Using drama to improve person-centred dementia care

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KONTOS P.C., MITCHELL G.J., MISTRY B. & BALLON B. (2010) Using drama to improve person-centred dementia care. *International Journal of Older People Nursing* **5**, 159–168

Aims and objectives. We implemented a 12-week drama-based educational intervention to introduce to dementia practitioners person-centred care that emphasizes the notion of embodied selfhood (defined as non-verbal self-expression).

Background. Person-centred dementia care guidelines emphasize the assessment of individual needs, and where appropriate, the use of non-pharmacological interventions before resorting to pharmacological management. However, dementia care is not consistent with these guidelines suggesting conceptual limitations and reliance on passive knowledge translation strategies.

Design and methods. Focus groups and semi-structured interviews with practitioners (*n* = 24) in two nursing homes in central Canada were undertaken to assess the effectiveness of the drama-based components of the intervention.

Results. Our findings suggest that drama was effective as an educational modality, and helped implement the person-centred approach into practice. Significant practice outcomes included: new awareness that residents' body movements and dispositions can convey meaning; seeking biographical information from families; increased time efficiency; and supporting residents' independence.

Conclusions. Our findings make an important contribution to person-centred dementia care by broadening the notion of personhood, and by facilitating implementation using drama.

Implications for practice. As an enhancement of person-centred care, the support of embodied selfhood may significantly improve residents' quality of life, quality of care, and practitioners' care-giving experience.

Introduction

Dementia is often accompanied by verbal and/or physical aggression, agitation, restlessness and abnormal vocalizations, which are typically understood as behavioural symptoms of dementia (Cohen-Mansfield & Mintzer, 2005). Predominantly treatment has been mandated by institutional policies of control and containment (i.e., combinations of environmental, mechanical or pharmacological restraint) (Andrews, 2006). However, there is growing dissatisfaction with these approaches due to concerns about adverse side effects resulting from pharmacological interventions (Katona, 2001), and the inhumane consequences of physical restraint use (Andrews, 2006). Further, evidence shows that many behavioural issues stem from discordance between individual needs and the degree to which they are met (Cohen-Mansfield & Mintzer, 2005).

In contrast to traditional approaches to behavioural management, advocates of person-centred care emphasize the importance of using knowledge of the particularities of the resident to identify patterns of behaviour to reveal unmet needs (Kitwood, 1990, 1997), and to individualize non-pharmacological interventions as a first line of approach in instances where acute physical/psychotic illness is excluded as the trigger of behaviour (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003; Cohen-Mansfield & Mintzer, 2005). Despite advances in recognizing the importance of person-centred care (Brooker, 2003; McCormack, 2004), large proportions of nursing home residents with dementia continue to receive major tranquillizers (Briesacher *et al.*, 2005), despite evidence of only modest efficacy, high placebo response (Street *et al.*, 2000; Sink *et al.*, 2005), and serious adverse consequences (Schneider *et al.*, 2005; Sink *et al.*, 2005). This suggests that limitations persist in how person-centred dementia care is conceptualized (Nolan *et al.*, 2004; Kontos, 2005; O'Connor *et al.*, 2007), and translated into practice (McCormack, 2004).

Specifically, many proponents of person-centred dementia care conceptualize personhood as constituted in collective social activity (Kitwood & Bredin, 1992; Kitwood, 1997; Bond, 2001; O'Connor *et al.*, 2007); consequently, interpretations of needs and of behaviour reside within a strict psychosocial framework. This overlooks the significance and complexity of personal realities (Jonas-Simpson & Mitchell, 2005) and embodied selfhood (Kontos, 2004,

2005, 2006) – which refers to bodily expressions of vocation and class distinction; the spontaneity of actions; and the often subtle attentiveness to appearance, cleanliness, and social etiquette by persons with dementia. Whilst there is some attention given to body language in educational interventions for dementia care practitioners, non-verbal expression is most often understood in terms of emotion (Magai *et al.*, 2002; Ruckdeschel & Haitsma, 2004) or physical discomfort and pain (Williams *et al.*, 2005). Approaches to person-centred care that fail to address the breadth of bodily movements and gestures for self-expression may contribute to the misreading of behaviour as symptomatic of dementia, and the consequent overuse of pharmacotherapies (Andrews, 2006; Kontos & Naglie, 2009).

Next, a gap exists between research on person-centred dementia care and its incorporation into clinical practices. The gap persists because of negative perceptions of dementia held by practitioners (Brodaty *et al.*, 2003; Kontos & Naglie, 2007a), the lack of investment in education for practitioners delivering dementia care (Cohen-Mansfield *et al.*, 2005; Sung *et al.*, 2005; Testad *et al.*, 2005), and appropriate knowledge translation methods for health care practitioners (McCormack, 2004; Kontos & Poland, 2009). Complex social interventions that target cognitive and/or psychosocial behaviour change are particularly difficult (Pawson & Tilley, 1997) because there is considerable leeway for misinterpretation, resistance or even rejection of the innovation (Upshur, 2000). Therefore, it is imperative that complex interventions make use of approaches that facilitate critical self-reflection by practitioners about how contextual and cultural factors influence and shape their understandings, assumptions and practices (Saltmarche *et al.*, 1998; McCormack *et al.*, 2002). Drama is particularly effective in helping clinicians attend to the human dimensions of care, achieve a better understanding of patients' experiences, recognize the clinician's role in alleviating suffering (Shapiro & Hunt, 2003; Lorenz *et al.*, 2004; Rosenbaum *et al.*, 2005; Mitchell *et al.*, 2006a,b), and appreciate the power imbalance in the patient–clinician relationship (Rosenbaum *et al.*, 2005). For the most part, however, drama-based methodologies are neglected in educational initiatives to improve dementia care, despite their potential to foster critical awareness, encourage the envisioning of new possibilities, and to affect change (Denzin, 1997; Gray *et al.*, 2003; Mitchell *et al.*, 2006a; Kontos & Poland, 2009).

We developed an educational intervention for health care practitioners to address these conceptual and knowledge translation limitations in person-centred dementia care practice. The purpose of this study is to discuss the qualitative evaluation of the effectiveness of the drama-based components of the intervention.

Methods

The educational intervention

The intervention was a 12-week interprofessional arts-informed educational programme to improve person-centred dementia care. Sessions were 2 hours per week with each session offered twice weekly to accommodate staff availability. The intervention utilized dialogue, critical reflection, role-play and dramatized vignettes as educational modalities. Its purpose was to sensitize personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), and allied health practitioners to the importance of supporting embodied self-expressions of persons living with dementia (Kontos, 2004, 2006).

We modified an existing curriculum (Mitchell & Bournes, 1998) that had successfully enhanced culture change and the promotion of person-centred care across various clinical settings and populations (Mitchell *et al.*, 2000). Research validated changed practice and increased practitioner and patient satisfaction on two surgical units (Northrup & Cody, 1998; Saltmarche *et al.*, 1998; Mitchell *et al.*, 2006b). The original curriculum used story, drama, human becoming theory (Parse, 1998), and videotaped vignettes to foster critical reflection by practitioners regarding their understandings, assumptions and practices, as well as contextual factors that facilitate or impede change efforts. For example, one vignette, entitled 'Good Morning Mrs. Vickers' from the DVD *Real Stories* (Deveaux-Babin Productions, 1995), contrasts two care scenarios to challenge the assumption that it takes more time to practise person-centred care. In the first scenario, a home care nurse hurriedly provides care without attending to what the patient struggles to communicate. In the second, she undertakes the same care tasks but actively engages in communication throughout the interaction; the impression is one of a much calmer, less rushed care interaction yet the difference in time is a mere 7 seconds. In this way, vignettes are intended to provide insights regarding person-centred care and invite individual reflection on practice opportunities to improve quality care.

One enhancement to the original curriculum (Mitchell & Bournes, 1998) was the inclusion of the notion of embodied selfhood (Kontos, 2004, 2005, 2006) as a central learning objective. To facilitate understanding of this concept, a DVD of a research-based production about embodied selfhood (Kontos & Naglie, 2006, 2007b) was used. *Expressions of Personhood in Alzheimer's* is based on ethnographic research on an Alzheimer's support unit (Kontos, 2004, 2006). It consists of five separate vignettes intended to illustrate the fundamental aspects of selfhood that manifest, even in the presence of severe dementia, in the way the body moves and behaves. The vignettes are also intended to prompt reflection on missed opportunities to support residents' non-verbal self-expression in practitioners' own practice (Kontos & Naglie, 2006). To further facilitate understanding, practitioner–resident interactions observed in earlier qualitative studies (Kontos, 2004, 2006) were translated by a playwright into prescripted role-plays that were enacted by study participants. Role-plays were intended to simulate the experience of impairment, evoke understanding and foster empathy (Ballon *et al.*, 2007).

For the purpose of this study, analysis was restricted to postintervention data to facilitate interpretive evaluation (Stetler *et al.*, 2006) of participants' perceptions regarding the effectiveness of drama as an educational modality to teach an approach to person-centred care that emphasizes embodied selfhood, and to influence direct care.

Setting and participants

The exploratory, in-depth methodological nature of the multi-method trial necessitated study sites be few (2), similarly staffed and sized (Facility A, 32-bed; Facility B, 40-bed) and have strong administrator support. University-based ethics approval was obtained for each site.

The primary sampling strategy was non-random convenience. All full- and part-time RNs, RPNs, PSWs and allied health practitioners were eligible to participate in the intervention, and in a focus group discussion at baseline and at 3-months postintervention. Theoretical sampling (Denzin & Lincoln, 2000), in which the objective of developing an explanation determines the specific criteria by which a sample is selected, was used to secondarily select a subgroup of study participants for interview. Since agitation management is identified as a critical challenge to care (Cohen-Mansfield, 1996; Cohen-Mansfield & Mintzer, 2005), health care practitioners who were caring for at least one resident with high agitation at baseline, as measured by the Pittsburgh Agitation Scale (Rosen *et al.*, 1999), were selected for interview at baseline and at 3-months postintervention.

Following study introductions, informed consent was obtained from 24 practitioners (Facility A, $n = 12$; Facility B, $n = 12$) who participated in the intervention and all

	Facility A (*n* = 12)				Facility B (*n* = 12)				Table 1 Demographic data
	PSW	RN	RPN	Allied health	PSW	RN	RPN	Allied health	
Gender									
Male	1	0	0	0	0	0	1	0	
Female	7	1	0	3	8	1	1	1	
Age									
≤39	1	0	0	0	1	1	1	0	
40–49	3	0	0	1	3	0	1	1	
≥50	3	1	0	1	4	0	0	0	
Missing	1	0	0	1	0	0	0	0	
Length of time at facility (year)									
≤1	2	0	0	1	0	0	0	0	
1.5–3	0	0	0	0	4	0	1	0	
≥4	6	1	0	2	4	1	1	1	

postintervention data collection. See Table 1 for demographic details of study participants. Participant confidentiality was protected by restricting identification to occupational role. Where residents were referred to by name by study participants, pseudonyms have been used to protect their confidentiality.

Focus groups and interviews

Of 24 participating health care practitioners, 14 participated in focus groups (Facility A, *n* = 7; Facility B, *n* = 7) and 10 in interviews (Facility A, *n* = 5; Facility B, *n* = 5). Each audiotaped focus group consisted of seven participants and lasted approximately 60 minutes. An open-ended discussion guide was used by the moderator to explore the effectiveness of the intervention in teaching person-centred care that emphasizes embodied selfhood, and changes in practice that resulted from its implementation. Focus groups also explored the factors related to the intervention itself (e.g., role-play scenarios) that influenced the effectiveness of the intervention as an educational modality. Focused, audiotaped interviews lasting approximately 60 minutes were subsequently conducted by research assistants to specifically probe issues regarding resident agitation and individual treatment approaches.

Data analysis

Verbatim transcripts were analysed using thematic analysis techniques (Denzin & Lincoln, 2000). Segments of text were assigned a code reflecting the original statement, and then clustered as categories of emerging themes. Through an inductive, iterative process, categories with similar content were investigated for inter-relationships, and further refined. Transcripts were again reviewed to clarify the context and

meaning of coded text. Finally, analytical categories were examined to illuminate the effectiveness of the drama-based components of the intervention as an educational modality, and changes in clinical practice that resulted from their implementation.

Kontos developed the initial coding scheme. To maximize credibility and trustworthiness (Denzin & Lincoln, 2000), Kontos and two research assistants each independently open-coded 20% of the transcripts followed by discussion to resolve any differences in code application. Remaining data were divided equally amongst the research assistants for coding.

Results

Findings are organized thematically. 'Meaning beyond dementia' captures practitioners' understanding that behaviour is not always symptomatic of dementia, and that deciphering the meaning of behaviour facilitates tailoring care activities to accommodate residents' strengths and interests. 'The influence of the approach to care' illustrates both practitioners' awareness that their own practice styles can have both positive and negative implications for residents' disposition, and changes in their approach to care including not rushing residents during care activities, being more patient, and supporting residents' independence. Both themes capture the effectiveness of the drama-based components of the intervention in teaching an approach to person-centred care that emphasizes embodied selfhood, and in facilitating the positive relational outcomes that resulted from its implementation.

Meaning beyond dementia

When asked to discuss the effectiveness/ineffectiveness of the drama-based components of the intervention as learning

techniques, many respondents identified role-play scenarios and *Expressions of Personhood in Alzheimer's* as sources of new awareness that residents' actions can be meaningful self-expressions. For example, in both study sites practitioners reflected on their new insight that behaviour is not always symptomatic of dementia, and the importance of deciphering the meaning of residents' behaviour:

[The role-play] was an effective tool because now you've gotta try different stuff to find out what they really want. You can't just brush off. It's something important they're telling you so…now you try your best to try to figure out what's going on. Don't brush it off, they're saying something. (Facility A, Interview, Recreational Therapist)

Oh my god, [the vignettes] it's *very* good!…because we didn't think about it. Now we have to think, you know, 'what's going on?…Why she screaming?'…You have to think, 'Why she don't like it?' You have to think 'what's going on?' (Facility A, Interview, PSW, original emphasis)

[The vignettes]…teach you that you don't just *assume* that [residents] are being difficult…take the time to figure out what is wrong, what is it that you're not doing that she wants you to do because she cannot express what she wants. (Facility B, Interview, PSW, original emphasis)

In order to facilitate understanding of the meaning of residents' behaviour, practitioners indicated they learned to seek information from the families about residents' biographical history and preferences which was a key message of the role-play scenarios. For many practitioners one particular role-play scenario stood out in terms of illustrating the importance of family for gaining familiarity with residents' preferences. The role-play required study participants to portray one of two roles: either a non-verbal resident who intensely disliked the orange juice repeatedly offered her yet could only communicate this non-verbally; or the practitioner serving the juice who was confronted with seemingly non-sensical grimaces, abrupt hand motions and thrashing when serving breakfast to the resident:

(T)he role play…didn't tell us everything because we couldn't figure out why she was pushing [the orange juice]…but it tells us there is meaning [and] why it's important to understand it…. (Facility B, Interview, PSW)

Later in the role-play, practitioners realized the importance of family for seeking information in relation to the behaviour associated with the food aversion:

(B)efore [the role-play] we would…give them the orange juice and they don't drink it, okay, they don't drink the orange juice, maybe

because of the dementia…. But speaking to family gives us, you know, turn on a little light in your head that said, '*Oh*! So *that's* why she didn't [drink] it!'…(Facility B, Interview, PSW, original emphasis)

The role-play served as a springboard for discussion about a central learning objective of the educational intervention – that care decisions should be consistent with a resident's life history, values, beliefs, past routines and activities, and preferences – and the importance of family's involvement for achieving this. In reference to the role-play, some PSWs reflected on their own practice experiences involving resident preferences and the subsequent insight gained from family members:

(W)e give her coffee, and then the daughter came and said "she's English, she likes tea! She always have tea!" You know, so… sometimes we are doing this complete opposite of what they really want or what they're used to. (Facility A, Interview)

Tailoring activities to accommodate residents' strengths and interests was additional insight practitioners acquired from the role-play and subsequent discussion about the contribution of family as a source of information about residents. In the following example, an RN described how she sought information from family about a resident's prior talents. After learning that she was a painter, the RN shared this information with the recreational therapist, and would accompany the resident to the creative arts programme to paint which would calm her when she became agitated:

Because when she get agitated, like restless…and then you tell her 'okay! We going to…start painting, would you like to come?' and…she will go and join a little bit and then reduce her agitation. So that's one method really. Knowing the interests of the residents prior to them having dementia, it does help. (Facility A, Interview)

The influence of the approach to care

In addition to practitioners using information gained from speaking with family to contextualize residents' behaviour, they also reflected on how their own approach to care interactions influenced the residents. For example, in reference to the vignette 'Good Morning Mrs. Vickers', practitioners reflected on the implications of rushing residents during care activities. A PSW spoke of the two versions of the vignette and how the contrast between them highlighted for her how rushing signals lack of caring:

The video taught us, because the nurse…you can see how she was rushing. [The patient]…thinks "okay, you don't care about

me''…and after [in second version of the vignette] you know when she sits, when she talks nicely and she asks [the patient] what's going on, this mean she care. (Facility A, Interview)

Another PSW indicated that the same video served as a reminder to him when interacting with residents that rushing can cause agitation:

But sometimes, especially in the morning you have to rush rush rush. Sometimes I said 'Oh my god, I remember my education', the one [from the video] that don't…rush residents because if you rush them it will affect you, it will affect me and it's going to be a disaster, it takes a lot more time…don't rush the residents because it cause agitation! Oh, with Mr. Reynolds, when you rush him eating?…Oh my god, he will give you a big whack and a big kick. (Facility A, Interview)

The power of the video as a pedagogical tool is further evidenced by the following PSW who indicated that she will 'catch' herself when rushing a resident:

PSW 1: We have a lot of residents on our floor…they're gonna lash out they're gonna probably spit on you, try to hit you, they'll get aggressive…especially if you're in a hurry. If you're in a hurry, you all do it, 'cuz we're in a hurry we have to get done at this certain time…We all do it, but sometimes I catch myself. So then if I went up to Mrs. Campbell 'Hi…I'm gonna get you ready now' [speaking in a calm tone]…and she would let me wash because she feels more calm and I'm treating her with respect. But if I come in and startle her…

Moderator: Sorry, catching yourself because of…?

PSW 1: Of the video. It makes us more aware. Like when we *first* we probably go in and [rush the resident] and *then* after watching the video, it's like…[observation note: PSW begins to jostle the PSW beside her to demonstrate how she rushes a resident and then stops abruptly to illustrate how she catches herself in the course of doing so]. (Facility B, Focus Group, original emphasis)

In this same focus group, further reflection on the vignette 'Good Morning Mrs. Vickers' yielded a seeming paradox: slowing down actually saves time. A PSW first described the behavioural consequences of rushing care:

If you approach a resident rushed…you know they're not gonna cooperate, they're gonna fight back, they're gonna resist. And you're gonna have to leave them, go do something else, and then come back. (Facility B, Focus Group, PSW)

Other PSWs then described how they changed their practice as a consequence of viewing the vignette. Patience specifically was identified as a significant outcome of the realization that

rushing signals an uncaring attitude, and can cause agitation and resistance to care:

PSW 1: Our patience is much better, our approach is totally different.

PSW 2: Now instead of spending 10 minutes, now we're extending that time because we really know that patience is a virtue for them. They can *feel* when we're patient… And now because of the video we know how to reach out with that patience. (Facility B, Focus Group, original emphasis)

The role-play scenarios were also identified as a significant impetus for increased patience in that they offered insight into the experience of the residents. The following comments illustrate the impact of having played the role of a resident:

…(w)hen we had the [role play] we put ourself in position of the residents. So we really know *what* they're feeling and how to relate…(Facility B, Focus Group, PSW, original emphasis)

Being in their position makes *me* as a caregiver…more cautious about the fact that one second that I couldn't *wait* before, now I give…one more minute. For example, I'm feeding a resident…if the resident would tell me 'wait a minute', I would understand better *now* that wait a minute means 'just wait for me, do not rush me'. (Facility B, Interview, RN, original emphasis)

The purpose of the role-play scenarios was to simulate for practitioners some of the discomforts and impairments that are common to the residents. For example, practitioners were asked to switch their shoes so the right shoe was on the left foot and vice versa, to keep their fingers stiff, hunch over, and to wear glaucoma glasses. As the following comment suggests, the simulation facilitated practitioners' understanding of the challenges the residents face, and acquired patience as a result:

You always imagine…you're really feeling that discomfort or awkwardness…they struggle, you know? They struggle to do the simple tasks that we may feel we can do [for them]…when you see a resident…struggling to do something…[now] you say 'maybe if we'll give this person five extra minutes it's good you know, 'cause they're trying'. (Facility A, Interview, PSW)

Practitioners also gained from the simulation technique a heightened awareness of the importance of independence which for all of the residents was compromised by their impairments:

I mean, you totally, I think you just relate more with the individual, you know? You compare yourself being able, you know, being independent and being able to do everything for yourself and how we

take everything for granted. And you know, we don't even give it any thought! And then…all of a sudden you just can't. (Facility A, Focus Group, PSW)

Another PSW illustrated how she supports the independence of the residents with the example of dressing:

PSW: It make you be a little bit more patient with the resident if they're trying to do something for themself you don't go 'oh come on, come on, it's too, you're taking too much time' and trying to do it for them. You have to be patient.

Interviewer: Do you have an example…?

PSW: …you…get their nightgown and they'll put it over their head and they'll be fighting to push their hands in. So…you have to give them a little bit of independence so you will try to just push the sleeve over so they will find the sleeve and let them push it in there themselves, they feel they accomplish something. So that's what I'll do. (Facility B, Interview)

Feeding was another care activity that practitioners discussed to illustrate how residents' independence could be supported. In the following example, a PSW described how role-playing a resident being fed gave her insight into why residents often resist being fed, and as a result she now allows them to feed themselves:

PSW: She come in with spoon to put in my mouth. *Geez* god help me, don't feed me [observation note: putting her hands up in front of her mouth], I can feed myself. So then it opened my eyes. When I come to feed the residents and they always say 'no no no no'…That's the same thing, they put their hands up in front of you like this [observation note: she motions how the residents raise their hands in front of their mouths to resist being fed].

Interviewer: What you did [in the role-play].

PSW: Same thing that I did.

Interviewer: What changed…after that?

PSW: So here you are trying to tell them you have to eat. And they don't *want* it. And here you bringing the spoon…and then [they] get angry. So now when I come, and [they] put their hand, I leave them. If [they] want it, [they] will eat it. [Some] don't want you to feed. (Facility B, Interview, original emphasis)

Discussion

We developed and implemented an educational intervention for dementia care practitioners that addressed the importance of recognizing and supporting the breadth and significance of non-verbal self-expression in person-centred dementia care. It was a novel intervention in its use of DVD presentations of dramatized vignettes, and role-play as innovative educational modalities. The intervention was intended to convey a more comprehensive understanding of selfhood in dementia, to foster critical reflection by practitioners regarding their own practice style and how it signals underlying assumptions about dementia, and to impact practice making care more person-centred and quality enhancing.

Our study found that when practitioners embraced person-centred care that emphasizes embodied selfhood it facilitated understanding that behaviour can be indicative of self-expression. This prompted them to speak to family in order to help decipher the meaning and significance of behaviour that was previously unrecognized or deemed symptomatic of dementia. In attributing to residents' behaviour, a greater range of meaning, practitioners further understood how their own approaches to care interactions often provoked residents' aggressiveness and resistance to care. Patience and slowing down during care activities were notable outcomes of this new understanding that reduced residents' agitation and resistance to care, which in turn improved the time efficiency of practice in the absence of pharmacotherapies and other restraints. This is significant given that quality of care is presumed to be compromised by staff shortages, increasing workloads and the related insufficiency of time (Mark, 2002; Hall & Kiesners, 2005). Our study is the first to incorporate the notion of embodied selfhood into an educational intervention to improve person-centred dementia care, and thus an important direction for future evaluation of this approach is its impact on efficiency of care activities.

Our study strongly demonstrated the effectiveness of drama as a pedagogical tool. This is consistent with other studies that found that drama is a well received and effective medium of education for health care practitioners across disciplines (e.g., medicine, nursing, and allied health) and training levels (e.g., pre and postlicensure) (Gray *et al.*, 2003; Shapiro & Hunt, 2003; Lorenz *et al.*, 2004; Rosenbaum *et al.*, 2005; Kontos & Naglie, 2006). Drama has been successful in helping health care practitioners and medical trainees reflect on the care they provide, and increase their understanding of the human dimensions of care and patients' experiences of sickness (Gray *et al.*, 2003; Shapiro & Hunt, 2003; Lorenz *et al.*, 2004; Rosenbaum *et al.*, 2005). This has been demonstrated in the areas of schizophrenia (Mienczakowski, 1992), substance abuse (Mienczakowski & Morgan,

1993), metastatic breast cancer (Gray *et al.*, 2001), ovarian (Shapiro & Hunt, 2003) and prostate cancer (Gray *et al.*, 2003), palliative care (Deloney & Graham, 2003), dementia care (Kontos & Naglie, 2007b), and traumatic brain injury (Colantonio *et al.*, 2008).

Our evaluation suggests that dramatized vignettes and improvisational role-play were a powerful catalyst to empathetic connection and person-centred care. They allowed practitioners to imagine what the 'emotions and wishes and desires that someone so placed might have' (Nussbaum, 1997, pp. 10–11). Drama has a uniquely compelling emotional quality that engages participants on both an affective and cognitive level which is arguably central to the success of educational interventions for inter-professional practice (Shapiro & Hunt, 2003; Lorenz *et al.*, 2004; Rosenbaum *et al.*, 2005; Mitchell *et al.*, 2006a; Kontos & Naglie, 2007b). Although the limitations of traditional educational approaches to promote practice change are increasingly recognized (Saltmarche *et al.*, 1998; O'Brien *et al.*, 2001; Grimshaw *et al.*, 2003), and the importance of engaging practitioners 'kinesthetically' with research evidence is strongly advocated (Kemeny *et al.*, 2006), experiential learning techniques such as role-play are utilized with surprising infrequency for educational initiatives to improve person-centred dementia care (McCallion *et al.*, 1999; Kemeny *et al.*, 2006; Kontos & Naglie, 2007b; Gnaedinger *et al.*, 2008). Drama-based approaches are well positioned to strengthen initiatives that seek to improve dementia care (Mitchell *et al.*, 2006a; Kontos & Naglie, 2007b). Research on the extent to which drama impacts health practitioners and why it has the impact that it does would further our understanding of this methodological approach (Rossiter *et al.*, 2008) and its potential to bridge the gap between research on person-centred care and dementia practice.

Conclusion

Quality of care in residential and nursing homes is in need of radical improvement (Ballard *et al.*, 2001). The incorporation of the notion of embodied selfhood (Kontos, 2004, 2005, 2006), and drama as a novel pedagogical tool into educational initiatives (Mitchell *et al.*, 2006a; Kontos & Naglie, 2007b) has enormous potential to facilitate a shift from viewing behaviour as a problem to be controlled, to understanding the breadth of meaning underpinning self-expression in dementia. It is this shift that is required to create a new ethic of dementia care that respects individuals with Alzheimer's disease as embodied beings deserving of dignity and worth.

Implications for practice

- By broadening the current conception of personhood to include non-verbal communication, practitioners who might otherwise prescribe drugs for aberrant behaviours may now consider the possibility that these behaviours are indicative of meaningful self-expression.
- When the trigger of behaviour is accurately identified, the appropriate tailoring of care has the potential to reduce agitation by addressing the need expressed, thereby improving the time efficiency of practice in the absence of pharmacotherapies and other forms of restraint.
- Reducing agitation and resistance to care by an appreciation of the meaning behind various behaviours may lead to a reduction of psychological distress in practitioners by improving the care-giving interaction.

Acknowledgements

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