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Care Aesthetics and 'Being in the Moment' Through Improvised Music-Making and Male Grooming in Dementia Care

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Abstract

Care aesthetics is a unifying concept that aims to make visible the often-invisible aspects of sensory and embodied practices of care. Relations shaping care can be understood as aesthetic practices, requiring us to unlearn an overreliance on technical perceptions of care, and reframing our understanding of care by recognizing that the technical elements are intertwined with sensory attributes. In this article we map out the concept of care aesthetics and using a case study approach, apply it to two examples of care within dementia settings – one an example of hairdressing in an

NHS in-patient assessment ward and one community-based music-making programme for people living with dementia and their carers. The study's rationale is based on the claim that expanding the richness, complexity, quality, and craft in care relations (between people, and between groups of people in care settings, to include families and broader context) *improves* the quality of life of people receiving care. If there are multiple skills and behaviours available in care relationships in health and social care settings that are undervalued and unacknowledged, what might attention to those skills' embodied, sensory, and crafted nature help to demonstrate? The article places care aesthetics in dialogue with the "in the moment" framework for dementia care research and aims to foster learning about how to better understand everyday life practices in health and social care settings. With this, the article demonstrates how attention to aesthetics reveals often unacknowledged elements of care.

Introduction

Care aesthetics is a concept that identifies the sensory relations and embodied practices between two (or more) people in a caring relationship as a site of importance for both analysis and recognition. It makes the claim that these relations can be understood as aesthetic practices. That is, they cannot be fully comprehended if we rely on analysis that reduces them to technical proficiencies or natural/intuitive competencies. In using the term aesthetics, attention is drawn to the practiced or crafted nature of care relations and the resulting sensory experience. The use of the body, the exercise of touch, the tone of voice, the awareness of space and the construction of practice across time, all contribute to care aesthetic experiences. The framework of care aesthetics is noting the "craft" or "artfulness" of care practices and applies equally to informal care undertaken at home or provided in formal care settings, such as in a hospital ward or a care home. It focuses on, for example, those care practices that demonstrate acute awareness of the use of the lifts, holds, touches and embodied presence that are important for the quality of care that is delivered, but are too often edited out of more technical accounts.

The concept of care aesthetics also designates something broader. It proposes that the moment of care, whether between two people, or between multiple people in a care context, can be analysed for the reciprocal contributions of all those who are present in a caring moment (Kittay, 2011). Care aesthetics therefore claims that there is a shape, feel and sensory experience to the caring moment that is made possible by the actions of all those involved (Thompson, 2022). Care aesthetics thus covers the moment of care between individuals and the care culture across broader practices and institutions. It is concerned with the minutiae of embodied relations but also the wider relations that, in formal care settings, could include networks of people (family members, visitors, volunteers, and other health and social care

professionals), objects (beds, intravenous drips, clothes) and environments (lounges, canteens, décor, and building structures). All these elements contribute to an aesthetic of care.

The concept also draws on multiple interconnected traditions of analysis of care. It emerged as a concept in the arts and humanities, particularly in the work of James Thompson (2015, 2020, 2022) and then in the literary work of Josephine Donovan (2016) and the pioneering work on everyday aesthetics from Yuriko Saito (2008, 2017, 2022). It draws directly on the field of care ethics, and the work of feminist scholars (Gary, 2021; Hamington, 2004; Held, 2006; Leget, Nistelrooij, Visse, 2016; Robinson, 2011; Tronto, 1993, 2013) who have insisted that the care encounter is a site of ethical importance. It speaks to the work on emotional labour (Hochschild, 1983, 2003; Smith, 2012) and is in conversation with the notion of bodywork pioneered by writers such as Julia Twigg (2000, 2002), Carol Wolkowitz and colleagues (Twigg et al., 2011; Wolkowitz et al., 2011), and Christina Buse and Julia Twigg (2018). It borrows from their critiques that have demonstrated the significant demands of both bodywork and emotional labour, and points to those pressures in care systems where financial, cultural, and policy demands might diminish the aesthetic relations established between individuals and groups.

However, while the concept is descriptive in focusing on positive and negative care aesthetics in practice, it has an evaluative emphasis in seeking to draw attention to where a focus on aesthetics, and the qualities of the sensory relations between people, leads to more life enhancing relations/outcomes. There is a broad emphasis in the work on emotional labour and bodywork which concentrates on the problems encountered in work on, and with, the bodies of others. Care aesthetics does not ignore the inequities, power relations, and ambivalence found in many care relations, but tends, instead, to draw attention to the positive capacities that can be demonstrated in the moment of care. It does this not to deny the real problems that exist, but to give a space so that we might value the under-documented capabilities of some of the lowest paid staff and life experiences of patients/residents whose capacities are too often minimalised. This indicates a political orientation to care aesthetics and connects to the social justice aspect in Joan Tronto's (1993) work on care ethics. In particular, it links to the fifth component of her outline of phases of care, "caring with," which was added in her book *Caring Democracy* (Tronto, 2013). It is also a response to the demand from the authors of the Care Manifesto to place care at the centre of a project to create a more just society (Chatzidakis et al. 2020).

The opportunity that care aesthetics provides, is to focus on the moment of care and to ensure that "caring with" includes all parties directly or tangentially involved in the analysis. A person receiving care will bring a bodily presence, a set of movements, speech and vocal demands, and physical responses. A family member will similarly contribute through a set of

body practices, including voiced concern, physical actions, and the sensibility of the witness, and then finally carers, in different professional groupings, will draw on a range of practices and competencies. This inclusive analysis also welcomes those bodily actions that often elude analysis because they fall outside those that are a designated or acknowledged part of a professional practice. This might include the place of a body in a room and its relation to others, the use or not of speech, including its tone and volume as well as its content and formal aspects. It focuses on the different types of touch, including holds, grips, taps and strokes. It explores attentiveness to the multiple signals of others in a space and how sensitively to adapt to unspoken or hard to communicate needs. These might be called artful practices because they have refinable elements analogous with artistic practices, or "craft-like" to suggest the more inclusive category of craft, connected to the validation of craft practices as beneficial for practitioners' sense of worth in the work of writers such as Richard Sennett (2009) and Tim Ingold (2019). However, aesthetics is used here as a term to focus specifically on experience and sensory capacities outside the traditional definition of "the arts." Care aesthetics seeks to provide a framework for examining the complex aesthetic experience of care that accepts there is always more to a care moment than the successful completion of a technical skill such as fitting a cannula, adjusting an intravenous drip, or taking a temperature.

The Lived Experience of Dementia

In this article, we have located our dialogue on care aesthetics to people living with the more "advanced" stages of dementia. This positioning is purposeful because people living with more advanced dementia experience: significant and worsening challenges in their everyday lives, such as impaired memory recall (including autobiographical memory); displaced orientation to time, place, and person; impaired decision-making and information-processing abilities; and reduced verbal communication and social interaction (James & Jackman, 2017; Jones et al., 2023). The person living with more advanced dementia will usually need help and assistance with most, and eventually all, of the activities of daily living, such as washing, dressing, toileting, and feeding oneself (Prizer & Zimmerman, 2018), leading to an increased risk of care at home breaking down at this point in the caregiving trajectory (Edwards et al., 2018; Jones et al., 2023; National Institute for Health and Care Excellence, 2018).

Over the last two decades, the dementia care field has attempted to respond to this situation by applying sensory and embodied ways of understanding the communication practices of people living with more advanced dementia (see for example, Campbell, Dowlen, and Fleetwood-Smith, 2023). By focussing on the body as a site of communication and aesthetic practices, it becomes possible to view the person's gestures and other sensory and embodied expressions as pathways to everyday interaction. The Canadian researcher Pia Kontos has been at the forefront of this movement and has suggested that for people living with more advanced

dementia, care work in this embodied space can either support or undermine a process of aesthetic enrichment for that person. Indeed, Kontos et al. (2017) go on to suggest that the stimulation of such sensory connections for people living with more advanced dementia is best attained through relational practices in art, music, and imagination. Moreover, rather than dwelling on the long-term impacts of such relational practices for people living with more advanced dementia, such sensory and embodied stimulation is seen to resonate and be-in-the-world through a moment-by-moment frame of understanding. For example, almost twenty years ago now Killick and Allan (2001) advised that healthcare professionals should aim to meet people living with dementia "in the moment" in order to ensure that each encounter was entered into with full attention and an open mind. These authors suggested that this reflexive positioning enabled a deeper person-to-person connection to be made and facilitated a greater understanding about a different perception of time that might be experienced by a person living with dementia. Such an acceptance and empathetic point of connection between those with and without dementia was seen to be foundational to person-centred care and in all interaction that subsequently followed (Kitwood, 1990a, 1990b, 1997; Kitwood & Bredin, 1992; Kitwood & Brooker, 2019).

The two case studies that follow illustrate our thinking on care aesthetics and sensory and embodied practices. Our claim is that a focus on a "moment" is illuminating for care aesthetics because it overlaps with a concern for 'experience' in the aesthetics literature. The aesthetics of "care aesthetics" is one located not in the appreciation of objects by disinterested observers, but rather in the sensory experience of an event or moment. It places experience, and the embodied sensations shared between those present to that moment, as a focus of study. Keady et al.'s (2022) definition of "being in the moment" is crucial here:

> Being in the moment is a relational, embodied and multi-sensory human experience. It is both situational and autobiographical and can exist in a fleeting moment or for longer periods of time. All moments are considered to have personal significance, meaning and worth (p.687).

This sense of openness to difference in length of experience and acceptance of a significance whatever its intensity, ensures that there is productive connection to the field of "everyday aesthetics" (Saito, 2017; Shusterman, 2012) and subsequently care aesthetics. Again, these interconnections will be dealt with more in the case studies below.

Methods of Study

The study's rationale is based on the claim that expanding the richness, complexity, quality, or craft in care relations (between people, and between groups of people in care contexts, to include families and broader context) *improves* the quality of life of people receiving care. If

there are multiple skills and behaviours available in care relationships in health and social care settings that are undervalued and unacknowledged, what might attention to their embodied, sensory, and crafted nature help to demonstrate? To begin to address these questions, an outline of the two case studies involving people living with more advanced dementia are first presented below.

Case study 1 is taken from Sarah Campbell's doctoral work exploring the everyday experiences of men living with dementia in care settings. The case study has been developed from a video observation within a National Health Service (NHS) specialist dementia hospital hair salon. Don, the participant involved in the observation, was a resident in an NHS in-patient dementia assessment ward at the hospital at the time of the observation and was compulsorily detained under a section of the Mental Health Act 1983 due to behaviour changes that were regarded as paranoid and aggressive. The case study has been selected to explore aesthetic care practices through male grooming, in this instance through hairdressing. The doctoral study was embedded within a wider study funded through the UK's Economic and Social Research Council (ESCR) and known colloquially as "The Hair and Care" project (Ward et al., 2016a, 2016b). The study received ethical permission through an approved NHS Research Ethics Committee (study reference: 11/WA/0147).

Case study 2 shares findings from Robyn Dowlen's doctoral work examining what it means to be "in the moment" in the context of music-making with people living with more advanced dementia. This case study brings together data collected in the context of a community-based music programme (*Music in Mind*) led by Manchester Camerata (an orchestra based in Manchester). Manchester Camerata's *Music in Mind* is a music therapy-based programme for people living with dementia and their family carers. *Music in Mind* is co-facilitated by a music therapist and a Manchester Camerata orchestral musician. The principles of *Music in Mind* are centred on choice and agency for the person living with dementia, enabling a democratisation of the musical space through supported improvisation using percussion instruments, the human voice and body percussion. In this study, Dowlen followed one *Music in Mind* group over 15 weeks and used video observation (Cook, 2002) and video-elicitation interviews (Henry & Fetters, 2012) to unpick the "in the moment" musical experiences held by people with dementia, their family carers, and the musician and music therapist who facilitated the sessions (Dowlen et al., 2022). This case study will explore the caring relationship between the musician and music therapist facilitating the project and one of the group members living with more advanced dementia, Phillip. Ethical approvals for this study were provided by the NHS Social Care Research Ethics Committee (study reference: 16/IEC08/0049).

In line with the study protocol for both case studies, all data are anonymised, and all participants consented to take part. Where concerns were expressed with regards to an

individual's capacity to consent, capacity assessments were completed in line with the protocol for each study. The consent process was carried out following the Mental Capacity Act (Department of Health, 2005) which included inviting a relevant consultee to consider providing consent on behalf of the identified participant.

Case Study 1: The Craft of Male Grooming in an NHS In-patient Dementia Assessment Ward Salon

The observation in this case study is taken from viewing a video observation recorded with Don, a resident on a mixed ward in an NHS in-patient dementia assessment ward. The observation takes place during a visit to the hospital hair salon. The salon environment was often used to offer some therapeutic space outside of the heightened tensions of the ward atmosphere. Ward residents were accompanied to the hair salon by Occupational Therapy assistants (OTA). The hairdresser, Dina, had worked for more than twenty years as a hairdresser at the hospital. The analysis here uses care aesthetics to illustrate the highly skilled and attentive bodily practices and sensibilities of the hairdresser and OTA.

Don is a smart, neatly dressed man, who talks quietly, sometimes inaudibly, and though using conversational cadence his words are not always understandable and he often gesticulates whilst talking. On arrival at the salon Don is guided to a seat in front of a long rectangular mirror that runs the width of the wall. He and Kay, the OTA, sit down. Immediately he is in his seat, Dina begins her work, preparing Don for his haircut. First, she tucks a towel gently into his neck collar and she asks if she can take his glasses off, before he responds she removes them from his face and folds them neatly placing them on the counter in front of him. She then collects a hairdressing gown which she flicks out and as it floats down over Don, Kay catches an edge of it and helps by smoothing it across Don to ensure it covers the whole of him. The two members of staff fall into synch working together to support Don.

Don turns towards Kay and says something to her, and she leans in towards him to listen whilst Dina continues to add layers of protective coverings to his body. On top of the gown is another towel and then on top of this a rubber collar that provides weight to hold down the towels and gown. Dina efficiently smooths each additional layer out over his shoulders as it is added. Despite previous concerns about Don being too anxious to attend the salon that day, he appears at ease in front of the mirror and is happily chatting to Kay about his dog. Dina begins to comb Don's fine white hair, and he watches himself in the mirror. Dina works with the comb, follows Don's natural parting line and then she takes the scissors and begins to cut. She artfully snips sharp lines around his ear, and he is quiet as he watches.

Figure 1. Dina and Don's bodily position as Dina carefully trims Don's eyebrows.

Kay's attention is on Don, and she leans in towards him as they talk about the different music he listens to, all the while Dina moves her body around Don, creating well-defined edges along his hair line with the scissor work. She expertly holds his hair between her fingers and snips, occasionally joining in the chat, and working attentively and swiftly. Don's head is leaning forward as he talks to Kay who leans her head forward mirroring him, trying to listen. Then after a few minutes the salon falls into comfortable silence lulled through the sound and rhythm of the scissors cutting and Dina's movement. She cuts and combs in a repetitive rhythm, all the while Kay watches keeping Don in her attention. After a little while of quiet Kay begins to talk to Don again. She asks Don some questions about his wife, and then asks if he goes to a barber usually, and he responds to Kay's queries which centre the attention on him.

At a later moment, Don says "excuse me" to Dina, and Dina stops her work to listen. He then says something inaudible and touches the back of his head. Dina says, "let's have a look," she combs some hair at the point he has shown and looks closely. She then rubs her fingers along his scalp. She says "alright" and returns to cutting. Kay, then in a reassuring tone, says "she'll be careful Don, she'll be careful." The salon again falls into silence, all but for the sound of Dina's movement and the noise of the scissors cutting while hair settles on the rubber collar. As she cuts Dina smooths out Don's hair adeptly, sometimes barely seeming to glance at the hair in her manoeuvres.

She uses firm touch to adjust Don's bodily position as she works, and then she says "I'm just going to lift your head up a little bit" as she gently but decisively holds the side of his head and moves Don into a more upright position. She tells him that she is going to trim his eyebrows and the back of her fingers rest across his cheeks as she cuts his long brows. There is a great deal of attention to her practice and technique as Dina continues to spot hair that she wants to neaten, and she shifts to trim the front of his hair and around his ear again, this time from a new angle. She trims the second brow from a sideway position and as she finishes Don blinks his eyes open.

Then Dina turns on a set of hair clippers as she says "just using these clippers," always carrying out the action as she tells Don what she is doing. She affords no room for concern, hesitation or boredom from the task as she carries out each part of her process. The clippers are loud, and their buzzing takes up the air space, and Don talks, but no-one can quite hear what he is saying. Dina moves the clippers across the back of his neck and smooths the hair fluff away as she works. She trims more hair that is held expertly in the comb and glances her clippers across the hair. Through each new process, Dina moves one way and then back across moving her comb and clippers or comb and scissors through the hair. She bends to look closely and uses her fingers to smooth out hair and check its positioning and straightness, paying careful attention to her craft.

Finally, she turns off the clippers and again moves around Don's body combing and smoothing hair with her hands. She then turns to Kay to ask, "does he want it any shorter?" and secondly to Don asking "is that alright for you?" When he doesn't reply she asks, "do you need your glasses on?" and Don nods, and Dina says, "just a minute I'll give them a wash." Don nods saying something inaudible to Kay, who responds smiling and watchful. She begins talking to him and engaging him about his brother's visit earlier in the week, telling him they look alike. Dina's reflection can be seen in the mirror as she holds up Don's glasses inspecting

Figure 2. Shows Kay leaning her body and attention to Don

her work and the cleanliness of the lenses. She brings the glasses over and Kay helps her to position them over Don's ears, and Dina leans in saying "shall I show you the back?" Kay asks, "what do you think of your haircut?" and Don replies "it's alright." Kay tells him it looks lovely – "very neat and tidy" and then she adds "Martha (his wife) won't recognise you." Kay jokes that his wife will think "who's this younger version of Don" and they all laugh together.

Dina's attention turns to taking off the layers of protective gown, towels and rubber collar. Don is smiling the most he has since his arrival. Before he gets up, Dina suddenly notices a long hair, and wants to get it and then Don is complete as she finishes her practice. Don smooths his hands over his hair. Kay says "Can you see yourself in the mirror? What do you think of your haircut?" and he smiles and nods, and smooths it down again.

This short extract of video observation shows two members of staff working together with sensitivity to hold Don's attention to ensure they are able to support him to feel calm and relaxed throughout his haircut. The salon provides a therapeutic role as well as hair care. The care-based hairdresser works expertly with swift and firm skill, her techniques are embodied and crafted as she moves around Don's body using different tools and touch to administer her practice. She commands authority of both the space and equipment and similarly manoeuvres Don's body with decisiveness to ensure she can attend to his haircut adeptly and efficiently.

Whilst Dina works on Don's hair, Kay's attention is focussed on Don, attuning her body and mirroring his movements, adjusting to his moods, and using different tones of voice to calm, gently tease and engage him whilst the haircut takes place. She maintains upbeat chat at the beginning and end of the haircut, reassures him when there is a sore part of his head, and falls quiet as they listen to the sounds and rhythm of the cutting. The snipping of scissors and Dina's movement work to lull the salon into a meditative state as she moves with the flow of the cut.

For Don, the experience of a haircut will be something that he is familiar with, sitting in front of the mirror allowing himself to be guided by the hairdresser. Through the re-watching of the video small details are noted. Moments that show how Don responds with his body by allowing Dina to move and position him as required. When Dina moves to the part on his head where something is tender or sore, he responds by pointing out to her that something is not quite right there, and she carefully examines this part of his scalp. The video captures the multi-sensory (Pink, 2012) and affective experience of the salon (Sumartojo et al., 2020), as we see, hear, and sense feelings at play. This is most often demonstrated through Kay and the sensibility she demonstrates as she responds to Don. Kay is captured moving her body to mirror Don's as she leans in towards him, holding his attention as they settle into the space. This attention is a feature of the inter-corporeal work of both the hairdresser and the OTA as they work together to ensure that Don remains calm and relaxed.

Case Study 2: Musicians' Beautiful Care

Using care aesthetics as a framework, the following case study will explore the caring relationship between the musician and music therapist facilitating the project and one of the group members, Phillip, who lives with dementia. There is a growing area of research examining so-called "healthcare musicians" – those with a professional degree in music who work with a health and wellbeing agenda in their socially engaged practice (Koivisto, 2022). Manchester Camerata have placed this practice at the heart of their community work, building a team of professional musicians from the orchestra who can facilitate musical work with people with dementia in a range of settings (i.e. care homes and community settings). The *Music in Mind* model brings together these socially engaged musicians from the orchestra with a trained music therapist to co-facilitate the programme and the dynamic of this relationship will be explored further in this case study. In the context of the doctoral research, the *Music in Mind* sessions were co-facilitated by a music therapist (Barbara) and a musician (Nicola). Both had extensive experience of facilitating the *Music in Mind* programme and had been motivated to work with people living with dementia due to familial experience of dementia. The following sections will outline two caring moments between the musicians, Phillip, and his wife – i) a moment of careful teaching; and ii) finding his voice through silence.

Phillip, a man living with Lewy Body dementia, attended the sessions with his wife Esther. Phillip had moved to the UK from Ghana a few years before receiving his diagnosis. Esther expressed that Phillip had found his diagnosis very distressing and would often cry and seem withdrawn. Phillip's dementia impacted his memory and physical movements, with the condition giving him stiffness in his limbs and slow movements. This meant that Phillip was largely chair-based in the sessions and often held uncomfortable looking positions with his hands which impacted on his ability to use hand-held percussive instruments. Esther was Phillip's full-time carer and received very little formal support – relying on friends and family to support Phillip when she worked early hours of the morning as a cleaner. She received some formal care support, but she was responsible for the majority of Phillip's care tasks. Both Phillip and Esther had a life-long love of music, with their shared musical tastes forming the soundtrack to their early relationship and holding significance for them spiritually through their Christian faith.

A moment of careful teaching. When observing the sessions both "live" and through reviewing the videos, it was clear how attuned both Barbara and Nicola (the *Music in Mind* practitioners) were to Phillip. He was the only member of the group who was unable to communicate verbally, but he "spoke" through his body and his eyes. In the early sessions, Phillip did not appear to have control or autonomy in his musical contributions. Esther, with every good intention, would manipulate his hands and arms to make a sound, rather than allowing Phillip to choose for himself when he wanted to contribute musically. Having observed these practices, the practitioners implemented a number of strategies to encourage Phillip to play for himself. For example, during one improvisational exercise, Barbara moved around the perimeter of the music-making circle and encouraged each group member to tap out a solo on the tambourine she was holding. The first few times Barbara moved around the circle, Esther would take Phillip by the wrist and place his hand down on the tambourine to make a sound.

The next time Barbara brought the tambourine around the circle, Nicola noticed this interaction, and stepped in to support Phillip's improvisation, encouraging Esther to allow Phillip to have the opportunity to play for himself. Nicola suggested that Esther place her hand under Phillip's wrists (see Figure 3), perhaps as a way of ensuring Esther still felt like she was supporting him but allowing him the freedom to contribute for himself. The screenshot presented in Figure 3 illustrates how Phillip was able to play the tambourine for himself, tapping out simple rhythms but smiling and seeking eye contact with Barbara as he played. This was a moment of gentle care, and there was skill in showcasing this approach to Esther without the need to tell her what to do verbally. It relied on gentle touch, eye contact and care for both Phillip and Esther.

The resulting action was that Phillip was able to contribute by gently tapping his fingers on the skin of the tambourine. Nicola retook her seat after the successful shift and Phillip maintained strong eye contact with Barbara who was holding the tambourine and contributed several short but intentional taps. Barbara repeated these tapping sounds back to Phillip and he smiled. This level of attunement both to Phillip, to Esther, and to each other led to a moment of empowerment for Phillip and it shifted Esther's approach to his participation in following weeks.

Figure 3. The musicians support Esther to allow Phillip to play independently.

During the final practitioner interview, the musicians watched this excerpt of the video, and we unpicked this moment together:

> Robyn: I think this is one of the only instances I've come across where you've sort of stepped in and said have you tried…
>
> Nicola: I was just… should I? I don't know! I think maybe we knew each other well enough to do that by then, you, it's such a thing you don't want to step on, she gets up

> at four on Wednesday morning to go and work and do her cleaning job then she gets back and she gets him up and she does this and she does that. Well it's not for me to jump in and go actually "will you stop moving his arm like that?" […] I think we were at a point where we could do that 'cos she could see what was happening with [another group member] and how that was working and so I think she was slightly receptive to it but it's so engrained with the two of them that, that physicality […]
>
> [Practitioner Interview 26.09.2017]

This excerpt highlights the challenges that the practitioners faced in trying to navigate the ingrained "carer" and "cared for" roles that had developed between Phillip and Esther. They wanted to ensure that Phillip was free to choose when he contributed but they also did not want to offend Esther, or question her caring practices, in doing so. In this instance, the way in which Nicola approached the situation allowed for more active participation by Phillip than would have been achieved if she had not intervened. The reason that Nicola felt comfortable to intervene in this moment was because of the relationship and trust she had built with Esther as a result of the shared musical experience.

Finding his voice through silence. At first, it appeared as if Phillip's involvement within the sessions was passive, with it being assumed that he enjoyed listening to the music rather than contributing actively. However, on reviewing the video and audio footage from the first few weeks, it became clear that Phillip was improvising using his voice rather than an instrument. The reason this was not clear within the sessions was because his contributions were not very loud. On reviewing the footage, Phillip's vocals could be isolated more easily than in the live sessions, and this led to hearing that he was contributing a low hum for the duration of most sessions. It was only when Phillip found a silence to improvise within that it became obvious to the group that he was actively contributing.

One example of this was observed within week 8 of the programme. During a moment of silence, Phillip had begun to improvise around the harmonic structure of the previous improvisation. His voice could be heard clearly, and Alice (a stand in musician) repeated his musical phrases back to him, perhaps as a way of demonstrating to Phillip that his contributions were valid in the musical space. I reflected on this with musicians, as they had requested to review this moment. The excerpt below details Barbara's interpretation of Phillip's vocal improvisation:

> Barbara: That's got an immediate response, isn't it? The high note on the piano makes his voice go up suddenly to the [note] D. It just shows how tuned in he is, isn't he? I always think that when people can't use language to communicate then they will tune

> into music in such a big way because it's something they understand and that's a medium that is accessible. […] What's amazing is how he sticks with it. He just carries on singing for the best part of two minutes, isn't it?
>
> Yeah I think that tells us that it's alright, it's sitting alright with him, the music kind of meets him I think, and the fact that most of the group are listening to it is just wonderful and that always tells me that the connection is audible, the connection between my playing and him in this case mostly is audible to everybody and it's musically so exciting that they think oh, or so complete that they stop playing and they find that their attention is drawn to that.
>
> [Practitioner Interview 14.06.2017]

This moment signifies the skills of the musician and music therapist in this context in ensuring everyone's voices were heard. This interaction led to further moments of silence within sessions where Phillip's voice could be heard by the group. This led to Phillip being placed in a "musical spotlight" where the attention of the whole group was on him. This led to some shared emotional moments with the group, where group members would reach out their hands to him, give him a round of applause, or even cry in response to his contributions. The group and musicians wanted to see Phillip succeed in these moments and extended caring practices to both Phillip and Esther.

Discussion

The two very different case studies are brought together here to focus on how attention to aesthetics reveals often unacknowledged elements of care. The discussion will focus on four thematic areas to illustrate the case for care aesthetics as a framework for validating both the practice of the carers, musicians, and hairdressers and the responsiveness of those receiving care. These overlap with Joan Tronto's (1993) phases of care ethics, particularly her third phase of care giving and its ethical element of competence, and the fourth phase that refers to the reactions of the person receiving care and the need for responsiveness. Here the focus will be on process, voice and cadence, touch and eye contact, and spotlighting. Each one is chosen as a disciplinary intersection where both arts/aesthetics researchers and care/health researchers have already contributed. "Process" draws on the commitment to person centredness evidenced in the work of Kontos et al. (2017) and the "in the moment" studies outlined by Keady et al. (2022). It is also a commentary on the focus on process within arts practices where the debates around "process or product" have appeared across multiple community-based arts literatures (see for example, O'Toole, 1992; and in a dementia context, see Hatton, 2019). Voice/cadence speaks to person centred care but also debates about the "voice" of participants in community arts (for example: Brenner et al., 2021) and in music making (see:

Stokes, 2010). "Touch" responds to the debates on inter-human contact in dementia practice, notably in the work of Luke Tanner (2017) but also seeks to draw attention to the importance of touch in care ethics (Hamington, 2004; Van der Vlugt, Jewitt & Hubner, 2023a; Van der Vlugt, 2023b) and the arts, where writers such as Eve Kosofsky Sedgwick (2003) have noted the importance of touch practices which "make a nonsense out of any dualistic understanding of agency and passivity" (p.14). Finally, "spotlighting" discusses the visual register of aesthetics and the difficulties faced if appearance becomes the sole indicator of quality. This draws on critiques of the dominance of the distal senses within aesthetic theory (Shusterman, 2012) and then the power dynamics implicit in demands for residents in care homes to comply with certain norms of appearance (see: Buse & Twigg, 2018).

Process: Each case study draws attention to an experience that exists not as an outcome of an intervention but as a set of micro activities that take place over time. They value, following the quotation used above, "relational, embodied and multi-sensory" moments that "are considered to have personal significance and worth" (Keady et al., 2022, p.697). As each study notes, these moments have a routine with a certain pace and rhythm. Although a haircut might be familiar as a daily activity more than participation in a music group, both illustrate the value of repeated, sensory, and relational experiences. The expertise of those giving care in each example, the OTA and hairdresser in one, the family member and music therapist in the other, are explained through multiple interconnected embodied practices. While there are aspects of the technical skills that are brought into the process, they are creatively developed, adapted, and refined in the moment of their encounter with the person with dementia. In nursing literature from over forty years ago, this is referred to as the difference between an empirical and an aesthetic pattern of knowing in health care practice (Carper, 1978). Here we are noting, however, that rather than a strict division between these "hard" and "soft" skills, we see the technical embedded within the aesthetic or sensory attributes of the care process. Care aesthetics is not a claim that there is a separate range of aesthetic skills alongside the technical capabilities of a carer. In these cases, we note it in the subtle attention to the anxieties attributed to Don, the welcoming of the pattern of beats from Philip and the ability to respond to others present, as Dina reacts to Kay, or Esther subtly adapts her care from the shift suggested by Nicola. Care aesthetics conceptually tracks process, therefore, as it points to the shape and feel of how, in the words of the first case study, carers might "fall into sync" to support another person. It is not about the care technique done to a person, but how an activity sensitively, in the words of the second study, "kind of meets" a person living with dementia. The sensory world of these practices combines, simultaneously technically and aesthetically, to attune and adapt to the rhythm of people receiving and responding to care.

Voice and cadence: Each of the case studies here draws attention to the importance of voice and the quality of that voice. While one approach might be to focus on the content of the

speech in these cases, the point to make here is what the talk does and what the sound of the voice contributes to each moment. It is notable that in the first case study Don's conversational cadence is mentioned, and this is of course a musical term referring to its rhythm or flow. In the hairdressing case study, the chat between each person overlays the flow of time and draws Don into biographical conversation about his dog, his brother and his wife. A care aesthetics focus does not deny the actual meaning of these important aspects of his life but suggests in addition that it is the shape of this conversation that affectively contributes to the passage of time across the routine of the haircut. They produce a sensory world that will perhaps have an element of both familiarity and comfort. The cadence is shaped by Kay and Dina as they creatively orchestrate an experience that diminishes the difficulties that Don faces and gives him an encounter where his anxieties are no longer his primary focus.

Cadence is significant for the second case study in a way that is even more striking for the attention to the sound of the voice rather than the content of the words. By noting, responding to, and welcoming the sounds that Philip made in the space, his presence is validated, and his contribution to the music group is given weight. This is music as "an activity, something that people do" rather than noun referring to a thing in the abstract (Small, 1998, p.2). The musical frame here ensures that it is given literal value based on how it tunes to other sounds in the room, rather than a meaning based on verbal or discursive properties. A care aesthetics focus argues that the explicit aesthetic register of the second case study, that worked in the realm of sound, rhythm and beat, in fact was the implicit register of the first which also had its cadence, pace and shape. Following musicologist Christopher Small's idea of "musicking" (1998), the claim here is that the soundscape of both case studies became an important conduit for their meanings. In the hairdressing case study, it was the timbre of the voice, its affect, and how it rocked back and forth between those present that produced the valuable sensations of the experience.

Touch and eye contact: Each case study here explores different touch practices, between those people present in each moment. They both, in different ways, exemplify what cultural historian Constance Classen (2020) has called "tactile aesthetics" (p.74). Touch is of course always two way, as a person touching is also always touched back in the process (drawing on the phenomenological approach of Merleau-Ponty, 2013). It might include certain precise skills and patterns of action, but it is then adapted and responded to in the moment of its execution. As Dina snips and shapes Don's hair, she is always adapting to its length and feel in her hands, and then his look back to her in the mirror. It is important to note how the collaborative process documented in the music-based case study explicitly links "gentle touch, eye contact" to care. In both studies there is a multi-person relationship that demonstrates the close connection between different participants in a care moment. Dina, Kay and Don interact through routine touch, visual signalling and verbal play in the first, and Philip, Esther, Barbara

and Nicola collaborate with eye signals and respectful shifts in touching practice in the second. The hair cut involves touch that has an expertise that ensures the care for Don is in a form that avoids alarm or anxiety. Its efficiency and precision, with rapid, clear rhythmic movements, creates the "meditative state" that the case study reports. The embodied fluency of Dina's practice with its "no room for concern, hesitation or boredom" contributes to the aesthetic of this experience. Similarly, as Nicola replaces Esther's hand under Philip's to change the relation of care both gently and subtly, we notice a practice of support for Philip and Esther that is completed through micro changes in touch. The intervention that Nicola is making here is a shift in the aesthetics of this practice of care – one that enhances the involvement of Philip in the wider group. As Luke Tanner (2017) notes in his writing on touch in dementia care, this gentle attention to the hold of a hand between people, can sustain improvements in practice in broader initiatives that are seeking positive changes in "our culture of care" (p.24).

Spotlighting: One important claim of the concept of care aesthetics is that aesthetics is concerned with the full sensory experience of human bodies in relation to others and the world around them. It rejects a narrow focus solely on the visual, on that which can be seen or contemplated (drawing on foundational work of Dewey, 2005; and Shusterman, 2012). That said, it is important that the visual is still one part of the aesthetics of care, and one to be considered alongside an understanding of care as a multisensory experience. In the music case study, this is noted in how Philip was given a "musical spotlight" within his group as all attended to his presence in the group. His visual presence in the session led to him receiving applause from others as his contribution was celebrated. While the metaphor of spotlight here suggests that this was a form of visibility that he did not previously have in this group, it was of course for his sonic involvement that he was being noted. So paradoxically, Philip was seen for the sound he made. If caring is attending to someone and being given the attention one deserves, care aesthetics notes how the quality of this attention includes how you are seen in different contexts, alongside how you are felt and heard.

In the first case study, the visual register is first found processually, in the presence of Don before a mirror that provides an ongoing visual reminder of the progress of the haircut. The mirroring is also noted in the empathetic copying of movement that Kay does as she "leans her head forward mirroring him." The quality of the visual cues here are a signal of the quality of the activity, but the quality of the caring relations at play during the haircut process cannot be reduced to them. This echoes Christina Buse and Julia Twigg's (2018) concern, in their work on dress and dementia care, that a "homogenous appearance" should not supersede the 'embodied biography and personal aesthetic' (p.346) of the person living with dementia.

The second moment of the visual register is of course in the commentary on how Don looks at the end of his appointment. Both Kay and Dina use the finished process to tell him how good he looks and jokingly how his wife will not recognise him. The visual plays alongside the verbal here, to create a moment that seeks to boost Don's sense of worth or esteem. Care aesthetics, in taking seriously all sensory aspects of an experience, specifically argues that feeling great and looking great are connected but not synonymous. The visual aesthetics of care, for example how a patient or resident is "turned out," does not equate simplistically to the quality of the care that has been taken of that person. Again, drawing on Buse and Twigg's (2018) work, the "aesthetics of care" is not therefore, a synonym for a "visual indicator of care quality" (p.341). In this case study, instead, we see the visual end point fully integrated into a much longer process which has prioritised all sensory aspects of the care for Don. The trim has not been a cursory activity to get him ready to demonstrate how he's been cared for, but a full sensory experience combining visual, vocal, touch-based and other sensory caring elements. Being in the spotlight is a vital aspect of care but a care aesthetics framework would examine how this is combined with these other sensory aspects of care. Being acknowledged, valued and given due attention is of course vital for those whose lives are assumed to be less valuable, but the argument here is that these involve an interplay of all the senses that make up a care experience.

To summarise, we have brought together the elements of process, soundscapes, touch, and spotlights in Figure 4. This table presents a summary for each, what elements they comprise of, and questions for research and practice that can facilitate understandings of "moments" through a lens of care aesthetics. This is not definitive but refers to those elements of care aesthetics in action that are included in this article.

What?	Significance	Elements	Questions
Process	The importance of focusing on the timescale of an activity and not the outcome: attention to the moment of care.	Process has pace; it follows timing or 'time signature' based on attending to the person and not only completing a task; it has a rhythm determined by the actions and responses of all present; process can be momentary or over a relatively long period of time; pace is not static and can change within a single experience.	What pace determines the interaction that is taking place; what is the pace of the people we are working with; who determines the pace and rhythm of an interaction; how might slowing down aid this process; what do my movements contribute to the feelings of pace or rhythm in an activity?
Soundscapes	The importance of focusing on the sounds	Use and tone of voice; listening; silence; awareness of the other	What are we saying by the tone of our voice; where is the room for

	that exist within the care experience	sounds in the space; awareness of those sounds that enhance an experience and those that interfere or disorientate it; the voice of people being cared for, both the content of words and the quality and pitch of the sounds they make.	silence; are we listening to all sounds in this space; what pitch are the sounds at; what rhythms do they make; does the soundscape interfere with the work or enhance it?
Touch	The importance of the physical relations between people, both actual contact, eye 'contact' and proximity more broadly.	Touch is always two way, so a person touching is simultaneously being touched; touch has different meanings cross-culturally; eye contact similarly; touch has multiple elements from harsh to soft, from momentary to long lasting, from smooth to rough; touch can be procedural, task focused or comfort/therapeutic focused; it has different negotiated forms of consent; touch requires skill, precision and self-awareness in its usage; touch is an aesthetic practice.	When do we use touch and when do we not; how is consent negotiated; what does the absence and/or presence of touch in this context do to the care experience; which elements of touch (holding, stroking, grabbing, caressing, tapping etc) are appropriate in this context, for different activities and for different people; how to we maintain, change or shift eye contact to change the quality of the care experience?
Spotlight	The importance of drawing attention to care or ensuring the care practice is witnessed; or understanding the pressure to show care to others for its validation.	Doing a care activity with consideration for how it looks; drawing attention to the visual elements of a process/practice; showing your care to others; being held accountable for the care you give through the visible consequences of it.	Has this been done for how it appears to others or for the experience of those involved; what is the relation between the way care looks and the way it feels; has the need to show care changed the way care is executed?

Figure 4. Care aesthetics in action.

Conclusions

As we have seen in this article, the craft or artfulness of a carer is a notable part of a care aesthetic experience, and certainly care aesthetics seeks to validate/document these capacities. However, it also aims to acknowledge Tronto's (1993) fourth stage of care ethics, that is the responsiveness of the care receiver, in order to offer an inclusive concept that draws the embodied practices and responses of people receiving care, including all the activities within extended networks of care, into an analysis. The distinction between "craft" or "art" is fraught with hierarchies of value and the ambition here is in focusing on a care aesthetic experience, to question which component parts of care are seen as most significant. The denigration of usefulness in craft work (see Gauntlett, 2011) is a legacy of multiple assumptions in aesthetic theory, particularly about the need to maintain a division between artistry and everyday life. The use of both "craft" and "artfulness" here in reference to the skills of a carer is done to trouble the differentiation between them. However, the preference for the term aesthetics overall insists that, in Tronto's (1993) terms, caring for, care giving and responding to care, are all equally important in understanding the overall care experience. Attending to the embodied and the sensory through a lens of care aesthetics demands that people living with dementia are viewed as individuals with preferences, wishes and desires, rather than simply a site of care-oriented tasks or behaviours to be managed (Fleetwood-Smith et al., 2022). It also recognises the role of caregivers, or those supporting care in more indirect ways (i.e., the hairdresser and musician/music therapist in our context), in gently attending to people with dementia in ways that may go unacknowledged. It is here where care aesthetics can make the invisible, visible, and add a new dimension to the repertoire of caring practices and care experiences.

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