little research has employed an arts-based ethnographic approach, which opens new registers of communication and possibilities for data collection. This dissertation also contributes a phenomenological analysis to understandings of people's experience of sociality in long-term care, focusing specifically on the significance of sound. The chapters take up the role of sound and music-making through the following themes: the un-making and re-making identity, estrangement and recognition, expressions of resistance and repossession of selfhood, relating to one's self and other people in new milieus and alternative music-based forms of personhood, and finally, the public performance of a veteran identity.

Chapter 3

Restoring a Generation of Veterans

“Memory is identity.... You are what you have done; what you have done is in your memory; what you remember defines who you are; when you forget your life you cease to be, even before your death.”

— Julian Barnes, *Nothing to Be Frightened Of*

At the time of my fieldwork, there was concern among staff about the looming veteran transition that heralded the end of a generation of WWII and Korean War veterans. Recalling the introductory chapter, losing a veteran meant many things. Socially, losing a veteran meant losing a “living legend,” a tangible link to the past and a witness to national history whose first-hand accounts of wartime had no substitute. Institutionally, losing a veteran threatened the sustainability of the facility. Prolonging the longevity of the veteran-residents was in everyone’s best interest.

Unfortunately, caregivers in charge of maintaining the health and well-being of veterans were not only fighting against time, they were also fighting against the effects of dementia. Veteran-residents arrived older than in the past and many had diagnoses of dementia that put their ability to perform their veteranhood in jeopardy well before death claimed their lives. The veteran-focused care at the facility included medical care and care through the creative arts. This chapter will focus on the use of music as therapy.

Music was used to restore veterans’ biological bodies, addressing them in a biomedical framework of symptoms and treatment, as well as veterans’ socially-situated selfhood, attending to their identities and social relationships with one another. The first section of the chapter will consider the use of music in its most clinical application for symptom relief for veteran-residents

living with Alzheimer's disease and dementia. The second section of the chapter will explore how music was also used as a social therapy, working on reminiscence and reinforcing aspects of veteran-residents' identities. The chapter will also take up the use of music as a way to re-member selfhood by experiencing memories "again." The chapter's final section will draw upon Frank and Frank's (1993) work to address the way the creative arts as therapy fulfilled the institutional program of "milieu therapy." Music was a cornerstone of the facility as a veteran-centred milieu. Through the collective re-membering of self through music, groups of veteran-residents shared stories of their time as young soldiers, long before they became veterans. Indeed, the creative arts were a means through which the facility sought to restore the remaining members of the generation of WWII and Korean War veterans.

Treating the Biological Body

A creative arts staff member sat with me in the workshop one day describing her work on the veterans' dementia unit. She recounted that one Sunday morning she had been walking through the unit with her art cart, visiting residents who wanted company or who were looking for something to do. Making her rounds, she looked through the open doorway of one of the residents' rooms to find a disturbing scene. The man had wheeled himself to his dresser, opened one of the drawers, and was madly rummaging through it, frantically searching for something. Hearing her approaching the door, he looked up at her with his hands still in the drawer. She paused in her story to catch her breath before continuing, "He said to me, with tears in his eyes, 'Please, save me from my insanity.' What could I do? What could I say? It is a horrible situation. There is no easy answer."

A point of overlap between the creative arts doxa of care and the biomedical doxa of care was the Cartesian approach that separated mind from body (described in Chapter 2). The disease model articulated dementia as a problem of the individual biological body. One of the

recreation therapists described the biologically-based concept of “retrogenesis” using the metaphor of the mind as a film strip that was progressively cut by dementia. He explained, that if you are 80, the disease may take 30 years of the film strip, so you are working from only 50 years of your “documentary.” Things that came later in the movie are forgotten. Sometimes a lot is lost and people are working with the first 18 years of their film strip, and sometimes that is in another language entirely. People decline toward the first learned body functions, losing years in stages until they get to zero. The recreation therapist clarified that, “people don’t die of Alzheimer’s, they die from complications associated with the disease, such as falls, forgetting how to swallow, and so on.” The biological body was believed to follow a predetermined trajectory. It was a necessary decline until death, attenuated by therapeutic intervention. According to this biological process, the veterans from this generation living with dementia would be “gone” before they physically passed away.

Creative arts staff held that the arts was a way to access, harness, and evoke the healthy person inside the ailing body with its “symptoms”. When I accompanied one of the music therapists onto the veterans’ dementia unit, one of the first questions posed to the nurse on duty was if any residents had exhibited symptoms that day or evening. The nurse shared which residents had been yelling, fighting with other residents, or were experiencing agitation. These behaviours were considered symptoms of dementia and were interpreted as signs of distress that required the music therapist’s intervention. In consultation with the nursing staff, the music therapist aligned her goals with those of the biomedical doxa of care, focusing on people exhibiting symptoms of dementia as defined by a Cartesian disease model.

Despite the clinical focus on the biological body, music therapy interventions were usually offered to residents as “musical visits” or opportunities to “play music together.” A

social language was used with residents, while a medicalized treatment language was used with nursing staff. Sessions were one-on-one or in small groups of residents. In groups, the feeling of a social musical encounter rather than a “therapy session” veiled the clinical intention from residents; however, the music therapist used the group setting to realize her clinical goals. The following story illustrates this point.

A Cup of Coffee and a Song

Mr. Saunders was a resident that people found difficult to like. He swore loudly, yelled at people without cause, and said mean and venomous things to the staff and volunteers. Nobody liked dealing with him because of his outbursts. The unit was often silent except for Mr. Saunders’ hollers. Other residents tolerated the yelling, but remarked quietly that something was wrong with him. Some residents were deeply offended by his coarse language.

The music therapist attributed his expressions to symptoms of dementia. His actions were interpreted as fear and anger. He did not know where he was, who was going to take care of him, or if he was going home. Much of the agitation seemed to come from not knowing where they were or what was happening next. Over the course of several months, the music therapists were directed to attend to Mr. Saunders. His constellation of outward expressions was consistent: yelling, shouting, agitation. On this spring evening, he was pushing chairs around the dining room with a frustrated and agitated energy. Directed to help him calm down by a nursing staff, the music therapist gently offered him music. He declined with a great burst of energy, “No, no! Go away!”

There were a couple other residents in the room, so the music therapist took an indirect approach: she tried to normalize the situation by creating a more social atmosphere. She offered the other residents a coffee. The residents accepted, and she had a short chat with one about what

he might like in his coffee. She asked the other resident the same question with the same short chat about milk, cream, or sugar for the coffee. Then she returned to Mr. Saunders. While she had been asking the other men about coffee, Mr. Saunders' body posture changed from leaned over, pushing and pulling on chairs, to sitting upright with his arms on the chair. She asked Mr. Saunders if he would like a coffee as well and he was receptive, accepting the offer. The music therapist concluded that the whole process of "would you like a coffee and what would you like in it?" normalized the encounter, opening a gateway to the possibility of music-making together. When the music therapist returned with the coffees, she brought the other two men near Mr. Saunders, forming a loose semi-circle that effectively surrounded him. He did not seem threatened. With guitar in hand, she said to Mr. Saunders, "I'm going to play a song for you." This time he said, "Okay, but hurry up!"

Mr. Saunders remained the focus of the group session. The theme for the evening's songs was Irish tunes because St. Patrick's Day was coming up in a few weeks. With songs like "My Wild Irish Rose" and "Danny Boy," the men started to sing along with the guitar. Sound carried enough to attract the attention of other nearby residents who made their way over in their wheelchairs to join in. Singing continued around Mr. Saunders who was listening and attending to the music. Within ten minutes of the music starting, Mr. Saunders was singing along, too. Towards the end of "Danny Boy," Mr. Saunders appeared to become agitated again. Noticing this, the music therapist called out to him directly, "Mr. Saunders, we're going to do 'Rose of Tralee!' Sing with us!" He stayed and sang along quietly. His focus was broken only a few times when a PSW came to take a resident away to bed. "What's the matter? Come! Come!," Mr. Saunders started to say, but his words faded into an incoherent mumble and he was quiet until the end of the session.

Treating the “Living Death”

The music session was directed to treat Mr. Saunders’ symptoms of dementia, first, by normalizing the situation so that he would engage in the group, and, second, by keeping him engaged in singing. Purportedly, the music harnessed the healthy part of him and drew it out beyond the symptoms or “behaviours” by focusing his attention and providing a social and temporal structure to his experience. It is worth noting that this Cartesian conception of dementia as a cage that binds and erodes the mind, and therefore also the person within, is common in popular and academic circles. Such biological understandings locate personhood in the mind. Frightening metaphors of a “living death” or even jocular phrases like “the lights are on, but nobody’s home” are part of the Cartesian biological dementia discourse. Kontos (2006) explained that “this presumed loss of selfhood is itself a product of the Western assumption that status as a full human being is completely dependent upon cognition and memory, both of which become impaired with advancing Alzheimer’s” (p. 195). Music therapy was meant to capture the traces of selfhood that remained intact and amplify them through the shroud of illness, as though, following Fontana and Smith (1989), the music was fighting a war against the “unbecoming of self” (p. 36). A music therapist once explained to me that, “These men are stuck inside their bodies. They are suffering and miserable. The music gives them life while the disease is busy stripping it all away.” Family and staff articulated that they looked for glimpses of the person “within” whenever the resident remembered favourite songs or stories, hoping that “person inside” could be evoked through a kind of magic practiced by the music therapist.

Following the Cartesian conception of the body as a machine that runs like clockwork, staff used the concept of “sundowning” to explain Mr. Saunders’ expressions that occurred in the late afternoon. “Sundowning” is the concept that people living with Alzheimer’s disease

experience more symptoms like agitation and disorientation in the late afternoon and return to their regular state by the next morning, only to decline again the following afternoon. It suggests that the individual surrenders to a new diurnal rhythm where their dementia symptoms fluctuate like clockwork. I always thought that it was not a coincidence that “sundowning” co-occurred with the 3 p.m. shift change and requisite staff briefing meetings, when the nursing staff sequestered themselves in a side room and the activity level on the unit slowed. Programs drew to a close at about this time and unlike the morning that was busy with breakfast and lunch within a few hours of each other, and numerous morning doctor appointments, the late afternoon had a wait time of a few hours when nothing was happening before dinner. In any case, “sundowning” was often the primary explanation used by both medical staff and creative arts staff when residents were agitated in the late afternoon or evening.

On another occasion, I recall visiting the unit in the late afternoon with a music therapist who had gone to the unit specifically for Mr. Saunders. When we found him, he was sitting in his wheelchair in the middle of the hall yelling and swearing at no one in particular: “Fucking hell! Go to hell!” He sounded mean and hostile to me, but the music therapist assured me that he was just agitated and scared. She explained that these were symptoms of his dementia that were worsening in the afternoon. The music therapist tried to “re-direct” Mr. Saunders by walking him down the hall, drawing his attention to the window, plants, and pictures in the hallway. If she moved too fast or too slow, he hollered. When he insisted on stopping, she tried to play music ahead of him to attract him toward the sound, but he did not budge. He covered his ears and continued to yell. Nearby residents were visibly disturbed by his yelling. It was not the kind of situation that lent itself to a group session. In order to contain his sound, the music therapist wheeled him into his room and positioned him where he could see her. She stayed at the

doorway, giving him some space, and sang quietly with her guitar. After a few songs, it sounded as though he had calmed down or even fallen asleep. Gesturing to me to follow her, we started to leave the unit. As we neared the exit door, we heard him holler profanities again. “We did all we could,” she said, looking perhaps disappointed that the treatment was not a perfect fix for his symptoms. There was a tone of resignation that this was just how Mr. Saunders’ life was now and very little could be done to change its course.

Following Leibing (2006), I suggest that the therapeutic creative arts were fighting against the threat of “biosocial death,” whereby “a social death occurs because of a person’s biology, and biology cannot be described apart from the social body” (p. 248). Biosocial death occurs when “a person’s capability of participating in society diminishes to the point that the person is considered a nonperson or as not having full personhood” (Leibing, 2006, p. 248). In order to treat biosocial death, the creative arts work to restore a personhood that they see being stripped away by the illness. There was an effort to encourage the recollection of past social roles that the person lived, but there was a parallel intention to emphasize the veteran-residents’ social life as veterans. A kind of social healing through the arts takes place that was just as important as the restoration of the biological body.

Re-membering Veteran Identity

The creative arts were also used therapeutically to restore veteran-residents’ social body. The restoration of memory was one way to re-member a sense of selfhood in a social context and restore a feeling of veteranhood among the men. Creative arts staff got to know residents in a more social than medical way; the focus was on each person’s social life, rather than the biological life described in nursing charts containing daily vitals, medications, procedures, and test results. As one artist said, “I may not know their bowel movement schedules or their

complete medication schedules, but I do know their birthdays, their spouses' birthday, where they vacationed, the names of their kids, where they served in the war, what they liked to do during the summer, and all about the things that filled their lives." This exemplified a key difference between the creative arts and biomedical doxas of care (the doxas of care will be discussed further in Chapter 5). The significant details about residents' lives were important to know in order for creative arts staff to help people remember who they were before they were residents (the experience of becoming a resident will be discussed in Chapter 4).

Musicians and music therapists used songs to connect people with their past identities by evoking earlier life experiences. Songs were believed to have emotional gravitas and deep connection to people's pasts. The phenomenon was described by staff as a re-experiencing, or experiencing something *again*. A musician who worked for over a decade with the veteran-residents explained her perspective on song and memory in terms of returning to "the source." She said that a song could bring you back to something that you recognize as you when your memory will not take you there on its own. For the veterans, this meant going back to a time when they were 17 years old and first heard the wartime songs. "It's going back to the source," she said, "It's going back to the time before they knew what would happen in the war, when things were new."

Turning to Straus (1970), the notion of "the again" can be further unpacked. Straus explained the following basic maxim of memory:

In remembering we turn to the past as past, and that will say we turn to it at and from the present. There is a dual aspect of time in remembering; present and past are entwined. The act of remembering belongs to my actual present; the events remembered belong to the past. Experiencing, therefore, cannot be understood as a mere sequence of particular

impressions and ideas following each other in clock time. Our experience has – it must have – an intrinsic temporal structure of time lived and experienced in a state of becoming. (p. 47)

The idea that through remembering people experience *becoming* is an interesting alternative to the Cartesian legacy of *unbecoming* espoused by biomedical views of dementia. Remembering, for Straus, is a fundamentally personal experience, based on one's own history and life story. He considers a person's memory to be a private object, that can be recalled in a social setting and shared with others. Remembering is not merely a stark repetition of a temporally-bound object, it is also a matter of personal transformation through the act of remembering. Straus explains this experience of seeing or hearing something again for an individual:

Sensory experience, then, obviously must have a polar structure, viz., my acts of seeing and the things seen, the sight is mine but the things seen are public, they are visible. There is also an encounter of two temporal orders: the order of the things and that of my own becoming. Such polarity makes repetition possible. I saw the hall again; I heard the Beethoven symphony again. But the phenomenon 'again' has not the same character in the various modalities of seeing, hearing, touching, and so on.... Obviously, the first time must be over and gone if and when a second performance should happen. But if the first were completely gone there could be no repetition, no second time. What is the link between the two performances? What is carried over from the first one, belonging to the past, to render the latter, the present one, a second one?.... The one who hears something *again* – he is aware in the present of a past performance.... *Experience, then, transcends the realm of physical events.* Repetition does not explain memory...remembering makes repetition possible. (1970, pp. 49-50)

Thus, there is something more to remembering than a neurological process of conjuring up mental copies of an original object. In order to hear the music *again*, the “suchness” of the music heard the first time must be detached and it is this repeated gestalt that is reactivated or re-substantiated by the music (Straus, 1970, p. 50). In other words, the emotional significance of the music that was experienced when the music was first heard had impressed itself upon the individual. This emotional valence remains attached to music and is repeated when the music is heard again. Music that did not leave a lasting emotional impression upon the listener may not be remembered at all or may hold no transformative power upon a second listening. Straus’ notion of the *again* may speak to the emotional significance of music as guideposts in each person’s life history. It can be said, then, that if veteran-residents responded strongly to hearing and singing old war songs again, it was because there was something deeply personal that resonated in them. These songs were connected to emotionally-significant events in their lives, as the musician said, when they were 17 and went off to war with these songs juxtaposed to the gripping scenes of war.

The “again,” or re-experiencing, took place in the social encounter of the musical, not medical, milieu. For many staff the re-experiencing or regaining of memories or capacities had to do with accessing a selfhood that was buried beneath pathology or stifled by the medicalized environment. One musician explained the experience of singing Spanish songs and playing guitar with a 97-year-old veteran: “He is much better than he was a year ago and he’s improving. His daughter comes to support him in the group. It’s him again and that smile. It’s just him. It’s the part of him that’s still well.” The same response might not have been possible without the Spanish language context, a francophone musician, and Spanish music that was familiar to him.

Remembering is thus a collective activity that takes place in a particular social context with other social actors who participate in the remembering process.

The music was directed toward creating a veteran-centred social environment that facilitated collective memory. When I began my fieldwork, war songs dominated the musical repertoire. Whether army, navy, or air force, there was a canon of war songs that were familiar to the men. The songs from WWI resonated the most with residents, even though many had served in WWII. When musicians played first world war songs like “It’s a Long Way to Tipperary,” “Pack Up Your Troubles,” “White Cliffs of Dover,” “Keep the Home Fires Burning,” the veterans all sang. “They naturally sing when this music starts,” said one of the music therapists. Previously silent bodies suddenly began to sound together, following the melodic lines of the old familiar songs. These were songs that meant something to the men. They recalled details from their past that were connected specifically to this music.

During an evening music session with some of the men on the veteran dementia unit, the music therapist asked the men in the group what they would like to sing next. One of them called out “Bless ‘Em All,” a military song written during WWI, but known as a popular song in WWII. The 83-year-old army veteran sitting to my left stirred and said to me,

I remember the first time I sang that. I was in the back of an army truck. We were going from one location to another. For some reason or other somebody started singing it. Before you know it, the whole blooming truckload is singing it. We were going down a main street in Ireland, singing at the top of our voices. Roll out the Barrel! We were going from one barracks to another. We were in a summer camp and going to the winter camp. We were just going along and a couple of guys started singing it. We got to the

camp, the driver said, ‘I didn’t enjoy the ride too much, but the entertainment was good.’

We used to have fun. I was in the army for 5 or 6 years. There are lots of other songs, too.

Whether he meant “Bless ‘Em All” or another popular tune of the time, “Roll Out the Barrel,” the songs were connected to his identity as a young man in the service, far away from home, and finding himself in a community of other young men who endured the war together.

At the time of my fieldwork, war songs were the musical bread and butter of the facility. Everyone who worked there came to know them all by heart, myself included. For most of the men, war songs had a waking effect that was positive for the individual and his caretakers. During my fieldwork there was only one exception I heard about. This 90-year-old veteran had served in the navy during the Second World War and he hated war songs. The story goes that he was in charge of 150 or so men where he was stationed during the war. One night, they were out at sea and they started singing war songs to keep themselves occupied. The enemy heard the singing, located the ship, and gunned most of them down. This resident survived, but he lived with the guilt for the rest of his life. He refused to attend sing-alongs or participate in war songs.

Now, the men were older veterans living away from home in long-term care, surrounded by a community of other older veterans. Together, they endured the end of their lives through song. “The memory is here,” said the music therapist, “but the experience is different from when they heard it the first time. They are in a sterile environment of long-term care. It’s nothing like it was before, but the music brings things back.” In the music program, she continued, she constructs a musical narrative to draw out the memories.

I make up a story. My story up to now starts the same way: it’s a nice day so we’re going to sing standing on the corner watching the girls go by. Because I work with men, we do that. So, standing on which corner? They always say Lacewood and Windsor because

that's where the girls would leave their offices at lunch. The offices were there. Okay, we see a girl, she's sweet (then we sing, "Ain't She Sweet"). Okay, what's her name? We take her on a date. We do a dancing song, or we marry her, or give her a kiss. Through the story, you're drawing out memories. They become engaged in the music, in the memories!

Often, the songs touched on earlier years when the men were young before or during the service, or just after they returned from the service. During these years, most men met and married their wives. The family relationship was central to many narratives, but it was inextricably linked to their time in the service. The songs traced the common biography of the WWII soldier who went off to war with the song, "Wish Me Luck as You Wave me Goodbye," endured the war with songs like "It's a Long Way to Tipperary" and "Pack Up Your Troubles," enjoyed romances during the war with songs like "Lili Marlene," and dealt with longing for home with "Keep the Home Fires Burning." When they returned, nostalgic songs like "White Cliffs of Dover" sang of hard-won peace that reassured the men that their fight was not in vain. The men recalled and embodied their pasts through familiar songs of wartime and the peacetime that followed. The ethnographic story below will illustrate the experiences that were re-lived together in the music.

Re-experiencing Shared Pasts through Song

On a fall afternoon, seven male veterans were gathered in a semi-circle around the music therapist at her piano. The hour-long music therapy program began with introductory songs to draw the men into the music and warm up their voices and get them into a music-making mood. After the first set of songs, an army veteran looked up from the drum he was playing and said, "Old songs are better because their melody was better and they had a story. They brought people together." The group of men agreed, nodding their heads, and the music therapist tried to

encourage more discussion among the men about their appreciation for older music. The group did not immediately take up the topic, so she continued the session, guiding the group into the next song.

How about “I’ll Never Smile Again?” she asked. As if not hearing the question, the lead vocalist in the group, Mr. Teasdale, said,

It’s true. The old songs were the best. When I was 15 years old, I went to the 1939 CNE fair. It was the last one before the war. Tommy Dorsey was in a tent and Sinatra was singing with him. Those were the good old days. All us boys were excited for adventure. We were going to go overseas and chase away the Nazis! Us boys, we planned to make love to our girls when we got back, but when we realized we might not come back, we thought we should make love to them before we go! That day at the CNE fair Tommy Dorsey and Sinatra performed together. Those were the days...”

In a chorus, the men all jumped in saying, “oh yah, oh yah, mhmm,” in agreement with Mr. Teasdale. Together the group sang “I’ll Never Smile Again,” with Mr. Teasdale crooning the vocals as he remembered hearing them that day at the Canadian National Exhibition (CNE), an annual fair in Toronto, Ontario, before he went to war.

The session was far from over. From the song pack, the music therapist selected the song, “Lili Marlene.” All the veteran-residents knew “Lili Marlene.” This was another song from WWI that continued to the front lines of WWII. Associations between this music and the physicality of service years were deeply felt by the veteran-residents. The music therapist began the introductory chords to the song. Immediately, Mr. Teasdale said, “It’s a marching song that one. Left, right, left right. You sing it like a marching song. It’s a German war song.” The veteran-residents told different explanations for how this song came to be part of the Canadian soldiers’

repertoire. By whatever path it came to be integrated into the canon, it remained a beloved war song that continued to be sung regularly by veteran-residents, evoking sentiments of wartime.

The session continued with the song, “All the Nice Girls Love a Sailor.” As the music therapist played some introductory chords, she asked, “Was anyone in the navy?” A veteran living with dementia spoke up, “I was a navy man! I was on a merchant ship taking food to Britain. They didn’t have enough food for their people, so Canada sent food to England. I went over in the ship. They had the blackout on and the enemy dropped bombs on us in the water.” He looked around the group and then at me, continuing, “When you’ve been in a crisis, you appreciate your life better. You’ve been there, so you can appreciate what it’s all about. Guys chasing you all over Europe with a machine gun, that’s scary. My parents would have had a fit. My father didn’t know I’d joined up...” As his voice trailed off and his story seemed to conclude, the music therapist held time playing chords softly on the piano in case the resident had more to add. When it seemed as though no more would be said, the music therapist began playing the chords a bit louder, leading back into “All the Nice Girls Love a Sailor.” Just then, the resident turned to me and asked, “Do you know any of the old war songs? Maybe you’re too young...” “Oh, I know a few songs,” I replied, “How about ‘All the Nice Girls Love a Sailor’?” He said he liked that one and the music therapist began singing and the men followed her into song. As the song ended, he leaned back over to me and said, “You sound like you were in the woman’s army. Were you in the service?” By knowing the same navy song as him, the veteran-resident included me in the circle of veterans, granting me a place among them.

The session continued through songs that elicited the men’s memory of serving in the war and reinforced their shared identity. At times, the music therapist probed the group, asking who had served where and related men to one another. Drawing upon experience working with these

and other veterans in the past, she had a readily accessible short list of common experiences to which the men could relate through song. The music therapist was not at all surprised when she began the popular war song, “It’s a Long Way to Tipperary,” and the men began their barracks version, “It’s a Long Way to Tickle Mary.” Often in these moments, the veteran-resident sitting next to me would lean over to me and say quietly, “We have our own version of this song that we learned in the service. I can’t help it!” There were many songs for which the men had their own “service-version,” or specifically, “navy-version.”

As previously discussed in Chapter 2, creating parodies of well-known popular songs was common among soldiers during wartime (Cook, 2009; Pieslak, 2009). Cook (2009) noted that the song “It’s a Long Way to Tipperary” was no longer sung by the second year of WWI because it came to represent a war effort rather than the soldiers’ experience. In response, the soldiers parodied the song, inserting their own “racy or vulgar lines” in order to reclaim ownership of the music (Cook, 2009, p. 233). In the context of the veteran-residents, singing their own version of the songs reflected the kind of collective self-authoring that was part of soldier culture. Cook (2009) also noted that songs were meant to demarcate groups, and the in-jokes, vulgarities, and soldier-authored works were not meant for civilians or civilian society.

Though the memories are private and related to biographical time, the cohort of veteran-residents shared similar experiences during war. “A single bar or refrain,” wrote Cook (2009), “could spark up deep memories among veterans in the post-war years. They were badges of identity.” They shared memories about life as young men in the service, a time before any of them were veterans. Thus, the songs remained meaningful to all of them as a group. In the context of dementia, Bassett and Graham (2007) argued that memory as a pragmatic synthesis of the individual is co-constructed in a social context. Through the commemorating process,

identity can be re-located. This is not at odds with Straus' (1970) logic of memory that figures memory as a function of biographical time associated with the re-markable, emotionally significant events of one's life. Indeed, a group of veteran-residents singing songs associated with a particular time in their lives created the social environment that evoked memories that bound them together in veteranhood.

In its more humanistic modality, the creative arts as a doxa of care provided opportunity for veteran-residents to assemble and share the experience of hearing war songs again. In groups like the resident bands (discussed in Chapter 6), they could reflect on war stories together that had special meaning to them as a cohort. Private sitters, volunteers, and non-veteran residents who had not served in the war were important as audiences, or witnesses, to the shared veteran experience. The following section explores music as a form of milieu therapy.

The Creative Arts as Milieu Therapy

The creative arts oscillated between the medical doxa and the more humanistic doxa of care that focused on social engagement, relationships, and self-expression. As a therapy, the creative arts participated in the biomedical doxa by alleviating symptoms; however, the creative arts achieved something that the biomedical doxa could not: eliciting residents' identities as veterans through playing war songs and engaging them in recalled narratives of their lives as servicemen. The power of music to constitute veteranhood, build camaraderie, and provide a stage for performance of these relationships was integral to the veteran-centred model of care that sought to restore a generation of veterans.

Frank and Frank (1993) noted, "Various creative arts therapies – music, art, poetry, and dance – may be a specialized part of a milieu program. Beyond the aesthetic pleasures of artistic expression and the manipulation of symbols for therapeutic purposes...these modalities are often

especially helpful for patients who are not verbally skilled or who are too disturbed to participate in a free-interaction group” (p. 288). Even those veteran-residents who lived with advanced dementia responded to music. The music carried a social history through which veteran-residents constructed their sense of self in relation to others. Singing war songs was a tradition that was carried on in the facility and lasted despite the turnover as older residents passed away and new residents arrived. These old war songs were an essential part of the social environment.

The music crossed temporal and spatial boundaries within the facility. It did not contain itself to one individual, as a prescribed medicine would. Instead, it spread throughout the facility, carried by the people in the community. For example, private sitters and volunteers who attended music sessions with veteran-residents often borrowed song books to sing the same songs over again together with their resident. Many of the sitters and volunteers had personal connections to the military, as veterans themselves or as spouses or relatives of veterans. The environment was populated by people with a vested interest in the veteran population, so it is not surprising that while walking through the halls, I often heard people sitting and singing the war songs together. Through repetition, the music spread beyond the hour-long music session and beyond the room in which it was administered. Veteran-residents even sang their songs in the facility’s official ceremonies and presentations, which was possible because it was so well-rehearsed (this will be discussed further in Chapter 7).

The creative arts enlivened the already veteran-focused facility. Part of the power of the arts as milieu therapy was because of the musicians and music therapists who lead the songs. The arts staff were akin to the charismatic leaders described by Frank and Frank (1993). They had “warmth, energy, and persuasive skill” in their delivery of the music. Families, staff, and residents regarded the creative arts staff as lifelines for their loved ones and themselves. There

was a time that when a particular musician was so beloved that a group of residents planned their day around her programs, following her from unit to unit. This exceptional affinity for staff was not uncommon. When staff went on holiday or were absent from a program, some residents even experienced feelings of despondence. Although the war paintings and service memorabilia that furnished the facility were important to the maintenance of the veteran-centred image of the facility and to the veterans who called the space their home, the music had an invigorating effect on the environment. Recalling Goffman's (1961) description of the total institution as a closed system, the people and programs that filled the facility were the only source of a person's validation in most cases. This bestowed exceptional power on the people, artifacts, and music in the social environment to shape residents' selfhood and social relationships.

Conclusion

This chapter has argued that the creative arts were used as a specialized form of milieu therapy within the total institution. The benefits of milieu therapy, according to Frank and Frank (1993), included improved patient morale, a humanizing influence on relationships between staff and residents, and improved social adjustment for patients who internalized the institution's values. In the context of this field site, milieu therapy operated most strongly through music, specifically wartime music or music that was associated with veteran-residents' experience in the service.

For residents, the benefit of participation in the milieu therapy were both physiological and social: music eased tension and reduced symptoms and it provided a social community in which veteran-residents' related to themselves and others as veterans. The creative arts also gave a forum for others to witness the milieu therapy. People experienced veteran-residents in live performance, and they were able to purchase paintings, wooden planes, silk scarves, and various

pottery works that had been made by the veteran-residents. All of this was perhaps evidence that the milieu therapy was effective, that the generation of WWII and Korean War veterans was being restored through the facility's exemplary care.

In the following chapter, the experience of being un-made and re-made into a veteran-resident. Ethnographic stories illustrate how the necessities of the institutional structure of biomedical care separated people from familiar social roles and ascribed new roles to integrate into the community. The chapter explores the politics of recognition (Butler & Athanasiou, 2013), and related issues of estrangement, dispossession, and misrecognition that impact the everyday experience of veteran-residents.

Chapter 4

Becoming a Resident

“As for most of us, the struggle for being plays out in small ways, in everyday life, as a matter of gaining a slight edge over the forces that threaten to deplete, disparage, and degrade. Life is never a secure possession. Life is lived...between a rock and a hard place, between the devil and the deep blue sea”

– Michael Jackson, *The Wherewithal of Life*

This chapter will investigate the ways in which people entering long-term care experience the “transition” to becoming veteran-residents at the facility. The first section of the chapter will discuss how the medicalization of ageing contributed to the un-making and re-making of personhood, leading residents to experience self-alienation and dispossession as they were acted upon by the institution. The second section of the chapter will explore how veteran-residents understood their social location in long-term care in relation to the other veterans with whom they lived. Here, residents continued to feel acted upon by both other residents and the institutional milieu. The third section of the chapter looks at veteran-residents’ expressions of resistance to being acted upon, whether by re-possessing their personal space or by adopting the medicalizing language of the institution.

This chapter speaks through key theorists Turner (1969), Goffman (1961), Foucault (1995[1975]), and Butler and Athanasiou (2013). For the purposes of this dissertation, the experience of transition into the long-term care facility is considered to be a liminal stage (Turner, 1969), where individuals are un-made and re-made into docile bodies (Foucault, 1995[1975]) as they are acted upon and expected to follow the norms of the total institution (Goffman, 1961). As a result of objectifying medicalizing discourses of diagnoses and

symptoms, and the routines of the total institution, individuals were dispossessed and alienated from a sense of self and agency. In their efforts to reclaim agency, residents engaged in performative struggles for recognition (Butler & Athanasiou, 2013).

Being Acted Upon

The Medicalization of Life and Fragmentation of Self

Sociologists were among the first scholars to examine medicine as a mechanism of social control (Foucault, 2012[1963]; Zola, 1972). Irving Zola (1972) is credited with the seminal explanation of how medicine, a key social institution of power and control, became more influential than religion or law in defining social order. Zola explained that the power given to medicine led to the medicalization (“to make medical”) of everyday life, interpreting and defining daily life through the lens of health, illness, and treatment. Schepers-Hughes and Lock (1987) argued that the tradition of Cartesian dualism provided a mechanistic model of the body in Western culture that leads to self-alienation and estrangement. Cartesianism underpins biomedical approaches to the body, setting mind and body, spirit and matter in opposition to one another. In cases of ageing, particularly Alzheimer’s disease and dementias, causality is thus located in the neurological structure of the brain. Once a person carries the diagnosis of Alzheimer’s disease or dementia, even normal human action, such as moving in space, becomes medicalized and subsequently pathologized as a symptom in need of treatment and surveillance (Graham, 2017b).

This materialistic view of ageing is especially complicated in cases of Alzheimer’s disease and dementia which, I will argue, are experienced predominantly as cases of social suffering. Anthropologist Leon Eisenberg was the first to draw the distinction between disease and illness (Schepers-Hughes & Lock, 1987). Disease is the biomedical abnormality that doctors

locate in the structure and function of organs and the body (including the brain). Illness is the patients' subjective experience of suffering, including the social relations of sickness. Schepers-Hughes and Lock (1987) posited that the social body is reduced to the individual medicalized body when biomedicine claims both disease and illness for itself, by reducing the social to the individual. Early on in my fieldwork, one of my informants recounted his experience of receiving his diagnosis from his doctor. In his account, he inadvertently troubles and resists the biological reductionism of the medical diagnosis by preserving and ordering the social body above the individual body through his own made-up language.

On a March afternoon in 2016, I walked to the veterans' unit to collect Mr. Davison, an 87-year-old army veteran, to play with the resident band. I found Mr. Davison sitting in his favourite chair and reminded him that we needed to go to the performance. Before we could leave, he was adamant that we find his hat. He became frustrated when we couldn't readily locate it. "I am very disorganized all by myself. My kindly old doctor, my ex-doctor now, I fired him, tapped me on the head and said, 'Young man, you have *brain damage*'. I didn't make any fuss over it at the time. He said I have what is called quote *Demen-t-ia*. Ever heard that word? When he told me, I told everybody I had 'dispensia.' I don't know what that means, but it was wrong anyway." I had heard Mr. Davison tell this story several times in the first few months of knowing him. Each time he recounted the story, he said the word "dispensia" before he found the word "dementia."

As we walked down the hall, Mr. Davison continued to express concern about his missing hat and elaborated on his illness experience. "I never know what is going on anymore. I do suffer from quote..de..dementia. [what does that mean? I asked him.] That means I can't remember anything and I hate to admit that because I never forgot anything up until recently and

now I forget everything. Especially short-term. Everything. I could even tell you my grade 1 teacher's name, but I couldn't tell you where I went yesterday. I'm so upset that my hat disappeared...where are we going?"

As I reminded Mr. Davison about where we were going and reassured him that we would find his hat, I was struck by his insight into the alienating experience of medicalized ageing. Just as Straus (1966[1930]) explains that metaphors of the body reveal social understandings of the body, Mr. Davison's improvised word, "dispensia," captures the feeling of being dispensed with – alienated from society and from self – and conjugates it as a disease with the suffix "ia." This is what Kleinman (1988) would call an idiom of distress that reveals the anxiety Mr. Davison experienced when he received his medical diagnosis. I am certain that Mr. Davison never read João Biehl's ethnography *Vita* (2005), but his made-up word follows a similar trajectory as Catarina who created her own medicalized language to express the experience of social abandonment in a dumping ground for the mentally ill.

Medicalization, as Scheper-Hughes and Lock (1987) said, may lead to the loss of the sense of bodily integrity, wholeness, and continuity to the self and to the social world. Casting ageing and its expression as a disease of the individualized body, rather than an expression of social suffering, sets people on a path to medical care. With the body construed as a machine, the social relationships are not seen to have any bearing on the body's health and sickness. Through the medical lens, Mr. Davison's insightful term "dispensia" would thus be recast as a sign of expressive aphasia, a symptom of his brain damage, rather than as an expression of social suffering and fear of abandonment. It might also have been used as additional evidence that he belonged in long-term care where his disease could be treated.

The medicalization of ageing is part of the overproduction of disease in contemporary Western society. Later in this chapter, I will illustrate two ethnographic cases where active protest is redefined as medical symptoms of dementia, or breakdowns of the ageing body. For now, I will continue the argument that the medicalization of ageing sets older people on a journey of progressive experiences of self-alienation by reinscribing the social as personal and pathological. The next section of this chapter will look at the experience of alienation that accompanies the move into a long-term care facility.

Becoming a “Resident”

If the first alienating experience is receiving a medical diagnosis, then the second is being moved into a long-term care facility because this medical disease of ageing is regarded as a personal problem for the individual and their family, not a societal problem. Generally speaking, the medicalization of ageing has effectively downloaded responsibility of care from the state onto the private family unit through mechanisms of neoliberal logic (Clark, Mamo, Fosket, Fishman, & Shim, 2010). Long-term care facilities are medicalized spaces that provide biomedical care to the individual health care consumer. Society writ large does not take responsibility for the individual experience of ageing bodies. This falls to the health care staff who are charged with caring for the ageing body as the body is articulated through medical knowledge. Following the Cartesian tradition that separates body from mind, individual needs and considerations of the ageing experience fall beyond the body are located beyond the scope of direct physical medical care. This division generates tensions that will be discussed in subsequent chapters.

Importantly, the move into long-term care changes personhood status. One becomes a “resident.” Following Conklin and Morgan (1996), personhood in Western medicine is a

capacity-based designation ascribed by those bestowed with authority of deciding who counts and who does not. If a body performs socially sanctioned roles, it is granted value; this value can be revoked if the body becomes deviant, calling personhood into question. The body is based on fixed structural individual marks, rather than conceptualized as the product of ongoing social relations. With the diagnosis of dementia, older people are eventually deemed unable to care for themselves at home and require long-term care. The transition is made without consideration of the change in personhood that will inevitably occur through the new social relations in the long-term care space.

When people arrived at the facility, it was known that there would be a transition phase for the new resident and their family. There was a dedicated “Transition Team” of volunteers to help new residents adjust or become acclimatized to the facility. The volunteer usually met the resident at the front door when they arrived at the facility with their family. Throughout the day, the volunteer stayed with the family and the resident. When it was time to do intake paperwork, the volunteer stayed with the resident and toured them through the facility as an institutional orientation. The process of being un-made and re-made into a “resident” was rarely comfortable unless someone was already accustomed to institutional living (*i.e.*, they had come to long-term care from an assisted living facility). Both veterans and non-veterans went through transitions that were often disorienting, alienating, and frustrating, despite reassurances from staff and family.

“You’re one of the lucky ones, Dad,” said an adult daughter to her father who had just moved into the secure veterans’ unit. As the daughter walked her father from the breakfast room back to his private room, she continued, “They have lots of programming here and activities for you, so you won’t be bored or alone. A lot of people never get chosen to come here.” “Why am I

here? When can I go home?” asked her father.” “This is your home now, Dad. You will like it here. You’re a veteran and veterans take care of their own.” The father did not respond again as he followed his daughter down the hall to his room in silence.

Being a “lucky,” a “chosen one,” resulted in the same path of estrangement and unmaking. The medical diagnosis of dementia coupled with the special care promised to veterans recast the family decision to put this man in long-term care as if it was a blessing. Indeed, the daughter’s words made it sound as if it was an accomplishment to be given a room on the veterans’ unit. Perhaps this made the process less painful for the daughter, or perhaps she was attempting to console her father through a more positive articulation of the dilemma. Ultimately, both likely suffered the experience of estrangement and alienation that was made possible and was commendable by the medicalization of ageing coupled with Western society’s incapacity or unwillingness to care for ageing parents at home.

My field site can be understood as one of Goffman’s “total institutions” (1961, p. 5). It is not simply the first type of total institution, a home for the aged, that was established to care for people whom society deemed in need of supportive care. Rather, it will become increasingly clear throughout this dissertation that for residents who held the status of veteran, the facility was a hybrid with Goffman’s fourth type of institution, those established to pursue a kind of work-like task, such as army barracks. Following Goffman, it is immediately apparent that the features of the facility align with those of a total institution (outlined previously in Chapter 2). “The total institution,” Goffman says, “is a social hybrid, part residential community, part formal organization; therein lies its special sociological interest” (1961, p. 12). Indeed, the long-term care facility may be thought of as a hybrid because of its many social and political roles beyond medical care alone, and the myriad social actors and networks that operated in parallel with the

facility's biomedical care function. Moving into such a hybrid institution was a profound experience.

During my fieldwork, I noticed that the experience of transition was not a gentle matter of being between two worlds, the familiar and the strange. This displacement left the individual vulnerable, un-made in one world and waiting to be re-made in the next. "The recruit comes into the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements" (Goffman, 1961, p. 14). There is a sort of existential no-man's land at the point of transition. The experience of transition brings to mind van Gennep's (1960[1909]) concept of the rite of passage. All rites of passage or "transition" are marked by three phases: separation, margin (or threshold), and aggregation. During the separation phase, the individual is detached from the familiar social context. In the following liminal phase, the individual is conceptualized to have let go of markings of the past, while not yet taking up markings of the future. The individual is ambiguous and yet-to-be formed. In the final phase of reaggregation, the individual is formed anew with a new social status and again behaves according to sanctioned social norms.

Turner (1969) elaborated upon the intervening liminal phase by describing the attributes of people who exist in the betwixt and between. People in liminality are,

Liminal entities [who] are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial.... Their behavior is normally passive or humble; they must obey their instructors implicitly, and accept arbitrary punishment without complaint. It is as though they are being reduced or

ground down to a uniform condition to be fashioned anew.... Secular distinctions of rank and status disappear or are homogenized. (Turner, 1969, p. 359-360)

For the liminality to occur, deliberate separation takes place between the individual and their “home” society. Goffman notes that this barrier placed by the total institution between individual and wider world marks the first curtailment of self (1961). He remarks that “role dispossession” occurs when the individual can no longer assume his or her accustomed roles. This dispossession may be accompanied by a feeling of “civil death” and a deep sense of loss as the machinery of the establishment begins to shape and code the new admission into a manageable entity. Goffman (1961) noted that it is best for the establishment if cooperation can be obtained from the new recruit and if he readily accepts the role of the routinely pliant participant in the community.

Residents are stripped of their home resources, supports, and accustomed social roles, and thrust (often against their will) into a new space to which they are cajoled to adjust. Through the liminal period, the veteran-resident will begin a long process of being shaped by the institutional environment. Berger and Luckmann (1966), assert that “the process of becoming man takes place in an interrelationship with an environment.... That is, the developing human being not only interrelates with a particular natural environment, but with a specific cultural and social order, which is mediated to him by the significant others who have charge of him” (p. 48). The resident’s mode of being is molded by limits and permissions given to him through particular socio-cultural formations. In this case, the socio-cultural formation is dominantly biomedical. People are moved into long-term care by family because they are deemed to be unable to care for themselves. In the majority of cases, advanced age, frailty, degrees of dementia, and age-related decline are the primary medical conditions that land people in long-term care. These medical conditions become social conditions whereby the social is

pathologized. The social body is subsumed by the biomedical discourse and reduced to the individual biological body that is subject to regimes of care and treatment. These regimes are the machinery of the total institution that work upon the personhood of the veteran-resident.

Day Schedules and Docile Bodies

Turner (1969) describes that those who enter the liminal phase are stripped of their individuality and are symbolically leveled with other individuals. One aspect of the process of re-making people into residents of long-term care is the facility's schedule. There were multiple registers to the daily schedule, including regimented medication dosing, appointments with doctors, receiving care, meal times, and daily programmed activities.

The daily schedules (or "Day Sheets") were posted in the central part of the building and outlined recreation activities punctuated by common meal times. Across the units, the rhythm of the day was fairly consistent. Mornings were generally quiet. By 9:30 a.m. (or as soon as residents had their last sip of coffee) a staff member or volunteer was rounding up people to go to different programs on the unit or elsewhere in the facility. Aside from the barbershop and art studio, most of the morning programs were on the units. Exercise class was at 10 a.m. and often in competition with arts classes. Doctors, nurses, caregivers in training also made their house calls on the unit throughout the morning.

Meals began at slightly different times depending on the unit, but generally residents had to be back on the unit around 11:30 a.m. By 1:30 p.m., the second round up for activities was in full swing. At 2 p.m. there were activities on the units, but also concerts, card games, bingo, choir, or the pub (for a beer or ice cream), to go to in the main facility. Residents who could be taken safely off their units were porteried to activities or taken out for walks by private sitters, family, and volunteers. "Portering" is a specific duty whereby a staff member or volunteer assists

and accompanies a resident from their room to a scheduled program and from the program back to their room. The phenomenological significance of portering will be discussed in Chapter 5.

During the early afternoon, the hallways were busy with the circulation of volunteers, visitors, and tours for prospective families, donors, and government groups. Family often visited at lunch or shortly after to accompany residents to afternoon programs. The 3 p.m. shift change and debriefing of care staff (the different care staff positions and roles will be discussed in Chapter 5). The shift change affected wait times for residents by leaving them with a span of unsupervised time. The staff did not leave the unit, but they were not as evident at the substations and around the unit.

By 4 p.m., the main facility was a ghost town. There was no activity in the main halls. The cafeteria was closed and just a few care staff sat having an early supper. While the main facility was quiet, there was plenty of activity on the units as staff prepared for supper and portered residents to tables. After dinner, the unit transformed again. Residents were porter to evening programs at 6pm, reducing the number of residents walking through the unit hallway. Those who stayed on the unit were dressed in their pyjamas. Usually, they sat on the chairs in the hall at the nursing station watching the television, alongside the PSW who was doing computer work. For many residents, 8:30 p.m. was the time they were helped into bed by care staff. Some residents stayed up late because that was their routine. By 9 p.m., most residents were in bed.

Transitioning from life at home to life in long-term care changed people's experience of themselves and others in the world. For each person, it meant leaving the familiar and integrating into the strange, adopting the identity of resident, and acting and being acted upon accordingly. When I began fieldwork, staff spoke of the "care effect" when a resident began to lose their voice a few months after living at the facility. The "care effect" referred to the impact of using

the voice exponentially more than when the resident was living at home. Now that they were in care, their response to questions was solicited countless times a day. In addition to answering routine questions, they were also brought to sing-alongs and encouraged to sing, which some had not done in many years. The vocal cords had changed with age and lack of use, and the sudden overuse of the voice left some new residents with a case of laryngitis. One could say that this was a sign of the profound nature of the transition process and the impact it has on people's bodies.

Another change for some new residents was the insistence on getting dressed, or being dressed, in the morning before breakfast. There was a firm rule that pyjamas (even the shirt with regular pants), not be worn throughout the day or to programs. Night clothes were worn only after dinner, preferably after attending evening programs. There was only one time during my fieldwork where I saw residents in hospital gowns during the day. A new veteran-resident had moved in and brought scabies in with their clothing. For a few weeks, to control the infestation, the personal clothes and bedding from all the other residents-veterans on the unit had to be sent out for industrial cleaning. Individual grooming was encouraged and appointments were made with the in-house barber or hairdresser as required.

All residents were encouraged to wear their watches, rings, and personal adornments. Added to the residents' dress was a plastic identification bracelet to be worn at all times. The identification bracelet had the residents' name, unit, room number, and a series of colour-coded dots that symbolized an individual medical profile (*e.g.*, an orange dot meant someone was aggressive, a green dot meant they were at risk of falling, a black dot meant that the person did not wish to be resuscitated in a case of cardiac arrest). This colour-coded medical profile was also included on the resident's name card below their room number next to their door.

Over time, residents became habituated to the imposed schedule, the volunteer porters, and the routine programming. If a resident was in a wheelchair, you could always tell they were new if they did not automatically lift their feet when they were going to be portered. Those who had been living at the facility for some time had acquired a habit of lifting their feet so that the porter could easily push the wheelchair. In a way, it was as if they had been acted upon so long by the system that they readily conceded to any request. They had become Goffman's "routinely pliant" participant in the institutional machinery. One could say they had become Foucault's (1995[1975]) "docile bodies" through repeated pressures and expectations from an environment that constructed residents as passive bodies that are acted upon by the institution.

Berger and Luckmann (1966) argue that the process of habitualization occurs when an action is repeated frequently and becomes a pattern. For example, as the volunteer porter steps behind the wheelchair, grasps the handles, and says, "Let's go to music, Mr. Cross," the resident, Mr. Cross, immediately lifts his feet without being asked to do so. For Berger and Luckmann (1966), this pattern of behaviour is indicative of institutionalization and the associated power of historicity and control of the establishment over residents' bodies. "Institutions also, by the very fact of their existence, control human conduct by setting up predefined patterns of conduct, which channel it in one direction as against the many other directions that would theoretically be possible" (Berger & Luckmann, 1966, p. 55). The resident's automatic lifting of his feet is thus indicative of the efficacy of a system of social control.

The argument can be extended to issues of power by drawing further upon Foucault's (1995[1975]) concept of the docile body. Interestingly, Foucault's analysis of the docile body drew a parallel to the body of the ideal soldier who was acted upon, transformed, and improved by a governing body that was concerned with the soldier's utility. Like the ideal soldier, the

veteran-resident's body was directed in time and space from one modular care space to another according to a schedule that was not of his own making. Though there was an element of resident-choice regarding leisure activities, meals and care work was fairly non-negotiable. The bodily comportment of long-time residents was noticeably different than new residents in terms of its internalized habits and gestures that were conducive to daily routines. As a porter, it was easier for me to transport bodies that were "pliant," but as an anthropologist, I found such moments ethically complex because they represented not an agreeable individual, but a deconstructed and reconstructed resident who had become the product of the institutional environment.

Crisis and Protracted Liminality

The transition into long-term care was not comfortable for many residents. During fieldwork, I heard that some residents were "duped" by their families into living at the residence. Sometimes families and staff reassured new residents that they were staying for only a short time, but these short-term stays never ended. Other times it was made clear that this was the new situation and the person would have to get used to it. Transitions were difficult on the family who left their loved one in the facility, and for the new resident who often felt confused and abandoned. Even when the need for advanced care was undebatable, the transition was often fraught with mixed emotions for the family, and an overwhelming feeling of dispossession for the new resident which often led to some form of crisis.

I sat with Mr. Parry, a resident on the veteran dementia unit, who was upset that he had lost some of his personal belongings. "I had a warm blanket. I lost it. I wish some of my clothes would come back. I'm missing pants too. My family says I should quit. They say they can't afford to keep getting new clothes. I started with this red, yellow, black, and this one. The yellow

sweater went missing ages ago. Two pairs of pants gone. They're summer weight, light. I use them to paint, there are paint splotches on them. I used to wear them at the cottage. They're white, they're summer. One had a wallet in it, the wallet's gone. Not possible my family took it home for summer. They would have asked, they would have told me. There's no money in the wallet to steal. I haven't got a nickel." I listened to him and commiserated as best I could, offering to check with the staff to see if the sweater and pants were in the laundry, reassuring him that we would locate his wallet, and reminding him that labels were put in clothes when people came to live at the facility and surely his missing items would come back to him. Mr. Parry continued, "I think I told you, I came in feet first, unconscious. Two or three days later, I found myself in a bed. I didn't care. I just did as I was told."

Mr. Parry's story tells us several things. It provides an account of someone who did not willingly enter the long-term care residence and had to negotiate his new reality. His story reveals the nature of being acted upon and being powerless in his own life. Finally, through a story of lost objects, he points to the experience of loss inherent to the transition into long-term care. Mr. Parry's items were not lost, nor had they been stolen. They were either in the laundry or with his family because they turned up over the weeks to come. The alienation from self that Mr. Parry experienced with his very quick separation from family and sudden liminality may have manifested as a narrative of material loss. The dispossession of self was translated to the perceived loss of his material belongings through an act of theft, or violation.

Turner (1969) reminds us that the liminal phase is marked by a stripping away, materially, symbolically, and ontologically.⁴ He said, "it is as though they are being reduced or

⁴ In Turner's (1964) later work, he extended van Gennep's (1960[1909]) work on liminality to include the concept of the "liminoid" (Spiegel, 2011). Where the liminal was intended to speak to "tribal and early agrarian societies" in which rites of passage had society-wide significance,

ground down to a uniform condition to be fashioned anew..." (p. 359). The un-making and re-making that characterized the transition was a different experience for each resident. An individual's response to entering long-term care varied depending on their age, health condition, or the place they had moved from (people who had been at home with family often had a more difficult experience than those who had come from another assisted living community). Staff had to improvise responses to each new resident within the institutional structure. There was not a predictable set of responses, nor was there an established, guaranteed set of procedures for facilitating the transition. Navigating the change in social status was a challenge for those directly involved in the care of the newcomer.

Some new residents struggled with wanting to go home and not being able to leave the facility. Repeated pleas to go home were whispered and shouted in the halls to little avail. This was usually how new residents became known to visitors. Staff tried to calm anxious residents by reassuring them that their family knew where to find them, phoning a family member so the resident could connect with them, re-directing their attention to familiar photographs or belongings in their room, or playing music to soothe them. These were some of the most morally trying experiences during my fieldwork. It felt wrong to sidestep residents' questions about how they could get home or if anyone knew when they could go home to their family.

I recall one resident, Mr. Samuel, an 88-year-old army veteran, whose daughter came up from her home in another country and stayed a month to help her father adjust to the long-term care environment. Family can help ease the transition, but the daughter made a critical error with her father: she took her father out of the facility for the whole day every day she was there. To

the liminoid was introduced to describe comparable experiences in post-enlightenment societies. Although this research was conducted in a post-enlightenment society, the term "liminal" is more meaningful in relation to the ethnographic material and will be used throughout the dissertation.

Mr. Samuel, the accommodations seemed temporary and not entirely out of the ordinary since he was leaving with his daughter every day. Eventually, his daughter had to fly home and Mr. Samuel did not understand why he had to stay on the unit. His expressions became anxious and agitated. Staff said that he was having “a hard time adjusting.” I was tasked with inviting him to choir one day, but was advised against taking him off the unit by a nurse because she expected I would have a difficult time getting him to return. Mr. Samuel became a resident at risk of elopement and was given a movement surveillance device to wear that locked the unit door when he approached.

A similar situation happened a year or so later with a new resident whose daughter was deemed by staff to be overly involved in her father’s life. From the time the new resident arrived, the daughter visited every day. The visit was described by staff as anxiety-filled for both father and daughter because the daughter actively sought out one staff member after another to ask questions, make requests, insist on certain measures being taken immediately for her father’s care. While this may have seemed like good caretaking to an outside observer, staff found it to be overbearing and an interference with the new resident’s transition. The constant pestering also created tension among the staff as fingers began to get pointed at one another. Staff began to ask the daughter to let the father attend programs on her own to reduce the father’s anxiety. Later on, it came out that at the first care plan meeting about a month into the father’s stay, the daughter was asked to take a step back and reduce her involvement for a while so that the father would have time and space to adjust to the new environment. Staff said that settling in and forging new bonds with the staff took residents about six months. With the average stay being about 100 days, it should be noted that residents do not always survive the transition phase because they have arrived in an already fragile condition. The daughter’s presence prolonged and complicated

the separation phase for the new resident. This was a social problem of sorts, not a medical problem. The prolonged lack of separation frustrated staff and created tension around the residents. The residents also became highly anxious in this protracted tension between social worlds. Incidents of agitation, aggression, and exit-seeking were common expressions of discontent which staff then documented in the form of “progress notes” on electronic health records. The documenting of these incidents as “behaviours” or symptoms of a condition recast the social problem as a medical problem. The behaviour was subsequently addressed by nursing staff according to their practices (documentation will be discussed further in Chapter 5).

Residents’ memory loss also made the transition experience more difficult because they continuously lost ground. During my fieldwork, I saw residents living with dementia experience incredible frustration and confusion regarding where they lived. Memory loss complicated the “transition” process, particularly when residents forgot the earlier separation and liminal phase. Suddenly, they were caught between the old and the new self, between an existential rock and hard place. One afternoon, the jazz band members were invited to watch the creative arts staff rehearse for an upcoming Hallowe’en concert performance of selections from the Broadway show, *Mary Poppins*. The band loved listening to familiar songs sung and acted out by the five staff members who were each dressed as their respective character: the lead male chimney sweep (“Bert”), Mary Poppins, The Bird Woman, Mrs. Banks, and an extra chimney sweep. The ensemble was cohesive and lively, engaging the residents completely as the staff rehearsed their parts.

When the rehearsal was finished, a volunteer and I took Mr. Parry back to his room for dinner. We chatted about how much fun the staff had rehearsing for the upcoming show and how they each had assumed an almost familial role in the cast of characters. Mr. Parry said he

enjoyed watching the rehearsal. However, this opportunity seemed to change something in Mr. Parry's reality. As we approached his room (just as we had done for at least a year), he demanded to know where we were going. "It's late and I have to get home to my family. It's dinner time and I'm supposed to be with my family," he said. The volunteer and I exchanged nervous glances. Showing Mr. Parry the familiar belongings in his room did not seem to help the situation. He became confused about why his belongings were in a place he did not recognize. Things continued to deteriorate from there. It was as if the rehearsal of familiar music that Mr. Parry had perhaps seen or sung with his family had brought the past to the fore, obfuscating the present. A sense of order that had been achieved was thrown into chaos and disorder as another iteration of the liminal phase set in. Mr. Parry's experience was fundamentally a social problem, where the tension between home and institution became painfully apparent and he lost his social bearings. He found himself stripped of his usual social supports and his social role. "Being home for dinner" became the narrative device by which Mr. Parry tried to reclaim a sense of social order for himself.

This section has illustrated the tensions inherent to the transition into long-term care. Medicalizing discourses and routines act upon individuals, separating them from their past habits and integrating them into the collective body of the total institution. The experience of un-making and re-making is marked by feelings of self-alienation, dispossession, and estrangement that often result in an expression of personal crisis (*e.g.*, attempts to elope from the unit, concerns about the theft of personal belongings, and anxiety about missing family events). If the transition process is "successful", new residents become docile bodies that internalize new habits and become accustomed to the new group routines. The following section will briefly discuss how

some people integrated into the collective of veteran-residents and located their social position on the unit relative to their peers.

Back to the Barracks: Living Together as Veteran-Residents

Veteran-residents occupied a hybrid category in the long-term care facility. Coming into a care space that was largely subsidized by the government meant that veterans received a different level and kind of attention than non-veteran residents. The presence of the veteran-residents and the influence of the government created an environment that may be considered a hybrid total institution. Veteran-residents, in particular, had the option of being actively involved and productive, particularly through work in the creative arts studio and arts programming. Thus, they were not merely confined as medical subjects, they were engaged in myriad forms of work. The facility stood apart from other long-term care facilities in the country because of the veteran-residents, the government funding that supported numerous programs and initiatives, and the media attention. To become a veteran-resident at this facility was to take on a hybrid identity of medicalized subject *qua* resident and living legend or symbol of nationalism *qua* veteran. Men and women who had arrived thinking they had been sent to a typical long-term care facility found that it was exactly the opposite for those with veteran status.

That said, veteran-residents still went through a transition phase, but they did so in a different way than residents who were not veterans. Although veteran-residents shared a common identity as members of service groups (air force, army, or navy), the use of particular service terms (*e.g.*, WWII, the Korean War, and so on), it did not make the transition any less difficult for some people. If one's primary social role before long-term care had nothing to do with being in the service, part of the transition was taking on a new identity as a veteran-resident in long-term care. One had to be stripped of past social roles and rebuilt as a veteran who was

being cared for by the government in fulfillment of the social contract. With few exceptions, being a veteran-resident was a levelled identity within which there were only a few instances of overt social order.

Veterans of all different ranks and service tenures lived on the units, but they did not necessarily know this about one another. In terms of accommodations, residents were not ordered or formally given preferential treatment based on former rank. During my fieldwork, there were only few ways to find out a resident's rank: to see and interpret their displayed memorabilia and medals, hear it from the resident, or learn about it from another caregiver. Apart from special occasions (*e.g.*, Legion day trips, Remembrance Day, and other official events), most residents did not wear their uniforms or medals on an everyday basis. In a few cases, a resident wore the blue fleece Legion vest, the green beret if they served in Korea, or occasionally attached a poppy on their clothing or walker. Other residents who were highly placed in the service were known to staff by particularities in their behaviour. One high-ranking officer who lived with dementia was known for his fastidious housekeeping habits. Every day he straightened his bedsheets, folded his towels, and laid them out on his bed in an orderly fashion. Staff attributed the habit to his life in the service. High rank in the service did not afford residents obvious special treatment or unique status among the other residents or staff on the units. Toward the end of my fieldwork, another high-ranking officer moved onto the veterans' dementia unit. I heard him addressed by one of the Legion representatives as "General," but assumed this was a colloquial term between men who had served in the war. It was not until I was on his unit one day that I said hello to him in a rather casual way and the nurse nearby told me that he wanted everyone to call him "General" when they spoke to him. He was one of the few residents I had ever heard request such salutation.

For the most part, veteran-residents were only somewhat aware of one another as veterans. Residents without dementia were generally more aware than those with dementia of other residents as veterans, but not exclusively. One evening, I was sitting and chatting with a few residents on one of the veteran dementia units. Among them was Mr. Edwards, a former army veteran from the Canadian West Coast. I had met him briefly earlier in the week and had sung the song “Springtime in the Rockies” with him and a music therapy student. Turning to Mr. Edwards, I said, “You haven’t been here that long, you’re new.” Mr. Edwards replied, “I am new. Just a month or so.” I continued, “How do you find it so far here?” He said, “It’s okay. I got no kicks. I spent the last few years of my life in the army, in a million barracks. It gets you used to almost anything.” As we continued talking, the loud call bells overhead started to ring. “There’s a lot of noise here,” I said to him. “It doesn’t bother me,” said Mr. Edwards, “because I was in the army and when you go into an army barracks, there is no silence. No silence. It can be noisy. The language is never very clean, as you might say. I enjoyed the army life.” I asked him how many men there would be to a barrack. “Maybe 30 guys in an army barrack,” Mr. Edwards said, “then you get the call that you had to go out on parade, everybody is running out the door at the same time [laughing]. What the heck is that noise, you’d ask. Well, it was the bugler who got out and walks up and down between our huts blowing reveille. He got plenty tossed at him [laughing].” As a relative newcomer to the space, Mr. Edwards’s early impression of the unit shows a readiness to liken the experience of living among other men to his time in the barracks.

On another spring evening, I was visiting the unit and found Mr. Parry in his usual spot. Mr. Parry was a navy veteran who had worked on the convoy escort ships that protected supplies that crossed the Atlantic. He sat in an overstuffed recliner located in a corner area where he had a television he could watch by himself. This evening, baseball was on the television. I sat down on

the couch next to him and smiled saying, “Hey, Mr. Parry.” “Toronto is losing...” He announced. “I’m doing this because I have nothing better to do. I’m watching this because there’s nothing else to watch. I’m not a baseball fan, but you know, there’s no hockey tonight.” He turned to me and looked down at the violin I held in my hand. “Have you been playing somewhere with your fiddle? Just entertaining us tenants? We can call them many things. That’s the most charitable thing.” I took the opportunity to remind him that everyone who lived on the floor was a veteran and had served in either the army, navy, or air force. Mr. Parry said, “Well, the war was on, what else was there to do? I was 17 when I joined up. That’s what you did. All your friends were joining up and their fathers were joining up. My dad is a World War I veteran. My parents were very upset when I joined up. They did everything to talk me out of it. Living in the barracks with a bunch of other men. Some of them were real troublemakers. That’s what you get. I just wanted to help in the war. At that age you’re pretty stupid. I think of all the things I wouldn’t have done.”

The game that was playing on the television caught his attention for a moment, pausing our conversation. When the game cut to a commercial break he continued, “The war was on. Everything was crowded and unsanitary. You had an awful mix of residents. They didn’t all go to Sunday school. A very mixed crowd and it never bothered me. I just didn’t get involved with them. They could find enough of their own type. And I was well brought up as the saying goes, and I knew what was good and what was bad and what to do and what not to do. I hadn’t discovered women at that point. I hadn’t.”

I asked him, what was it like to live on a corvette in the navy? “You didn’t know what a bed was,” he said. “A hammock. You hung it up and they used a pipe and hoisted yourself in, which you had trouble doing. So, I got stronger. You weren’t allowed to cheat. I could have

gotten a box to stand on. You had to jump and swing your legs and rear end over and let yourself plop. And you drop in." Empathizing, I said, "You must have been exhausted at the end of the day." Mr. Parry replied, "Well yes, the end of the day. But it was expected of you. You don't just say, 'I can't do that.' They just wouldn't accept that. You just did it. That's how we won the war."

Just then another resident in a wheelchair came into view, wheeling toward us and calling out something that was not quite discernable. "Private?" Mr. Parry called to him. "He's not with us at all. Most of them are not. They don't know who they are. I feel sorry for them I really do. You can't have a conversation with them. They don't know what you are talking about, whatever it is." Suddenly, Mr. Parry asked me, "Am I a good communicator?" I laughed at the question having just listened to quite a long story and said, "You're fine." The other resident moved on, and Mr. Parry continued, "We were on a corvette for a couple years. Learned a lot you wouldn't learn in Sunday school. All the guys on the floor were in the service. Someone told me that. I'm not sure that's a plus or minus. Lots of guys joined the service and didn't do anything. Just sat in the barracks. They wanted to get away from the home life. They were well-fed. I was just a teenager, so it didn't matter to me."

In both Mr. Edwards's and Mr. Parry's case, they remarked on the feeling of living once again in "the barracks." Over their respective lives at the facility, Mr. Edwards had a much easier time getting along with the other men than Mr. Parry did. They represent two styles of approaching others: Mr. Edwards was more laid back and took things in stride, while Mr. Parry tended to be more critical of others which I came to learn mirrored a self-critical and self-deprecating disposition. Both men expressed a passivity that Turner (1969) said was characteristic of people in the liminal phase. As the men had integrated into the institutionalized

social structure, they had adhered to new social norms and accepted the actions of medicalized routines upon them. Their accounts did not reflect a sense of community. One might expect a more immediate camaraderie among the veterans, especially since they were all suffering a displacement from their homes into long-term care; however, this was not always the case. In fact, it makes sense that it would not be the case. According to Turner (1969), liminality is marked by anti-structure, or an inversion of the normal social structure that governs social interactions. The previous social structure that would have organized their behaviour and familiarity toward one another was not present in this new medicalized space.

Later in my fieldwork, I was chatting with Mr. Coates, a 90-year old army veteran, about how veterans relate to the long-term care space and to one another on account of being veterans. Choir rehearsal had been cancelled that Tuesday afternoon and Mr. Coates had come to the pub for a glass of red wine and a bit of conversation with the volunteer bartender. Recognizing me from the music groups we both played in, he waved me over to join. Sitting in the dimly lit air-conditioned pub with his small glass of red wine, we chatted about weekend plans and the goings-on of the facility. Mr. Coates explained that he had been to three other “nursing homes” before this one. He liked this one the best for the music and the volunteers. He also loved spending time in the gardens where he had never seen the white balls of a hydrangea grow so big. He said that he had tried to get his sister to move into one of the first nursing homes he was in, but that she didn’t like the semi-private rooms. He said, “I didn’t mind. It’s like here. We have our own rooms, but you’re around other people all the time. It’s like being in the service. You get used to living with other people. You just don’t have a choice about the matter.” This reflection on how life in the service had prepared him in a way for living in long-term care echoed the statements from Mr. Parry and Mr. Edwards.

Each person who transitioned into long-term care living had to make sense of their social position relative to other veteran-residents. The staff at the facility wanted the new residents to transition cooperatively from their social role in their home environment to their new social role as veteran-residents. The process of being un-made and re-made required that people be acted upon by the institution. While some people seemed to accept this process, other residents created their own way to act against the institution. In the following section, expressions of resistance among veteran-residents will be explored as ways in which agency was performatively reclaimed.

Reclaiming Agency

Performative Struggles for Recognition through Idioms of Resistance

In the long-term care setting there is a constant struggle for appearance and recognition that takes place against the re-making forces of long-term care. Following Butler and Athanasiou (2013), the self is not created from scratch, but has been undone and re-done through “self-authoring” and “self-authorizing” performances (2013, p. 65). For example, the performative use of “I” and “My self” are examples of self-authorizing statements. The recognizable self, or the livable life, is performatively recast into a self-poeitics that responds to the questions “Who are you,” and “What are you?” (p. 65). Adding to this, Jackson (2013) writes, “As for most of us, the struggle for being plays out in small ways, in everyday life, as a matter of gaining a slight edge over the forces that threaten to deplete, disparage, and degrade. Life is never a secure possession. Life is lived...between a rock and a hard place, between the devil and the deep blue sea” (p. 225). In long-term care, people had become residents through a process of un-making and making, in more or less coherent stages of van Gennep’s (1960[1909]) separation, liminality, and reintegration. After days, months, and years of being acted upon, alienated, and dispossessed,

residents found ways to resist and reclaim or re-possess their sense of self. As will be discussed further in Chapter 7, while veteran-residents received far more visibility and recognition than non-veteran residents from the institution, government officials, and the media, it was not necessarily recognition for an identity of their own authoring.

During fieldwork it seemed as though every unit had one resident who was particularly vocal. Sometimes it was a positive and supportive presence where the resident was very talkative and tried to make conversation with other residents and staff. For example, Mr. Nicholson was known as the “unofficial mayor” of the facility. As a recreation therapist said, “He is like a politician, kissing women and babies and shaking everyone’s hand.” Though he lived with memory loss caused by dementia, Mr. Nicholson was a friendly social presence, greeting people with a smile, a handshake, and a pithy remark wherever he went.

Other times, the resident was vocal in a negative and disruptive way that upset other residents and put staff on edge. Responding empathetically to residents who yelled, swore, and became violent was a challenge. Recalling Mr. Saunders’ story (Chapter 3), he could be heard yelling from his wheelchair in his room or in the hallways, often with expletives that residents, staff, and visitors found offensive. Other residents had little tolerance for the yelling and either ignored Mr. Saunders or hollered back at him to be quiet. Interestingly, after he passed away, the unit felt somehow empty.

Residents took up space in different ways. Some did it vocally through greetings, singing, or loud yelling, while others claimed more physical space for themselves. For example, Mr. Parry claimed the television nook in one of the corners of the unit as his own. He had a lazy boy recliner and a remote. He could be found there almost every evening. Mr. Green occupied the right side of the couch at the substation, where he could talk to people who passed by and watch

the television. Mr. Singer made it his business to announce the opening of the doors for dinner to the other men, usually with a very commanding tone. Each person had a way of re-possessing the social space for himself. The following accounts illustrate two examples of this repossession.

“This is my House”

On both veteran dementia units, tensions arose between one resident and a group regarding ownership over the space. Two particular incidents from fieldwork stand out. The first took place on a January evening on the secure dementia veteran unit. I was assisting the music therapist gather residents into a group for a small sing-along at the nursing substation. The substation was a social space with chairs, a couch, a television, and an electric fireplace. It was a home-like space where residents could gather and the PSW could do charting on a small mobile laptop station. In the evenings, these spaces became locations for small group music programs (the “kitchen party” will be discussed in a later chapter).

As I walked down the hallway, the men began to stir and engage with me and the music therapist. The relatively quiet hallway was starting to buzz with activity in anticipation of the music. “Salut, ma belle,” said Mr. Auclair, an army veteran, in his French accent. “How are you, Roger?” I asked. “And how are you, my dear?” “I’m well,” I said, “Let’s go for some music.” “Well, okay, if you want to go, I will come with you,” Mr. Auclair said. In the background, Mr. Windsor, an air force veteran, rolled his wheelchair up to the music therapist and began reciting the words to the song, “Home on the Range.” Mr. Windsor was known for his poetry. Though he lived with dementia, he maintained a remarkable facility with language. The lyrics to *Home on the Range* were particularly meaningful for him because he was from the Canadian Prairies and related to the feeling of open plains and skies. The energy in the space increased. Over Mr. Windsor’s continued sung-spoken lyrics, care staff directed residents who emerged from their

rooms to sit down near us, residents passing through tried to find space through the gathering group, fragmented pleasantries between residents could be heard, and movement swelled until everyone was settled in a place.

“All ready...” sang the music therapist, strumming the guitar and drawing everyone’s focus to centre on her. “I’ve got a lovely bunch of coconuts,” she continued singing. Within a few words, the residents joined in. Some singing along with the music therapist, others a little slower or faster than her music. “Well done. We’re all set for the night. We can go to sleep now,” said one resident. “We are,” said the music therapist, quickly going into a favourite legion song, “Hail, Hail, the Gang’s All Here.” Just as before, the men joined her, singing along for the most part.

Not long into the activity, the resident who lived in the room adjacent to the substation opened his door. Standing in his pyjamas and slippers, he looked as though he had been winding down for the evening and was not sure he liked what was happening outside his door. “I hope we aren’t bothering you, Mr. Payne,” said the music therapist. “No no no no no,” he said. “Go ahead,” said a resident, urging the music therapist to continue playing. Mr. Payne closed his door again, retreating. Picking up where the group began, the music therapist played *Home on the Range*. Residents sang the lyrics or sang vowels. Making a quick segue, the music therapist said, “Ain’t She Sweet.” A resident to the side began reciting the lyrics. Everyone joined in with the music and the song continued. The goal was resident engagement, so the addition of incorrect lyrics and creative vowel sounds did not interfere with the music-making.

The mixed group of singers did, however, seem to interfere with Mr. Payne’s evening routine. Just as the group crooned the songs “Roamin’ in the Gloamin’” and “I Belong to Glasgow,” in honour of Robbie Burns day, Mr. Payne emerged again from his room. “When is

this party over?" One of the residents seemed to respond to his question with a verse of his own lyrics to a song. This seemed to increase Mr. Payne's irritation with the sound. "When is this party over?" He repeated. The music therapist asked, "Would you like us to be quiet now?" "I would like it to be *finished* now," he said. "We will sing one more song and we are done," said the music therapist. "Absolutely not," said Mr. Payne, "I'll let you in on a little secret, this is done." The poetic resident said to him, "You must understand old boy, this is British. Rule Britannia." The situation escalated when Mr. Payne told the resident, "Shut up." The resident laughed at Mr. Payne. "Who are you?" asked Mr. Windsor. "I own this place!" shouted Mr. Payne, "So you shut your big mouth!" "I am a Canuck," stated Mr. Windsor. "Oh God," sighed Mr. Payne." The music therapist interjected and said gently that the group was almost done. "I don't want it to be almost done, I want it to be done," Mr. Payne said. "Can we sing goodbye?" asked the music therapist. "Sing goodbye, now!" Mr. Payne shouted, followed by a series of expletives under his breath.

"I'm Not Invited in My Own Home"

Another winter evening, I was visiting a resident on the upstairs veteran dementia unit to play Christmas carols with him. While I was walking down the hallway, I found Mr. Parry at the substation where a few residents were also sitting. We chatted a bit and he told me there was something wrong with the piano in his room. I offered to come and see if I could fix it for him. From down the hall, Mr. Thornhill, another army veteran, approached us with his walker. He was in a confused and agitated state. "Can I go this way? I can't go this way? I can't pass through," he said. The PSW tried to guide him to sit down on a nearby chair. As he sat down, he overheard me saying I would come by Mr. Parry's room to check the piano in a few minutes. "Do you know each other?" Mr. Thornhill asked us. "Yes," I said, "We play in a resident band together.

We've known each other a long time now." "For a long time," Mr. Parry emphasized to Mr. Thornhill. Mr. Thornhill said, "Oh for a long time?" He started to get up from his chair. "Where are you going?" asked Mr. Parry. "I'm coming with you," said Mr. Thornhill. "No, you're not," said Mr. Parry. "Why not," asked Mr. Thornhill. "Because you're not invited!" yelled Mr. Parry.

A PSW appeared from down the hall encouraging Mr. Thornhill to sit down again, "You're really making me work tonight, guys," she said. Mr. Parry and Mr. Thornhill began talking over each other: "He's telling me I'm not invited." "You're not invited." "He's saying I'm not invited in my own home." At first, a nearby private sitter who was with another resident addressed Mr. Thornhill, "This isn't your house. This is everyone's space. Everyone who lives here pays to be here and shares this space. Your room is your personal space, but this space is shared." Mr. Thornhill looked a bit shocked, but continued yelling. Then the PSW tried to defuse the situation, saying "You're not invited to *his* home, you're invited to *my* home. Let's go." Mr. Parry and I continued down the hall, away from Mr. Thornhill who was still audibly upset.

Re-possessing Selfhood

In the above accounts, both men's frustration with being recognized as authorities in the space is evident. The men expressed individual and social discontent. If this had occurred in a non-Western setting with a socio-centric approach to illness and the body, then their outbursts would not have been pathologized as disease symptoms or a breakdown in the body. Both Mr. Payne's and Mr. Thornhill's expression were likely documented as a "behaviour" report by the care staff because the men's behaviour and language were aggressive in tone and could have led to physical violence against other people. Following Scheper-Hughes and Lock (1987), if we had traditional cultural idioms for expressing social discontent, the men might have instead made claims that witchcraft, magic, or sorcery were at work. Instead, both men used "home" to define

personal and social boundaries. In Western culture, the home is meaningful as a private space over which the proprietor (often the male) has control. In the context of long-term care, expressions of wanting to return home and defining collective spaces as one's own home may not be a pathological symptom at all, rather an expression of wanting to reclaim one's sense of self.

Goffman (1961) explains that the process of transition into a total institution is marked by "mortification" of the self. The new recruit is not only stripped of his previous supports, and social roles, he is also stripped of any adult executive competency and any symbols pertaining to self-determination and independence. Goffman notes that use of speech is an important way in which people express personal (in)efficacy: "One implication of using words to convey decisions about action is that the recipient of an order is seen as capable of receiving a message and acting under his own power to complete the suggestion or command. Executing the act himself, he can sustain some vestige of the notion that he is self-determining. Responding to the question in his own words, he can sustain the notion that he is somebody to be considered, however slightly" (1961, p. 45).

Veteran-residents' choice of speech is a way in which they can reclaim, or feel as though they are reclaiming, some command over their world. The biomedical lens interprets such expressions as pathological symptoms, whereby staff attend not to the meaning behind the speech, just the expression itself. Anthropologically, we can understand these events as moments of self-authoring and appeals for agency and recognition in response to an assault on the self. Butler and Athanasiou (2013) write,

...when the 'self' (and we know that the self is always in relational sociality and affectability) who struggles for recognition and self-recognition has been violently

misrecognized, constituted as radically or uncannily unfamiliar by a recognizable self-same human, then the economy of recognition gets potentially and provisionally destabilized. The unintelligible and uneconomic self (emerging in conditions of alienation/dispossession, rather than in conditions of plenitude/possession and through matrices of belonging and co-belonging) is not an absolute occasion of miraculous, alter-ontological identity, reducible to regulatory discourse of tolerable and inclusive recognition, but rather a contingent rupture in proper iterability, a possibility opened by a failure to repeat properly, whereby the sovereign position of the (self-)knowing self is dislocated by a call of responsiveness and response-ability. (pp. 65-66)

The events were ruptures in the normative fabric where the two men refused to be acted upon by others. In an environment of dispossession, they responded through self-authoring and self-authorizing expressions. The trope of “my house” is symbolic of self-determination, autonomy, and freedom of action for the veteran-residents described above. It is a way in which, as Goffman (1961) says, these men have found “different personal lines of adaptation at different phases” in response to the deconstruction and reconstruction of their past identities (p. 61). Furthermore, it is an interesting symbolic choice because it throws into sharp relief the tension between home world and new institutional world that, as Goffman argued, the total institution tries to smooth out in its management of its residents.

In the first account, the situation was escalated by another resident who refused to recognize Mr. Payne’s claim to authority. It was only defused by the music therapist who conceded to his demands and validated the social position he was trying to establish for himself. In the second account, the situation was somewhat defused by a nearby private sitter and PSW who spoke directly to Mr. Thornhill, reasoning with him that it was not his home. This logic did

resonate with Mr. Thornhill who lived with advanced dementia. The situation ended when I walked away with Mr. Parry and the PSW re-directed Mr. Thornhill back to his room. When these events are interpreted as appeals for recognition and self-authoring in a space where control is relinquished to nursing staff, it is difficult to categorize the men's expressions as pathological or symptomatic behaviours. The expressions could be said to illustrate that the pathological is simply a deviation from the social norm. However, in both cases, the outbursts likely were documented in their resident charts' progress notes as "behaviours," rather than as expressions of reclaiming a sense of autonomy and selfhood in that environment. Though I do not know for certain that these were documented, I had seen many similar instances documented in this way. This illustrates the totalizing power of medicalization at the institution that re-interpreted expressions of social suffering and attempts to exercise agency as medical problems that required documentation and follow-up.

The language of symptom and disease was common among direct care staff. It was so present in the environment that residents even adopted the language and used it to describe other residents, either as a way to express empathy for another person or as a way to create social distance between themselves and another resident. During my fieldwork, I encountered residents who looked critically at other residents who did not or could not comply with the sanctioned way of behaving. Interestingly, these "model residents" had also been subjected to the alienating effect of the medical gaze and surely also experienced its dehumanizing impact. The following story illustrates this point.

One afternoon, I visited Mr. Graves with another staff member to return some borrowed music. As we sat with him in his room, he told us lots of stories about his life. He was the type of resident you could easily spend hours visiting. Between our conversation, the robotic pet cat

“Betsy” purred and meowed next to us. “She’s really good company, you know? Sometimes when I’m watching television, I’ll say, ‘Do you like that program?’ and she’ll go ‘Meoww.’ You’d think she knows what the hell I’m saying.” He liked the cat as a pet. He told us about his three dogs and how they met their eventual deaths. Mr. Graves paused before saying, “You know, that’s what I miss here. There aren’t too many you can talk to that has a brain. I’m having trouble here right now. I was down in the mess hall down there and Joe is a mental case. His table was close to mine and he would get to the table first and cough and get a mouthful of spit and take the bib from someone else’s place and spit in it and roll it up and put it back there again. As far as I’m concerned, this place is not run right. There are enough of those people to fill a wing and they should be kept by themselves.” He also expressed very strong views about other residents and that they should be kept far away from where he lived.

He had several accounts of incidents with other residents. “One day,” he said, “I went in and he was sitting in my place in his wheelchair. I went in and pushed him away from the table. The staff said, ‘you can’t do that.’ I said back to them, ‘I just did.’ So, they posted me up to this dining room and there’s a crazy guy here doing what he wants. They have this guy who’s a pain in the ass. He shouldn’t be there.” At that point, the staff member who accompanied me tried to explain to Mr. Graves that the man he dislikes is human “just like us” and deserves to be treated with respect. “Yes, well, sure,” said Mr. Graves “but they aren’t 100% human because they have lost their minds. I bet there are enough to fill a whole wing of those types of people. A nurse said to me that you’ll find that type of people in every dining room in the home. So, now I’m in the process of trying to get out of here.”

Mr. Graves’s account reveals an illness experience of self-alienation and dispossession. His life history included stories about his estranged wife who tricked him into entering long-term

care, a first love who got away, a family that did not care about him anymore, and a series of detailed stories about the timely deaths of his beloved dogs. Like many residents who were not under lock and key, Mr. Graves said he felt like a prisoner at the facility. This feeling of restriction and limited movement frustrated him and worsened when his motorized scooter was taken away from him.

He embodied the dispossessed. It is difficult to say that Mr. Graves's suffering and frustration was a pathological symptom of depression and mild cognitive impairment. His illness experience is more characteristic of the feeling of social death in what Biehl (2005) would call a zone of social abandonment. Biehl explains, "In this bureaucratically and relationally sanctioned register of social death, the human, the mental, and the chemical are complicit: their entanglement expresses a common sense that authorizes the lives of some while disallowing the lives of others" (2005, p. 20). Building upon this, Butler's (2015) questions can be added: "Which humans count as the human? Which humans are eligible for recognition within the sphere of appearance, and which are not? What norms operate to distinguish among those who can be recognized as human and those who cannot?" (p. 36). From Mr. Graves's account, his reaction toward other residents can be interpreted as a complex way of resisting medicalization, by medicalizing fellow residents. If he diagnoses them as the care staff do, then he is not also one of them. Instead of pathological or symptomatic behaviour, Mr. Graves's intention to recognize other residents as not-human was an appeal to be recognized as more than a resident being acted upon by the facility. From a marginalized position, Mr. Graves was marginalizing others. He created distance between himself and other residents, thus reclaiming his own humanity.

Despite distancing himself from other residents, Mr. Graves still embodied the role of the resident: participating in the common schedule, wearing an identification bracelet, receiving care

and scheduled medication, and so on. Perhaps another form of resistance can be found in his room. Unlike most rooms that were sparsely decorated and had only a few sentimental objects, his room was over-crowded with boxes, furniture, knickknacks, and other personal belongings. He held onto everything he had. Early on in fieldwork, I had borrowed a piece of music from him when he insisted I take it. Against my better judgment I did and though I returned it, somehow it was lost shortly afterwards. For months, I did not hear the end of it. Eventually, I purchased a replacement copy online and gave it back to him. Our rapport improved after this gesture. Every item mattered to Mr. Graves when he had so much already taken from him. In reclaiming material things, social space, and authority over others, he tried to reclaim what had been alienated from him through the process of biomedicalization.

Conclusion

This chapter illustrated that life in a long-term care facility is not a secure possession, and that there is an ongoing battle for the repossession of selfhood. Both the self and the other made their appearance in the space between actors in the context of a medicalized setting that routinely acted upon and dispossessed people of their agency and selfhood, only to impose an alternative selfhood upon people. Specifically, this chapter introduced the undercurrent tension of acting and being acted upon in long-term care. The ethnographic accounts above explained the ways in which people living in long-term care came to feel dispossessed, and had to, between one another, find ways to repossess a selfhood. This led to interpersonal conflict between residents and care staff, and particularly, among residents. Residents were stuck in dilemmas of alienation, dispossession, and re-possession that stemmed from the fundamental biomedical understanding of the body and the medicalization of ageing. Butler (2015) explained:

To be radically deprived of recognition threatens the very possibility of existing and persisting. If we cannot find our way within the norms of [identity] assigned to us, or can

only find our way with great difficulty, we are exposed to what it means to be at the limits of recognisability: this situation can be terrible and exhilarating. To exist at such a limit means that the very viability of one's life is called into question, what we might call the social ontological conditions of one's persistence. It also means that we can be at the threshold of developing the terms that allow us to live. (p. 40)

In the context of long-term care, recognition was equivalent to life. When one failed to recognize oneself or failed to be recognized by others, one was pushed to the margins. Contrary to stereotypes of long-term care as a place of unconscious ageing bodies, it was evident that the residents were fighting for their lives through expressions of self-authoring and resistance. Their existence was marked by ambivalence, as they simultaneously depended upon the institution that cared for them, but resisted the processes of being un-made and re-made as residents.

The following chapter will address the tension between biomedical and creative arts milieus that construct different forms personhood according to their respective doxas of care. The porters, or volunteers who accompany residents to and from programs, had the task of not just moving people between physical spaces in the facility, but also helping people make the existential shift between the biomedical and creative arts milieus. The logistical and ethical problems of facilitating resident-veterans' shift between these two modes of being in the world will be addressed.

Chapter 5

Ambivalence and Parallel Doxas of Care

This chapter investigates the two predominant practices of care at the long-term care facility: biomedical care and creative arts care. Following Bourdieu's (1977) concept of doxa, a set of practices and beliefs that are reproduced by social actors, biomedical care and creative arts care expectations constitute two separate, but ambivalently related, approaches to care. The creative arts department was integrated into the therapeutic regime of the facility, remaining its own humanistic doxa that focused on engagement and restoration of selfhood and social relationships among veteran-residents. The different care priorities created an ambivalent environment in which tensions arose and were negotiated on the ground. Additionally, residents were acted upon by these two doxas, and received different messages about their capacities and limitations that in turn shaped their experience of self and others. This chapter will illustrate the existential challenges encountered by residents as they moved between doxas of care.

The Social Field of Care Staff

When I began my fieldwork, entering the care unit was a confusing and almost overwhelming experience. In addition to the residents who lived on each side of the unit, there were myriad staff performing care work. As a newcomer, I could not tell the staff apart, so knowing who to ask for assistance was difficult. Bourdieu (1975) asserted that the “social field” represents a network of positions and power relations. Moreover, each field has its own set of values and resources (capital) upon which it draws in practice (Bourdieu & Wacquant, 1992). The social field of the unit was governed by care staff who embodied the doxa of biomedical care. Those who did not conform to this doxa felt like a visitor with no claim to authority. The

units where residents slept, ate, and spent most of their days was biomedical, with pockets of smaller social fields, such as the creative arts.

There was a hierarchy of direct care staff on the unit. Registered nurses had the highest authority, they did not wear scrubs, and they were not often in evidence on the unit unless there was a specific problem to address. Next on the rank were the registered practical nurses who administered medication to residents and could be identified by their scrubs and the medication cart they manoeuvred through the unit at meals and at night before residents went to bed. In my experience in the field, the real gatekeepers to the residents were the PSWs. They were on the units all of the time. Dressed in scrubs, they assisted residents with activities of everyday living, such as getting in and out of bed, getting dressed, personal hygiene, bathing, toileting, and so on. They seemed to be chronically overworked and short-handed, running to one room after another answering residents' call bells and yells for help.

In addition to the direct-care staff on the unit, there were other care personnel who were moving through the units during the day. Physiotherapists worked with residents in the hallway or taking residents to group exercise class with the help of volunteers. Doctors in white coats and other health care specialists paid private visits to residents in their rooms. Housekeeping staff dressed in scrubs delivered clean clothes took care of cleaning work on the units. There were usually a few kitchen staff in white coats working the dining room kitchen preparing meals and cleaning up the kitchen afterwards.

Additionally, there were private sitters who accompanied residents. Through the informal private care economy, sitters were hired by family members to keep their loved one company during the day, take them to activities, and assist them at meals. Private sitters became well-known within the facility because they were regularly present. They were often hired by word of

mouth by families who had loved ones on the same unit or who attended the same activities as the resident with whom the sitter worked. Thus, private sitters worked on the same units for years, as new residents arrived and needed assistance. Both private sitters and certain family members were regular audience members at music program. Sometimes they were instrumental in accompanying residents to programs and facilitating their participation. Other people in the social field included a herd of volunteers, summer high school student volunteers, and student interns who helped with creative arts programs and other activities at the facility.

Further removed from the everyday work with residents was the maintenance staff and the executive administration. The administration wore suits and business attire and stood out from the volunteers, care staff, and creative arts and recreation staff who were more casually dressed. They worked in a separate section of the building. I usually saw them at lunch and during official tours and ceremonies.

Central to this dissertation was the presence of the creative arts staff. Often combined with the recreation staff under the title “therapeutic recreation and creative arts,” their offices were adjacent to the units. As described in the introductory chapter, artists and musicians used roving carts to bring music onto the units for individual and group sessions, in addition to the art classes in the central arts studio. There were some central music programs, such as weekly music in the pub events and weekly choir rehearsals. Most of the music programming took place on the units. From the perspective of social fields and doxas of care, the music programs were part of the creative arts doxa and they had to make space for themselves in the biomedical social field. Tensions arose when sharing the social field of the unit needed to be negotiated and when residents had to be transferred between doxas of care.

Portering between Doxas of Care

Residents needed assistance from staff and volunteers to get to and from creative arts programs. This practice of assisting people from their rooms to programs and back again was called “portering.” For group programs, portering began about a half-hour to hour before an activity began. Required assistance ranged from brief reminders that the program was taking place, to more involved procedures of waking people up, persuading them to come along to the program, and often finding staff to assist with transfers from the bed or chair to their wheelchair, filling oxygen tanks, toileting and changing clothes before leaving the room. In all of my fieldwork activities, portering was the most challenging because it was never predictable; the only thing predictable was its unpredictability.

There were times when portering was straightforward. Rounding the corner on a unit, a PSW often recognized me and asked excitedly, “Are you here to take this or that resident to choir, the band, the music?” “Yes, I sure am!,” I responded, mirroring their excitement. Then, together, with great enthusiasm, we marched into the resident’s room where the PSW announced, “Mr. Hill, this young lady is here to take you to music! You are so lucky! Let’s get you into your chair so you can go with her!” Swept up in the wave of enthusiasm, the PSW whisked the resident from bed or chair into the wheelchair and transferred the chair to me with a great smile and affirmations about how much the resident enjoys music and how good music was for all the residents.

Some PSWs ascribed to a more holistic understanding of care and quality of life for older people than other care staff. One afternoon before band rehearsal, I assisted a PSW in transferring a resident from his wheelchair to his bed to be changed. I asked if she had noticed how the residents felt about the music programs from her perspective on the unit. She said,

“Some of them, like this man, loved music all his life. And even though he has dementia, the last thing you forget are the meanings and the songs. They never ever forget. They are able to sing and all those things. For them, having the chance to go is amazing. It’s like quality of life.” She was not sure how long the effects of the music lasted after the program, but she was certain that they returned to the unit looking happier than when they left. Perhaps her faith in music participation was attributable to the 30 years she had spent teaching elementary school before she came to Canada from South America, or perhaps it was because of the benefits the music had on her residents. Though many PSWs were supportive of doing everything necessary to facilitate residents’ participation in arts programming, not all were as keen on breaking their daily work regimen to assist this initiative.

Portering showed the tense fault lines between the two doxas: biomedicine and creative arts as healing. Following Bourdieu (1977), “doxa” refers to the beliefs of an individual as “a quasi-perfect correspondence between the objective order and the subjective principles of organization [with which] the natural and social world appears as self evident” (p. 156). In long-term care, the way medical care staff perceived, evaluated, and behaved toward residents was socially constituted according to their particular set of biomedical norms. Since the community of care staff ascribed to biomedical beliefs, the workers took for granted that their perceptions and actions were correct, or “natural” (Bourdieu, 1977). The same can be said for the doxa by which creative arts staff worked with residents. As described in Chapter 3, some creative arts staff aligned themselves with nursing staff’s approach to resident care, at the same time as they practiced a holistic, socially-oriented approach to care. Some creative arts staff did not give diagnoses and treatment models much attention, resisting the perception of residents as medical subjects. This is illustrative of the “divided gazes” described by Leibing (2006) wherein the same

resident is either perceived through a medicalized lens that concludes the presence of a pathology and symptoms of dementia, or a humanistic lens that finds wellness and moments of flourishing.

Bourdieu (1977) asserts that doxa becomes apparent in social interactions when divergent or competing discourses and practices come to bear simultaneously.

During programs there were conflicts between the doxas. The arts staff did their best to protect what they perceived to be the residents' enclave of creativity. Programs on the unit took place in the medicalized space over which the nursing staff held jurisdiction. Call bells, medication dosing, scheduled snacks, and care work often interrupted arts programs on the units. A musician who ran a classical music hour playing music by Chopin, Rachmaninov, and Brahms went so far as to put signs on the unit's activity room door that read, "Music Session in Progress, Please Do Not Enter." She did this because residents enjoyed the "bubble" of music, listening and allowing themselves to be transported to other places in their minds.

In my field notes, I documented an evening program where a PSW interrupted a resident mid-song to give him juice and a sandwich for immediate consumption as per his scheduled snack time. The music therapist played music, hoping the PSW would wait until the end of the song before administering the snack. The PSW did not wait. The juice was spilled on the resident's shirt and the resident started to swear loudly. Meanwhile, the atmosphere of the group was made hostile by the interruption. It seemed that when the doxas clashed, a resident suffered. Arts staff were upset because the interruption not only said that the program was less important for the resident than nursing care, but it also spoiled the resident's experience of the program. The music was a respite from the traffic and noisiness of care work that dominated every other moment of residents' lives.

“It is an issue of perspective,” explained a creative arts staff member after an evening program where residents were taken out of the program mid-session. She said, “The PSW’s agenda is to get them to bed. They may know what his physical needs are, but I know that he will sleep better if he has had some music.” The experience of caring for residents for many years afforded staff with different knowledge about how music can shift residents’ experience. For example, music therapists explained that even though someone may express agitation and reject the invitation to attend a music program, the resident may change his or her mind. “Within 15 minutes of music, he is singing everything at full volume.” That evening there were tensions even between the older and younger PSWs on the unit, where the older PSW wanted the residents to go to music and the younger one insisted on adhering to a strict bedtime. Younger PSWs may have internalized the structure of the institution more literally or may have been more afraid of making a mistake on the job, than older PSWs who had more experience with residents and knew how to improvise within the structure.

Portering encounters sometimes became a tense, silent battle between myself (a representative of creative arts) and the PSW (a representative of a biomedicine), with the resident at the centre. Invitation to the program raised ethical tensions about what was best care practice for the resident in that moment. To be a porter was to be a mediator; on one side was the music program that promised enhanced quality of life in the most holistic sense of the term, while on the other side was biomedicine that protected the sleep and rest of ageing bodies. Even when a resident was known to live for participating in music, at 2 p.m., some PSWs insisted that either the resident needed his rest, or that he was just put to bed and could not be gotten up for a program. The decision to keep the resident in bed seemed to contradict the families’ wishes for their relative to participate in as much music as possible. As a porter, I learned that I had to get to

the resident before the PSWs did, or he would be put to bed for the afternoon with no hope of finding support to get him up.

Those who had experience with residents knew that often a dozing resident would come alive with music participation and be grateful to have been at the program and for not being left alone to sleep more. For example, one afternoon I went to Mr. Tozer's room to invite him to a music program. As I walked down the hallway toward the room, the PSW on the unit asked me who I was going to see. When I told her, she said that Mr. Tozer was sleeping and that he was not in a mood to go anywhere. As she sat at her portable computer station by the resident television, she added that I should just let him rest. Having been in the field for a while, I decided to pop my head into the room to see how he was doing for myself. Indeed, Mr. Tozer was sleeping. I backed out of the room a bit and saw one of the recreation staff coming down the hall. "Who are you looking for? Mr. Tozer?" "Yes," I said, "but he's sleeping." "Nonsense!" she retorted. "He needs to get up and sing." With that pronouncement she led the charge back into his room, arms open wide singing to him. Just as she came to the refrain of "Let Me Call You Sweetheart," Mr. Tozer chimed in and sang just as loudly as the staff member. He was not in a bad mood at all. She teased him a bit and he laughed and sang more. He was more than ready to go to do something. I told her that the PSW said he was not able to go. The staff member said to me, "Anytime you need something, come and get me. I will help you. Anytime. I will do it." Mr. Tozer had a great time at choir that day. Whether or not the invitation is presented to the resident is first a matter of who the gatekeepers are and what they understand the needs of the person to be.

In this long-term care space, "care" was understood and practiced differently by the many social actors who act upon the residents. It came down to whether the resident was recognized as

a medical subject or a creative arts subject to whom different ideas of best care were applied. The invitation was a complex matter embedded in webs of ideology and power relationships. This created a push and pull effect for the resident who was acted upon by both doxas of care. The following section explores the existential struggle inherent to shifting between two modes of being in the world.

Invitations to Play as an Invitation to Expand the Self

Making the invitation to participate was one of the most challenging practices to learn. As an ethnographer, I watched how experienced staff did it and tried my best to copy what I saw. The practice was reminiscent of the description of young female war aides who worked with returned WWI soldiers (Morton, 1998). As described in the Introduction chapter, the young women were tasked with persuading and cajoling battle-worn returned soldiers out of bed and into activities. As I read over my fieldnotes from years of portering, I realized that not only was this moment an epistemological battle between biomedicine and the creative arts, but also an ontological battle for the residents' selfhood as medical subject or as creatively-engaged veteran. The question, "Do you want to come to music?" was not as simple a question as it appeared.

The discourses and practices of the care staff and creative arts team created different environments of everyday life which in turn constructed different versions of the veteran-resident and his needs and capabilities. As discussed in the previous chapter, Berger and Luckmann (1966) explained that the process of becoming a person, or in this case a veteran-resident, takes place in an interrelationship with the environment. Socio-cultural influences shape the way a person understands him or herself in the world and either delimits or permits different degrees of variation and expansion from the norm. The total institution sets parameters on residents' identities, and the socially-constructed reality then "determines not only activity and

consciousness but, to a considerable degree, organismic functioning" (Berger & Luckmann, 1966, p. 182). In long-term care, the power of the medical milieu to delimit residents' self-perceived capabilities seemed especially powerful, more so for some residents than for others. In fairness, the medical milieu was neither mandated to care for, nor equipped with the tools for, the restoration of veteran-residents' identity and social being. Even so, residents lived in and between both care environments, and as the examples below will illustrate, some residents had more difficulty shifting out of the medicalized subjecthood than others.

One day I went to invite Mr. Chapman, a veteran-resident, to choir. He lived with dementia and was beginning to feel the tension between staying in his room as an ailing medical subject and wanting to participate in the world fully. After several rounds of reminding him that we had choir and making small talk between the reminders, the last invitation got through to him: "Let's go to choir rehearsal, Mr. Chapman," I said. Mr. Chapman replied, "Oh, is that today? Is my hair a mess? I haven't done anything all day. Did I have lunch here?" "Do you feel hungry?" I asked him, hoping that the answer would be that he did not feel hungry and we could head to the rehearsal. Belching a bit as he sat up, he said, "I can't believe this is me. I've never been sick, not once. I didn't miss school or work for anything." "Let's go to choir so we have good attendance again, then!" I said to him. "Where did you say we are going? To the choir? I don't remember that at all. That's awful. I feel terrible. I can't get over this terrible feeling I have. I don't want to do anything. I want to do everything, let me put it that way. I'm losing my temper at people I don't even know." We continued out of the unit and down the hall when he said, "I had a strange dream like this. I...I was going down to the cafeteria...and singing...I don't know... I don't think my mind is all there. My mind is *not* there. It's lost its sense of keeping things in order..." Just as his voice trailed off we arrived at the rehearsal room. His

awareness that he did not want to do anything but wanted to do everything signaled a feeling of pull to stay in the medical milieu of rest and decline, and the push from within himself that told him it is not like him to do that. The tension between these two modes of being in the world created the “terrible feeling” inside Mr. Chapman. He was grappling with his very existence in the world.

Not all veteran-residents felt the same inner turmoil about shifting from one mode to another to attend programs. Upon invitation, some threw up their arms, tossed off their blankets, and shouted “Let’s go!” at the mention of a music program. “You talked me into it, you sweet thing,” said another man, each time launching into song, “Let Me Call You Sweetheart.” When invited to choir rehearsal, another resident joked, “Chore! You want me to go to Chore?! You ladies always want us men to do something around here. C’mon, let’s get going.” There was no persuasion, no cajoling, no reasoning needed. Simply the mention of a music activity and there was no barrier to taking a step forward.

Other men, like Mr. Chapman, found it more difficult to transition out of the medicalized resident role. While individual disposition and preference may be factors in this transition, it is still important to look at the social factors that inform the transition experience. A social worker told me that the residents became so used to being asked about their bodies and symptoms that they learned to open social encounters with health-related discussion. I was told that there was one female resident who offered her calendar with recorded bowel movements to anyone who came to see her because she assumed that was the information they wanted from her. After meals, residents seemed to fall into a routine of sleeping or napping and it could be hard to interrupt this pattern with an alternative activity. Many complained that they were too old to expend their energy. Others were concerned about discomfort, incontinence, or finding their way

back (even though accompaniment to and from was promised). Fatigue and reluctance to leave their resting places was especially endemic on days when the sun was occluded because of rain or shorter winter cycles. In response to invitation, the resident would say something like, “Oh, not today, dear. I’m just so tired.” Some residents who had been musicians in their younger years declined the opportunity to listen to or participate in music programs. “I don’t play music anymore. That was a lifetime ago,” said a former trumpet player. Often, I was comfortable pushing only so far, and though the choice to sit in a chair or lie in bed sleeping until the next meal seemed like terrible quality of life to me, it was the resident’s choice in that moment and that had to be respected. Still, it felt as if the medicalized personhood had won over any alternative modes of being in the world and that seemed somehow tragic.

At times, I wondered if declining participation was sometimes an act of agency, one of the few things they could refuse. Early on in my fieldwork, I was charged with portering Mr. Fields to Sunday band rehearsal. Mr. Fields was a somewhat challenging case because he preferred to sleep in the afternoons, but his wife (as power of attorney) dictated that he must be woken up and taken to activities to be kept active. Once, she arrived unexpectedly at the rehearsal and found that her husband had been allowed to sleep instead of being brought to the activity. My field notes detail the sound of her four fingers with artificially long glitter pink manicured nails drumming on the raised back of my chair as she addressed the band leader in a very terse tone. It was an impasse. We had to try to rouse her husband and nearly strong arm him to band. Yet, every Sunday without fail, I found him in his room, lights off and blinds drawn, reclined and dozing in his arm chair under a blanket pulled up to his chin. Gently, I would approach him and ask if he would like to come to band rehearsal. Invariably, he declined. I pressed, reminding him that he enjoyed playing the ukulele in band and he could return for a nap

afterwards. Again, he declined, saying he was too old and too tired to move. An informal rule of three refusals guides porters: you continue efforts to persuade residents from their rooms until the resident declines three times. In Mr. Fields case, I often left him to rest for 5 minutes and sought the more experienced music therapist to try working some magic. In many cases, this worked. I later learned that the music therapist was not afraid to take the blanket off Mr. Fields. In retrospect, this could be considered an appropriate application of power, justified by therapeutic goals. The removal of the blanket constituted the removal of a physical and symbolic barrier to engaging in a new mode of being.

Over his time living at the facility, Mr. Fields' case shored up discussions about resident-focused care and resident agency. His was not the only case where the resident clearly resisted and declined the invitation, but the family member insisted that they needed "the exercise" or "to just get out of the room" whether or not the resident wanted to go. These ethical dynamics were situated in power dynamics between family caretakers, residents, and staff, and in the climate of person-centered care where the resident gets "a voice and a choice," the best course of action was never entirely clear.

The invitation came down to a matter of framing. Following Bateson (1972), framing is the "spatial and temporary bounding of a set of interactive messages" that act as a metacommunication (p. 197). Framing theory argues that the way in which a message is presented to the audience will influence how the audience member responds to the information or request. In long-term care, framing was quite explicit in terms of the way the invitation was composed (*e.g.*, "Would you like to come to the program or are you feeling too tired and would rather rest, versus "We're late for the program and we'd better get going!"), but it was also be more covert in terms of the comportment, style of dress, and tone of voice of the person

presenting the invitation (*e.g.*, a care staff in scrubs asks in a soft voice whether the person would perhaps like to go to the program, versus an arts staff member in plain clothes, perhaps with an instrument in hand, says there is music to make and its time to go). These framing cues impacted how readily the resident shifted from one mode of being to another.

My field notes included scattered references to the techniques used by porters and staff. There were linguistic strategies they used to persuade the resident to agree to join the activity. For some residents, staff knew to say, “We’re late for rehearsal, let’s go,” instead of presenting a yes or no question, which typically elicited a reflexive “no” response. The choir director explained to me, “My volunteers have their tricks. It’s amazing what they do. They’ll tell residents they have a solo that day. They may have a solo, just maybe not that day. The point is, it gets them out of bed and doing something.” Sometimes residents were told they had an appointment with the creative arts staff member and they could not be late. Each new porter had to be enculturated into the performance mode. Everything from how you appeared when you greeted the resident to the way in which you phrased and delivered the invitation mattered. I only realized how much I had internalized this invitation craft when I accompanied a new volunteer and heard the “wrong” or “less effective” way of asking. If I had been away from the field for a week or so, I also noticed that I had to take a few days to regain the performative facility, the “touch”, or the “pace” of long-term care. A fine line was walked in the delivery and persistence of the invitation.

Over time, I came to realize that most residents wanted to accept the invitation. It was other residents in the programs who provided this insight. For example, as I stood next to Mr. Hodgson, a 92-year old navy veteran, in front of the arts studio display window looking at his latest wooden birdhouse, he said,

You know, people don't think they can still do things, but they can. Some of them are just afraid to try or think they are too old to bother. What's wrong with a lot of vets is they come here and they don't do anything. They don't think they're capable of doing anything. Even though they have done so much their whole life and in their career in the service, they think they can't do more at 80 or 90. They are surprised when they find out they can. The staff artists spent their life learning their craft and then they bring that here and teach us to do it.

On another afternoon, I was portering Mr. Clarke to choir. He was an air force veteran who loved to sing in his room and it was especially important that the songs had "pizzazz." As we walked down the hallways of his unit to leave for choir, he saw a man in a wheelchair in front of us sound asleep. Mr. Clarke turned his head around to me, pointed at the man, and said, These people don't want to be sleeping! They want to be doing things! They want to wake up. They don't want to be sleeping. The reason they're sleeping is because there isn't anything to do. If you give them the words to the songs, they'll all sing [he threw his hands in the air] and rise up!

One of my earliest field experiences was with a veteran who I only had the chance to know in passing. He stopped me in the hallway on my way to gather residents for band rehearsal, saying, "The thing is, people out there in the real world, they all think that the people in here are tired and sleeping. But it is our medication that makes them tired. They don't want to be sleeping, but what choice do they have when the option is pain?" Creative arts staff were aware that residents' medication could impede their ability to participate in programs. A senior creative arts worker confirmed that residents often expressed how much they wanted to join in and make things, but they were so tired. Their bodies fought them. These words are good reminders that the medical

milieu was responsible for physical well-being and that many residents lived with chronic pain conditions or illnesses where the pharmaceutical treatment for pain relief kept them in bed, not the decisions of direct-care nursing staff.

Indeed, the biomedical doxa was informed by a disease model of illness where pharmaceutical treatment is the norm, and the medical environment reinforced this approach. Residents' existence was influenced by several factors: first, the biological register of the body that processed the medications that had been added to its system; and second, the environment that surrounds the resident and acts upon them as dependent medical objects to be medicated, fed, toileted, bathed, and put to bed. The porter had to reach the resident when they were in a biomedical mode of being and then compel them to change modes to something else. The following story will illustrate this point. It describes over a year of invitations made to Mr. Hughes, a 90-year old veteran living with moderate and ultimately advanced Alzheimer's disease. Over time, his identity shifted from having no association with the band to internalizing the physical motions of drumming. In the early months, his existential battle with himself most apparent.

Shifting Between Modes of Being: I'm not in the Jazz Band

One February afternoon, I knocked on Mr. Hughes's door. "Hi, Mr. Hughes!" I called as I nudged the door open a bit. Peeking around the corner to see if he was in his room, I saw Mr. Hughes sitting in the chair by his window. His head was in his palm and he appeared to be dozing. "You're sleeping!" I said, seeing if he responded to me. Still with his eyes closed he replied, "I wish I was." He lifted his head and looked at me. "Well, why don't you come to music with me? I'll play the violin," I offered him. "Oh! That kind of music!" he said with a smile. Perking up even more, he asked excitedly, "Where are we going?" "Just down the way," I said, "Go slow and take your time." "I have to. You gotta be good at something," He retorted. I

helped Mr. Hughes find his way into a wheelchair and we started to make our way down the unit hallway and toward the exit. “You’re going to play the violin!,” he started, “I knew a childhood friend who played the violin, but he died,” Mr. Hughes shared more about his friend who had passed away. “As we get older, that’s what happens to us. We die...Where are we going again?” “To the jazz band,” I said. “Now I remember. Am I really in the jazz band? Have I ever been tested to see if I belong? Because I don’t think I should be there,” he said. “Oh, you should be there.” I reassured him.

For months when I invited Mr. Hughes to the jazz band he went through a very similar pattern of questioning. He came along with me willingly, especially when I mentioned having the violin to play. “Better than sitting here and looking out the window which is what I do all day long,” he often replied. Mr. Hughes’ words reflect that he felt as though he was without purpose, just an object to be acted upon, as he sat in his room on the secure dementia unit. In contrast to this bleak existential mode of being, I offered an alternative existence. Though he came along willingly with me because I had a good rapport with him and promised violin playing he enjoyed, his repeated protests that he was not in the jazz band, did not know how he got recruited for it, and certainly could not belong signal a deeper existential battle about who he was in the world.

After several months of knowing one another, Mr. Hughes and I had established a good relationship where he was comfortable joking with me. As we approached the rehearsal room one afternoon, he said, “I don’t know how I got into the jazz band. Are you sure I should be here?” “You’re in the jazz band!,” I confirmed. “Why?” he asked. “Because you like to sing, or you convinced us that you do,” I responded. Mr. Hughes replied, “In jazz band you don’t sing. People just yell.” A moment later, the band director called us over and assigned Mr. Hughes to

the drums. He looked at me and huffed, “See what I mean? They all yell. Did you hear that? I’m not on the drums today.” Though he maintained a steady, often intricate beat pattern throughout each song, and took the microphone to sing from time to time, Mr. Hughes insisted to me (even while he was playing) that he did not know what he was doing or why he was in the jazz band. Eventually, with a shrug and an “oh well,” he continued using the drum brushes and sticks with great flourish, particularly enjoying heavy sounds of the floor tom drum.

Several months later, he expressed a recollection of having heard the band before. While he did not remember being a member of the band, he became more open about his musical background. One afternoon in March on our way to band rehearsal, Mr. Hughes spoke more about his personal history in music. “Oh band,” he said, “I’ve been there. I’m not a jazz enthusiast. I am mostly classical. I was always in an orchestra in high school.” Mr. Hughes’ train of thought switched tracks, then returned to the band. “I’m not the jazz band type. I used to be in the high school band. I loved it, every bit of it. It’s long gone, I haven’t touched the horn in ages. I joined the orchestra and they teach you to play there. I always liked the orchestra. You get to listen all the time. I took my horn home to practice. I had to get a job when I was done high school.”

Mr. Hughes explained that they had played in the military barracks in the city. He did not remember much about the performances or what the musicians wore or played, but he remembered being there and playing. Lines of memory crossing and blending together, Mr. Hughes connected his recruitment into the military band to his recruitment into the residents’ jazz band: “I think I went down there one day to listen, and someone said, oh you sit right here. And now I’m in the jazz band. I don’t even know what I play, do you?” “You play many

instruments, but mostly the drums.” He continued, “I know I do not play the violin. I’d like to play it. One of our family friends was a master of the violin. We all grew up listening to him.”

A year later, Mr. Hughes stopped asking about how he got into the jazz band and what his role was there. I noted the day in my field notes because I was astonished he knew where we were going and what he was going to do there. Two years later, on a December afternoon, I went to his room to invite him to the jazz band and right away he knew that he was a member. As I asked, “Do you want to come to jazz band today,” he made the sign of playing drums in the air with both hands. Whether he was lying in bed or sitting with a newspaper in his recliner by the window, this drumming gesture was now a routine. The vigorous motion of drumming was a big change from the long narrative about how he could not do anything, he did not belong in the band, and did not know how he came to be in it in the first place. Though he continued to speak about his brain damage when we were on the unit and when we were leaving the unit, he asked if he was supposed to bring drum sticks to the band. This signalled that his identity as part of the band was beginning to become more accessible to him and that the transition from a medicalized personhood to a creative music-centered personhood happened faster than before.

Walking back from the rehearsal, chatting as Mr. Hughes sat in the wheelchair I pushed, he said, “I like to listen, that’s my preference. I like the drums. Banging away at them, I have my own sense of rhythm. I try to listen to the tune and hope it fits.” Without warning, the conversation switched completely to the plants in the hallway and his father’s life as a gardener and Mr. Hughes’ own work on his own gardens. Then, as if a switch was thrown, he reflected again on his role in the band: “If I told my friends from long ago I was in a jazz band they’d laugh. I have no experience in jazz. I like to listen to it. I get the rhythm. I think it comes naturally; it has to or you couldn’t do it.”

In the end, the band became the dominant part of Mr. Hughes's life in long-term care. It became a natural alternative mode for being in the world. He enjoyed talking about the band, participating in rehearsals, and took pride in the performances which will be discussed in Chapter 6. During this time, his family remarked on how the band breathed new life into their father and they were happy to see him enjoying it so much and living for something again. "New life" really was given to him in the form of an alternative identity to a medical object who did nothing in his room, felt slow, useless, and disoriented in time and space.

Mr. Hughes' early insistence that he did not belong or have the skills to participate in the band represent an internal ontological struggle of who he was as someone living with dementia in long-term care. Situated in a medicalized milieu of care that felt to him like a void of nothingness and boredom, he had to allow himself to be drawn out of that milieu and transported to a new creative musical milieu. As Mr. Hughes increasingly recalled his past identifications with music playing, he assembled a new identity to take up. Gradually, this became increasingly accessible to him, until it even presented itself within the medical milieu of his room when I came to invite him to the jazz band.

Once the gatekeepers have been passed, the resident has been persuaded to shift into another mode of being and had enjoyed an alternate sense of self in the musical milieu (Chapter 6), porters had to return the resident to the care unit. The following section will explore the difficulties related to returning residents the care unit, including negotiating a return with a person who resisted the shift back to their identity as a resident in the long-term care facility.

Returning Them to What?

When a program was over, the task of portering involved accompanying residents from music back to their rooms. Away from the atmosphere of creativity and potential, the porter was

charged with returning the resident back to a unit that was marked by interrupting call bells, the sounds and smells of other bodies in pain, carts of dirty linens, conversations focused on one's medical condition, and routinized care work. Everything about the social context reinscribed a medicalized personhood. Returning someone to this existence always made me uncomfortable. It somehow felt ethically wrong.

The programs ended and they had to be returned to their units, but for what? For a meal, yes. For necessary medication, yes. But what would they do here? Often when I returned residents to their rooms, they turned and asked me, "What am I to do now?" With a knot in my stomach, I suggested perhaps watching television or looking through a book or photo album in their room. I felt the most reprehensible when I suggested they have a nap before their 5 p.m. dinner. What else was there to do on the unit? The staff were either on shift change or busy and other residents were not necessarily available for a conversation. Sometimes residents would engage the porter in conversation or begin showing artwork or family photos. In such moments it was impossible to disengage. If there was an immediate reason to return, I had to learn to physically move toward the door, signalling the end of the encounter, apologize for having to go, and reassure them I would come visit again. When the resident was hard of hearing, this strategy was less effective.

Residents were not unaware of where they were returning. They felt the contrast more acutely than staff and volunteers did. After band rehearsal, the music therapist and I were accompanying a group of four veterans back to their rooms. As we walked down the hall in a line, one of the veterans said quietly from his walker, "Old soldiers never die; they just fade away." This military adage was adapted from an old British war song, entitled, "Old Soldiers Never Die" (Brophy & Partridge, 1930). The music therapist and I exchanged a knowing look

and felt the profound contradiction we were facilitating. Was this veteran-resident aware that he was making the return trip to a medicalized world that would claim his existence for itself and respond to him as a pathological subject of advancing symptoms and declining faculties until one day he would pass away?

After an evening pub event with live music, I accompanied one of the drummers from the resident band, Mr. Hammond, back to his room. “The musicians around here are all gone now, so to speak,” he began. “It used to be that you’d meet up on someone’s porch and play through the night. We’d blow the roof off! I used to get out my spoons and really get the crowd going.” Approaching the unit elicited associations that compared a past time of social inclusion to a present of feeling alone and returning to a solitary place. He was still willing to make the existential transition back to the unit environment. Not every resident was willing to do so.

Something similar happened on an evening with another veteran-resident, Mr. Thomas, I accompanied to an evening concert at the facility. He had been a musician in the military band that had played at the facility regularly years ago. Now he was a resident himself. He was a bit agitated throughout the performance, but the music seemed to calm him some, and he moved to the music when it stirred him. On the way back, I asked if he liked the concert and he nodded in reply. He said he thought they were all very talented. I responded to him, “Yes. There’s a lot of talent around here.” Then suddenly he said, “They’re burying a lot of talent.” I was taken aback. He was suddenly speaking clearly and seemed more at ease. As we arrived back at his unit (the secure unit for veterans living with dementia), I felt almost guilty for returning him to this space. As I opened the door to the unit, I heard another resident’s voice boom through the hallway, “Let me out of here! Help! Help!” The atmosphere of the concert was completely incongruent with the atmosphere of the unit. It felt unethical to return the resident to their medical care unit.

There were other difficult situations that came up with this part of portering. For example, sometimes residents insisted they did not live at the facility and refused to be returned to their rooms. “Oh, I don’t have a room here, dear. My home is in Trenton Park,” Mrs. Blackwell, an 88-year old navy veteran would say when someone began to take her back to her room from the music program. This resident had been part of a women’s performing group, touring and singing for overseas soldiers during WWII. Music was something she knew well and it was integral to a past identity. She was adamant that she did not live at the facility and she did not know how she got here. It was as if the shift into another musical identity had erased any memory of being a resident. Sometimes staff would say that they had prepared a room for her to wait for a taxi and would offer to get her a cup of tea in the meantime, other times staff took a more direct approach and reminded her about where she lived and the reason for this change. Recalling Mr. Parry’s disorientation when he returned to his unit and his instance that he had to be home for dinner with his family (Chapter 4), we can understand his experience and that of other residents’ in phenomenological terms.

The return to the unit represented the un-making of one self and the re-making of another. Following Berger and Luckmann (1966), the subjective reality and objective reality came into direct conflict as did residents’ associated conceptions of self. In the above cases, the residents responded to this experience in several different ways: first, some anticipated and rejected the process before it could occur by not allowing staff to return them to their units; second, some lamented the process through reference to “fading,” “dying,” and “burying” of the past self with which they identified; and lastly, one resident rejected the role as someone who lived on the unit once the physical location had been changed, insisting that he needed to be home with his family,

not at the facility. For these residents, re-integration into the medical milieu was not what they wanted. They were returned to a world of pathology and symptom in need of treatment.

The division between biomedical care and creative arts care was not always a clear divide. In both doxas, staff's beliefs were situated along a spectrum; some were more clinical in their approach and others were more holistic. The following section will discuss one of the ways in which the facility's mandated documentation processes further blurred the lines between the doxas of care and increased the ambiguity of each one's role.

“Doing the Stats”

As therapeutic programming, documentation was a mandatory part of the creative arts staff's job. The staff referred to this practice as “doing the stats.” Musicians and music therapists alike had to “do stats.” In fact, everybody working in either recreation or creative arts had to do stats. It was often undertaken reluctantly and under a degree of time pressure as the staff tried to wrap up their shift. Staff remarked that they preferred the electronic mode of data collection to the old way of recording attendance on paper and submitting stats at the end of each month. Staff were happy with the software interface, but it seemed unidirectional. In practice, they put data in, but rarely consulted it for their work. Some kept personal notes about residents, but most knew residents well enough that they remembered how residents were doing from one week to the next. The measures were input by the creative arts staff and then compiled and reviewed by the facility administration.

After staff had completed their program with residents, they returned to an office space where they logged on to a software program that allowed them to input certain measures. The first measure was attendance: which residents did the staff member visit or which residents attended the program. I sat with staff as they worked through a series of dropdown boxes, selecting the unit, the activity, and the participating residents they had seen in the last hour.

Activities are organized according to categories of engagement: physical, intellectual, emotional, social, spiritual, and self-directed. For each resident, a pie chart appears in a report that breaks out what the resident likes doing. One day during my fieldwork, I accompanied the staff member on duty putting in her reports. She showed me the pie charts of various patients she had worked with during the day: “This is Mr. Potter. All the things we put in appear here. He likes eating, going to ice cream parlour, one to one sessions, and going to music.” If residents declined going to programs, that was recorded along with the reason for decline, such as being sick, absent, or sleeping. Unfortunately, the program did not have a space to log how many times the resident was invited and how many times he or she declined the invitation. As discussed in above, porters and staff did their best to encourage, persuade, and cajole residents into engaging in activities, but sometimes the resident wanted to be alone. She explained that there was a category for self-directed activities, like reading, but noted that there was no way to catch every moment of self-directed activity. The report summarized the documented minutes of engagement. Mr. Potter’s report had 1,159 minutes of engagement logged in, which seemed like a huge number, but likely was compared to an averaged standard or to his own records to track any changes in his behaviour.

Once the participating residents were selected, another window appeared on the screen. This section asked the clinician to select an engagement score on a scale of one to three. One meant the least engagement and three the highest level of engagement. While sitting with a music therapist who was completing her evening stats, she said to me, “It isn’t a grade. It doesn’t reflect on him in any way.” I noted in my field notes that it seemed like a grade to me. Some of the criteria were “absence of cognitive degeneration,” “adds challenge to activity,” “asks related questions,” “maintains attention,” “makes choices,” “understands instructions, rules, and

processes.” I recall thinking that it read like a school child’s report card. Another recreation staff member went through her stats process out loud with me:

For Mr. Lambert, this activity is about remembering. It is an intellectual activity domain, not an emotional one. He got a 2 today because he really wasn’t present and understanding what was happening. Mr. Jacobs was a 3, Mr. Teasdale was a 3, Mr. Lambert was a 2.... He really is a 1, though, because he goes to sleep, he has cognitive degeneration and difficulty reasoning.

I followed the same process alongside another musician who ran a group music program. She scored her residents along more affective lines. A “3” meant that the resident showed an appropriate emotional response, was attentive to others, was making suggestions, was in a happy or cheerful mood, and was able to verbally express personal feelings and participate actively in the group. “Most get a 3,” she said. “Mr. Reynolds never sings, but he listens, so he gets a 2.” I asked if there was room left for growth in the assessment. She replied, “It is designed to capture what the residents are doing that day, in that moment.”

The ultimate purpose of this assessment was explained in a variety of ways. The ranking system was explained as a way for administrators to see whether or not a program was successful. A hallmark feature of the biomedical paradigm is documentation and evidence-based approaches to care. This ranking system was another example of the dominance of the biomedical paradigm in the institution. If everyone got a 1, perhaps the program was not engaging enough. The ranking software also generated reports for families and care staff. The report provided a historical record of improvement or decline that could be triangulated with the residents’ medical charts. Occasionally, decline appeared in the creative arts programming with

the shift in capacity to engage in singing, keep basic rhythm, or copy an image in an art class. Later, when the medical staff registered a decline, the creative arts staff had often flagged it first.

The electronically documented statistics reflected veteran attendance and showed any veteran-residents who were “at risk.” This meant that they were “at risk of isolation” if they had five or fewer contacts from recreation and creative arts staff. “There should be no one with zero, and there isn’t. This man had 2 contacts, she had 2, and he had 4. It’s not a lot but it’s better than zero. Less than or equal to 10, that’s not so bad in a month.” I always found it a bit ironic that deceased residents remain in the system as “deactivated residents.” “Doing the stats” was an essential component of proving that the facility was providing extraordinary care to the veterans and making the care results publicly visible.

Conclusion

Amidst the myriad categories of staff that work in the facility, the dominant personnel who provided veteran-resident care were the direct-care medical staff and the creative arts staff. The medical and creative arts doxas of care were ambivalently related to one another, sharing a social field marked by negotiations for authority over resident care. Porters were the mediators between these two doxas. The above ethnographic stories illustrate how each doxa had its own influence on residents’ experience of self and others, and the ways in which porters facilitated residents’ shift between these modes of being. Although the creative arts doxa constituted a separate milieu from the biomedical milieu and had a different impact on residents’ lived experience, it remained ambivalently related to the biomedical doxa because of required practices, such as documentation about resident engagement.

This chapter conceptualizes the relationship between biomedicine and the therapeutic creative arts as ambiguous. One an institutional level, the lines between creative arts and

biomedical approaches to care became blurred through the change to the department's title ("therapeutic"), as well as in the implementation of biomedical practices (expressed clinical intention to address "behaviours" and the regime of "doing the stats"). In other practices, the creative arts staff were holistic in their approach, making the social dimensions of people's lives a primary focus of music making. Biomedicine tended to locate the social as marginal aspects of care, considering it as secondary to the physical concerns. Further, whereas biomedicine saw "symptoms" and "behaviours" of dementia, the creative arts were open to framing the same moment in terms of an expression of a deeper need, thereby resisting individual pathologization. Thus, although the biomedical and creative arts doxas have been drawn closer through the overarching institutional paradigm, they remain distinct from one another.

The following chapter explores the significance of group music-making for constructing new individual and collective identities beyond the medical milieu. The analysis draws upon key phenomenologists who emphasize the role of sound in communication, memory, and personhood. In the musical milieu, veteran-residents established a new personhood and a collective identity. Beyond the medicalized milieu of the care unit, veteran-residents enjoyed new identities associated with music-making and received peer recognition for their performance. The significance of the musical milieu as a space for sociality and self-authoring as part of a collective will be illustrated through ethnographic stories.

Chapter 6

Constructing New Personhoods through Group Music-Making

“...The Greeks held, the mother of all arts, the living activities of action, speech, and thought would lose their reality at the end of each process and disappear as though they never had been. The materialization they have to undergo in order to remain in the world at all is paid for in that always the ‘dead letter’ replaces something which grew out of and for a fleeting moment indeed existed as the ‘living spirit.’”

— Hannah Arendt, *The Human Condition*

This chapter will look at the construction of new individual and collective identities among veteran-residents when they move beyond the care unit space into the creative arts milieu. In the context of the resident bands, the residents “become” a new selfhood, temporarily leaving behind the medicalized personhood. Collective music-making programs created a place where residents were recognized for more than their medical needs by staff and volunteers, and by their peers. In the programs led by music therapists or musicians, or by both together, residents were provided with a forum for self-expression. Many residents revived an identity from their younger days when they played in music ensembles. The new identity was constructed and supported by the musical milieu.

Evoking New Identities in a Musical Milieu

Music rehearsals for both the resident band and the jazz band were an occasion for residents with common interests to gather and do something together. It often took residents some time before becoming completely comfortable in the new musical environment. This was the case with Mr. Hughes, who resisted definition as a jazz band member (Chapter 5). Led by a creative arts staff member, usually a music therapist, and supported by volunteers, the program

was designed to support residents' music-making for about an hour of time. The bands had an average of six core members: two lead vocalists, a drummer, and about three players on maracas, cabasas, and wooden spoons. The drummers were essential to the rhythm-keeping of the group and interestingly they were the members who were still alive at the end of my fieldwork. During my fieldwork, I participated both bands at the facility.

The residents who incorporated band into their routines were often professional or highly accomplished amateur musicians earlier in their lives. In the resident band that met on Sundays, there were several former musicians, both amateur and semi-professional. Mr. Goodall, a WWII air force veteran from the Canadian Maritimes had grown up surrounded by music. He knew every song we ever played from memory. He had such an incredible musical knowledge that he was brought in to sing as a "ringer" for performances when other residents were sick. We also had Mr. Hammond who was a WWII army veteran. He played drums in the Cameron Highlanders and had countless stories about his life in music, playing at square dances and for porch parties in his neighbourhood. Other core band members included Mr. Jenkins, a WWII air force veteran and multi-instrumentalist, and Mr. Stinton, a WWII army veteran and pianist.

There were residents who participated regularly in both bands for years, others participated regularly for the duration of their life at the facility, which was sometimes just a few months. Early on in my fieldwork, the core members of the jazz band included predominantly veteran-residents: Mr. Matthews, who played piano as long as he could (he had been the leader of a big band in Montreal during the 1940s and had rubbed elbows with some of the biggest names in jazz music); Mr. Lambert, who had been a pianist, trombone player, and band leader in his own right after the war; and Mr. Hughes, who had been a drummer in the navy band and a horn player in his youth. There was also a trumpet player who had been a professional jazz

performer in the 1930s and 1940s. He had played at most of the theatres in town that were only known today through legends or from the faded names painted on the brick side of the old buildings downtown. Finally, Mr. Teasdale, who came to be known as “Frankie” had been an amateur of music his whole life, but did not have previous ensemble experience.

It is worth noting that not everyone who had been a professional musician in their younger years assimilated into the band. There was a case of a veteran saxophone player, living with dementia, who had a fine reputation in the community but who could not bring himself to play alongside residents in the band. He had been encouraged by staff musicians to try the band when he arrived at the facility in the hopes that it would be a life line for him. He attended one rehearsal and never returned. This could have been because he was frustrated with the deteriorated muscle tension in his lips that made it difficult to play the instrument, or because he could not tolerate being part of a non-professional ensemble (the quiet rumour was that it was the latter). For this resident, attempting to revive his identity as a professional musician was intolerable because his body could not perform the way as it once did, and it served as a harsh reminder of diminished capacities. For veteran-residents who had been professional musicians, or who were highly critical of their abilities, group-music making was not always a positive experience.

Among residents who enjoyed group music-making, many new relationships evolved within the band. The band members became a community within a community. Regular members were known to staff and their participation in the band was usually referenced in everyday greetings in the hallway or when introducing residents to one another at social gatherings. “There’s the famous singer,” called a recreation staff member to a lead vocalist when they passed each other in the hall, or “Have fun drumming in jazz band,” as Mr. Hughes and I

walked by each other. Some residents remembered one another between rehearsals, met to practice lyrics together, or chatted about band outside of rehearsal and in other programs. They looked forward to the band as a touchstone to return to amidst other changes.

For example, the first February of my fieldwork was marked by one of the longest “outbreaks” in years. An “outbreak” meant that enough residents were sick with an infectious disease (usually respiratory or gastro-intestinal) that the unit was closed to visitors, and residents were not allowed to leave. This outbreak persisted for well over a month. Residents who were not sick were still quarantined on their units and began to get bored and restless because they could not keep up their routine activities that took place in another part of the building. At the first rehearsal after the outbreak ended, the band had started to assemble. The music therapist was asking how people were doing and what had been going on during the outbreak for them. One of the drummers, Mr. Jacobs, was explaining that he had fallen when he was getting out of bed and hurt his hip. Another resident was talking about how glad he was to be allowed off the unit again. He remarked, “I was getting cabin fever, being cooped up. It gave me a chance to learn a few songs anyway.” As the lead singer wheeled himself into the rehearsal room, he looked across at us with a wide smile and a wave, exclaiming, “The gang’s all here! We survived it! Half a dozen from my unit didn’t survive it...” The band was a constant amidst the coming and going of neighbours, friends, and one’s own sense of mortality.

The bands were a social space beyond the medical milieu. They were a microcosm of community within the macrocosm of the long-term care facility. The framing of the musical milieu was entirely different from the medical milieu. The musical space was directed toward music-making goals that were not about the veteran-resident’s diagnosis or medical needs (at least not explicitly within the band context). Schütz (1951) explains that approaching music,

particularly as an experienced musician, connects the individual to their own history as well as past and present fellow men. The musicians' stock of musical knowledge is both socially derived and socially approved. In this context, the resident as medical subject whose existence is constantly in the realm of the pathological and the deviant finds that their contribution is positively recognized and holds substantial value because of the music-making. Participants in the band not only connect to one another through a different personhood than the medicalized subject, but they also connected to their own histories and social networks through their engagement with the music. The immediate connection through the musical milieu to one's past fellow men was evident in the following account:

Potential new members were welcomed to rehearsals. One afternoon in April, a sitter came to the band with a new resident: "Mr. MacDonald was looking to see what the jazz band is all about. He used to play the trombone in a band and wanted to sit in for the afternoon." The band leader asked, "Did you used to play the trombone in a jazz band? That's great! This is a jazz band for former musicians. Come on in." The leader introduced Mr. MacDonald to the other band members according to what instrument they used to play or still played: the piano, the trombone, the drums, or singing in the bathtub. The atmosphere was always lighthearted and focused on their musical identity, not their medical identity.

In this new milieu, Mr. MacDonald sat next to the band's vocalist, Mr. Teasdale, and shared some of his background:

Mr. MacDonald (Mr. M.): I used to play the valve trombone, I loved the horn too. I played almost the same music as the baritone.

Mr. Teasdale (Mr. T.): I'd love to hear you play it!

Mr. M.: It's funny, you think back, I played in a band pretty well all my life until I got to be about 50 and then I just didn't anymore. I was in a corvette in the sea during the war and people in town told me 'MacDonald, your lips are too fat, play the trumpet.' So, I still remember, I was in London and I spent seven pounds and bought a trumpet and I used to sit out in the quarter deck practicing it. One day I went to get it and somebody had cut the lanyard. I had hung it out the port hole of the corvette on a lanyard because someone yelled at me to get rid of the horn. I was practicing over the chief petty officer's mess. They didn't appreciate the noise. It's funny how you think about things like that.

Mr. T.: I'd love to have played the trombone or clarinet.

Mr. M.: We had a piano in my house.

Mr. T.: I didn't do too well at the piano. They had a school band at the high school and I was good at the horn there. I played the horn for 40 years off and on.

Mr. M.: It'll be just like Morse code, you never forget it. You may need to tune up every once in a while, but you never forget it.

Individual diagnoses, prognoses, or medical needs were not brought to the fore. Members appreciated one another for their musical contribution and were somehow less concerned about any apparent deficits. It was normally only a few residents over my fieldwork who expressed impatience and frustration with another musician. It was a long-standing dislike between two men that carried over across programs and contexts. For example, the visitor, Mr. MacDonald, did not stay long in this band. He enjoyed the Sunday resident band more, despite some friction with other members. He usually became a bit agitated during rehearsal and grumbled that Mr. Goodall "used to sing, but now he just yells." Mr. MacDonald once got out of his chair and left the room scowling and pointing at Mr. Goodall as he left the room. Animosity in this context

could be attributed to “artistic differences,” but the men also shared a unit and a dining hall for several years and may have become annoyed by one another. It is ironic that given the tense relationship between these two men, Mr. MacDonald passed away the week after Mr. Goodall.

The band was arranged in a semi-circle around the leader who played the guitar or piano as harmonic accompaniment. The band members became known to one another by their band nicknames and signature songs. Sometimes these musical identities were picked up by family members or private sitters who accompanied other residents to the band on a regular basis. Other creative arts staff even came to know the residents by their musical personae. I am not sure how the medical staff knew the residents, likely only by their name, diagnosis, and symptom profile.

For example, Mr. Stannard, a 92-year old air force veteran, became known for his steady rhythm on drums and hand-held percussion instruments, as well as his signature songs that he brought to band. By “brought to band,” I mean songs that he would sing by himself spontaneously during rehearsal. Sometimes he sang these songs during a pause in the music, while other times he sang his song instead of the song that was on the lyric sheet he held in his hands. During my fieldwork, Mr. Stannard had a few signature songs, but the most enduring was “Love is Just Around the Corner.” The band leader often brought out the song as a way to connect with Mr. Stannard during the music session.

The jazz band drummer, Mr. Jacobs, an 86-year old air force veteran, became known for his love of Broadway songs and an over the top cymbal crash he added to the end of songs. Confined to a wheel chair with advanced Parkinson’s that had reduced his mobility and his voice to a whisper, Mr. Jacob’s grand gesture was significant on many levels. Over the years, band members encouraged the cymbal crash ending and certain songs felt unfinished without it.

Mr. Hughes, described above, was known for his rhythmic drumming pattern with particularly heavy beats. Even when aesthetically his sound did not blend in with the group's sound, it was appreciated because it was unique to him. It was an audacious and almost sarcastic beat that matched his enigmatic personality. At the very least, no one ever complained about the big sounds. In addition to his signature rhythm, Mr. Hughes had a few signature songs of his own, such as "Boogie Woogie Bugle Boy of Company B" and "Besame Mucho."

Most band members who spent time playing with the band came to have a signature song or something that was uniquely their own. Other band members, staff, and volunteers associated signature songs with the residents. In palliative care visits, these songs were sung for the resident because they were thought to be integral to their musical selfhood. The association between song and resident was so fixed that when the resident passed away, the band sang the song in their honour. Years later, at performances of a resident's signature song, music staff recalled still seeing and hearing the resident sing the song. Though privacy laws became stricter during fieldwork to the point that we could not say the specific resident's name out loud, we could say that it reminded us of a dear friend who used to love singing it.

The resident who most thoroughly engaged with the arts and embodied his alter ego role of Frank Sinatra, "Frankie," was 91-year old air force veteran, Mr. Teasdale. He had not been a professional musician, but he had an uncanny knack for showmanship. He quickly became a known entity at the facility – participating in every art class and music program he could. There were only a handful of past residents who had become so completely involved in the creative arts at the facility. Mr. Teasdale did not arrive ready to participate with vigor. In fact, he arrived as a defeated man, struggling with his masculinity and sense of self in the world. I remember when Mr. Teasdale first appeared at the facility. It was just about the time my fieldwork began. He was

new to the Sunday band rehearsal and during a break in the music I remember him turning and saying to me that he had been dead for 11 years. Confused, I asked how so? He said that he had not been with a woman in 11 years and life just was not worth living anymore. When he found the facility's arts studio, his life turned around for the better.

It didn't take long for him to acquire the alias "Frankie" in the bands. Mr. Teasdale sang Frank Sinatra tunes like no one else we had heard. He made the music his own, adding tonal inflections and giving and taking with the rhythm to capture the feeling of the song. Mr. Teasdale wore a Sinatra-style fedora hat to performances and often requested his signature songs. Reading back over field notes, it is interesting to recall where he began and to pair this beginning with a story he told two years later about Frank Sinatra's past. Mr. Teasdale told the group about Frank Sinatra and Ava Gardner, who was doing a movie with Clark Gable. "She wanted to get rid of him," he explained. "She got a part in a movie and got famous. A lot of people fell in love with her. He was a nice young guy, but he wasn't much of a lover. He stuck with her and when she came back, it was years later, she was sick and in a wheelchair, he went down and met her and got her out of the taxi in the wheelchair, he still felt for her I think."

Later in the rehearsal, we listened to a recording of Frank Sinatra singing 'Night and Day.' Mr. Teasdale offered, "This song is going to come back for our performance next month, I think." Moving his hand in the air in time with the music and humming along, he continued, "Sinatra would ad lib a bit. He wouldn't stick to the words. I like to do that. It identifies you. It *dignifies* you. If you don't know all the words you make them up. You just have to get the words to rhyme, that's all." He placed deliberate emphasis on the word "dignifies," insisting that the very definition of the self was constructed through a personal interpretation of the music. To sing

the music with one's own unique spin was to embody a particular self that was not only known to the individual, but could also be recognized by other people.

Mr. Teasdale staunchly defended his interpretation of the music. In my fieldnotes, I documented a Sunday band rehearsal during which Mr. Teasdale became upset when the song was not played as he felt it should be played. The music therapist asked everyone to turn over the page in their songbooks to the next tune, "I've Got You Under My Skin." "Oh, that's mine," said Mr. Teasdale, "The story of my life! Always wanted the girls I could never get." It is of note that this paralleled with his previous story during the jazz band rehearsal. Mr. Teasdale sang into his microphone with his eyes closed and book in his lap. Suddenly, he stopped singing and glared at the keyboardist. "That's not how it goes!" he shouted, picking his book off his lap and slapping it down onto the chair beside him. "It's too fast! It's all wrong." With training to navigate such situations, the music therapist consulted with Mr. Teasdale about how he would prefer the tempo. They agreed on something slower and proceeded with the song, carefully following Mr. Teasdale's melodic line.

This outburst can be interpreted as a defense of personhood. It was the defense of a very particular persona he had cultivated over his time at the facility. If the smallest of embellishments and improvised turns of phrases dignified a person, he was not willing to surrender his dignity in that rehearsal. Mr. Teasdale was not always assertive and outgoing. Like everyone else, he had his own battles to fight at different times. I recall him returning to band after a few weeks of being absent and one of the members asked him if he had been sick. "I have a habit of going astray once in a while," he said. A few years into his stay at the facility, I went to invite him to the band rehearsal. I found him lying on his back in bed. He looked tired, frail, and worn. This was not the persona of the exuberant flirtatious Frankie we were used to seeing. I

reminded him we had rehearsal and he said he would like to go. He explained, “I’m tired today and I don’t know why...Everyone I know is dead. I’m the last one of them. That’s what it’s like to grow old.” I asked him how old he was now. “91,” he said, “It’s hard to be old.” Just as quickly as he had opened up, he seemed to shrug it off and hoist himself into his wheelchair. We went to the rehearsal together where his mood improved and he visibly transformed into “Frankie,” who flirted with the young music therapist as they sang Moon River in harmony, negotiating the finer points of the arrangement.

In this creative, music-filled space, he was “Frankie,” who could croon, improvise, and draw in a crowd of warm admirers. His transformation was embodied in sound. Following Goffman (1961), one could look at the band rehearsals as forms of institutionalized get-togetherness that permit a release from the “formalities and the task orientation” that characterize relationships between residents and care staff (p. 94). With music staff, the usual role of “resident” as medicalized subject was released and replaced by a familiar role as a musician, or a “musicalized” subject. Given that this identity was part of the individual’s younger years and something about which they were proud, the new role as a musician-veteran was a positive opportunity. In these moments, Goffman (1961) notes, there is a breakdown in the distance between staff and the resident. In the case of my fieldwork, music staff and musician-veterans did not experience the same barriers in their relationship as the direct care staff did with non-musician residents on their service. The “role release” for veteran-residents was facilitated by changing environment, in terms of space, activity, and personnel.

In the later part of Mr. Teasdale’s time at the facility, a local newspaper published a photograph of him in performance during an event for veterans. In the photo, he was dressed in a white collared shirt with a black bow tie. He appeared clean-shaven, with his white hair brushed

to the side. His eyes were closed and his left hand was raised outward toward the audience, it looked as though he was singing soulfully into the microphone. The caption read: "Lost in the music." My perspective on this caption is that he was hardly "lost" in terms of total sense of time and space, but rather through the music, he embodied another selfhood. The only thing that had been "lost" was his medicalized subjecthood that delimited his capacities as an ageing body. What was "found" in the music, then, was a transcendent selfhood of one's own devising and an expression of self-authoring made possible by an alternative milieu.

Peer Recognition

In addition to the embodiment of a new identity through sound, there was a shift in collective identity and transformation of social bonds among members of the band. This assembly of residents was recognized as a coherent group in social encounters that validated the community of players. In addition to the passing greetings from staff and volunteers in the facility, there was another validating group of people. The other residents helped to construct the band as an organized group of players. Peer recognition became an important and unsolicited source of recognition and validation.

One of the most influential figures in terms of peer-recognition appeared in the latter part of my fieldwork. Mrs. Sauter was an exceptional 87-year old woman. She was usually dressed in a long green army-type coat over beautiful blouse and scarf paired with a long heavy skirt. She wore a blue toque that covered her snow-white hair. She spoke with a heavy eastern European accent with grand hand gestures. A character in her own right, she was zealous in her praise and demonstrable admiration of other people. When approached by the music therapist, she raised her hand with open palm, gesturing in circular motions, exclaiming the therapist's name and complimenting, "the hair, the eyes, the blouse, the shoes." In the band, this ritual of appreciation was extended to the band members. Mrs. Sauter admired the hair, the eyes, the hands, of the men

who played the music. Over the years, there had been a few male band members whose attitude was very positive and they openly encouraged others to play and were quick to compliment others, but there was something entirely different about Mrs. Sauter's manner of recognition and its effect on the band members.

I had met Mrs. Sauter on a summer afternoon when I went to a non-veteran unit to help with a sing-along. I had my violin with me, and the recreation staff member asked if I would take a few minutes to play something classical for the lady beneath the canopy in the courtyard. When I greeted Mrs. Sauter, she extended her hand to shake mine. I introduced myself and asked if I could play some music for her. She smiled and nodded. After I played a short piece, she told me she used to play piano as a little girl, but she could not play anymore, not even scales. We chatted about when I had started playing and she took my hand and said in her heavy accent and joyful voice, "and you've maintained it! I am very happy to know that!" I showed her the book of music asking if she had a favourite composer. The question seemed to disappear with the breeze, as she ran her fingers over the notes on the page. I stayed quiet, not wanting to interrupt her process. She soon lifted her head, took her hand from the pages, and thanked me for visiting her.

Since Mrs. Sauter enjoyed music so much, we decided to bring her to the band rehearsal. In my field notes from an early November rehearsal, I noted Mrs. Sauter's response to the men in the band.

She is amazing at witnessing, recognizing, appreciating and thanking the guys in the band. She plays shaker during the band with great vigor. At the end she goes to each man and thanks him for playing. She exclaims with great enthusiasm, almost as loudly as she can and at a somehow reverent pace, "Thank you, thank you! I could listen to you for

hours and hours and hours!” She tells [the leader] that it was “extraordinary!” and she means it. She shakes the men’s hands and looks them straight in the eye. The men smile and light up! They thank her for the compliment. Mr. Lambert took Mrs. Sauter’s hand and kissed it today after she complimented him! It is a big deal to her and a bigger deal to the guys. It is someone their age appreciating their playing.

This attention from a peer, particularly a female, was welcomed by the men. The atmosphere of the group was enhanced by this lavish display of gratitude and appreciation that recognized and confirmed the men’s new roles as musician-veterans. The following ethnographic story will illustrate the impact of performing in a more formalized social situation for an audience of peers.

The Jazz Café

Performance was another way in which collective identity and social bonds were transformed through the creative milieu. Each band had its own performance venues. The Sunday band played once a month or so for afternoon “socials” hosted by the recreation staff on an adjacent unit on which many of the band members lived. This meant that they recognized their neighbours and other staff in the audience and they were in turn recognized as performers. The jazz band also had its own unique venues. For a period of time, the jazz band presented “Jazz Café” performances for residents on different care units. An event was made out of it with tablecloths, snacks, and battery-operated tea lights on each table. This “gig” was in the evening and positioned as a formal affair; and the performers were dressed up for the event.

“This music is their era,” said the jazz band leader, “It’s not the singalong stuff. It’s more sophisticated. It’s reaching the musician inside them. They are the ones creating the music.” Performance was an integral part of this identity. The band leader continued,

For Mr. Lambert, it's allowing him to live part of his hey day because he did that every night. He's in the band, he's doing that. Dressing up to perform is the feeling that *we* are the band. *We are the guys in the band.* For Mr. Teasdale, it's a sense of pride and specialness that he doesn't have in his life at all. [As long-term care residents,] they can't do any cooking, they can't go to the store, they can't fix a car, they can't do anything for other people. This is a way that they can give to others that is an important part of who they were and who they still are.

The men's appearance changed completely when they were dressed to perform with the band. Something in their demeanor changed as well. Simmel (1971) explained that fashion, in and of itself, is a form of social life. "The adornment and accentuation that it lends to the personality is accorded to it only as the member of a class that is collectively distinguishing itself from other classes by adopting a new fashion.... The adoption of a fashion represents an internal leveling of the class and its self-exaltation above all other classes" (Simmel, 1971, p. 260). Later in my fieldwork, a new jazz band leader had taken over and special hats were made for the band. These matching top hats added to the band's collective identity. They wore the hats when the band performed at happy hour for the adjacent apartment building of tenants, at the Christmas variety show, and at the opening of an art installation at the facility. The band leader and volunteers also wore top hats. They did not ultimately become emblematic of the band, but they made the members recognizable while they were used. Within the band, the men expanded their individual identity to become part of this new group of musicians, and beyond this, the group of musicians ("the band") was set apart from the other residents.

The musicians in the band were distinct in dress and comportment that their role as "veteran-resident" was occasionally completely released. For example, on the evening of the jazz

café performance, I went to Mr. Hughes's unit to accompany him to the band performance. On my way to Mr. Hughes's room, I walked right past Mr. Hughes. In my mind, I had not passed Mr. Hughes, but perhaps a visitor or Father John, the facility's priest. When I reached Mr. Hughes's room, I looked inside to find it empty. I turned around with the intention of finding a PSW to help me, and there was Mr. Hughes walking towards me. It was an uncanny moment. Often one mistakes older family members as new residents, but it rarely (if ever) happens that one mistakes a resident for a visitor or staff. "Do you recognize me?" Mr. Hughes asked. I laughed and said, "I do now!" I helped him get ready, helping him put on a tie he borrowed from his neighbour, Mr. Montgomery. As I fussed with the knot, Mr. Hughes asked, "Where are we going? I got a message and all it said was be sure you're wearing a white shirt. I'm glad you're here. I don't know what I'm doing. The man I saw said, 'be sure you're wearing a white shirt. That's all he said.'" I explained that the other band members would be wearing white shirts and dark bottoms so that we were coordinated. "Usually," said Mr. Hughes, "I wear a war medal because I'm a war hero. Don't ask me where it is. It's at my home somewhere. Do you know where we're going?" I reminded him we had a performance with the jazz band and that we had to get going or we would be late.

At the Jazz Café, the mood was set. Band members were brought in one at a time, each in his white shirt and black pants, with a hat on top. As the audience filed in, brushes, shakers, and small instruments were handed out to the band members. "Not many people here," said Mr. Jacobs. I replied, "It's a nice setting. It's a performance, you know." "Tell me the rest of the story," chimed in Mr. Hughes, "Are we going somewhere to perform?" Nope, we are staying right here, this is your spot. "Oh, this is it," he said, picking up his brushes and appearing content with the answer.

With the lights dimmed and the stage set, the recreation staff member introduced the band to the audience, “The jazz band is going to play for us, we can relax and have a few snacks.” The music therapist added, “Welcome to the jazz café!” [the audience clapped]. “Tom, your waiter will be coming along with some refreshments… pretend wine. We’re going to have fun tonight. We have the resident jazz band for you tonight. This band comes out every week to play their favourite jazz tunes. Everyone in the band used to be a musician. Piano players in church, their own bands, military bands, navy ships, Mr. Teasdale a great singer of Frank Sinatra, singing in the shower and everywhere he could. We have Mr. Hughes on the drums, Mr. Jacobs on the drums, Mrs. Jensen on percussion, and Mr. Teasdale on the voice singing.” Mr. Teasdale, the lead vocalist, picked up the introduction and announced into his microphone, “First off, we’re going to sing about a pretty little gal and the song is called, “Ain’t She Sweet.” On cue, the piano began the introduction to the song, cueing the drums and shakers to play until Mr. Teasdale/”Frankie” began the melodic line in his usual flare.

Between songs there was shuffling around of instruments: switching drum sticks for brushes and trying to let the members know what song was next as quickly and clearly as possible without creating confusion that would require long explanation. Mr. Teasdale looked in his book for “Unforgettable,” but could not seem to locate the page quickly. Ever the showman, he said into the microphone, “It’s unforgettable because I’ve forgotten where it is in the book!” The song set of about seven songs was played through. For the next song, Mr. Teasdale announced, “The next tune we’re going to play is “Fly me to the Moon”, formerly played by Frankie Sinatra.” Emulating his idol, Mr. Teasdale led the group in “Fly me to the Moon,” calling out to the members, “Let’s get those drums going,” or “I want to hear that shaker!”

Mr. Teasdale was not the only member with a signature song or two. Mr. Hughes was invited to sing “Boogie Woogie Bugle Boy” for the audience. I handed him the lyrics, but he was worried he didn’t know them. “Will you hold my hand?” he asked. “No,” I said, “I need my hand.” “I wasn’t prepared for this. I have to read the words. I can’t use my own words on any of these... Well, this is a surprise to me.” Just then, the band leader announced, “Ladies and gentlemen we are going to sing, ‘Boogie Woogie Bugle Boy.’” With a vocal trumpet solo to lead the group in and a crash on the cymbal, Mr. Hughes was singing the opening lyrics. The audience applauded, delighted with the ensemble. Mr. Hughes turned to me and exclaimed, “I didn’t know I could sing!” “Yes, you can,” I reassured him. “But, I really can’t!” he said with more assertion, to which I stated, “You can!” mirroring his tone. “You sound like my wife,” he responded playfully. This kind of repartee was routine during band rehearsals and performances, marking the milieu with a playfulness that was less common on care units.

Suddenly, a member of the audience asked where our missing drummer was. The reality of long-term care ruptured through. The band leader said, “He’s in the bath, we’re getting him.” Only in long-term care would a performer arrive in pyjamas straight out of the bathtub. Parked in place behind the drum kit, Mr. Lambert was handed a microphone to amplify his voice through a speaker so that everyone could hear him. The song he was going to sing was his signature song and he did not need the lyrics to sing it. “Love is just around the corner...” he sang. The piano carried the harmonic line and the drums beat together keeping time as Frankie proudly looked on. When Mr. Lambert finished the audience called out “excellent!” “Way to go!” Mr. Lambert and the other members beamed.

The performance closed with “On the Sunny Side of the Street.” At the end of the song, Mr. Jacobs crashed his cymbal (his signature move). Mr. Teasdale thanked the audience, “Thank

you so much. We'd like to do this for you again. Hopefully, we can struggle through and learn a few more songs. We're very grateful for the small audience we have. We know we're going to get a bigger one next time because you're going to tell your friends and then they're going to come and then we're really going to have a ball!"

Afterwards, staff reported that the residents were surprised that it was not an outside band. They had not expected the evening entertainment to be composed of their peers. There was certainly no hiding that these were older bodies, some mobility-restricted, others confused and occasionally disoriented. However, the audience enjoyed the music. A recreation staff member reported that a man from the unit said he thought the guys "weren't bad for amateurs." The band members felt proud afterwards, and those who were able congratulated the others. A feeling of camaraderie emerged during and post-performance.

The residents' experience of making music together follows Schütz's (1951) analysis of coperformance among fellow men. In playing music together, there is a mutual tuning-in relationship in which the players share in each other's experience in a synchronized active present. The band blends and moves together as a "we." Given that some of the band members lived with dementia, conceived by Leibing (2006) as a disorder of time, it is interesting that in music-making, those living with dementia tuned into the shared inner time of the unfolding musical events and the outer time of making music in a community of space. Schütz (1951) explains,

The coperformers have to execute activities gearing into the outer world and thus occurring in spatialized outer time. Consequently, each coperformer's action is oriented not only by the composer's thought and his relationship to the audience but also reciprocally by the experiences in inner and outer time of his fellow performer.... Each of

them has, therefore, to take into account what the other has to execute in simultaneity. He has not only to interpret his own part...but he has also to anticipate the other player's interpretation of his – the other's – part and, even more, the other's anticipations of his own execution....and [he] has to be prepared at any time to be leader or follower (p. 94-95).

Band members play along with the music, responding to one another and adjusting their own playing to match and blend with the music. The drummers would slow and lighten their beat according to the vocalist's melodic line. "The other's facial expressions, his gestures in handling his instrument, in short all the activities of performing, gear into the outer world and can be grasped by the partner in immediacy...these activities are interpreted by him as indications of what the other is going to do and therefore as suggestions or even commands for his own behavior" (Schütz, 1951, p. 95). Drummers and percussion players also had to be prepared to take solos when the band leader calls upon them, picking up the tempo and mood that had come before them. Other men become accessible fellow men in the flow of music making, to the extent that they participate together in one another's stream of consciousness and in so doing, they are "growing older together" (Schütz, 1951, p. 95).

Additionally, the band members were set apart from all of the other residents and recognized in their new roles as jazz band musicians. Members were recognized by the long-term care community as band musicians outside of band rehearsal or performance time, reinforcing their new identity. Berger and Luckmann (1966) argue that "The self is a reflected entity, reflecting the attitudes first taken by significant others toward it," and that socialization takes place when, "society, identity *and* reality are subjectively crystallized in the same process of internalization" (p. 132-133). New musical identities were supported and encouraged by

recreation and creative arts staff, the volunteers, and some of the care staff that ascribe to the humanistic approach to care, and the shift to a new mode of being seemed to be a positive experience that enriched life in long-term care.

Conclusion

Once resident-veterans had made the shift to the musical milieu, a new horizon of self-expression and social relationships emerged. Rather than being medicalized subjects who napped or watched films in their rooms, they became actively engaged music-makers and coperformers with other residents. The men came to know one another through their biographies as musicians in the past and in the present. Individual nicknames, signature songs, and signature musical gestures were adopted and reinforced in the group and helped each band member to stand out as a unique participant. Perhaps one of the most important aspects of the group music program was the opportunity to perform in concert dress for their peers. The performances not only gave the group a clear goal to work towards in rehearsal, but the experience of performance had a galvanizing effect for the group. It was particularly powerful for these residents because they had been performers in their younger years and this mode of self-presentation was not only familiar to them, but was part of a selfhood that did not carry the same constellation of age-related illness labels. Music-making facilitated each man's embodiment of an alternative version of himself.

Participation in the creative arts music programs also took place on the care units. The musical milieu overlapped with the medical milieu, making existential shifts more ambiguous as the intention of the program was framed by the clinical environment.

In the following chapter, I will illustrate how the recognition of the veteran-resident was significant to the operations of the facility. The chapter will explore how recognition transformed the body of the ageing veteran from a biological body to a politicized body. Further, I will

consider the social conditions that informed the politics of recognition among the veteran-residents.

Chapter 7

The Politics of Recognition

“Only the existence of a public realm and the world's subsequent transformation into a community of things which gathers men together and relates them to each other depends entirely on permanence. If the world is to contain a public space, it cannot be erected for one generation and planned for the living only; it must transcend the life-span of mortal men.”

— Hannah Arendt, *The Human Condition*

“Dispensia” Reprise

Recalling the ethnographic account from Chapter 4, veteran-resident, Mr. Davison, had explained to me that when he was first diagnosed with dementia he had told people that he had “dispensia.” This may have been a benign error on Mr. Davison’s part, but it may also have signalled an insight into the social consequences of the diagnosis. As discussed in Chapter 3, those who enter long-term care facilities have already failed at so many things socially, that they may feel rejected by society (Frank & Frank, 1993). New residents often feel abandoned and disoriented, and they may seek validation from the limited personnel in the long-term care facility (Goffman, 1961). The institutional influence upon residents’ identity cannot be overestimated. The doctor’s diagnosis of dementia was also a sentence of social “dispensia” according to Western norms of ageing and invisibility. When Mr. Davison arrived at the long-term care facility, he was just an old man who was confused and disoriented. He felt estranged from himself and his familiar surroundings, entrenched now in a seemingly anonymizing space of medicalization. However, in this milieu, Mr. Davison’s status was not simply “resident,” it was “veteran-resident.” The “V” next to his medical health record afforded him a new status as it did other veterans. He was not socially dead at all. In this environment, he was about to become

eagerly sought after and counted among the engaged, at least while his body and mind could be engaged.

The body of the ageing veteran is complex. On the one hand, it is marked by old age, a social category that is summarily dismissed and cast to the margins of society; on the other hand, the body is marked as a veteran and must be called forth to be remembered as a national symbol. As previously discussed, these men were the remaining members of a generation of living legends whose efforts had to be remembered; “Lest we forget,” the adage reads. Unfortunately, some veterans develop dementia, both mild and advanced, and were not always able to remember their stories. In a space devoted to remembering veterans who are living legends of the recalled past, what happens when those who are supposed to be remembered forget? How are the forgetful remembered? Under what social conditions were veteran-residents recognized?

This chapter will explore the way in which veterans’ bodies are multiply-inscribed and examine how the creative arts work not only on the individual and social body. It will also discuss how the musical performance facilitates recognition of veteran-residents as veterans during formal events. Ethnographic accounts will illustrate the social conditions that underlie the recognition of veteranhood among veteran-residents.

The Ethopolitics of Veteran Care

As described in the introductory chapter, the supportive care for veterans is in fulfilment of the social contract between the Canadian government and the overseas war service veterans. The national ethos underlying the social contract speaks to recognizing and rewarding the senior veterans for their service and ensuring benefits that “exceed the benefits afforded to non-veteran seniors” (Ives, 1998, p. 92). The discourse of veteran care centres around themes of sacrifice, service, and extraordinary recognition of the veterans.

At the local level of the long-term care facility, the national ethos of providing extraordinary care to veterans that is visibly superior to that provided for civilians was evident. “We feel grateful, honored, and proud to provide care for our veterans,” said the head of the facility at the 2015 Remembrance Day ceremony. “We know that we have a unique responsibility.... I would like to thank our veterans for giving us the opportunity to serve you.” The institutional ethos echoed the national ethos of veteran care, which in turn was adopted by workers in the facility. Staff and volunteers took a special pride or expressed that they felt “honored” to care for the veteran population, and thus needed to provide exemplary care. This expressed ethos of veteran care follows Rose’s (2007) definition of an ethopolitics of care, “attempts to shape the conduct of human beings by acting upon their sentiments, beliefs, and values.... [including] the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are” (p. 27). The concepts of “quality of life” and agency (“a voice and a choice”) stood for a politicized vitalism related specifically to higher standards of care for veterans. Rose notes that biomedical understandings of vitality have made life and biology malleable endowments that can be “reverse engineered,” and can open questions about the worth of different human lives (2007, p. 40). In the context of long-term care for veterans, doctors, nursing staff, and the creative arts staff all become professionals of vitality and are drawn into the politics of life.

As discussed in previous chapters, the facility’s exemplary service was visible in the recreation and creative arts programs dedicated to the veteran-residents. Herein lay the first level of vital politics where veterans were recognized differently than other residents. In particular, the recreation and creative arts department was used as a means to make veterans’ engagement and well-being statistically visible to the government and outside stakeholders, demonstrating that

they were upholding their end of the social contract. The creative arts were a specialized form of milieu therapy that restored veterans' bodies and identities through vital engagement, and provided a medium through which veteran-residents could be seen and heard performing as productive bodies.

A Veteran-Centred Milieu

The facility's environment evoked veteran identity. National political concern for veterans' care and public representation acted like a meta-doxa that encompassed the biomedical and creative arts approaches to care. This meta-doxa's intention toward the maintenance and promotion of veteranhood provided a point of unity between the doxas in the form of a higher-level instrumental purpose. As discussed in Chapter 3, the therapeutic intention was focused on emphasizing this common, shared aspect of veteran-residents' identities. As described in the introductory chapter show the cenotaph at the front of the building, the many banners with poppies and images of soldiers that adorn the hallways, and the paintings and memorabilia that memorialize past combat scenes. Visitors were invited into the veteran community through the facility's books, magazines, and other casual reading material, such as the newspaper of the Maritime Forces. The veteran population was the most visible group of residents at the facility.

As previously discussed, the creative arts helped make veterans visible through the production of artwork. If the goal of the creative arts programs was "civil re-establishment" for post-WWI and WWII soldiers, then it is arguable that the creative arts at the facility continued to establish a certain social order where the veterans were celebrated above others for their service to the country. Government officials at the national, provincial, and local level toured the creative arts studio, speaking with selected veterans about their art work, their experience during the war, and their lives at the facility. Visiting officials were sometimes given the opportunity to paint alongside a veteran-resident, with cameras on hand to capture the interaction. Some

residents enjoyed the opportunity to speak with officials, while others did not want the attention. One veteran-resident was known for painting remarkably detailed war scenes, but he was not much for media attention. When he was told he was selected to talk to the provincial premier and have his photo taken, he shook his head and said, “Oh shit...” Government tours were arguably less for the residents and more for the administration to show the exemplary quality of life provided to the veterans.

At the end of the encounter, the outside official was presented with a gift from a veteran-resident. The gift was often a piece of artwork that the veteran had created, such as a painting, or an object made from clay or wood. The living veteran-resident and their artwork carried a powerful aura, as noted in the introduction. The veteran-resident was a kind of living legend, the last of this quickly declining generation. Few firsthand witnesses to the events of WWII remained, thus the veteran-resident was a rare commodity with high social value. The artwork that the resident produces is also a rare commodity. How much longer would one be able to obtain the creative output from a WWII veteran? Following Mauss (2000[1925]), the clay mug and wooden birdhouse produced and signed by the veteran-resident take on a socially endowed fetishlike power, imbuing it with exceptionally more value than the same objects made by a resident who was not a veteran. I was not privy to all that was received by the veterans and the facility in exchange for the visit experience and gifts, but recognition of performed veteranhood was certainly given.

Veteran-residents were made visible through their artwork in a variety of other mediums. The facility itself published a professional-quality monthly newsletter, filled with high resolution photographs, quotations, and stories about its residents and staff. These photographs and stories were also published on the facility’s social media pages throughout the month. There was a non-

stop flow of new stories and images of veteran-residents at work. Each year at Christmas, the facility's foundation raised money by producing sets of holiday cards that featured the artwork of a veteran-resident. The original painting was framed and presented to the chosen resident at the Christmas concert by a local member of Parliament. Pamphlets, newsletters, social media posts, and a variety of other print media made some of the veteran-residents famous in the community.

The residents who were well and engaged in programs were seen, while those who were not able to leave their units because of their medical condition or because they did not want to participate were not seen. Age and illnesses such as dementia threatened to disrupt the social organization and social relations between society and the veteran. This could occur by rendering this population of living legacies extinct or reshaping the self such that veterans could no longer perform as veterans sharing their stories of war events and embodying the veteran identity. It is surely no accident that a selection process occurred when deciding which veteran-residents ought to be made visible, and which ones should be kept out of the picture.

Following Shillmeier (2014), the bodies of veteran-residents became more than bare life, they become "*political agents* in the diverse ways their orderings disrupt, question, alter and even endanger the normativities of 'healthy' bodies, their practise and relation" (p. 2). A selection of veteran-residents became the face of the entire veteran-resident population: those who maintained the image of the productive, well-cared for veteran. When these individuals were no longer healthy enough to participate, new individuals moved into the spotlight. I will return to the politics of recognition later in the chapter. For the time being, I would like to illustrate a key event during which veteran-residents were made visible to public audiences through music programs, specifically during the weeks leading up to and on Remembrance Day.

Self-Presentation and Singing “In,” not “Out,” of the Choir

The choir was one of the more structured music programs at the facility. It was run like a professional music rehearsal, with time allotted for vocal warm-ups at the beginning of each session. Voices were not divided into parts (soprano, alto, tenor, bass); instead, they sang in unison, with men singing down the octave when needed. The choir leader worked over sections of songs that were not familiar to residents or that were missing important articulations or rhythmic precision. The choir practiced a set program of songs in anticipation for upcoming concerts. In this case, the choir was rehearsing for the upcoming Remembrance Day ceremony.

“We sing as *one* voice, one,” the director firmly reminded the choir, “You have to sing *in* the choir, not *out of* the choir.” This musical format was very different than the more casual and improvised atmosphere of the resident bands and other music groups. In the choir, there was less room for signature songs and personal interpretations of the music. The rehearsal atmosphere was more serious and a higher level of personal comportment and blending into the ensemble was expected. Individual voices were not supposed to stand out, but rather blend in as one coherent sound. Musical beginnings, endings, and the placement of consonants like “t” had to occur in unison. The director did not simply sing through a song once and then move on to the next. “Group, group, group!” the director said. She explained to the choir, “Watch me, sing with me, always be aware of what is going on, and we will be together.”

Veteran-residents, particularly those without dementia, appreciated the way the choir was run. They liked the formal warm-up and the insistence on precision. These veteran-residents tended to be highly intolerant of people who disrupted the group by starting or ending lyrics too early or too late, adding personal flourishes to the endings, or speaking when the choir director was speaking. During my fieldwork, I sat with a resident who constantly called out, sang out of

time, and interrupted the group. Other residents who took choir seriously would angrily tell him to “shut up” and speak to the choir director afterwards about the disruption. Soon, we were relegated to the back row of the choir and eventually this resident was dismissed for his unruly and disruptive behaviour. Another veteran-resident living with dementia once arrived to the choir in a disgruntled state and during the warm-up he hollered out loud, “Oh, this is bullshit!” He, too, was removed by a volunteer and did not return to the choir.

The insistence on order came from the director and the choir members. This made the choir markedly different from any other music program where personal expression was encouraged. Not only did the choir resemble the rehearsals people were used to from church, community choirs, and early school years, but it also resembled the order and structure demanded in military settings. These residents were used to this kind of direction and routine and they took pride in the professionalism of the group. The desire for a professional music rehearsal may also speak to the way in which veteran-residents wanted to present themselves. Their identity included adhering to order, structure, discipline, and precision. The choir members followed instructions, performing each detail in perfect unison. Repetition ensured that the parts were well-rehearsed so that they could be performed cleanly. This particular mode of self-presentation mattered to the veteran-residents who participated in the choir, and as is the way with musical ensembles, if one person makes a mistake, the whole group makes the mistake. For the sake of their identities, conformity to the group norms mattered.

At one rehearsal, I spoke with a volunteer in her 30s. She was a modern veteran who had served in Afghanistan and returned with PTSD. Volunteering with other veterans was part of her rehabilitation into civil society. She hoped to start a business working with veterans and helping them recover from war trauma using the arts, so she found the choir very interesting to work

with. “The choir is structured. There is routine. I get that with the military. I’m very military,” she said. “I’m always early, I’m always punctual. This is how we are trained. Without structure, I try to figure out when I should get up, sit down, what do I do with myself?” She recounted her experience working with a few veteran-residents in the woodworking class, “They have their schedule but if you break them from their schedule, things change.” Resident-veterans who needed order and routine were happy to be in the choir and became upset with other residents who did not observe the same decorum in the choir rehearsal. Certain residents had to be seated at opposite ends of the group to keep the peace.

Expressions of resistance, like those discussed in Chapter 4, were not always welcomed by other veteran-residents. Self-presentation was important to many people and some people admonished those who broke the social norms. The implicit expectations of comportment may have been generational, but they may also have been related to military identity. The following section will illustrate the visibility of veteran-residents on Remembrance Day, the facility’s biggest day of the year.

Recognizing Veterans on Remembrance Day

Remembrance Day was the biggest day of the year at the facility. Residents could have only one family member accompany them to the Remembrance Day ceremony, and the facility was closed to any extra visitors for the morning. Some staff who had worked at the facility for over 15 years had never worked on November 11th. The weeks leading up to Remembrance Day were filled with special programs and tributes to the veterans. Legion outings, visits to the war museum, and programs focusing on reminiscence kept veterans busy. School children sent in drawings and thank you notes in English and French that were posted on bulletin boards in veterans’ units or given to the resident-veterans to keep. The children’s messages read along the

lines of, “Thank you for protecting our country and for helping the people.” The residents appreciated the sentiment, though often had to have the message read to them.

On November 11th, veteran-residents were dressed in a white button up shirt, neck tie, and their blue blazers (green blazer if they were Korean War veterans). Miniature medals (or “miniatures”) were taken out of the residents’ glass display case and fastened to the left breast of their blazer. The veterans transformed for a day. Suddenly, the men and women in uniform looked completely out of place at their usual breakfast tables on a long-term care unit filled with unremarkable hospital-style furniture and plain linoleum flooring. The residents looked healthier than usual and more distinguished. Even the way they carried themselves changed on this day. Their bodies were in a more upright posture and there appeared to be a new confidence about them now. No matter what one’s feelings are about recognizing veterans for their service, this transformation left everybody awestruck. I wrote in my field notes, “*These* are the men I have been playing music with?!” The divide between myself and the men I had known rather casually instantly became wider. It was not that prior to this they were not treated respectfully or kindly, but their simple status as resident-veterans did not imbue them with the same authority that they now commanded when in uniform.

Most veteran-residents participated in the day by attending the ceremony, while a select few were chosen to lay wreaths or deliver a reading. About 35 veteran-residents participated in the facility’s choir throughout the year and the highlight of the choir program was performing at the Remembrance Day ceremony. Some veteran-residents also sang at smaller ceremonies hosted by the facility and attended by government officials, such as the Vimy Ridge memorial ceremony and the official opening of additional long-term veteran beds. The choir was the largest group of performing veteran-residents. As mentioned above, uniformity in voice and in

self-presentation were expected for performances, aligning very much with the expectation of military service.

Two weeks before one Remembrance Day, the choir director finished the warm-up and handed out the song books for the ceremony. She reminded the choir, “We are preparing for Remembrance Day in two weeks. On the day, we sing between 10:15 a.m. and 10:45 a.m. Then the service starts, and later on there are two hymns. Volunteers will start getting residents at 9:30 a.m., and we will sing for about half an hour.” Veterans were reminded to wear their blazers with their medals, dark pants on the bottom, and a white shirt under the blazer. The songs were all classic wartime tunes, many from WWI, that the veterans knew without the written lyrics, “I’ve Got Sixpence,” “All the Nice Girls Love a Sailor,” “Lili Marlene,” “Bless ‘Em All,” “White Cliffs of Dover,” “It’s a Long Way to Tipperary,” and “Pack Up Your Troubles.” In the middle of songs, the choir director called to the group, “Put the song books down! You all know these!” There was a common stock of musical repertoire that was shared among this cohort of veteran-residents. As the veteran transition progressed, the songs that were known by heart and so beloved by this group of veteran-residents gradually disappeared from the everyday repertoire. Nevertheless, the songs were still sung at the Remembrance Day ceremony I attended with the choir in 2017.

The choir setting and the repertoire made the cohort of veteran-residents visible. “How many sailors do we have here today?” asked the director. Several men put up their hands. “How many from the army? And how many from the air force?” More vocal residents cheered as their service was called out. Within the choir, recognizing each other as veterans was given time and space. A few of the choir members were not veterans or were tenants from the adjacent assisted-living apartments. These members spoke about what an honor it was to sing with the men and

women who had served the country. Audiences for whom the choir sang also recognized the veteran-residents. The songs the choir sang did not just make these veterans visible, they also made past generations of veterans visible. The music and the people were there for themselves as visible living legends, but they also symbolized those who were not visible because they had passed away, did not choose to sing in the choir, or were too ill to leave their units.

On the day of the ceremony, all staff, volunteers, and residents were given poppies to wear. Special instructions included helping residents make sure they were on the correct song at the correct time, especially for the hymns that were printed in the program in a font that was too small for residents to read. Much of the ceremony, though dedicated to the veteran-residents, was not designed for them. The program was printed in tiny font, the speeches were long, and the program seemed to run on without any indication of the order for the residents. It was a very long time for many of the veteran-residents to stay still and silent, particularly those living with dementia. Choir volunteers had to make sure that a few members of the choir were placed in specific spots so that they could be easily moved when the time came to lay a wreath or deliver a reading.

The veteran-residents were portered to the cafeteria where the ceremony would soon be held, then they were assembled in rows in the area reserved for the choir. Some residents brought themselves to the choir. The sound level began to rise in the space as more and more people entered. Looking around, one of the 10-year choir volunteers said to a new volunteer, “It’s going to be wall to wall people here. Just watch. You’ll see. It’s nice.” Residents who arrived without their poppy and medals were assisted back to their rooms to get them. As we helped get resident-veterans arranged, another long-time volunteer advised the group of newer volunteers to watch out for residents who try to stand during the singing of the national anthem. “They’re in another

mode today. They have their jackets and their medals and they think they can stand because they did it for so many years, but some of them will need help because they aren't as steady as they think they are. A really nice thing you can do is say, 'Thank you for your service.' I always say that to whoever is sitting around me. And if you have Kleenex, take them, because I cried for the first 4 years."

I helped porter Mr. Hughes. I found him in uniform, sitting at his breakfast table finishing his morning coffee. He had one of the annual children's cards in his hand. The card was written in blue pencil crayon with poppies drawn all around it. The message read, "Bonjour, je vous remercie pour proteger notre pays et la liberté." Another on the table read, "Thank you for fighting in the war for us." "That's nice of them. I can't read them," said Mr. Hughes, "so what are we doing today?" Just then, another resident's wife called out to Mr. Hughes, "Look at you! You look so handsome!" It was a day for compliments to the veteran-residents. "I didn't know it was Remembrance Day...I should have," said Mr. Hughes. I reassured him that it was alright and we were going to sing with the choir. With Mr. Hughes in tow, I found my next resident, Mr. Clarke. He was not dressed in a white shirt. The PSW said that he refused to get dressed up, "He said no to everybody. 'Why do I have to dress up just because it's Remembrance Day,' that's what he said." I brought Mr. Hughes down to the choir and checked with the choir director about what to do. She said that if he did not want to dress up, we were not going to force him, he could come and sing anyway. This seemed like a much more lenient position than had been espoused in rehearsal; however, I carried out the instruction to bring Mr. Clarke, no matter what he was wearing. I signed him out on the resident sign-out sheet at the unit desk and we started our walk to the cafeteria. As we arrived at the choir, Mr. Clarke looked around at the other resident-

veterans and modern servicemen who were assisting for the day, and said, “I should have worn my medals, so everyone would know I was a war hero!”

Sitting in place at the ceremony, the piper began to play over the loud sound of the assembling audience. When the piper stopped, the choir began singing “I’ve Got Sixpence,” urging the audience to start taking their seats. The choir sang through the song pack that was rehearsed in the weeks before. The mood was light and fairly casual as the resident-veteran next to me sang the “navy” version of the songs under his breath. For the song “I’ve Got Sixpence,” the veteran-resident next to me added the words “dead drunk” to the refrain “Rolling home [‘dead drunk’], Rolling home [‘dead drunk’], By the Light of the Silvery Moon. Happy is the day when we line up for our pay, As we go rolling rolling home [‘dead drunk’].” The veteran-resident also liked changing the words from “It’s a Long Way to Tipperary” to “It’s a long way to tickle Mary.” Despite cautions from the director during rehearsals that Remembrance Day was not the time to sing the alternate versions of these songs, a few residents, including the one seated next to me, did it anyway. When I cast a sideways eye toward him, he raised his eyebrows and said, “What? I can’t have a little fun?!” In the middle of the somber Remembrance Day ceremony, I was not prepared to get into a discussion about the director’s instructions, nor was I comfortable admonishing a veteran in this setting.

As the choir finished the set of songs, the organ took over playing and I turned to Mr. Clarke, the veteran-resident, who was sitting next to me to explain the program. I said that we would need to sit quietly through the program that included a welcome, then a message from the Prime Minister of Canada. “Oh, wow!” said Mr. Clarke, “Do I have to go up and make a speech?” “No, no,” I said, “We stay here.” I continued explaining that there would be an address from a member of Parliament, then the Veterans Affairs minister, then the National Anthem had

to be sung, then there was a long list of wreaths that would be laid. About 5 minutes later, the ceremony began with a welcome from the President of the facility. His address spoke of “remembering with deep respect the lives of the men and women who paid the ultimate sacrifice for *our* freedom.” He invited a veteran-resident to read the address from the Prime Minister, Justin Trudeau, in English and then in French. By this point Mr. Clarke was already becoming impatient. There was a great deal more ceremony left to go.

The local member of Parliament was next to address the audience, which had started to cough, grumble, and try to listen quietly. His speech emphasized the discourse of remembrance and strength:

Whether it be warm memories of last dances and the anticipation of deployment or much more sober recollections of lost opportunities, lost friends, and the true meaning of sacrifice, today is an open invitation to deepen our collective memory. What we are remembering is a message of hope, justice, peace, and remembrance...We remember the Canadians who gave so much of themselves through long and deadly battles with the forces of tyranny, aggression, and despair, those who indeed tested their strength...They have gone to fight for those who cannot fight for themselves.

The speech spoke of remembering the people who were present, but also the “common humanity” that everyone shared. Several more speakers gave an address, including a representative from Veterans Affairs Canada. As Mr. Clarke hummed softly next to me and tried to get my attention, I could hear the speaker offer similar words about sacrifice for the values of freedom, truth, knowledge, justice, and peace, and the institution of Veterans Week as a way to “salute the courage of our veterans and their fallen comrades for the benefit of generations to come...It is a time to renew our pledge as a nation to continue to work for the well-being of our

veterans, Canadian Armed Forces, RCMP personnel, and their families...It is a special time for Canada to honor our heroes. It is a point of pride to publicly demonstrate to those who are still with us our gratitude for their service to our country. Today we are remembering those who never got to grow old.” After this discourse of universality, national pride, and veterans’ sacrifice, the audience stood to sing the national anthem and the playing of “The Last Post.” Mr. Clarke hummed along with the melody and at the end leaned toward me and said, “That a boy! He didn’t miss a note!”

From out of sight, the piercing sound of bagpipes began, going straight to the bones of the audience. Louder and louder the single piper sounded as he led a slow procession of wreaths to be laid at the altar. Residents began to get restless, waiting in silence and unable to see what was happening. The traditional reading of “In Flanders Fields” was followed by a hymn, addresses by spiritual care leaders, the collective recitation of the Lord’s Prayer, and final words,

“You may be seated,” said the announcer, to which Mr. Clarke responded, “I was about to fall down.” The speaker began again over the sounds of one resident’s hacking cough. Mr. Clarke looked astonished, saying, “There’s *more*?” The program closed with a reiteration of the institutional ethos of care for the veterans from the head of the facility: “I would like to take a moment to express what most likely our volunteers and staff are feeling today. We feel grateful, honored, and proud to be able to provide care for our veterans. Everyday our volunteers and staff bring their hearts to work, which is part of what makes this place so special.” As the audience thinned out, there were numerous media interviews that took place with veteran-residents who had been selected. Numerous photos were taken and the adjacent pub was filled with modern servicemen and women sharing a drink with veteran-residents. No doubt, those being interviewed were of relatively sound body and mind to qualify for the opportunity. It was a long

ceremony, designed less for the resident-veterans' enjoyment than for the documentation of an official discourse. The visibility of the veteran-residents was important, but for political reasons.

The Politics of Recognition

As an ageing veteran in this facility, one did not readily disappear as older people in Western society typically did. They were not “dispensed with” as Mr. Davison worried about in the opening ethnographic account. Following Foucault (2003), the careful surveillance of the facility by the government bodies ensures that they ascribe to the biomedical ethos of “make life,” lest they “let die” (discussed in Chapter 2). Veteran-residents were shown to be alive and productive through the therapeutic creative arts, or what Rose (2007) would brand “technologies of life.” Such technologies applied to the healthy and the infirm, promising to “intervene upon them in order to optimize the life chances of the individual” (p. 19). Whether woodworking, painting, doing pottery, or making music, or singing in the choir for rehearsal and performance on Remembrance Day, there was evidence of life happening on an individual and collective level. The performance of a certain type of veteranhood was part of the social conditions for recognition. Here, the concept of the politics of recognition refers to the power asymmetries and processes of social construction that select and reproduce veteranhood.

The collective productivity of the veteran-resident population was significant on an everyday basis, but their performance was especially important on Remembrance Day. Following Arendt (1958), the performance of the veteran role by veteran-residents fulfilled a productive function. The comportment, dress, and discourse that accompanied the performance was important to show sameness within the community. Not only did they look the same in their uniforms, but they also symbolized the same historical narratives and values. It was this assembly that granted them political visibility and gravitas. Arendt (1958) said, “The space of appearance comes into being wherever men are together in the manner of speech and action....

Wherever people gather together it, [the space of appearance], is potentially there, but only potentially, not necessarily and not forever.... Power is what keeps the public realm, the potential space of appearance between acting and speaking men, in existence" (pp. 199-200).

Whether in the setting of a formal Remembrance Day ceremony, or around the workbenches in the art studio, the presence of a collective of veterans had political weight. "The only indispensable material factor in the generation of power," said Arendt, "is the living together of people. Only where men live so close together that the potentialities of action are always present can power remain with them.... Whoever, for whatever reasons, isolates himself and does not partake in such being together, forfeits power and becomes impotent, no matter how great his strength and how valid his reasons" (1958, p. 201). In the context of a veteran-centred long-term care facility as a total institution, veteran-residents who engaged in programs, such as the choir and the resident bands, become more visible than those who either choose not to, or were unable to participate. Further, those who participated in programs like the choir were expected to follow certain social norms of conformity and self-presentation. When residents did not abide by the social norms, measures were taken to reduce their visibility and impact on the group. On Remembrance Day, a formal mode of self-presentation was implicitly expected from the veteran-residents as part of the social conditions of recognition.

The veteran-residents were not mere biological bodies to be kept alive through medical care. Far more than biological entities, these residents had political significance. Their bodies were politicized as symbols of nationalism, and as testaments to Canada's war history. Veteran-residents' visibility was also connected to the viability of the facility as a model of veteran-centred care. The veteran-residents who spoke about their experience in the war, painted scenes of war, sang war songs, and remembered together were important for the maintenance of the

total institution. Even more powerful was when the veteran-residents gathered together *en masse* as they did on Remembrance Day. Arendt writes,

Power preserves the public realm and the space of appearance, and as such it is also the lifeblood of the human artifice, which, unless it is the scene of action and speech, of the web of human affairs and relationships and the stories engendered by them, lacks its ultimate *raison d'être*. Without being talked about by men and without housing them, the world would not be a human artifice but a heap of unrelated things to which each isolated individual was at liberty to add one more object; without the human artifice to house them, human affairs would be as floating, as futile and vain, as the wanderings of nomad tribes. (p. 204)

The music programs created spaces where veteran-residents can be assembled together to sing the same songs that symbolized a common historical narrative. In so doing, their collective presence also symbolized a common set of values within the political community of veterans. The creative arts program was the most important milieu in the facility through which veterans' political significance and visibility was produced. The resident-veterans' engagement in these programs and their artwork and performances had social meaning far beyond entertainment for themselves and other residents. Indeed, there were myriad layers of political significance and visibility that were negotiated through the creative arts activities.

The veteran-residents remained political objects because they were members of the declining generation of WWII and Korean War veterans. Arendt (1958) reminds us that the *vita activa*, a life of action and speech, materializes, memorializes, and makes permanent the human artifact that permits remembrance and power. This remembrance and power ensure that the living deeds and words (in this case, the narratives of war service), survive beyond the present

generation. The audience of *vita activa*, achieved through the creative arts, constitutes a community of listeners and transmitters of the immortalized narratives. The audience (or the facility) becomes a political community and a community of remembrance: “Behind the actor stands the storyteller, but behind the storyteller stands a *community of memory*” (d’Entreves, 2018). The following ethnographic story illustrates the social conditions of recognition in the case of an official Veterans’ Week ceremony where a small group of resident-veteran singers was selected for performance.

A Selected Few Singing for a Generation

In 2016, a ceremony was held during Veterans’ Week to introduce the new poster commemorating the battle of Vimy Ridge. The 100th anniversary of Vimy Ridge was coming up the following April, and special efforts were being made to recognize Canadian veterans. As part of the ceremony, a small group of about six veterans was assembled to perform for the large audience in the great hall. These veteran-residents were chosen because they knew the song repertoire exceptionally well and were known to perform well for an audience. The men also enjoyed singing in concerts. Sitting amongst the ensemble, I noticed that the room was full of government officials, men and women in uniform, and well-dressed visitors. The poster was covered with fabric, waiting to be unveiled. The audience chatted amongst themselves, as the veterans were assembled into their positions by the piano.

I was seated between two veteran-residents living with dementia. On my left was Mr. Leduc, an air force veteran, and on my right was Mr. Barnes, an army veteran. We were arranged in two short rows, side-by-side. “Look at them, they look lovely” said a staff member off to the side, remarking on the blue choir neckties they all wore on top of white collared shirts. The mood in the ensemble was light-hearted and carefree. As the men and I bantered about the

weather, the musician at the piano began playing. Mr. Barnes turned to me and asked, “What’s going on here, young lady?” “I don’t know,” I said to him. “What do you mean you don’t know, you’re a sort of a boss here,” he retorted. Just then, Mr. Leduc to my left, who thought I said that I didn’t know what song was being played said aghast, “You don’t know Roses in Picardy?” Before I could answer, the veteran behind me asked if I had given him a sheet earlier to read from the Bible, but I corrected him that it had not been me. He said he left it in his room, and it was his. I spoke quietly with a staff member and she said that he was doing the reading on Remembrance Day, not this day. It was obvious that he didn’t know what the ceremony was; he just knew he was there to perform. As I turned back toward the room where the event had not yet officially begun, Mr. Leduc, asked if I ever cut my hair, to which I quipped, “No, it keeps my ears warm.” To my right, Mr. Barnes asked, “Something special going on here, dear?” “Yes,” I said, “something special for the veterans,” as I pointed out all the men in uniform and the recording cameras that stood at the back of the hall.

The piano continued playing background music, as Mr. Leduc asked me, “Have you ever been to Vimy Ridge?” I told him I had not and asked if he had and what it was like. “It was pretty rough,” he said. “There were a lot of army troops when I was there. I didn’t have a camera to take a picture. When they told me I was going to go to Vimy Ridge, I thought, ‘Oh my God, no...’” His voice trailed off as a new song began and the men joined in word for word on “Bless ‘Em All.” The crowd stilled, then picked up again, and the music segued into “We’ll Meet Again,” another wartime song. A few lines in, Mr. Leduc asked again if I had been to Vimy Ridge, forgetting he had asked me before. I replied that I had not and he told me more of the story he had begun before. I was surprised by what he said. “It was quite the place. Very simple. There’s nothing really elegant there. I was disappointed when they said I was going to Vimy

Ridge, I thought I'd see something. I didn't see nothin.' I was only 19, though. Just a kid." I did not have time to ask anything else because just then the audience rose to their feet. The piper made a grand entrance as the skirl of the bagpipes filled the room.

The audience was asked to remain standing for the national anthem and the ensemble of veteran-residents sang loudly along with the piano. As the audience took their seats, Mr. Barnes asked, "How come they don't stand for us old soldiers, I should say, *we old soldiers?*" "I don't know," replied Mr. Leduc. Mr. Barnes continued, "They just sit down and look at us." The Master of Ceremony began the event, welcoming a long list of government officials, members of the Legion, the residents, veterans, including members of the Korean Veterans Foundation, and many others. An official from the facility came to the podium to speak. He expressed gratitude to the veterans for their sacrifices for peace and freedom in the country and to the supporters who ensured that exceptional care for the veterans continued. He went on to explain that Veterans Affairs Canada funds the recreation and creative arts program that is "the jewel in the crown" of the facility. He remarked on the long history of the veterans' choir, adding, "It is not the words that bring back the memories, it is the voices and the music that make it so remarkable."

With an introduction from the piano, the men launched into "I've Got Sixpence," segueing into "White Cliffs of Dover," then into a jaunty rendition of "Pack up Your Troubles" followed immediately by "It's a Long Way to Tipperary" as was the usual sequence when they were sung at the facility. The short performance concluded with the chorus from "The Battle Hymn of the Republic" they sang "Glory, glory, hallelujah! Glory, glory, hallelujah! Glory, glory, hallelujah, His truth is marching on." The audience erupted in applause, and from my right, I heard Mr. Barnes say, "What nice people!"

With an additional list of acknowledgements, the Vimy poster was unveiled. The speakers' closing remarks thanked the staff for keeping the residents in a "happy, comfortable, contributing state," remarking on the role of the arts in building a sense of community and building better lives for the veterans. The event lasted perhaps a little over half an hour, and the music was the dominant feature of the program. While the ensemble was enjoying cake and coffee, the former Minister of Veterans Affairs introduced himself to the veterans, shaking their hands and thank them for their singing. "Whether your economy is up or down," he said, "what keeps people connected to community is the arts."

The arts, the veteran-residents, and the construction of a community of veteranhood went hand-in-hand. This small group of veteran-residents stood for their entire generation of veterans, whether they realized what the occasion was or not. To the audience, the veteran ensemble's songs made the event authentic. As mentioned above, the veteran-residents were chosen because they were able to perform well and were known to enjoy such experiences. On some occasions just one veteran-resident was selected to perform a song for an official ceremony, standing alone as the representative of a generation. In return, they were recognized by the audience, receiving grand applause, media attention, and special recognition from government officials. Once again, song was used to restore veteranhood (Chapter 3). Unlike band performances where the men could assume any personality they chose (Chapter 6), these performances required the production of a certain kind of military identity as a social condition of recognition.

Conclusion

The politics of recognition are important to consider for several reasons. It is important to understand social conditions in which people can be unmade and re-made as medicalized subjects and as political subjects in different environments. In both cases, a normativized

identity, either as model resident or model veteran, is impressed upon the individual receiving care. Those who are able and choose to conform to the idealized image become visible in the community; while those who are not able to or resist conformity become less visible. Conforming to a normative identity was part of the social conditions for recognition.

Expressions of resistance were an important way in which residents who were acted upon reacted against the institution and reclaimed their agency. In this chapter, expressions of resistance were evident when veteran-residents did not want to be photographed, outwardly complained about the choir rehearsal warm-up and the length of the Remembrance Day ceremony, and sang their own versions of the choir songs in performance.

This chapter also illustrated that even the most earnest doxas of care, the creative arts, were practiced in socio-political and economic contexts. The artwork and music made by veteran-residents was created in a milieu that valued their contribution for itself and enhanced their feeling of competence and selfhood in a dominantly medical milieu with its own approaches to care. Performances and artwork produced by veteran-residents was imbued with social power because of its association with a disappearing generation. Participation in the weekly choir rehearsals was an important way for veteran-residents to engage in a high level of music-making with a professional tone, akin to the precision expected in the service. The choir was called upon to sing for ceremonies of political significance that garnered media attention, but the priority was placed on residents' enjoyment of the weekly rehearsals. Throughout my fieldwork, I did not question that the artists, musicians, and music therapists wanted anything but to provide the best, most humanizing care for the residents.

The creative arts provided a milieu that allowed for the socially and politically significant performance of veteranhood as articulated by the milieu. The power of the creative arts to evoke

and showcase veterans was essential to sustaining the facility, and it was something that the biomedical milieu could not accomplish. Thus, even though the creative arts were often recruited into an ambivalent relationship of therapeutic care under the auspices of the biomedical doxa, they also stood alone and accomplished their own socially and politically significant ends.

The following concluding chapter will summarize the key points made throughout this dissertation and raise important concerns and critical questions for future research.

Chapter 8

Conclusion

The dissertation has investigated the significance of the creative arts in long-term care for ageing Canadian veterans. This ethnographic study raised questions about national memory and identity construction, as well as how the creative arts makes veterans visible by providing a milieu for self-expression. Across the chapters, it was evidenced that the performance of veteranhood was not only important to the lives of the resident-veterans, but it was also vital to the survival of the facility dedicated to serving the ageing veteran population.

This dissertation contributed to the anthropological literature that investigates the nuances of age and ageing as a situated experience, helping to address the gap in knowledge signalled by Lamb (2005). Not only does this work contribute to the lacunae in ethnographic research of long-term care in Canada (Stern, 2006), but it also contributes to the knowledge gap about the experience of ageing men (Wentzell, 2013) as Canadian veteran-residents in long-term care. While the gendered focus of the work was circumstantial because very few female veterans participated in the music programs that I observed, this limitation was also a benefit to the academic field. This research provides a perspective on ageing that goes beyond previous ethnographic research that focused on critiques of biomedicine and ageing (Cohen, 1998; Lock, 2013). By approaching the experience of sociality among Canadian male veterans in long-term care through a creative arts lens, this work extends the anthropological discussion to a more humanistic dimension of selfhood and relationship. From the perspective of the creative arts, the work gleaned novel insights that might have otherwise been overlooked.

One of these insights is the impact of the national and institutional ethos on the un-making and re-making of identity among veteran-residents in the facility. Following Lamb's

(2005) observation that we are aged by culture, it is important to understand how environments can influence how people experience ageing. Critical long-term care ethnographies have remarked on the impact of social structure and staff-resident relationships on residents' experience of selfhood (Baumbusch, 2011; Diamond, 1986; Hornum, 1995). The organizational tensions inherent to the everyday practices of the care facility were found to shape how residents experienced ageing. This research illustrated the contested and ambivalent character of long-term care as a social space. The tensions between the dominant biomedical doxa of care and the creative arts doxa of care were explained in terms of their impact on veteran-residents' experience of self and capacity to engage in programming (Chapter 5). Each doxa constructed residents according to its own practices and beliefs about what it meant to be an ageing body in long-term care, which in turn influenced the residents' mode of being in the world. Residents made not only a physical shift between their unit and a program, but also an existential shift, assisted by porters who negotiated the tensions between the two doxas of care.

It was shown that the creative arts doxa was ambivalently related to biomedicine as a therapeutic intervention through its focus on symptom alleviation and statistical documentation; However, by virtue of its more holistic approach to care, the creative arts doxa was also shown to be useful in ways beyond the capacity of biomedicine (Chapter 3). Returning veteran-residents to the medical environment from the creative arts environment shored up ethical tensions about quality of life and well-being. Ethnographic findings illustrated that the tensions between the doxas of care were not only felt by porters, but were also felt by the staff and the residents who sometimes refused to return to the care unit and adopt the identity as a resident at the facility.

This dissertation also showed that people living with Alzheimer's disease and dementia possess forms of agency. This finding builds upon the work of scholars interested in embodiment

and selfhood theories (Kontos, 2003; Silverman & McAllister, 1995). Silverman and McAllister (1995) explored the importance of continuity of social roles in long-term care and the influence on resident engagement, sense of self, and self-worth that accompanied being able to continue habitual practices in the care environment. Similarly, Kontos (2003), explored the central role of the body and its expression for communicating one's sense of self and personhood (an "embodied selfhood"), among people living with dementia in long-term care. The present ethnographic data illustrated that even in advanced dementia, people were able to communicate with each other and staff in meaningful ways and assert their selfhood through expressions of resistance on and off the care unit (Chapters 4 and 7). Within the creative arts milieu, veteran-residents expressed resistance to being acted upon by the institution. They performatively reclaimed their agency during music sessions on care units (Chapter 4), in band rehearsals (Chapter 6), and in the choir rehearsal and performance (Chapter 7). These findings about expressions of resistance among older people in long-term care constitute a novel contribution to the field of the anthropology of ageing. Performances of resistance as expressions of agency ought to be further considered in future research.

Moreover, using a phenomenological lens, this research emphasized the significance of sensory experience for constructing a sense of identity and establishing relationships among veteran-residents. Drawing upon phenomenological theories of perception (Merleau-Ponty, 2012[1945]; Straus, 1966[1930]) and of intersubjectivity (Schütz & Luckmann, 1973), the research showed that sound (both remembered and produced) had a significant role in veteran-residents' relationship to themselves and to one another (Chapters 3 and 6). It was also shown that the experience of music, such as playing in resident bands and singing old war songs, had a strong influence on shaping veteran identity, individually and collectively. In resident band

settings (Chapter 6), the men adopted new identities through nicknames and signature songs. These music-based identities were a refreshing alternative to the medicalized identities they were assigned on the care units. They were recognized not for their pathology or symptoms, but for their musical talents. Performances of these new individual and collective identities as band members had a galvanizing influence on the group. Events such as Jazz Cafés and larger-scale performances elicited recognition and applause from peers, volunteers, care staff, and sometimes family members.

This dissertation has shown that the creative arts play a central role in the recognition of veteran-residents as veterans (Chapters 3, 4, 6, and 7). The dissertation traced the experience of transition and un-making through medicalization (Chapter 5), to being the experience of being re-made into a veteran in the creative arts milieu (Chapters 4, 6, and 7). In the context of group music-making, the cultural accent of the remembered war songs reinforced the men's identities as soldiers. Remembering old war songs (and their alternative versions of the songs from their service days) connected them with emotionally powerful experiences that they could only truly share with fellow veteran-residents (Chapter 3). In the musical milieu, the veteran-residents shared their narratives of the experience of war from their younger years, something they rarely spoke of to one another in the halls. The music seemed to create an evocative space that supported sharing recalled narratives. The performance of these war songs and war stories made them veterans. In Chapter 3, I argued that the effect of singing war songs was so strong that it seemed as though the creative arts became a milieu therapy to restore veteran identity and provide performances of veteranhood that reinscribed the facility's broader function as a veteran-centred institution.

Finally, this dissertation showed that the creative arts milieu was integral to the recognition of veterans, providing them with a means of expression that was simply not available in the medical milieu of the care unit. Through music performance, artwork, and recalled war stories, this work engages with the broader topic of national memory and identity construction. Following Foucault's (2003, 2008) work on biopolitics and docile bodies, and Rose's (2007) concept of vital politics and ethopolitics, this dissertation explored how the national ethos of veteran care was translated and reflected in the institutional ethos of care for the veteran-residents. There were social conditions that informed how, when, where, why, and how a selected individual was recognized. Recognition was a socially-situated practice with its own tensions of power, resistance, and agency. Veteran-residents were made visible because of their value as national symbols and living testimonies to national war history; however, visibility was not a guarantee, and depended on qualifying factors (Chapter 7). The public visibility of the veteran-residents has significant socio-political implications. It raises challenging questions about identity construction and production of the ageing veteran population, and about the matter of continued reciprocity from the veteran-residents to the government that supports their care.

The thrust of this dissertation lies in the role of the creative arts in the lives of veteran-residents living in long-term care. Participation in the creative arts provided a life-line for residents who needed one. The arts milieu was important for people's lives because it created a forum for embodying an alternative identity to the medicalized one that was based on pathology and symptoms of ageing: it provided social relationships that were forged through music-making and shared identities; and it also provided purpose, direction, and meaning for veteran-residents during their time in long-term care. If ageing is a situated experience that is shaped by culture,

then the veteran-residents who participated in the creative arts had a more positive experience at the end of life because of the humanistic culture fostered by the arts staff and volunteers.

Integrating a holistic approach to care into a biomedically-dominant bureaucracy required negotiations. At the everyday level of creative arts practice, music rehearsals and performances were vital outlets of self-expression, agency, and self-authoring for veteran-residents. At an institutional level, there was a complex register of political exchange that intersected with the creative arts in various ways, such as mandatory documentation, touring officials through the art studio, and the public promotion of the veteran-residents' engagement and war narratives. The politics of recognition are a broader part of the institutional story of the facility that informed the veteran environment. The reader should keep in mind the phenomenological insights and the everyday lived experience of sound in long-term care. In particular, it is important to consider the influence of sound (and music), both remembered and produced, on residents' experience of self-alienation, recognition, and self-authoring in the long-term care environment.

Future Research Directions

Future ethnographic research is needed to more closely examine the ethopolitics and the politics of recognition among veterans living in long-term care, particularly veterans' expressions of resistance. As discussed in the dissertation, music was a way through which veterans expressed resistance and vehicle for self-authoring. Future research with new cohorts of veterans would uncover more about the connection between military culture and musical culture. Looking at expressions of resistance would facilitate discussions about the tensions between lived experience and institutional structures. This research would speak to larger issues of institutionalization, governance, and the performance of self and sociality in private and public life.

Gender must be more closely addressed in future work and should capture the experience of female veteran-residents living in long-term care. A limitation of the present dissertation is the absence of female veteran-residents' voices because there were proportionately fewer female veterans than male veterans at the facility, and even fewer female veterans who attended the music programs in which I participated. As the women of the men in this dissertation begin to move into long-term care, their experience of music, selfhood, sociality, and veteranhood should be explored. Pursuing a gendered approach would contribute new findings to the experiences of Canadian veterans in long-term care. Specifically, such a direction would open opportunities to explore gendered experiences of musical cultures during the war and look at the relationship between past and present expressions of veteranhood through music. Further, it would be interesting to explore the differences among music cultures of the Army, Navy, and Air Force, comparing veterans' wartime musical cultures to their experiences of music in the long-term care setting. This would be both historically and phenomenologically significant.

Future research should include additional perspectives from family members and caregivers who witness the transition and could speak to the changes between home-life and institutional-life for the resident, particularly with regard to the institutional emphasis on veteranhood at the end of life. Insights may be gleaned from engaging with different modalities of creative arts therapy, such as painting, pottery, and woodworking where veteran-residents also spent their time together. As the cohort of veterans shifts to include younger veterans who served in modern combat, it would be worthwhile to look at how veterans construct their identities with one another across generational divides in creative arts spaces. Preliminary notes show that the WWII and Korean War veterans do not share a common musical repertoire with modern veterans to the same extent as they did with the WWI generation. Locating points of relationship between

the cohorts within the arts would be interesting in understanding sociality among the cohorts now living together in long-term care.

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