PRE-THERAPY AND DEMENTIA: AN ACTION RESEARCH PROJECT

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Abstract

This study explores the introduction of an approach called Pre-Therapy to staff working with people with dementia. Pre-Therapy contributes to the existing range of therapeutic approaches which aim to engage with the subjective experience of the world of people with dementia who have severe difficulty communicating. Pre-Therapy aims to facilitate engagement and create relationships with people who are traditionally seen as beyond contact or out of reach. The approach involves using contact reflections. The worker reflects back to the person their words, facial expressions, actions and surroundings. Until now, the application of Pre-Therapy to dementia care has not been explored in depth. An Action Research process examined the research question - What happens when staff learn and use Pre-Therapy contact reflections with people with dementia? The question involved three aspects: the response of people with dementia to contact work, the use of contact work by staff, and the learning process undergone by staff. Underpinned by values of inclusion, participation, democracy and collaboration, the study demonstrates joint inquiry and cyclical exploration. The research process involved self-participation, participation with health care staff and engagement with an expert community (The International Pre-Therapy Network). The entire research process spanned five years. Eleven staff in three residential settings participated as co-learners for 18 months of the process. Located in the real world context, the study accommodated organisational flux, service instability and changes of personnel in a climate of modernization and reorganisation. Data were generated through observation, which included 14 hours of video recordings of interactions, and ongoing dialogue with health care staff and the expert community. The analytic process accompanied the research activity, using comparative analysis and Schatzman’s Dimensional Analysis. Findings indicate that Pre-Therapy Contact Work has the potential to add to existing approaches in dementia care, facilitating greater self-expression of the experience of the subjective world of the person with dementia and promoting greater communication with workers. However, minor adaptations of the approach are indicated. Despite the apparent simplicity, contact work challenged staff. Barriers to learning and using contact work arose from intrapersonal, interpersonal and contextual factors. Factors which mediated the learning and use of contact work led to the emergence of a theoretical model of the emotional management of interactions. Resting on theories of constructed role identities, the model contains two contrasting positions: the emotional custodian and the emotional container. The thesis proposes that the model may be part of an underlying social process around maintaining emotional social order in interactions with people with dementia. In turn, this may help understand difficulties workers face when engaging in the emotional world of people with dementia and enacting values of being person-centred which are inherent in the policy and literature.
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I am indebted to Garry Prouty for his support and encouragement and to members of the International Pre-Therapy Network who were so warm and welcoming. Ian Morton introduced me to Prouty’s work, and he has been a source of inspiration over many years. The local NHS Trust, Colin Lindridge in particular, supported the research. This support allowed me to incorporate the research into my Trust role. I am indebted to my supervisors, Julie Scholes and Trevor Adams. Their diligence and patience has been invaluable. I am grateful to John Reilly (Information Technology Department, University of Brighton) who recovered my data files which had corrupted. Finally, thanks go to the people who participated in the study and joined me in a small episode of inquiry.
Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated with the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed: [Signature]
Date: 2/9/08
Introduction

This thesis explores the process of introducing Pre-Therapy to dementia care. Within Pre-Therapy are specific techniques called contact reflections. These facilitate engagement with people deemed beyond therapeutic contact. The worker uses contact reflections with the client, communicating what they notice about the client's face, body, words or situation. Reflections are very concrete – for example, your eyes look down, the window is open. This is known as contact work.

Pre-Therapy originates from psychotherapy and is the work of Garry Prouty (Prouty 1976, 1984, 1990). Prouty worked in institutions with people termed regressed, schizophrenic, catatonic, retarded or psychotic. These terms reflect the historical nature of diagnostic labels. In today's terms, Prouty's client group would be seen as people with learning disabilities, psychosis, schizophrenia or a dual diagnosis of mental health and learning disability. He identifies the 'birth' of Pre-Therapy happening in the late 1960s. It was noticed that his approach with clients was succeeding and differed from that of other therapists or workers. Articulation of exactly how Prouty responded to clients led him to develop the theory of Pre-Therapy (Prouty et al 2002).

Ian Morton was the first person to link Pre-Therapy and dementia care. He collaborated with Dion Van Werde, a psychologist and Pre-Therapist, producing a chapter about Pre-Therapy within a publication of person-centred approaches in dementia care. Morton proposed that Pre-Therapy might help offer 'emotional palliative care' to people with
dementia (Van Werde and Morton 1999). This resonated with my experience in dementia care and I saw the potential for research to explore contact work.

This thesis charts the introduction of contact work to staff who work with people with severe dementia and is located within existing therapeutic approaches to communication in this field. Specifically, the research question asks *What happens when staff learn and use Pre-Therapy contact reflections with people with dementia?* There are three aspects to this question: using contact reflections with people with dementia, the process staff underwent learning contact reflections, and the implications of contact work as an approach for dementia care. As such, it provides ideas about social processes that affect the learning process and the application of new practice in the clinical setting. This may have wider application, helping towards understanding why the introduction of therapeutic approaches including Pre-Therapy may be problematic for staff who are involved in everyday care.

This thesis reflects the opportunity to use the formal research process as a mechanism to support the introduction of an innovation to practice. This was aided by my joint role as a Lecturer Practitioner, which involves combining a Nurse Specialist role in an Older Persons Mental Health Directorate of an NHS Trust, and an academic role in the School of Nursing at a University. It is feasible that I could have facilitated the introduction of Pre-Therapy contact reflections to practice without the discipline of the research process. However, this would have missed the opportunity to explore the innovation and examine the process of introducing new practice in a systematic and rigorous way.

The research was collaborative: staff participants and people with dementia took part and I joined the International Pre-Therapy Network. Headed by Garry Prouty, this group meets yearly and has provided a forum for me to discuss the research. Simultaneous engagement with staff participants and the expert community permitted an ongoing
iterative process, which helped shape emerging ideas about the use of Pre-Therapy contact reflections in the context of dementia care. This work is also personal, since the study includes my own participation in learning and using Pre-Therapy contact reflections alongside the other staff participants. The impetus for the research was influenced by a personal philosophy of wishing to improve care for people with dementia and a commitment to supporting staff.

Action Research methodology was used to research the process of introducing contact work to staff. The work of Waterman et al (2001) has been influential in constructing the thesis. Their eight pivotal features of Action Research have been used as a framework to structure the discussion of the methodology, research process and methods.

The thesis has been structured to present the work in an orderly manner. This does not reflect the experience of the research process. Action Research, by nature, involves research activity that is disjointed, asynchronous and ‘messy’, but for clarity the thesis has been ordered into four parts.

Part One provides the policy and literature. Chapter 1 outlines the policy context that shapes the services that people with dementia receive. Chapter 2 reviews the literature, drawing on communication and dementia, Pre-Therapy, empathy and staff training. These chapters provide theoretical perspectives that form the backdrop to the research activity.

Part Two presents methodology, the research process, methods and data analysis. Chapter 3 discusses Action Research methodology with reference to the values and beliefs that underpin the approach. Participation, democracy, power, authority and my relationships with others receive particular attention.
Chapter 4 combines the research process, methods and analysis. The research process generated data through observation, reflection on action and critical discussion with participants and the expert community. This chapter also shows how data were gathered using the medium of video recording as an active part of the research process. The methods are discussed in relation to conducting the research in the real world context of existing patterns of care and services. The research process involved simultaneous research activity, validation and data analysis. The analytic process is discussed with reference to a description of how a conceptual framework was devised to support the analytic process in order to explore different aspects of the research question. The framework or scaffolding permitted comprehensive questioning during the research process, data gathering and analysis. The process of data analysis draws on an amalgamation of Comparative Analysis and Schatzman's Dimensional Analysis (Schatzman 1991). This chapter offers the rationale behind my voice appearing in the data and the importance of validation.

Part Three presents the findings and these span chapters 5, 6, 7 and 8. Chapter 5 presents staff using contact reflections and the response from people with dementia. The data were peppered with contradictions. Chapters 6, 7 and 8 use the contradictions to build a picture of complexity, which shows different factors that mediate the use of contact reflections. Chapter 6 examines the skill development of staff. This gives insights into not only how staff learn and use contact work, but may also help us understand why, despite much training, there is a concern that the everyday practice of communication in dementia care remains relatively inadequate. Chapter 7 explores the relationship between contact reflections and the organic nature of dementia. This provides guidance about when contact work may or may not be helpful. Chapter 8 draws together the experiences of staff that led to the emergence of a model of the emotional management of interactions. Within this model, staff balance four things: i) being responsible for people or being responsible towards them; ii) doing things for people or being with them,
being emotionally distanced or emotionally close, and iv) being task focused and being person-focused. The act of juggling the tensions in the model of emotional management is offered as an explanatory theory clarifying why using contact reflections was not as simple as it first appeared. This tension is at the heart of the emotional management of interactions. Although contact reflections are potentially difficult to learn and apply, they do enable workers to be more in tune with the person and their world thus closer to offering humanity and empathy to people with dementia, who remain some of the most emotionally isolated people I have met.

Part Four presents the discussion, reflection on the research process, and conclusions. Chapter 9 consolidates the findings, discussing the potential for the model of emotional management to be part of a larger social process about emotional regulation and emotional order. This generates ideas about what might be necessary to achieve care presented in the policy and literature which is person-centred and underpinned by empathy. Prouty's Pre-Therapy was the vehicle through which the theory emerged. It exposed an underlying tension around social norms of maintaining emotional order. Using contact reflections demands stepping into the world of the person with dementia as they experience it. This demands empathy, understanding of the subjective world of another and an ability to be focused on the other person. The risk is that the world of a person with dementia is not always comfortable to be with and witness. Skill and self-management of our own emotions are necessary in order to be with the emotional world of another. Alongside this we are increasingly demanding workers show empathy and are person-centred. This raises an issue that is potentially uncomfortable – is it preferable to restrict being empathic and offering understanding of the subjective world of the person with dementia to the domain of the qualified therapist or do we continue to ask those without professional training in managing the emotional intensity to provide care that may be too emotionally demanding? Chapter 9 also provides a critical reflection on the research process. The conclusion (Chapter 10)
identifies the potential for Pre-Therapy to contribute to the range of existing approaches to communicating with people with dementia. This study also contributes to the body of knowledge about Pre-Therapy. The ideas that emerge from studying the process of introduction of a new approach have wider implications about how we improve the communication skills of workers who are largely unqualified and who work with people who are affected by dementia.

What started out as naïve practice development intended to operationalize a change in practice arrived in the field of the sociology of emotions. This was rather unexpected, but it offers a contribution to understanding why developing emotion-focused work with people with severe dementia poses such a challenge. Overall, this thesis achieves three things. First, it offers a detailed exploration into the application of Pre-Therapy to dementia care, an area which has not been previously examined in depth. Second, the process-oriented nature of the research activity offers an explicit account of the learning process of staff and the barriers encountered when introducing something new in the real world and everyday context of care. Third, it challenges the current conceptualization of care, which is termed person-centred care, proposing that we embrace a concept that encompasses social processes and social actions aimed at maintaining emotional order.
PART ONE

Policy Context

Literature Review
Dementia in the UK

The UK population is ageing. It is estimated that by 2025 there will be one million people with dementia. Currently, estimates for the costs of care of people with dementia are between £14.3 billion and £17 billion per year (Alzheimer's Society 2007; National Audit Office 2007).

By 2015, the number of people over 65 will increase by 15% and those over 85 by 27%. People over 65 form a fifth of the UK population and by 2051 this will have risen to a quarter. In addition, the older population is itself ageing. In 2003, people over 85 represented 5.5% of the population. This is projected to rise to 9.1% in 2031. These demographic changes indicate a significant rise in the numbers of people living with dementia. Dementia primarily affects older people: approximately 1/1000 over the age of 60, rising to 1 in 4/5 in those over 85 years. Currently, dementia affects over 560,000 people in the UK. This is predicted to rise to 600,000 by 2015 (Bowers et al 2005; Department of Health 2005; Government Actuary's Department 2005; Commission for Healthcare Audit and Inspection 2006).

The World Health Organisation defines dementia as:

... a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is a disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. Consciousness is not clouded. Impairments of cognitive functioning are commonly accompanied, and
The term includes specific types of dementia, for example Alzheimer's Disease, Vascular Dementia, and Lewy Body Dementia. Commonly, people are forgetful, particularly about recent events, have difficulty in handling complex tasks and show behaviours such as pacing and restlessness. People may also experience hallucinations and have difficulty expressing themselves and understanding others. In later stages people may be unable to maintain personal hygiene, may respond in self-protective ways that are aggressive or may withdraw from others. Where speech is still present, it is more disjointed and difficult for others to understand (Cheston and Bender 1999).

The medical definition sits alongside broader issues that affect the well-being of people with dementia: family members, carers, social relationships, environment and housing, legal and ethical issues, societal aspects and care services. Care for people with dementia and their carers varies according to need and is provided by statutory, voluntary and private sectors. Together, agencies from these sectors provide support in the community, day care and respite services, and specialist hospital care and residential care when people can no longer be supported in the community. Services are not static and are influenced by the national policy context.

Social policy and mental health in old age

The wider policy context of older people in society provides a framework of principles promoting citizenship, social inclusion, reducing inequalities in health and anti age discrimination. In this way national policy relates to the social and financial position of older people and their role and status, tackling specifics of pensions, work, discrimination and equality as well as health and social care. The first ever national strategy on Ageing - Opportunity Age (Department for Work and Pensions 2005) - identified health and social care of older people (which includes
dementia) as one of two dominant issues. Governmental and advisory bodies collaborate, striving for equality of health and social care services for older people with services for younger people, stressing the principles of age-inclusivity, treating people with dignity and respect and promoting health and well-being (Bowers et al 2005, Department of Health 2005; Age Concern 2006; Commission for Healthcare Audit and Inspection 2006).

Services for older people with mental health needs are led by the National Service Framework for Mental Health (Department of Health 1999) and the National Service Framework for Older People (Department of Health 2001a). Although the national service framework for older people states that people should have access to integrated mental health services to ensure effective diagnosis, treatment and support for them and their carers, there are limitations to this being achieved. A New Ambition for Old Age: Next Steps in the Implementation of the NSF for Older People (Department of Health 2006a) identified areas which still needed attention. These are: removing barriers to services based on age, treating people with dignity and respect, providing choice and involvement in decision making, and person-centred care. In the policy context, person-centred care is used to indicate quality care that is focused on the needs of the person; promotes autonomy and independence rather than control and is based on a collaborative philosophy (McCormack 2004; Innes et al 2006). However, the reality of achieving person-centred services is questionable where eligibility criteria for services limit access to services and budgetary constraints and scarce resources lead service provision (Help the Aged 2002; Parkinson 2004).

Alongside the drive for age-inclusivity of older people into mainstream mental health and social care services, there is recognition of the need for investment in specialist old age mental health services which includes care for dementia (Department of Health 2005; Audit Commission 2002). Following the publication of Securing Better Mental
Health for Older Adults (Department of Health 2005), the Care Services Improvement Partnership published Everybody’s Business (2005a) as a guide to the development and modernization of services. The impact of modernization has been a trend to focus on early intervention, health promotion, and maintaining people in the community. Consequently, the trend is to rely less on residential care (Commission for Healthcare Audit and Inspection 2006). Key directions are the development of ‘out of hours’ and crisis services, care and discharge from acute hospital beds, intermediate care and mental health promotion, for example tackling loneliness and isolation. Priorities emerge in relation to people with dementia. The inclusion of dementia in General Practitioners’ performance targets contributes to an emphasis on early diagnosis and intervention. The development of specialist dementia community services and greater use of direct payments, which allow carers to arrange their own support, also aim to maintain people at home. The national documents focus attention on particular areas where there are difficulties. Acute hospital care environments have been identified as having insufficient understanding of dementia to provide sensitive help, and intermediate care (rehabilitation to either prevent admissions or speed up discharge from hospital) often excludes people with dementia. Overall the emphasis is on independent living in the community with community-based services (Age Concern 2006).

Simultaneously there has been a steady reduction in residential care beds. During 2004 and 2005 these decreased by almost 10,000. In addition there is a reduction in NHS continuing care beds, where the health need entitles a person to free care (Age Concern 2006). The knock-on effect of modernizing services is that residential and hospital care have to manage people with more challenging behaviour and more complex needs. Also, the proportion of people in residential care settings who have dementia is increasing (Cantley 2002; Bosanquet et al 2006). This is coupled with concern about skills and training for staff (Commission for Health Care Audit and Inspection 2006). A training needs analysis by the North West Dementia Centre identified staff
training as a top priority with a specific focus on dealing with challenging behaviour and identified low levels of training for staff (North West Dementia Centre 2004). At the same time the policy and guidance call for staff to be skilled at promoting health and independence, therapeutic psychosocial interventions and communication (Department of Health 2006b; NICE-SCIE 2006). There is some acknowledgement that improving skills is not straightforward. The National Institute of Clinical Excellence and the Social Care Institute for Excellence show awareness of difficulties in training staff, acknowledging that training alone is insufficient to bring about change (NICE-SCIE 2006). Additional factors of organisational barriers and staff turnover work against implementing training in daily practice and changing practice. In order to counteract this, it appears preferable to embed and sustain training in practice with support from organisational structures. This leads to improved knowledge and skills and consequently job satisfaction, morale and retention of staff (Lintern, Woods and Phair 2002). Lack of sustainability and the dilution of benefits from training are beginning to receive more attention. The need to recognise the influence of the work context in training has recently been strengthened by the Mental Health Foundation (2007). They call for the development of skills and training in conjunction with learning strategies which sustain the effectiveness of training, promote learning through practice and are responsive to contextual factors.

In dementia care, the focus of training is often managing difficult behaviour, for example reducing agitation and aggression, although the emphasis typically uses an emotion-oriented or person-centred approach (Burgio et al 2002; Opie et al 2002). This approach focuses on understanding the individual's social history and life experiences and how they are responding to dementia. This demonstrates a social psychological perspective to dementia rather than a medical or symptom management approach. In this way the direction of training embraces the principles and values of national policy on personalised services, autonomy and individuality.
The need for training is also evident in the improvement of existing services. Specific investigations identified institutionalised practices, substandard care and neglect of people with dementia. As a result, the Care Services Improvement Partnership recommends training and supervision to help overcome conditions that lead to neglect, closed and inward-looking cultures and unacceptable standards of care (Commission for Health Improvement 2003). However, staff training is only part of wider improvements. Key improvements include: upgrading institutional environments, increasing permanent staffing levels and reducing 'agency' staff, ensuring effective management at ward and locality level, leadership, combating isolation of services and raising involvement of staff in clinical governance (Care Services Improvement Partnership 2005b).

At the same time as modernization and improvement of services there is national concern over funding for health and social care. The economic cost of dementia exceeds that of stroke, cancer and heart disease combined (Lowin et al 2001; Care Services Improvement Partnership 2005a; Knapp et al 2007; National Audit Office 2007). The majority of the financial burden rests with families. It is estimated that 25-30% of residential care home costs are met by private funding, and approximately a third of people with dementia require residential care, which is largely provided by the independent sector contracts with local authority social services. An estimate of the current annual cost per person for a year for residential care is £31,263 (National Audit Office 2007).

The financial pressure on the NHS and Social Care services results in continuous tightening of eligibility criteria for services, regional variations in access and payment rates for services, and a financial management

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1 Everybody's Business (Care Services Improvement Partnership 2005a) is not specific about what is included in their term 'direct costs'. The reference they use to support this is Lowin et al (2001) who show their methodology for calculating the costs in detail.

Frontline staff have the difficult job of providing care, influenced by national policy, against a backdrop of organisational constraints such as budgetary restrictions and increased bureaucracy. As a result they are expected to enact the principles of inclusion, promoting autonomy and anti-discriminatory practice within a climate of rational managerialism (Innes 2002; Innes et al 2006). Whilst this tension is acknowledged, morale of National Health Service staff is low, sick leave is high and it has been estimated that nurses experience stress at nearly twice that of the general population (Gulliver et al 2003; Bosanquet 2006). In dementia care, the translation of the principles of policy to practice is commonly termed ‘person-centred care’, which encompasses valuing people, treating them as individuals, being able to understand the world from their perspective, and providing a positive social environment which promotes well-being (Brooker 2004; Innes et al 2006; McCormack and McCance 2006). Central to this are the skill of listening and communicating, which require patience, compassion, empathy and sensitivity (Bryan et al 2002).

The policy context sets out ideals of care. Ideas such as being person centred, valuing the individual, viewing the world from their perspective, promoting autonomy and citizenship and providing positive social environments are commendable. However, realising these presents a challenge (Brooker 2004).

Arguably policy and national guidance fall short in two areas. The first concerns investment in staff skills. Whilst there is general acknowledgement that staff require knowledge and skills specific to dementia care (including communication and addressing psychological needs), insufficient attention has been paid to how this will be achieved or what conditions are necessary to accomplish this. The Mental Health
Foundation (2007) comes closest to addressing this, recommending training in situ and embedded in work places and practices, buddying systems, mentoring and peer and self-assessment. However, in the absence of a comprehensive education and training strategy for dementia, training remains a patchwork of initiatives. Greater attention to the process of skill acquisition may help organisations achieve training which is more sustainable.

Second, there is insufficient detail about strategies to address contextual factors which lessen the effectiveness and sustainability of training. Whilst acknowledging the features of the workforce which contribute to the difficulty of embedding training and driving up standards, there is no national strategy to change the negative features of the workforce, namely transient workers (many of whom work through private agencies), poor leadership, and the high proportion of unqualified staff working without supervision.

The policy and guidance leave one possible area of concern. It may be that the moves to improve standards of knowledge and skill will inadvertently lead to increasing the negative factors in the workforce. Private and residential homes could potentially be one area affected. This might arise as The Commission for Social Care Inspection aims to introduce a star rating system to care homes. Whilst the aim of this is to drive up standards of care for people with dementia in residential homes, this action may result in unintended consequences. These consequences may include: the cost of staff training being passed onto the individual receiving care via rising costs; reluctance of staff to engage in developing skills in a job with relatively low pay leading to additional difficulties in recruiting staff; and further pressure on organisations and individuals arising from greater emphasis on auditing, monitoring and assessment of staff.

This study is anchored in the wider concern about future care and services for people with dementia. The policy context promotes the need
for developing person-centred care and communication and Pre-Therapy is one approach which may help this. Also, the design of this research embeds staff development in practice rather than treating it as separate from practice.
Introduction

In the absence of a body of work specific to Pre-Therapy and Dementia, literature was drawn together from different fields. Three key domains of literature were identified to construct parameters for searches (Hart 1998). The domains were: Pre-Therapy, therapeutic approaches in dementia care and training interventions with staff.

The search strategy is presented prior to an overview of the variety of paradigms in the dementia care literature, which leads to an outline of current therapeutic approaches. This provides a theoretical location for the thesis: viewing dementia care in terms of the interactions and relationships based on an understanding of the subjective experience of the person with dementia. The literature illustrates the potential for excellence in therapeutic communication with people with dementia. Despite the plethora of therapeutic approaches there is currently distance between the theory and practice of person-centred care. Once the origins and theoretical foundations of Pre-Therapy are discussed, the detail of Pre-Therapy Contact Work is outlined. It is possible to make comparisons between Pre-Therapy and other approaches, in particular Validation Therapy (Feil 1993), Positive Person Work (Kitwood 1997), and Killick and Allan's work on communication (2001). The comparison allows for the difference and similarities to emerge. The chapter explores emotional contact and empathy. This aspect links Pre-Therapy and the other approaches. Because Pre-Therapy has not been explored in
dementia care, the introduction of this approach to staff working in dementia care context needs consideration and the chapter concludes by reviewing the literature on training staff in practice. Lessons from the literature around learning in context provide the rationale for a process oriented methodology for the research.

Searches were conducted using key words (full and truncated), and refined using combinations of words and following citations. The availability of full texts was enhanced by having access to both University and National Health Service library systems, the Health system gateway being KA24. Given the length of the inquiry, auto alerts were set up with both organisations. Articles and key texts were supplemented by grey literature (Hek and Moule 2006). This included editorials, policy and guidance documents from voluntary and statutory organisations, and journals which were not peer-reviewed. The most useful of these was the *Journal of Dementia Care* which provides a source of material about contemporary practice. The validity of this source is strengthened by the amount of contributions from authors who also publish key texts and articles in peer reviewed journals. Whilst acknowledging the potential for bias, grey literature provided a base of literature in which to locate peer reviewed material. Personal membership of the Pré-Therapy Network provided access to an International data base of publications about Pré-Therapy. This provided articles and drafts of articles from Network members. In addition, the yearly network meetings and email contacts provided the opportunity to discuss work directly with the authors. Appendix 1 provides a checklist of search strategies.

Whilst the inclusion criteria was wide, material was excluded which addressed topics but in contexts judged too far removed from this research inquiry. For example, communication in relation to stroke was deemed not sufficiently similar to communication in dementia. Similarly, dementia in physical care or acute hospital settings was discounted as
the care contexts were considered to be too dissimilar. Material was also eliminated if the use of the term did not match the use in relation to this study. For example, the term Pre-Therapy attracts different meanings in different fields. In relation to some physical care procedures, Pre-Therapy refers to health status or baseline assessment prior to a medical intervention, rather than being a specific reference to the approach called Pre-Therapy devised by Garry Prouty.

The search drew together previously unrelated domains of literature relevant to the introduction of Pre-Therapy to dementia care practice in the context mental health residential settings.

2.1 Paradigms in dementia care

There are various perspectives about dementia in the literature. As seen in Chapter 1, the medical definition views dementia as a neurological syndrome that primarily affects cognitive functioning. The medical perspective classifies dementia into different types, the most common being Alzheimer's Disease, Vascular Dementia, Lewy Body Type Dementia and the Fronto-temporal dementias. An illness perspective focuses on the physical and neurological changes. Alongside these changes run psychiatric and behavioural changes associated with the progress of the dementia (Finkel 2000; Burns et al 2005). The medical perspective offers broad classifications of the stages of dementia, for example early stage, middle stage and late stage dementia. Whilst acknowledging the uniqueness of the presentation of each person with dementia, this perspective offers broad ideas about how the person is affected at each stage. In the early stages, the dementia is more likely to affect short-term memory and may cause confusion, anxiety or distress as the person is aware of their cognitive changes. In the middle stages, people commonly become more forgetful of events and require support with everyday activities such as using the toilet, washing and being involved in activities. Accompanying these changes might be greater disturbance in behaviour such as aggression or responding to
hallucinations. In later stages communication is further impaired and the ability to recognise familiar places and people is more impaired. There are physical changes such as difficulties in swallowing, walking and the individual becomes increasingly physically dependent. Over the last 15 years the biomedical perspective has been challenged, leading to a growth in alternative perspectives and psychological and social approaches.

A phenomenological perspective on dementia has developed in the last ten years, addressing the previously neglected area of the lived experience of dementia (Goldsmith 1996a, 1996b; Downs 1997; Sabat 2001; Mayhew et al 2001; Clare 2003). This perspective stresses the subjective experience of dementia, the individual's sense of identity, and sees them as a person alongside the neurological changes (Sabat and Harré 1992; Kitwood 1997; Small et al 1998; Cheston and Bender 1999; Clarke, Hanson and Ross 2003; Hughes, Louw and Sabat 2006).

More recently there has been greater discussion of how (and if) a person with dementia maintains an internal sense of self, a social or outer self as well as a relational self. This questions the very nature of defining humanness and whether dementia takes this away. Aquilina and Hughes (2006) tackle the idea that a person with dementia may have lost the essence of being a person, opening up a debate about the role and relationship of those who are in the position of caring.

One of the shocking things about talk of the 'living dead' is that it might suggest that those of use who are involved in looking after people with severe dementia are doing something gruesome. Perhaps we are looking after dead people. This would be terrible if it were true. Against this stands the idea of a 'relational self': the idea that other people are crucially important in maintaining, at some level, the personhood of people with severe dementia. But this could just be sentimentality. Perhaps it makes us feel better if we think that what we do makes a difference to the (so-called) 'empty shell' that used to be a person (Aquilina and Hughes 2006: 155).
The discussion around retaining a sense of self and person-ness has expanded the dementia literature to a philosophical and moral perspective, which may in the future inform practice in relation to ethical issues around end of life decisions and advanced directives (Widdershoven and Berghmans 2006). Whilst calls to continue to view people with severe dementia as having a sense of 'being' may enrich care practices because people are treated as people, this may place additional burden and guilt on relatives who are grieving. Relatives may need to distance themselves from a person who they see physically deteriorating and the person they once knew who is 'no longer there' (Davis 2004). Whilst Davis discussed this in relation to relatives, a similar argument could be applied to staff providing care to those in the later stages of dementia (Kitwood and Bredin 1992).

A humanist perspective is evident in the literature. This perspective is person-centred, as it focuses on the experience of the person with dementia, and relationship-focused, as it acknowledges the importance of relationships between the person with dementia and other people (Woods 1997; Morton 1999; Stokes 2000; Aggarwal et al 2003; Harris and Keady 2006).

Social processes and interactions between people with dementia and others are seen as a major force in the construction of self, where the person with dementia is seen as retaining a self, having agency and existing in social relationships with others (Sabat and Harré 1992; Sweeting and Gilhooly 1997; Davis 2004). Taking a position of valuing and supporting a person and acknowledging their sense of self we move away from seeing people with dementia as dependent, ill, becoming an empty shell, and not there any more.

The focus on social relationships and interactions has led to the use of the paradigm of Symbolic Interactionism, which emphasises how meaning is created and conveyed through everyday interactions (Adams 2008). Symbolic interactionism has been influential in the exploration of
everyday interactions of people with dementia in relation to relatives, spouses, paid carers and other people with dementia (Neufeld and Harrison 2003; Hubbard at al 2003; Heinrich et al 2003; De la Cuesta 2005; Karner 2005; Orulv and Nikku 2007). The paradigm offers a theoretical framework to help understand social contact and micro-analysis of social interactions which are challenged by the lessening ability of the person with dementia to communicate and convey meaning (Tibbetts 2005). This paradigm with its attention to the relationships with people with dementia has been influential in seeing how the experience of dementia is affected, and potentially enhanced, by the nature of the interaction with others (Kitwood 1997).

The emphasis on the micro-perspective is challenged by those preferring a more macro-perspective. Adams (2008) embraces symbolic interactionism, but argues that interactions are part of the social co-construction of social systems within dementia care. He aligns this with the theoretical perspective of Discursive Psychology (Thornton 2006). The emphasis of Discursive Psychology is on construction through language, drawing on theoretical perspectives offered by Ethnomethodology, Discourse Analysis and Conversational Analysis (Adams 2008). Whilst this study accepts that, on a larger scale, there may be value in the perspective of Discursive Psychology, this study confines itself to exploring the social processes and social action involved in the relationship between staff and people with dementia. The perspective taken is that the experience of using Prouty's contact reflections is mediated by the meaning an actor (staff) attributes to the interaction in the context of social norms that guide or affect the understanding of the interaction.

The term 'dementia' has been critiqued as a social construct affected by social expectations and societal factors that form perceptions about dementia (Clarke 1999; Forbat and Service 2005). Broadly framed under a social constructionist perspective, this paradigm illustrates the arbitrary demarcation of a person from 'normal' to 'abnormal'. As the
ability to diagnose organic changes is brought forward through technological advances, people receive a label of having the illness of dementia earlier than ever before (Whitehouse and Moody 2006). In this way society creates meaning about dementia, rather than it being a neutral objective diagnosis. This perspective is taken up by those who take a social-political perspective (Fox 1989; Davis 2004).

A critical theory perspective deconstructs the concept of dementia, exploring power relationships, discourses and ideology, and challenges the dominance of the medical/biological perspective. A focus of this perspective is to examine how society excludes and disempowers people and how social policy manages the costs of caring (Clarke 1999; Hill 1999; Gilliard et al 2005). In addition, there has been a call to view dementia from a social disability perspective to allow people with dementia the same opportunities as those without (Gwilliam and Gilliard 1996; Harding and Palfrey 1997).

These paradigms co-exist and provide a tension. Issues of equality, partnership and citizenship arise within a social constructionist view in health and social care policy. These issues encourage services to promote inclusion, advocacy and collaborative working practices. However, a bio-medical or illness perspective may deflect attention from these issues, with less emphasis on the perspective of the person with dementia, their relationships and their role in society.

At the same time, paradigms can be complementary. Scientific advances that promote early diagnosis of dementia have led to developments in care that are empowering. People with dementia and relatives/carers are offered greater support to live alongside dementia, encouraging ownership and control over diagnosis and the illness. In practical terms, this has given rise to an emphasis on self managed care in early stages, psycho-education programs for carers and the rise of the 'anti-dementia drugs'. As stigma and exclusion lessen there is hope for living positively alongside dementia rather than for individuals being
Literature Review

constructed as 'sufferers' (Traynor et al 2004; Clare et al 2005; Scott and Donnelly 2005).

The position taken in this thesis is that people with dementia continue to be experiencing beings and to retain a sense of self (Dewing and Pritchard 2004). Expression of their sense of self is compromised by the neurological changes but this does not detract from the importance of trying to gain an understanding of their subjective phenomenological experience. Accessing their experience and creating meaningful emotional contact is done through relationships. Concurrently, the embodied or physical challenges presented by the dementing process pose a challenge to how we form relationships. This is linked to a second influence: social interactions and social context. The importance of social relationships in context is consistent with social interactionist perspective, which accommodates the potential for meaning to be constructed by and between individuals. Again, social relationships and the expression of self through a social context is mediated by the physical, neurological nature of the dementing process.

The variety of paradigms discussed above shows the breadth of theoretical perspectives informing the literature in the field of dementia care. As a result there has been an expansion in the academic field of dementia over the last decade which is rich in its theoretical diversity. The influence of these paradigms can be traced through policy guidance and services offered to people with dementia.

The application of paradigms to practice
Paradigms affect research, care and treatment. The biomedical paradigm, linked to a positivist scientific research tradition, focuses on objectivity and measuring variables. This is evident in the focus on categorising and measuring cognitive ability and behaviour with the development of assessment tools and scales used for research and clinical practice (Burns et al 1999; Finkel 2000; Ballard et al 2001; Potkins et al 2002; Shah et al 2005). Advances in specificity of diagnosis
and early identification have led to medical and psychosocial interventions to delay cognitive changes (Spector et al 1998, 2004; Orrell et al 2005). In addition, measurement of psychological aspects is possible, namely exploring quality of life, functional abilities, participation in pleasant events and the quality of interactions by staff (Burgener et al 2005).

The paradigm which focuses on relational aspects of care promotes preserving social identities, personhood, and facilitating opportunities for people with dementia to engage as social beings (Keady 1996; Surr 2006). Workers are called to relate to people to maximise their abilities and interact in ways that counterbalance the effects of the neurological changes (Kitwood and Bredin 1992; Kitwood 1997; Hubbard et al 2003).

Whilst alternatives to the biomedical paradigm have widened the field of dementia, the positivist research paradigm dominates investigations into treatment and therapeutic approaches (Sykes and Marks 1999). This is reflected in health and social care guidance, with the adoption of evidence-based practice into service guidelines and National Service Frameworks (Department of Health 1999, 2001a; NICE-SCIE 2006). Since guidelines and frameworks favour evidence from the scientific tradition, greater weight is given to research using the gold standard of the Randomised Control Trial. Arguably, as a result of this bias, evidence-based practice is skewed towards a biomedical, scientific perspective. As a result, care and treatment which are more amenable to scientific study are more likely to be legitimised and sanctioned, possibly at the expense of evidence from alternative sources (Agar et al 1997; Cook et al 2001; Pusey and Richards 2001; Rycroft-Malone et al 2004).

Many research studies pursue a scientific methodology in relation to care and communication (Kitwood and Bredin 1994; Rovener et al 1996; Hadley et al 1999; LeDorze et al 2000; Innes and Sur 2001). However, psychotherapeutic (as opposed to medical or interventionist) approaches
may be less amenable to scientific evaluation. This is illustrated by Burns et al (2005), who attempted what they believe to be the first randomised control trial of a psychotherapeutic intervention (psychodynamic interpersonal therapy). They concluded that, whilst the experience was qualitatively important, there was no measurable improvement. The significance of the dominant paradigm is that this favours approaches which can be evaluated by scientific methods. Meanwhile, approaches not proven by scientific study do hold value and currency in everyday practice - for example Validation Therapy and Reminiscence (Feil 1993; Woods et al 2005a, 2005b). Both of these have been subjected to systematic reviews and are mentioned in the National Service Framework for Older People (Department of Health 2001a). However, the results are not strong, methodological difficulties have been acknowledged and further well-designed studies are required (Neal and Briggs 2003; Thorgrimsen et al 2003). The implication of this is that approaches used in communication may receive less kudos due to the relative lack of "evidence".

There is no doubt that the phenomenological research perspective has increased awareness about the experience of dementia and been influential in developing approaches which are sensitive to the personal experience of dementia (Pratt 2003; Smith et al 2006; Upton and Reed 2006). However, the dominance of evidence-based practice along scientific lines has the potential to hinder more creative practices which are more difficult to research unless a variety of paradigms are adopted or until researchers embrace the positivist tradition and find ways of overcoming the methodological barriers (Bond 1998; Bond and Corner 2001).

**Therapeutic approaches**

Different approaches fit with different stages of the dementing process (Powell 2000). Approaches in the early stages focus on retaining existing cognitive functions and utilising remaining abilities (Butler 2002; Reinstein 2004; Saczynski and Rebok 2004; Zarit et al 2004; Holm et al...
Early on, the primary impact of the cognitive changes is loss of memory rather than substantial changes in a person's ability to communicate. Because communication is relatively unimpaired, there is the opportunity for therapeutic work that explores the impact of diagnosis, future planning, and collaborative work promoting self-managed care and coping and adjusting (Clare 2003; Clare and Shakespeare 2004; Cheston, Jones and Gilliard 2004; Gilmour and Huntington 2005; Heimonen and Grano 2005).

As the dementia progresses, neurological changes affect speech, language and comprehension (Shakespeare 1998; Bryan et al 2002; Bayles 2003). Interactions between staff and clients become more difficult to sustain as traditional rules of syntax and cohesion in sentences are affected. People talk tangentially or repeat things. The content of conversations may be reduced with less obvious connections between topics and this requires staff to piece together themes in conversations (Moore 2002). Turn taking becomes more frequent as turns become shorter, and relatives/workers may need to take the lead in conversations where clients become less able to initiate interactions. Speech may become obscure, more inclined to be metaphorical or poetic or the meaning may be located in the past (Killick 2002, 2005; Knocker 2002). Consequently, communication between staff and people with dementia becomes more challenging with increasing likelihood that their attempts to communicate are not acknowledged. This results in either poor communication or lack of communication. Specific approaches may be used to counteract this and facilitate communication. Reminiscence, for example, can be used to help people relive times when they felt useful and review their lives (Woods et al 2005b; Holm et al 2003). Validation therapy works with the underlying meaning of the words of people with dementia, helping staff communicate with people whose speech may becoming more disjointed and difficult to follow (Feil 1985; 1992; 1993).
As communication becomes more difficult, approaches using creative media (such as dance, art, activity and environmental changes) aim to improve communication and social relationships. These enhance self-esteem and promote well-being (Perrin 2000). An emphasis is on workers to initiate structure and organize activities and media for communication (Pulsford 1997; Pulsford et al 2000; Miller et al 2001; Pool 2001; Peak, and Cheston 2002; Lepp et al 2003; Abraham 2005). In later stages, media other than language are used. This may be necessary because the dementing process significantly inhibits communication. These media include the use of sensory experiences such as touch, movement and music, and the use of transitional objects such as dolls (Jones and Miesen 1992; Haggstrom and Norberg 1996; Kim and Buschmann 1999; Aveyard et al 2002; Baker et al 2003; Götell et al 2002; Graham 2004; Nystrom and Lauritzen 2005; Sherratt et al 2004; Sung and Chang 2005; Verity 2006). Other approaches not formally evaluated offer general guidance to workers about how to accommodate changes in communication patterns as they become more disjointed and altered in reality and time (Pinner 2000; Kuhn and Verity 2002; Moore 2002; Minardi and Hayes 2003; James et al 2004; Walker and Dale 2004). As well as being therapeutic the approaches outlined above counteract the withdrawal and subsequent isolation and solitude that people in the later stages experience (Killick 1997).

Although the approaches identified above provide therapeutic and positive ways of communicating, there are difficulties in putting them into practice. As a result, psychological and social care receives less attention than physical care. Whilst physical care is important, there is a need to improve psychological and social care (Kitwood 1995a, 1997; Small et al 1998; Norbergh et al 2001; Kontos 2005). Pre-Therapy Contact Reflections may be part of overall improvements in providing psychological care.
The need for improvements in communication

Writers who acknowledge the need for improvement in communication see interactions as frequently 'brief and instrumental' (Killick and Allan 2001: 152), relatively ineffective (Kitwood 1997) or composed of interactions directed at a person such as questions, statements, commands and directions (Jones 1992). Interactions show paucity of meaningful communication and are often focused on routines, physical care or tasks (Brooker 1995; Hendryx-Bedralov 2000; Skovdahl et al 2003; Wadensten 2005). Whilst physical care is part of the daily work, other needs - psychological, social, and spiritual - have to be met, and communication skills are essential to this. Kitwood (1997) draws attention to the poverty of communication. He categorised social interactions, showing how they may be detrimental or even malignant (e.g. infantilising, treacherous, invalidating, objectifying). Through this categorisation Kitwood highlighted ways of interacting which lessen the well-being of a person with dementia. At the outset of the research, I wondered if Pre-Therapy Contact Reflections might contribute to the range of positive therapeutic approaches, offering a counterbalance to some of the more detrimental patterns of care.

Research specifically exploring detrimental patterns of communication is limited. However, criticism arises from findings of observational studies that explore patterns of communication within interactions. The lack of research explicitly exploring detrimental communication may be explained by the potential ethical and managerial implications of studying poor practice. Given the need for ethical and research governance approval it is not possible to conduct research that explicitly aims to study poor practice which could potentially expose staff and organisations, and unethical to ask workers to participate in a study which was aimed at identifying poor practice. Where poor or bad practice has been exposed by research, disciplinary protocols for staff have to be followed (Vass et al 2003). However, studies exploring improving communication provide some detail of communication patterns as baseline observations.
The most explicit research illustrating the poverty of interactions finds residents with dementia spend only 10% of their time engaged in interactions with others: 2% is with care staff, and 78% of these interaction are task focused (Ward et al 2005). Communication is fixed in routines with the pattern emerging of openings (greeting), intent ("we're going to the toilet"), accomplishment (narrative on the task) and closing ("that's it", or a silent closing where the staff simply leave). Greater communication is present where residents resist or do not understand the task in hand. Staff employ a variety of strategies: desisting (stopping, leaving), persuasion (sweetening statements, using pet names - 'darling'), coalition (getting another staff member), enforcement (verbal authoritative commands, or non-verbal e.g. holding the residents' hands to prevent them pushing the staff away). Ward et al (2005) concludes that if care is accepted as more than the simple act of doing physical care and is understood as addressing the person as a whole human, then residential care is falling short of providing adequate care.

In the absence of research specifically studying poor care, awareness comes mainly from national investigations into poor practice, which include poor communication - for example, the Rowan Report (Commission for Health Improvement 2003; Royal College of Psychiatrists Faculty for the Psychiatry of Old Age 2004), personal accounts (Johnson 2004), commentary (Bender and Wainwright 2004; Edwards 2004), and voluntary agencies. Together these highlight basic lack of kindness, poor attitudes of staff and, at the extreme end, abuse. Accompanying this is concern that care practice needs to improve and that the investment in staff required to provide good care is inadequate or patchy (Anchisi et al 2003; Featherstone et al 2004; North West Dementia Centre 2004). Seen from a socio-political perspective, there is a lack of political and economic commitment to improving care which is perpetuated through current health and social care provision, and executed by policy (Harding and Palfrey 1997; Cheston and Bender 1999; Innes 2002; Clarke 2005). This results in staff with the least training, financial reward, and social status delivering most of the face-
to-face care (Pietro 2002). Blake (2002) proposes that the veil of the new culture of care (i.e. person-centred care) remains an aspiration, 'gilds the cage' and does not address the more fundamental issue of the confinement of people with dementia by society. This rather bleak picture of the standards of communication and care provides the backdrop to the research.

Theoretical perspectives in dementia care have broadened possible ways of approaching people with dementia. As therapeutic approaches have flourished, an emphasis on communicating with people and the importance of relationships has emerged. This has not necessarily been realised in practice. In the later stages of dementia the work force who deliver the majority of the care are unqualified care staff. It is debatable to what extent therapeutic approaches have been translated to everyday practice. It is with this in mind that the research set out to explore how a new therapeutic approach (Pre-Therapy) was learnt and applied in practice.
2.2 Pre-Therapy

Pre-Therapy is the theory and practice of making psychological contact with people who cannot express what they are thinking and feeling, due to a disturbance of their emotional or mental health (Prouty et al 2002). A therapist or worker uses particular techniques, called contact reflections, to facilitate the restoration of emotional contact. Contact reflections are the practical application and what the therapist does in relation to the behaviour of the client. This term will be explained in more detail later in this section. By restoring contact clients may get in touch with their emotions, their place in the real world and communicate these to the worker. The prefix Pre attached to Therapy identifies it as an approach used prior to therapy for people who cannot engage in therapy because of the severity of their psychological disturbance. The explanation of Pre-Therapy is structured as follows: theoretical and philosophical foundations, central constructs, and detail of the contact reflections.

Theoretical and philosophical foundations of Pre-Therapy

The foundation of Pre-Therapy is the synthesis of two traditions within psychotherapy. First, the relationship focus of Rogerian Person Centred Psychotherapy. Second, the 'focusing' of Gendlin's existential psychotherapy, which emphasises reflecting the concrete as a way to access the client's own experiencing process. Prouty's philosophical position is that humans live and experience their own perception of the world through a concrete, physical and 'embodied' way and that humans live in interactions with others. Prouty states his philosophical position as follows:

> Experiential thought is grounded in existential-phenomenological philosophy (Gendlin 1973). Fundamentally, experiential thinking is rooted directly in experience via Husserl's phenomenology. Second, experiential thought is anchored in Heidegger's existentialism, which conceives of 'man as being in the world'. Both views point toward man as being concretely in a life situation. Within that context, experiential thought is further influenced by Merleau-Ponty's philosophy of the 'lived body',

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which is a description of concretely living in the organism. Additionally, experiential thought is affected by Buber's (1964) concern for the realm of the 'inter-human'. This philosophical notion results in an interactive conception of a human relationship. (Prouty 1994:16)

Prouty deviated from Rogers and Gendlin in two ways (Prouty et al 2002). First, he questioned the assumption by Rogers that the client and the therapist could establish psychological contact. He saw inadequate theoretical definition of psychological contact, lack of ideas on how to gain contact if it is absent, and exclusion from therapy of those who could not engage in psychological contact. His second deviation arises from his critique of Gendlin's approach. For Gendlin, experiencing was a prerequisite for experiential psychotherapy. Clients are required to experience, notice and articulate their own internal processes. Gendlin saw an absence of the interactional experiential process in people with schizophrenia. Conversely, Prouty viewed people with schizophrenia as having an 'experiencing self', but the lack of integration of these experiences meant this was expressed in a pre-symbolic way or pre-expressively – for example via hallucinations. For Prouty, neither Rogers nor Gendlin had provided adequate methods of working with people who were experiencing severe psychosis. For Rogers this stemmed from them not being able to form relationships, for Gendlin it came from them being unable to talk about their own experiences. Therefore, there was a need to develop new ways of working with people who were contact impaired by psychosis or other cognitive or mental health difficulties. Contact impaired is Prouty's term for a people who are out of emotional contact with themselves and the reality of the world they are living in and who are not able to communicate this to others. Prouty's development was Pre-Therapy, the work that needed to be done with people who were out of contact, before traditional therapy could progress. Prouty's philosophical position has resonance with paradigms in dementia care which also draw on influences of Rogers and Gendlin. In addition, the influence of Merleau-Ponty's concept of the concrete experience of the lived experience has resonance with my experience of working on an emotional level with people with dementia. People with dementia may
clearly show their experience of the world in a very concrete and physical manner. For example, a person who is searching their environment trying to find their mother (who has been dead for many years) may be clearly showing physical expressions of fear and anxiety.

Prouty's contribution to psychotherapy is unique in two ways. First, he offers a therapeutic approach to people seen as beyond therapy. Due to the severity of their mental ill health or learning disability, Prouty works with clients who he views as having disorganised ego states, a lessened ability to internally locate and experience their own affect, and inhibited communication (Prouty 1976). Second, his view on the phenomenological experience of the client - the concrete behaviour and situation of the client - is the focus rather than the emotional or cognitive aspects that would be the focus of other forms of therapy.

The Central Constructs of Pre-Therapy

The Pre-Expressive Self

Contact impairment rests on the concept of the Pre-Expressive Self. People in a pre-expressive state are removed from their own experience of the world, of themselves and are not able to verbalise this. The Pre-Expressive self is described as:

\[ a \text{ meta-psychological concept that refers to the propensity for yet to be integrated experience to form expression. It can be interpreted as an aspect of the self-formative tendency (Prouty et al 2002: 20). } \]

Therefore, speech perceived by another to be disorganised, incoherent and meaningless is from the Pre-Expressive self (Prouty 1997). Thoughts, feelings and self-knowledge are communicated in a way that is puzzling to the outsider, as they have not been integrated by the client and their experience of the world and themselves cannot be communicated to another in a way that is understandable.
The impairment of contact functions renders the individual, to a greater or lesser extent, either unable to locate themselves as the locus of their own experience, and process or unable to communicate that experience to others (Van Werde and Morton 1999: 143).

A person in a pre-expressive state requires contact work to restore their expressive self and establish psychological contact with their self and with others before any other therapy can begin. Again this has resonance with working with people with dementia, who may often appear to be removed from their own sense of experiencing or are not able to communicate their experience of the world to another person. For Prouty, establishing psychological contact involves: contact functions, contact reflections and contact behaviours (Fig. 2.1).

<table>
<thead>
<tr>
<th>Contact Functions</th>
<th>The psychological functions necessary for an individual to engage on an emotional level with another person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Reflections</td>
<td>The techniques employed by the therapist to restore contact functions</td>
</tr>
<tr>
<td>Contact Behaviours</td>
<td>The observable behaviours in response to the contact reflections which indicate restoration of contact functioning</td>
</tr>
</tbody>
</table>

Fig. 2.1. Elements of psychological contact.

Contact functions
Prouty identified three aspects of contact which are required for an individual to be expressive and in contact with their emotions and the world around them and to be able to communicate with others. Prouty terms these as contact functions (Fig. 2.2). Where a person is pre-expressive, restoration of these three contact functions are the goals of the therapeutic work.
1. **Reality contact (contact with the world)**, which refers to our contact with, and our awareness of, the world—people, places, objects and events.

2. **Affective contact (contact with the self)**, which concerns our awareness of how we respond to the world; it refers to our relationship with our self and our experience, our moods, feelings and emotions. Affective contact is described as the use of feeling words (e.g. sad, happy), the behavioural expression of affect through the body (e.g. kicking a chair) or through the face (e.g. looking frightened).

3. **Communicative contact (contact with others)**, which consists of our attempts to convey our perception of reality and affect to others. It is a precondition to our forming psychological contact with others and primarily involves the use of socially understandable language. Communicative contact is the use of words and/or sentences.

---

**Fig. 2.2. Contact functions.**
Adapted from Van Werde and Morton 1999.

**Contact reflections**

Contact functions are restored by making empathic contact through the use of contact reflections by the therapist (Fig. 2.3). The reflections are offered by the therapist in response to what the therapist sees and notices in the client. Reflection enhances the therapist’s understanding of the client’s perception of the situation (Prouty 1990). For Prouty, reflections are used with the client who is pre-expressive, reflecting the client’s own experience back to them. The aim is to facilitate the movement of a person from a pre-expressive state to an expressive state, leading to contact and the formation of a relationship that can then be the foundation of a therapeutic work.
<table>
<thead>
<tr>
<th>Contact Reflection</th>
<th>Action of Therapist</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situational Reflections (SR)</td>
<td>The therapist uses the world around the person and makes a reflective statement about the situation. These reflections strengthen the reality contact function.</td>
<td>'John is standing in the corridor'. 'The birds are singing'. 'The chair is here'.</td>
</tr>
<tr>
<td>Facial Reflections (FR)</td>
<td>The therapist notices and makes a reflective statement about the client's face. These reflections strengthen the affective contact function.</td>
<td>'Grace's face is sad'. 'Your eyes are closed'.</td>
</tr>
<tr>
<td>Bodily Reflections (BR)</td>
<td>The therapist reflects verbally and/or non-verbally the body position, or movement of the client. These reflections strengthen the client's experience of themselves within their body.</td>
<td>'Anna's hand is on her head'. 'Shoulders are hunched'.</td>
</tr>
<tr>
<td>Word for Word Reflections (WWR)</td>
<td>Words or elements of sentences are offered back as a verbal reflection to the client. These reflections strengthen the communicative contact function.</td>
<td>Client: 'and you and it'. Therapist: 'you and it'.</td>
</tr>
<tr>
<td>Reiterative Reflections (RR)</td>
<td>These reflections rest on the idea of offering a statement that aims to re-contact or strengthen contact. Any contact reflection that has worked is repeated. This may be immediate or longer term where the therapist refers to a previous dialogue.</td>
<td>Client: smiles. Therapist: 'you smile'. (Client: has eye contact with therapist). Therapist: &quot;you look at me and smile'.</td>
</tr>
</tbody>
</table>

Fig. 2.3. Contact reflections.

Contact reflections are the building blocks of empathic contact and Prouty is clear that reflections are very concrete, duplicative and a meticulously literal mirroring of the client's behaviour and words (Saunders 2007: 31).

An extract of dialogue using contact reflections given below shows the concrete and literal nature of the exchanges. Prouty described the client as semi-catatonic, suicidal and often in a 'lethargic stupor' (Prouty 1976). The concreteness is shown as the therapist states what they see without
interpretation, questioning or directing the conversation. However, this does not show the non-verbal aspects and the manner in which the therapist conducts the interaction, which is a limitation of reading a psychotherapeutic approach on paper.

<table>
<thead>
<tr>
<th>Key:</th>
</tr>
</thead>
<tbody>
<tr>
<td>C = Client</td>
</tr>
<tr>
<td>T = Therapist</td>
</tr>
<tr>
<td>WWR = Word for Word Reflection</td>
</tr>
<tr>
<td>FR = Facial Reflection</td>
</tr>
<tr>
<td>BR = Bodily Reflection</td>
</tr>
<tr>
<td>SR = Situational Reflection</td>
</tr>
<tr>
<td>RR = Reiterative Reflection</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>C:</td>
<td>Careful, pink elephant there</td>
</tr>
<tr>
<td>T: WWR</td>
<td>Careful, pink elephant there</td>
</tr>
<tr>
<td>T: FR</td>
<td>Your face looks scared</td>
</tr>
<tr>
<td>T: FR</td>
<td>Your eyes are big</td>
</tr>
<tr>
<td>T: BR</td>
<td>Hands on legs</td>
</tr>
<tr>
<td>C:</td>
<td>Look out.......hurt....gonna get</td>
</tr>
<tr>
<td>T: WWR</td>
<td>Look out.......hurt....gonna get</td>
</tr>
<tr>
<td>T: BR</td>
<td>Your whole body is stiff</td>
</tr>
<tr>
<td>C:</td>
<td>It's over there.....a lot of animals</td>
</tr>
<tr>
<td>T: SR</td>
<td>Over there</td>
</tr>
<tr>
<td>T: FR</td>
<td>Your eyes got bigger</td>
</tr>
<tr>
<td>T: RR</td>
<td>Over there</td>
</tr>
<tr>
<td>C:</td>
<td>All kinds hurt you.....it will hurt you</td>
</tr>
<tr>
<td>T: BR</td>
<td>You point</td>
</tr>
<tr>
<td>T: SR</td>
<td>You point over there</td>
</tr>
<tr>
<td>T: BR</td>
<td>You point, I point</td>
</tr>
<tr>
<td>T: BR</td>
<td>We both point</td>
</tr>
<tr>
<td>C:</td>
<td>They are big and pink and ugly</td>
</tr>
<tr>
<td>T: WWR</td>
<td>They are big and pink and ugly</td>
</tr>
<tr>
<td>C:</td>
<td>They laugh and yell and hurt you</td>
</tr>
<tr>
<td>T: WWR</td>
<td>They laugh and yell and hurt you</td>
</tr>
<tr>
<td>C:</td>
<td>They hurt me</td>
</tr>
<tr>
<td>T: WWR</td>
<td>They hurt you (a few minutes of silence)</td>
</tr>
<tr>
<td>T: RR</td>
<td>Before, you pointed over there</td>
</tr>
<tr>
<td>T: RR</td>
<td>Before, you pointed over there and said 'they are big and pink and ugly'</td>
</tr>
<tr>
<td>T: RR</td>
<td>You said they laugh and yell and hurt you</td>
</tr>
<tr>
<td>C</td>
<td>They hurt me</td>
</tr>
</tbody>
</table>

(Prouty 1990: 650)

Contact behaviours

Contact behaviours are the observable, behavioural reaction of the client to the contact reflections. Contact behaviours indicate an increase in the contact functions of the client and the contact with the therapist: for example, a client may acknowledge the presence of the therapist.
Pre-Therapy development in other client populations and settings

The historical and philosophical evolution and the application of Pre-Therapy in other settings and client groups can be seen in the key publications and development of a network of people interested in Pre-Therapy (Pre-Therapy International Network). The development is documented in the time line (Fig. 2.4).

<table>
<thead>
<tr>
<th>Key Publications and Pre-Therapy Network Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1957</td>
</tr>
<tr>
<td>1940—1970s</td>
</tr>
<tr>
<td>1950-1970s</td>
</tr>
<tr>
<td>1960s</td>
</tr>
<tr>
<td>1960s</td>
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<tr>
<td>1964</td>
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<tr>
<td>1966</td>
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<tr>
<td>1976</td>
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<tr>
<td>1985</td>
</tr>
<tr>
<td>1989</td>
</tr>
<tr>
<td>1980s</td>
</tr>
<tr>
<td>1990s</td>
</tr>
</tbody>
</table>
Literature Review

<table>
<thead>
<tr>
<th>Year</th>
<th>Event/Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Collaboration with Dinacci to develop centre of Pre-Therapy in Italy. Prouty, G. and Dinacci A. Pre-Therapy: early pilot studies. Private Paper distributed at the Pre-therapy network meeting. Ghent 7-9.11.02</td>
</tr>
<tr>
<td>2004</td>
<td>Dodds, P., I. Morton, G. Prouty. 2004 Pre-Therapy and Dementia</td>
</tr>
<tr>
<td>2005</td>
<td>Peters 2005. Pre-Therapy from a developmental perspective</td>
</tr>
</tbody>
</table>

Fig. 2.4. Time line of the development of Pre-Therapy.

Through the formation of the Pre-Therapy Network, awareness of Pre-Therapy spread into European psychiatric hospital settings and to other client groups: people with learning disabilities and dissociative disorders and trauma (Peters 1996, 1999; Portner 1998, 2000, 2002; Coffeng 1995, 1998, 2000, 2001; Prouty et al 2002). This led to theoretical evolution in four areas:

- Development of construct validity
- Grey zone functioning
- Pre-Therapy by non-psychotherapists
- Contact

Collaboration between Prouty and the Italian Pre-Therapy community led to the confirmation of the construct validity of contact (Prouty and Dinacci 2002). Observability, validity and inter-rater reliability recording the effects of Pre-Therapy were strengthened with the development of the Objective Evaluation Criteria for the Pre-Therapy Interview and the Pre-Therapy Scale (Dinacci 2000; Prouty and Dinacci 2002). These
permit quantitative evaluation of change using Pre-Therapy in one-to-one sessions (Chiara 2002). However, quantitative evaluation of the effectiveness of Pre-Therapy is limited to small-scale or single-case studies. Retrospective analysis of Prouty’s studies is currently underway (Dekeyser, Prouty and Elliott in press).

The move to incorporate Pre-Therapy into residential and hospital settings led to expansion of the concept of the expressive or pre-expressive self. Van Werde (psychologist, Belgium) identified Grey Zone Functioning - where a person may be to some extent out of touch with their affective, reality and communicative contact. This showed greater acceptance of a continuum of functioning and fluctuations in functioning (Fig. 2.5) (Van Werde and Morton 1999; Van Werde 1994, 2001). Whereas Prouty initially worked with people in a state of extreme contact impairment with occasional episodes of lucidity, Van Werde identified greater fluidity between expressive and pre-expressive states. This development arose from the difference in the client population that was observed by members of the European members of the Network.

*Here I see a difference from what Garry is doing; my patients are not as regressed as those Garry describes. We have to meet the clients on the level where they are. With some whom I know well and who know me well, I don’t work just strictly with the reflections, but apply the principle in a somewhat extended way.* (Interview with Wim Lucieer by Marlis Portner: Prouty et al 2002: 157).

<table>
<thead>
<tr>
<th>Expressive Self</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grey Zone Functioning</td>
</tr>
<tr>
<td>Pre-Expressive Self</td>
</tr>
</tbody>
</table>

**Fig. 2.5. Grey Zone Functioning** (Van Werde and Morton 1999).
In the expressive state, the client is able to express thoughts, feelings and their own experience. Here the client can use the psychotherapeutic relationship. In the pre-expressive state the client is removed from their own experience, dissociated, or experiencing psychosis that prevents engaging with the therapist. Here the therapist uses contact reflections to help establish contact in order for therapy to proceed. In the grey zone functioning, the therapist fluctuates between pre-therapy contact reflections and therapy with contact work used to anchor the person in an expressive state. The relevance of developments of Pre-Therapy with different client groups adds weight to the potential that it might have relevance to dementia care. In particular, the concept of grey-zone functioning is attractive for dementia care, because people with dementia show fluctuations in levels of confusion. Further developments in Pre-Therapy led to extending its practice beyond the field of psychotherapy and introducing it to other professionals such as nurses.

Whilst Prouty introduced his work to non-psychotherapists, and much of the work in the United States was carried out by people without a professional training, it has been Van Werde who has built on this. Van Werde has strengthened this through his collaboration with nursing staff working on an inpatient unit for people with psychosis at Saint Camillus Hospital, Ghent, Belgium. By strengthening existing contact functions using contact reflections, the nurse offers a web of contact within a contact milieu. Contact work is used as part of the daily interactions and the nurse is required to be selective about using a Pre-Therapy response or an alternative response (Van Werde 1990, 1998, 2002). The role of the nurse is not to provide in-depth psychotherapy, rather anchoring the client in their expressive self, limiting the deterioration into a pre-expressive state and working with grey-zone functioning where a person may slide between psychotic functioning and more congruent functioning. The differences between the role of a nurse and that of a therapist are shown in Fig. 2.6. There is relatively little detail in the literature about how or when a nurse uses a contact reflection rather
than another form of communication such as a congruent response or a question. Rather, this decision is based on having an understanding of the differences between pre-expressive, grey zone and expressive functioning.

<table>
<thead>
<tr>
<th></th>
<th>Uses Pre-Therapy to establish contact and strengthen contact functions in order for therapy to progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>Uses Prouty's Pre-Therapy contact reflections to enhance the expressive self in order for nursing interactions and practical work to continue and to reduce slippage back into a pre-expressive state.</td>
</tr>
</tbody>
</table>

**Fig. 2.6. Role differences.**

A significant contribution has been made by a Network member who has a background in Learning Disabilities – Hans Peters. His contribution has particular relevance for dementia care because of the similarities in working with cognitive or neurological changes. Peters expanded the concept of contact in Pre-Therapy, exploring the development of attunement by drawing on Stern's ideas of mirroring, reflection and affective/empathic attunement in child development (Peters 1999; 2003; 2005). For Stern, imitation was not simply mechanical or *parroting* another person but involves a degree of empathic attunement and intersubjectivity (Stern 1985). Peters clarifies this, offering explanation of subjectivity and intersubjectivity:

- **Subjectivity** – how an individual sees, thinks and feels about the world.
- **One way intersubjectivity** – the capacity of taking on the subjectivity of others, which requires empathic attunement to the other person. Within one-way intersubjective attunement the carer picks up the feelings from the child and imitates or mirrors these. The child then understands that the parent's response is related to the child's own original emotions and experience.
- **Two-way intersubjectivity attunement** – two people are reciprocally aware of each other.

(Adapted from Peters 2005.)
Peters sees the Pre-Therapeutic relationship as one-way, that is, the therapist uses contact reflections using intersubjectivity. In psychotherapy, the purpose is to move to mutual contact and a relationship based on two-way intersubjectivity. Traditional therapy requires two-way intersubjectivity. The primary application of Prouty Pre-Therapy is to restore the very basic contact functions and establish a relationship that can allow therapy to proceed. Peters (2005) proposes a secondary application. Where some contact is possible but limited, he sees the contact reflections as having the potential to enhance or reflect momentary level of functioning. The use of the contact reflections becomes a tool through which the therapist enhances moments of two-way intersubjectivity. This complements Van Werde's concept of grey zone functioning and the use of contact reflections to restore and sustain contact, where contact is inclined to deteriorate between the client and the therapist. Peters' contribution is threefold. First, he offers detail about contact work in relation to how two people develop mutual understanding of each other, and awareness that one person has an awareness of another. Second, he expands our understanding of the use and function of contact work with people who have an irreversible cognitive impairment by drawing on pre-developmental capacities. Third, he directs attention to enhancing emotional and affective contact functioning, with less emphasis on the cognitive domain. The attention to contact and the pre-developmental abilities may have application to dementia. As the dementing process affects cognitive ability, increased attention to the emotions and feelings of people is indicated which parallels Peters' work in learning disabilities. By exploring Pre-Therapy in relation to people with a cognitive impairment such as a Learning Disability, Peters adds to the potential usefulness of exploring Pre-Therapy in relation to dementia - a progressive cognitive condition. Peters work has resonance with another body of literature within learning disabilities which is not addressed in the literature review. An approach termed Intensive Interaction (Nind and Hewett 2001) bears many similarities with Peters use of Pre-Therapy.
Limitations of Pre-Therapy

This thesis does not attempt to critique the theoretical and philosophical foundations of Prouty's approach itself. This would require a critical examination of the discipline of Person Centred and Experiential Psychotherapy. Rather, this thesis questions the introduction and application of the approach, thus maintaining healthy scepticism and suspension of judgement about its usefulness for dementia care.

Accounts of the introduction of Pre-Therapy show mixed success. Whilst inspiring changes in attitudes, projects also proved difficult to sustain and met with some resistance (Prouty et al 2002; Sommerbeck 2003). Three reasons for these difficulties can be offered. First, lack of attention to the process of introducing a change in practice: arguably the literature shows an assumption of a linear relationship between teaching and change. Second, lack of attention to the nursing context and how this mediates change. Where the organisational, structural and contextual factors are discussed, there is little discussion of how this could be overcome (Portner 2000). This indicates a need to consider the social nature of interactions and how social processes within the care context might affect the use of Pre-Therapy in practice. Third, the unquestioned assumption that nursing staff will be able to offer the empathic presence that is required for contact work. There is an implicit assumption that staff have the capacity for understanding and using Rogerian core conditions (empathy, acceptance and unconditional positive regard). This may be problematic given the argument that empathic contact cannot be simply learnt as a technique or skill without having the foundations of a therapeutic way of being with people (Myers 2000). This does not heed nursing literature that identifies low levels of empathic contact in nursing practice (Reynolds and Scott 2000; Morse et al 1992). The relative lack of attention to the context in programs to introduce Pre-Therapy to healthcare staff increased my curiosity. The difficulties faced by Pre-Therapy Network members seemed familiar and resonated with personal experience of introducing change and practice.
development in a nursing context. This led me to be more curious about the process of introducing Pre-Therapy to others in the context of dementia care. This raised questions as to whether or not staff would be able to use the approach and whether or not Pre-Therapy might contribute to the existing range of approaches.

**Pre-Therapy and dementia**

Speculation that Pre-Therapy in dementia care may offer *emotional palliative care* (Van Werde and Morton 1999) echoes the secondary application from Peters (2005), where contact via Pre-Therapy contact reflections is an end in itself to enhance lucidity rather than a achieving the goal of restoration and recovery of the client. By overlaying expressive, grey zone and pre-expressive functioning with cognitive and language ability, the relationship between Pre-Therapy and dementia can be seen (Fig. 2.7).

![Fig. 2.7. Pre-Therapy in relation to the dementing process.](image-url)
This locates the use of contact reflections to people with greater cognitive disability, who are by definition more likely to be pre-expressive.

However, there are few theoretical and empirical studies about the use of Pre-Therapy and people with dementia (Morton and Van Werde 1999; Morton 1997). Morton (1997) includes a brief outline of the principles of Pre-Therapy in a critique of Validation Therapy. The chapter by Morton and Van Werde (1999) is speculative, drawing on a clinical example based on one older person. One UK publication describes two case studies where contact reflections result in getting brief emotional and relational contact with people with dementia (Dodds, Morton and Prouty 2004). Greater research on the use of Pre-Therapy and the teaching of Pre-Therapy to staff is indicated, with more rigour than limited case material. To my knowledge, there is no literature exploring how the techniques are learnt or used by people who are not trained as psychotherapists. The problem with this is that without adequate exploration of how staff learn and then use the contact reflections with people with dementia, we do not even know whether staff can learn and use them, let alone know if contact work is useful for dementia care.

Summary of Pre-Therapy literature

- This section of the literature review charts the development of a clinical and academic community (The International Pre-Therapy Network), supporting further developments in the theory and practice of Pre-Therapy.

- The key concepts have been outlined: the pre-expressive self, contact functions, contact reflections and contact behaviours. The contact reflections are the techniques used by the therapist or worker to establish psychological contact. This contact is observed by the contact behaviours.

- Construct validity of the contact functions and behaviours was established by the collaboration of Prouty with other members of the International Pre-Therapy Network.

---

2 The case studies used in this publication are different from those used in this thesis.
• Pre-Therapy developments can be seen in four areas:
  
  i. The development of the use of Pre-Therapy with client groups which differed from Prouty's clients – for example people with dissociative states arising from trauma.

  ii. The recognition of grey-zone functioning and the place of Pre-Therapy and contact work with client populations where grey zone functioning was more evident than sustained pre-expressive states.

  iii. Elaboration of how two-way intersubjective attunement is achieved by the use of Pre-Therapy.

  iv. The dissemination of Pre-Therapy to staff other than psychotherapists and psychologists.

• There is some work that speculates that Pre-Therapy may have an application in dementia care as emotional palliative care and as a method of communicating. However, this is limited and further research is needed.
2.3 Person-centred approaches in dementia care compared with Pre-Therapy

The works of three authors on dementia have been chosen to compare with Pre-Therapy. The rationale for this comes from similarities to aspects of Prouty's approach, although there are also differences. The authors in dementia and their key approaches are: Feil's Validation Therapy, Killick's work on listening, and Kitwood's work, which provides positive person work (Feil 1993; Killick and Allan 2001; Kitwood 1997). Similarity between Prouty and the three authors in dementia care is seen in that they are grounded in a humanistic and phenomenological philosophical perspective. This perspective values the experience of the individual, the relational aspect of communication, the need for workers to adapt their communication to engage with the client and the imperative for the worker to reach out in the best way possible (Martin and Post 1992; Post 1995; Lillemoen 1999). The humanist approach has its origins in Carl Roger's work. In the practice of psychotherapy this is referred to as the Person Centred tradition. The use of Person Centred in psychotherapy refers to this particular Rogerian approach. The term person-centred is also used in relation to dementia care. A person-centred approach in dementia care is a generic term, which involves seeing the person as an individual with autonomy, to be viewed from physical, psychological, social and spiritual dimensions. The use of capitals indicates the difference: Person Centred indicates psychotherapy tradition; person-centred indicates the terminology in dementia care or a more generic term.

Central to the work of Feil, Killick and Kitwood is the need for a greater understanding of the experiential world of the person. From this they take the perspective of valuing the experience of the person with dementia, even if it is difficult for others to understand. This is based on the premise that, although cognitive ability declines, emotional
responses remain intact. Emotional expression is frequently evident in people with dementia. Woods (2001) argues that the dementing process possibly heightens emotional expression, resulting in a raw emotional honesty in the way people with dementia approach others. As a result of the dementia people may show heightened emotional sensitivity. Common to Feil, Killick and Kitwood is the importance of engaging in the inner emotional experience of the person with dementia. Subjectivity is implicit in the work of Killick and Allan (2001). Once a subjective perspective is adopted, how a person with dementia presents to others is as much to do with how the person is experiencing the world as any neurological changes taking place. It is the interplay between the dementing illness and the psychological and social relationships that led to a dialectical view of dementia (Kitwood 1990). Another similarity with Prouty is the position on the relationships between people. For Kitwood this rests on three central ideals: respect for the person, forming a moral solidarity with people and relating to them from a position of subjectivity (I-Thou relating) rather than from a position of objectivity (I-It relating) (Buber 1958). This has resonance with Prouty who also draws on this position of relating to another (Prouty 1994; 2002).

Prouty, Feil, Killick and Kitwood all attend to micro interactions and the process of interaction. Feil's approach validates the client's internal world. This helps staff engage with the subjective meaning of that world and allows meaningful communication to develop (Feil 1992, 1993). The Rogerian influence of Feil's Validation method appears in the emphasis on tuning in to the world of the person, and the use of one technique - mirroring. Although Feil's work evolved from a Person Centred approach, her work diverges from Humanist origins with the integration of Erikson's psychological developmental stage model. This draws on psychodynamic influences and the success of addressing or failure to address past psychological conflicts. Conflicts may be re-enacted in the disorientation of the older person (Feil 1985). Killick uses enhanced listening, noticing and following the world of the person with dementia as
the cues to entering and understanding their subjective experience of the world. Kitwood promotes the attunement as part of understanding the meaning being conveyed by the person with dementia. Killick is explicit about the process of making contact, paying particular attention to presenting an authentic presence and acceptance. Killick calls upon staff to notice and attend to the non-verbal communication. This echoes Prouty's call to notice the concrete in the facial, words, situational and bodily presentation of the person, which are influenced by Gendlin's noticing and focusing on the experiential process of the client.

Killick draws attention to the same four domains that Prouty uses in the contact reflections:

...aside from the actual words we utter, part of what makes each of us unique and recognizable are the ways in which we use our faces, bodies, voices and the environment around us to express ourselves (Killick and Allan 2001:53).

Whilst he uses these dimensions to call workers to be aware how they communicate with others, they are the same dimensions in which Prouty devised the contact reflections. This illustrates similarity in focus on the interactional quality but with a different emphasis. Killick's emphasis is on asking staff to be more self-aware. For Prouty the emphasis is the focus on the client's experiencing and reflecting this back.

**Making contact – a fundamental similarity between dementia care and Pre-Therapy**

A parallel between the four authors is apparent in the emphasis on making emotional contact. For Pre-Therapy this is through the use of the contact reflections. For dementia care this is by more general attention to listening, noticing and tuning in. It appears that Killick's understanding of making contact is similar to that of Prouty. With a focus on non-verbal communication, Killick describes contact work with the emphasis on the worker following (and not directing) an intervention. This contact making approach is advocated when more traditional overtures in conversation
result in no response from the person with dementia. Killick and Allan (2001) describe Killick's practice accordingly:

When developing relationships with certain people who do not speak, John has found in general the most effective way of establishing and developing contact is to confine himself to using only those channels of communication the person with dementia uses. The practice that we have called mirroring has developed in a natural way in the course of John's work, as a response to individual people and situations, and has become part of his overall approach. Others have developed similar approaches in related fields, such as work with people with learning difficulties (Nind and Hewett 1994). It can include words, but is most powerful and moving when it occurs in a purely nonverbal manner. Put simply, it involves being engaged in a one-to-one interaction, focusing closely on the person's movements, and reflecting back what they do, and in the style they are doing it, essentially following the leads that they give. If they rock their body, and stroke the arm of the chair you would do so also. As well as doing what the other person is doing, mirroring demands that you do it in a similar way so that attention must be given to the speed at which the person moves, the degree of muscle tension or relaxation involved, and the way one movement or gesture merges into another. It requires a great deal of concentration and attention, and being highly sensitised to the whole range of non-verbal channels (Killick and Allan 2001:54).

This quote illustrates how Killick establishes contact using mirroring and non-verbal reflections of the client's body movements. In Prouty's terms this is one of the contact reflections - a bodily reflection.

Killick, Feil and Kitwood all expect engagement with the person on an emotional level. This may be demanding for the worker, akin to an intense spiritual experience (Killick and Allan 2001) and require free attention from the worker (Kitwood 1997). Kitwood refers to an aspect of his positive person work as holding. Here, the worker offers their presence to contain and be receptive to the emotional world of the person with dementia in order to establish and sustain interactions. Although Killick and Kitwood urge staff to engage emotionally as a moral imperative, they acknowledge this may be difficult. Arguably, they focus on the psychological capacity of staff to do this with less emphasis on
how role and context of nursing or care staff affects offering engagement (Graneheim et al 2005).

A difference between Prouty's approach and other person-centred approaches is the purity of Pre-Therapy – using only contact reflections. This approach is non-directive in that the client's experience determines the direction of the interaction and the worker adopts a 'non-expert stance' (Saunders 2006). This differs from Feil's work, which recommends directive strategies (for example - questioning, initiating) on the part of the care worker. Kitwood provides principles of positive person work but the application of these is frequently to encourage workers to initiate interactions or activities rather than being non-directive. Killick includes prompting and questioning as part of the listening process. Person-centred approaches in dementia demand staff create a combination of communication that is rooted in the subjective world of the person and that also draws on other verbal and non-verbal strategies. Fig. 2.8 tabulates components of the approaches of Killick, Kitwood, Feil and Prouty.

Prouty's Pre-Therapy could be seen as focused on the contact work as a means to an end – the enhancement of the expressive self, expansion of episodes of lucidity, and an approach which is non-directive as the therapist follows the experiential world of the client. There are certainly similarities with the person-centred approaches - for example, the theoretical foundations and many of the core features: observing the subjective experience of the person, entering into a relationship based on the subjective understanding, being present, listening, noticing and understanding. However, a main difference can be seen. All four attend to the relationship between people and the person with dementia but the authors in dementia vary from Prouty in the detail of how this is achieved. Prouty's emphasis on the concreteness of the reflections breaks down the formation of the relationship further than the authors in dementia care.
<table>
<thead>
<tr>
<th>Killick</th>
<th>Kitwood - Positive person work</th>
<th>Feil – Validation therapy</th>
<th>Prouty – Pre-Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resisting talking</td>
<td>Recognition</td>
<td>Stimulate energy</td>
<td>Contact reflections:</td>
</tr>
<tr>
<td>Using silence</td>
<td>Negotiation</td>
<td>Mirroring</td>
<td>• Situational</td>
</tr>
<tr>
<td>Eye contact</td>
<td>Collaboration</td>
<td>Music and movement</td>
<td>• Facial</td>
</tr>
<tr>
<td>Facial expressions</td>
<td>Play</td>
<td>Exploring rhymes and unusual</td>
<td>• Bodily</td>
</tr>
<tr>
<td>Voice tone and pitch</td>
<td>Celebration</td>
<td>word combinations</td>
<td>• Word for Word</td>
</tr>
<tr>
<td>Touch</td>
<td>Relaxation</td>
<td>Speaking their language to</td>
<td>• Reiteration</td>
</tr>
<tr>
<td>Pacing</td>
<td>Validation</td>
<td>build trust</td>
<td></td>
</tr>
<tr>
<td>Going with the flow</td>
<td>Facilitation</td>
<td>Repeat their last words</td>
<td></td>
</tr>
<tr>
<td>Prompting – suggesting endings to sentences that are unfinished</td>
<td>Holding</td>
<td>Linking – getting in tune with their emotions</td>
<td></td>
</tr>
<tr>
<td>Mirroring</td>
<td></td>
<td>Be empathic</td>
<td></td>
</tr>
</tbody>
</table>

Fig. 2.8. Comparison of Prouty’s Pre-Therapy with other approaches.
For Prouty, the focus is on gaining contact and paying greater attention to the embodiment of the experience of the client, their facial expressions, bodily movements or position, the situational or environment and their words. The therapist uses this to frame reflections to offer back to the client. For the authors in dementia, the process of getting contact is less explicit, (but is still the therapeutic goal), and a range of approaches that facilitate psychological well-being may achieve this goal. Put simply, Prouty takes us back to the basics of establishing contact - the therapeutic approach is contact. For Kitwood and Feil contact arises through their therapeutic approaches. Killick seems to have the nearest approach to Prouty's, but arguably Prouty offers a more explicit or concrete outline of exactly how we can achieve this contact.

The person-centred approach in dementia draws on many techniques and approaches and Killick advises caution of avidly adopting single approaches.

There is an obvious danger in embracing any one of these techniques wholeheartedly. We can all point to examples of the fanatic with a one-track mission to overturn the tried and tested and replace with the narrow and novel. ....One of the most striking things about opening ourselves up to a variety of such innovative approaches is how much they have in common (Killick 2004: 23).

Whilst acknowledging Killick's caution about overenthusiastic adoption of one approach over another, person-centred approaches are multi-faceted, difficult to study and there is insufficient research into how person-centred care may be achieved by staff. In addition, there is insufficient discussion about how staff can 'do empathy', where this is the foundation of the relationship. As a result, it may be precisely the 'back to basics' approach that Prouty offers that might be useful in helping us understand more about the foundations of our relationships with people with dementia. These foundations are crucial because person-centred approaches rest on the underlying position that staff engage in an empathic relationship. From the literature in person-
centred dementia care there is possibly a paradox – the literature emphasises the importance of how to be, whereas staff need to know in more specific terms what to do or say in order to be. This is supported by the substantial variance between the production of theoretical and conceptual frameworks in dementia care and the relative lack of change in actual practice (Dewing 2004). Therefore, exploring Pre-Therapy may offer more detail concerning how we establish an empathic relationship, offering very concrete and tangible directions on what to do and say in order to move towards offering an empathic presence and building a relationship based on valuing the subjectivity of the person with dementia. If so, there is the potential for Pre-Therapy to be seen as part of the mosaic of good practice which leads to excellence in dementia care.

Underpinning all four is the position of the worker in providing an empathic presence. This concept is explored further.

Empathy

An empathic approach is frequently stated as a requirement in person-centred dementia care, although there may be problems with this. Norman (1996) sees no clear operational definition. However, general use of the term does indicate a common understanding of what is means to be empathic. The concept of empathy is itself multifaceted. Theoretical influences in the concept of empathy vary, as do views about how empathy is used within therapeutic relationships (Saunders 2007). Other problems with being empathic stem from anxiety, defence mechanisms and internal barriers that inhibit staff in forming empathic relationships with people with dementia (Kitwood 1997). Killick notes the danger of being overwhelmed by the emotions of a person with dementia (Killick and Allan 2001). Where empathy is seen as fundamental to the helping relationship, Reynolds and Scott (2000) sees low levels of empathy present in professional caring relationships and minimal empathic contact with clients. Factors that contribute to this are
environmental and working conditions that inhibit staff (Ward 2002). Organisational demands focus on product and outcome-related care, and the upgrading of nursing tasks means basic emotional caring is not perceived as work. Despite this, unqualified staff are expected to provide it (Staden 1998). However, caring embodies emotional labour and requires skills and training to manage feelings that arise (Smith 1992). Morse et al (1992) argues that uncritical adoption of empathy, derived from psychotherapy, does not fully take into account what is meant by empathy in relation to nursing practice and the clinical setting. She offers a model of communication that identifies engagement with patients on two continuums: patient-focused/self-focused and spontaneous response/learnt response. She argues that where staff are patient-focused and offer spontaneous emotional empathy (compassion, pity) this may open staff to the suffering of the patient without the learnt professional psychological protection gained from professional training. In order to shield themselves from the suffering of the patient, nurses employ strategies for their own emotional self-protection, by acting in a way that is anti-engaged (distancing, withdrawing) or disengaged (rote professional behaviours, professional distancing). Therefore to some extent an absence of empathy is inevitable where staff do not have the professional training in managing themselves in offering empathy. There is some consensus that empathy used by professional therapists differs from empathy used by nursing staff or other non-professionals. Both Norman (1996) and Morse et al (1992) see therapeutic empathy as the realm of psychotherapists or counsellors, whilst emotive empathy is more suited to nurses. Emotive empathy is learnt from experience and is a more 'intuitive sensing of a response to the patient's plight' (Norman 1996: 314).

Norman (1996) builds on the debate from Morse and relates it to working with people with dementia. Empathy in relation to dementia is defined as follows:
Empathy in the care for the EMI (Elderly Mentally Ill) is the ability to see beyond dementia, to recognize each client as an individual—a person, not an illness. To empathize with your clients is to comprehend their predicament and, because of that, to facilitate a better quality of life through an understanding and caring involvement (Norman 1996: 315).

Empathy is frequently advocated as being beneficial to people with dementia but Norman is sceptical because, although beneficial, an emotive empathic approach is largely absent. Norman’s prophecy stands as a challenge to health professionals:

This situation is likely to continue until it (emotive empathy) is incorporated as both a diagnostic method and a therapy—unashamedly interventionist—in the teaching of clinical practice. (Norman 1996: 317).

Empathy does promote understanding between a worker and a person with dementia. Within the literature there is an overlap between dementia, empathy, making emotional contact and intersubjectivity. Berg Hallberg and Norberg (1998) link intersubjectivity and communication with people with dementia. Through closeness and intersubjectivity, a worker and a person with dementia create a shared meaning. This enables staff to achieve mutuality and contact on a human level, which enhances job satisfaction for staff and emotional care for the client. The intensity of encounters of this type where emotional contact is made between two people is similar to two-way intersubjective attunement from which a felt sense of connection with another arises (Peters 2005). However, within the literature there is a lack of attention to precisely how to move from having no relationship to a relationship of two-way intersubjectivity. This gap in the literature may be where Prouty’s work can offer some help. Also, there is insufficient attention to the needs of the staff in managing themselves within this empathic relationship.

In the area of empathy we are left with a problem: person-centred approaches to dementia care are underpinned by an empathic
approach. The empathic approach helps us towards a subjective understanding. However, the application of the concept of empathy from counselling to nursing presents us with difficulties in definition and practice. Whilst empathy is promoted, in practice it may be relatively absent. A further problem is the effect on the individual who is trying to be empathic. Because empathy means having a subjective understanding of another, this opens us to the pain and distress of another person's world. Professional, trained counsellors learn to manage this, maintaining a position of:

...understanding the world of the other 'as if' it were your own, without ever losing the 'as if' quality (Norman 1996: 314).

Without support and development in managing a relationship based on empathy, workers may be susceptible to disengaging emotionally from relationships or avoid emotional interactions (Kitwood and Bredin 1992).

A strength of Prouty's work is the degree to which he is explicit about how to establish contact (what to do), by focusing on the concrete experience of the person, and reflecting back the concrete by using contact reflections. However, Prouty does not address how non-psychotherapists can combine what to do with how to be. Arguably this is because psychotherapy training has already addressed the how to be. Feil, Killick and Kitwood focus on how to be, with some detail on how this is actually done by staff. Although the literature identifying the lack of person-centredness in staff indicates that this does not translate into practice. The problem is knowing how to replicate Killick's skill (the ability to listen and make contact), or exactly what to do and say to provide Kitwood's positive person work, or how to know which aspect of Feil's techniques to use. It is difficult to provide operational manuals on what to do and say when person-centred care is the development of empathy and attitude. Still, the individual is left to try to develop a person-centred attitude from literature that may be too abstract. As a result, the move from theory to practice poses problems. There is insufficient literature on how people make the step between learning and
implementing therapeutic approaches. There are limited studies that explore how staff learn and implement person-centred approaches. Some begin to address this, stressing the need for process-oriented, staff-centred learning which offers reflective space for staff (Freshwater 2004; Adams and Richardson 2005). More commonly, the focus is the outcome of training or the effect of training on measurable behaviours in people with dementia (Moniz-Cook et al 1998; Lintern et al 2000, 2002; Hyer and Ragan 2002; James et al 2003; Featherstone 2004; Freshwater 2004). By paying attention to the process of learning and the use of contact reflections, this thesis aims to address the lack of attention given to how staff learn and implement a therapeutic approach based on person-centred values which is Person Centred in its theoretical origins.

2.4 Changing practice

There is frequently a call to offer training to improve care although the relationship between improving care and training is not straightforward (Koury and Lubinski 1991). Training has been shown to be effective in improving values, skills and satisfaction, although these improvements may be difficult to sustain (Kilhgren et al 1994; Canon 1995; Moniz-Cook et al 1997; Moniz-Cook et al 1998; McCallion et al 1999; Banazak et al 2000; James et al 2003; Pietro 2002; Freeman Astill 2004; Ryan et al 2004). Research frequently uses the reduction of challenging behaviour as an outcome measure, or other measures such as Dementia Care Mapping to evaluate change (Perrin 1997; Payne 1998; Shah and De 1998 Draper et al 2000; Brooker et al 1998; Brooker 2002; Innes 2003). The message of containment is reflected in staff training, which focuses on improving skills in managing behaviour (Hyer and Ragan 2002; Brodaty et al 2003; Dewing 2003), or helping staff use training to reduce staff stress (Proctor et al 1998a). Simultaneously there is greater expectation that staff will provide person-centred care (Watkins 2002).
In the current climate, person-centred care has for Nolan et al (2004) become a 'watchword' for good practice. Arguably, training to promote person-centred care or relationship-focused practice requires staff to acquire the underpinning capacity for a sensitive and empathic approach. However, for Kunyk and Olson (2001), there is a lack of clarity of the concept of empathy and how this relates to nursing practice. Coupled with insufficient discussion about levels and depth of empathic engagement (Hart 1999), there may be inadequate discussion about what is expected of health care staff in developing a person-centred empathic approach and how 'training' can achieve this.

One study demonstrates how skills-based training can increase nursing staff's capacity for empathy (Cutcliffe and Cassedy 1999). Using a pre and post test design, trained staff received 13 hours training over 3 weeks, which resulted in 37 out of 38 participants showing some increase in empathy. However, the authors acknowledge the self-selecting nature of the sample and the lack of reliability tests on the measures used. In contrast, Larson and Yao (2005) question whether empathy can be achieved through skills training because developing empathy is a slow immersion process that can be likened to the maturing of a fine wine (Larson and Yao 2005: 1105). Drawing on the principle of emotional labour (Hoschchild 1979), they highlight the difference between deep acting empathy (where the worker offers empathy consistent with cognitive and emotional reactions to the client) and surface acting empathy (where empathic behaviour is offered in the absence of a consistent cognitive and emotional understanding of the person). Therefore attempts to increase an empathic approach require either a capacity to develop an understanding of the person or greater emotional labour or effort on the part of the worker.

The capacity for developing a person-centred or empathic understanding of the person may be dependent on traits and characteristics of individuals (Gilson and Moyer 2000) and affected by environmental factors such as workload, stress and tiredness of workers (Baillie 1996).
The context in which staff deliver care is complex, and interacting with people with dementia is difficult. Staff are engaged in simultaneous activities, providing individual care at the same time as having responsibility for a group or ward of people. It is in this context that staff are required to deliver value-driven compassionate care whilst simultaneously delivering physical task-oriented care (Berg et al 1994; Johnson 1998; Williams and Tappen 1999; Hansebo and Kihlgren 2002; Smith and Godfrey 2002; Graneheim et al 2005).

The drive to implement change in practice has resulted in a proliferation of training packages, courses offering accreditation of trainers and audit tools (Kitwood and Woods 1996; Williams and Rees 1997; Surr and Brooker 2002). Given the policy background calling for improvements in standards of communication, it is timely to investigate a strategy aimed at improving communication. Studying the process of introducing a change in practice is also timely. Given the known difficulties of introducing and sustaining change, this thesis contributes to the knowledge about factors affecting the introduction of new practice by explicitly exploring these as part of the research question.

Training aimed at introducing person-centred care demands attention to interpersonal barriers to change and transformation and learning styles. It also requires consideration of structural and organisational mechanisms which support change (Clarke 2001; Mueller Hergl 2003). Process-oriented learning utilises learning in action, reflection on practice and the experiential world of staff. Process-led change attends to the dynamic relationship between learning, practice and the context (Adams and Richardson 2005). However, the positive effects of change are likely to cease once training projects are complete and training packages delivered. Without leadership to sustain change, the effects of organisational change and staff turnover result in atrophy of any beneficial effects (Bryan 2002). Furthermore, change may be introduced but fade. This may lead to suspicion of change and frustration and guilt at the lack of change (Cheston and Bender 1999). From the literature,
four factors appear central to implementing learning which leads to change in dementia care:

i) The infrastructure to support learning and change

ii) Relevance to learners

iii) Facilitating and sustaining learning which can lead to the implementation of learning and subsequent change

iv) Emotional support

In addition, there needs to be attention to developing values of being person-centred and providing concrete ways that staff can achieve this. Developing these factors needs to be pitched at the ability of staff and to recognise the context and existing demands of their work. Otherwise, training provides inspirational ideas but limited potential to be incorporated into daily practice. The literature about difficulties in achieving change through training provided a theoretical context to the introduction of Pre-Therapy contact work to staff.

In order to address the research question of what happens when staff learn and use Pre-Therapy contact reflections, lessons from the literature proved valuable. In particular:

i) Creating an infrastructure to support learning. This included working with organisational structures and managerial structures.

ii) Ensuring the relevance to staff. This involved taking the experience of staff as a starting point and aligning Pre-Therapy contact work to their prior knowledge and experience.

iii) Reflecting on my own teaching process and maximising my skills in facilitating learning in others. This also includes demonstrating a sustained commitment to staff.

iv) Ensuring that emotional support to staff is embedded in the research process.
2.5 Summary

This thesis contributes to the literature about developing communication skills of staff by introducing and exploring a new approach – Pre-Therapy. Pre-Therapy holds the potential to offer staff practical communication skills aimed at addressing psychological needs and relationships between people with dementia and staff underpinned by empathy and compassion.

The literature review has provided an overview of the theoretical perspectives in dementia care. These emphasise subjective and relational aspects of dementia care, contextualising dementia as a social phenomenon. This provides a value base to practice, which is person-centred rather than purely illness centred.

Prouty’s Pre-Therapy has resonance with major authors in dementia care. A key similarity is in the philosophical base of the approach. The value base stresses the importance of the individual and relationships are based on having an empathic understanding for another. Prouty differs in the purity of his approach. Contact reflections are concrete and tangible. The clarity has the potential to offer staff very clear instruction about using contact reflections to engage in emotional contact with people with dementia.

Central features of Pre-Therapy have been presented. Key developments have been using contact work with different client groups and the use of Pre-Therapy by staff other than psychotherapists. There is insufficient research on the use of Pre-Therapy with people with dementia, and how non-psychotherapists might learn and use Pre-Therapy contact reflections in the context of their own work settings and roles.

Pre-Therapy is underpinned by attitudes of acceptance, unconditional regard and empathy. Much of the dementia literature makes statements
about the need for empathy. However, there is an argument that nursing has uncritically adopted empathy from psychotherapy without sufficient discussion of what it means to be empathic in a nursing role. In spite of this, empathy is generally accepted as the foundation of a relationship in dementia care.

Pre-Therapy is attractive because the contact reflections appear simple. Prouty is clear what a worker does. It was this clarity and simplicity that stimulated my curiosity to explore what happens when the Pre-Therapy contact reflections were taken from the page into practice. At first sight contact reflections seem straightforward – four types of reflection, and reiteration to strengthen the response to the contact reflections. The opportunity arose to conduct a research study which introduced staff to Pre-Therapy contact reflections in their own practice settings.

The research question asks *What happens when staff learn and use Pre-Therapy contact reflections with people with dementia?* Within this question are three aspects: the use of contact work with people with dementia, the learning process of staff, and the implications of contact work for dementia care. The literature review has provided a theoretical location for the research question and the three aspects of the question. Specifically the literature review examined person-centred approaches in dementia care, Pre-Therapy and challenges to training and change in practice.

Given the existing literature surrounding the difficulties of introducing and sustaining change in practice, a process-oriented methodology for this inquiry was indicated. To maximise the effect of learning in practice, the methodology would need to work within the existing organisational, managerial and care context. It is this attention to the process of implementing change that points to an Action Research Methodology.
PART TWO

Methodology

Research Process, Methods and Data Analysis
Methodology

Introduction

To research the process of introducing Pre-Therapy Contact Reflections a methodology was required which was action-oriented, context-specific, cyclical and captured the ongoing nature of the research activity — Action Research. This chapter presents underlying ethical and moral values fundamental to Action Research, and their relevance to this study. They shaped the way the research was conducted and my approach to others in addressing the research question. They also shaped the perspective on knowledge, the position on objectivity/subjectivity and theory generation, and these ontological and epistemological positions are inherent in the methodology. Particular attention is paid to: participation, collaboration and democracy. These values were enacted in the real world context and through the researcher/participant relationship. This chapter introduces an evaluative framework for Action Research which is used to demonstrate rigour within the process of this thesis (Waterman et al 2001).

3.1 Action Research

“Action Research is a period of inquiry that describes, interprets and explains social situations whilst executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future-oriented. Action Research is a group activity with an explicit critical value base and is founded on a partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked. Knowledge may be
advanced through reflection and research, and qualitative and quantitative methods may be employed to collect data. Different types of knowledge, including practical and prepositional, may be produced by action research. Theory may be generated and refined, and its general application explored through the cycles of the Action Research process." (Waterman et al 2001: vi)

The research question asked: What happens when staff learn and use Pre-Therapy Contact Reflections with people with dementia? Over time, cyclical processes (involving teaching, facilitating learning, working alongside staff, reviewing their experience and evaluating the outcome) led to further reflective cycles based on learning from previous cycles (Waterman et al 2001). The emphasis on the introduction of change, reflexivity, innovation and researching the process of change indicated the value of Action Research as opposed to alternatives such as Realistic Evaluation or Fourth Generation Evaluation (McCormack and Manley 2004). Through reflection on practice and cycles of learning in action, theory was simultaneously generated, verified and refined (Bhattachary 2000; Zuber-Skerritt 2002a, 2002b). These features were central to the design of the study which, through critical reflective cycles, explored change, worked collaboratively in implementing the change, facilitated learning and exploration, and evaluated outcomes (Hart and Bond 1995; Morton-Cooper 2000; Coghlan and Brannick 2001; Day et al 2002; Prince and Chiu 2004; McNiff and Whitehead 2002; Whitehead and McNiff 2006).

Fig. 3.1 provides an overview of the research process of this study. A reconnaissance period formulated the research question. This was followed by recruitment of and engagement with staff participants. Simultaneously, links with the Pre-Therapy Network were established as the wider expert community (Torbert 2001). This was followed by an ongoing and cyclical process of research: activity, learning in action, data gathering, analysis and validation.
The research activity permitted verification as an ongoing process inherent within the research process. The position of this study on validation and verification requires clarification as both terms are frequently used interchangeably (Schatzman and Strauss 1973, Heath and Cowley 2004).

Validation refers to the process of member checking with participants, Garry Prouty and members of the International Pre-Therapy Network. This includes engaging in critical dialogue and debate about emerging ideas with both parties and weaving back and forth between personal experience, staff experience and the expert community. The term verification is used in a wider sense and is part of the internal and
iterative process of the research activity that ensures rigour (Tobin and Begley 2004). For Morse et al (2002), verification is:

...the process of checking, confirming, making sure, and being certain. In qualitative research, verification refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigour of a study (Morse et al 2002: 9).

Verification for these authors involves validation of emergent ideas in relation to theory and validation of emergent ideas with others. It also involves strategies within the research process, namely: investigator responsiveness, methodological coherence, attention to sampling, analytic stance and saturation. Detail of the research process, methods, validation activities in relation to others and process of analysis are discussed later in Chapter 4, providing an audit trail of the research and the verification inherent in the process.

In order to lay the foundations of the methodology, this chapter discusses the underpinning principles within this study: principles of social justice, participation, collaboration, empowerment and researcher reflexivity (Le May and Lathlean 2001; McNiff and Whitehead 2006). These principles, driven by ethical and moral values, formed a foundation for the study and influenced my epistemological position on knowledge, objectivity, truth and generalizability (Homan 1991).

3.2 Moral and ethical values as foundations

The values of this study were justice, humanity, compassion and valuing practice; these were enacted throughout the research process (Martin and Post 1992; Watson 1994; Brody 1997; Kendrick and Robinson 2002; Noffke 2002; Woods and Pratt 2005).

Social justice, inclusion and respecting experience

Social justice relates to the inclusion of people with dementia in the study. This reflects wider concern about difficulties of inclusion, or absence of inclusion in research and consequential exclusion of people
Methodology

with dementia from the research arena (Cotrell and Shultz 1993; Downs 1997, 1998; Burchardt et al 1999; Snyder 1999; Wilkinson 2002a; Clarke and Keady 2002). From the outset, there was a commitment to be inclusive. Even though the level of severity of dementia prohibited full inclusion in the research process, opportunities were maximized to promote involvement. Paradoxically, in order to maintain respect and dignity, and to reduce the potential for the person with dementia being seen as an object of study their inclusion was limited. However, despite limited actual participation of people with dementia, this study contributes to the body of research which is inclusive and where participation and capacity to consent to research pose particular difficulties to involving service users (Nolan et al 2002; Wilkinson 2002b). Social justice was also inherent in the belief that the experience of people with dementia should be improved.

Valuing experience through practice and valuing the experience of others was intrinsic to the research process (Hart and Bond 1995; Seng 1998; Nolan et al 2002; Wilkinson 2002a). Valuing practice placed emphasis on building theory from practice, rather than applying theory to practice. Furthermore, this study strove for social justice by providing opportunities for staff to be part of the research. Unqualified staff are some of the least advantaged in terms of status and arguably they are distant from research. This study offered them an opportunity for active participation and collaboration in the research. Inclusion was closely linked to collaboration. Collaboration required respecting the experience and practice of staff and valuing their contribution to the research process and the study would not have happened without this. Their inclusion meant staff had the opportunity for a voice in the research process, and opportunities to direct it and areas of inquiry and to shape the development of theory\(^3\). Collaboration provides a vehicle to illustrate the epistemological position on knowledge, subjectivity and truth.

\(^3\) The use of the past tense presents an artificial impression that enactment of the values stopped once the Action Research cycles of the research ceased. This arises from the
Knowledge, subjectivity and truth

I have taken the perspective that knowledge is fluid, dialectical and founded on the unpredictable nature of a practitioner's work. Living theory is internal, generated within and between people through collaboration. This is essentially an interactionist perspective (McNiff and Whitehead 2002). Through cycles of doing, reflecting and experiencing, knowledge is generated, leading to a synthesis of research and practice which is driven through practice (Vaughn and Edwards 1995; Bate 2000; Rolfe 2001; Fox 2003). Underpinning this perspective on knowledge is an additional value that expert knowledge belongs to no one individual; rather, people have their own expert knowledge and collective inquiry generated through collaboration engenders theory. Working alongside staff participants facilitated this. Through collaboration, the position is taken of working alongside people rather than studying them, which in turn requires a commitment to valuing their experience, and the knowledge gained from that experience (Watson and Foster 2003).

In order to enact the principle of valuing it has been important to focus on the real world experience of staff. This included: locating the research in their lived experience and context, using known difficulties of how to communicate with people with dementia as a foundation, and acknowledging challenges and stress staff face in enacting values of being person-centred when their reality is often task focused (Jenkins and Allen 1998; Proctor et al 1998b; Brodaty et al 2003; Sammut 2003a, 2003b). Alongside valuing and having compassion for their experience, the intention of this project was to offer something new, rather than approach staff from a critical, devaluing position that their practice was somehow deficient.

Given that knowledge incorporates many subjective experiences, the position taken is that there is no single truth. Rather, truth is multiple and

necessary but artificial division of writing action research for a thesis and action research as a continuous activity.
constructed. However, within this study truth is complicated and needs to address the issue of relativism (Smith and Deemer 2000; Ladkin 2005). This study has to hold a tension. Whilst valuing individual experience and the position of multiple truths arising through experience, the study has to encompass the alternative position that there is a common understanding or reality about Pre-Therapy and contact reflections that exists alongside an individual's experience of it.

The tension of relativism, 'truth' and multiple meanings of an experience in Action Research has been articulated by Ladkin (2005). She sees an inherent struggle between subjective ways of knowing and objectivity or 'truth'. This is particularly apparent where the researcher is engaged in the research and using their own experience as part of the inquiry (Torbert 2001). Ladkin suggests that the balance between subjectivity and objectivity can be struck by appreciating an individual's subjective experience of tangible 'things'. She does this by drawing on phenomenology.

One of the most radical stances of phenomenology is its recognition of the relational characteristics of consciousness. It posits that, fundamentally, consciousness is always directed, it is always consciousness of. Through this recognition, the primacy of 'things' towards which consciousness is directed is asserted. In other words, phenomenology posits that consciousness cannot function independently of 'things' to be conscious of. It is important to note here that phenomenologists consider 'things' to encompass both the material, such as trees, pottery, squirrels, as well as the immaterial, such as concepts, dreams, emotions, or even thoughts themselves (Ladkin 2005: 111).

Although this study is more in line with an interactionist position, rather than phenomenology, Ladkin's position has relevance. Contact Reflections stand as tangible, concrete, 'things'. In this sense there is an element of objectivity, rather than a relativist position that contact reflections exist only subjectively as an individual understands them. This indicates that contact reflections are not a social construction or defined by an individual's experience. Rather, contact reflections exist as 'things' that are defined, commonly understood and have an existence in their own right. Variations occur in the individual's experience of the
journey of learning and using them. As a result the subject-object relationship is intertwined. Subjectivity within this study comes from the emphasis on the individual's own subjective experience of the 'thing' – the experience of using contact reflections. This is further entwined with the reflexivity and subjective experience of my role as an active participant in the inquiry. Within this study, the generation of theory was also influenced by engagement with a wider community (The International Pre-Therapy Network) and by self-participation, which carried 18 years clinical experience in Older Persons' Mental Health services (Marshall 2004).

Whilst staff remain experts in their own experience of learning and using Pre-Therapy Contact Reflections, their experience sits alongside the greater expert knowledge and experience of Garry Prouty and Pre-Therapy Network Members. This does not detract from the participants' knowledge, experience and constructed meaning of the experience of using contact reflections; rather it recognises that an expert community has a general consensus on what Pre-Therapy is (Blumer 1969). This added to the study by providing the opportunity to make comparisons between the use of contact reflections by staff in relation to the theory and greater experiential wisdom of Garry Prouty and Pre-Therapy Network members. Therefore, for this study, the emphasis is on the subjective experience of staff gained through participation, in relation to a wider body of expertise, in order to encapsulate what happens when staff learn and use contact reflections in their own practice.

The purpose of this study is not to unpick contact reflections themselves, rather to focus on what occurs when they are transposed to a new setting. This purpose is therefore compatible with the acceptance of a continuum of relativism and truth. The existence of a professional expert community who hold a shared 'truth' about what Pre-Therapy is, and the generation of ideas about the use of contact work in dementia care through the various subjective experiences of those (including myself) using them facilitate a particular approach to the research process. This
approach accommodates the interplay of participants' experience with the theory and practice of people with greater expertise in Pre-Therapy. It is demonstrated throughout the research process and the analytic process, which used comparative analysis of the experiences of staff participants alongside validation activity with staff and the Pre-Therapy (expert) community.

This study is located in the real world context of the participants. Arguably there are limits to how the ideas can be generalized to other staff and other settings, precisely because the study is context-specific. However, there is room for natural generalization about the application of the Pre-Therapy Contact Reflections to dementia care. Although the experience of individuals within this study may not be universal, theoretical ideas about the use of contact reflections may resonate with others, leading to wider application across dementia care settings and possibly services for other client groups and care contexts (Stake 2000).

The moral and ethical pillars that underpin Action Research are evident through the position on knowledge, subjectivity and truth. In addition, the moral and ethical dimensions of Action Research inform three areas of particular significance to this study: participation, democracy and the researcher/participant relationship.

### 3.3 Participation

**Introduction to the complexities of participation**

Degrees and types of participation may vary. The extent of participation which is integral to Emancipatory Participatory Action Research, for example, differs from other approaches within Action Research. Participation in this study is pragmatic. Staff were invited to participate in a broadly predetermined project, following its design, rather than a project being defined and driven by participants (Kemmis and McTaggart 2000).
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Within this study, there are three aspects to participation: staff participation, participation by people with dementia and self-participation. In order to understand the dynamics of staff participation and influences affecting participants, literature was drawn on that gathers together features pertinent to this study. The involvement of people with dementia as participants is discussed in relation to limitations. Measures to accommodate research activity with people unable to participate in research in a traditional sense were taken whilst remaining true to the spirit of participation and inclusion. The provision of detail about self-participatory activity, the active role of the researcher in collaboration with others, reinforces the value base of this study.

3.3.1 Staff participants

Staff participation was compromised by different factors: organisational and contextual factors, relationships and relational factors, and intrapersonal factors. Awareness of the effect on participation was useful, since individual staff deliver care in their own context of working in teams, which in turn are part of a wider health care organization (Kemmis and McTaggart 2000; Gibbon 2002).

Contextual factors

Contextual factors stem from tensions between a health care model based on technical rationality and which simultaneously promotes autonomy in professional development. Workforce factors such as changes in personnel and an agenda of managerialism inhibit collectivism and collegiality (Walsh 1994; Williamson and Prosser 2002; Busza 2004). Metaphorically, organisations have attracted terms such as clockwork, snake-pits, psychic prisons or rainforests. Clockwork depicts characteristics such as logical, rational, certainty and control. In contrast, snake-pits may be experienced as chaotic and disordered, creating landscapes to be survived (Schwartz 1990; Darwin 1998). Psychic prisons are environments where (through conscious and unconscious processes) meanings and norms are constructed which
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may be self-limiting (Morgan 1997). More optimistically, rainforests provide opportunities for co-evolution, interconnectedness and cooperative working (Darwin 2001). Staff may experience dual organisational messages and organisational forces may inhibit change and development, whilst at the same time espousing and encouraging development (Fineman 1993; Smith 1999; Scholes 2000). On a practical level, this tension is seen in the difficulties between maintaining minimum staffing levels, implementing financial recovery plans, ensuring mandatory training (fire, moving and handling) and at the same time promoting a philosophy of professional development that requires time for staff to be released. As a result there may be dis-harmony between the organisational message of learning and the provision of conditions to help staff achieve this (Manley 2000a, 2000b). An outcome of organisational tensions may be powerlessness or inertia to participate in change and atrophy of practice development (James et al 2003; Bender and Wainwright 2004).

Workplaces may be incompatible with learning and development, affected by job demands, poor support, effort/reward imbalance, lack of job control, poor job satisfaction, problematic relationships with managers, lack of time to fulfil job demands, lack of resources, poor pay, job insecurity and high turnover of staff (Banazak 2000; Dallender and Nolan 2002; Hughes 2002). Studies that aim to show how to overcome these problems stress the importance of structural and managerial support for learning programmes that allow staff to reflect on practice. The supported learning that results raises staff morale and leads to improvement in practice (Meuller Hergl 2003; Featherstone 2004). To strengthen change, attention to process-orientated learning which is student/nurse-centred rather than didactic is indicated. This requires organisational commitment which promotes a consistent message to staff that the context is supportive of development (Innes 2001; Adams and Richardson 2005). Process-orientated learning, supported by managerial structures, creates the opportunity for learning to be used in practice rather than being separated from it (Banazak 2000). Arguably,
training is frequently separated from practice in the form of external study days, without equal emphasis on how learning is internalised and applied. Potentially, this leads to a false economy as the investment in training is not reflected in change in practice. Mindful of the gap between intended and actual change, this study promoted cooperative activity collaboration and participation, with the emphasis on learning being embedded in daily practice rather than an external activity. In relation to valuing individuals, it was born in mind that they existed in a social and organisational context which may have an influence on them and their capacity for participation.

Instability of the context was relevant to the research; service instability and job instability of both managerial and direct care personnel were evident. This is shown in detail later in the thesis. Knowing about these did not equate to being able to influence them and a degree of acceptance was needed to work alongside contextual challenges, monitor and regulate any personal frustration or anxiety and rely on participation through perseverance. Consequently, it took longer than anticipated to secure participation and greater time and energy promoting, initiating and sustaining research activity.

Relational factors
To be autonomous in their own practice, staff need the capacity to be self-directive within the context of an interdependent care team. This leads to the need to consider group dynamics and processes and the implications of this when working with groups of staff (Tyler and Blader 2001). Staff teams and groups create their own micro-cultures and social norms. These micro-cultures may contribute to resistance to participation and carry the danger of self-limiting behaviours, stifling or oppressing others and result in disempowering relationships between staff (Adams 2003; Randle 2003; Daiski 2004). This perspective offers an alternative to the view that individuals have their own autonomy to engage in change. MacDonald (2002), Sherwin (1998) and Donchin (1995) present the view that an individual's autonomy to change practice
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cannot exist unless the micro-culture supports this. This draws on the concept of *relational autonomy*, which is viewed as:

_the complex webs of personal and institutional relationships that make possible, or sometimes hinder, the making of real choices_ (MacDonald 2002: 195).

Conformity and affiliation to dominant group behaviour may give individuals a social identity that offers self-esteem, affiliation and self-worth. Where a dominant group culture is resistant to learning, staff face peer pressure to resist engaging (Doosje et al 1999; Guinote and Fisk 2003; Coultas 2004; McFarland 2004). A function of group connectedness is to protect the group against pressures from outside and maintaining a status quo. However, this creates difficulties for those who wish to step outside the norm and may inhibit participation in new practice (Secrest et al 2005). This may also account for particular wards which develop micro-cultures which include collective hopelessness, powerlessness and helplessness in the face of change. Change then threatens the groups' identity and practice and may be expressed as resistance or apathy (Bahn 2001; Norman et al 2001; Garcia 2003). However, a critical mass of participation or leadership, which can model the positive benefits of change, has the potential to raise morale and allow staff to develop practice in the company of others (Mezirow 1991, 1994; Langan-Fox 2002; Norman 2003).

In order to approach Action Research in existing micro-cultures, awareness of how the research process interrupts or shifts relationships between staff was useful (Waterman et al 2001). Nursing teams themselves cannot be assumed to be cohesive groups. For Fahy (1996), this is a limitation of Action Research, the argument being that Action Research requires group inquiry, whereas the reality is that much nursing work is not group activity; rather, people working on an individual basis in relation to each other within ever-changing configurations of smaller groups working on any particular shift. Whilst staff may exert individual autonomy in their own interactions with service users, this is
mediated by relational autonomy arising from the group working as a team. For 'space' to be created for the research activity, awareness of the effects of this on the staff team as a whole is needed.

In relation to this study, a gentle approach to engage participation was used. Anticipating the possibility of resistance, non-engagement or a perception that the research would add to their work pressure, it was emphasized to staff that the research activity was not meant to impose, interrupt or criticize their current work. In order to secure participation, a balance had to be struck between bullishness, which might increase resistance, and being overly tentative and hesitant, which might not convey sufficient enthusiasm to motivate others. Tension between 'pushing' the research forward and gently 'inviting' participation was a theme throughout the research process. This illustrates that participation is not simply securing participation at the outset, rather requiring constant attention and reflexive management. Adopting a perspective of relational autonomy moves away from blaming individuals or labelling them as 'resistant' if they do not comply with innovation and places equal responsibility on the researcher to secure participation (Clarke 2001; Grant 2001). Developing skill in engagement to secure participation requires being sensitive to the daily reality of nurses' work, demands an understanding of resistance, and working with that resistance to avoid approaching them in a way that is perceived as further pressure and coercion (Miller 2000).

Individual factors
Added to the contextual and relational factors are potential barriers from individuals themselves. This study introduced staff to something new. This required people to self-reflect on their practice, which held the potential to disrupt self-identities and mobilise defence mechanisms to avoid discomfort (Menzies 1970; Kitwood 1994, 1997; Bond and Holland 1998; Mason 2002). Personal threat itself poses a threat to participation, with disruption having the potential to cause dissonance leading to resistance, cynical distancing and non-engagement. In this sense
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resistance to participation is self-protective, as individuals deflect feeling de-skilled and guard against experiencing 'moral stress' that may arise from self-challenge or challenge-promoting activities (Walsh and Ford 1991; Corley 2002; Flemming and Spicer 2003). In response to the potential for resistance, my approach aimed to emphasise the supportive nature of the research process, underlining the opportunity to learn and reflect on something new, rather than criticise existing practice. This required staff placing trust in me in the interpersonal relationship between us (Cotton 2001).

Other factors may jeopardize participation. Engagement in change requires emotional literacy for self-reflection (Freshwater 2004). This may be demanding as staff may have limited experience in analysing their practice or little opportunity and actual space for reflection (Alerby and Elidottir 2003; Dawson 2003; Edmonstone 2003). This caused me concern from the outset as the majority of the participants were unqualified staff, unused to having opportunities for reflection on their work. In addition, reflection may not be perceived as 'real work' and reflecting on emotional work may not be valued by staff (Smith 1992; Staden 1998; Freshwater 2004). To counter this, it was important to provide a learning relationship to support reflection, place value on the emotional work that they already do, and be supportive of the emotional work involved in using Pre-Therapy Contact Reflections.

Participation of staff – risks and opportunities

By viewing participation in relation to contextual, relational and personal aspects, risks and difficulties of participation become clearer. On an individual level, staff are asked to expose their own practice, with the potential for weaknesses to be pointed out (Marsick and O'Neil 1999). Risk can also be seen in relation to group affiliation. Participation held the potential to disrupt existing dynamics of a ward by the participation of some staff and not others (Ospina et al 2004). Risk in relation to an organisation may be present where the organisational message promotes technical output or tasks over self-reflective practice. Should
this message be internalised by individuals, the participant who engages in an activity which runs counter to the dominant message exposes themselves to criticism or putting themselves before patient care. Organisational risks were taken by participants, as involvement required time away from the work setting to allow for learning and reflecting on practice.

Measures were taken to minimize risk. Initial sessions or meetings aimed to reassure staff that the research process was not designed to be critical or threatening, although it would require them to consider something new. Initial meetings included stand-alone teaching sessions about Pre-Therapy and an invitation to participate, attendance at staff meetings to provide information and invite participation, and meetings with individuals.

Relational risks were acknowledged in meetings with staff and organisational risks were minimized by liaison with ward managers to avoid disruption to wards. In securing participation, a delicate balance needed to be sought between stressing the potential value of participation and avoiding over-emphasising benefits. This was particularly so, given the lack of certainty about whether or not staff would be able to use contact reflections or whether they would prove of any benefit in communication with people with dementia. In this way the benefit of participation was presented as the opportunity to join me in the exploration and to find out more about contact work with people with dementia. By way of a summary, factors affecting participation which were key to this study are presented in Fig. 3.2, showing whether they pose a threat/risk or an opportunity.
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<table>
<thead>
<tr>
<th>Factor</th>
<th>Threat</th>
<th>Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational/ Contextual factors</td>
<td>Message of procedural rationality, productivity, task focus</td>
<td>Message of being a learning organisation, service change, innovation and improvement</td>
</tr>
<tr>
<td>Relational factors</td>
<td>Relational autonomy and interdependence of nurses within a staff team, resources, exposure in relation to others</td>
<td>Co-learning, development and learning in the company of others</td>
</tr>
<tr>
<td>Intra-personal factors</td>
<td>Threat to self-identity, de-skilling, psychological defence mechanisms and resistance</td>
<td>Transformational, self-improvement, raising job satisfaction and self-esteem</td>
</tr>
</tbody>
</table>

Fig. 3.2. Factors affecting participation.

Reflexive management and monitoring of participation in relation to moral and ethical values

Tensions exist between the threats and opportunities which required monitoring to ensure the research process was not detrimental to individuals and environments. Organisational support and awareness of group and individual forces leading to resistance, are necessary if change agents are to build cooperative alliances with staff. Without alliance, groups and individuals may experience the change as destructive and individuals may feel de-skilled. As well as attending to organisational, relational and personal factors, the approach of the researcher requires consideration. Seeking alliance based on humility and respect for the position of participants was deemed preferable to stepping in, expecting change and pushing participation, since:

*organisations such as schools and hospitals will, like dragons, eat hero-innovators for breakfast* (Georgiades and Phillimore 1975: 315).
Arguably, inadequate attention to contextual, relational and individual factors results in a failure to produce change and, at worst, inoculates staff against development as change is perceived as something negative. These factors were the source of vulnerability in this study due to the reliance on participation. By conceptualising participation it was possible to develop a greater understanding of the real world context of staff and factors which might affect viability.

In relation to the research, contextual, relational and intra-personal factors form part of the factors to be navigated to secure participation. Although these factors were part of the real world context, investing energy in monitoring and attempting to overcome them became part of the personal emotional labour of the research process. The process of conceptualising participation led to a period of personal negativity and disillusionment with organisational and contextual factors which held the potential to work against practice development. As a result, I observed my own position towards participants and staff who chose not to participate becoming more protective, wishing either to help provide or improve the context as a place of learning, development, change and nourishment for staff. This position reinforced my concern about not wanting the research itself to become an additional contextual pressure, rather for it to offer a positive experience. This position may have been taken at the expense of gaining a higher level of participation and involvement as I did not want to 'push'.

The process of conceptualising participation was used to generate a checklist for self-monitoring as part of the reflexive management (Fig. 3.3).
• Record organisational, relational and personal factors in reflective diary and audit trail of research activity.

• Monitor contextual factors which affect participation.

• Emphasise the research is independent of managerial drivers. Awareness and monitoring of effects of managerial agendas.

• Monitor for relational factors between staff participants (e.g. gauge ward/group dynamics, team cohesion, group processes).

• Monitor cultural norms and perception of participation for individuals in the research (e.g. expressed attitudes to training, staff development and research, readiness to engage in reflection and review of practice).

• Monitor intra-personal factors affecting staff participation (including my own) (e.g. discomfort, distress, negativity or lowered morale prompted by reflection on practice. Awareness of defence mechanisms and resistances).

• Critical self reflection about support systems built into the research processes designed to offer safety. Support systems such as psychological safety of learning process, participant access to researcher by telephone, and researcher skills in interpersonal relationships and facilitation skills.

• Review participation at each contact ensuring that participation is realistic, meaningful, voluntary and not burdensome.

• Monitor any paradox (e.g. the tension between protecting staff and allowing dissonance and discomfort to arise as a result of learning and using the Pre-Therapy contact reflections.

• Monitor and evaluate potential ethical issue (e.g. best interests of staff compete with researcher interests of gathering data, sensitivity to support needs should staff be unable to learn and use contact reflections, critically reflect on tensions between researcher desire to complete research and pace of participation affected by contextual, relational and intrapersonal factors).

• Reflect on moral responsibility to a care setting to ensure that participation of some and not others does not have a detrimental effect on the service and the care of service users.

Fig. 3.3. Self-monitoring and participation – checklist.
3.3.2 People with dementia as participants

Participation by people with dementia was compromised by inability or fluctuating ability to consent (Berghmans and Ter Meulen 1995; Kitwood 1995b; Proctor 1995; Aggarwal et al 1996; Adams and Clarke 1999; Bond and Corner 2001; Bartlett and Martin 2002). This problem poses a challenge that needs to be met if the methodology is to be inclusive of people with dementia (Jones 2001; Hubbard et al 2002; Kapp 2002; Howarth and Kneafsey 2003). However, this methodological challenge can be embraced to explore everyday problems that are unique to this group or aim to improve care (MacDonald 1996; Bond and Corner 2001; Koivisto et al 2001). To include people with dementia, a degree of participation can be achieved by adherence to a clear ethical framework, collaboration with relatives, assent by others as substituted consent and observing Research Governance and Department of Health guidance (Department of Health 2001b, 2001c; Allan 2002; Bravo et al 2003; Vass et al 2003; Grout 2004; Molinari et al 2006; Dewing 2007). The position of this study was to aim for realistic participation. People with dementia were included in the data, appearing in recordings of interactions where staff were using the contact reflections. However, sensitivity about maintaining participants' dignity meant recordings of people with dementia were kept to a minimum. Assent was sought from relatives. Assent was an ongoing process, as was assessment of the level of tacit agreement or comfort with participation from the people with dementia. As a proponent of process consent, Dewing (2007) sees it widens inclusion for people with dementia but requires researchers to take some risks with their practice. Arguably these risks are no more or no less than clinical staff are taking in their everyday encounters with people with dementia where they are trying to adhere to principles of being person centred. However, the research process does require the actions and relationships with people with dementia to be made explicit.
In relation to the moral values underpinning the methodology, participation of people with dementia for this study drew on the following key concepts:

i) Social justice and the right of the people with dementia to be participants in research.

ii) Collaboration in micro-interactions with people with dementia.

iii) Participation which involved a constant review of discomfort or signs of unwillingness to participate.

iv) Valuing the individual and their right to privacy or the right not to be used as a vehicle or object of study in their time of ill-health.

3.3.3 Self-participation

Action Research requires self-participation, reflexivity and engagement in the research inquiry (Reason and Marshall 1987; Koch and Harrington 1998; Alverson and Skolberg 2000; Taylor and White 2000; Adams 2003). Self-participation followed Torbert’s three levels of inquiry: self, others and a wider community (Torbert 2001). Self-inquiry focused on learning and using contact reflections, reflecting on practice and learning in action and gathering data which was personal. Participation alongside others allowed for shared inquiry, asking people to do only things that I was willing to do myself. This respects different levels of knowledge and promotes mutuality in joint inquiry (Bate 2000; Ospina et al 2004). Practical strategies included role modelling and openly reflecting on my own practice in the presence of others (Brockbank and McGill 1998). Learning alongside others led to simultaneous reflective processes – personal reflective cycles and cycles in others. This interface of self-reflective learning in relation to others is shown in Fig. 3.4.
At the point of teaching others, self-knowledge would alter through critical self-reflection, new thinking arose as a result of the encounters. New reflections were then taken into future cycles of doing, teaching and reflecting. This echoes an earlier position of the study, viewing knowledge being generated with and relation to others.

Self-inquiry in relation to a wider community was established by engagement with the International Pre-Therapy Network, which has allowed me to learn from those with expertise in Pre-Therapy. A variety of learning opportunities and activities were sought which helped me gain a basic level of knowledge and competence (Fig. 3.5).
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- Learning through teaching and discussing Pre-Therapy with others in the reconnaissance phase.
- Data collection on my own experiences of learning and using Pre-Therapy.
- Learning alongside and with staff participants in practice.
- Learning from staff to inform further research activity.
- Sharing of ideas, face to face meetings, phone calls and personal correspondence with Ian Morton, who initially proposed the potential usefulness of Pre-Therapy for dementia care.
- Attendance at the yearly international Pre-Therapy Network meeting (learning by assimilation).
- An ongoing email dialogue with Garry Prouty and other members from the Pre-Therapy community.
- Reading Pre-Therapy literature.
- Co-authorship of an article outlining Pre-Therapy and dementia (Dodds, Morton and Prouty 2004).
- Attendance at Pre-Therapy training workshop delivered by Dion van Werde (University of Paisley 2004).
- Mentoring relationship with Garry Prouty via email.

Fig. 3.5. Personal learning activity 2002-2007.

In addition to the learning activity, it was useful to verify my understanding of Pre-Therapy in order to disseminate ideas to others. Engaging with the wider community helped confirm that my embryonic understanding of the theory and practice of Pre-Therapy was congruent with Garry Prouty and other Pre-Therapy Network Members. This activity raised confidence in 'trustworthiness' when spreading knowledge of Pre-Therapy as well as generating ideas about the application in dementia care. This was formalised by receiving accreditation from Garry Prouty at the Chicago Institute of Pre-Therapy as a basic trainer in Pre-Therapy Contact Reflections. It is important to stress that having a
basic understanding of key theoretical, and philosophical origins of Pre-Therapy and a basic understanding of contact reflections does not qualify a person as a Pre-Therapist. My position is restricted to that of a nurse who is beginning to develop knowledge and skill in using contact reflections, not that of a psychotherapist. Opportunities to demonstrate my knowledge and teaching delivery were created (Fig. 3.6).

- Co-delivery of a two day workshop (Prague 2003) with Garry Prouty. For part of day two (observed by Garry Prouty) I used the workshop format and materials that were to be used with staff participants.

- Discussion with Pre-Therapy Network members (Network meeting 2006 and contribution to subsequent email discussions from November 2006 and June 2007) on core competencies and knowledge required for using Pre-Therapy by staff without a psychotherapy background.

- Conference presentation within the Trust on Pre-Therapy (April 2003).

- Conference presentation to Gerontology Stroke Interest Group on Pre-Therapy (May 2005).

- Seminar presentation of research activity, my teaching materials, content and process to other members of the Pre-Therapy Network (Oct 2004 and 2005).

- Reflection on my experiences of teaching pre-registration and post registration students about Pre-Therapy (2001-2006). This allowed me to evaluate my teaching process, clarity of disseminating information, teaching strategies and teaching materials.

- Critical self-evaluation of own level of knowledge and skill.

- Teaching to others outside the research process: pre- and post-registration mental health nurses and other professions (social work and psychology).

Fig. 3.6. Activity to consolidate teaching process and dissemination of Pre-Therapy to others.
3.3.4 Variations in levels of participation and collaboration in the research process

Levels of collaboration and participation varied and a matrix was constructed to capture degrees of participation (Fig. 3.7).

<table>
<thead>
<tr>
<th>PARTICIPATION</th>
<th>COLLABORATION</th>
<th>LEVEL OF COLLABORATION WITH RESEARCHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation at all stages. Engagement with others part of participation</td>
<td>Limited to infrequent or short periods of collaboration</td>
<td>Garry Prouty: ongoing dialogue and sharing of ideas via email between Garry Prouty and researcher</td>
</tr>
<tr>
<td>MEDIUM:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in part of the local research activity</td>
<td>Limited to infrequent or short periods of collaboration</td>
<td>Garry Prouty: ongoing dialogue and sharing of ideas via email between Garry Prouty and researcher</td>
</tr>
<tr>
<td>LOW:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited participation in local active research activity</td>
<td>Limited to infrequent or short periods of collaboration</td>
<td>Garry Prouty: ongoing dialogue and sharing of ideas via email between Garry Prouty and researcher</td>
</tr>
</tbody>
</table>

**Fig. 3.7. Variations in participation and collaboration.**
People with dementia had the most limited opportunities for collaboration and participation as a direct consequence of their health. Individual staff participants had varied levels of collaboration with other staff participants within their own units. The variation in their opportunities to collaborate is influenced by the number of staff participants in each research site and practical issues inhibiting them working alongside each other. Therefore, staff collaboration is seen as resulting in medium participation and medium collaboration with others. Garry Prouty and network members collaborate (through sharing of ideas) without any direct participation in the local research activity. Higher participation and collaboration for my role is demonstrated through contact with three groups: people with dementia, staff and the wider community (the Pre-Therapy Network).

The Action Research approach for this study may not follow the ideals of an emancipatory participatory model of action research, falling down on participation and collaboration. However, a variable approach was necessary because:

i) The research question demanded introducing an innovation that was unknown to staff, therefore the initial idea was not collectively generated.

ii) I was responsible for creating the topic and by linking the research to the PhD programme. I acknowledge self-interest in the research. Therefore this project is researcher-led, rather than being a consequence of a collective action directed towards emancipation.

This fits with the professionalising/organisation type of Action Research which acknowledges researcher directed Action Research for change and innovation (Hart and Bond 1995; Grundy 1988; Kemmis and McTaggart 2000; Krimerman 2001; Altrichter et al 2002; Gibbon 2002). However, at every stage, attempts were made to redress potential imbalance, attempting to maximize participation and collaboration within the specific research context.
This leads to the conclusion that for this study participants were involved in a collaborative co-learning process rather than acting as co-researchers. The reasons for this are discussed below in relation to principles of democracy, power, authority and responsibility.

3.4 Democracy: power, authority and responsibility

Variations in collaboration and participation have a knock-on effect on the level of democracy in the research process, potentially resulting in variance in power, authority and responsibility (Denscombe 1998; Waterman et al 2001). These issues require clarification to avoid any ambiguity in the ownership of the research (LeMay and Lathlean 2001; Reason and Bradbury 2001). Within this project the variations in power, authority and responsibility are illustrated within three aspects: managing the research process, securing participation, and in relationships.

First, the management of the research process can be separated into the management of outward space (social relationships and preparatory work outside the direct research activity) and the inward space (social relationships within the research activity) (Ospina et al 2004). Within this study I held responsibility of the outward space. The inward space was more democratic. Staff were encouraged to discuss and suggest how the research activity would progress, permitting minor adaptations in timing, logistics and the order of research activity to ‘choreograph’ the design (Janesick 2000). For example, staff on one research site requested more time to learn and practise the contact reflections before using them in their practice. Consultation with staff participants on learning and implementing contact reflections offered staff some ownership and control, allowing them power and authority over the pace and direction of the research.

The second issue, securing participation, involved monitoring dynamics of coercion or manipulation, in order to avoid co-opting staff (Morse
Adopting the principle of voluntary participation runs the risk of staff electing not to participate, and this runs counter to a researcher's motivation for the project to progress. This point is worth reiterating in relation to power, as the researcher role within this study required continuous self-monitoring of the personal drives of the research in relation to the personal world of the participants. This tension was held throughout, resulting in personal anxiety of non-participation and counteracted by personal values wishing to avoid any pressure or disturbance to staff, whilst at the same time continuously reviewing the sample size.

The third aspect is the potential tensions in being democratic within relationships. For Ospina et al (2004) navigating researchers' expertise and participant experience requires a delicate balance to ensure neither voice is omitted. Creation of a democratic space provides an arena for the voice of participants as well as permitting the researcher 'where necessary' to take authority within the relationship. This allows space for staff whilst allowing personal experience and knowledge some space. Mutual respect for people's expertise was mirrored in my relationship to the Pre-Therapy Network. Members were welcoming of my experience of dementia, and I welcomed and respected their expertise in Pre-Therapy. Authority and power were also relevant to relationships with groups of staff participants. Facilitating reflective groups initially requires authority and leadership before shared autonomy and flattening of power relationships develop, which leads to shared ownership and non-authoritarian relationships (Heron 1989, 1993; Bion 1991). Therefore, it was appropriate to assume a greater level of authority in the earlier stages of the research activity. For example, in the initial teaching workshops I was more likely to lead and direct staff. Later meetings were more collaborative and democratic. Staff felt greater power to make suggestions, share their perspectives, or withdraw. The shifting patterns of authority and democracy are reflected in the research methods. Chapter 4 shows how contact with participants was not purely through interviewing, but rather, a blend of learning, joint inquiry and supervising.
as well as interviewing. In this way, the power, authority and democratic ideals were, rather confusingly at times, in a state of constant flux.

Participation, collaboration and democracy are fluid and dynamic, not static and one-dimensional, and mediated by the relationships between the researcher and the participants.

3.5 Researcher/participant relationship

The researcher/participant relationship requires analysis. Values are evident within the relationships built between the researcher and participants and an *We relationship promotes a sense of joint inquiry leading to trust and credibility (Gilbert 1998; Cutcliffe and Grant 2001; Sixsmith et al 2003; McNiff and Whitehead 2006). Values are enacted through the interpersonal relationships between the researcher and participants (Coghlan 2001a, 2001b). However, these are affected by two factors: pre-existing roles and interpersonal skills. My own position within the research process was predetermined by my work role that spans both the Trust (including the clinical areas involved in the research) and the University (Murphy 2000).

I have conceptualised my position as ‘otherness’/‘togetherness’, rather than ‘insider/outsider’. This aims to reflect a relational dynamic between people rather than the terms ‘insider’ or ‘outsider’, which, I feel, reflect a status rather than a relationship. ‘Otherness’ is being an outsider/stranger who is remote and different from the participants, but still known to them (MacCullum 2002). ‘Togetherness’ holds a different relationship, where the relationship is one of an ally or colleague working alongside the participants. In this way I could still be known to them, but move between being an ‘other’ and being in a relationship of ‘togetherness’. The concept permits being able to be simultaneously other and together. However, the two positions may produce tension, lessening the effectiveness of the researcher/participant relationship. My part-time role with the university distanced me, increasing ‘otherness’. This runs counter to ‘togetherness’, which promotes non-elitism,
proximity and collegiality with staff (Coghlan and Casey 2001; Rolfe 2001). During the research process, managing the paradox of tempering 'otherness' to achieve 'togetherness' was recorded in personal reflections⁴.

Over time the differences in my relationship with others became clearer. There were times when an approach that promoted togetherness was important (building alliances with staff participants). At other times an approach of otherness was required (external promotion of the research activity). In addition, this required being able to be close but separate and being the same but different, which drew on skills of managing personal and professional boundaries in relationships (Watson and Foster 2003).

Personal and interpersonal skills are also seen in the process of securing collaboration, requiring soft skills and the avoidance of an over-zealous approach (Zuber-Skerritt and Perry 2002; Le May and Lathlean 2001; McCormack and Garbett 2003). Qualities of tenacity, emotional engagement, empathy, optimism, flexibility and patience are some of the qualities required for transformation (McCormack and Garbet 2003). However, this runs counter to Buchanan et al (1988) who view access as primarily chance rather than skill (McCormack and Garbett 2003). From this, a middle ground of maximising any chance opportunities through skilled engagement seems a realistic combination.

⁴ Reflective Diary Extract - June 2003: In relation to my own proposal, I will need to consider the balance between perceived expert and ‘other’, and insider status. Ownership of the research by staff is likely to be greater if they feel ownership towards me. This demands an approach that sets aside expertness, assuming humility and overtly conveying that I am learning from them, and in turn we are learning from the patient. However, part of the AR process emphasises presentation and dissemination of work (Zuber-Skerritt 2002b). Having recently presented the project at a regional conference, attended by many Trust staff, the paradox arises of appearing an expert but not wishing to appear so. Countermeasures of proving ordinariness in practice become more imperative. This leaves the researcher the difficult task of moving between two roles. On the one hand, 'otherness' expressed as being different, special or expert. On the other hand, aspiring for ordinariness promotes ownership of the researcher by staff leading to a sense of 'togetherness'.
Specific features of the researcher/participant relationships were relevant in this study: working with resistance, being supportive and clarifying personal and professional boundaries. Working with resistance parallels psychotherapeutic approaches that build a non-confrontational and collaborative alliance (Moniz-Cook et al 1997; Kasl and Yorks 2002). Drawing a parallel with horse whispering, Miller (2000) stresses the importance of approaching participants with a commitment to their welfare and seeking collaboration via the relationship aiming towards 'getting alongside'. In this sense, support is required to nurture change. In the context of dementia, there is an argument that education/training and change require addressing the sophistication gap - the gap between asking staff to engage in emotional interpersonally sensitive therapeutic work with patients when they do not receive similar emotional sensitivity themselves (Sheard 2002). It was possible that staff might be reluctant to engage with me because it would involve engaging in an unfamiliar therapeutic approach. So, the approach used with staff may be key to whether or not they decide to engage. Therefore, the alliance with staff needed to be safe and supportive, but sufficiently challenging to enable them to reflect critically on their practice and be mindful of the potential for creating moral distress where staff begin to articulate any tensions that arise, for example between what they want to do and what they actually do (Corley 2002; Doane 2002; Mason 2002). Thus, staff support, rapport, and therapeutic holding within researcher/participant relationship offer safety and trust (Mearns 1994; Merry 2002; Mearns and Thorne 1999). This is evident in nine core values that are taken into the relationship by the researcher: synergy (willingness to share knowledge), collaboration and team spirit; admitting ignorance and failure; openness; trust; focus on learning and questioning insight; symmetrical communication (mutual respect for individual needs and differences, sharing responsibility); creativity including taking risks; and flexibility and innovation (Zuber-Skerritt 2002b).

Personal and professional boundaries require monitoring through awareness of interpersonal dynamics and researcher reflexivity (Zeni
1998). Waterman et al (2001) identify these as familiarity clouding understanding, dependence on the relationship, conflicting alliances, and closeness leading to issues of confidentiality. Despite having no managerial responsibility a potential difficulty was considered - witnessing or being told something that would warrant breaching confidentiality under my own code of professional conduct (Bond and Holland 1998). This was addressed in the research agreement and stated in the research information sheet for staff (Appendix 2).

3.6 Rigour

One way of assessing rigour in Action Research is by attending to the way in which values are put into action and to the process of the research. For some, this has led to wider acceptance of Action Research as a methodology (Hyrkas 1997; Meyer 1993; 2001; Le May and Lathlean 2001; Maggs-Rapport 2001; Davies and Dodd 2002). Further steps to enhance rigour are evident in work by Waterman et al (2001), who identify eight pivotal features against which rigour is demonstrated, evaluated and assessed (Fig. 3.8).

<table>
<thead>
<tr>
<th>Eight pivotal features of Action Research (Waterman et al 2001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Real-world focus</td>
</tr>
<tr>
<td>2. Knowledge</td>
</tr>
<tr>
<td>3. Participation</td>
</tr>
<tr>
<td>4. Action researcher/participant relationship</td>
</tr>
<tr>
<td>5. Research methods</td>
</tr>
<tr>
<td>6. Project and process management</td>
</tr>
<tr>
<td>7. Key persons</td>
</tr>
<tr>
<td>8. Resources</td>
</tr>
</tbody>
</table>

Fig. 3.8. Eight pivotal features of Action Research.

Rigour is shown by the presence of the key features. Whilst the eight pivotal features are not theoretical constructs and by themselves do not
define Action Research methodology, they may be used to structure the discussion of how the Action Research process manages each feature. Verification of Waterman's criteria is offered by showing the relationship between Waterman's features, the five key domains of action identified by Reason and Bradbury (2001: 12), and significant features of the methodology of this thesis (Fig. 3.9).

<table>
<thead>
<tr>
<th>Eight pivotal features (Waterman et al 2001)</th>
<th>Five key domains (Reason and Bradbury 2001)</th>
<th>Significance for this study</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Real-world focus</td>
<td>Knowledge in action</td>
<td>Joint learning through practice</td>
</tr>
<tr>
<td>2. Knowledge</td>
<td>Emergent developmental form</td>
<td>Knowledge developed over time</td>
</tr>
<tr>
<td>3. Participation</td>
<td>Participation and democracy</td>
<td>Self-participation and collaboration with others</td>
</tr>
<tr>
<td>4. Action researcher/participant relationship</td>
<td>Human flourishing</td>
<td>Using the relationship to provide the opportunity for exploring and developing my own practice and the practice of others</td>
</tr>
<tr>
<td>5. Research methods</td>
<td>Practical issues</td>
<td>The research process and methods used, working with others, the resources available and key people in the organisation</td>
</tr>
<tr>
<td>6. Project and process management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Key persons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Resources</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 3.9. Correlation of features of Action Research.
3.7 Summary

The values and beliefs underpinning the study are that knowledge is created with people in the context of their lived experience. Personal moral and ethical beliefs drive the study and are summarised in Fig. 3.10.

**Personal moral and ethical beliefs**

- A desire to contribute to the care and communication between staff and people with dementia.

- A position of valuing the work of largely unqualified staff. Compassion for the lived work experience of staff working in dementia care settings where training, support and resources are inadequate.

- A belief in working alongside people in the spirit of collaboration rather than studying them. This extends to their inclusion in the validation/verification process.

- Holding a belief about injustice of research which studies phenomena that are more amenable to being studied. This means that people with dementia and staff are more likely to be excluded.

- Conducting the research in a way that contributes to their understanding of their work, rather than research that is distanced from their work or critical of it.

- Wishing to include people with dementia, without exploiting them.

- Accepting that whilst participation is the ideal, there are limitations to this.

- Promoting a spirit of democracy through my relationships with others.

*Fig. 3.10. Summary of personal moral and ethical beliefs.*

Understanding participants requires understanding contextual, relational and intrapersonal forces. My epistemological position is that individuals create meaning and understanding through relationships with others; this is influenced by the context in which they work. This resonates with a symbolic interactionist position. Nursing staff work in teams and care
Methodology

contexts characterized by instability: this is their real-world situation. By adopting a position which views individuals within relationships and in context it is possible to understand how these factors affect participation. This argument is congruent with the underpinning value base of valuing and supporting individuals in practice as it avoids blaming individuals for not participating and accepts that the research process may add to their burden (Illich and Verne 1976; McNamee and Bridges 2002).

A position is taken that democracy, ownership, power and authority are not static, but vary, as the research process is a dynamic event. However, there was an intention to achieve a spirit of democracy in the progress of the study, and striving to create the conditions in which participants feel they have a voice. Rigour in the methodology has been shown in relation to four key features of Action Research, namely the real-world context, knowledge, participation and the researcher/participant relationship (Waterman et al 2001). Rigour will continue to be demonstrated in the next chapter by addressing the remaining four features: project and process management, key persons, resources and methods.
Research Process, Methods and Data Analysis

Introduction

The chapter is structured in a linear sequence of project process, methods, validation and analysis. This is a practical solution to the difficulties in writing about action-oriented research and cyclical processes (Gibbon 2002). The linear presentation of the chapter does not reflect the messy, asynchronous and simultaneous nature of the inquiry. The iterative and intertwined nature of the Action Research process means that data collection, validation and analysis are concurrent, generating living and organic theory (Whitehead and McNiff 2006). An overview of the simultaneous activities is presented at the beginning, showing the project process.

The first part of the chapter is guided by the remaining four features of Action Research: project process and management, key persons, resources and methods for data collection, (Waterman et al 2001). Together these four elements provide a picture of the chronology of the research activity. Key people involved in the research and research sites are discussed and linked to sampling. The topic of resources links back to the real world context. The methods for gathering data are explored in detail, providing an audit trail of the project process. Specifically, the methods section charts the use of video (one medium through which data was collected) and addresses confidentiality, consent and practical issues.
Validation, which was inherent in the research process, provides a bridge between the methods and data analysis. The discussion on validation illustrates how the research inquiry moved between three levels of inquiry: self, self in relation to participants, and self in relation to a wider expert community (The International Pre-Therapy Network) (Torbert 2001). The final section of the chapter discusses the process of data analysis. Within this section it is shown how a conceptual overview of the field of inquiry was used as scaffolding within which the process of data analysis occurred. The analytic process shows how Schatzman's Dimensional Analysis was used to facilitate the emergence of theoretical ideas over time.

4.1 Research Process

Fig. 4.1 gives an overview of the research process. This diagram provides greater detail about the cycles of research activity within the Action Research process which was outlined in the Methodology Fig. 3.1. Unpicking this process provides an audit trail and contributes towards the authenticity of the inquiry (Lincoln and Guba 2000).

Prior to the start of the research activity there was a reconnaissance period spanning from 2002 to 2003. Recruiting participants began immediately after ethical approval and the active part of working with participants took place between summer 2004 and autumn 2005. Engagement with the Pre-Therapy Network started in 2001.
Research Process, Methods and Data Analysis

Reconnaissance period

ONGOING REFLECTIVE CYCLES PROMPTED BY CONTACT WITH NETWORK

DATA GATHERING THROUGH DISCUSSION AND EMAIL DIALOGUE

LEARNING AND REFLECTION IN ACTION WITH AND THROUGH OTHERS

VALIDATION OF OWN KNOWLEDGE WITH NETWORK

PRE-THEAPY NETWORK

SELF

ENGAGEMENT WITH WIDER EXPERT COMMUNITY

STAFF

ENGAGEMENT WITH STAFF PARTICIPANTS

DATA GATHERING THROUGH OBSERVATION, VIDEO RECORDING AND FIELD NOTES

VALIDATION OF EMERGING IDEAS WITH STAFF

Fig. 4.1. Research process.
Built into the research activity were cycles of learning in action (Zuber-Skerritt 2002a; 2002b). Iterative cycles were planned through repeated contact with participants. Contact with staff participants took the form of research encounters. This term reflects the broad nature of the working with participants. Encounters included: teaching about contact work, rehearsal in the form of role play, modelling in practice and observing staff using contact work in practice. There were also repeated encounters with staff (individual or groups), which facilitated reflection on practice, gathering staff experience and discussion, which led to refinements of practice and formulation of ideas to be further tested in practice. Data were gathered from the encounters with staff through observation and the use of video-recording. This process included my own participation in learning in action alongside the participants and joint inquiry as we explored the introduction of contact work together. The iterative nature of emerging ideas was made possible through these repeated encounters. This process permitted an ongoing process of validation with participants within the research process. This involved clarifying their thoughts and ideas, re-playing video recordings and creating a shared understanding of the experience through discussion.

Engagement with the Pre-Therapy Network took the form of attending yearly meetings in Europe and engaging in an ongoing email dialogue with Garry Prouty and other members. The meetings provided an opportunity to share, discuss and disseminate emerging ideas over a five year period. Contact with the Network also provided an opportunity for validation of my understanding of Pre-Therapy and contact work. This is discussed later in relation to the process of data analysis. The analytic process used comparative analysis and validation of emerging findings through repeated contact with participants and the Pre-Therapy Network members.
4.1.1 Key persons

Recruiting participants required navigation of organisational/managerial structures and negotiation with gatekeepers who determined access to participants. The research was vulnerable to changing agendas, which did not fit with my research agenda. Maximising commitment from others involved dovetailing the research agenda and the managerial agenda (Schatzman and Strauss 1973; Harrington 2003), and strategic planning to promote the research. This was based on symbolic exchange with mutual value to both researcher and the organisation.

Three areas of compatibility were used to link managerial and researcher agendas in order to counteract vulnerability:

i) Trust agenda for research and development in practice and the researcher agenda for introducing innovative practice.

ii) Trust agenda to implement the National Service Framework for Older People. Researcher agenda to explore clinical care and communication with people with dementia which is part of the National Service Framework.

iii) Trust agenda for staff learning, supervision and development. Researcher agenda of using Action Research process with explicitly offered learning, support and supervision of practice.

Regular information was provided to senior management, Nurse Executive and staff at Strategic Health Authority level. The research was promoted as being valuable to the organisation by presenting the study as an opportunity for the organisation to develop innovation and expertise. The exchange of mutual value included agreeing to represent and promote the Trust at conference presentations and other means of dissemination. Repetition of information was necessary when personnel changed and reorganisation of the Trust structure changed lines of management.

Gatekeepers are in a position ‘to support or thwart a study’ (Waterman et al 2001: 32). Potential dangers of opposition, resistance, and lack of
support have been addressed in the methodology in relation to participation, but are also apparent where the organisation does not recognise the significance or benefit of the research to stakeholders and gatekeepers. A more benign threat is instability arising from the organisational context. This is reflected in this study, for example, on an organisational level the Trust was undergoing major restructuring leading to changes. At a local level there were changes in ward manager on two research sites and on a personal level my line manager has changed four times in six years. In addition the turnover of nursing staff slowed down the research process. As a result, the preparatory work with gatekeepers and potential staff participants was labour-intensive. Arranging meetings with staff was difficult because of practical obstacles of contacting staff who work shifts, last minute cancellations due to staff shortages, sickness or work demands. An extract of the audit trail (Appendix 3) illustrates how access was affected.

No gatekeepers were full participants. The number of gatekeepers (staff) overall was 11:

- Site A – 2, Unit Manager, Ward Manager
- Site B – 3, 2 Service Managers, Deputy Manager
- Site C – 3, Service Manager, Ward Managers
- Site D (not used) – 1 Service Manager
- Others – 2 Consultants in Old Age Psychiatry.

The ward with the most stability in leadership at ward management level recruited most participants, indicating that stability of gatekeepers is significant in Action Research spanning a period of time in an unstable context. Securing participation involved adopting principles of exchange and giving: information about the study was offered and repeated where necessary, and additional teaching sessions on topics not related to the study were given in exchange for contact with staff to recruit participants. For example, on research site B a total of 14 staff attended initial teaching sessions on Pre-Therapy, which led to recruiting three subjects. Exchange was apparent as the Unit Manager requested certificates of attendance to help fulfil her audit of training requirement. Presentations
at two carers' meetings (ten carers in total) were given. The mutual exchange approach possibly eased some of the practical difficulties of access.

Research sites

Three sites participated and are referred to as Sites A, B and C. A fourth site withdrew at the consultation stage, stating a priority to improve basic care rather than introduce new practice.

Site A — A 22-bed National Health Service continuing care mental health facility. People with dementia, some with challenging behaviour, who cannot be cared for in residential or private residential care settings, are admitted to this unit. Staffing levels vary, but commonly would include one trained staff (Registered Mental Health Nurse) and four untrained staff on a morning shift, and one trained and three untrained on an afternoon shift. The ward is a lower ground floor self-contained unit, housed within a larger unit with two other wards which offer long-term physical care for older people. Variations in staffing levels mean that there are times when agency and bank staff are used; however, the core permanent staff have been relatively static. The Ward Manager and the Deputy Ward Manager are well established and remained stable during the research. There is a garden which is frequently used and the atmosphere is friendly and relaxed, and the involvement of relatives is encouraged. The staff have an established relatives group, occupational therapy input and consultant cover from the Older Persons Mental Health Directorate. Each resident has his or her own room. The layout allows for people with dementia to walk freely, there are two sitting areas and a conservatory overlooking the garden. This unit was due to be moved in August 2005. This was delayed. The unit closed in October 2006 and the service was relocated and incorporated into a new service run jointly with social services on a new site. Staff were either redeployed or relocated to the new service or to site C as a temporary measure.
Site B – A 20-bed wing. The unit was part of a national private organisation which had contracts with local Social Services and the National Health Service to provide beds alongside privately funded beds. The facility offered some respite care but mainly long-term and permanent accommodation for people with dementia. Staffing levels usually were four staff per shift. The numbers of permanent qualified staff was low during the research period. At one point this dropped to one trained nurse (State Registered Nurse, not Mental Health) and one enrolled nurse (mental health). Agency and bank staff were used, and the unit had recently recruited a number of eastern European staff. Although no formal relatives group was in place, contact with relatives was encouraged and visiting by relatives was flexible and welcomed. The unit manager of the facility changed once and a new deputy was appointed during the research period. Each resident has his or her own room and two communal areas provide space for people to walk freely.

Site C – A 17-bed NHS assessment unit for dementia housed within a general hospital building. Despite adaptations to the environment, the ward was small and people with dementia had limited space to walk. As an assessment unit, the expectation was that people would stay for short periods. However, difficulties in finding residential placements for people meant that some people remained on the unit for longer than anticipated. The input from the multidisciplinary team is high. Staffing ratios include higher numbers of qualified staff than either site A or site B, but it experienced similar variations in the numbers of permanent staff and agency and bank staff. The Ward Manager changed three times over the research period. There was a period where the Deputy Ward Manager was temporarily promoted to cover the Ward Manager, but he left shortly afterwards. There were two dormitory areas and five individual rooms. The site was scheduled to be closed and relocated into the building housing Site A in December 2006. The moved occurred in February 2007. Staff were either redeployed to other services within the Trust or moved with the ward to Site A.
Sampling

In order to recruit staff participants, the following approach was taken. An initial presentation/workshop about Pre-Therapy was given. Staff were invited to participate in the research, given further information, and initial consent was sought (Appendix 4). Then, further meetings were scheduled, offering further teaching opportunities, and I began planning with Ward Managers and potential participants how we would organise times to meet. The total sample was 11 staff. Sampling was purposive in the choice of the research sites. Criteria for staff were that they were permanent staff and that they had worked with people with dementia for over six months. Variations in staff sample were apparent – three staff were qualified (one Registered Mental Nurse, one Enrolled Nurse, one State Registered Nurse); seven staff were unqualified Nursing Assistants. One member of staff had the role of being an Activity Support Worker but also had the additional qualification of being an Accredited Person Centred Therapist. This person proved to be a critical case (Patton 1990), having unique features of a psychotherapy background and a non-nursing role. The sample were self-selecting, expressing interest in participation, and snowballing occurred in two sites where three participants were suggested to me. However, a cautious approach was needed; a manager suggested a staff member whom they felt required additional training to address poor performance. This instance illustrated the potential danger of staff being 'volunteered' by others who were driven by personal motivations.

The sample of participants was similar, all working in residential settings with people with dementia but with sufficient variations to view the sample as multiple-cases (Miles and Huberman 1994; Stake 2000). Variations arose from the fact that there were three research sites which were not identical in the service they offered, that there were a mixture of qualified and unqualified nursing staff, and that one participant was included who was not in a nursing role and also held a psychotherapy qualification.
Staff participants selected people with dementia to work with. Collaboration in the detail of the research process meant staff determined whom they worked with and the pace at which they practised using contact work with residents.

Once staff identified people with dementia as potential participants, relatives were approached, offered information and their assent sought for video recording. Posters displayed information about the research and carers were directly approached through the carers group (Site A) and by arranging a meeting with relatives of possible participants (Site B). Although the number of people with dementia participating is only three, staff used the contact reflections with other people as part of their daily interactions with residents. The numbers of staff and relatives approached and subsequent numbers of participants appear in Fig. 4.2.

<table>
<thead>
<tr>
<th>Staff and people with dementia (via relatives) approached</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of staff attending preliminary teaching session or presentation about Pre-Therapy and the research</strong></td>
<td>Site A – 15</td>
</tr>
<tr>
<td><strong>Number of relatives approached either individually or at carers’ meetings</strong></td>
<td>Site A – 7</td>
</tr>
<tr>
<td><strong>Total number of participants recruited</strong></td>
<td>Site A – 7</td>
</tr>
<tr>
<td>Staff participants</td>
<td></td>
</tr>
<tr>
<td>People with dementia (whose relatives agreed for the person with dementia to be video recorded)</td>
<td>Site A – 1</td>
</tr>
</tbody>
</table>

Fig. 4.2. Recruitment of participants.
A variety of reasons for the disparity between the numbers approached and the numbers recruited can be offered. These thoughts remain speculative as no official mechanism was sought to elicit why people chose not to participate. Lack of interest of staff was the most likely reason for non-recruitment of staff. Some preliminary teaching sessions or presentations were met with a relatively unenthusiastic response, or staff had been sent to attend as part of their in-house training. Some staff who attended sessions were passive in the learning environment and this may be a contributory factor, as engagement in research requires some energy and activity on the part of participants.

Relatives were unanimously enthusiastic about the research and supportive of any measures to improve care. However, it was difficult to follow up relatives once they had received information, as their visits to the unit were unpredictable, and only site A had a relatives' meeting, which was not attended by all relatives. The rapid changes of ward manager on Site C was a barrier to being able to recruit participants.

Staff participants, pseudonyms and profiles
Staff participants have been ascribed pseudonyms and a short profile is offered below. Pseudonyms were given with the initial letter of the name matching the letter given to the site.
Site A

- Apollo, Nursing Assistant – worked on the unit for about a year. His outside commitments meant he had additional pressures from undertaking his NVQ, and supporting a young family in the UK and needing to make visits to support his family in Africa.

- Anna, F Grade Charge Nurse - worked with dementia for over 15 years mainly in residential care settings. She has previously undertaken training courses specific to dementia care.

- Ayline, Nursing Assistant – about four years' experience of working with dementia. Previous occupation – secretarial work.

- Alison, Nursing Assistant – many years' care work experience in both physical care and more recently dementia care.

- Adam, Nursing Assistant – ex-Falklands veteran. Worked on Site A for about six years.

- Andy, Nursing Assistant – used to be a builder. Joined Site A six months ago, new to dementia care.

- Amy, Ward Manager – not strictly a full participant, but frequent contact and involvement in project and requested to do a video interview.

Site B

- Brian, Enrolled Nurse (general nursing) – longstanding member of site B. Worked with dementia for 16 + years, considering doing his Registered Mental Health Nurse training.

- Bruno, Nursing Assistant – awaiting recognition of his general nursing registration from Germany. Romanian by birth. Varied nursing experience including dementia. Has worked on the unit for six months.

- Barry, Nursing Assistant – worked with people with dementia for about 20 years, currently doing an Open University degree in social science.

Site C

- Cathy, Support Worker/Nursing Assistant – combined role of Activities Worker plus some Nursing Assistant hours to assist with physical care at lunchtime. Trained in Person Centred Therapy as a counsellor. She obtained registration as therapist towards the end of the research.
Features which unify the sample are: experience working with people with dementia, motivation to engage with the research, an understanding of the effect of dementia on lessening the capacity of people and similar service provision on each site. Diversity within the sample comes from variations in age, ethnicity and life experiences, length of time working in dementia care, role and status. Despite variations, sampling could be viewed as using comparable case selection with sufficient diversity to offer variation (Miles and Huberman 1994).

People with dementia
Staff used the contact reflections in daily practice with a variety of people with dementia. Assent was obtained for video recording of three people with dementia:

Mr AS (Site A). Assent was given by his wife. He had been on the unit for over six months. He had little language and spent much time walking around the unit. He had been aggressive to others, on occasions requiring restraint by staff.

Mrs KP (Site A). Her daughter-in-law, who has power of attorney, gave assent. She cannot walk and uses a wheelchair. Her speech is difficult to understand. She used to be a lecturer in mathematics.

Mrs YS (Site B). Assent was given by her husband. She spends her day walking slowly around the unit. She has little language and makes sounds and grinds her teeth. She rarely acknowledges other people.

Attrition of staff participants was a problem. Two staff participants left during the period of data collection. Barry went on holiday and never returned, and Andy left nursing to return to building work. However, they completed initial learning cycles and video data was captured about their experiences. One staff participant (Ayline) withdrew after the third interview because she found the response to the techniques upsetting. This will be explored as part of the findings. All the people with dementia remained stable.
The time spent in practice on the research activity is difficult to quantify. This is not offered as an excuse for inadequate logging, rather aiming for an honest account of the challenges faced in a research process which is ongoing, embedded in practice and incorporated into an existing role and relationships in practice. Whilst good practice research guides emphasise the importance of logging research activity (Lofland et al 2006), the following rationale is offered to justify why it was not possible to capture every detail of research activity, particularly activity which is located and sustained in context:

*Capturing all data is unrealistic.* Although the audit trail captures contacts with research sites, some encounters are intertwined with other work. For example, as part of my work role, I would be attending Site A for something other than the research; conversations about Pre-Therapy might arise with staff as an adjunct to the purpose of my visit. For example, I might come into contact with participants in other contexts and there would be casual conversations about their practice or experience. Recording every casual or small conversation is unrealistic.

*Opportunistic data collections and being unprepared.* There were times when I did not have the video camera to hand, or I found myself having an impromptu encounter and no time to get the camera.

*Technical error.* For example, on 7.1.05 I spent 2½ hours teaching, practising and discussing contact work with four participants. I was aiming to record the discussion after they had been onto the ward practising the techniques. Novice technical skills meant I failed to record this discussion.

*Over-immersion in context.* For example, it was difficult to separate out my experience as a worker within the Trust, and when this experience was personal contextual data. Arguably all personal experience was data, but it was unrealistic to record all Trust activity. My Trust role involved 15 hours per week; for an 18-month period a day a week was assigned solely to activity related to the research.

Extracts from the audit trail illustrate the difficulty of quantifying the exact number of hours spent on the research activity. Below is a snapshot of time involved in trying to secure collaboration and mobilise interest in the project. It is unlikely that the audit trail captured every contact, conversation and phone call needed to secure participation. Whilst this
detracts from the quality of data it shows the difficulty in recording every moment of research activity when the activity is so closely embedded in everyday work.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.6.04</td>
<td>Introduce idea to Research Site A — Ward Manager — who introduced me to possible Nursing Assistant participant.</td>
</tr>
<tr>
<td>1.7.04</td>
<td>Phone conversation with XXX about using Site D</td>
</tr>
<tr>
<td>2.7.04</td>
<td>Phone call to Locality manager re: using Site C</td>
</tr>
<tr>
<td>7.7.04</td>
<td>Meeting with new Manager of Site B, (previous Manager on long-term sick leave) — she's agreed to unit participating, allowing me access. I need Criminal Records Check as this site belongs to a different organisation.</td>
</tr>
<tr>
<td>7.7.04</td>
<td>Popped on to Site C — the new Ward Manager appointed last month is now off on compassionate leave (she subsequently left one month later). Saw two Nursing Assistants, I know from previously having done some work on this unit, they were interested, but need to secure senior nurse help and support. Difficult at present.</td>
</tr>
<tr>
<td>17.7.04</td>
<td>Meeting with Research Site A gatekeepers — set time for staff teaching and appearance at carer's meeting.</td>
</tr>
<tr>
<td>23.8.04</td>
<td>One-hour teaching at Research Site A wing — presentation and recruitment of participants.</td>
</tr>
<tr>
<td>31.8.04</td>
<td>Letter faxed to A2 asking her to distribute the formal invitations to which people will reply. Suggesting outlines of next teachings.</td>
</tr>
<tr>
<td>2.9.04</td>
<td>Meeting with B3 — new acting Senior Nurse at Research site B — Previous Manager has left.</td>
</tr>
</tbody>
</table>

The next extract illustrates a flurry of activity and recording and a period when more time and energy could be devoted to the research activity.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.05</td>
<td>Phoned during morning to check they were still OK for me to visit. Session with Group 2 on Site A — including Anna — Deputy Ward Manager also included as linking person, video did not work, see memo reflecting on teaching.</td>
</tr>
<tr>
<td>12.1.05</td>
<td>Phone call to Site B — told that as I had not heard anything I'd come and see her, appt arranged for 14.1.05.</td>
</tr>
<tr>
<td>14.1.05</td>
<td>Meeting with manager Site B plus enrolled nurse — see reflective diary.</td>
</tr>
<tr>
<td>15.1.05</td>
<td>Letter sent to Site B following meeting yesterday — offered eight dates for doing either a three-hour training or shorter depending on unit.</td>
</tr>
<tr>
<td>17.1.05</td>
<td>Phone call to Amy to check arrangements for next meetings with staff.</td>
</tr>
<tr>
<td>17.1.05</td>
<td>Unexpected event — one of my personal students (in my University role) put me onto Cathy as potential participant, he knows about Pre-Therapy and the research from my teaching role at Uni. Met Cathy, spoke to her for about 30 mins about project.</td>
</tr>
<tr>
<td>18.1.05</td>
<td>Posted project outline and info to Cathy, happened to bump into her at XXX (Venue) again, spent 10 mins talking about how it related to her psychotherapy training.</td>
</tr>
</tbody>
</table>
Together, these extracts show the messy and unpredictable nature of the research and are a reflection of the real world context. However, Fig. 4.3 offers specific quantities of research activity in order to provide some concrete information about research activity, although this does not capture the unquantifiable research activity.

<table>
<thead>
<tr>
<th>Research activity</th>
<th>February 2002 - August 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconnaissanc period formal teaching sessions</td>
<td>7 teaching sessions (minimum 2 hours, maximum 3 hours)</td>
</tr>
<tr>
<td>(Pre-Registration Diploma in Mental Health Nursing, Post-Registration Dementia Module, Post Registration Community Mental Health Nurse Practitioner Degree)</td>
<td></td>
</tr>
<tr>
<td>Teaching as self-participation in learning and dissemination.</td>
<td>8 formal workshops minimum 2 hours each.</td>
</tr>
<tr>
<td>Delivery of workshops to outside organisations:</td>
<td></td>
</tr>
<tr>
<td>University of Paisley, Gerontological Society, Stroke Interest Group,</td>
<td></td>
</tr>
<tr>
<td>Rampton Special Hospital, International Pre-Therapy Network meeting (x3), Prague Pre-Therapy workshop (co-facilitated with Garry Prouty)</td>
<td></td>
</tr>
<tr>
<td>Active period of research process (teaching staff, encounters with staff, learning in action, co-learning with staff)</td>
<td>August 2004 - August 2005</td>
</tr>
<tr>
<td>Number of weeks worked which included between one and two days per week devoted to research study in the Active period (August 2004 - August 2005)</td>
<td>49</td>
</tr>
<tr>
<td>Numbers of formal teaching sessions or presentations in research sites settings</td>
<td>10</td>
</tr>
<tr>
<td>Number of separate episodes of video recordings</td>
<td>33</td>
</tr>
<tr>
<td>Video recordings – total hours of footage</td>
<td>14 hours 38 minutes</td>
</tr>
<tr>
<td>Number of yearly attendances at the International Pre-Therapy Network</td>
<td>6 (2001 - 2006)</td>
</tr>
<tr>
<td>Total number of encounters with individual participants video recorded</td>
<td>41 encounters (on 33 occasions)</td>
</tr>
<tr>
<td>Number of encounters recorded on video with each participant</td>
<td></td>
</tr>
<tr>
<td>Anna</td>
<td>6</td>
</tr>
<tr>
<td>Apollo</td>
<td>3</td>
</tr>
<tr>
<td>Ayline</td>
<td>3</td>
</tr>
<tr>
<td>Alison</td>
<td>6</td>
</tr>
<tr>
<td>Amy</td>
<td>1</td>
</tr>
<tr>
<td>Adam</td>
<td>5</td>
</tr>
<tr>
<td>Andy (not including video where sound failed)</td>
<td>2</td>
</tr>
<tr>
<td>Brian</td>
<td>3</td>
</tr>
<tr>
<td>Barry</td>
<td>5</td>
</tr>
<tr>
<td>Bruno</td>
<td>3</td>
</tr>
<tr>
<td>Cathy</td>
<td>4</td>
</tr>
</tbody>
</table>

Fig. 4.3. Research activity.
4.1.2 Resources

The viability of Action Research can be questioned (Busza 2004). Projects are at risk of fading out due to the reliance on funding, time and unstable work settings (Waterman et al 2001). However, these features are the real world context of health care. The position taken is that conducting Action Research in this context simply mirrors the context in which research findings are to be implemented, making it even more imperative to conduct research in the real world context.

To try to combat barriers of time and finances, extra funding was sought from the Strategic Health Authority and replacement costs for two days of my post was obtained for one year. Achieving this was time consuming and I felt that reliance on funding increased my vulnerability and job insecurity. The funding was not sustained, and time available for research activity shrunk and had to be incorporated into my usual workload. The instability of services culminated in plans for the relocation of two research sites in 2005. This generated uncertainty for staff and was fraught with delays; the units finally moved in 2006. In spite of these difficulties, research activity persevered, incorporating it into the everyday staff activity with minimal disturbance to work patterns, staff rotas and existing resources. The purpose of this was twofold. First, to reduce additional burden from taking part in the research activity. Second, in order to avert additional resistance, all research activity took part at the convenience of staff participants, ward managers, and relatives. This meant contacting staff at weekends and evenings. The instability of staff had to be accepted. The demands of the units determined the availability of staff and I took opportunities to interview whoever was available.

The research process, key persons and resources form three of the features of Action Research (Waterman et al 2001). The remaining feature (methods) is explored in detail in the next section.
4.2 Methods

Action Research requires methods which can capture the unfolding nature of the research process, reflect the real world context and portray the relationship between the researcher and the participants. For this study data collection was opportunistic as well as pre-planned and used formal and informal encounters. The data illustrates the life history of the research process and documents my own participation (McNiff and Whitehead 2006). A variety of methods created a *thick description* (Holliday 2002). The primary methods were observation and interviewing, using video recording as the overarching medium for data collection. Field notes, emails and a reflective diary were also used to record data. Together these methods addressed the question: *What happens when staff learn and use Pre-Therapy contact reflections?*

**Observation**

Observation covered a variety of activities, the most obvious being watching staff practising and using contact reflections with people with dementia. Some observations were planned and some were unplanned. Field notes recorded observations about context and the reflective diary provided an historical account and captured ideas for development. Personal reflective accounts recorded self-observation (Koch and Harrington 1998).

The data reflects the intertwined nature of self-participation in collaboration with others. This complicates observation, as self-participation influences the actions of the participants as well as holding the potential to bias data or influence analysis (Torbert 2001; Ladkin 2005). Other people's awareness of being observed could be seen on a continuum (Adler and Adler 1998; Fontana and Frey 2000). When the video camera was used, observation was obvious. Without the video equipment, observation became less explicit. Staff participants and gatekeepers were aware the research included me observing, so their level of awareness was high. I would sometimes openly make notes,
often telling people that I needed to write things down to reinforce the episode as research activity. On the other hand, there were occasions when new staff or staff not involved in the research were present. These staff were less aware or even unaware and, whilst not participants themselves, they formed part of the social landscape of the units in which participants worked (Lofland et al 2006). In this respect, observation of other staff was at times unavoidable and contributed to the relational and contextual aspects of the research settings. Although each unit was aware of the research, individuals' level of interest varied. Less formal periods of observation also provided data which was free from staff 'performing' or reacting to being observed (Bowling 2002).

Another issue was separating out my own knowledge and bias, whilst at the same time valuing my own experience. Although my own active role in the research helped towards knowing through doing (Merleau-Ponty 1962), this needed to be balanced by keeping an open mind to the different experiences and perspectives of others. Therefore, staff were encouraged to reflect on their own experiences with me in order to have their experience heard. Personal written reflections separated descriptions, behaviour and events from thoughts and feelings to help facilitate critical self-reflection on my action within the field (Appendix 5). This helped capture emerging ideas and aid the continuous analytic process and ongoing reflective cycles. In turn, this activity contributes to the process of data analysis, which was creating links between my experience, others, observations and theoretical ideas (Miles and Huberman 1994). The reflective diary recorded events, for example attendance at the yearly Pre-Therapy Network meetings. The merging of my own participation and observation is reflected in the diary. Ideas were expanded in memos and the reflective diary, which captured thoughts that contributed to generating theoretical ideas (Chitpin 2006).
Encounters with staff

Action Research includes learning through critical reflection and ongoing joint inquiry which includes learning in action as part of the research process. As a result, interviewing was not sufficient to capture data. An alternative term to 'interviewing' has been chosen which reflects how the episodes of engagement with participants extended beyond formal interviews or periods of observation; this term is encounters with staff. Encounters with staff had multiple functions: interviewing, supervising, teaching, facilitating reflection and mutual learning or inquiry. During encounters, staff needed to consolidate knowledge as well being given an opportunity to reflect on their experiences. The process of learning pointed to facilitated reflection within a democratic space, allowing mutual inquiry through the researcher/participant relationship. Encounters were with individuals or groups, and in both the researcher role was as co-participant. The encounters could best be described as being a blend of unstructured interviews, instruction, supervision, reflection and discussion (Fontana and Frey 2000; Johns 2000; Driscoll and The 2001). The blend of functions raised the potential for lack of clarity. However, this was tempered by being explicit to participants about the purpose of the meetings, being overt about the blend of functions and allowing for staff to have the opportunity to learn, reflect and discuss their experiences. In this way the multipurpose function of the encounters could still keep to principles of learning in action (Zuber-Skerritt 2002a).

Some encounters with staff were in groups. The potential drawback of group interviews, which may lead to 'groupthink', needs to be balanced with the benefits of working with groups (Fontana and Frey 2000; Johnson and Johnson 2003). Groups strengthened the message that the research was collaborative, providing a space where staff were mutually supportive, challenged each other and developed a common understanding of the Pre-Therapy techniques and how to use them. This drew on principles of group supervision, group reflection and clinical supervision (Van Ooijen 2000; Cutcliffe 2001) and required approaching
the meetings with staff with a mixture of roles: interviewer, facilitator of reflective learning and a participant in reflective learning. Group encounters contained structured reflection, for example, drawing on Johns' reflective cycle. This parallels models of clinical supervision (Johns 1995; Bond and Holland 1998; Bourner et al 2000a, 2000b; Driscoll et al 2000; Gilbert 2001; Doi and Ikemi 2003). Underpinning this approach was the need to value and reinforce staffs' practice, challenge practice and invite them to review practice from different a perspective, give feedback on their use of the contact reflections where necessary as well as use open-ended questions to explore their experience (Hannigan 2001; Grech 2004).

Group encounters which occurred after staff had received initial instruction about Pre-Therapy were more unpredictable than initial encounters which were focused more on instruction and experiential learning. Latter encounters commonly were started with an opening inquiry such as 'Tell me what your experience has been'; the direction or nature of the encounter was mainly led by participants. Some encounters were more clearly educative or informative; some more clearly had an interview function; in other encounters there was more blending of purpose.

At times it was necessary to make judgments about the direction of an encounter. For example: whether to encourage staff to reflect, offer support, elicit experiences or difficulties, direct/follow a line of discussion, challenge practice, clarify their knowledge, or simply to stay silent and listen. As well as being unpredictable, the combination of possibilities may have compromised depth in any one aspect and encounters sometimes flitted in different directions. This may have led to superficial reflection or learning, insufficient learning, and inadequate opportunities for staff to review their experiences in depth. This was an ongoing source of personal anxiety, sustained throughout the research process. However, this anxiety was positive as it drove constant critical reflection of my own skill and role in the research. Despite this, the lack
of depth continued to haunt me. However a position of having to accept that *this was the data*, and *this was the experience of the research*, became incorporated into the data analysis. It could be argued that this anxiety contributed towards sustaining inquiry, preventing premature foreclosure of ideas. Generally the approach taken was to trust the self-knowledge and experience of staff, let them direct the encounter, and where necessary intervene and change direction when my knowledge, experience or curiosity prompted exploring one aspect in more depth.

Practical concerns steered the decision to meet with staff individually or in groups and the ward environment determined the availability of staff. In the initial stages of the research group meetings were arranged so that staff could receive initial information and teaching about contact work. This meant that units needed to make special arrangements to release staff in order for participants to be free to leave the unit. After an initial teaching session I moved towards a position of not disturbing the environment or their work patterns, taking opportunities to interview whoever was available, or arrange my time around their work patterns. Adopting the strategy of minimal disruption meant that planning further encounters with staff varied widely. Initial teaching sessions lasted between one and two and a half hours, and subsequent meetings varied between an hour, as little as seven minutes, or not being possible at all.

Conducting research with minimal disruption meant encounters were exposed to the features of the context. Interruptions were a particular feature of encounters in one site. A spare bedroom was used for the interviews, but a hoist was stored in this room that was sometimes needed by staff, and on occasions other interruptions came from staff needing to ask questions of one participant who held a more senior position. On another site a meeting room adjoining the ward was used and no interruptions occurred, but lateness was a feature as staff had to negotiate their release for a research encounter. The participant from the third site was interviewed in an office away from the unit and, as will be seen later, her work role was different from other participants in that she
had more autonomy over her own time. By aiming for minimum disruption I maintained my commitment to working in the real life context, however this was frustrating and some doubt remains as to whether this was the best approach. Locating learning within practice settings brings to the fore awareness of the effect of contextual factors on practice development and the limits they impose on achieving depth and quality of reflection and learning.

It was necessary to collect data which captured staff participation and self-participation and use a medium which was flexible enough to permit me to move between being a participant alongside others and a partial outsider observing. Video-recording provided this and the argument for video as a primary data collection tool is presented below.

4.2.1 Video as a medium for data collection

Video recording is the method that ties together observation and encounters with staff. Historically, video has been used in covert observation of social interactions, although ethical issues now prohibit this (General Medical Council 2002). There is a tradition of using visual information (film, television, video footage) to explore social phenomena and, more recently, to make observations over sustained periods of time (Harrison 2002; Vass et al 2003; Hesse-Biber and Leavy 2004). Despite criticism that video does not capture contextual information, brief elements of context appear where video is used in health care settings where actual care is being carried out (Bottorff 1994). In relation to dementia there has been an increase in the use of video (Cook 2002; Aggarwal et al 2003; Skovdahl et al 2003; Knight 2005). It has been used as a medium to capture the experiences of people with dementia and interviews with people with dementia where additional information from the visual and non-verbal communication is required (Cook 2003; Knight 2005). This is particularly relevant given the non-verbal aspect of Pre-Therapy (Prouty et al 2002).
Video captures dense and permanent data with validity in relation to analysis of interactions and emotions (Hanson 1994; Rose 2004), making it preferable to audio recording or observation supported by note taking (Knight 2005). However, commonly, video material is used solely as data, rather than an activity that is used as part of the method. Within this study, videoing was used as an active part of the research process, providing a medium which was flexible enough to gather information while staff were learning and using contact reflections, record interviews, capture information that was non-verbal, and capture contact with single, pairs and groups of participants (Erikson 1992). In addition it allowed movement between positions of being on the outside looking in, being a co-participant, and being fully immersed as a participant (Finlay 2002). As an outsider, I could stand behind the camera and film staff in interactions with people with dementia, and as a participant I could be in front of the camera and have another participant film my interactions with people with dementia. The benefit of using video to record the teaching and learning process of staff comes from being able to separate my participation from the recording of data. The video could be reviewed afterwards, allowing me to concentrate on what I was doing as well as gathering data, and be a participant in group reflection (Frake and Dogra 2006). I found literature supporting the use of video as an active part of research some time after I had finished collecting data. Shrum et al (2005) published what they term a 'primer' on the use of digital video as a modern methodology. They argue that technological advances have changed the field of visual ethnography, partly because they are readily available and portable. Shrum et al argue that video recording has an interactionist perspective, whereby the camera becomes an actor in the drama of a project. They also describe how video creates a 'fluid wall', meaning that behaviour and observations happen both in front of and behind the camera. Roles blur because the researcher-subject boundary can be fluid, and roles of observer and participant are changeable depending on who is filming, watching or performing, or watching recordings on playback. This reflects the experience during the research: staff filmed me, I filmed them, together
we watched their practice on film and, at times, the camera was static so that one-to-one encounters and group encounters were filmed with all parties being in front of the camera. In this sense, the act of videoing became part of the research process itself, not simply a neutral tool for gathering data.

To some extent video offered a thread of continuity – learning was videoed, as were interactions and interviews. In addition to continuity, it accommodated capturing data for different purposes such as: the learning process by staff, recording experiences, recording joint inquiry and recording the use of the techniques by participants with people with dementia. Videoing encounters provided the flexibility needed for the learning process which also captured data particular to the research inquiry (McGill and Beaty 1995). Specifically, video permitted data collection on the following aspects of the research question:

- **What happens when staff learn?** – the video recording captures data on the teaching and learning of contact reflections
- **What happens when staff use?** – the video records observations of staff implementing their learning by recording (limited) episodes of using contact reflections with people with dementia
- **What is their experience?** – interviewing gathers the perspective of the staff.

In addition video enabled the relationship aspect of the research to be recorded. At times I was in front of the camera alongside participants. Here, mutual inquiry was evident in dialogue which focused on sharing ideas about how the contact reflections applied to people with dementia. Another benefit came from staff being able to review their own practice by watching the video recording and then reflecting on themselves (McNiff 1992). There were two practical advantages. First, video provided a permanent record of staff using contact reflections that could be shown, with consent, to members of the Pre-Therapy Network, which allowed for validation of whether staff were using reflections and second the video could be used with people with dementia who were on the move (Lucero 1993).
In total, 33 episodes of video were recorded, totalling 14 hours 38 minutes (Fig. 4.4). Some were long encounters which, being more akin to interviews, gathered their experience (e.g. Cathy, VHS13/22.3.05). Other videos recorded discussions with participants before and after episodes where I had been modelling the techniques in practice or had observed them (not videoed) in practice (e.g. Adam, VHS 16 & 17. 6.5.05).

<table>
<thead>
<tr>
<th>VHS No.</th>
<th>Date</th>
<th>Participants</th>
<th>Duration (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29.11.04</td>
<td>Anna, Ayline, Apollo, Alison</td>
<td>60</td>
</tr>
<tr>
<td>2</td>
<td>29.12.04</td>
<td>Anna, Ayline, Apollo, Alison</td>
<td>60</td>
</tr>
<tr>
<td>3</td>
<td>1.1.05</td>
<td>Anna, Andy, Adam</td>
<td>43</td>
</tr>
<tr>
<td>4</td>
<td>10.2.05</td>
<td>Ayline</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>10.2.05</td>
<td>Andy</td>
<td>15</td>
</tr>
<tr>
<td>6</td>
<td>10.2.05</td>
<td>Alison</td>
<td>17</td>
</tr>
<tr>
<td>7</td>
<td>15.2.05</td>
<td>Anna</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>15.2.05</td>
<td>Apollo</td>
<td>10</td>
</tr>
<tr>
<td>9</td>
<td>24.2.05</td>
<td>Cathy</td>
<td>56</td>
</tr>
<tr>
<td>10</td>
<td>17.3.05</td>
<td>Brian, Barry, Bruno</td>
<td>59</td>
</tr>
<tr>
<td>11</td>
<td>17.3.05</td>
<td>Amy</td>
<td>18</td>
</tr>
<tr>
<td>12</td>
<td>18.3.05</td>
<td>Adam</td>
<td>21</td>
</tr>
<tr>
<td>13</td>
<td>22.3.05</td>
<td>Cathy</td>
<td>60</td>
</tr>
<tr>
<td>14</td>
<td>1.4.05</td>
<td>Brian Barry, Bruno</td>
<td>60</td>
</tr>
<tr>
<td>15</td>
<td>22.4.05</td>
<td>Cathy</td>
<td>57</td>
</tr>
<tr>
<td>16</td>
<td>6.5.05</td>
<td>Adam, Adam and KP</td>
<td>18</td>
</tr>
<tr>
<td>17</td>
<td>6.5.05</td>
<td>Adam</td>
<td>12</td>
</tr>
<tr>
<td>18</td>
<td>6.5.05</td>
<td>Anna</td>
<td>25</td>
</tr>
<tr>
<td>19</td>
<td>15.5.05</td>
<td>Alison</td>
<td>14</td>
</tr>
<tr>
<td>20</td>
<td>15.5.05</td>
<td>Penny and KP, Alison and KP</td>
<td>13</td>
</tr>
<tr>
<td>21</td>
<td>15.5.05</td>
<td>Alison</td>
<td>6</td>
</tr>
<tr>
<td>22</td>
<td>15.5.05</td>
<td>Apollo</td>
<td>6</td>
</tr>
<tr>
<td>23</td>
<td>16.5.05</td>
<td>Brian</td>
<td>13</td>
</tr>
<tr>
<td>24</td>
<td>31.5.05</td>
<td>Bruno</td>
<td>46</td>
</tr>
<tr>
<td>25</td>
<td>2.6.05</td>
<td>Penny and AS</td>
<td>8</td>
</tr>
<tr>
<td>26</td>
<td>2.6.05</td>
<td>Anna and AS</td>
<td>16</td>
</tr>
<tr>
<td>27</td>
<td>1.7.05</td>
<td>Barry</td>
<td>31</td>
</tr>
<tr>
<td>28</td>
<td>1.7.05</td>
<td>Penny and YS</td>
<td>7</td>
</tr>
<tr>
<td>29</td>
<td>1.7.05</td>
<td>Barry and YS</td>
<td>9</td>
</tr>
<tr>
<td>30</td>
<td>1.7.05</td>
<td>Barry</td>
<td>25</td>
</tr>
<tr>
<td>31</td>
<td>22.7.05</td>
<td>Cathy</td>
<td>60</td>
</tr>
<tr>
<td>32</td>
<td>1.9.05</td>
<td>Penny and AS</td>
<td>9</td>
</tr>
<tr>
<td>33</td>
<td>1.9.05</td>
<td>Penny and YS</td>
<td>5</td>
</tr>
</tbody>
</table>

Fig. 4.4. Episodes of video recording.
Visual methodologies bring particular challenges (Harrison 2002). Ethical considerations result in video recording being rather complex in health care research and mental health care settings. Specific to this study are consent by people with severe dementia, confidentiality, practical issues, and the issues in interviewing.

**Consent and confidentiality**

As the people with dementia within the research sites were unable to give informed consent a safeguard was required. Existing strategies were followed: encouraging the person with dementia to handle the camera, view their own image, and ongoing monitoring of any signs of discomfort (Cook 2003; Dewing 2006). In addition, an assurance was made that the well-being of the person with dementia would be monitored and that filming would be stopped if they showed any discomfort. This was included in the research information sheet for relatives (Appendix 6). A low threshold for signs of discomfort was taken. Signs of discomfort included gestures and facial expressions from the person with dementia, drawing on theoretical ideas of the non-verbal expressions of ill-being (Kitwood 1997). In the absence of written or verbal consent by the person with dementia, assent was sought from relatives and consultation occurred with the responsible medical officer and the nursing team (Grout 2004). The consent and consultation process is shown in Fig. 4.5.
ABANDON or DISCONTINUE PARTICIPATION

Staff participant has received initial training in Pre-Therapy techniques, been given information about project, signed consent and had sufficient time for consideration

No

Yes

Staff member has identified a patient to work with

No

Yes

Patient has been consulted, given consent (if able) received Information. Project has been discussed in a way that is sensitive to cognitive difficulties, patient demonstrates willingness to participate

No

Yes

RMO and multi-professional team have been consulted, received information, information sheet placed in patient notes. MDT give approval

No

Yes

Patient's representative has been consulted, given information sheet, gives assent, form completed. Has had sufficient time for consideration.

No

Yes

Unit manager consulted, given information and agrees for video recording/data gathering to take place

No

Yes

PROCEED TO PREPARE TO START VIDEO RECORDING / DATA

No

Yes

Remind staff of conditions which will halt video recording (patient distress, other emergency, staff wishes to terminate recording). Staff agree to start recording

No

Yes

Consent / willingness to participate confirmed with patient. Patient encouraged to handle video camera and no signs of distress/dissent.

No

Yes

START VIDEO RECORDING

No

Yes

Patient continues to display verbal and non verbal contentment about presence of video camera and recording.

No

Yes

Continue to record.

Fig. 4.5. Consent and consultation process.
Confidentiality was complicated by having both staff and people with dementia as participants. Whilst it is difficult to anticipate ethical and legal issues in ownership and viewing of video footage (Williams 2003), measures were prepared in advance for Ethics Committee and Research Governance approval (Royal College of Psychiatrists 2000; Department of Health 2001b; Royal College of Nursing 2002). By anticipating potential scenarios which would challenge confidentiality, consent forms were created which catered for a variety of hypothetical situations. It was recognised that staff consent would be needed if a relative wished to view the person with dementia in an interaction with a staff participant (Appendix 7). Also, in this scenario, the relative would be required to sign a statement of confidentiality (Appendix 8). In this way the confidentiality of the staff would be protected whilst at the same time not excluding relatives.

Although guidance advises limiting video material being viewed by others (Department of Health. 2001c; General Medical Council 2002), it was anticipated that it might be desirable to have sufficient flexibility to be able to show the videos to members of the Pre-Therapy Network. Planning ahead for this involved building in additional statements seeking consent for this. These statements can be seen in the staff consent form and the assent form for the representative for the person with dementia (Appendices 9 and 10).

A further consent form was designed to allow staff and the patient's relatives to consent to allow video material to be used for training purposes (Appendix 11). This explicitly states that episodes of good practice can be used to be shown to a professional audience for teaching purposes and recognizes the value of recordings for teaching purposes (General Medical Council 2002). Overall, this aimed to balance confidentiality, valuing of practice, and dissemination of ideas.

The process of managing consent and confidentiality and creating multiple forms, whilst appearing complicated, was necessary in order to
anticipate possible dilemmas and provide a framework of consent to act in the interests of all parties involved; relatives, staff, Pre-Therapy network members, and people with dementia.

**Practical issues in the use of video recording**

Videoing staff interacting with people with dementia generated practical challenges from the environment and concern over the quality of recording. Filming was limited to common areas (no bedrooms or bathrooms), and filming other residents was avoided. Given that people with dementia and staff were sometimes walking during filming, it was necessary for me to walk backwards. Known as *guerrilla-style filming*, the use of hand-held filming can potentially lead to poor quality compared with *the editor's method* where the camera is mounted on a tripod (Shrum et al 2005). Sharpness was aided by the automatic focus on the camera; however, wobbling images, camera shake and the occasional thumb over the lens are apparent. The built-in spotlight on the camera proved distracting to people with dementia. Therefore reducing the use of the light lessened the intrusion of the camera, but also reduced the clarity when filming in dark corridors. A basic lighting technique of not filming with bright light behind people was also difficult to avoid where people with dementia were walking near windows and glass doors. But despite these factors affecting the quality of the images, the definition was adequate for analysis.

Overall, consent, confidentiality and practical issues proved the main challenges in using video as a medium. Consent and confidentiality were achieved and the flexibility of video allowed me to capture a variety of data. The benefits of using video lie in providing a dense and permanent record that is located in a real world context with the additional aspect of being part of the interactive nature of the research process. However, practicalities limit the quantity and quality of the data. In addition, video episodes do not record four important aspects: the historical and contextual features of the research sites, the life span of the research activity, relational aspects, and theory generation (Grimshaw 1982;
Therefore video is complemented by additional methods of observation and the reflective diary.

### 4.2.2 Audit trail, emails and reflective accounts

Additional methods of collecting data added depth to the data: an audit trail, email dialogue, reflective accounts by staff, memos and a reflective diary. The audit trail of research activity is discussed in more detail later in this chapter in relation to difficulties of access in the study.

Emails with Garry Prouty and other members of the Pre-Therapy Network are included as data. These provide an historical archive from 2003 (still ongoing), which document my reflective process and sharing ideas. These provide dialogue as a form of data that charts theory generation. This is bounded within my relationships with Network Members.

An additional method - reflective accounts from staff – proved relatively fruitless (Thorpe 2004). Only two staff did this, each on only one occasion. This was not pursued in order to avoid the research activity becoming a burden for staff. Whilst this limited the richness of the data, staff used the meetings to reflect on practice and these reflections are captured on video. The use of a reflective diary provided a rich source of data, permitting comparison of self in relation to others. Ongoing critical reflection was prompted in meetings with my research supervisors, leading to further notes in the diary. These notes often prompted writing theoretical memos, which were part of the simultaneous and ongoing activity of data analysis happening in tandem with the research activity.
When to stop?

The difficulty of Action Research being ongoing and living means a stopping point is difficult to identify. Therefore an artificial stopping point for working alongside staff was created as a critical point for evaluation and reflection. This judgement was influenced by the following:

- Using major service reorganisation as a natural stopping point. Site A closed and relocated as part of a merger with Local Authority care provision in another part of the county. Site C closed and subsequently relocated to the building previously housing Site A. Attrition and redeployment of staff accompanied these changes.

- Rich data source from 33 videos, reflective diary, emails and memos.

- Saturation of ideas, emergence of preliminary themes requiring time spent on analysis.

- Time pressures imposed by both organisation and timescales of the PhD program.

Had future cycles in practice been planned, six areas for exploration can be identified:

i) Comparing responses to contact reflections with alternative approaches or techniques with people with dementia.

ii) Recruitment of new research sites, which would permit consolidation of ideas about content and process of initial teaching sessions to staff and verification of the transferability to other settings.

iii) Re-engagement with Site C after the closure and relocation with the intention of attempting to recruit staff and investigate if the previous contextual conditions had changed to permit participation.

iv) Personal curiosity about lack of participation, searching for conditions which enhance readiness for engagement and practice
development. Knowledge about this might be useful for future attempts to introduce change.

v) The application of Pre-Therapy Contact Reflections to different client groups with cognitive impairment is indicated. The research activity has already generated preliminary interest from the University of Paisley Stroke Interest Group and nursing staff working in Rampton Special Hospital. As part of the preliminary evaluative reflective cycles both groups have received an initial workshop about Pre-Therapy and the contact work. Each group demonstrated a similar response, seeing the immediate potential for their client groups.

vi) Introduction of contact work to staff working with older people with functional mental health needs.

However, the iterative process, engagement with the Pre-Therapy Network and others outside the three research sites, has continued to date. At the time of writing I am in the process of inviting people to join a regional Pre-Therapy Interest Group with a view to continuing to explore the application of Pre-Therapy in mental health settings and counselling roles.

4.2.3 Summary of methods of data collection

The primary sources of data were observation, meetings with staff and the reflective diary. Other methods of collecting data added to the depth of data, namely, the reflective diary, the audit trail, email dialogues, and the (limited) data from staff writing their own reflective accounts. In order to give some detail of the life history of the research activity, the following section discusses the project process and management, access, resources, context, sampling and detail about research sites and participants.
4.3 Validation

Validation, or member checking, has been an active part of the analytic process, fitting with the epistemological position which sees meaning created within a social context and through social interactions (Blumer 1969; Lofland et al 2006).

For Lofland, member checking involves:

...the solicitation of group or setting member's assessment of the research's hypothesis, findings or analyses (Lofland et al 2006: 94).

The process of validation address a specific feature of this study which is the subtle balance between subjectivity and 'truth' which was presented in the methodology. This presented the position that whilst staff participants were experts in their own experience and knowledge, the Pre-Therapy community had greater expertise about contact reflections as a commonly recognised set of techniques which are used in the practice of Pre-Therapy. This study also views the 'facts' of social life as socially embedded artefacts, i.e. contact work (the artefact) attracts meaning to participants through the social context and interactions in context (Lofland et al 2006). Staff participants create meaning about the experience of using contact reflections which exist as tangible 'things'. At the same time, the expert community have a different, more expert knowledge about the 'thing' itself – contact work. Therefore, member checking or validation involved checking my understanding of participants experience as well as sharing ideas about the use of contact work.

By moving between staff participants and the expert community it was possible to check that what I and others understood about contact work matched that of the expert community. Member checking with people with more expertise in Pre-Therapy was embedded in the research process and this helped validate my developing knowledge of contact work. Yearly contact at the International Network meeting and ongoing email dialogue with Garry Prouty gave me opportunities to validate ideas
with others. Specific episodes of validation activity are described in Appendix 12. Validation with co-participants was also ongoing. Within research encounters I would clarify my understanding, offering paraphrasing and questions to check that we had a shared meaning. Arguably, together this built towards a socially embedded understanding of using contact work in practice. This was enhanced by me working with individuals modelling the techniques and then watching them. It was possible to enhance this by jointly watching a video recording with a participant and discussing the reflections they were using. This provided the opportunity to check their understanding of contact work. Member checking also involved contact with the daughter-in-law of one participant, KS. I sent her a preliminary outline of my thoughts about using contact reflections. The same report was used as a handout at a workshop with staff in Scotland and was based on material that I had circulated amongst some Pre-Therapy Network members.

Through the ongoing contact with the expert community and participants reciprocal cycles of validation occurred which aided the analytic process. Thoughts arising from work in the field were taken to the Network and Garry Prouty. This itself was reciprocal, with ideas from the research contributing to the collective knowledge of the Network as well as validating my own knowledge and experiences. At the same time, thoughts arising from contact with the expert community could be fed back into the work with participants in the field. This might take the form of discussing ideas with participants following email discussions with Prouty and contact with the Network. Together this created an ongoing cycle of validation which utilised the engagement and collaboration with both experts and staff participants. A pattern of reciprocity can be seen in the way experience in the field fed into the Pre-Therapy Network and how the expertise of the Network fed into the research activity in the field. This occurred through the interconnection between myself and the Network and myself and the staff participants.
Fig. 4.6 illustrates this interconnection and the points of contact with others which had multiple functions, including validation. It shows how this was intertwined with other activities such as research encounters with staff and reflective processes. The diagram illustrates points at which ideas could be consolidated, or tempered. As the iterative process continued, renewed ideas fed into further cycles of contact with others.

ENCOUNTERS WITH STAFF:
Validation of ideas.
Teaching, supervising, joint inquiry,

REFLECTIVE CYCLES LEADING TO FURTHER REFLECTIVE CYCLES

PRE-THERAPY NETWORK

SELF

STAFF

REFLECTIVE CYCLES LEADING TO FURTHER REFLECTIVE CYCLES

MEETINGS WITH PRE-THERAPY NETWORK MEMBERS AND EMAILS: Validation of knowledge, confirmation of teaching, moderation of ideas, joint inquiry

ONGOING DATA COLLECTION AND ANALYSIS

Fig. 4.6. Validation in relation to collaboration.
A range of specific validation activities is shown in Fig. 4.7.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Validation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussions with staff participants about emerging ideas from the</td>
<td>Validation of understanding of the experience of learning</td>
</tr>
<tr>
<td>experience of learning in action</td>
<td></td>
</tr>
<tr>
<td>Staff watching video recordings of themselves using contact reflections</td>
<td>Validation of creating a shared meaning about contact work</td>
</tr>
<tr>
<td>Co-delivery of a two day workshop with Garry Prouty</td>
<td>Validation of my teaching process, knowledge and skill</td>
</tr>
<tr>
<td>Participation in workshop with Dion Van Werde and Dave Deady (Scotland)</td>
<td>Validation of knowledge</td>
</tr>
<tr>
<td>Discussion with fellow workshop participants who work in dementia care</td>
<td>Validation of emerging ideas with staff with experience of dementia who</td>
</tr>
<tr>
<td></td>
<td>attended the workshop</td>
</tr>
<tr>
<td>Co-teaching of introductory session on Pre-Therapy applied to dementia</td>
<td>Validation of personal knowledge and understanding of Morton’s work.</td>
</tr>
<tr>
<td>with Ian Morton</td>
<td></td>
</tr>
<tr>
<td>Review of sample transcripts by network members (2004)</td>
<td>Validation of accuracy of personal understanding of reviewing the</td>
</tr>
<tr>
<td></td>
<td>performance of others when doing contact reflections.</td>
</tr>
<tr>
<td>Presentation of formative ideas about the process staff experience when</td>
<td>Validation about the learning process in comparison with other</td>
</tr>
<tr>
<td>learning about contact reflections and beginning to use them (2005/6)</td>
<td>network members' experience of teaching</td>
</tr>
<tr>
<td></td>
<td>Validation of emerging theoretical ideas</td>
</tr>
<tr>
<td>Sharing ideas on email with Garry Prouty and network members about the</td>
<td>Validation of emerging ideas. The permanence of email dialogues leaves a</td>
</tr>
<tr>
<td>application of contact work to dementia and differences in application</td>
<td>trail of sharing ideas.</td>
</tr>
<tr>
<td>which arise from the nature of the dementing illness</td>
<td></td>
</tr>
<tr>
<td>Writing three book chapters (including one for Garry Prouty)</td>
<td>Validation of my own knowledge through contribution to Pre-Therapy</td>
</tr>
<tr>
<td></td>
<td>academic community</td>
</tr>
<tr>
<td>Sharing ideas with staff generated by contact with Garry Prouty and Pre-</td>
<td>Validation of ideas prompted by contact with network and feeding this</td>
</tr>
<tr>
<td>Therapy Network</td>
<td>research encounters with staff</td>
</tr>
</tbody>
</table>

Fig. 4.7. Validation Activity.
Validation activity formed an ongoing dynamic process which was integral to the analysis. The process itself demonstrates how values of democracy, participation and collaboration were actualized in relation to the analysis. Although the end result of the analysis is mine, it was arrived at through collaboration and validation. This arrives at a shared understanding of the experience of participants in relation to the expert community's greater knowledge about contact work.
4.4 Summary of project process and methods

The notion of interviewing did not accurately reflect the research activity with staff and the more fluid concept of encounters with participants has been used. By using the concept encounters, the nature of Action Research methodology is more accurately represented and includes different elements of the process; learning in action, the relational dynamic, and self-participation. Meetings with staff demanded educational, facilitator and supervisory roles as well as a more traditional interviewer role. Frequently encounters were a blend of roles. Together these gather a range of data about learning, doing and experiencing as a collaborative venture. The collaboration in inquiry is perhaps most evident in meetings in which ideas are being shared. In order to gather the data, video has been used with a total of over 14 hours being recorded. This medium allowed for observations of staff interacting with people with dementia and provides important information on the non-verbal aspects of the Pre-Therapy Contact Reflections. Particular issues of consent, confidentiality and practical issues have been highlighted, with particular attention to providing a robust system of consent in order to protect the confidentiality of multiple groups of people. The use of video also gathered data about the teaching and learning process. A key benefit of the medium was its flexibility, permitting self-participation to vary between being an outside observer to a full participant. Field notes, a reflective diary, emails and an audit trail contributed to creating a thick, dense pool of data. The data provided a picture of the research activity over time and the variety overcame the limitations of each method.

The methods used in the study can be justified by acknowledging their relationship to five of the features of the Action Research Framework: methods, project management, key persons, resources, and real world context (Waterman et al 2001). These are presented in Fig. 4.8.
<table>
<thead>
<tr>
<th>Research phase</th>
<th>Data gathering method</th>
<th>Significance in relation to Waterman et al</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconnaissance</td>
<td>Reflective diary</td>
<td>Real world context</td>
</tr>
<tr>
<td>Setting up the research (including research design, ethics committee and research governance approval)</td>
<td>Log of activity to access research sites</td>
<td>Data on context of research</td>
</tr>
<tr>
<td></td>
<td>Reflective diary</td>
<td>Data on difficulties faced</td>
</tr>
<tr>
<td></td>
<td>Log of activity to access other key persons</td>
<td>doing Action Research in the real world context</td>
</tr>
<tr>
<td>Promotion of the research (presentations to Trust staff, conference presentation, Pre-Therapy Network members)</td>
<td>Reflective diary/ Observation notes in practice settings.</td>
<td>Data on research activity and project management</td>
</tr>
<tr>
<td></td>
<td>Email dialogues with Garry Prouty and network members</td>
<td>Participation of wider community of experts.</td>
</tr>
<tr>
<td>Recruitment of staff participants</td>
<td>Log of activity of delivering initial teaching sessions to staff</td>
<td>Gauging real world focus to staff and gauging level of relevance</td>
</tr>
<tr>
<td></td>
<td>Reflective diary with reference to reflection on my learning and teaching of Pre-Therapy</td>
<td>Establishing researcher/participant relationships</td>
</tr>
<tr>
<td>Collaboration and participation</td>
<td>Reflective diary</td>
<td>Participation, democracy, ownership and collaboration.</td>
</tr>
<tr>
<td>Negotiating design and process with staff</td>
<td></td>
<td>Maintaining the real world focus.</td>
</tr>
<tr>
<td>Negotiation with relatives and ward personnel</td>
<td>Reflective diary to reflect on their experiences and my own continued learning process</td>
<td>Participation, reflective cycles on learning and teaching, Initial ideas about knowledge generation</td>
</tr>
<tr>
<td>Initial teaching to participants</td>
<td>Video recording of encounters with staff, recording of staff using contact reflections with people with dementia.</td>
<td>Real world focus</td>
</tr>
<tr>
<td>Implementation to practice</td>
<td>Staff encouraged to keep reflective diary/ record critical incidents. Observation notes.</td>
<td>Reflective learning cycles of staff, reflective learning cycles of myself. Interplay of their learning and my learning.</td>
</tr>
<tr>
<td>Staff use Pre-Therapy contact reflections in their day to day practice</td>
<td></td>
<td>Contribute to knowledge generation</td>
</tr>
<tr>
<td>Verification and Validation</td>
<td>Video interviews with staff. Email dialogue with Pre-Therapy Network members. Presentation of ideas and research activity to Trust staff and Pre-Therapy Network members. Reflective diary.</td>
<td>Participation and collaboration in generation of knowledge. Iterative cycles of knowledge leading to new reflections, leading to new action.</td>
</tr>
<tr>
<td>Discussions with participants and others regarding emerging ideas</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 4.8. Methods of gathering data.
Observations and the reflective diary add to the data about context, the learning process, and keep a thread of reflexivity. The email dialogue and theoretical memos chart emerging theoretical development and together can be synthesized for analysis (Miles and Huberman 1994).

Context and access affected the research process. In order to counteract the vulnerability of the research, five principles were embraced:

i) Adopting a strategic approach ensuring that the research agenda complements long-term organisational plans - this minimises vulnerability arising from short-termism and organisational changes.

ii) Offering an exchange or ‘trade off’ to key personnel. This may be in the form of complementary agendas, time and input in areas peripheral to the core research activity.

iii) A willingness to work with the difficulties encountered in the real world and care settings. This may be in relation to staff emphasis on the participants’ priorities and demands, which may conflict with the research priorities and demands.

iv) Communication with and between individuals and the organisation. This requires the use of strategic diplomacy, tact and provision of information.

v) Researcher flexibility in engaging with key persons who hold different posts.

The five principles are relevant to the methods, research process, working with key persons and resources but also resonate with the values, beliefs and attention to the researcher/participant relationship which was discussed in the methodology chapter. In retrospect the most threatening aspect affecting the study was the flux in personnel. Major service reorganisations were slow to occur, which allowed for forward planning to continue the research activity and support to staff whose anxieties were raised by threats of redeployment or unit closures. The rapid changes in personnel were less predictable and significantly slowed the research process. Future cycles within the process would
benefit from focusing on clinical sites where clinical leadership was more stable.

The project process and methods provided data that were rich and varied. In essence three research sites provided 11 staff participants acting as a collective case study (Stake 2000). Validation was ongoing, weaving between research activity, data collection and analysis. The validation process and activities described in this section were part of the overall process of verification. Verification involves examining, re-examining and strengthening emerging theoretical ideas throughout the research process leading to incremental inductive theory building (Morse et al 2002). The verification process in embedded in the next section which details the analytic process which accompanied the research activity and the generation of data and the emergence of theoretical ideas.
4.5 Data analysis

Introduction

This section presents the analytic process, an overview of which is shown in Fig. 4.9. Whilst the methods and analysis appear as separate chapters, this does not reflect the experience of conducting the research where both were occurring simultaneously (Glaser and Strauss 1967; Schatzman and Strauss 1973).

Fig. 4.9. Analytic process.
Comparative analysis led the iterative process. The analytic process drew on the influence of Schatzman and the use of the principles of Dimensional Analysis, which facilitated the emergence of theoretical ideas (Schatzman 1991). The analytic process is influenced by using structure. A conceptual map was created which provided an overarching structure. The structure acted as scaffolding, supporting the analysis process. The process of analysis was ongoing, iterative and cyclical. As new ideas emerged, contact and validation activity shaped new areas of inquiry. Together this process offered verification of emerging theoretical ideas within a research process which drew on different perspectives and experience of staff participants, self and the expert community.

4.5.1. Constant comparative analysis

Although constant comparative analysis is more commonly associated with Grounded Theory, the method can be used more generally for qualitative data analysis from a variety of research paradigms (Miles and Huberman 1994). Due to the chameleon-like nature of Action Research a variety of methods of analysis are possible, including constant comparative analysis (Dick 1999).

Within this study, comparisons were rich: staff compared with staff, resident with resident, my experience with that of others, comparisons between sites and comparison in relation to theory (Glaser 2002; Miles and Huberman 1994; McNiff and Whitehead 2006). Specific strategies were employed. Themes and patterns were identified, drawing on the variable oriented approach – for example, participants on all sites described gauging which people might be suitable for reflections and all described the characteristics of 'withdrawn' and 'isolated'. In addition case oriented strategies were used, such as comparing data from one participant and comparing this with data from others (Miles and Huberman 1994). An example of this was the difference between the perspective of Cathy and Ayline on whether facilitating expression of emotions was a 'good' or 'bad' thing.
The analysis involved making choices about using predetermined categories or allowing categories to emerge (Miles and Huberman 1994; Lofland et al 2006). This study required both systematic management of the data and at the same time a more unstructured approach which could embrace the fluidity and fragmentary nature of the study (Glaser 1992 Seale 1999; Easton et al 2000; Ryan and Bernard 2000; Woods et al 2002; Priest et al 2002). Biott (2002) advocates anarchic thinking to free the researcher from preconceived ideas, particularly in situations which require novel thinking. Freeing the researcher helps them to notice strangeness in what might be familiar (Green 2002), and concept is reconsidered when describing cognitive processes involved in generating ideas. The only aspect of the data analysis which used a preset category was the comparison of staff's performance in using contact reflections with the preset theoretical ideas of Prouty, i.e. each type of reflection formed the heading for a category and the data was scoured in relation to the categories.

It began to feel as if overly detailed questions and the intricacies of coding would sanitize the data (Strauss and Corbin 1990; Kendall 1999). Coupled with my personal preference for conceptual structures, I began to experience my analytic process as more compatible with Schatzman's Dimensional Analysis. This complemented the conceptual scaffolding which had already been created. The scaffolding provided the structure within which to fragment the data, and Dimensional Analysis provided the structure to support the analytic process, - i.e using a structured creative process (Dimensional Analysis) held within a conceptual structure (the scaffolding). In this sense, Dimensional Analysis was overlaid on top of the scaffolding.
4.5.2 Schatzman's Dimensional Analysis

Dimensional Analysis\(^5\) originates from the work of Schatzman, arising from what Schatzman perceived as, insufficient structural foundation in the analytic process in Grounded Theory. This led to the development of Dimensional Analysis, an analytic framework which permits a researcher to be explicit about their analytic process. Two key concepts are central to the approach, natural analysis and dimensionality.

(natural analysis is)... a normative cognitive process generally used by people to interpret and understand problematic experience of phenomena. According to Schatzman, this natural analytic process is learned through early socialization and provides individuals with a schema that they can subsequently use to structure and analyse the intricacies of phenomena of ordinary life as well as in complex scientific problem solving (Kools et al 1996: 314).

Through social interactions individuals use natural analysis to develop dimensionality.

*Dimensionality refers to an individual's ability to address the complexity of a phenomenon by noting its attributes, context, processes, and meaning* (Kools et al 1996: 315).

Schatzman sees that analyzing data is an exaggerated and extended form of natural analysis. Dimensions are created by labelling or naming pieces of data. The dimension is explored by investigating the attributes or properties, relating the data to context, conditions, processes and consequences. This helps explore the properties of the dimension. The simple example from Kools et al (1996) is that AGE is a dimension with properties of youngest to oldest, or GENDER is a dimension with properties of male and female.

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\(^5\) Schatzman's relative lack of publications compared with Strauss, Corbin and Glaser has resulted in Dimensional Analysis being less well known (Schatzman and Strauss 1973; Schatzman 1991). Through the formation of a research group under the direction and mentorship of Schatzman, four researchers (Kools, McCarthy, Durham, Robrecht) have begun to redress the imbalance by publicising the method of Dimensional Analysis (Kools et al 1996).
By exploring the properties of a dimension new labels or names emerge, a process which Schatzman refers to as designating. This new dimension is a more abstract representation. This, too, is then explored in relation to context, conditions, processes, and consequence. Theoretical memos accompany the process of identifying and exploring multiple dimensions of the phenomena.

Dimensions are collated and then a further process of exploration leads to the emergence of an overarching theme or perspective which has explanatory potential. To do this, each dimension is temporarily elevated in importance to see whether it holds explanatory power. Its properties are explored (context, conditions, processes, and consequences) to see whether this dimension helps explain the other dimensions. This process is applied to each dimension until a central dimension emerges. This central dimension maintains the raised status, becoming a perspective.

The dimension that provides the greatest explanation for the relationship among dimensions is ultimately selected as the central or key perspective from which to organize or 'choreograph' the data (Schatzman 1991, cited in Kools 1996: 319).

This attention to using the process of exploring properties of dimensions in a structured way leads to constructing and reconstructing the multiple elements of the topic of inquiry. For Kools et al (1996), this sets Dimensional Analysis apart:

In the traditional Grounded Theory method, the explanatory matrix or paradigm model is used merely as a means for coding data. It is used as a procedure in axial coding and is only one of many techniques in Grounded Theory method employed to develop and relate categories.....However, in Dimensional Analysis, the explanatory matrix is considered to be the cornerstone of the analytic process. It provides a framework that helps to move analysis beyond description and into the realm of explanation. In dimensional analysis method, the explanatory matrix is the overarching framework for the analysis of the complexity of a problematic situation. As such, it furnishes the research with both structure and a context for explanation. (Kools et al 1996: 317).
My understanding of the process of Dimensional Analysis is summarised below (Fig. 4.10).

**Process and actions within Dimensional Analysis**

1. Identify parts of the whole phenomenon by designation (labelling or naming dimensions) of bits of data

2. Scrutinize the dimension in relation to attributes: considering context, processes, conditions, and consequences. This simultaneously leads to new designations or naming, which again are explored in relation to attributes.

3. Collate multiple dimensions – there is no requirement to assign relative importance or identify relationships or meanings at this point.

4. Collate a critical mass of dimensions which appear to have an explanatory power.

5. Select central dimension – this becomes raised to the status of perspective whilst under scrutiny.

6. Scrutinize in relation to conceptual components, i.e. context, conditions, processes, and consequences.

7. Remaining dimensions are placed in conceptual components. Integration and reintegration of dimensions within the perspective.

8. Repeat until a perspective emerges which has the most convincing explanation for relationships between dimensions. This is called the organising perspective.

9. Theoretical sampling continues.

10. Clarify and solidify any conceptual links and theory through further integration and reintegration of domains.

11. Repeat until theoretical saturation has been achieved.

Fig. 4.10. The process of Dimensional Analysis.

Dimensional analysis provides a structure for the analytic process. In addition, this study used a second structural process. This involved building a conceptual overview or conceptual 'map' of the research. This
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was used to prompt areas of inquiry during the research process and the ongoing analysis.

4.5.3 Building a conceptual map: the scaffolding

The construction of a conceptual map to provide scaffolding was driven by a pragmatic need to ensure the research question was fully explored. This created a structure that identified different aspects of the research and was used to generate questions during the research process, interrogate data and emerging ideas and contribute towards the process of verification (Morse et al 2002; Heath and Cowley 2004). This helped towards ensuring that data generated from three perspectives (self, participants, and expert community) was considered. This widened the angles from which the research process was considered, creating a set of interrelated concepts which provides a framework for conceptual entrée (Schatzman and Strauss 1973: 55). The scaffolding facilitated making links between areas of inquiry. This was enhanced by the clear identification of literature in the scaffolding which allowed for comparison analysis in relation to theoretical concepts. A number of examples illustrate this:

i) Where participants discussed how contact work differed from their usual approaches, we could jointly explore this in relation to current approaches in communication. *How is contact work different from/similar to how we usually communicate with people with dementia?*

ii) In the co-learning process, we could compare our emerging practice in contact work with the theory provided by Prouty. This allowed us to identify where our experience resonated with or varied from Prouty’s work. *Is our experience different/similar to Prouty’s descriptions of his approach?*

iii) Debates with Prouty and the Network about engagement/contact could be related to data being generated by staff participants working in a dementia care context. *Do contact reflections result in contact and engagement in people with dementia in the same was as with other client populations or in a different way?*
The following steps were taken to build a conceptual map:

1. Laying out the three main areas of literature.
2. Identifying three main domains within the research question.
3. Overlaying these domains on the literature.
4. Acknowledging the Action Research Process as part of the data.
5. Subdividing the research question.
6. Linking elements in order to question the data and relate these links to subsidiary research questions.
7. Gathering all links between research domains, literature and subsidiary research questions into one complete picture or conceptual map.

Step 1: Laying out the literature.

![Fig. 4.11. Step 1: Three areas of literature.](image)

Step 2: Subdividing the research question.

The overall research question - What happens when staff learn and use Pre-Therapy Contact Reflections? - has been divided into three subsidiary domains:

- staff learning and using Pre-Therapy Contact Reflections
- staff 'doing' Pre-Therapy Contact Reflections in context
- implications for using Pre-Therapy with people with dementia.
Step 3: Overlaying domains of research question (Fig. 4.12).

Step 4: Including the Action Research process.

Fig. 4.12. Step 3: Overlaying domains of the research question.

Fig. 4.13. Step 4: Overlaying the Action Research process.
Step 5: Subdividing the research question.

By fragmenting the research question different components of the research question are exposed and these were broken down further (Fig. 4.14).

Subsidiary the research questions:

1. Staff
   a. Can staff learn contact reflections?
   b. Can staff use contact reflections?
   c. What is the staff's experience of using contact reflections?

2. People with dementia
   a. What happens when people with dementia receive contact reflections from staff?

3. Learning/using Pre-Therapy techniques in the clinical context
   a. What is the impact of the clinical context on staff using contact reflections?
   b. What is the impact on the clinical context when staff use contact reflections?
   c. What is the impact of the clinical context on staff learning the contact reflections?

4. The action researcher introducing Pre-Therapy techniques to staff
   This begins with my own knowledge and skill base
   a. How can I learn and use Pre-Therapy?
   b. What is my own experience of using Pre-Therapy techniques?

   This leads to the introduction of the techniques via the Action Research and Learning in Action process.
   c. How do I teach staff to use contact reflections?
   d. What are the ongoing developmental processes involved in the learning?

5. The application of the techniques in relation to dementia care
   a. How does the use of Pre-Therapy Contact Reflections with people with dementia relate to the Pre-Therapy literature?
   b. What does the application of Pre-Therapy Contact Reflections contribute to the literature on Pre-Therapy?
   c. What does the application of Pre-Therapy Contact Reflections contribute to the dementia literature?
   d. What does the application of Pre-Therapy Contact Reflections contribute to care for people with dementia?

Fig. 4.14. Step 5: Subdividing the research question.
In the early stages of data analysis, these questions were fragmented even further (Appendix 13). However, I began to feel that this was making the process overly structured and feel that the questions were leading the analysis rather than being a vehicle to aid an inductive process (Robrecht 1995). In this sense, the analytic process is closer to Glaser’s approach rather than to that of Strauss and Corbin (Glaser 1992; Strauss and Corbin 1990; Heath and Cowley 2004). Nonetheless, the exercise of generating questions helped in the preparation of data analysis, guiding rather than directing the comparative process (Miles and Huberman 1994).

**Step 6: Linking elements.**

Linking elements in the conceptual map opened up areas for comparison within the study. Fig. 4.15 illustrates how a link is created which prompts exploration of how participants’ practice of using contact reflections compared with Prouty’s theory.

![Fig. 4.15. Step 6: Linking elements in the conceptual map.](image)

The theory and practice of Pre-Therapy would also be the basis of examining other dimensions of the research. For example, exploring
what happens when contact reflections are used to make contact with people with dementia in the clinical setting (Fig. 4.16).

Fig. 4.16
This develops subsidiary research question 2 (What happens when people with dementia receive contact reflections?). These are linked by the theoretical base of contact or attunement, Pre-Therapy Contact Reflections and the response from the person with dementia. Comparisons can be made from accounts from staff, personal experience, and videoed interactions between staff and people with dementia.

Fig. 4.16. Linking elements in the conceptual map.

Fig. 4.17 illustrates another link (use of contact reflections to make contact in relation to existing theory and practice in communication in dementia care).

Fig. 4.17
This links subsidiary research questions 5c and 5d (The contribution of Pre-Therapy to the existing body of knowledge about communication in dementia. Comparisons of the experience of using contact work in comparison with other approaches in dementia care).

Fig. 4.17. Linking elements in the conceptual map.
This process of linking different points continues until all subsidiary research questions have been located on the framework.

**Step 7: Final Framework.**

All subsidiary research questions were overlaid onto the domains of the research question and the literature. Fig. 4.18 shows the completed framework. The questions generated in step 5 are superimposed onto the framework.

![Diagram](https://via.placeholder.com/150)

**Fig. 4.18 Overview of conceptual scaffolding**
Summary

The scaffolding provided a theoretical prism through which the inquiry could be viewed. It acted as a theoretical structure to hold the research process and facilitated inquiry into all angles of the research question. This was particularly important as this study was aiming to explore uncharted territory – the learning and use of contact work by staff, the application of contact work to dementia care, and the place of Pre-Therapy in relation to existing approaches in dementia care.

Within this scaffolding the ongoing analytic process of comparative analysis using Dimensional Analysis occurred. This happened over time as the repeated encounters with staff and contact with the expert community generated data, emerging ideas and validation. The ongoing process of analysis shaped further action and inquiry in the field whilst simultaneously offering new ideas to the expert community.

4.5.4 Illustrations of analytic process

This section offers illustrations, addressing the need for qualitative research to show procedural accounts of the research into how findings were arrived at (Miles and Huberman 1994). These show the influence of Schatzman's approach, the use of this in comparison, an example of an emerging dimension, and cognitive processes to help prompt creative or anarchic thinking.

Early coding, the dimensional matrix and comparison with theory

Coding and recoding occurred – for Schatzman this is naming or designating, until this term is elevated or redundant as it belongs to a bigger dimension. Appendix 14 offers an early coding exercise where codes were being explored and clustered. Appendix 15 shows a more refined coding list. Fig. 4.19 uses an extract of data from one of the video tapes to illustrate how initial codes were obtained from the data.
POSSIBLE CODES
(PWD = person with dementia)
USE/BR – using contact reflections – bodily reflection
USE/ENV – environmental features when doing reflections
USE/WWR – using word for word reflection
USE/NOT P-T – using a response which is not Pre-Therapy
RES/PWD – response of person with dementia
REA/STAFF – staff reaction to response from person with dementia
PUR/CR – purpose of using contact reflections
COMM/ALT – alternative way of communicating (not contact work)
FACIL/ENABLE – facilitating the abilities of the person

FACIL/ENABLE – facilitating the abilities of the person

<table>
<thead>
<tr>
<th>Action</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>saying it’s like baby talk, I managed to gain contact by going down on my knees to her level</td>
<td>USE/ENV (physical conditions of doing)</td>
</tr>
<tr>
<td>and mirroring what she was doing and she was saying</td>
<td>USE/BR and USE/WWR (Using bodily reflection non verbal, and WWR)</td>
</tr>
<tr>
<td>some words about teaching….writing and reading….what I could</td>
<td>(?Pre-Expressive? Or not knowing PWD history, difficult to understand)</td>
</tr>
<tr>
<td>make out and I was copying those words and she was nodding, I got eye contact,</td>
<td>RES/PWD (behaviour/response)</td>
</tr>
<tr>
<td>so I then put a newspaper on her lap she was pointing to the letters and trying to spell them and she managed to spell some correctly…</td>
<td>RES/PWD (initiating activity, contact)</td>
</tr>
<tr>
<td>and I was copying her, rather than her copying me …….and then I gave her a piece of paper and asked her if she’d like a pen. I gave her a pen and I said, ‘could you please write your name for me and sign for me?,’ which she did. She was very very good contact, possibly the first time she’s done that for don’t know how long.</td>
<td>FACIL/ENABLE (limited abilities, using ability)</td>
</tr>
<tr>
<td>though the words didn’t make sense, none of the writing made any sense. There are a few letters you can understand, spelling the letters. It was impressive what she’d written, very impressive, even, and I showed all the other nurses. They were surprised and pleased, as I was pleased, managed to</td>
<td>USE/BR (Non verbal), COMM/ALT (following PWD, different)</td>
</tr>
<tr>
<td></td>
<td>FACIL/ENABLE</td>
</tr>
<tr>
<td></td>
<td>RES/PWD</td>
</tr>
<tr>
<td></td>
<td>REA/STAFF (surprised)</td>
</tr>
</tbody>
</table>

Fig. 4.19. Coding (VHS4 10.2.05 – Andy).
Coding allowed for early dimensions to emerge, for example, *Performing Contact Reflections*. The influence of the dimensional analysis matrix points can be seen in the process of beginning to identify the properties of this category: the context, conditions, processes, and consequences. An example is given in Fig. 4.20 drawing out the features from Andy’s transcript.

**Dimension: Performing Contact Reflections**

**Context** — using past abilities, contact facilitating activity, alongside thinking about tasks. Performing contact reflections 'gets' something from them.

**Conditions** — on his knees, physical disability, staff responded to response, devoting time to this.

**Processes** — accurate use of WWR, BR getting eye contact, see how far you get, getting more, staff pleased, is she pre-expressive? Difference of Pre-Therapy to other ways of communicating in dementia care.

**Consequences** — (for Andy) sustained activity, satisfaction for staff, surprising response, (for KP) expression, involvement in activity, one to one time and attention.

---

**Fig. 4.20. Dimensional analysis of raw label.**

**Theoretical emergence using Dimensional Analysis**

Dimensional Analysis involves elevating dimensions to test their explanatory power. An example given below is of a dimension which seemed of central importance at the beginning but became subsumed as part of another dimension.

Very early in the research the category called ‘Discomfort in Doing’ emerged. It seems particularly strong as it was mentioned by participants on the same site (within case comparison) and by people
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who have never met and work in different sites (cross-case comparisons) (Miles and Huberman 1994). It was also a theme in early reconnaissance work. Some examples of video extracts which come under this category are shown below. Anna illustrates the dimension in relation to processes, i.e. discomfort arises in the interaction.

Anna: It's just that sort of feeling, does it feel right or does it feel like a mockery or taking the micky, which you don't want to do (VHS 17 6.5.05)

The context of discomfort seemed to be related to being watched or observed by others and as a consequence Anna and Alison both experience awkwardness.

Anna: um, from a person who's doing the techniques point of view its probably..., we'd feel awkward, we'd be mimicking people.
(Aanna/VHS 6 /15.2.05)

Alison: I just feel like I'm copying them – yes, awkward I suppose. I don't feel quite comfortable doing that one, keep saying everything they do. (Alison/VHS 18/15.5.05)

Conditions can be seen and compared between participants. For example, both attributed feeling discomfort to the fact that they did not want to be seen to be mocking the patient. Therefore, the data could be explored in relation to the conditions and social norms against which contact reflections were being used.

Anna: We get the feeling that the patients would think that we are taking the micky. (Anna/ VHS 6/15.2.05)

Alison: I just feel like I'm copying them and taking the mick, I suppose. I don't feel quite comfortable. (Alison/VHS 18/15.5.05)
Following the Dimensional Analysis model of analysis the properties of the dimension of discomfort would be explored. Below are ideas which emerged during the exploration of the category of discomfort.

**Context** – staff doing contact work in shared areas, experienced discomfort when being watched by other staff.

**Conditions** – exposure to the gaze of others who don't know about contact work, feeling embarrassed or awkward

**Processes** – inadequate learning? Social learning? Not fully understanding the rationale behind using contact reflections, feels disrespectful, underlying ideas about the right way to interact.

**Consequences** for staff – feeling that they are mocking, patronizing, avoidance of reflections that incite feelings of awkwardness? Feels wrong or bad. Discomfort arising from social norms?

The ideas emerge further as the dimension is explored and verified by revisiting data, which leads to either strengthening the dimensions or subsuming it as part of another dimension. The dimension of discomfort was enhanced by further comparisons and verification. A comparison of staff on all three sites (cross-case comparison) illustrated that discomfort is a shared experience. The raw data seemed to confirm this. The following quotes illustrate this.

*Ayline: I personally think it's quite difficult to do it, do it in the work environment, necessities overtakes being able to do it, and also I'm also still quite conscious that it feels like you are taking the micky...... because you are repeating what they are doing and not getting any particular response back (Ayline VHS 2 29.12.04)*

*...because they (talking about other staff) might think it is silly to reflect gestures or body language (Bruno VHS 13 1.4.05)*

*I found it much easier working one-to-one alone, you know, I could take more risks. I could say things like 'the birds are singing outside'. I could be a bit more.. It freed me up not having other patients or members of staff in the same room (Cathy VHS12 22.3.05)*
Comparisons to expand dimensions were rich in opposing statements which could be used to explore the properties of various dimensions. For example, in comparing situations (within site and across site) where participants experienced discomfort with situations where staff did not express discomfort it was possible to further cross-check the conditions of either comfort or discomfort. My own lack of discomfort was considered against the discomfort of others, generating ideas from the differences. I was not concerned about how others might view my behaviour as a learner using contact work in practice. I understood the rationale behind contact work and therefore did not feel it was disrespectful. By exploring the difference between my response and that of others, the significance of my role in relation to others and the awareness of the rationale behind contact work was strengthened. This led to considering role differences between myself and others and how these might influence using contact reflections in the care context.

In Dimensional Analysis, relationships between dimensions can be fruitful, creating links which may be dimensions in their own right, or which have explanatory power. For example, discomfort was explored in relation to another concept which is about gauging the level of expressiveness. This led to considering how both linked to the level of knowledge about the difference between pre-expressive and expressive states and the skill involved in gauging this. Both dimensions were properties of another dimension - accuracy in learning. This illustrates creating mental links between concepts. An illustration of this process is given below (Fig. 4.21).
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<table>
<thead>
<tr>
<th>Analytic process/ cognitive activity</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relate experience and data to theory</td>
<td>The literature indicates that contact work is used where a person is pre-expressive. Where a person is expressive contact reflections would not be used (Prouty et al 2002).</td>
</tr>
<tr>
<td>Consider theory in relation to data</td>
<td>The data indicated discomfort arising from possibly gauging the level of expressiveness wrongly.</td>
</tr>
<tr>
<td>Consider implications for context of this study by comparing data and theory</td>
<td>Consistency between the data and theory substantiated the use of contact reflections in dementia care, but more thought needed about gauging levels of expressiveness in dementia compared with other client groups where Pre-Therapy has been used.</td>
</tr>
<tr>
<td>Verification with participants</td>
<td>Plan to discuss this in research encounters with others</td>
</tr>
<tr>
<td>Validation of ideas with experts</td>
<td>Plan to recheck knowledge of levels of expressiveness, issue included in email to Prouty</td>
</tr>
<tr>
<td>Consolidation of idea</td>
<td>Growing confirmation that expressiveness may be problematic for dementia. Consider this in relation to other dimensions – for example, learning and skill, where staff need to understand and gauge expressiveness.</td>
</tr>
</tbody>
</table>

Fig. 4.21. Cognitive activity in analysis.

Unsurprisingly, I experienced a sensation of moving backwards and forwards between emerging ideas, literature, data and more research encounters. Ongoing exploration of dimensions meant some dimensions became stronger, and previous dimensions appeared to fit within them. Role Perception became a dimension which persisted and seemed to explain other dimensions, although later on it became part of a higher dimension, which eventually became what Schatzman would call the perspective. This appears in Chapter 8, where a theoretical model is presented to explain the social process which emerged from the data.
Analytic techniques

Theoretical memos were used. The example shown in Fig. 4.22 was at a later stage of the research and ideas formulated are a formative version of ideas which appear in the findings and conclusion. Here they are less ordered because the theoretical ideas are at an embryonic stage. This memo also illustrates the use of cognitive maps and metaphors (Miles and Huberman 1994).

In the formative stages there was the need to understand the data in relation to a wider theoretical background. The following memo used cognitive maps and marked a point where I wondered in which direction the data was taking me (Fig. 4.23). At this stage I was differentiating between the learning process and the experience of using contact reflections. Learning was beginning to emerge as a finding of the study rather than simply a theoretical framework to analyse the data. From this memo, theoretical framework 1 provided the basis of the structure of Chapter 6. At the foot of this memo, I had also made a note of the cognitive process I felt was happening while I was writing this memo.

Gaining clarity felt difficult because of the ongoing nature of the research. Other techniques were used (Sanger 1994). Diagramming was used extensively throughout the research process, both handwritten diagrams and sketches, and diagrams constructed on word documents. Examples are provided in Appendices 16-19. Writing helped clarify ideas. Fig. 4.24 shows the use of a Free Fall list (Bond and Holland 1998).
MEMO August 2006. Collating ideas about the process of skill development and issues arising in learning

Emerging category/perspective – naive learning/development of skill
A theme from the data: seems simple but is difficult to do; it's not so easy. This seems to be part of the wider issue of the development of skill.

Locating this to other dimensions of the conceptual map to expand the conditions and properties, the following emerge from the data:

- at the outset the contact reflections seem obvious and simple to staff – this changes when they start to do it
- staff can identify that to some extent they 'do it already' but once they try them they see that they don't
- staff can receive short instruction and start using contact reflections which get contact or a sudden response
- they feel different (to their normal way) when they do them
- staff do not readily use all the contact reflections, in particular situational reflections
- staff feel uncomfortable using the contact reflections in a non-verbal way
- staff feel inhibited doing them in front of others, or not and share it with others
- by doing them, the staff experience how they are different from their usual ways of communicating.

Bigger Dimension – difference between learning and doing, and provisional hierarchies of learning and using may emerge.
Learning – where outcomes are measured in behaviour, this shows only replication of behaviour. Doing PT is more than this. It is difficult to define level of competence, level of skill (as demonstrated by the PT Network subgroup which failed to identify what constituted level of competence in learning and using PT). Despite difficulty in defining this, I suggest hierarchies of levels of knowledge and practice. This could be related to learning theory and ideas about skills acquisition.
Depth of knowledge from understanding contact reflections through to understanding of Pre-Therapy in relation to psychotherapy practice.
Gradient of competence: novice – to expert (using contact reflections, differentiating, selectivity, as part of therapy)
These typologies could be related back to my teaching. What did staff achieve and the implications this has for wider dissemination of PT to non-psychotherapists? Preliminary thought is to emphasise that staff do contact work, not Pre-Therapy. (Which is similar to Dion Van Werde's ideas from his work in Ghent)
Theoretical idea emerging from this: The peacock and the toy pigeon.
The peacock – Prouty's complex and rather elegant Pre-Therapy
The toy pigeon – the use of contact reflections in a rather simple or mechanical way
The danger is holding a pigeon and saying it's a peacock – or staff believing they are doing contact reflections when they are not.

Fig. 4.22. Example of a Memo.
Fig. 4.23. Memo demonstrating comparison with theory.

Memo – Theoretical frameworks to inform data (May 2006).

Maybe two main theoretical frameworks can be used which incorporate comparison of the data with other theoretical ideas. The two frameworks would be linked to the two main actions in the research question: What happens when staff learn and use contact reflections?

Using contact reflections implies comparison of the data with the theory of Pre-Therapy.
Learning contact reflections implies comparison of the data with a theoretical model of learning.

Because the research is multifaceted, one theoretical model is not sufficient to address the complexity. Therefore I am wondering if two theoretical frameworks can be created which incorporate a clear theoretical choice through which to analyse the data, but which does not inhibit the emergence of ideas from the data.

Theoretical framework 1

Main focus: Using

Primary theoretical concept: Theory and practice of Pre-Therapy

Primary author: Prouty

Key constructs of theoretical concept

- Pre-expressive self
- Contact reflections
- Contact behaviours
- Making contact

Additional theoretical concepts

- Grey zone functioning (Van Werde)
- Attunement (Peters)
- Empathy
- Relationship (Buber) or nursing role?
At the moment I am still unsure how theory drives the analysis without inhibiting the emergence of theory (read more), but I wonder if it seems to be a process of

1. Having a clearly identified theoretical perspective in approaching the data
2. Managing the data using constant comparison, creating dimensions and exploring properties
3. Identifying key constructs in the theoretical perspective
4. Using these to systematically review the data, recreating or renaming dimensions
5. Ordering the data in relation to the key theoretical concepts
6. Drawing out theoretical ideas that emerge from the data
7. Integrating, comparing, synthesizing the emergent theoretical ideas in relation to data, literature or other theoretical ideas
8. Drawing out/discussing the implications of the theoretical findings.

Fig. 4.23. Memo.
June 2006 Thoughts arising from the research process.
Problems encountered are related to
Contextual
Staffing levels
Resistance and barriers – individual and inte-personal
Organisational barriers and agendas

Effect of the research process
Staff attitudes
Greater engagement with patients
Research as a supportive process

Staff experience during learning activity (which includes using)
Staff perception of what is work, and/or getting somewhere
Staff fear of opening a ‘can of worms, desire to make it better
Staff difficulty of leaving a person
Staff giving up trying out contact reflections
Staff self-consciousness in front of others
Staff difficulty in recognition of directive and non-directive
Staff difficulty in self-noticing in micro-interactions – automatic pilot interactions
Staff perception of feeling ‘natural’ and ‘not natural’
Difficulties with ‘the concreteness’ of contact reflections – i.e. not interpreting, just stating and reflecting
Difficulties with looking and seeing – to reflect effectively you need to look, see and notice the patient to a high degree – Is there a tendency for busy staff to look but not see the patients experience and the tiny responses, rather their own?
Difficulties with doing plus feeling (toy pigeon vs. peacock)
Tendency to avoid feeling - ?natural defence against anxiety by staff
Tendency for ventriloquism and hijacking
Dilemma of non-directiveness. When is it better to be directive?

A typology of interactions to locate Pre-Therapy Contact Reflections?

- Constructive directive interaction – i.e. quality of life enhancing and directed by staff
- Directive task-orientated – led by staff – ‘Come to the toilet’, ‘Eat this’
- Unconstructive – i.e. malignant social psychology
- Directed (at) - questions, commands, statements
- Contact reflections – non-directive

The significance of this is that staff move between all five types rapidly (this typology can be compared with others who categorise – i.e. Ward, the constructs of Perrins Quality of Interaction scale, Kitwood’s positive person work).
The analytic process was strengthened by the use of 'critical reflective dialogue' with my supervision team or others whom I deliberately sought out for discussions to prompt thinking (Brockbank and McGill 1998; Gibbon 2002). Disseminating ideas through teaching and seminars generated more ideas, which stimulated further cycles of thinking, creating memos, testing ideas against data, and revising ideas. Writing, as an analytic process in its own right, was resonant of Lofland et al's (2006) descriptions of surprise writing, which aided analysis and stimulated ideas. Appendix 20 offers an extract of an episode of writing which followed a supervision meeting where I was trying (unsuccessfully) to articulate emerging theoretical ideas. Immediately after this meeting I produced over 11,000 words which I was able to scrutinize, to theme and solidify the ideas. Appendix 20 offers part of this writing on three concepts which were emerging as important. The writing is chaotic, which reflects the way I had not fully organised my ideas, but it is an example of the function of critical reflective dialogue leading to writing prompted by academic supervision which is providing the supervisee a formative educative type of support (Inskipp and Proctor 1998; Brockbank and McGill 1998). The value of creative or anarchic thinking and creation through dialogue receives some attention in the literature, although this receives relatively less attention than more formalised processes and procedures such as comparing, coding and sorting (Miles and Huberman 1994; Taylor and Dawson 1997; Brockbank and McGill 1998; Biott 2002).
4.5.5 Equality of voices in the data

The analysis was informed by personal knowledge and experience and needed to be reflected in the findings. This was done by using my experience of the research in the comparative analysis and using my relationships with participants as a component of the research. There was a danger that by including my own voice I would simply generate findings which fitted my own understanding of the experience. Striving for balance between the researcher’s voice and those of participants was discussed in the methodology, with the goal of permitting all voices to be heard. In relation to the data analysis, personal experience was used as another aspect of comparison, aiming to add depth to the analysis rather than tainting it. Through comparison, differences between my own experience and that of others became part of the process of interrogation of the data.

In the same way that the researcher’s voice should not taint the analysis, neither should the danger of elite bias be ignored, i.e. the bias arising from the inclusion of participants either of higher status or who are more articulate (Miles and Huberman 1994). Within this study, elite bias was a potential with one participant – Cathy. Whilst Cathy’s role status was low, four features differentiated her from other participants: her capacity for critical reflection, her level of articulation about the use of the contact reflections, her articulation of her practice in relation to Person Centred Theory, and her use of the research encounters, which were usually a full hour conducted in an environment free from interruptions. The potential for bias has been held in mind during the research. An additional strategy has been to use Cathy’s experience as a comparison. Relative to other participants, she was an unusual ‘case’, as she did not share many of the characteristics of other participants. Therefore her unusualness has been used as an analytic lever to enhance the comparisons as opposed to creating bias. By way of illustration, comparison between Adam and Cathy showed a difference in levels of self-reflection: Cathy is better equipped to give full accounts. Adam is...
less used to self-reflection and analysis of his own practice. This is shown in an unedited encounter between me and Adam; I am trying to find out why he was experiencing surprise at feeling he was able to use the contact reflections. The conversation required me to sustain questioning and prompting but Adam often simply ceased talking and waited for me to continue the dialogue.

Penny: Anything else about that? (asking about a situation he had described with a resident)

Adam: I was quite surprised how it naturally came to me, I suppose, cos to be honest I wasn't quite sure what I was going to do when it started and that and it just came to me.

P: So why are you surprised?

A: I just, I suppose I feel surprised that I managed to do everything that you taught me some weeks ago and it just came naturally without thinking about it really

P: So how has that come about?

A: I don't know. I try think how really... I was..., well I just felt, thought about me being in her mirror I suppose, in a way, and just doing everything she does her body language and that, and just tried to mirror that which was getting responses, positive responses.

P: So it sounds like it started to flow. Is that what you are saying?

A: It did start to flow, yes.

P: That's really interesting, and I'm interested that you are surprised.

A: Yes I was surprised, I suppose. I surprise myself a lot sometimes, you know.

P: You're surprised?

The quality of the data is compromised by some participants being relatively less familiar with using critical reflection or able to articulate their experiences (Greenwood 1993). However, this study is located in the real life context where many unqualified staff may have had limited opportunities to develop skills in critical reflection or work within a
context which promotes a critical self-reflective discourse. Limited ability should not prohibit inclusion in the research process and therefore attention has been paid to trying to hear a fair balance of all voices of all participants irrespective of ability.

4.6 Summary

The process of analysis addressed the research question. After a faltering step which 'over-fragmented' the research question, a more structural thinking process influenced by Schatzman's Dimensional Analysis was used in conjunction with the conceptual scaffolding. The scaffolding helped contain confusion which arose from the different facets of the research. In this way the scaffolding was useful to support and expand inquiry throughout the research process rather than close it down. In line with the epistemological position of the study, ideas were generated through interactions, and validated with others, thus illustrating the iterative nature of the analytic process.

Together the research process, methods and analysis formed an ongoing process which shaped the inquiry. Through a process of reciprocal validation and ongoing verification of emerging theoretical ideas, the Action Research process provided findings which settled into four distinct sections. These sections address the aspects of the research question: the use of contact work with people with dementia, the learning process of staff, the application of contact work to people with dementia and the experience of staff.
PART THREE

Findings
Introduction to the findings

The findings are arranged in four chapters, reflecting the aspects of the overarching research question: *What happens when staff learn and use contact reflections with people with dementia?*. Chapter 5 presents the use of contact reflections and the response from people with dementia, painting a relatively straightforward picture of the use and response to contact reflections, comparing the data with the theory of Pre-Therapy (Fig. 5.1).

Chapters 6, 7, and 8 build a picture of complexity, presenting factors which mediate the application of contact work to the context of dementia care. These begin to cast a shadow of doubt on the automatic translation of the approach to dementia care. This helps inform us of some of the challenges faced when introducing contact work to the dementia care context. These are: the skill of staff, the nature of dementia and the perspective of staff (Fig. 5.2).
Together, the findings show that, whilst contact reflections have a place in dementia care, there are particular features specific to using them with people with cognitive impairment. The process of learning challenges staff and rests on contextual factors and the alignment of the worker with an approach that parallels the philosophy behind Pre-Therapy and permits engagement with the emotional world of the person with dementia. Mediating factors may lessen the impact of the introduction of contact work to the context of dementia care. Greater awareness of these factors has wider application in helping to understand contextual and relational forces which inhibit practice development.

Each chapter uses selected quotations from participants. For clarity, quotes have been shortened and extraneous content has been removed. Below is an example of a quote before and after editing.

**Before editing**

*With the three people I was thinking about mmm yes... the gentleman with the red eyes, the gentleman, him, who is very*
active oh.. and the lady who's under sixty-five I think.. it would be very easy to contact those relatives and arrange a time, it wouldn't be a problem with those people (Brian/VHS22/16.5.05)

After editing
the three people I was thinking about, yes... it would be very easy to contact those relatives and arrange a time. (Brian/VHS22/16.5.05)

Quotes are representative of all voices of participants. The findings also use illustrations of other data sources which include my reflective diary and field notes.
The use of, and response to contact reflections

Introduction

The data provided the opportunity to examine staff using contact reflections, the response from people with dementia, and whether staff were accurate in their use of the approach. From this, particular features of using contact reflections with people with dementia emerged. This chapter presents findings supporting the view that staff can use contact reflections. After comparing the practice of staff with the theory of contact work it became evident that using contact reflections with people with dementia requires considering: i) greater emphasis on using non-verbal reflections, ii) physical distance with the person, iii) the language used when doing contact reflections.

Contact reflections sometimes resulted in small but significant responses from the person with dementia; these were sometimes unusual and surprising. Contact reflections may be useful in enabling people with dementia to maximise their practical abilities when combined with other aspects of care such as physical care. These findings indicate the potential for contact work to be a useful addition to dementia care. The structure of this chapter is outlined in Fig. 5.3.
Findings

The use of and response to contact reflections

Staff performing contact reflections

- Staff using the range of contact reflections
- Specific features of delivering reflections
- Contact behaviours and changes in contact functioning
- Extra-ordinary and unexpected responses
- Beneficial effects

Response from person with dementia

Fig. 5.3. The use of contact reflections and the response from the person with dementia.

5.1 Staff performing contact reflections

It is useful to start by seeing whether, in fact, staff were using contact reflections, prior to evaluating the response. Participants demonstrated four types of reflection (Fig. 5.4).

<table>
<thead>
<tr>
<th>Reflection Type</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Word for Word Reflection (WWR):</td>
<td>She said 'I love my mum' and I said 'You love your mum' CATHY/VHS8/24.2.05</td>
</tr>
<tr>
<td>Bodily Reflection (BR - non verbal)</td>
<td>Well if she was moving, I would do the same ALISON/VHS2/29.12.04</td>
</tr>
<tr>
<td>Facial Reflection (FR - non verbal)</td>
<td>She was chewing. I was mimicking her doing the chewing... ADAM/VHS11/18.3.05</td>
</tr>
<tr>
<td>Situational Reflections (SR):</td>
<td>You're looking at the window BARRY/VHS28/1.7.05</td>
</tr>
</tbody>
</table>

Fig. 5.4. Contact Reflections.
Findings

These illustrations show contact reflections may be verbal or non-verbal and offer a concrete reflection of what the worker notices. The illustrations above are consistent with the definitions offered in the Pre-Therapy literature (Prouty et al 2002).

By offering concrete and specific reflections, participants focus on the subjective experience of the person with dementia, again consistent with Prouty’s descriptions of contact work (Prouty et al 2002). A challenge for staff was reflecting even when it was difficult to understand what the person was experiencing or their speech was almost unintelligible.

(she) was talking all the time and I was mirroring her and repeating what she was saying even though the words didn’t make sense ANDY/VHS4/10.2.05

This is comparable with working with contact reflections in other fields, where staff reflect what they notice, suspending judgements and avoiding questions or interpretations of the person’s behaviour. In dementia care the worker also avoids assumptions about speech, assuming that utterances may have meaning even though they may appear unintelligible.

On a basic level, staff used the four contact reflections (word for word, bodily, facial and situational reflections). Only one participant (Cathy) mentioned the fifth type of reflection, reiteration. Reiteration aims to strengthen contact by remaking contact by repeating a contact reflection that has shown an effect (Saunders 2007). For Prouty, reiteration can be immediate or over time. Cathy demonstrates both.

... she was talking about a baby...so I reflected about the baby, just about the baby, I tried it another time and just said something like ‘You were talking about babies’. CATHY/VHS8/24.2.05

... I know she has lost two children, so the next time I go in I’ve got that bit of a relationship to work with CATHY.VHS30/22.7.05
Evidence of reiteration was scarce. Moving on too quickly in an interaction or failing to notice the response to contact is a likely explanation why staff used little reiteration. This is addressed in Chapter 6 in relation to skill development. In my own experience, reiteration was more difficult. Whilst other contact reflections are of the immediate moment, reiteration requires returning to a moment of contact, whether from a previous interaction, or from a moment which has just passed within an interaction. Using reiteration requires staying with the contact. Comparing my practice with that of others, I also experienced times when, rather than strengthening contact by reiterating, it was tempting to offer another type of reflection or move the interaction on to more congruent functioning such as asking a question.

Staff were able to replicate the reflections, aside from reiteration. However, replication is only part of the artistry of using contact reflections. Prouty points to subtlety of contact work, which involves empathy, looking and seeing the client, noticing minute responses in the client and making judgements about the pace of delivery. Whilst the contact reflections are the concrete manifestation of Pre-Therapy, contact work is more than a mechanical replication. Prouty offers a reminder that Pre-Therapy is about embracing and reflecting the phenomenological 'lived world' of the client as they experience it, not simply mirroring it in a mechanical way.

Specific features of reflections

Three particular features emerged when staff used contact reflections. These were in relation to non-verbal communication, closeness and proximity, and the use of language (specifically nouns).

Non-verbal communication

Contact reflections require a worker to convey empathic understanding. The literature review highlighted the complexity of empathy and whilst empathy is called for in the rhetoric of policy, there is a debate about its
use by health care staff (Morse 1992). Conveying empathy involves words and non-verbal communication. Therefore, contact reflections involve non-verbal communication. Participants used non-verbal communication and reflections were frequently accompanied by gestures, movements and sounds which enhanced the verbal reflection. As well as helping to convey an empathic understanding this helped reinforce the reflection. Cathy illustrated how she used non-verbal communication in her reflections.

*She started crying and I said ‘You’re crying’, then I said ‘You have a tear trickling down your face’, (Cathy gestures to her own face tracing a tear trickling down).* CATHY/VHS/2.4.05

Non-verbal reflections included adopting similar body postures, echoing the tone, pitch and sounds, and mirroring the style of talking. The data suggests that emphasising non-verbal communication when using contact reflections with people with dementia is useful. This is entirely compatible with existing dementia care literature that also stresses the use of body language, gestures and non-verbal communication (Killick and Allan 2001).

Seemingly, staff were combining existing practice of enhanced non-verbal communication with contact reflections, bringing their past experience and expertise about communication to contact reflections. Non-verbal reflections may be of primary importance in creating empathic contact in more severe stages of dementia as there is greater reliance on non-language based communication. An example from personal experience illustrates this point.

*I was attempting to use contact work with a woman who was silent, isolated and beginning to look in slight discomfort. Her facial expression was difficult to read, but seemed to indicate an element of ill-being or discomfort. She began to rub her side. There was no contact from a verbal reflection. I offered a Bodily Reflection by mirroring her actions non-verbally and strengthening it with a low groan. She looked at me and looked at her hand rubbing her side. Reflective Diary/Sept 2003.*

Using non-verbal communication to convey empathy is not new, but the data indicated staff freely used non-verbal communication. This may be
partly intuitive on the part of workers, and partly explained by the familiarity of working in non-verbal modes with people with dementia.

Closeness and proximity

Physical distance between worker and the person with dementia emerged as a feature of using reflections. Prouty discusses spatiality (distance) in psychosis, seeing the experience of psychosis may mean distortions in space or distance. Hallucinatory experiences may require physical space and the worker adopts a physical distance from the client to accommodate this (Prouty 1990; 1994). As this study is with people with dementia there could be no assumption of parity between psychosis and people with dementia. Indeed, the findings indicate physical distance with people with dementia differed from proximity between a worker and a person with psychosis (Rapp 2000).

The data showed this differed for dementia care, indeed the findings indicate physical closeness was often used in conjunction with the reflections. In dementia care, physical closeness is a feature of everyday care. Staff provide physical care which involves touch and physical closeness, and this featured in the use of the reflections. At times staff were using contact reflections on the person with dementia. Alison explains why she instinctively used a bodily reflection that included touch to increase the likelihood of contact.

When she'd touch her blouse, instead of me touching my blouse, I'd touch her blouse ....Why would I do it on me when she's talking about her blouse? I could connect with her by touching her blouse, I'm acknowledging her. ALISON/VHS20/15.5.05

Interactions with people with dementia were frequently of an intimate distance (less than 18 inches), as opposed to personal distance (18 inches to 4 feet) or a social distance (4 - 12 feet) (Porritt 1990). Where the client accepts closeness, the worker can use this to maximise awareness of reflections.

It is not possible to make generalisations about personal space; some people require more personal space, others invite closeness. Staff
judge this in relation to maintaining their own personal safety and the response of the person with dementia. It would seem that staff make similar judgements when using contact reflections. The data indicates that using closeness and proximity enhanced the potential for the reflections to be noticed. By enhancing closeness, the worker maximises the chance of the person with dementia to see themselves reflected in the presence of the worker. Reflections at close proximity may enhance relational engagement because the person with dementia experiences a physical aspect to the contact with the worker. Contact work for dementia care is more likely to involve closeness and proximity combined with therapeutic touch and reflections physically on the person with dementia.

**Language and contact reflections**

A third area relates to language. Prouty stresses the importance of being concrete – for example, ‘Your arm is on the table’. Staff showed this by naming and reflecting the concrete, for example, ‘You’re walking in the corridor’, ‘Your hand is on the chair, you are pointing at the plate’. However, there is a potential difficulty with the use of nouns in relation to dementia. Difficulty recognising or naming objects is a relatively common feature of dementia, for example, a cardigan may be interpreted as a ‘duster’. Disorientation in time, place and person means the person with dementia may not understand their experience in the same way as someone without dementia. For example, the person may believe the ward environment to be the inside of a boat. Visual disturbances, hallucinations or misinterpretation of objects occur. For example, a cushion may be perceived as a child sitting on a chair.

All these indicate caution in using concrete reflections and using correct nouns. I introduced this idea in discussions on all sites. A discussion illustrates the dilemma.

*Penny: ... I’m curious about when do we use a very specific noun, when do we use an abstract term like 'it'.......*
Cathy: Would you collude with their use or misuse of a noun, or would I reflect? Hmmm. I'm unsure in my own mind whether I'd use the word 'spoon' because I don't know if that person recognizes it a spoon...

CATHY/VHS8/24.2.05

The data shows that through reflections staff convey a shared understanding. This does not necessarily mean being factually correct, as the overriding purpose is to attune to the meaning and the experience.

I guess the reflection of going through the motions (gestures holding spoon to mouth), ...rather than 'you mean spoon' because you're with them in the movement. I guess they feel that you're understanding them by your (gestures) with them.

CATHY/VHS8/24.2.05

At times, correct nouns had little response and this may be because the noun meant little to the person with dementia. Difficulty in judging the language and comprehension ability of the person with dementia is explored further in Chapter 8.

When using contact reflections it is necessary to consider whether to use a concrete, factually correct reflection such as 'You touch the newspaper', or use a vague pronoun such as 'You touch it'. Factually correct reflection may result in the worker imposing their perception of reality on the person with dementia. Vague reflections stay with the reality of the person with dementia. This maximises the chance of engaging with the world of the person with dementia, even if that reality is not shared in a factual sense. This point was discussed with Garry Prouty, who affirmed that if staying with the subjective reality of the person was achieved by vague pronouns this was preferable over concrete reflections where the person with dementia may not recognise the words. (Email dialogue: 25.3.07 and 27.3.07) Use of reflections requires gauging linguistic ability in order to judge when to use correct nouns or vague pronouns.
Findings

The data is ambiguous about whether factually correct reflections or vague nouns are more effective. There are many variables within micro-interactions: individual cognitive and linguistic ability, the fact that verbal reflections are interwoven with non-verbal communication, environmental factors such as noise, and the individual staff approach.

The dementia literature already provides guidance on the use of nouns. Vague pronouns are part of Validation Therapy, used to acknowledge and validate the world of the person with dementia (Feil 1993). This is a clear overlap between Validation and Pre-Therapy. Killick, too, uses poetic and metaphorical patterns of talking, including vague pronouns, to engage with subjective experience.

Taking the issue of language beyond nouns, the complexity of how to respond in order to offer contact reflections emerges. For example, if a person holds a spoon and says 'trowel'. The worker has to make a decision about what reflection to use. They might say any of the following (the list is not exhaustive). The first two responses illustrate the option of noun or vague pronoun. Subsequent statements are alternative ways of reflecting.

- You hold the spoon
- You hold it
- You say trowel
- You hold the spoon and say trowel
- You look at it
- You look at the trowel
- You look at the spoon and say trowel

This indicates that, despite the apparent simplicity, knowing what to actually reflect becomes complicated when an interaction is broken down to minute components.

The findings indicate flexibility when reflecting - gauging language to maximise chances of meeting the subjective reality of the person with dementia. This offers possible variation from the Pre-Therapy literature, where reflections are more likely to use correct nouns. It is not easy to
assess the cognitive and language capacity of a person with severe dementia and workers may have to experiment.

Summary of using contact reflections
So far, the findings have been restricted to examining how workers use contact reflections in relation to the theory and practice of Pre-Therapy. The following findings stand out. First, staff used the four contact reflections, and reiteration was less apparent. Reflecting non-verbally seemed particularly important, and physical distance often seemed less than that in other client groups. The use of nouns or vague pronouns depended on the cognitive and linguistic capacity of the person with dementia.

5.2 The response of the person with dementia
The responses of the people with dementia to contact reflections can be categorised thus: contact behaviours with changes in contact functioning, extra-ordinary responses, and beneficial effects.

Contact behaviours and changes in contact functioning
Prouty's work outlines how, reflections facilitate greater functioning in a client. By making a comparison between the data and theory, it is possible to see whether contact reflections establish contact with people with dementia. Prouty sees the response of the client as the gauge of contact. Responses are termed contact behaviours and indicate a change in the functioning of the client. There are three levels of functioning: reality, affective and communicative functioning. Reality contact is shown by awareness of people, places, things or events in a subjective or objective sense. Affective contact is awareness of moods, feelings or emotions. Communicative contact means the person expresses the world as they understand it and conveys this to another person (Prouty et al 2002). Fig. 5.5 offers a reminder of these key concepts and sample responses (not taken from the data).
Participants shared an understanding that eye contact indicated contact. Increased eye contact indicates a change in reality function – the person with dementia is more aware or more in tune with the surroundings. What emerged from the data were times when eye contact felt unusual to the participants; it felt more profound and the emotional contact felt 'deeper'. Apollo describes this, emphasising the fact that AS looked him straight in the eye. Apollo and AS are reciprocally aware of each other and engaged in a mutual meeting.

He (AS) was drinking tea and having a cake on his other hand and I was doing the very same thing (bodily reflections) and he...turned round and came back and then look at me straight in the eye APOLLO/VHS1/29.11.04

In relation to theory, Peters refers to this as ‘two-way intersubjective attunement’, and the sensation of attunement is indicative of the development of psychological contact and a relationship (Rogers 1980; Mearns and Thorne 1999; Peters 1999).

Profound eye contact was relatively rare. More generally, staff simply noticed eye contact, rather than make statements about it. The consequences for staff of profound contact are explored later (Chapter 8). It is sufficient in this chapter to acknowledge that an increase in

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<table>
<thead>
<tr>
<th>Example of contact reflections</th>
<th>Example of a contact behaviour or response to contact reflections</th>
<th>Contact function</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are sitting</td>
<td>Client looks at chair</td>
<td>Reality contact</td>
</tr>
<tr>
<td>(Bodily Reflection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You smile</td>
<td>Client smiles more and nods in agreement</td>
<td>Affective contact</td>
</tr>
<tr>
<td>(Facial Reflection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The bell is ringing</td>
<td>Client says 'It's loud'</td>
<td>Communicative contact</td>
</tr>
<tr>
<td>(Situational Reflection)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
contact functioning, expressed through eye contact, can result from the use of contact reflections with people with dementia.

Eye contact was a component of feeling in tune with the person. A term used by participants on different sites was being on their wavelength. Barry explicitly linked establishing contact and being in tune:

*If you're on the right wavelength there is quite a response*  
*BARRY/VHS26/1.7.05.*

Judging contact was not always simple. In contrast to Barry's experience, Alison illustrated the difficulty in gauging whether contact has been made.

*... sometimes you can be talking to AS and you think you have got contact and you realise you only have to move and he's looking into space, you haven't got that contact. Other times you come in and you think he's looking into space and he's not, he's actually following you and you have got contact*  
*ALISON/VHS18/15.5.05.*

The experience of being engaged in profound eye contact and being in tune may result in workers having their own reaction or 'felt sense' of the relationship (Gendlin 1973). This is in line with Prouty's idea that reflections enable a relationship of existential depth, where two people are being together at a deep level based on attunement. Cathy described an occurrence of attunement:

*...the emotional contact, I felt inside her, that I wasn't removed from her.... and it was just was like this huge feeling....*  
*CATHY/VHS8/24.2.04*

Whilst occasions of this depth were relatively rare, they echoed reconnaissance work and the experience of others. An extract from my reflective diary shows similar depth of contact, fitting Peter's definition of two-way intersubjective attunement.
Findings

A student has approached me wanting to describe what has happened. She works in a day centre. One woman spends a large part of the day walking. She used the contact reflections whilst the woman was in a corridor. The nurse reported to me that the woman looked at her intensely, touched the nurse on the chest and said 'You know', then touched herself on the chest and again said 'You know'. The nurse felt they had established a deep contact and the woman was showing her that she felt the nurse had an understanding of her and that there was a mutual understanding. After this initial contact, every time the woman saw the nurse again, she repeated this gesture and the words 'You know'. The intensity of the contact and the unusualness had led to the nurse seeking me out to tell me. DATE - 10.10.04

Rapid contact was seen in response to reflections. For example, 'You're holding the chair' 'Oh, yes I am'. The data is not conclusive whether rapid contact necessarily resulted from contact work. Possibly, the simple act of reflecting (which by nature requires staff to avoid other ways of communicating) allows more opportunity to engage or the person was not pre-expressive, simply passive. In this case the overture offered by the staff results in immediate contact.

However, rapid contact could lead to expression of a very emotive subjective experience, for example 'Your head is down' (bodily reflection). 'I'm dead' (response). Rapid emotive contact opens up possibilities for psychotherapeutic work with dementia to be woven into everyday interactions. Contact reflections have the potential to facilitate expression of unresolved emotional wounds such as the death of a child, fear about being lost or a host of other emotions. This provides an opportunity for beginning to engage in more in-depth psychological work with people with dementia in areas such as: loss, grief and mourning, the experience of losing a sense of self, existential chaos or a narrative of chaos; or simply engaging and responding to a person's fear (Phinney 2002; Sammut 2003; Tibbets 2004; Rentz et al 2005). However, as is shown in Chapter 8, being open to the experience of others is not always easy, particularly for staff who have little training in therapeutic counselling skills.
Findings

Changes in contact functioning

Further comparison with theory is possible in relation to Prouty's idea that contact reflections facilitate a change in contact functioning. What follows now are examples of contact behaviours indicating changes in contact functioning.

Changes in reality and communicative contact are seen in the following extract. At the time of this interaction AS was walking in the corridor, his eyes seemed unfocused and he was walking slowly without any discernable purpose next to the wall and seemingly unaware of the presence of others. The reality and communicative contacts are evident at the end of the interaction where he has contact with his environment and communicates this to me. Abbreviations indicate the type of reflection (BR - bodily reflection, SR - situational reflection, FR - facial reflection, WWR - word for word reflection, RR reiteration reflection).

\[ Penny: 'We're walking.' (BR) \]
\[ (I was also reflecting his bodily movements of walking) \]

\[ AS: (no response) \]
\[ (continues walking, making no eye contact, no change in behaviour) \]

\[ Penny: 'The rail is there'. (SR) \]
\[ (I reach across and touch the rail; whilst this may seem intrusive there is a need to provide greater visual and non-verbal cues for people with dementia as the capacity to comprehend language may be severely impaired) \]

\[ AS: (no response) \]
\[ (continues walking, making no eye contact, no change in behaviour) \]

\[ Penny: 'We're walking, your hands by your side, the rail'. (SR, BR, SR) \]
\[ (verbal reflections are also reflected non-verbally) \]

\[ AS: (no response) \]
\[ (continues walking making no eye contact, no change in behaviour) \]

\[ Penny: 'The wall is here'. (SR) \]
\[ (I touch the wall, this means reaching over putting my hand in his field of vision) \]

\[ AS: (looks at my hand - this indicates contact) \]

\[ Penny: 'Is here, you look at my hand on the wall'. (SR, FR, RR) \]
Findings

AS: (continues walking – contact is lost)

Penny: 'We're walking, your face is down'. (SR, FR)

AS: (touches the wall)

Penny: 'A picture here'. (SR)
(I touch the edge of the picture frame, running my hand up and down the frame)

AS: (touches the frame – reality contact indicated by his engagement with the picture)

Penny: 'Your hand on the frame'. (SR)

AS: (looks at the picture and looks at me – reality contact with the picture and communicative contact with me)

Penny: 'You look at me and the picture'. (FR, SR)

AS: ‘Grrrrrrrrrrrrrrrr’. (He touches the image on the picture, then looks at me, growls and then smiles. The picture is of a tiger.

PENNY/VHS4/10.2.05

Reality contact does not need to be either a shared reality or the 'correct' reality. An illustration of this was captured filming Alison with KP. KP showed contact with her reality, which is not technically factually correct. She notices the camera, and on seeing the light attempts to blow it out as if it were a candle. Whilst she has factually misinterpreted the camera light as a candle, she is in touch with her understanding of reality and her reality functioning is at an expressive level whereby she is engaging, expressing and communicating her experience of reality.

Changes in affective and communicative contact are illustrated next. Cathy had been reflecting for a short period, with a man whose speech was disjointed.

...he suddenly came out with 'I feel guilty. I feel ashamed'.

CATHY/VHS 30/22.7.05

In this instance, the statement about how he feels indicates affective contact with his emotions. Momentarily, affective functioning is restored and conveyed.
Findings

The presence of contact behaviours and changes in contact functioning in response to reflections indicate an element of ‘success’ in applying contact work to dementia care. The data indicates that contact reflections do indeed make contact. Changes in the behaviour of the person with dementia would match with Prouty’s definition of contact behaviours. In relation to Prouty’s theory, the data indicates that contact reflections result in contact behaviours which affect affective, reality and communicative functioning. This strengthens the potential for the application of Pre-Therapy to dementia care to facilitate awareness of sense of self, surroundings and relationships.

Because the reflections are non-directive, interactions remain focused on the subjective experience of the person with dementia. This is compatible with Prouty’s work. It would be ambitious to claim that responses are entirely due to the contact reflections, but within this study it is impossible to find out if the person with dementia would have responded differently to another type of interaction. A limitation of this study is the lack of information about the quantity of success. Further exploration could investigate the measure of success of contact work; this study stands simply as preliminary exploration into the potential for the applicability of contact work to dementia care. It might be possible to develop an objective measure of response to contact work. This could involve building on existing work by Prouty and Dinacci, who have devised scales for recording changes in contact functioning in clients but making them specific to people in later stages of dementia (Dinacci 2000).

Extra-ordinary and unexpected responses

Some responses to contact work were seen as out of the ordinary, unusual or surprising.

I was a little bit surprised there was so much of a response. There has been more verbal response from this lady since your last visit here. BRIAN/VHS22/16.5.05
Findings

Although these occurrences were brief, they were significant.

... he looked straight at me and reached out and touched my head and I haven't had that happen at all before.... touching is not something that normally happens.
BARRY/VHS26/1.7.05...

Alison and Ayline illustrate surprise arising from the contact which resulted in extended eye contact and affective contact (AS started crying). This reaction was unique: his emotional states were more commonly agitated, aggressive, smiling and interactive, or passive, withdrawn and distant.

AYLINE: I've only known him for about eighteen months, and I truly don't think I've seen him cry like this

ALISON: No he wouldn't have cried like this, he has other emotions. I've never seen this emotion, whatever he was feeling inside.

AYLINE/ALISON.VHS1/29.11.04

Other responses were surprising. Staff found they could have longer conversations, get responses from people where communication was virtually absent, and noticed that residents would initiate physical contact with the worker instead of the other way round.

Contact was often quite small and short-lived. This is in line with Peters' work in the context of Learning Disabilities which found that contact reflections enhance moments of lucidity (Peters 1999). Bruno describes such a moment:

He was looking at me and he started to smile. He doesn't talk much. When he smiled, I smiled too, and I was looking straight into his eyes and he said 'Hello. How are you?'. This doesn't happen very often. I couldn't engage a conversation with him, it was only this in this minute he realised that I was, you know, eye to eye, we smiled at each other and that's all – 'How are you?'
BRUNO/VHS9/17.3.05

The accounts which staff felt were unusual were small in number, and caution needs to be exercised in presenting this finding. It is possible that staff found these significant simply because they were concentrating on the person, being non-directive and offering some time. However, there were responses which were sufficiently out of the ordinary to
warrant being presented as a finding. This is substantiated by: clinical activity outside the research, personal experience, accounts from people attending Pre-Therapy workshops outside of the research activity and relatives. A relative within the research illustrates this.

I spent some time talking to Mrs X about the research on site B, explaining the techniques and the rationale behind trying to improve the communication skills of staff. She was sitting next to her husband. I showed her what the contact reflections were. Her husband was sitting back in a chair, no facial expression, staring ahead, shifting about slightly. He did not seem aware of his surroundings but looked uncomfortable and fairly distressed.

I shifted to sit in front of him, mirroring and reflecting his hand movements, using touch so that where he was tapping his leg I did the same thing, saying 'tapping'. I don't know whether he is able to understand any language. He seemed to become aware that I was there, turned his head, and over a short period of time looked at me. This look was much less blank and he reached out and touched the side of my face and made a sound. His wife immediately said 'Oh look what you've got him to do, how lovely'. This event was unusual and obviously important to her - as I heard her talking to another relative about it later that day.

REFLECTIVE DIARY/Site B/15.3.05.

The significance of responses was evident in the reconnaissance work as well as the data, although the importance of this had not gained sufficient status in the early stages of the research. In retrospect, one extra-ordinary response was a defining moment which prompted me to think more about the element of surprise.

Freddy (pseudonym) contacted me telling me that 'Something remarkable has happened'. He has introduced contact work to his ward following the half-day workshop (this was part of a teaching program for post registration nurses, not part of the research study). Freddy, other staff and the man's wife have been using contact reflections. Freddy told me that the man's speech has improved to the point that he formed full sentences.

The incident that provoked Freddy to contact me occurred on the ward with the man's wife. She (the wife) was primarily using word for word reflections, lots of silence, and bodily reflections. She picked up on one word that she could make out in a sentence - the word 'love'. He (the patient) then turned to his wife, looked her in the eye and told her that he loved her.
Findings

Freddy told me that this incident has been important to her; she was moved to tears, the staff are very touched, and Fred described it to me as one of only two 'golden moments' in his entire nursing career. Reflective notes: Aug 2003.

Three years into the research an incident from September 2006 illustrates consistency of the theme of surprise.

Sept 2006. I have been asked to assess a person to see if contact reflections would help staff. Client was described as difficult to have any physical closeness with, resistant or aggressive in response to physical care, has no language, but the staff feel that his level of comprehension is good. Whilst he is aware of other people approaching him, his usual reaction is to walk away and staff find him very difficult to approach. I demonstrated the techniques to the staff. Two staff observed me from a distance.

I approached him, keeping a distance of about 6 feet. He is very quick to notice anyone within his vision (NOT out of contact with environment) and I wanted to see if the contact reflections would allow me to build any sort of relationship or communication with him. I used bodily reflections — he was sitting with his hands on his lap, feet on the floor, occasionally tapping. I reflected these. I used situational reflections, drawing attention to the room, other people, and the furniture. These reflections resulted in almost instant eye contact. I spent some time reiterating verbally — 'You are tapping your leg and you looked at me', 'I said telly and you looked at the telly', 'I'm sitting near you and you have looked at me'.

After about five minutes of reflecting, he smiled at me. I then tried to say 'hello' and introduce myself (a congruent response, based on feeling that he was expressive), but he walked off. The charge nurse told me that to receive a smile and to remain in the company of someone new was unusual. REFLECTIVE DIARY/9.9.06

Whilst these occasional extra-ordinary responses may not be representative of responses generally, they hold significance to workers. People outside the research study contacted me to relay experiences. I acknowledge that no staff actively sought me out to report a lack of response, however the strength of surprise is considered significant.
Beneficial effects

I still wasn't getting a full sentence ... but a lot better than normal. ANDY/VHS4/10.2.05.

Contact reflections were seen to be beneficial. They could be used to help whilst staff were doing other things and helped maximise the abilities of the person with dementia.

All staff used contact reflections as part of their everyday work as well as setting time aside to use contact work as the sole purpose of an interaction. Cathy's role, being outside the nursing team, gave her the most opportunity for concentrated contact work. For others, the real life context meant using reflections as part of an interaction with an alternative purpose such as providing physical care. Contact reflections were seen as being helpful, making physical care easier. Amy sought me out to describe how they had helped a colleague carry out personal care with a man who was frequently resistive and aggressive.

He calmed right down and he allowed them to undress him, wash him and give total intimate care. AMY/VHS10/17.3.05.

This indicates that contact reflections may have the potential to reduce resistance or aggressive responses.

Staff saw some lessening in unwanted behaviours. YS provided an illustration. Throughout the day, she walked the corridors grinding her teeth loudly. Brian noted that contact reflections sometimes resulted in her stopping the grinding. As well as immediate responses, the data suggested delayed effects. Anna commented on the after-effects of my session using contact work with KP.

We had KP in such a disturbed state and then you came and gave her extra attention (the contact work) and she was really settled and calm after that, it was really unbelievable. ANNA/VHS25/2.6.05.
As well as reducing behaviour, this may have consequences for other aspects of care. During a chance encounter I overheard a conversation between Cathy and Anna.

Cathy was writing her notes in the office and telling me about an interaction with a resident. She has been using the contact reflections with him. She has felt that it had calmed him down. Anna came into the office and spontaneously said to Cathy that what she has been doing with him had avoided them having to give p.r.n. medication. REFLECTIVE DIARY/SITEA/4.6.06.

Staff saw the potential for using contact reflections whilst doing other tasks or physical care.

While you’re helping someone you are interacting with them as well so it’s killing two birds with one stone really ADAM/VHS11/18.3.05.

This echoes the use of contact work by Van Werde (Prouty et al 2002) where reflections are used to anchor a person with psychosis by strengthening contact functioning and nurses use contact reflections alongside other nursing activities such as practical activities. Cathy illustrated this in relation to helping someone undress. She moves between contact reflections and a question.

even, as taking a patient to the toilet today and saying 'You're touching your buttons, do you want the toilet', and then saying 'I'm undoing your zip' just so that there is that contact. CATHY/VHS30/22.7.05.

Whilst this may seem simple or obvious, Brian reminds us of the common practice of providing physical care as if the person were an object. This highlights the variance between providing physical care which acknowledges the person and care which does not:

there is no communication going on, no explaining what we are about to do.....it is 'Onto the bed', its turning and it's washing and propping up. Actually, we're not even using the person's name, there's no explanation of what we're doing, on the hoist one minute and then they're on the bed and then they're rolled. BRIAN/VHS13.1.4.05.

6 P.r.n. (Pro re nata) medication is additional medication that is administered as and when needed. For this resident the p.r.n. medication was sedation used to help manage his disturbed behaviour.
Contact reflections hold the potential for staff to have more 'person focused' interaction, helping move the relationship away from seeing the person with dementia as an object and towards seeing the person as another. In theoretical terms, this parallels the work of Buber and Rogers, who see relating as either I-it or I-thou (Buber 1958; Rogers 1980).

Maximising the abilities of the person with dementia

On occasions, staff felt reflections resulted in 'getting more' from the person; variously, more talking, more emotion, or more activity. Cathy describes getting more information and life history as fragments of a man's biography unfolds (Addis and Tippett 2004; Surr 2006).

I just used the contact reflections, finding out so much about him being in the merchant navy, how he got burnt, learning all about his experiences how he got pensioned off and where the burns were. CATHY/VHS12/22.3.05.

As a consequence, occasionally, the person with dementia was able to do more than staff expected.

and then I gave her a piece of paper... possibly the first time she's done that for don't know how long, and she didn't just scribble - she wrote in lines. ...There are a few letters you can understand... Spelling the letters as she was writing them and she was saying "yes yes", as I was spelling it out for her. I had contact for twenty minutes and then left her and came back after another twenty minutes. She was still holding the pen, still had the paper... it was very impressive what she'd written. I showed all the other nurses; they were surprised and pleased. ANDY/VHS 4/10.2.05.

Contact reflections may permit the person to be more self-directive, reducing other approaches which stifle self-determination. As a result, staff saw the person with dementia exerting more agency.
5.3 Summary

At face value, the findings show that staff are able to use the contact reflections and these elicit contact behaviours, which were sometimes surprising or unusual. Reflections facilitated changes in contact functioning. This is in line with Prouty's theoretical ideas and implies that Prouty's theory of Pre-Therapy has an application to dementia care.

Particular features of applying Prouty's theory to dementia care are:

- **Enhanced use of non-verbal medium.** Contact reflections are both verbal and non-verbal. For dementia care, emphasis on non-verbal communication in reflections strengthens or replaces verbal reflections.

- **Closeness and proximity.** Staff may be physically very close with some people with dementia; this strengthens the client's awareness of the reflections.

- **Greater use of vague pronouns.** Prouty stresses using very concrete and tangible reflections. In dementia care, there needs to be an adaptation to include the option of using vague pronouns to reflect the concrete subjective experience of the person. This is necessary as the nature of dementia means that language and comprehension are affected. The use of vague pronouns to reflect mirrors other approaches in dementia care which encourage workers to engage with the subjective reality of the person with dementia, even if that reality is distorted in time and perception.

The therapeutic potential of contact work with people with dementia can be summarised:

- Contact reflections offer a different way of communicating which is non-directive, allowing the person with dementia greater opportunity for self-direction and expression within an interaction.

- Contact reflections have the potential to be enabling. The person with dementia can expand on their experience of the world and sustain periods of communication.

- Contact reflections can enhance other aspects of care. They can help ease the provision of physical care and they hold the potential to remind staff to offer some communication during physical care.
• Contact reflections may help maximise levels of activity and communication.

• Contact reflections are the concrete manifestation of a worker seeing, hearing, listening and attending to the person with dementia.

• Contact reflections offer a practical way into engagement with the subjective emotional experiences of the person with dementia. This holds potential to provide care with a more psychotherapeutic intent, for example, helping hear a person's grief, or struggle with their loss of self.

It remains possible that the contact reflections themselves do not result in changes in contact functioning. Changes occur because contact work does not try to lead an interaction, but simply allows space for the person with dementia to express themselves at their own pace. In this sense, contact work is the absence of forms of communication that override the world of the person with dementia. Therefore, contact work provides an alternative to other forms of communication that are less than helpful to the person with dementia.

Whilst this chapter indicates the potential usefulness of contact work, it does not adequately address three issues:

i) Contact reflections in relation to dementia as an organic illness

ii) The development of skill by staff

iii) The influence of the perceptual world of the staff in the application of contact work to dementia care.

These factors mediate the use of contact reflections and are addressed in Chapters 6, 7 and 8 respectively.
Mediating Factor One:
Skill Acquisition

Introduction

This chapter examines the process staff underwent when developing knowledge and skill and includes challenges and barriers that temper the application of contact work to dementia care.

The Action Research process prompted reflective learning, giving staff the opportunity to review their experiences (Ghaye and Lillyman 2000; Clouder and Sellars 2004). They talked about how it felt to do contact reflections as well as giving descriptions of their work. I compared participants' descriptions with my observations of their practice and compared their experiences with mine. I then used differences and similarities to continue to generate ideas and theoretical memos. During the learning process staff showed growing awareness of how contact work differed from their usual patterns of communication, and they experienced deterrents which sometimes led to them abandoning reflections. There were limitations in the level of skill staff achieved and they demonstrated mistakes or misunderstandings. As time progressed, staff began to describe how they were beginning to develop sensitivity in using contact reflections.
Barriers arose as contact reflections challenged social rules of interactions and the context and other people around them affected using reflections. Fig. 6.1 displays the structure of this chapter.

Fig. 6.1. Skill acquisition: learning process and barriers.

This chapter is aligned to the theoretical stance on Transformative Learning from Illeris who draws on research and experience of unskilled workers and adult learning in the workplace. Illeris takes the novel focus of 'non-learning', which covers: mis-learning, distorted learning, not learning, inadvertent learning, insufficient learning, defences against learning, and active avoidance of or resistance to learning (Illeris 2002, 2003a, 2003b, 2004). In a critique of Mezirow’s transformative learning process, Illeris places greater emphasis on the emotional and social domains of learning, as well as on more familiar cognitive perspective (Mezirow 1991; Illeris 2003b). Illeris’s domains are evident in this chapter. The cognitive aspects of non-learning and learning are present in the first section, which explores knowledge development and mis-learning of contact reflections. The emotional aspect shows the
discomfort staff experienced. Social factors are evident where the context mediates the behaviour of staff. Understanding factors which might lead to 'non-learning' helps understand barriers to learning contact reflections, and these barriers have applicability to practice-based learning in general.

6.1 The process of learning

Developing awareness

The learning process broadly had three stages. Initially, contact work seemed obvious, but this was followed by a sense of unnaturalness and then a growing awareness of difference. This indicates learning disturbed thinking, creating a shift in the cognitive domain and knowledge (Mezirow 1991, 1997).

To begin with, staff found contact reflections obvious. Staff recognised them as behaviours in their own practice and the practice of others. This is directly comparable with responses from reconnaissance work where contact reflections seem obvious and nurses felt they do them naturally. The Person Centred principles of empathy, acceptance, and unconditional regard are part of the early teaching. These, too, were familiar to staff and the teaching allowed them to link theory to their practice and they felt that I was telling them something that they already knew.

*Ayline:* It wouldn't occur to me till last month that's what he's (Apollo) doing AYLINE/VHS2/29.12.04

The reaction that reflections were obvious and familiar was both helpful and unhelpful. Helpful because the reflections resonated with the staff's own experience and frame of reference; unhelpful as it held the potential to be seen as common sense dressed in theoretical and academic jargon.

The initial feeling of familiarity changed when rehearsing the contact reflections with their own residents; using reflections felt awkward and
unnatural. This sensation of difference and the presence of some discomfort indicate a disturbance in their sense of knowing (Mezirow 1997).

I don't feel natural doing it. ALISON/VHS2/29.12.04.

The sensation of unnaturalness implied that contact work was unfamiliar once used more deliberately. Discomfort occurred because the worker used only reflections and no other types of communication such as questions or commands. The discomfort came at the point of tipping over from a perceived 'normal' interaction to something new. The difference between understanding contact work in theory and understanding contact work in practice indicates the need for an experiential learning process. A single loop learning (action, reflection on experience, review of experience and re-evaluation) provides the opportunity to move from knowing about reflections in principle to understanding them by experiencing them in practice (Kolb 1984; Adams and Richardson 2005). Moving from principles to practice prompted the shift from them being obvious to being experienced as slightly unnatural and unfamiliar. This indicated that contact work was a different way of communicating with people with dementia.

The transition from obvious to unnatural was prompted by staff being more aware, noticing how it felt using the contact reflections (Mason 2002).

Yes, noticing; I'm noticing more. BARRY/VHS13/1.4.05.

Research encounters prompted staff to review and notice their own practice. This was not always comfortable as Brian showed in a critique of his practice.

It's brought it home about the lack of communication that goes on with a lot of people. Not thinking you are actually dealing with people, rather it is just a job. Doing this really makes you think - wow you've had no contact with that person. I'm occasionally to blame, getting on with the job and not explaining what I'm doing. I occasionally kick myself halfway through and try and put it right. BRAIN/VHS13.1.4.05.
Findings

Alison illustrated growing awareness of her interactions, prompted by the research process.

*It gives you more awareness to spend a little bit more time with them ...I would never have thought about doing the reflections. I think I would have just waffled on to them, chatting away and maybe not being aware.* ALISON/VHS 18/15.5.05.

Barry illustrated how he was becoming more deliberate about interactions.

*Well you would normally go up to someone and say 'lovely day'. Now, it's thinking more about how you start and choosing what you say. I wouldn't go in and say 'oh lovely day today', I would be looking more closely at the person.* BARRY/VHS26.1.7.05.

Participants noticed an essential difference between contact reflections and other patterns of communication. Contact reflections follow the experienced world of the client, the client's experience is central and so they epitomize a client centred approach. This contrasts with other ways of interacting such as being directive and steering interactions, or using questions, commands or statements. Anna describes the difference:

*(Usually) you walk alongside them and start singing a tune and they start falling into with your tune and singing along, then they are following what you're doing, you've started it. But I'm trying to reverse it, and this patient is doing something and you're trying to join them in their activities to get a bond that way.安娜/VHS17/6.5.05.*

Reflection on practice was either with individuals or in a small groups: Anna, Alison and Ayline generated a discussion of the difference of contact work. They describe how the approach allowed an interaction which was client-led:

*Ayline: He (AS) doesn't come looking for us ever, if you think about it, we always go to find him for something or whatever, his daily life's routine is, we always go looking for him.*

*Anna: And then we take him and we put him somewhere where he probably doesn't want to be....*  

*Alison: ...Whereas this time he took us, that's the difference.*

*Ayline: He took over, it was just in the corridor.*  

ALISON/AYLINE/ANNA/VHS1/29.11.04
Findings

Contact reflections prompted a switch in the relationship from staff leading/directing to one which is client led, providing the person with dementia greater opportunity to participate in interactions. This supports the argument that engaging with the 'embodied self-hood' and 'embodied lived experience' of the person with dementia (i.e. their physical being in the world) combats tendencies to treat people as passive beings (Kontos 2005). Whilst Kontos is not specific about how staff could learn how to do this, Prouty's reflections offer a practical, tangible way to engage with the 'embodied self' and the 'embodied lived experience' as contact reflections use this as the basis of the interaction.

The reflective learning process prompted staff to notice and review their practice. The experience shifted from seeming obvious to being awkward and unnatural as staff noticed how contact reflections differed from their usual patterns of communicating. It became apparent that contact reflections posed more of a challenge to staff than expected and I had not anticipated how the emotional dimension of learning, such as feeling awkward, might affect the learning process. This indicates the need for support during the discomfort and disturbance accompanying the learning process.

As well as finding reflections unusual to carry out, there are other factors which can be seen as 'deterrents'.

Deterrents

During the process of acquiring skill, a lack of response increased the likelihood of staff stopping using reflections. Staff were less inclined to repeat something which they saw had no effect or which resulted in an undesired response.

Because you are repeating what they are doing and not getting any particular response back. AYLINE/VHS2/29.12.04.

There may be alternative explanations about the lack of response. Possibly the person had responded, but staff were not sufficiently sensitive to notice. Prouty points out that skill in Pre-Therapy relies on
the sensitivity of the therapist to 'look' and 'see' (Prouty et al 2002: 31). Alternatively, reflections may have been too subtle and so went unnoticed by the person with dementia: environments can be noisy and contact reflections may be lost in the mêlée. A lack of response or 'not getting anywhere' sometimes led participants to conclude the contact reflections 'had not worked' and give up. Cathy sums this up in her statement about having used contact reflections with one man where she felt it was futile.

*It didn't seem to be going anywhere.* CATHYVH530/22.7.05.

My own experience echoes this. There were times when reflecting for a sustained period appeared to have no impact. Sustaining reflecting became difficult, particularly when there were other demands in the work setting. My own response, and that of others, was to move away from the person when there was no response, or to try another approach. The data indicates that contact work may be hard to sustain where there is little or no response, the response goes unnoticed or the response is not considered significant. However, as is shown in chapter 8, this depends on the role perception of the staff and the value they place on small moments of emotional contact. We can draw the conclusion that, for contact reflections to be implemented, staff will need patience and to be prepared for them 'not to work' all the time.

**Novice practice and the potential for errors**

Throughout the research I have been mindful of claiming that people were using contact reflections when, in fact, they were not. This section draws together the common errors in novice practice. This contrasts data in Chapter 5, which showed staff using the contact reflections correctly. Errors stemmed from having insufficient understanding of the theory and being unskilled in using contact reflections. Awareness of these factors can improve future teaching programs.

Staff needed time to develop an accurate understanding of the difference between a contact reflection and other ways of talking. Brian
illustrated misunderstanding and his description of an interaction shows he is not using reflections, rather questioning and trying to initiate a conversation.

She looked as if she was in pain and when I mentioned that, when I asked her that, she did grimace to that question and then I went on. The music was very loud in the lounge and so I asked her 'is the music very loud?' and she was quite quiet, and I didn't get any response to that. BRIAN/VHS9/17.3.05.

In contrast, he later accurately described using a contact reflection. Here his observation of the resident is followed by a concrete reflection and he reports a minor change which is indicative of the beginning of contact.

She was crossing her legs and I said, 'Your crossing your legs' and there was a change in expression on her face. BRIAN/VHS9/17.3.05.

Staff also needed time to become familiar with the different reflections. Anna illustrates a common difficulty: being unsure what to do and say to reflect. Anna, AS and I were in a corridor with Anna practising whilst I gave instruction and video-recorded.

Penny (to Anna): If you're reflecting his environment you can draw his attention, so there is a thing here, a door.

Anna (to AS): 'You're stopping, you're turning round'.... (To me) would that be it?

Penny (to Anna): There is a window. The light is shining. The situational reflections are a way of drawing attention to the world.

Anna (to me): Oh I see, you sort of talk about the environment I see.

Penny: Or show it point to it, tap it.

Anna (to AS): 'Your taking quite a walk today'... (to Penny) That wouldn't be environment, would it?

Penny: No, that's bodily, 'You're walking'.

Anna: Oh dear.

ANNA/VHS25/2.6.05
Developing skill requires being adept at drawing on the range of reflections, selecting those with most meaning to the person and having the verbal and non-verbal repertoire to offer reflections. An element of 'stiffness' and favouring certain reflections became apparent. A video of Adam and KP was shown to two members of the Pre-Therapy Network, who commented on the rather mechanical delivery. Alison noticed she favoured bodily reflections and word for word reflections, being less confident with facial reflections.

*Alison:* The mirror (bodily reflections) I think I use more, the verbal one (word for word reflections) I use that as well....... I don't do the facial ones. If they look sad (pulls sad face), I don't do that so much. ALISON/VHS9/10.2.05

Situational reflections were used less, with staff showing a tendency to favour reflections of the person themselves, rather than reflections of the person in their environment.

Developing skill required making judgements about when to sustain reflections and when to try another response. This requires judging whether someone is pre-expressive or expressive. Barry illustrates judging the person as expressive and moves on to a question. Barry interprets that the conversation ended because it became circular. It may well have been that the person with dementia had nothing more to say. However, if Barry had sustained the contact work, rather than moving on to trying to get a conversation, the interaction may have evolved differently.

*(He) was sitting in a comfortable chair, (I said) 'Your sitting down', (reply) 'Yes'. (I said) 'Been busy'. I said 'Are you tired?' He looked tired. 'Oh yes I'm tired, I'm sitting down.' So it went in a sort of circle, so I thought it was the conversation came to an end quite quickly. BARRY/VHS9/17.3.05.*

In comparison, Cathy describes sustaining reflections.

*And just by reflecting, I learnt that she has four children that two died, that her husband was quite brutal, that she was married for 17 years. That the children died when they were very young, that she was in the air force. Just by constantly reflecting......, so just*
Findings

stayed with word for word reflections and felt that in five minutes, because it was literally five ten minutes, that I found an awful lot out about her, just for word for word reflecting. CATHY/VHS 30/22.7.05

Sustaining reflections requires taking the interaction slowly, resisting the temptation to change tack or give up (Saunders 2007). The data illustrates how judging pace, pitch and delivery and sustaining reflections is part of the skill which are disguised by the apparent simplicity (Prouty et al 2002; Saunders 2007).

Illeris serves as a reminder that teaching does not automatically equate to learning and that non-learning does not always arise from direct resistance, but can be simply an absence of learning or mis-learning (Illeris 2002). Variations in learning occur in relation to personal characteristics, learning style and learning capacity and the development of competence requires time, practice and reflection (McElroy et al 1991; Nicol et al 1996; Spalding 2000; Benner 1984, 2004).

Developing sensitivity

Despite initial difficulties, staff began to develop greater sensitivity in their practice by gauging expressiveness and improving their ability to stay with the subjective reality of the person.

Pre-Therapy is used when a person is pre-expressive rather than expressive. Therefore, staff need to identify differences in levels of expressiveness. Where a person is expressive they are in contact with themselves, their emotions, their own experience of their reality, and they can communicate this (Prouty et al 2002). Staff demonstrated trying to judge who might be pre-expressive. Anna shared her thoughts with Ayline, Alison and Apollo about the need to be selective.

It's not a technique that you can use on everybody, so it's finding the right person. ANNA/VHS2/29.12.04.

Independently, on all three sites staff identified the characteristics of people whom they felt were suitable for contact work. These people had
severe language impairment, were relatively quieter, withdrawn or displayed behaviour that was difficult to understand. Cathy provides a picture of those she considered suitable.

There are patients walking about just looking at the floor, behaving in quite a distressed way, pushing furniture, appearing half-dressed, just aimless really, and lonely, isolative; and those patients interest me more than the ones that join in the activities. CATHY/VHS8/24.2.05

Residents who were identified as expressive were unsuitable.

Lots of our patients are able to express themselves verbally quite well, so I didn’t feel it would be useful doing those techniques. Certainly doing contact reflections with those people would be totally inappropriate. BRIAN/VHS13/1.4.05

Gauging expressiveness is more problematic in people with dementia because of impairment of speech, language and communication. Therefore, gauging expressiveness involved judging people who were not coherent but still expressive. Adam illustrated this in a discussion about KP. KP has severe language problems and it is likely her level of expressiveness fluctuates between being expressive but not coherent, expressive and coherent, and pre-expressive.

Even though it was not legible (meaning comprehensible) to us, in her world it is - she knows what she’s saying, what she wants. ADAM/VHS11/18.3.05.

The importance of accurately gauging expressiveness is that reflections target a pre-expressive state not an expressive state. This adds complexity for staff in the learning process because it is not immediately apparent when a person is expressive or pre-expressive.

Developing sensitivity in contact work required engaging with the subjective reality of the person.

To enter their world and then see if you can contact them. ALISON/VHS18/15.5.05.

However, sustaining reflections, which requires maintaining a focus on the experience of the person, may be difficult if staff have a tendency to
impose their own agenda or switch away from contact reflections. Bruno illustrated this. His client frequently said 'babies' but not enough was known about her personal history to understand the significance of this. Bruno reflected ‘babies’, which led to her beginning to expand on her reality, saying ‘mummy daddy’. He moved away from reflecting to trying to engage her in a discussion, which resulted in loss of contact.

She's repeating 'Can I see the babies? Where are the babies? I want the babies'....... I said 'See the babies'. She was smiling I could see the expression on her face. Well, she started to mention her daddy and her mummy. I couldn't understand to engage her in a conversation about her mummy or daddy after two or three minutes she loses contact, she turns her head she is looking somewhere else. BRUNO/VHS9/17.3.05.

In contrast, Cathy stayed with the client's world:

She said 'I love my mum' and I said 'You love your mum'. And then she perhaps might say it again, 'I love my mum'. I said 'You love your mum, and you're crying and there's a tear down your face'. And then she said 'My mum loves me'. And I said 'Your mum loves you'. CATHY/VHS8/24.2.05.

The contrast between the illustrations above indicates a need to persevere with contact reflections. Developing skill involves being able to notice and engage with the subjective reality of the person and stay with the experience of the person with dementia, sustaining being with their experience.

**Implications for learning and teaching contact work**

So far, this chapter demonstrates that learning to use contact reflections is not straightforward. This helps develop ideas about teaching contact work and determining levels of competence for staff who may be unqualified or inexperienced in engaging in emotion-focused care. Developing competence requires levels of subtlety and awareness that staff may not immediately grasp (Dodds 2007). In order to learn to use contact reflections people need: an accurate cognitive understanding of the principles and key theoretical ideas, an opportunity for experiential
learning, and feedback on their performance. This study indicates two requirements to help put the ideas into action: supported reflective practice and ongoing support or supervision (Mental Health Foundation 2007). Only a basic level of competence was achieved from a short introduction and limited reflective cycles. From the data, two diagrams were created to show progression in knowledge and competence (Fig. 6.2 and Fig. 6.3). All participants apart from Cathy began to develop the basic level of knowledge and competence. Cathy's training as a counsellor gave her pre-existing knowledge and competence on which to build her knowledge of Pre-Therapy.

<table>
<thead>
<tr>
<th>BASIC LEVEL</th>
<th>INTERMEDIATE LEVEL</th>
<th>ADVANCED LEVEL</th>
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<tr>
<td>Understanding of the contact reflections</td>
<td>Theoretical and philosophical understanding of the concept of Pre-Therapy</td>
<td>Theoretical location of Pre-Therapy practice in relation to the field of psychotherapy</td>
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<tr>
<td>Understanding of principles of Pre-Therapy (contact function, contact behaviours, contact reflections, the pre-expressive self)</td>
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Fig. 6.2. Levels of knowledge.

By grading competence, it might be possible to help the Pre-Therapy community develop training standards. This would help Pre-Therapy establish itself amongst other training in psychotherapeutic practices. Fig. 6.3 suggests a hierarchy of competence. This moves from basic competence in using contact reflections through to competence in including Pre-Therapy in psychotherapy practice.
For this study, the aim was to develop only a basic level of competence in incorporating contact work into their everyday practice. Identifying different levels of competence helps further differentiate between a nurse using contact work and a psychotherapist using contact work.

Whilst there is debate about defining and measuring learning outcomes, Pre-Therapy may benefit from defining levels of competence in order to devise educational programmes (Wolf 1995; Power 1997; Edwards 1998; Eccleston 1999; Hussey and Smith 2002). For a very basic level of competence in using contact reflections, I propose the following areas of knowledge and performance indicators.

- Knowledge of the five contact reflections (word for word reflections, facial reflections, bodily reflections, situational reflections, reiteration).
- Knowledge of the contact functions – affective contact, reality contact, communicative contact.
- Knowledge of the pre-expressive and expressive self and the Grey-Zone (i.e. the intermittent or fluctuating expressive self).
- Knowledge of the contact behaviours (the response to the contact reflections which may be on different levels e.g. a behavioural response such as eye contact, an experiential level such as a feeling of connectedness.)
Findings

- Knowledge of the underlying principles of offering empathy, accepting the person, offering unconditional positive regard and noticing the subjective experience of the client.
- Demonstrate contact reflections.
- Demonstrate recognition of contact behaviours.
- Demonstrate recognition of changes in affective, reality, and communicative contact.
- Demonstrate differences between using contact reflections with a person who is pre-expressive and other responses when a person is expressive.

Should the Pre-Therapy community pursue the development of training, engagement with educational methods of identifying levels of competence, performance indicators and assessment criteria may be necessary. This work is underway. Ideas emerging from this study for defining different levels of competence and requirements for training were sent to Pre-Therapy Network members in December 2006 to contribute to the developmental work of the Network on establishing levels of competence in contact work and Pre-Therapy (Appendix 21). This work continues and the Network meeting scheduled for 2008 will continue to develop devising agreed content and levels of competency for training in Pre-Therapy and contact work.

Differentiation between contact work and Pre-Therapy

It needs to be clear this study provided staff with the chance to learn and use contact reflections, not Pre-Therapy. A metaphor emerged during the research process, helping me express concern to Garry Prouty that I felt I was in danger of corrupting his work. The metaphor used was *The Peacock and the Toy Pigeon*. The peacock represented Prouty's theoretically complex and rather elegant and intricate Pre-Therapy. The toy pigeon represented my attempts to help staff learn and use contact reflections where the toy pigeon is a crude representation of Prouty's work. Without the philosophical and theoretical knowledge that underpins the skill, contact reflections may be used in a rather crude and
mechanical way. By acknowledging the difference in competence and knowledge between using contact reflections and practising Pre-Therapy, it becomes clearer that contact work is using an element of Prouty’s work, not doing Pre-Therapy.

6.2 Barriers

Practising reflections was not a private activity for participants. Interpersonal, social and contextual factors affected their learning and use of contact reflections (Jarvis 1987; Banazak 2000). These factors caused barriers which had a negative affect on learning. Using reflections affected the relationship between the person with dementia and staff, and this was not always seen in a positive light. Other people in the context affected participants, increasing the likelihood of them avoiding using contact reflections.

Social rules of interactions

The sensation of awkwardness indicated a change in the nature of the relationship between a participant and a person with dementia. Contact reflections were a different way of interacting which caused a change in the usual way staff approached the relationship. This began to unravel assumptions, rules or beliefs staff held about the relationship. Contact work challenged these. Participants were concerned that it might appear as if they were mocking the person with dementia or being disrespectful. This concern first emerged in the reconnaissance phase and later in allied work running alongside the research. This was discussed by participants:

I just feel like I'm copying them. I don't feel comfortable doing that, saying everything they do. ALISON/VHS18/15.5.05.

She goes 'blurblurblurblur' doesn't she?, like that. And how would you feel as a nurse to stand there and go 'blurblurblurblur'; its like a mockery isn't it? AYLINE/VHS2/29.12.04.

Concern about mockery indicates that contact reflections somehow breached a social rule of conversation. In ‘usual’ conversations two
people take turns, respond to each other, and the relationship is reciprocal. Simply to reflect caused staff to feel uncomfortable about seeming disrespectful. Being disrespectful is in direct conflict with the dominant ideas according to which staff are committed to treating people with dignity and respect, and being mindful of not talking down to a person with dementia but treating them like an adult. Because reflections breach a social rule, staff may resist them unless staff have sufficient understanding of why, when used empathically and sensitively, they are fully respectful.

This sentiment was echoed by a relative concerned that the reflections would be perceived as mocking. Out of concern for preserving her mother-in-law's dignity, she expressed the following:

*God knows she has little enough dignity now anyway. FIELD NOTES/1.3.05.*

Word for word reflections attracted most discomfort because the language, words and sounds that the person with dementia made did not always sound coherent. Reflecting these worried participants.

*If you repeat whatever someone is saying, are they perceiving it as mimicking and could it be something that is disrespectful.* ANNA/VHS17/6.5.05.

However, not all participants viewed the reflections negatively, but simply as different:

*It's a different way of starting the conversation.* BARRY/VHS26/1.7.05.

In order to reduce discomfort, participants become hesitant, or tried to make reflections more conversational to disguise them:

*I noticed that I kind of couch it. I'll say 'a lovely comfy chair' rather than it be a just 'your sitting in a chair'* CATHY/VHS8/24.2.05.

A danger of couching reflections is a loss of concreteness. In the example above, Cathy introduced her own emotional response to the
world rather than producing a simple, concrete reflection of the experience of the world of the person with dementia.

Another barrier came from staff's perception of 'bothering' or "pestering" people by using reflections. Brian described his discomfort at initiating contact reflections with a man who was sitting with his eyes shut, even though the reflections appeared to be leading to contact behaviours.

And I did get the feeling that I was bothering him by my observations, so I backed off after that because I had that impression that if he was able to, he'd say 'Look, will you please buzz off'. BRIAN/VHS9/17.3.05.

There was sometimes tension between staff beliefs about how normal interactions should occur and interactions using contact reflections. This caused a degree of cognitive dissonance and discomfort for staff. In order to reduce dissonance, staff would need either to adjust their perception of communication or stop using contact reflections.

Arguably, 'usual' social rules apply to conversations where people are both in an expressive state: two people engage in a discussion or conversation. Contact reflections are used with people who are pre-expressive and do not follow usual social rules of conversation. Understanding this might help staff overcome the discomfort caused by the reflections. Overcoming feelings of mockery, disrespect and bothering requires understanding the sentiment behind using a contact work. If done with empathy and subtlety the work should be anything but disrespectful and mocking because it is addressing the subjective reality of the person. So, rather than being disrespectful, workers are very respectful of the world of the client. The world of the client is the focus of an interaction and the reflection is delivered in a way which is respectful towards the person. The need to experience how they can reflect and feel respectful indicates the need for staff to have time to develop practice coupled with accurate understanding of the principles behind Prouty's approach.
Self in relation to others

Whilst the previous section laid out the internal or intrapersonal factors affecting learning, additional barriers arose from participants in relation to other staff. Participants felt self-conscious and feared being judged by others. Participants reacted by trying out contact work in private, away from the gaze of others. This finding surprised me and I did not experience it myself. This was most likely due to holding a different role in relation to staff participants, being a 'guest' in their teams, rather than a member. In addition, my role carried a certain amount of legitimate authority, bestowed status, relative expertise and some confidence in using the contact reflections which protected me against feeling self-conscious or judged. This links to Illeris' perspective that context affects learning (Illeris 2003).

The public arena of practice: self-consciousness and fear of being judged

Earlier it was shown that fear of being disrespectful posed a barrier. This barrier was reinforced by the social context which helped sustain social norms of what an interaction should be. Participants did not wish to be seen by others as being disrespectful, or doing something that might be seen as detrimental to the resident. A group discussion generated conditions of being discrete and avoiding performing contact work in front of others:

Ayline: Yes, we can’t do this technique if there are other patients relatives there because they wouldn’t understand.

Anna: unless they were aware, or in the know, but for somebody to watch you do it, you’d feel awkward to say the least.

Alison: And then I think ‘I hope nobody’s looking at me’ while I’m doing this?

Apollo: You try to do it as discreetly as possible, as long as there are people who know what you are doing. You don’t do it in front of others because they will say ‘What’s up with you?’ So you just don’t.
Findings

Ayline: You don't do it in front of agency staff....

Alison: You wouldn't use it in front of relatives or visitors because it would look like you were standing there mocking them and you wouldn't feel comfortable doing it in front of them.


Bruno was the only person to state that he did not let self-consciousness inhibit him using the reflections.

I don't care. If I am interested in doing something or learning something I ignore what the others think, so my own opinion is important not others. BRUNO/VHS2/31.5.05.

Being confident to appear different enables Bruno to avoid feeling self-conscious. In this way, he was able to continue to practise contact work despite what others thought. Staff may feel self-conscious in front of colleagues who are not part of the research, agency staff who are likely to be unfamiliar to them and relatives. This indicates the need for whole staff teams to learn together to reduce self-consciousness, promote involvement of others, or address varied levels of self-confidence and to sanction using an approach which appears different.

Staff also had concerns about being judged by others, again reflecting the public nature of the work. For Brian, Barry and Bruno, this was a reality; they experienced some mildly disparaging teasing about being part of the research.

Bruno: .When you started to come to this home and Brian chose me and Barry to take part in these sessions, they were making fun about us. Something like 'so starting today you are able to talk to everyone so we don't have to' (imitates a sarcastic tone). BRUNO/VHS2/31.5.05.

For others being judged was a fear rather than a reality and linked to what others might think:
Findings

It's not about my lack of belief about what I'm doing. It's just 'what if I look stupid?' 'What if the patient hits me in front of everybody?' CATHY/VHS12/22.3.05.

Whether being judged was real or imagined, it posed a barrier. As a result, staff showed a tendency to practise in private.

Interactions with people with dementia occur in public areas such as lounges, corridors and dining rooms and in front of other staff, clients, relatives and visitors. This is a significant barrier to staff learning and practising contact work, as staff avoid being seen by others. Staff preferred to try contact work alone with the person with dementia, for example, when helping with personal care or when alone in public areas. However, this limits opportunities to practise contact work and negatively affects learning and implementing new practice.

Together social contextual factors pose barriers to introducing contact reflections. This supports the concept of relational autonomy where individual autonomy is tempered by group dynamics and social relationships (Donchin 1995; Sherwin 1998; MacDonald 2002).

Having not anticipated this reaction, I had not prepared participants for feeling self-conscious and the effect of the surroundings. This finding supports the idea that contextual factors significantly inhibit change in practice, whether this is contact work or any other innovation. Counteracting this requires a critical mass of people involved in change, leadership that can role-model change, and collective awareness that a new approach is being tried.
6.3 Summary
Learning and skill development form the first mediating factor affecting the application of contact reflections in dementia care. The learning process shows that implementing contact reflections is not straightforward. The findings indicate common errors in novice practice. Barriers arose from internal rules of what constitutes social interaction and beliefs about the nature of the interpersonal relationships with people with dementia. Contact reflections have the potential to pose a challenge to both of these. The social context increases the challenge and adds to the barriers. Social norms are sustained in context with self-policing and peer policing inhibiting staff using contact reflections. Training or practice development would benefit from greater attention to social influences and the context in which training is to be implemented. This needs to include the impact of established social norms of practice, relationships, relational autonomy and the performance of new skills under the scrutiny of others.

Key findings of this chapter are summarised below.

- Staff undergo a process of learning. This process allows perceptions of the contact reflections to change. The data indicates that staff move from thinking that the reflections are obvious and easy through to finding them more complicated and difficult to do.
- Reflection in a concentrated manner tips the balance from natural intuitive reflection towards communication that is more deliberate.
- The difference experienced by staff may cause discomfort.
- Staff have preconceived ideas about social rules of interactions with people with dementia. Contact reflections may challenge these.
- The learning process itself encourages people to notice the way they interact in detail.
- Staff may abandon using contact reflections particularly when they get no response or feel they are not getting anywhere.
- Staff may not notice contact behaviours.
- Common features of unskilled practice are: moving on from contact reflections too quickly, using reflections in a mechanical way and misjudging the level of expressiveness.
• Developing skill also demands being able to gauge whether a person is expressive or not and to sustain entering their world using the reflections.

• Staff need time to practise and experience using contact.

• In the novice stage of practice staff need sufficient understanding of the reflections and the theory behind them in order to use the whole range of reflections in a subtle and fluid manner.

• Intrapersonal factors inhibit the use of the contact reflections where staff perceive that contact reflections are discourteous. This implies that the contact reflections challenge normal social rules of conversation. This discomfort may hinder staff feeling at ease in using them.

• Staff work in environments where their practice is on display. Where staff feel inhibited in front of others they are less likely to use the contact reflections, preferring interactions which fit an accepted norm.
Mediating Factor Two: The Nature of Dementia

Introduction

The organic nature of dementia is a mediating factor in applying contact work to dementia care. It would be remiss simply to import contact work to dementia care without considering how this factor affects the application of the techniques. Prouty's work originated in the field of psychosis and, whilst the practice of contact work has spread to other client groups (Prouty et al 2002), the findings from this study indicate the use of contact reflections is tempered by the nature of the dementing illness. The data indicated two areas for consideration: practicalities and expressiveness (Fig. 7.1). Practicalities include physical and environmental limitations, and expressiveness relates to neurological and cognitive changes as a result of the disease process.
7.1 Practicalities

During the course of the research, practical and physical issues arose. Physical states of the people caused difficulties in offering reflections. People stooped or were seated or walking in a way which limited interaction with their environment. Anna found this in a practice session with AS who stoops. She felt that walking next to him was not working as he seemed unaware of her presence. It was difficult for her to reflect within his field of vision.

In order to do that (a situational reflection) I have to face him and I can't because he's walking and I'm stopping him.
ANNA/VHS25/2.6.05.

Adopting positions to be visible to the person with dementia was sometimes uncomfortable for the worker.

Mr X was sitting in a fairly low chair. I had to kneel on the floor, which I found quite difficult, so I didn't do that for very long.
BARRY/VHS9/17.3.05.
Other physical issues arose, for example, sight and hearing impairment. Contact reflections may not be seen and heard by a person with sensory deficits. On Site B participants speculated that tiredness also affected the response to the contact reflections.

_If we want to engage with some of these residents, it's better to do it early in the morning after night rest. In the afternoon they are tired, so it's better in the morning._ BRUNO/VHS9/17.3.05.

The difficulty posed by these practicalities was reinforced by apparent unresponsiveness, which led to staff ceasing to use reflections. It is possible that the dementing illness inhibits responsiveness and contact reflections do not offer sufficient stimulus, particularly where the organic changes result in passivity or lessens the ability to initiate interactions or respond to others. Another explanation could be lack of response due to impairment of the capacity to comprehend facial expressions (Ekman 1992; Hargrave et al 2002; Keane et al 2002; Shimokawa et al 2003). In this case, it may be possible that the person with dementia does not recognise the actions of the worker as a reflection of himself or herself and subsequently does not respond. A further complication arises with specific types of dementing processes. Particular forms of dementia affecting frontotemporal areas of the brain may impair the ability to recognise empathic overtures from others (Mendez and Perryman 2003; Rankin et al 2006). This indicates caution in assuming that reflections can be interpreted (Decety et al 2002; Decety and Chaminade 2003). Whilst Decety’s work does not specifically focus on dementia, her extensive work into the neurobiological processes involved in empathy can be seen to have relevance because her work explores the effects of neurological deficits on empathy, emotional recognition and interpersonal functioning.

However, a counterposition exists which supports the sustained use of reflections with severe dementia. This perspective argues that mirroring, imitation and recognition of emotional reflection (particularly non-verbal
reflection) are preserved in dementia and are central to sustaining interactions (Aquilina and Hughes 2006; Astell and Ellis 2006). Further work could take a more systematic approach to observing responsiveness to contact reflections. It may be that developments in measures to observe responses to contact reflections (Dinacci 2000) could be adapted for dementia care to provide some quantitative information about the efficacy.

From this study, there is insufficient data to begin to explain differences in responsiveness. However, practical features associated with physical infirmity, sensory impairments and cognitive changes which may affect how a person can relate to another may pose barriers to using contact work.

7.2 Expressiveness

Using contact reflections was complicated by neurological and cognitive changes which impair language and comprehension. These changes affect expressiveness of the person with dementia and impact on gauging expressiveness that is necessary to pitch accurately the use of contact reflections. A second feature emerged around the nature of the contact that was obtained. Namely, contact could be very rapid and emotive.

**Cognitive and linguistic ability**

A prerequisite of contact work is being able to judge the level of expressiveness. This was addressed in the previous chapter in relation to staff learning contact reflections. This section explores the relationship between expressiveness and the dementing process, looking at the implications for using reflections and in particular, the consequences of misjudging expressiveness. People with dementia are frequently highly expressive, although cognitive changes cause difficulties in the
communication of their thoughts and feelings to others. There is the possibility that people are not in pre-expressive states, rather their ability to coordinate speech is impaired or they have dysphasia.

*She wants to talk but she cannot talk properly.*
*BRUNO/VHS23/31.5.05*

In the field of Learning Disabilities, cognitive impairment may affect the use of contact reflections (Zinschitz 2002). Sometimes, with profound cognitive impairment, only limited degrees of contact are possible (Portner 2000; Hawkins 2002). At times, contact reflections may target an early stage of cognitive development; for example, offering reflections as a mother would to a child in order for the child to see themselves reflected through contact with their mother (Stern 1985; Blehar et al 1977). In the UK field of Learning Disabilities, this echoes the approach called Intensive Interaction and approaches which pitch contact at the appropriate developmental stage for an individual (Nind and Hewitt 2001; Caldwell 2006; Zeedyk 2006). In dementia, cognitive changes are ongoing and declining. In later stages of dementia, accurate assessment of a person’s cognitive and linguistic ability is difficult and may also fluctuate. This makes untangling whether a person is expressive or pre-expressive difficult.

The nature of dementia means that people may be aware of their own experience, but simply unable to be understood because of the linguistic impairment arising from the dementing process. Anna illustrates this in her description of AS.

*She is so obviously wanting to express herself. You can’t make out words, but her face and her eyes, she really talks to you and as far as she’s concerned she’s making sense.*
*ANNA/VHS2/29.12.04.*
There was a danger of judging a person to be pre-expressive, when they were simply unable to communicate their experience. Here, reflecting with a person who has been misjudged as being pre-expressive is potentially counterproductive. The data indicated some negative responses to reflections when a person was trying to express emotions such as frustration or agitation, emotions which the person was seeking to have resolved or helped.

Whilst there were only two occurrences (both on Site A) the response was sufficient to offer caution that contact reflections may potentially increase agitation or frustration where expressiveness is misjudged. Apollo described two situations where the contact reflections appeared to irritate the person.

*He was a bit irritable with what I was doing, when I was doing my mirroring and repeating what he was doing, so he ended up getting very irritated and then he just left me. There is another lady who can't speak properly, she also got very irritated in a sense that she clapped me (he gestures being slapped). APOLLO/VHS7/15.2.05.*

This echoes my own experience with a person who was anxious. My hope was that the contact reflections would enable her to elaborate on her experience of anxiety, or to engage with her experience of being anxious. Instead, reflections increased anxiety.

**When 12.9.04**

**Where** Research Site A – waiting for staff to go and talk to carer group – tried using contact reflections with a patient

**What Happened:**

A patient was searching for ‘George’. I decided to walk around with her. She was already communicative ‘looking for George’. She looked anxious. I used contact reflections –

P: You say ‘George’ and you look worried.
A: Have you seen him, have you got the babies?

P: You say ‘babies’ and hold your hand up (She held her hand to her heart – I mirrored the gesture).
A: Yes, George, he was such a lovely one.
Findings

At this point I felt that contact reflections were making her more anxious.

P: (I use a congruent response) Have you lots of babies? This distracted her to have a short conversation about babies. Then she returned to saying ‘George’. She was anxious and her behaviour was agitated. I encouraged her to sit down.

P: We’ll wait together.

I stopped using contact reflections as I felt she was becoming more anxious. Her behaviour was becoming more agitated, almost frantic. I was not able to lessen her anxiety about looking for George. She could be distracted only for a very short time and then would return to saying ‘George’. In the end I left her in the lounge to continue her search.

Thoughts about the event

People with high anxiety may not benefit from contact reflections (maybe need other strategies to contain anxiety). Contact reflections may be better for eliciting communication rather than containing anxiety. I seemed to switch between Pre-Therapy, validation, distraction, reminiscing and reassuring. I wanted to get away from the client as I felt communicating with her was making it worse. I could offer nothing which reduced her anxiety for more than a few seconds. This may be a limitation of contact work applied to dementia care...

These preliminary findings indicate that contact reflections with people experiencing anxiety and frustration are not advisable where they are expressive but the dementia interferes with being able to articulate this. People with dementia face declining ability to express themselves, and as the dementing process erodes their ability to communicate they are left with the emotions and experience but are increasingly limited in their ability to convey this. Where this is the case, people may be at their optimum capacity of being able to express themselves and any further reflections cause frustration when they are trying to seek answers and help. However, response to reflections is likely to vary. There were times when short episode of reflections to convey an empathic understanding of frustration were acknowledged by the person with dementia, which gave the impression that the person felt understood.

Expressiveness is linked to language. Often staff were left guessing what the person was saying because the words were not coherent.
I can sort of work out what he says, but if it's not clear then I have to go by his actions. ALISON/VHS18/15.5.05.

You know she, in the beginning she was talking nonsense. Some words you could understand but most of the others were completely difficult to understand. BRUNO/VHS23/31/5/05.

Commonly, organic degeneration affects communication, perception, speech and language. Cognitive and linguistic changes mean gauging expressiveness is difficult, and it may not be apparent if the person is responding to the reflections. In contrast to unresponsiveness there were times when the response was rapid, which is also a feature of the dementing process.

**Rapid contact and emotive expression**

There was some indication that contact reflections facilitated rapid contact, leading to communicative contact which was highly emotive. This indicates a high level of emotional experiencing on the part of the person with dementia and by using contact reflections it is sometimes possible to tap into this very quickly.

That was the greatest thing I think was just being in her world so easily, and that was the shock aspect, that Ahh (intakes breath) feeling... which I hadn't realized through reading the little bit I'd read, that that would happen ... I hadn't counted on that. CATHY/VHS8/24.2.05

The rapidity of contact means staff have not only to cope with the surprise but then quickly to decide whether to continue reflecting, or take an alternative approach such as asking a question, or use another therapeutic technique such as Validation Therapy, biographical reminiscence, or simply engaging in a dialogue using 'creative' speech patterns (Pitkin 2007; Walker 2007).

Peters (1999) sees contact work in his field of learning disabilities as producing moments of lucidity. The data indicates contact reflections appear to have a similar effect in dementia.
Emotive content

A feature of contact was the strength of the emotion. Emotions ranged in intensity and type, for example, annoyed, angry, abusive, sad, worried, fearful, joyous, hopeful. In the following extract a man became very expressive and emotional. Due to the nature of dementia, he was not able to express himself in coherent sentences.

*I just reflected and this is what I have put* (she reads from her notes): *Yesterday a gentleman called T.... he was telling me some really confused stuff about seeing babies killed, 'me killing babies', 'shouldn't have happened'. Very confused. So I was just picking out the words I could understand and putting them back to him. It was very upsetting for him but I feel he was telling me. I wasn't probing. I wasn't in any way looking for any information, simply reflecting back the words I could understand.* CATHY/VHS 30/22.7.05.

This needs to be balanced against less extreme content.

*Someone was talking about eggs. I said 'eggs', and it turned out they wanted some eggs.* BARRY/VHS13/1.4.05.

Highly emotive content raised the anxiety of staff. Reflections may have aided the person communicating something that was important to them but it was potentially difficult for staff to know how to respond to highly emotive contact. This also triggered responses in staff such as feeling helpless and hopeless. Ayline expressed this upon getting in touch with the emotional distress of AS.

*I got the impression today that he was, in his own way, realising where he was, what was happening to him and was desperately, desperately sad about it. And this raw emotion that was coming out, he knew. I felt hopeless for him. I get emotional talking about it* AYLINE/VHS1/29.11.04.

This issue will be revisited later picking up the theme of facing the emotions of others, relating it to the emotional labour of interactions, and explores how this affects role constructs held by staff.
7.3 Summary

The nature of dementia complicates or hampers the application of contact reflections to dementia care. There are practical and environmental limitations to using the contact reflections which are particular to aging, dementia and the residential environment. Additional difficulties come from gauging expressiveness and the cognitive and linguistic ability of the person with dementia. Assessment of their ability is difficult and it should be remembered that most of the care is delivered by unqualified staff. To use reflections they have to gauge whether a person is expressive, pre-expressive or has impaired expressive ability due to neurological decline. In the absence of skilled assessment, staff will have to gauge and use reflections on a 'trial and error' basis to see whether reflections are useful with individuals.

Speech may be disjointed, incomprehensible or contain meaning that is difficult to discern. Contact reflections may help facilitate greater expression of the subjective world of the person with dementia but staff may still be left unsure how to respond once they have contact. In order to continue interactions with people with dementia who, in their own way, are expressive and communicative we need to return to existing approaches already known to the field of dementia care. In this sense the contact work can act as a precursor to therapeutic approaches which are dementia-specific, or used as 'emotional palliative care' (Morton 1999; Van Werde and Morton 1999).

The rapid and sometimes highly emotive contact may be related to the nature of the dementing process where the raw emotions of people with dementia are sometimes a feature. In this case, when using contact reflections we need to be prepared for this and be able to know how to respond if we are faced with distress.
Key findings of this chapter are summarised below.

- Fine judgement is needed when using contact reflections with people as they may not be pre-expressive, rather they might be dysphasic or have trouble conveying their experiences.

- The cognitive changes which accompany dementia as a neurodegenerative disorder affect language, comprehension, perception and expression. The impact of this on communication may complicate using contact reflections as the person may not have the cognitive capacity to be in contact.

- People with dementia are frequently in contact with themselves (i.e. how they feel and how they are experiencing their perception of reality) but unable to express this. This is different from psychosis where a person is pre-expressive and the contact work is to help a person become more in touch with their own experiencing self.

- Contact reflections may have a negative effect on people who are expressive and are wanting a need to be met but are unable to convey this to others due to cognitive impairment.

- Rapid contact can be established with people with dementia using contact reflections. Staff require additional dementia-specific approaches to sustain an interaction once contact has been established.

- The content of contact can be highly emotive. Staff need preparation in how to manage this in themselves and in the person with dementia.
Mediating Factor Three: The Perspective of Staff

Introduction

This chapter introduces the third mediating factor, focusing on the emotional management of the relationship. Since relationships are interactive, this factor is not static; rather it is a dynamic, fluid process.

This chapter explores how contact reflections related to the emotional management of interactions. Contact reflections posed a challenge to how staff constructed their ways of communicating. A theoretical model of emotional management was built from the data to explain this challenge.

The model of emotional management contains four conceptual counterpoints. These being: responsible for/being responsible to, doing for/being with, emotionally distant/emotionally engaged, task focused/person focused (Fig. 8.1).
Findings

Fig. 8.1. A model of emotional management of interactions.

Staff constructed their role and perspective towards the person with dementia along these conceptual counterpoints and enacted them through the relationship. Managing the emotional experience of using contact reflections requires staff to manage the tensions arising from managing the four positions. This model emerged from contradictions and tensions in the data. Contact reflections required staff to be aligned with the right hand side of the diagram: being responsible to, being with, having emotional togetherness, and being person focused. This was sometimes at odds with how they would usually act or interact. This tension explains why reflections can pose a challenge to staff.

8.1 Responsibility

Tension arose from the contrasting positions of being responsible for another and being responsible to another. Being responsible to another means assuming responsibility for yourself in the relationship, rather
than assuming responsibility for them (Mearns and Thorne 2000). Participants in the study indicated contrasting perspectives about their responsibility within the relationship with the person with dementia. Features of responsibility are shown in Fig. 8.2.

Fig. 8.2. Responsibility.

8.1.1 Being responsible for or responsible to

The philosophical origins of Pre-Therapy point to being responsible to another, not for them. Following the concrete experience of the client means the worker's world does not lead the interaction and does not, therefore, determine the emotional direction of the interaction. In contrast to this, staff sometimes demonstrated a need to take responsibility for the emotional world of the person with dementia, wanting to offer comfort, and reassurance and to protect and intervene.

Ayline: But he was not able to tell us what he was so upset about we could offer him no words of comfort. AYLINE/VHS2/29.12.04.

Participants wanted to 'make it better', and this was exacerbated by the client's language and cognitive difficulties which meant it was sometimes not clear what the person wanted or needed.

Apollo: You can't reassure him because you don't know exactly what you'd be reassuring. You know he's crying. We have to reassure, to calm him down. APOLLO/VHS2.29.11.04
Contact reflections compete with the drive to comfort and reassure requiring the worker to stay with the subjective experience of the person. The discomfort of staff is exposed because the reflections, by their very nature, prevent staff stepping in and taking over the emotional world.

The drive to offer comfort was a reaction to the emotions of the person with dementia. Ayline was explicit in identifying this as her need. For Anna, offering comfort was instinctive. Both illustrate wanting to comfort in the presence of distress.

Ayline: I was holding his hand.... and that clearly wasn't enough and it wasn't enough for me either so I gave him a cuddle. AYLINE/VHS2.29.11.04.

Anna: mostly its instinct, you see somebody who looks sad and dejected and you do put your arm around, that's the first thing you do. ANNA/VHS2/29.12.04.

Cathy, on the other hand, held a different perspective. She continues reflecting to allow the person with dementia to continue to express how they are feeling, avoiding comforting.

She cried and she cried and it was all right. I didn't want to fetch a tissue too soon because I didn't want to stop the crying. I wanted her to be allowed to cry. CATHY/VHS8/24.2.05.

The desire to comfort and reassure comes from the internal position of the worker. Where they see their role as being to offer comfort and reassurance, they are less likely to feel comfortable with contact reflections, which require the worker to stay with the experience of the person rather than trying to prevent a person being upset. This tendency to take control of the interaction was linked to the drive to protect and intervene which exists in relation to the physical safety of the person.
A reality of dementia care is that clients require levels of supervision and intervention. Staff have responsibility for the environment and have to intervene to prevent harm. One research encounter illustrates this. Anna was using contact reflections with AS and encountered the dinner trolley in the corridor. Anna's reaction demonstrates the difference between contact work and her switching to taking responsibility for AS.

Anna (To AS): You're turning (BR) .. (to Penny) I don't like him near that trolley, shall I get rid of that trolley.

Penny: No, it's alright use it, use it (I was encouraging her to use the trolley as a Situational Reflection).

Anna: I just wondered..., Oh its not that hot, just warm.

Staff need to use contact reflections with an awareness of the everyday reality of ensuring safety of the person with dementia.

I followed her round the garden, she was collecting leaves and just silent. She was just wandering round looking at leaves. At one point she walked into the tree and got stuck in the branches. BARRY/VHS29/1.7.05.

Staff demonstrated protection and intervening on both a physical/safety level and also at an emotional level. Where this happened staff were assuming responsibility for both physical and emotional worlds. In the emotional domain, this is contradictory to using contact reflections.

These actions become integrated into the role of the worker:

Anna: That's the way that we nurses are programmed, aren't we? We try and jolly them along... and show them that there might be a positive way. ANNA/VHS2/29.12.04.

To use contact reflections, staff have to manage to hold contradictory positions of needing to protect people from physical harm whilst at the same time doing the opposite with the emotional world. The urge to take responsibility for the emotional world is challenged by contact reflections, which are not designed to 'make it better'.

The opposing position is being responsible towards another: here, the individual takes responsibility for managing themselves rather than managing the other person. The data indicated two conditions which
lead to this, which were coded ‘being there for them’ and ‘staying with their reality’.

You had the time and you gave him that time and that opportunity. ANNA/VHS1/29.11.04.

‘Being there’ involved creating the conditions in which the subjective world of the client could enter the interaction. Alison described how Ayline offered her presence to a resident.

Alison (to Ayline): Basically he had your attention for once instead of you getting his attention because you want him to do something. He had you and he could do anything as you were there just for him. ALISON/VHS1/29.11.04.

Anna illustrates how this contrasts with offering reassurance. She shows us that engaging involves entering a world, even if that is perceived to be unpleasant or difficult.

Anna (to Ayline): We are all programmed to (reassure) so what’s happening here is that we’ve got to get down to a level that the patients on and that could be unpleasant, so we’re going to enter that. ANNA/VHS2/29.12.04.

Staying present requires noticing the reality of the other (Mason 2002). Adam demonstrated when helping KP drink, that he was staying with her reality. In doing so he recognised that her experience was more important than his agenda.

She looked worried and I think the worry was more important to her than having a drink. ADAM/VHS11/18.3.05.

Again, the reality means combining communication with helping people physically. Cathy illustrated managing this tension; maintaining her focus on the subjective world of the person whilst at the same time helping someone who was resistant to physical care and was in danger of dehydration.

She was unable to relate to anybody and she just wasn’t going to eat or drink. She was quite angry, untouchable, you couldn’t get near her. I sat quite close, just gently stroking her hand and I remember she has really poopy hands and saying ‘Hello X you look sad, your face looks sad’. All the time I was (reflecting) ‘You love your mum’, ‘My mum loves me’, ‘Your mum loves you’. Then she said ‘Mrs. So and So and Harry is good to me’ so I just reflected that back. Then back to ‘Mum’. Then I said ‘Have a cup of tea. I knew she somehow assumed I was the mother....I felt
like the mother, so it was OK for me to say 'You have a good cry you have a cup of tea, nice hot tea'. And she just took the cup and drank the tea. So we continued, just reflecting and she had a second cup of tea. CATHY/VHS8/24.2.05.

In order to show how much this contrasted to other practice, Cathy stated how she has seen other staff respond in a way that ignored the subjective experience of the person.

There is this poor lady and she sits there going I'm really frightened, I'm really frightened. A nurse said 'You get more attention than anyone else in this unit and you still go on' and then she went by another time and she (the person with dementia) went I'm really frightened, and she (the nurse) said 'Yes we're all frightened'. CATHY/VHS12/22.3.05.

8.1.2. Summary of responsibility

Two extremes emerged from the data: being responsible for, and being responsible to. Being responsible for, involves staff taking responsibility for the emotional climate of interactions by offering comfort and reassurance with the intention of making it better for the person with dementia. People with dementia require protection and interventions to help maintain their physical safety; however, this seemed to extend to offering emotional protection. By protecting the person with dementia staff seemed also to be reassuring themselves or acting in a way which was congruent with their role. This could also be a way of emotionally protecting themselves whilst at the same time trying to make it better for the person with dementia.

Being responsible to involves self-management of your own emotions in order to be there for another person. Here, the worker offers their presence to the person with dementia, sustains this, and is oriented towards being there for the person with dementia. This position is wholly compatible with the conditions necessary for using contact reflections.

It would be foolish to imply that either position is right or wrong. Indeed, there is an argument that staff should determine the emotional flavour of
Findings

interactions and promote positive emotions as an antidote to the anxiety and fear of living with dementia (Balint and Ralph 2006). However, the emotional management of interactions means that at times we may be taking responsibility away from the person with dementia in an attempt to make ourselves feel less fearful, anxious and hopeless in the face of dementia. In order to maintain a balance in responsibility, a worker needs to be responsible enough towards the person to hear and engage with their world. At the same time, we need to recognise there are times when it may be preferable to step in, take responsibility for the emotional world of the person with dementia, and try to direct their emotional state away from distress. Dementia reduces a person’s capacity to use strategies to cope with emotional distress, and it could be argued that, at times, it is preferable to alleviate distress by taking the lead in an interaction.

8.2 Role

A second feature of emotional management revolves around the role adopted in relation to the person with dementia. The data indicated tensions between two positions: ‘doing for’ or ‘being with’ (Fig. 8.3).

![Fig. 8.3. Role.](image-url)
8.2.1 Doing for

'Doing for' involved being engaged in physical care with the person with dementia and managing their emotional state through a variety of ways of interacting that are essentially directive.

There are many instances where staff have to adopt a position of doing something for the person with dementia, in particular offering physical care. This can be at the expense of psychological care.

Brian: It makes me think about the amount of quality time with the residents, actually sitting down rather than doing something for them, changing pads, washing and dressing. Beyond that, people (staff) seem to be doing lots of things but not sitting with the residents, not involving the residents is quite noticeable and when we're talking about this.... BRIANNHS 9/17.3.05.

This resonates with literature highlighting how little time staff spent talking to people with dementia and how interactions focus on physical care (Ward et al 2002). 'Doing for' also involves managing the other person by steering interactions so the staff's goal can be achieved. This means using responses which are quite different from contact reflections. Anna noted that non-reflections are aimed at managing the emotions of the other person.

Anna: Socially we are programmed to say things like 'oh your wearing a pretty blouse today' or something like that. You say things to people to make them feel better, don't you? To lift them up. What we're doing (using contact reflections) really is the opposite. If they are sitting there looking hunchback, face down, what you want to do, what you're programmed to do is not what your meant to do. ANNAIVHS2129.12.04.

Staff use a range of interactions. Andy describes how he initiates singing and conveying happiness to make the person with dementia happy.

I normally sing; sometimes I can get them singing along with me because that gives out that I'm happy and they pick up on that, that I'm happy, and they give that back to me that I'm happy and they will la la along with me, 'la la la'.... ANDY/VHS 4/10.2.05.

Approaches which set the emotional tone can be successful and maybe used by staff to help with physical care or as an interaction in their own
right (Balint and Ralph 2006). Bruno illustrated how setting the emotional tone of an interaction helped gain compliance.

*If you say 'come on, please lets do this please' (said with gentle, slow intonation) you have no chance. But if you say 'Come on, lets do this quick quick quick!', like soldiers do, he becomes very reactive. Maybe its something from many years ago, it's like military discipline you know. I observed even his wife uses this voice, you know imperative. I don't mean we are very rude but if you tried to do this like military voice it's OK for him, you get the right reaction, exactly what you expect.* BRUNO/VHS23/31.5.05.

In terms of dementia care this is in line with using a personalised biographical approach as, in this instance, Bruno is charging the interaction with an echo from the man's life history (Surr 2006). This approach differs from contact reflections, superseding the experience of the person with dementia. In Bruno's example, the alternative approach is successful where contact reflections were not. Staff were combining physical with emotionally charging interactions in order to help provide physical care. This approach is the opposite to contact work, as the emotion is led and directed by the worker not the client.

Contact reflections may jar with the need to provide physical care, which involves a requirement to be directive. Anna illustrated this in her description of helping someone to walk and reminds us of the very physical nature of dementia, which often takes precedence over the emotional response.

*Quite often the physical capabilities diminish as well... it does help to get a rhythm going and they actually remember how to walk then and that can be counting or anything like that. And if you start that off and say 'Marching! One, Two' they get back in the rhythm and walk. I have known people get stuck on a rail, holding a rail and not able to let go and walk off and of course they can't express that, it must be a terrible feeling to think 'I can't do what I want to do'. 'I'm not able to walk'.* ANNA/VHS17/6.5.05.

'Doing for' involved both physical and emotional interventions. This links the concept of doing for to the previous concept of responsibility: staff have a responsibility to do things for the person. This approach is sometimes necessary where the person is more responsive to a
directive intervention than contact reflections. The dimension 'doing for' is contrasted with the alternative position of 'being with'.

8.2.2 Being with

In order to be with a person three things were necessary: bearing witness to the experience of the other person, being in tune with this and encountering emotions, including 'difficult' emotions.

Yes, for me its entering that world, to me that's what it is. Its showing them that they are not alone, its being there with them. ANNA/VHS2/29.12.04.

Witnessing arises from providing sensitive interpersonal skills, listening and attending to the person with dementia. All of these are advocated in dementia literature (Kitwood 1997; Morton 1999; Killick and Allan 2001). Cheston and Bender stress the importance of the act of listening, and this thesis suggests that contact reflections are a way of achieving this.

..using listening skills is to enable that person to feel that their experience of dementia is important... In order to bear witness we need to stay (in an emotional sense) with what people with dementia tell us about themselves and provide them with the space and time to do this (Cheston and Bender 1999: 217).

Bearing witness or listening and attending to the emotions of the person with dementia meant encountering emotions which were painful or as one participant termed it, 'seeing the dark side'.

I realize the dark side of life and I've got to enter it. This guy is sobbing and crying and is totally distressed and I've got to go there myself; its not a nice place to go......happy things are always much nicer to hear anyway. ANNA/VHS2/29.12.04.

Bearing witness was not always comfortable, having a profound effect on some occasions. Cathy experienced a lack of control in the interaction where a man was talking about babies being killed. Ayline found the experience disturbing.

It was more witnessing and not being able to stop it happening. CATHY/VHS30/22.7.05.

Ayline: It's complete raw emotion. The eye contact was (held) the whole time, And he was holding my hands and shaking them and saying 'Yes'... and tears.. It was total raw emotion and not pleasant to see. AYLNE/VHS1/29.11.04.
Findings

Engaging with more painful emotions poses a challenge for staff. As seen in Chapter 7, people with dementia may express powerful emotions. Facing these heightens anxiety of the worker and witnessing can become emotionally costly and painful (Hodges and Klein 2001; Decety and Jackson 2004). Moments such as this were described by all the female participants but more intensely by Cathy and Ayline.

*That was harrowing actually; he was so upset, it was quite awful.* CATHY/VHS30/22.7.05.

*Last time was quite distressing and maybe that's why I am feeling negative about it.* AYLINE/VHS2/29.12.04.

None of the male participants in the study describe this although in reconnaissance work and work outside this thesis similar reactions have also been described with equal intensity by male nursing staff.

In order to preserve personal emotional safety in the face of emotions, two ways of responding were described: withdrawal or witnessing without losing oneself. Ayline withdrew.

*Whether or not I subconsciously stopped it, I stopped the eye contact. I've avoided doing this with him.* AYLINE/VHS3/10.2.05.

Cathy was the only participant with a professional background in psychotherapy that involves skill in managing the balance between being there for another and maintaining your own self (Mearns and Thorne 2000).

*The professional thing is to keep that watching part of you for their safety as for your safety, it's experience of sitting being empathic but also having one foot in their world and one foot out of their world..... it is about touching someone. It's just remembering to keep that part of outside instead of fully immersing in their world whatever it is, sadness, chaos anger.* CATHY/VHS12/22.3.05.

Witnessing the emotional world was not necessarily anxiety provoking or distressing for staff if emotions were less distressing or the self concept of the staff member incorporated bearing witness as part of their role or personality traits (Gibson and Moyer 2000; Ferrucci 2006). The contact could enhance the relationship.
Ayline (talking to Apollo): Hmm. I was watching the other day, hmm... and then somehow the pair of you had this great rapport going and then you were both having fun. AYLIN/VHS2/29.12.04.

There were levels of 'being with'; Cathy describes how her sense of the relationship was very intense.

(It was) the emotional contact, I felt like I was inside her, that I wasn’t removed from her.... and it was like this huge feeling. I probably won’t have that for a long long time...It was a privilege and it filled me it was like I carried her emotionally just through going 'Your crying'. It seemed too simple but that's what it felt like. CATHY/VHS8/24.2.04.

The sensation of 'being with' resonates with the descriptions from Prouty and Peters where contact work leads to moments of two-way intersubjective attunement (Prouty et al 2002; Peters 2003). During these moments two people are reciprocally aware of each other. This has already been mentioned in Chapter 5 in relation to staff seeing that contact reflections can result in more meaningful eye contact, and it appears here because the contact deepens a sense of ‘being with' the person.

8.2.3 Role - Summary

The roles adopted in relation to the person with dementia have to accommodate the polar positions of 'doing for' and 'being with'. 'Doing for' involves actions which take control and or direct the emotional flavour of an interaction. In contrast, 'being with' uses empathy and engaging with the subjective experience of the person. Contact reflections prompt staff to adopt behaviours which lead to 'being with' someone. However, this means encountering emotions which may be difficult to face, raising anxiety and prompting staff to emotionally withdraw. Discomfort with doing contact reflections came from instances where they conflicted with the need to do something for another, or they challenged the role of managing the other person and needing to be directive.
Findings

This aspect of the emotional management illustrates differences in adopting a role of 'doing for' or 'being with'. The former involves assuming a position of responsibility for the person and then, as a consequence of adopting this role, acting towards them to offer help and taking the lead in emotional interactions. At the extreme end we fail to notice the world of the person. In contrast, the role of 'being with' develops the relationship in a different direction which includes deepening the relationship but witnessing emotions may be challenging for staff. This raises the question of whether the emotional demands of offering reflections is too high for staff without professional training in managing empathic relationships or emotional intelligence in managing one's own emotions (Kuremyr 1994; Sammut 2003; Ruckdeschel and Van Haitsma 2004). Chapter 9 pursues the implications of this.

8.3 Distance

The third counterpoint contains two poles of being 'emotionally apart' from another or being 'emotionally together' (Fig. 8.4). The positions resonate with Buber's concept of an I-It relationship and an I-Thou relationship (1958). Contact reflections require emotional togetherness and the data exposed tension between holding a self-concept of being apart and doing contact work which demands togetherness. This section uncovers the conditions that lead staff to lean towards either position and the consequences.
Findings

8.3.1 Emotionally distant

Keeping emotionally distant or apart arose from a belief that it was not in the best interests of the person with dementia to express difficult emotions. In addition, emotional distance was reinforced by not feeling qualified to engage and avoiding emotional engagement in case it provoked unhappiness. Keeping apart is based on emotional distance and detachment. Cathy describes this in others.

She has a way of talking that objectifies the patients. It's 'just sit there', 'no you don't want the toilet', 'eat your dinner'.... One lady says 'I don't know where my mouth is, I can't find my mouth'. She (staff) says, 'Yes you can. Yes you do', rather than saying 'Your hand's shaking and you can't find your mouth'. CATHY/VHS8/24.2.05.

Participants expressed ambivalence about the benefit of facilitating emotional expression, particularly if it resulted in distress.

Ayline: If someone's had a really traumatic childhood and adulthood, who am I to start delving into it. AYLINE/VHS2/29.12.04.
Findings

I've kind of mixed feeling; part of me wonders about the right we have to disturb those deep, deeply buried things, but then the other part of me thinks they have every right to express those feelings before they die. CATHY/VHS30.22.7.05.

The alternative to allowing space for difficult emotions in people with dementia would be to revert back to the actions of the previous categories and take control and responsibility for the emotional states. This would involve trying comfort and reassure rather than witnessing and being in tune with the difficult emotions. An extreme form of detachment was described, in which the client's emotional world did not even elicit a response from staff as it was considered normal for that person.

This lady does cry a lot and I think the care staff are used to that. And they don't respond because we've been told this lady cries and we don't tend to react at all. BARRY/VHS26/1.7.05

If emotional distance occurs because it is not considered beneficial or part of the staff's role, the question arises of who does emotional work. Literature about emotional labour indicates that emotional engagement may be seen as 'not proper work' or 'other work' (Staden 1998). This was reflected in the study and participants at times referred to 'usual work', which did not include emotional engagement. Some participants described not practising contact reflections because they were busy with their job.

Distance was compounded by staff discomfort when facing emotions and not feeling equipped to know how to respond. Apollo voiced this in response to an interaction which had been emotionally charged.

Apollo: The eye contact, I couldn't handle it myself; I find it emotionally demanding. On the other hand, the care we give being fed, being changed, there is no emotion involved. But once you get emotionally involved you have to say to yourself 'Will I be able to handle such a situation if it arises? 'What am I going to do if a person is like that?, APOLLO/VHS1/29.11.04.

Where staff feel ill-equipped, they are more likely to maintain an emotional distance. Ayline felt this most strongly.
I felt - and still do - quite ill prepared for...oh I wouldn't know what to do, basically I'm not qualified, I've no experience of what to do or say. AYLINE/VHS3/10.2.05.

I think it's probably a little bit dangerous because we are so inexperienced. AYLINE/VHS2/29.12.04.

Feeling ill-equipped was exacerbated by fear of provoking distress and uncovering painful emotions which cannot either be contained or are 'bad' for the person with dementia.

By doing this we could be opening up memories from childhood that perhaps they don't want opened up. What are we going to do if we open a can of worms?. AYLINE/VHS2/29.12.04 *

Associated with fear was discomfort that it might not be possible to 'put the lid back on' (which links back to the earlier need to 'make it better'). Keeping emotionally apart was reinforced by staff's discomfort at having to abandon someone in distress because they were needed elsewhere.

As a result, some participants voiced a preference to avoid the possibility of provoking difficult emotions in the first place and therefore remain distant.

If they have just told you that their twin children died in childbirth and you say 'That's really dreadful, your twin children died in childbirth, that's really sad and I see you're holding your face, oh we've run out of time now and I've got to go'. It's difficult. (With a person without the dementia) you would be able to say 'I'm so sorry, hang on there, we'll come back to this I'll just go and see to this lady because she has fallen over'. But the dementia patient wouldn't be able to see that, they would be in the midst of this terrible grief. What right have we got to do that, let them open up a can of worms and then leave them. I don't know the ethics are a bit questionable really. CATHY/VHS30/22.7.05.

Using Contact Reflections became a gamble; staff could not anticipate the response.

I'll be dreading to have the negative response. I'd love to see something different, happy, not somebody who's going to cry. APOLLO/VHS2/29.12.04.

The features of keeping emotional distance are balanced against data that favours emotional closeness. These ideas are contained in the opposing position – 'being together'.

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8.3.2 Emotionally engaged

Contact reflections had the potential to prompt a change in the relationship; they offered the potential to be emotionally together and experience closeness.

*Its made me more, I wouldn't use the word 'intimate', but more personal....so you build up a relationship with the patient.*

ALISON/VHS 5/10.2.05.

*You know its about building a bridge, yes that was the main theme I had in my mind.*

BRUNO/VHS23/31/5/05.

*I feel it's a way of tuning in, if you try and get into where they are, and if you could get on that wavelength, then that would benefit them.*

ANNA/VHS17/6.5.05.

This had the potential to affect job satisfaction.

*Brian: I suppose in some ways it would be great for someone who effectively doesn't communicate to actually get that bridge and actually, to actually get somewhere, I mean, what a buzz that would be.*

BRIAN/VHS13/1.4.05.

Excitement at feeling emotional engagement was also a feature of work outside this thesis. A diary entry noted this.

**Reflective Diary**

*Date/ when:* March 03

*What happened:* MD (colleague/manager) rings. He's tried it and is enthusiastic. He described getting a moment of intense 'knowing contact' with a person through the eye contact and her awareness of him. He talked about the feeling you get when "You know that you're in". He was excited about this and talked about how this fits with his experience and his capacity for feeling and empathy. He saw a direct link between using contact reflections and this moment of intense knowing contact with the person with dementia.

Whilst emotional togetherness had positive effects, there were also consequences, discomfort and the danger of the worker being overwhelmed.

*... I went right in there and it's like being totally submerged by someone.*

CATHY/VHS12/22.3.05.
Findings

Even Cathy, who has experience of managing herself in emotional interactions, found situations challenging. She described her response to one incident as follows:

*the more this went on, the more I felt like her mum. I almost felt like I was in her world, I was almost inside her. It was almost like we met, because I was in her world, there was no world. I was just with her emotion, which was sadness .....and it was quite incredible to have the privilege of going into her world and feeling her sadness and just it was quite amazing and I felt quite overwhelmed. CATHY/VHS8/24.2.05.*

A consequence of being emotionally together was the danger of feeling overwhelmed, possibly resulting in leaving workers feeling as if they are drowning in the presence of the person. It could be argued that where staff felt uncomfortable or overwhelmed, they were experiencing in a bodily, felt sense, the relationship and attunement with the person with dementia. This suggests caution when asking staff to use contact reflections or sufficient warning about the potentially profound effect that emotional togetherness may provoke in staff.

8.3.3 Distance – Summary

The third feature of the emotional management was around emotional distance. Contact reflections demand building an emotional bridge with the person with dementia. However, people were more likely to remain apart when emotional engagement was not seen as part of their job, they did not feel qualified, and there was fear of provoking difficult emotions. This facet of the emotional management of interactions is potentially volatile as we cannot predict what emotions the person with dementia will experience or present to us. If contact reflections facilitate closeness and communication which does not overwhelm the worker, then there is the potential for greater intimacy.

The two positions within emotional distance both contain risks. Keeping apart risks neglecting the subjective world of the person; being engaged carries a risk to staff. Reconciling these two forces indicates the need for support and supervision for staff as well as feeling suitably equipped to
manage the emotional responses when engaging in the emotional world of dementia. Contact reflections exposed this dimension as they challenge the mechanisms of keeping apart because they demand emotional togetherness.

8.4 The focus of the relationship

The focus or purpose of the relationship is the fourth tension within the relationship: being task-focused versus being person-focused (Fig. 8.5). As with the previous three features, contact reflections revealed the polar positions because they demand alignment to one end of the counterpoint — in this instance, being person-focused.

![Diagram of focus of the relationship]

**Fig. 8.5.** Focus of the relationship.

8.4.1 A task-focused relationship

*I didn’t take it any further. I had to get on with lunch at twelve o’clock.* CATHY/VHS30/22.7.05

Conditions driving a task-focused relationship were: needing to manage the environment as a whole, and time. These challenge doing contact reflections, acting as a mediating or inhibiting factor.
Staff work in an environment which affects the time available to focus solely on the experience of one person with dementia. The safety of the residents demands being aware of the wider environment and has to take priority. Barry illustrated this when having to respond to aggression from one resident towards another.

*We had to part them yesterday. If you see violent behaviour coming you remove one resident. We all tend to react to the more bizarre behaviour - the swearing or whatever - it's reactive.*

*BARRY/VHS13/1.4.05*

As a result, the nursing role is to respond and react to the whole environment and behaviours which are likely to lead to harm or danger. Under these circumstances using contact reflections is challenged by the environment, which is noisy, unpredictable, disruptive and not conducive to being therapeutic or using contact reflections.

*Most of them (residents) are very noisy. You stay all day long on the unit, one of them starts screaming, sooner or later they will all scream. It's a big noise in there. I don't mind, my nerves are strong enough for this, but some of my colleagues simply can't. Maybe this is one of the reasons why they do not try to approach them in a different way.*

*BRUNO/VHS23/31.5.05*

By way of contrast, Cathy's role included protected therapeutic time on a one to one basis. She compared her experience with that of others.

*They (nurses) have got 17 patients milling about and their way of dealing with their seven and a half hour shift is different from my way. I'm not stuck here.*

*CATHY/VHS12/22.3.05*

Responsibility for the whole environment adds to a focus driven by structures, routines, tasks and managing safety. They may have limited control of the environment, having to manage interruptions, phone calls, relatives. This affects their perception and they believe that there are limited opportunities for individual person-focused time with residents.

*To be honest here we don't have time.*

*APOLLO/VHS2/29.12.04.*
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However, there were times when people managed to overcome this, adopting an approach which is less task-oriented and more person-centred.

8.4.2 Person focused

*It felt very good, something on their terms. You’re thinking not about how the conversation is going to go but actually about that person.* BARRY/VHS26/1.7.05.

In contrast to being task-focused, contact reflections demand a person-focused approach to the person. This was appreciated precisely because it differed from being focused on physical care tasks.

Anna: *I think it’s very positive because we’re not just washing cleaning, feeding. We are also trying to respond to their emotional needs, making efforts towards communicating and taking account of their spiritual and emotional needs.* ANNA/VHS 6/15.2.05.

By attending to the person, perspective shifts away from the tasks to the person within, with the possibility to enhance the relationship.

*In the five minutes that we were there I have seen a different person.* APOLLO/VHS1/29.11.04

Because the contact reflections demand extra noticing, a worker may see more than usual, which can enhance the relationship and job satisfaction.

Andy: *(I feel ) much better, because you’re not just feeding them, you’re giving them contact. (This) makes you feel you are treating them more like a human being rather than just an ill person who’s beyond help or anything.* ANDY/VHS4/10.2.05

Brian contrasted task and person-focused relationships, highlighting how the least interactive people are most vulnerable to receiving care as if they were an object (Kitwood 1997).

*Some people (staff) go through the whole day, every day without really communicating at all unless its with somebody who can talk back to them.* BRAIN/VHS13.1.4.05

Achieving a person-focused relationship requires time and space for the person with dementia to be in the relationship (Cheston and Bender 1999). This means avoiding taking over and allowing the person with
dementia to contribute to the relationship, determining the content and
direction. Contact reflections by their nature meant that the person with
dementia (and what they are experiencing), leads the interaction.

You are not prompting a patient to do something.
ADAM/VHS11/18.3.05.

Being person-focused using contact reflections means staff do not
impose their own world or interpretations on the person with dementia.
This stems from their theoretical origins, which are Person Centred, and
means that they offer dementia care an approach which is nearer these
origins (Morton 1999). Due to the very concrete nature of the contact
reflections, they are useful in showing staff precisely what is needed to
achieve a position which is more person-centred and less task-focused.

8.4.3 Focus - Summary
Different experiences of using contact reflections drew out the
differences between being task-focused and being person-focused. The
extent to which staff aligned themselves with either position mediated
the use of contact reflections. Underpinning the focus of the relationship
is the tension between managing an individual and managing the whole,
which involves having an overview of the tasks to be done and watching
the unit as social environment. Being person-centred demands focus on
an individual. The tension for staff is to be able to focus on the individual,
whilst at the same time being aware of the overall context. Nursing staff
have a responsibility to an overall environment, not simply to an
individual, and this in turn affects the capacity of staff to maintain a
person-focused perspective. However, when they focused on the
individual, staff gained satisfaction from having a relationship which was
more humane.
8.5 A model of emotional management

This chapter concludes by collating the conceptual counterpoints into a model of emotional management (Fig. 8.6) and exposing two overarching theoretical perspectives within the model (Fig. 8.7). The model is dynamic and fluid, with tension between each feature. The model suggests that variations in responses and experiences of staff to the contact reflections were due to the alignment of each participant within their interactions.
Fig. 8.6 – Components of emotional management.
By redesigning Fig. 8.6, rotating the components of emotional management, the overarching conceptual counterpoints emerge: emotional custody and emotional containment (Fig. 8.7).

![Diagram of emotional custody and emotional containment]

**Fig. 8.7. Emotional custody and emotional containment.**

### 8.5.1 Emotional custody and emotional containment

This thesis argues that emotional custody arises from adopting the following positions: being responsible for another, doing for, keeping apart and having a task focus. In doing so, the worker becomes the custodian of the client's emotional world. They assume responsibility for the emotional world of the person with dementia, acting this out by managing or determining the emotional tone of interactions. The custodian has either an absence of an emotional relationship or emotional control which favours tasks and routines, working on the assumption that it is our job to make the person feel better. As custodians we either adopt a position of keeping emotionally distant, what Morse (1992) would term 'A-engaged' or 'dis-engaged'. As
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custodians we can focus on the tasks in hand because we are free from the emotions of people with dementia. In addition, the emotional custodian role is self-protective; actively not engaging with the emotional world of the person with dementia keeps the worker emotionally distant and emotionally safe. This role has a dual function. First, the custodian inhibits the person with dementia expressing difficult emotions. Second, custodianship protects staff from facing their own response to emotions that leave workers feeling anxious, hopeless and helpless.

The contrasting position is emotional containment. This term has been used deliberately. Containment is used to indicate the active nature of the worker in the process of holding the emotional experiential world of the person with dementia. ‘Holding’ would have been an alternative term, and is used by Kitwood (1997).

_Whatever distress the person with dementia is undergoing, the caregiver remains fully present; steady, assured and responsive, able to tolerate the resonance of all disturbing emotions within his or her own being (Kitwood 1997: 120)._ 

Rather than taking responsibility for another, we maintain responsibility for managing ourselves in the relationship and our own emotional management. The attitude is one of _being with_, being emotional engaged and person-focused. In doing so, we can safely hear and witness the persons experience of the world. At the same time the worker holds and contains their own response (Obholzer and Roberts 1994; Waddell 2000). As containers we are then able to be person focused, in the therapeutic or psychotherapeutic sense.

The relationship between the positions of custodian and container is not a simple right or wrong. Whilst containment permits engagement with the subjective world, there may be times when emotional custody and taking control of the emotions of the person with dementia is preferable — for example, offering comfort rather than reflections. Arguably, emotional custody complements a physical custodian role and
interactive approaches that lead, direct and offer control. Familiarity with physical custodianship seeps into the emotional management as staff deploy a similar protective approach. This would explain individuals' discomfort arising from emotional closeness and getting contact because it breaches their familiar way of working.

8.6 The Perspective of staff - summary
This chapter has explored the experiences of staff which led to the development of the model of emotional management of interactions which stands on four conceptual counterpoints. From this, two overarching positions emerged: emotional custodianship and emotional containment. These emerged from contradictions in the data which were exposed by the use of contact reflections. Tension arose within each counterpoint when using reflections because this requires alignment with containment as opposed to custodianship. This acts as the third mediating factor because emotional containment is sometimes at odds with how the staff usually act, react and interact with a person with dementia.
8.7 Summary of Part Three

Four chapters have outlined the findings. Chapter 5 showed the relatively successful outcome of contact work to facilitate emotional contact. For dementia care, particular characteristics emerged around the emphasis on non-verbal communication, proximity and language. Knowing this will help future work. Chapters 6, 7 and 8 built layers of complexity, illustrating that the application of contact reflections to dementia care is not straightforward. Learning was mediated by beliefs about rules of social interaction and the effect of the context which resulted in self- and peer-regulation. These factors are likely to be of relevance to any learning process which aims to develop communication skills of staff. Learning was not automatic or straightforward.

The challenges are potentially disheartening. If, as this study has shown, staff find it difficult to learn and use contact reflections, what hope is there for the introduction of more complex ways of interacting such as Validation Therapy, Kitwood's Positive Person Work and more sophisticated, abstract and artistic approaches which also engage in the subjective world of the person with dementia (Feil 1992; Kitwood 1997; Killick and Allan 2001; Pitkin 2007; Walker 2007)?

Chapter 7 explored the nature of dementia, in particular judging expressiveness and facing emotiveness from the person with dementia. Where people are highly expressive but have difficulty conveying this, we need to be cautious using reflections as they may heighten agitation and frustration. The nature of dementia at times requires us to initiate, direct and use additional creative ways of talking. Because dementia sometimes strips people of being able to organise meaningful and pleasurable activities themselves, workers need to initiate and create these opportunities. This is well established in the literature and covered
by a large umbrella of activities and ways of interacting that raise the 'well-being' of the person with dementia.

Notwithstanding, contact reflections have their place amongst the repertoire of therapeutic approaches in dementia care. Indeed, they bear a resemblance to existing work and the term mirroring is used in the work of Naomi Feil (1993) and John Killick (Killick and Allan 2001). However, Prouty's unique contribution is the specific focus on gaining contact, depth of detail about how this is achieved, the underlying theoretical basis for this, and the emphasis on contact as work in its own right. He returns us to the very foundation of an interaction, paying minute attention to how the client develops an experiential sense of themself and how a relationship develops. He also provides us with a theoretical and philosophical basis from which to provide 'emotional palliative care' or contact from which to establish psychotherapeutic-oriented work (Van Werde and Morton 1999; Davenhill et al 2003).

The model presented in Chapter 8 offers an explanation about why emotional engagement posed a challenge to staff. This model helps us understand the underlying social process within interactions that may affect attempts to change people's practice and communication skills. Given the push to improve emotional care embedded in policy drivers, perhaps we need to spend more time studying the process of how we achieve this in relation to social processes which inhibit emotional work (Mental Health Foundation 2007)?

Prouty offers something which is immediately accessible; the mechanics of reflections are immediately understandable to staff and the apparent simplicity may be Prouty's strength. This contrasts with Feil, Killick or Kitwood, whose ideas require more time to understand and integrate into practice.

Although the findings indicate there are many and varied barriers to and mediating factors concerning learning and using contact reflections, the
impact of contact has stood out. This can be profound, moving and emotionally challenging. A university colleague who had heard me speak about contact work reminded me of this. His mother has a severe level of dementia and he had used the contact reflections with her. A few months later, I was presenting my work to research students on his course and he remained in the session. I was discussing how the research process had left me feeling rather nihilistic and demoralised about achieving change in communication. He challenged this, reminding me of the importance of even the smallest change. He had used reflections with his mother and described how they elicited a profound eye contact and a smile from her that moved him to tears. He was visibly moved recounting the experience and he restated the significance this tiny moment had for him. I am indebted to him for reminding me of the importance of contact (Reflective Diary 22.11.07).
PART FOUR

Discussion and Reflection

Conclusion
Discussion and Reflection

Introduction

The discussion pulls together the findings from the study, namely the application of Prouty's work to dementia care, the contribution of this study to Pre-Therapy and the implications of the underlying social process of the management of emotions in interactions. The implications of the management of emotions will be explored in relation to the regulation of emotions in dementia care. A case is made for a more honest view of the limitations of emotional engagement. This poses a challenge to proponents of person-centred care in the field of dementia care and the rhetoric of policy which promotes person-centred care and training for staff. The argument is made for a more realistic goal of how much engagement we can ask of a workforce who may be ill equipped to provide it and who work in contexts that may be prohibitive.

This study investigated how new practice is implemented in everyday care, raising the uncomfortable idea that we are far from achieving person-centred practices and staff training is inadequate without necessary and sufficient attention to social, relational, structural and contextual factors. However, Prouty's approach offers a small, possibly achievable way to take a step towards giving staff guidance on what to do and say to interact in ways which are more consistent with a person-focused or Person Centred philosophy. The chapter ends with reflections on the research process.
9.1 The contribution of Pre-Therapy to dementia care

Prouty's contact reflections have immediate face validity with staff, as the basic concept of the reflections can be quickly grasped. Prouty's work has an immediate practical application. What the worker has to do is immediately obvious and this makes his approach accessible. Contact work has the potential for staff to begin to understand how they can operationalize micro interactions which are attuned to the person with dementia.

By exploring how contact work can be used in dementia care it became apparent that staff can attach the ideas to their existing experience in communicating with people with dementia. It was through this experience that it emerged that contact work in dementia care involves greater attention to non-verbal reflections, the use of vague pronouns, using physically close relationship and using reflections near and on the person with dementia. Contact work appears to hold potential to offer staff the opportunity to interact in a way which facilitates greater self-direction from the person with dementia, sustain interactions and possibly enhance the relationship when performing physical care tasks. Reflections offer staff concrete and specific guidance about how an interaction may address the subjective world of the person and promote emotional engagement.

The study showed that, for some participants, relatively short instruction can result in staff being able to incorporate contact work into their everyday practice. For staff in dementia care the ideas are accessible and have a 'common sense' value to them. One of the strengths of Prouty's approach is the apparent simplicity. However, this simplicity is deceptive and time is needed for staff to rehearse and practice using contact work before it can be integrated into their existing repertoire of communication skills. This study shows that it is possible to introduce contact work to people working in dementia care at a basic level. The
introduction of contact work is more successful where people hold the values which underpin Pre-Therapy and a humanistic or person-centred approach. Seen as a prerequisite for Pre-Therapy, the philosophical and theoretical foundations of being Person Centred (offering acceptance, empathy and being non-judgemental) are part of the everyday practice for psychotherapists and psychologists. This may not be so for nursing practice or people working in roles where there is an absence of professional socialisation into this way of being (Morse et al 1992). This is where the application of Pre-Therapy for dementia care may falter. Arguably, to use Prouty's approach one needs these foundations before being able to use the concrete application of the techniques – the contact reflections. The literature demonstrated how much interaction between staff and people with dementia is lacking in empathy or is routinized (Ward et al 2005).

So, the introduction of Pre-Therapy principles and contact reflections is problematic where staff enact role concepts which are more akin to providing practical task focused care rather than relationship and person-focused engagement. Barriers to the introduction of contact work arose from the social environment where staff held ideas about rules and norms of social interactions. As contact work offers a different way of interacting, the social norms of interactions were challenged. The social environment also posed a challenge and staff experienced self-consciousness in using the approach in the presence of others. Despite these barriers, contact work appears to hold the potential for staff to engage with people in a way that helps them see the person inside.
9.2 The contribution of this study to Pre-Therapy

This study has shown that Pre-Therapy has resonance with a new client group – people with dementia. This builds on the growth of Pre-Therapy in different client groups and clinical settings (Peters 1999; Prouty et al 2002). It also affirms the preliminary work by Van Werde and Morton (1999) which proposed that Pre-Therapy has the potential to offer emotional palliative care (160).

The variations specific to dementia (emphasis on non-verbal reflections, vague pronouns, physical closeness) arose from applying Pre-Therapy to specific settings in dementia care. Notwithstanding, the variations still mean that contact work in dementia care remains recognisable in relation to the theoretical ideas of the expert community (Prouty 1994). Hopefully this demonstrates that the integrity of the approach remains intact despite being used in a new care context. The study adds to the knowledge about Pre-Therapy and situations where it is necessary to be cautious about using contact reflections. This indicates being prudent in the blanket adoption of an approach which was generated from work with people with psychosis and learning disabilities. Specifically, the findings indicate caution in using reflections with people who are not expressive but are dysphasic.

The added complication for dementia care is the difficulty in gauging levels of expressiveness. Van Werde (2001) elaborated on Prouty’s work by identifying grey zone functioning, i.e. where a person is moving between being expressive and pre-expressive. This study takes this work further and indicates that people with dementia may move rapidly from being seemingly pre-expressive to expressive. The study also resonates with the work of Peters (2005), who notes how contact reflections facilitate moments of lucidity and contact with people with learning disabilities. This study also found that similar moments of
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Lucidity appeared to be facilitated by contact work. The rapidity of emotional contact raised concern in staff that contact work might open a can of worms or create intense emotional expression and that staff were unsure about how to respond to this.

Through the exploration of the experiences of staff learning and using contact reflections, this study also uncovered the potential social process which inhibits the use of contact work by staff in the field of dementia care. This was conceptualised in the model of emotional management. It is the relevance of this social process for dementia care that merits further discussion.

9.3 Seeing inside: social order and control of the (emotional) body

Prouty invites us to reflect the embodied experiences of the patient or client using contact reflections to engage with their subjective experiences. As shown in this study, contact reflections enabled moments of engagement with the subjective experience of the person with dementia which was sometimes deep and profound. In this sense, engagement helps us move towards being a witness to their experience and could be termed seeing inside. Seeing inside could be viewed positively or negatively by staff and the reaction of staff exposed the possibility that they provided a window into an underlying social process. The difference between the perspective of engagement being either a ‘good thing’ or a ‘bad thing’ invites a wider discussion about seeing inside a person, whether by contact reflections or by therapeutic approaches in dementia in general.

This discussion is triggered by the dualism of ‘good’ and ‘bad’ reactions to contact work in relation to role identity. Workers enact their role identity, and their social actions provide a window into an underlying ideology and discourse about social emotional order and control of the
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emotional bodies of people with dementia. This extends work on emotional labour and emotional control in health care work, suggesting that workers not only manage or control their own emotional labour, but that they also actively regulate the emotions of the person with dementia (Meerabeau and Page 1998; James 1992). The discourse has implications for the drive towards more person-focused care in the field of dementia.

As a 'good thing', contact work created small opportunities for staff to experience a sense of joining with the person, being able to get their work done, and provided a sense of satisfaction. Chapter 8 showed how comfort with contact work depended on the role concept held by the individual. When the response of the person with dementia to the contact reflections was perceived as useful by staff, it facilitated staff enacting their self-concept. In this instance, staff were able to meet their own expectations of the role as a nurse, here the contact reflections were viewed as 'good'. 'Good' results might include helping staff carry out personal care or, physical tasks, maximising the ability of the person with dementia, or simply enabling a pleasurable interaction with the worker. The perception of good depended on the role concept, and an experience was viewed as good when it meant the worker could enact their role concept.

In contrast, as a 'bad thing' (or difficult thing) the experience was less pleasurable. Seeing the unhappiness of the world of the person with dementia, staff found client's pain and sorrow more difficult to witness. Depending on individuals, the capacity to be with expression of the internal world varied and was associated with the individuals self-concept. Where social attributes of the self-concept included ideas compatible with the philosophical foundations of contact work, being in proximity to unhappy emotions was not negative but simply part of the role. In contrast, the contact reflections were seen as 'bad' or 'wrong' when individuals held a role concept where their job was to make things better or comfort the resident. Therefore, on the occasions when contact
was made which did not fit with the role concept of the worker, the worker experienced discord with their role concept and felt unable to 'help'. The feeling of discord arose from being unable to enact the social normative behaviours and trappings that accompany the constructed identity of being caring.

Taken together, the two conceptual positions of 'good' and 'bad' tell us something about the perspective of seeing inside — glimpsing the emotional world of the client. Extending this train of thought leads to speculating whether this study tells us something about perceptions of the social acceptance of emotions and whether there is a desire to regulate emotions in social situations. This might imply that there are aspects of people's 'insides' (emotions) which are permitted outside (in public) and other aspects of their emotional insides we attempt to keep inside the person.

The perception about the value of seeing inside is mediated by an individual's internalised constructs which determine whether they think this is a useful thing to do as well as the individual's capacity to do this. This argument is supported by the dynamic process of the management of interactions which was presented in Chapter 8.

Managing interactions involves juggling the two positions of emotional custodian and emotional container, positions which represent the conceptual extremities of the process of emotional management. The emotional custodian actively avoids seeing inside and has regulatory mechanism to stop the insides oozing out (Turner 1984). This is born out of staff's desire to protect the person with dementia from emotions which might be 'bad' — or even preventing these emotions - and at the same time staff protect themselves from emotional harm. The emotional container on the other hand is there, ready, willing and able to bear witness to the emotional world, be it 'good' or 'bad'. In this sense, containment is viewed as a social process in the management of emotions. It is acknowledged that the internal process of containment is
frequently identified with a psychoanalytic perspective but this discussion retains a focus of social and relational processes which ensures compatibility with the epistemological position of this study. However, exploration of psychoanalytic processes such as projective identification, countertransference and containing in dementia care can be found in the work of Balfour (2006, 2007) and Morton (2007a, 2007b, 2008).

It could be argued that the mechanism of emotional management, with the dramaturgical roles of the emotional custodian and the emotional container, is one which regulates social emotional order within dementia care.

To expand this argument the work of Turner (1984) and Armstrong (1983) are useful. They provide ideas about maintaining social order and regulatory mechanisms that achieved this. Turner provides a reworking of Hobbes' conception about social processes which lead to stability and order. Turner uses this to locate social processes of order towards how society manages physical beings - bodies.

I want to suggest that it is possible to rewrite Hobbes in order to produce a theory of social order which starts out from the problem of regulating bodies. (Turner 1984; p 90).

While Turner's starting point is order via regulating bodies, Armstrong focuses on how discourses about the body contributes to regulatory mechanisms and surveillance of individuals, role and society, which in turn shapes authority and order (Armstrong 1983).

By adopting these positions of Turner and Armstrong, it can be argued that the model of emotional management of interactions identified in this study is part of the regulatory and surveillance process of people with dementia and those who care for them: a process which acts to maintain emotional order and social order. This moves the discussion into the realm of the sociology of emotions. This resonates with Bendelow and
Williams (1998), who collate works around emotions in society. They state their position as follows:

*In short, the emphasis here is on the active, emotionally expressive body, as the basis of self, sociality, meaning, and order, located within the broader sociocultural realms of everyday life and the ritualized forms of interaction and exchange they involve. Seen in these terms, emotions provide the 'missing link' between personal troubles and broader 'public issues' of social structure; itself the defining hallmark of the 'sociological imagination' (Bendelow and Williams 1998: xvii).*

By locating the discussion in the sociology of emotions, it can be argued that current residential health care provision for dementia includes a discourse which contains variations upon the theme of emotional control and management. Variations arise as individuals engage in everyday interactions offering differing degrees of emotional custodianship or emotional containment. Variations also arise within specific units as each ward or unit acts as a micro-culture which shapes social norms and identities within relational social settings.

The discourse of emotional custodianship is supported through the organisation. In fact, it could be argued that the emotional management of the organisation works along similar lines. In the same way that a worker may act as an emotional custodian towards a person with dementia, the organisation may act as an emotional custodian towards its workforce (Obholzer 1994; Morgan 1997). This can be by default, where emphasis is placed on safety and protection of workers and service users – for example, in the monitoring of attendance at mandatory training for staff or the risk of falls in residents. Alternatively the emotional custodial model may be more overt. By having a focus on technological rationality, organisations have limited opportunity to enact a philosophy which offers to contain safely the emotionality of the workforce (Fineman 1993). The organisational messages to staff are overtly about productivity rather than emotionality, with an organisational requirement that a particular amount of physical work has to be completed within time limits. This causes tension for workers, who
experience emotions, but the conditions restrict them from expressing them (Olesen and Bone 1998). The organisation does not afford as much time, space and attention to providing emotional space, and as a result emotional work is less closely monitored or promoted. Forums for emotional expression which do exist, such as clinical supervision, reflective practice or simply open discussion of the emotional impact of work, are notoriously difficult to sustain.

As a result, organisational discourse may reinforce emotional custodianship of self and others. Where this happens, the organisation acts as what Morgan (1997) refers to as a 'psychic prison', where norms and social rules are constructed which are repressive or self-limiting for individuals. Within this culture, workers internalising the emotional discourse act to oppress their own emotional expression and the expression of others (Dartington 1994; Morgan 1997). This resonates with this study, which revealed the internalised self concept (of some) that engaging with the emotional world of the person with dementia was 'not my job', or was seen as another type of work - for example, 'I do that when I've finished my work'. As with many regulatory systems there are sanctions and punishments. The discourse of emotional custody may be enacted by frowning upon excessive 'emotional-ness' in colleagues and cultural messages of 'not being up to the job'. This might be enacted by: limiting opportunities for staff to engage in emotional dialogue, promoting messages of coping and encouraging suppression or removal of difficult emotions from the 'stage front' of the workplace (Goffman 1959; Newton 1995; Morgan 1997). Internalisation of emotional custody means that through social interaction the cultural notion of emotional suppression is maintained and perpetuated.

A discourse which includes emotional custody to maintain social and emotional order is at variance with much of the literature which promotes changing discourses or cultures of care. An old culture of care (Kitwood 1995) relies more heavily on the role of the emotional custodian. As far back as 1994, Kitwood requested that our approach to engage with
people with dementia required meeting them and addressing our own defence mechanisms and opening ourselves to them emotionally (Kitwood 1994b). However, despite repeated cries from a multitude of authors, emotional regulation is still evident. This study helps understand why such emotional regulation is present. The regulation maintains the social order of the constructed relationship between the member of staff and the person with dementia. For those with a role construct which includes ‘making it better’, offering comfort, making client’s better, the emotional custodian role is a requirement. It stops the unpleasant insides oozing out, which presents us with feeling inadequate to help if we are not able to contain our own responses of anxiety and impotence.

Paradigms in the dementia literature invite us to take more subjective, phenomenological approaches to understanding people with dementia and to pay greater heed to how we can interact in a way that promotes greater expression of the sense of personhood of the person with dementia. The emotional cost of this is known, and Killick in particular is explicit about how experiencing people with dementia was emotionally and spiritually painful (Gibson 1999; Killick and Allan 2001). However, calls to engage persist. Post (2006) states the moral imperative to ‘look (Latin — spectare) again (Latin — re)’ or ‘respect’ the person with dementia. Drawing on Kitwood’s work he sees that to exclude or ignore the emotions and our relationships with people with dementia is to be callous and inhumane.

*There is an emotional and relational reality in the lives of the deeply forgetful, the first principle of care for such persons is to reveal to them their value by providing attention and tenderness in love (Post 2006: 232).*

He restates Kitwood’s guidance on offering love, which includes comfort, tenderness, calming of anxiety, and feelings of security based on affective closeness. In addition, we need to offer attachment and formation of emotional bonds with people with dementia to enhance security and affirm their identity (Post 2006: 232). Both Post and Kitwood offer a reminder that engagement requires meeting whatever emotional
world the person experiences and engaging with the whole range of
emotions, including one's own anger, sorrow and fear.

Change in dementia care requires assimilation of new paradigms and
alternative discourses. Staff are being charged with being able to
provide care in the way Post describes (Post 2006; Mental Health
Foundation 2007). This is a tall order and change has been slow. One
explanation for the disparity between the potential change and actual
change can be offered. Change is slow because to adopt more person-
focused approaches to people with dementia demands risking greater
exposure to the insides of people with dementia and the accompanying
risk that the internal embodied world is a heaving mass of maggoty
emotions which may contaminate and overwhelm us (Moylan 1994). In
the face of difficult emotions workers may retreat, creating a social
distance between themselves and the person with dementia, or become
emotionally disengaged (Fleming and Spicer 2003; Menzies 1970;
Morse et al 1992). Alternatively they may mobilise emotional custodian
strategies such as trying to cheer the person up, distract them from their
emotions or replace 'bad' emotions with 'good' ones, thus negating the
'bad' ones.

To ensure stability of the negotiated social and emotional order,
emotional regulation of people with dementia is necessary for the safety
of those who work with them. The suppression of 'bad' emotions is
necessary for stability to be maintained and enactment of the emotional
custodian is a useful mechanism to achieve this. This may be one
explanation for the rather tortoise-like pace of actual change compared
with the hare-like speed of the growth in aspirational literature.

Thus a discourse of emotional confinement exists in parallel to new
paradigms of dementia care. By co-existing, the interplay between
paradigms may account for the variance of theory and practice.
Emotional custodianship acts as a resistant force against change
Discussion and Reflection

towards more subjective phenomenological, relational or interactionist approaches.

If we accept that the concept of the emotional custodian carries validity, we face a choice. In order to deregulate the emotional world of the person with dementia it needs to be accepted that their subjective world may be difficult to witness. Consequently, we need mechanisms to manage the results of emotional deregulation. This requires us to return our gaze to those who will be in receipt of the emotional world of the person with dementia – the staff.

At present, this study proposes that we are insufficiently prepared for entering into the subjective experience of the person with dementia. The very act of offering simple reflections back to the person with dementia is not as straightforward as it sounds. This implies that offering care advocated by key authors such as Kitwood, Killick or Feil is also potentially difficult to translate from page to practice.

This study has established that staff may respond in various ways, including positive acts of emotional custodianship such as initiating and taking responsibility for instilling positive emotional states in people with dementia, or negative aspects of custodianship, such as trying to distract people away from painful emotions. Moving away from patterns of emotional custodianship means challenging social norms and role identities where these identities are at variance with principles of being person-centred.

If we are to progress towards more person-focused care we need to consider whether we challenge a discourse and socially constructed negotiated order away from the influences of emotional control or work with it.
Discussion and Reflection

Honesty with the discourse of emotional control

A critical examination of the process of emotional control in dementia care requires questioning whether there may be value in adopting a position of rational honest collusion with elements of the discourse of emotional custody. This opens up the possibility of making a realistic commitment to taking a small step towards care which is less custodial and more able to offer emotional safe containment. This position requires three features:

i) Acceptance of the limitations of engaging with the subjective world of the person. It would draw on positive aspects of emotional custodianship whilst at the same time being committed to lessening the restrictiveness of emotional custodianship.

ii) Care practice would need to be sufficiently protective of the social norms and requirements to maintain an emotional social order. This approach recognises the dangers for staff when they face the emotional world of the person with dementia. The approach recognises a need for a degree of emotional custodianship in order to protect social norms and for self-protection.

iii) Simultaneously provide a way role identities can be safely and effectively transformed which is supportive enough to counteract emotional stress and the ontological security of the worker.

The advantage of this option is that it serves to protect individuals (staff and people with dementia) and the organisation. It also maintains social order because some emotional control is maintained but tempered. This is a more honest option as it requires open acknowledgement of the need for some emotional regulation. It would require reducing the cry for engaging with the subjective reality and hearing and seeing the person within to a more realistic goal - hear and see a little bit more but only that which we can manage.

The term 'rational collusion with emotional control' indicates a pragmatic acceptance of the limitations of what we have to offer, and acceptance that often we may fall short of being able to hear the voice of the person.
with dementia, simply because it is too difficult to bear. For the gifted few such as Killick, or Goldsmith, or other authors who regularly appear in the dementia literature, achieving the ideal of being able to *be there*, witness and hold the emotional world of the person with dementia, may be possible. In contrast, there are many more ordinary people who have internalised cultural expectations about being a good carer which are in fact rather emotionally restrictive, or who are less skilled in offering themselves as a *presence*. To expect, from the unskilled, the same measure of performance as the gifted is at best unfair and at worst potentially punitive: punitive in the sense that staff become more susceptible to being reprimanded for not being able to enact the new requirements. A further critique of the gifted is the absence of recognition of the difficulties of working in the real life settings of wards or residential units and the cultural and social processes at play, which, as seen in this study, have an effect on the social actions of staff. Arguably, staff in residential units are as captive as the people they care for, and outnumbered by residents in ratios sometime of four to one or more.

This feature suggests accepting a degree of custodianship, promoting and permitting emotional custody for people with dementia in a positive and safe way. The creation of opportunities for instilling positive emotions can be seen in various ways in the literature, such as prompting singing, dancing, pleasurable activities, stimulating laughter or provoking pleasurable memories. These activities with a person with dementia could be seen as a form of emotional custody, but in this case instead of suppressing the 'bad' emotions, we are limiting the 'bad' by promoting the 'good' emotional states. This is still emotional regulation, but with a specific therapeutic purpose to reduce the pain of the emotional experience of dementia. Openly and honestly promoting emotional custodianship carries a risk. The risk is that it swims against the rhetoric espoused in policy and might debunk the idea that we should be aspiring towards emotional engagement. This raises questions – if person-centred care involves emotional engagement and
emotional engagement is overwhelming, requiring a level of skill above that which we currently have, then should we continue to promote ourselves as doing person-centred care? Does this mean that much practice under the broad umbrella term 'person-centre practice' is in fact sugar-coated emotional custody? If so, then why not adopt a position of greater honesty and say we cannot provide care which engages with the subjective reality of the person; rather we will alter the experiences around them to give them a reality which is easier for us to tolerate. By being realistic about the limitations of engaging with pain we are more candid that our goal is creating a climate of merriment. Our role is to make it better and we (staff) should make them (the person with dementia) feel better. In the process we avoid the pain of being presented with their pain. Arguably, this is already in place, but without being overtly acknowledged. The data indicated in this study that staff held role expectations that they were there to offer comfort and desired to help prevent, or avoid hearing, distress. So why not assume this as the starting point and cease pretending that we offer something we don't?

If we continue to request emotional care and lessening custody in order to create more emotional care for people with dementia we need to ensure what we ask of staff is understandable and achievable. There is little point in adopting the position of, say, Post (2006), calling for staff to enact the moral imperative of emotional closeness and love, without providing staff with concrete ways this can be done. Indeed, the moral imperative may become oppressive to staff if they are asked to do something so abstract in prohibitive working conditions. In this sense the very act of asking staff to do something different may add to their burden, particularly if they are not provided with the conditions in which to try something new (Illich and Verne 1976; Friere 1970, 1972).

It could be argued that sustained calls from the abstract or theoretical perspectives - such as the moral imperative to love (Post 2006), the need to offer an I-Thou presence (Kitwood 1997) and to listen at an
existential depth (Killick and Allan 2001; Goldsmith 1996a; 1996b) - are as unrealistic as finding a unicorn in the high street: seeking the mythical in the everyday context. As shown in this study, even the seemingly simple act of introducing very concrete and tangible contact reflections, actions which could be seen to be the enactment of empathy, are far from straightforward. If contact work is difficult, then how much more difficult would it be to ‘teach’ staff to offer love and openness in abstract terms. In order for people with dementia to have greater opportunities for emotional and relational contact with staff, we need to ensure that we set realistic goals. By being realistic the ideal may not be achieved, but at least we are part way towards it.

The second feature recognises that a degree of emotional custodianship is necessary for staff as well as those with dementia. In this sense, we support and collude with the discourse of emotional control. For some staff, emotional custodianship could be seen as the ‘preservation of self in everyday life’. Staff enact their role concept and often this contains attributes of ‘making it better’ and suppressing difficult emotions, offering distraction and diversion away from pain towards more pleasurable emotions. This prevents staff being recipients of the emotional misery of the person with dementia and at the same time attempts actively to create positive emotions as an antidote to misery (Balint and Ralph 2006). We might do well to be more lenient about allowing them time to retreat ‘backstage’ or ‘offstage’ to help them contain their own emotional response to the emotional world of the person with dementia. This requires sanctioning time and space away from the residents and greater opportunities for discussion of the emotional aspects of care (Menzies-Lyth 1988). This is not to sanction poor care, for example, where residents are receiving very little communication which is predominantly brief and instrumental (Ward 2005), rather it is an honest acknowledgement of the sheer size of the job to change care and to face ‘emotional-ness’ for sustained periods of time with sensitivity without resorting to emotional disengagement.
Being honest about drawing on emotional custody and control we then give permission to staff to be unable to cope with the intensity of the emotional world and we could create expectations of being able to hold some, not all, of the emotions presented to us. This would provide workers with a more permissive environment where it is stated that it is desirable to try and engage emotionally, but recognition that this may be too difficult at times and staff may need to resort to (positive) emotional custody for their own protection. In this sense, we are providing a model of service which strives to be more compassionate to staff, precisely what we are asking them to be with clients.

The third feature is to consider how we support staff should they fail to manage emotional containment or in their role of providing emotional custody, because it is equally unlikely that either will be entirely successful. The woman searching for her baby who died may, despite intensive distractions, return to despair as a default emotional state. Emotional custodianship of her emotions may be only temporary, as painful or 'difficult' emotions have a habit of resurfacing (Hunt et al 1997). Whilst custodianship may be useful for staff, it may not be successful. The scenario also fails in emotional containment, as the extent of this sorrow is difficult to witness. Therefore, although we actively encourage staff to adopt positive custodianship, it might actually be detrimental to reinforce an identity of one who makes it better without providing somewhere to manage the consequences of failing to do this. It might be potentially dangerous to promote a role identify which cannot be fulfilled and sufficient protection against a failure to meet expectations is required. So rather than staff retreating emotionally and becoming disengaged, staff need permission to express sensations of failure, hopelessness and helplessness when they arise. The same forums provide a space for managing the emotional cost of containment. Through this, there may be the potential for attitudinal change in staff as they shift towards understanding their role as trying to use positive aspects of custodianship for their charges and that custodianship is
there to help protect them too. Then there is some limited space to allow for them to understand the need for containing.

So I support a new moral imperative – reduce the cries for staff to change and increase the volume on calling for creating conditions to support staff in change. A prerequisite for asking for change is to ensure that the accompanying role transitions can take place before we begin to add additional role stress and goals.

By stepping towards the goal of improving care, we need to acknowledge the interplay of the cultural context in which people work and the role this plays in constructing and reinforcing social identities. By acknowledging the relational and contextual world of the staff it becomes apparent that simply asking staff to change without equal attention to the context negates social processes and staff's relational experience within their own context. In short, the current approach to changing practice is blind to the subjective lived experience of the staff. In order to acknowledge the limitations of change we need to acknowledge openly the following: staff are unable to provide the ideal type of emotional care and we do not provide the working conditions in which staff can perform new roles. However, by openly stating the limitations we are being more honest about the extent of the emotional custody in place.

Transformation in practice requires that staff undergo identity reorganisation which is necessary for new roles to be enacted. It may be important to be reserved about what can be achieved and therefore it is critical to convey modest expectations to staff. This is a radical deviation from current practice and means expecting less of staff and providing emotional support in their failure to meet the new (lower) expectations.

This would recognise the emotional labour of the job and may mean simply valuing the fact that a member of staff is still able to be genuine and polite after having spent 8-12 hours in an environment where they are surrounded by the emotionality of a group of people with dementia. If
we create expectations of staff to be more engaged, then surely organisations and those calling for change are morally bound to examine critically the conditions in which people can be supported to change. This moves the emphasis towards ensuring structures within social settings which support change. This is not without cost but the price of enhancing structures has to be balanced against the costs of stress, burnout, long-term sickness, poor morale and retention difficulties that we currently face. Change involves a reorganisation of self-concept and role identity and this requires safe emotional space such as facilitated reflective practice, supervision and a place in which identities can be reconstructed and the growing pains contained (Liimatainen et al 1999).

The upshot of this is that we actively embrace the social defences which are at play in the emotional maelstrom that is a residential dementia care environment. In the same way that Miller and Gwynne (1972) identified two models of care, each of which had a central social process of defence against anxiety, I propose that there is another social process which stems from the self-protection against the anxiety of the work. Miller and Gwynne (1972) identified two models of care with 'incurables'. The warehousing model encouraged dependence, depersonalising and offering care to people as passive beings. This stems from a medical defence which promotes the prolonging of life, treatment and denial of misery, and the successful patient accepts care. The horticultural model promotes growth and achievement of abilities. It is based on more liberal principles of treating people as individuals and as normal. A successful individual flourishes and is happy. Both these models are evident in current dementia care. The former is seen as part of the old culture of care (i.e. negative), and the latter is evident in the flourishing industry of promoting positive person-centred care.

Roberts (1994) critiques the models, seeing both driven by defences of staff, a desire to remove the pain that the situation presents or a desire to avoid pain by striving for positive results and change with people. I propose that the model of emotional custodianship adds to Roberts's
critique. The horticultural model has been adopted by the dementia care community. This raises expectations of how staff will care and how people with dementia will perform in response to the care. The underlying social process which maintains the horticultural model is one of sly custodianship where we need to control actively the emotional world of the person with dementia in order to achieve the model. Whereas the warehousing model is more overtly about physical custodianship and control, the horticultural model relies on emotional custody.

I am not arguing against custodianship, rather suggesting that we have the option to acknowledge it and use it consciously. By doing so we acknowledge that to work in residential dementia care we need: to make ourselves feel better, to protect ourselves from clients' emotions, to see people expressing more tolerable emotions rather than despair, and we will adopt strategies to suppress the difficult emotions.

Summary

- An 'honest' approach to care might include owning up to the use of the discourse of emotional control and emotional custodianship to preserve staff and to offer emotional protection of people with dementia from themselves.

- The process of emotional control could be channelled more positively, with greater attention given to instilling positive emotional states in people with dementia in order to maintain emotional and social order.

- If emotional custodianship acts as a self-protective mechanism for staff, then we invite a more honest, open dialogue about how to support staff who are trying to enact greater emotional engagement. Staff would be given the message that they need to use mechanisms of self-protection which would have legitimate authority with the organization.

- Expectations of staff would be modest. This reflects the recognition of the difficulty of the work.

- Calling for staff to change without providing the necessary and sufficient conditions in which to change is potentially damaging.
Once a position of honest acknowledgement of the process of emotional custodianship is adopted, it might then be possible to see how the next step towards embracing a more Person Centred perspective or how offering containment might be achieved and what would be involved. In this way acknowledgement of custodianship is a stepping stone towards the rhetoric of offering empathic, meaningful and person-centred interactions which are able to contain the emotional world of the person with dementia.

9.4 Transformation in dementia care: overcoming custodianship?

This section explores what might be necessary to move dementia care further towards social interactions which have the capacity to hold or contain the subjective experience of the person with dementia. This itself raises further challenges. Change in practice away from custodianship towards containment would need not only instruction in new care practices and ways of interacting, but a more fundamental shift in role concept and identity. To change practice the individual would need to change their identity from someone who looks after people (by doing things for them, protecting and intervening, and making things better, overriding the person with dementia) to an identity which holds principles of being there for someone, witnessing and holding emotions.

In terms of theorists, this means either getting a new ‘face’ or self-concept (Goffman 1967) or putting in emotional labour in order to carry out the new role (Hochschild 1979, 1983). Providing containment for the emotional world requires offering yourself, and this new approach would be likely to place stress on the existing role and more emotional effort would be required to maintain the new role. To lessen the stress, learning would need to be ‘transformative’, allowing for transitions in self-concept and shifts in beliefs, values and attitudes. This differs from a
‘training approach’ to acquiring a skill (Mezirow 1991; 1997). For Goffman, ‘face work’ involves the effort needed when striving to adopt the social attributes and actions consistent with the new ‘face’ or concept. Therefore, to instil change in dementia care practice would involve facilitating new self-concept (for example, emotional container) and then allowing staff to do ‘face work’ to help meet the new role identity. The effort of adjusting to the new role identity requires support and acknowledgement. If transformation in identity is incomplete, a new tension is created when staff are asked to enact a new way of working without being fully ready to do this. Holding the identity of a custodian and being asked to be an emotional container potentially leads to an increase in emotional labour, or an inability to be able to perform the new role (Smith 1992). In practical terms, if we ask staff to do more emotional engagement with people with dementia without adequate preparation we are setting a new goal without giving staff the means to meet that goal.

Increasing emotional labour runs the risk of increasing ‘dramaturgical stress’ which arises from the threat to the security of individuals (Freund 1998). Freund’s interpretation of Goffman notes how the concept of spatial metaphors threaded through his work are a useful aspect from which to explore the dramaturgical work conducted between people and the tensions this may provoke within individuals. Dramaturgical work involves sustaining boundaries which protect the ontological security of individuals. The permeability of the boundary is considered to be the way in which individuals adapt to receiving more or less from others. Therefore, to put yourself in the shoes of another (via contact reflections or other approach) may breach the boundary and thus threaten the ontological security of the individual. This runs the risk of exposing staff to more emotions from another than they can manage.

The idea about boundary breaching rests on the assumption that changing the self/other boundary of the worker through contact reflections necessarily leads to greater stress. Indeed, the opposite may
be true. A criticism levelled at Hochschild's work was that emotional labour need not necessarily be a difficult or negative thing (Payne 2006). Asking staff to alter their relationships to include being more emotional (whether it is contact work or other forms of positive or therapeutic practices) may prove to be liberating for those who already hold a self-concept and role identity which encompasses greater emotional engagement. For those individuals new paradigms are deliverance from paradigms of care which have, for them, been confining (Ashforth and Humphrey 1993).

In preparation for emotional engagement we have to remember that the content of the emotive world of the person with dementia is powerful. It remains a challenge for even the most skilled therapist to hold and witness the raw emotions of a person with dementia in despair searching for their mother, for example, or crying out 'Oh God, help me die'. A custodial approach might be to distract the person, to try to provide a pleasurable activity or negate the experience with a statement such as 'oh you are all right'. A more containing approach requires engagement with the subjective experience of a person wishing to die. Responding to this is further complicated as the disjointed or emotive speech of people with dementia does not adhere to socially constructed norms of how conversations are conducted. As the person with dementia contravenes social rules of maintaining their own emotional self-custodianship, the emotional world of the person with dementia breaches the space between themselves and the worker. The emotional rules are broken and the emotional insides of the person with dementia seep out. Containment in response to the person wishing to die requires skill in managing the emotional-ness of the interaction as well as engaging in an interaction which does not follow social norms of conversation. As this study has shown, contact work, by its very nature, has the potential to create a window into the world of the person with dementia, which itself challenges a discourse of emotional custody. Overcoming custodianship requires adaptations in role concept, ontological robustness in workers, and support mechanisms to manage any
dramaturgical stress or ontological insecurity. In practical terms, workers need not only to hear the world of the person with dementia, but also to self-manage helplessness and hopelessness and to contain despair—-a tall order for those with low status, on relatively low pay, and who sometimes have very little training and often minimal support (Newton 1995).

Without change and transformation we risk consigning staff to carry the burden of the emotional world of the person with dementia when they are ill-equipped to do so. Without change we also risk consigning people with dementia to emotional isolation. However, if we move towards developing models of care based on emotional engagement and containment we may be nearer offering care where the world of the person with dementia can be met and held by workers.

9.5 The limits of emotional engagement

The discussion above shows that the sheer size of the task of transforming the workforce is daunting. Taking the step to move from emotional custodianship to emotional containment may not seem realistic. The alternative, more daring option, is to be more honest about relying on emotional control and accept the concept of the emotional custodian. Daring in that it challenges what Blake (2002) referred to as the *rather cosy, soft and fluffy backslapping world of the new culture of dementia care* (Blake 2002: 16). Blake offers a reminder that, despite psychological interventions to soothe the incarcerated, we are still custodians. My argument extends this, showing how the management of interactions includes emotional custody as the mechanism through which we enact emotional regulation and control.

If the premise of this discussion were to be used in a wider analysis it could indicate a discourse or ideology of emotional surveillance which runs through organisations, organisational relationship with staff, the
relationships between staff and the micro interactions with people with dementia. The model of emotional management of Interactions, with positions of emotional custody and containment, could be seen as part of the regulatory mechanism of control of emotions in the organisational arrangement of dementia care.

By opening out the possibility that social and emotional order is maintained through a mechanism of emotional control we face the opportunity to deregulate emotional order, either by instigating a process of change within staff, replacing staff or perhaps more realistically coming clean about the limitations of change and the reliance on emotional custodianship. Failure to come clean may be dangerous. Organisations are inclined towards impression management (Fineman 1993). This includes being susceptible to incentives (including financial) and being able to show higher bodies and paymasters that they are reaching targets. Where there is a requirement to attain directives of carrying out care which attends to the individual subjective experience of the person with dementia, organisations may need to convey the image that they are carrying out new cultures of care. This may be evidenced by providing training, but as we know training itself is not an indicator that change has happened (Lintern et al 2000; Hyer and Ragan 2002). Should this occur we have organisations purporting change which may not have occurred. In essence, organisations may have a vested interest in maintaining a façade and we may find we encounter a less than honest portrayal of person-centred care practices. In a pastiche of person-centred care, custodial care is paraded as person-centred care and emotional control of people with dementia masquerades as caring for them.

We could decide to be more honest about the limits of experiencing the worlds of others who have dementia, accepting the need for defences against anxiety (Menzies 1970). Then, in spite of a moral imperative we would need to be honest about how little we can sometimes do. At the same time we could provide staff with greater opportunities to engage in
slightly less custodial ways. We can tap into the positive aspects of custodianship and be honest that we are, albeit couched in person-centred terminology, taking a custodial role. Alongside this begin to ask staff to take emotional risks with people with dementia, risks such as opening ourselves to their experience and having reflected back to us our own sense of helplessness. However, embracing the need for custodianship means these risks are modified and practice could be seen as more realistic.

The implications for training and improvement

The policy drivers will continue to strive for improving the skills of staff providing care for people with dementia. This includes psychological and emotional care. Policy and guidance demand staff provide greater emotion-focused or person-centred care (Age Concern 2007). This approach fosters autonomy, agency and self-determination on the part of the person with dementia (Bowers et al 2005, Age Concern 2006; Commission for Healthcare Audit and Inspection 2006). Training of staff is part of the move to improve care (Age Concern 2007). However, this study proposes that the relationship between training and improving care may be tempered by the model of emotional management and the emotional labour involved. This study shows that the social process of managing emotions in interactions may act as a barrier to implementing new practice.

The dementia care literature demonstrates that therapeutic emotion-based approaches exist. There are currently a range of approaches which are advocated. These range from specific therapeutic approaches such as reminiscence, validation therapy, resolution therapy and cognitive stimulation as well as general principles for enhancing communication (Feil 1993; Morton 1999; Kitwood 1997; Killick and Allan 2001; Woods et al 2005b). At the same time, the literature highlights the difficulty of changing practice away from task focused or emotionally
distant care. The distance between theory and practice remains a concern.

Any change in practice will be slow, and sufficient change requires more than occasional training sessions. If we are to deregulate the emotional control over staff and people with dementia we might do well to first ask whether this is something we are willing and able to do. If we are to deregulate the emotional custody (of staff), we need to consider what should be in place to enable them to engage safely with human experiencing. Some protection is necessary, as we know that the emotional world of a person with dementia can be very difficult to be alongside. Arguably, emotional protection for staff is essential. Psychotherapists see individuals within a therapeutic time slot with time between clients, receive supervision, and have a professional education in managing their own emotions in response to the emotions of others. This is a very different work context from frontline staff who are largely unqualified.

Arguably, at present, attempts to implement person-focused or emotionally focused approaches in dementia care have not paid sufficient attention to the interpersonal, contextual and structural requirements for these approaches to be implemented. Neither have they explored in detail how staff go about learning and implementing emotional and relational approaches advocated in the literature. The conditions needed to foster greater emotional care include: adequate training to carry out new paradigms of care, a culture which can contain and engage with the emotional world of staff, safe holding of the emotional consequences of engaging with people with dementia through the provision of emotional spaces such as supervision and reflection, and nurturing wards as micro-cultures where emotional work is the work to be done.

This leads to the suggestion that national training agendas might do well to consider dementia care from the perspective of staff as well as what
approaches increase the quality of interactions with people with dementia.

There remains a danger that the policy drivers raise expectations on care staff which they are unable to fulfil. As a result we may be in danger of increasing the stress and emotional labour of staff. Emotional labour arises from the effort needed to induce or suppress feelings in order to maintain the feelings and actions needed for the new goal (Hochschild 1983). By requesting staff to perform Person Centred practices we may be requesting staff to perform or interact in a way which holds the potential to increase emotional labour.

It is unrealistic to suggest replacing the workforce with people who are professionally trained in managing emotions or psychotherapeutic approaches. Staff providing the day to day care occupy relatively low pay and low status roles. So it rests with the existing workforce and the organisations employing them to try to raise skills in emotional and therapeutic working.

This study took a first step towards this by examining what happens throughout the introduction of something new, rather than purely focusing on the outcome of a new intervention. In doing so it exposed a possible barrier to change and new practice. In order to move towards evaluating the usefulness of Prouty's work in the sea change towards more person-centred dementia care, it is first necessary to untangle whether we begin to challenge the aspirational notion of person-centred care. This might involve incorporating the findings from this study which show that there may be an underlying drive to act as emotional custodians of people with dementia and of ourselves.

This thesis makes a radical proposal. I suggest that we use the concepts of emotional containment and emotional custody to reframe what we currently understand as person-centred care. This involves exploring the possibility of taking an honest approach to the concept of emotional
control and how this is expressed in practice. By doing this we need to re-conceptualize some therapeutic approaches, seeing them as having aspects of positive emotional custodianship. These may be person-focused but not Person Centred in the theoretical sense. Once this is done, then we can explore how we take small steps towards care which can be nearer that advocated in policy and the person-centred literature and how Prouty's work may help us do this.

The extent to which this study provides sufficient foundations to support the discussion is provided by reflecting on the research process.
9.6 Reflections on the research process

Action Research was used for this study as opposed to alternative methodologies such as realistic evaluation or fourth generation evaluation (McCormack et al 2004). The rationale for Action Research has been:

- Personal involvement in the research.
- Collaboration and corroboration with others which included validation of ideas with participants, Garry Prouty and Pre-Therapy Network members, stakeholders and colleagues.
- The cyclical nature of the research activity.
- The development of knowledge through these cycles.
- The emphasis on introducing change.

Waterman et al (2001) provided a framework for the methodology and the methods. This is revisited to reflect on the process of this study (Fig. 9.1).

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<th>Waterman's pivotal features of Action Research</th>
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<td>• Real world context</td>
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<td>• Participation</td>
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<td>• Research methods</td>
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<td>• Action-researcher/participant relationship</td>
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<td>• Knowledge</td>
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Fig. 9.1. Features of Action Research.

Working in the real world context

The research was clearly affected by the real world context. Challenges arose from: organisational instability, irregular staffing patterns and social and cultural norms of clinical settings.
Organisational instability was apparent and towards the end of the research Site A closed, merging with Local Authority Social Services. Site C moved into Site A, assimilating some staff from both sites; others were redeployed. This caused significant instability and uncertainty.

Rapid change and modernisation is a feature of the real world context nationally and any contextually located research faces instability. Arguably, this needs to be embraced as it is unlikely to cease and researching practice that works with instability may have more relevance to practice than research conducted in artificially stable research situations.

The characteristics of services that provide 24 hour cover in shift systems are, by nature, unstable social settings where teams of staff constantly shift in configuration. This lessens opportunities for learning, or researching practice and organising group/team learning becomes more difficult than *herding cats* (Banazak et al 2000). As a result, encounters with participants was disjointed and erratic - a known factor that negatively affects developing staff and sustaining training (Featherstone 2004).

As part of the commitment to working with the real world context, this study deliberately avoided creating artificial situations. A more political position could have been adopted which would have taken greater personal and social responsibility for changing the situation. In this way, the research process could have been used to highlight the poverty of training for staff acting as a vehicle to improve the context. This approach might have involved establishing learning sets, or being more demanding that staff were released from duty to be part of the research. However, I remain sceptical that this would have worked. The power and autonomy of individual staff to resist the demands to help 'cover the ward' are limited. If staff were faced with having to choose between meeting me or helping colleagues to maintain basic staffing numbers on the unit - they would, quite rightly, choose to help cover the ward. It is
likely that demanding more time from staff to participate might have led to even less participation, which would in turn have lessened the viability of the research. This would have changed the flavour of the research towards a process aimed at changing organisations and systems. This research took the less political position of inviting change in individuals' practice rather than challenging a social system.

Participation
Securing collaboration and participation from staff was unpredictable. Five months into the project, Barry went on holiday and never returned. Bruno was moved to another unit once his professional nursing registration from Romania was accepted by the Nursing and Midwifery Council in the UK. Apollo withdrew after eight months due to mounting pressure to complete his NVQ. Other participants remained involved, although Ayline gradually withdrew from the research because of her less positive experience using contact reflections. It was fortunate that the three people with dementia who could be videoed remained stable.

The extent to which instability affected participation and the quality of the data are open to debate. From a critical stance, this research is limited to finding out what happens in the early stages of learning and using contact reflections by staff. A greater number of participants would have been useful, and involvement of entire ward teams would have been ideal. However, this study needed to be compared with other 'training' approaches which simply 'inject' staff with one-off sessions, with a complete absence of how this is used in practice. In comparison, the study offered more, even if it personally still felt insufficient.

Collaboration and participation with the expert community were invaluable, providing reassurance and encouragement and a forum for discussion and debate about my emerging ideas. Participation of staff within this study identifies them as being involved in a co-learning process. Primarily, the inquiry was researcher led, rather than being
Participatory Action Research with staff adopting a co-researcher role (Kemmis and McTaggart 2000). Although staff had control in the process of learning and using contact work within their own practice and settings, they had little active involvement in determining the research question and the overall research process. The thesis defends this from the position of the differences between managing the *inward space* and *outward space* of the research (Ospina et al 2004). This was addressed in the methodology in relation to democracy, power, authority and responsibility. An alternative approach could have created an inquiry that was nearer a Participatory Action Research model. Gathering an interested group of participants to act as co-researchers would have achieved greater shared ownership of the research. Whilst this may have broadened the inquiry, this has to be considered in relation to the real world context.

The context means that staff who provide the day to day ‘hands on’ care have limited opportunity to remove themselves from this role to participate in a project group. This creates a dilemma. Those in a position to participate in a more active role in the overall inquiry may not necessarily be those who are delivering the care and are the focus of the inquiry. Participatory Action Research in this context may be limited in its ability to recruit participants. The emphasis of this study on drawing participants from the real world context is both a strength and a limitation of the study: a strength as it included staff who are faced with the daily reality of care; a limitation as their position within the organisation limits the opportunity to step outside this role and engage more fully in researching practice.

Steps towards a more collaborative inquiry are currently being made. As a result of disseminating this study, an opportunity has arisen to initiate a regional Pre-Therapy Interest Group. Should this happen, there is the potential to gather a group of people who may wish to collaborate in further investigation into the application of Pre-Therapy. This forum
might provide a starting point which generates a group of co-researchers who could devise further inquiry.

Methods
The methods were closely linked to the values underpinning the research. On reflection, this was one of the most important aspects of the research process and, if anything, the research process has strengthened my commitment to collaboration, working alongside and valuing the personal experience and personal knowledge of individuals.

Collaboration was evident in the time spent with participants, and the element of joint inquiry and sharing within a democratic space was, I feel, successful. What was less successful is the quantity and quality of the data generated through group and individual encounters with staff where they reflected on their practice. Reflective journals failed, with only two people writing accounts of a single incident each. Prompting staff to reflect on their practice was difficult with participants who were unused to reflection-on-action. The availability of staff to be free to meet me in research encounters was compromised by staffing levels and workload. Sometimes encounters were brief, arguably too brief to achieve a depth of reflection. To some extent this was counteracted by the frequency of meetings with staff, the length of time of the research process and the use of three sites. This permitted repeated opportunities to take themes which arose between individuals and sites to add depth to the exploration. However, this remained an anxiety throughout the research process. Improvements in this could be made by demanding more time from participants and trying to secure greater commitment to the research process from stakeholders and gate keepers. This would enhance the availability of staff to engage in reflection. The capacity of staff for depth of reflection remains problematic, particularly when participants occupy roles where reflective practice is unfamiliar.
The research process and the use of video provided participants with an opportunity to have their practice valued, as Alison illustrates:

Well, I thought it was fantastic because looking back at the tape I realised that I did more reflections that I thought; it's given me confidence. ALISON/VHS20/15.5.05.

Video was necessary given that contact reflections involve more than dialogue, but depend on non-verbal communication. However, I had not anticipated how video magnifies the significance of seemingly small interactions. Casual comments that might pass in everyday life are immortalised and amplified on video. Fortunately, I was specifically videoing episodes where staff were using contact reflections. This reduced the likelihood that I would inadvertently capture any poor practice and then be required to follow any organisational disciplinary procedures as was encountered by Vass et al (2003). This will be useful to bear in mind for any future use of video.

The quality of methods of data collection could be challenged. Observation, field notes, video, and email dialogue with Garry Prouty and the Network provided multi-dimensional data. However, videoing people with dementia was limited. This was partly due to the practical difficulties of videoing people within residential settings and partly due to the commitment to avoiding using people with dementia as objects of study. A balance was struck between gathering material and being intrusive. This study and future work would benefit from gathering more video recording of staff using contact work with people with dementia. This might indicate creating time for data collection and setting aside time in practice where a participant and a person with dementia were available to be observed and recorded. Whilst this would raise the quality of the data collection, there is a danger this may produce more 'staged' interactions which detract from the 'naturalness' of interactions in practice.
Discussion and Reflection

Researcher/participant relationships
Access to research sites and sustaining the project were helped by my pre-established relationships with units and individuals. However, I felt the need to hold a tension in maintaining two activities which could possibly conflict and jeopardize the relationship — hoping their participation would be a supportive experience but not offering a guarantee that staff would not experience burden or discomfort. In hindsight, a parallel process of emotional management between me and participants was occurring (Miller 2004). I was experiencing similar responses to those they were experiencing with residents. It was only after the model of emotional management emerged that I felt I understood some of my own discomfort during the research. The balance for me erred towards wishing to value and support staff, rather than risk pushing them away. There is an element of self-preservation in this and my relationships with staff continue past this particular piece of research.

My relationship with participants was not always clear; I experienced all of the following roles, sometimes simultaneously: co-participant, co-learner, colleague, expert, teacher, supervisor, and researcher. In the end this simply had to be accepted. In the methodology chapter these roles were conceptualised as 'otherness' and 'togetherness'. Overall, I felt more togetherness than otherness in relation to the participants. My experience of the research in relation to the management tier of the organisation is more of 'otherness'; the research has set me further away, consolidating a view of my position as a clinical academic.

Resources
Time is a significant resource in participatory processes. In the early stages some time was secured by obtaining replacement costs for my post for a year from the Strategic Health Authority. This created some space where I was free from competing demands for my clinical role. However, this increased my sense of job insecurity, as it potentially
Discussion and Reflection

made my job conditional on external funding. For self-protection, it felt safer to be within organisation rather than financed from outside. Otherwise no additional resources were requested and, being realistic, were not available. The main critique would be of myself and whether I used the time I had to the maximum benefit.

Having insider status in the research process had advantages and disadvantages. On the one hand I had autonomy to devote time to the research within my own work role. This was an advantage as it meant I could maximize my own time. On the other hand it limited the status of the project. There was a danger that the research was seen as a private endeavour which could continue as long as it did not disrupt others. This meant that the research had little power to demand time from others and possibly reflects the lack of commitment to the research from the host organisation. Funding was not sought for the research. This possibly made this study vulnerable to the Catch 22 identified by Waterman et al (2001). They speculate that poor or an absence of funding leads to paucity of resources which may lead to studies not fulfilling their potential. In turn, this may lead to hesitation of funding. This study provides valuable lessons about the length of time needed to introduce new practice. These lessons might prove useful if funding was sought for Action Research in similar contexts in the future.

Project management and process
The project management and process follow the cyclical nature of both Action Research and, within this, learning in action. The extent to which this was systematic is debatable; learning in action learning was messy and asynchronous. The research process demanded simultaneous activity, rather than a clear linear process of reconnaissance, identifying the issue, collaboration with others, introducing the change, evaluation and dissemination. This led to personal uncertainty about readiness to make conclusions from the data. At times, the process of iteration between research activity, validation and analysis was bewildering.
The real world context meant that collecting data in the field was frequently haphazard and opportunistic. The thesis demonstrates this, providing an audit trail of the research process which captured data. Chapter 4 (research process, methods and analysis) justifies why capturing all activity is unrealistic in research which is embedded in daily practice. However, in hindsight, it may have been possible to create a tool to capture information about the research process that this study has failed to capture. For example, a daily tick chart could have captured activities such as numbers of phone calls, visits, and brief encounters with participants/non-participants. This may have added to the quality of the information about the quantity of activity.

Key persons
Key persons in this study were varied, and although they held different positions of influence, together they created a web of involvement (Appendix 22). A criticism of practice-based research is the over-reliance on others (Waterman et al 2001), but organisational change cannot avoid this and requires the action-researcher to be prepared to invest time in key persons. This raises the potential for conflict and a danger that the agendas of key persons do not match those of the researcher. This was most clearly demonstrated in the following quote from a service manager, who was gatekeeping a potential research site.

*we’ve had a bad complaint - we need to focus on the basics....so I don’t think we can help with your research at the moment.*

(Reflective Diary/April 2003).

Knowledge
Joint inquiry has been a useful part of this study. Ideas have been shared and generated through dialogue with participants, Pre-Therapy Network members and others inside and outside the geographical area of the research sites. The iterative nature has been helped by giving seminars and presentations locally, nationally, in the USA and in
Belgium at the Pre-Therapy Network meetings, resulting in the development my own living theory (McNiff and Whitehead 2002). Theoretical ideas have been generated in collaboration with others, processed through me, validated through contact with others and verified through the research process.

The generation of knowledge about the application of contact work to dementia care arose from the multiple experiences of staff participants and self inquiry. The ongoing process of validation with participants in the field and the expert community aimed to generate knowledge which was a synthesis of self inquiry, inquiry with participants in the field and the expert community. This enacted the epistemological position on relativism and truth outlined in the methodology. This meant that the subjective experience of the use of contact work by participants was balanced against the greater theoretical and experiential knowledge of Garry Prouty and the Pre-Therapy Network members. This led to the key findings which indicate that using reflections with people with dementia requires greater attention to non-verbal reflections, the use of vague pronouns, physical closeness and proximity and avoidance of contact work with people who are dysphasic rather than pre-expressive. There was sufficient consistency in themes to claim that these findings provide new knowledge which is robust and transferable to other settings which provide residential care for people with dementia. These findings provide a foundation to inform further work.

The experience of learning and using contact work led to the proposal that underlying this is a social process which may hinder providing emotion-focused care. The data provided a theoretical model of the emotional management of interactions with the conceptual counterpoints of emotional custody and emotional containment. This model appears to have face validity with people who work in different clinical settings and roles. Disseminating ideas has provided the opportunity to present the model to others for critical examination. However, this model may only have relevance for dementia care. A particular feature of dementia care
which was evident in the research process was the presence of rapid emotional contact and the raw intense emotions which were sometimes expressed by people with dementia. Contact reflections had the potential to facilitate a person with dementia expressing these and the model arose as a result of exploring how staff managed themselves in their relationship with the person with dementia. Whether or not this model of emotional management has an application to other fields requires further investigation. It may be that this aspect of knowledge generated by the study is specific to the context of dementia care rather than having wider implications.

I have felt pressure for the introduction of contact reflections to dementia care to 'succeed', producing knowledge which showed their usefulness. There was organisational and managerial pressure to show that the organisation had produced 'something new that worked'. In addition, there was a request to include my findings (before I felt they were ready or would be supportive of Pre-Therapy) in a document for National Institute of Mental Health Excellence promoting Pre-Therapy. Maintaining integrity between my own thoughts about the emerging findings and the pressures from others was testing. At worst, this took the form of feeling as if I was helping others to meet their own agendas. At best, I feel that I maintained a dialogue with the Trust, Pre-Therapy Network and others which allowed discussion of complexities and ambiguities of the emerging findings. In concrete terms the latter is demonstrated in a book chapter which discusses the strengths and difficulties of non-therapist staff learning and using contact reflections (Dodds 2007).

The thesis indicates three other areas of knowledge which could be explored further. The first is to continue to refine the ideas about Pre-Therapy Contact Reflections and dementia care, taking them outside the study area and disseminating ideas for others to critique. Having established that it is possible (to some extent) for staff to learn and use contact reflections, this opens the way for studies with different
methodologies to explore efficacy. This could include quantitative studies which could determine, in more detail, the response of people with dementia to contact reflections. This might involve developing measures and tools which are sensitive to capturing the behavioural response of the person with dementia to contact work.

Second, is an area which has not been touched in this thesis but arises from two strands which overlap in the literature. Pre-Therapy makes reference to attunement via the work of Hans Peters (Peters 1999). Attunement is part of a technique called Intensive Interaction which is gaining popularity in learning disabilities care in the UK (Nind and Hewitt 2001). Killick draws attention to the similarity of his approach and the work of Nind and Hewett. I have drawn attention to the similarity of Killick and Prouty. The circle could be closed by exploring attunement, Intensive interaction and Pre-Therapy. In the same way that aspects of Prouty's work are familiar to dementia care, I predict that Pre-Therapy would be remarkably familiar to those using Intensive Interaction.

Thirdly, future work might include an exploration of contact work in other fields of health care. The Stroke Interest Group at Paisley University were positive about contact work, seeing an application for their field. There are other clinical areas which might be interested in contact work, such as in head injury or coma. In relation to coma work, it will be interesting to watch the work of John Killick. Killick's detailed descriptions of how he works has resonance with contact work. Certainly there are areas of overlap. It may be that Prouty's Pre-Therapy Contact Reflections are more recognisable to people outside a psychotherapy community and these links simply need to be pointed out.

A criticism levelled at this thesis has been that it has not offered a challenge to the theoretical and philosophical foundations of Pre-Therapy itself. This carries a danger that the thesis may have given the impression of adopting Pre-Therapy uncritically. In defence of this, the research did not set out to challenge the theory; instead it took a critical
look at the application of the approach to the context of dementia care. To critique the theory of Pre-Therapy would require a greater depth of knowledge of psychotherapy and different traditions in psychotherapy than I possess. This thesis rests on personal expertise as a nurse in dementia care, not as an expert in psychotherapy. Therefore scepticism about Pre-Therapy remained in the sphere of the application, rather than about the theory itself. Arguably, holding a healthy scepticism or caution about the application to dementia care drove me further in seeking validation about emerging themes and ensuring the process of verification was used to explore the research question as fully as possible.

As a result, knowledge generated is limited to the application of Pre-Therapy to dementia care rather than expanding the theoretical foundations of Pre-Therapy.

9.7 Summary

The research process was attentive to the pivotal features of Action Research identified by Waterman et al (2001). The emergence of the theoretical ideas about the contribution of Pre-Therapy to dementia care arose through the co-learning process of self inquiry and inquiry with others. This was validated through a research process which intertwined the experience in the field with the expert knowledge of the Pre-Therapy community. The limitations of the research process in terms of the practical difficulties of engaging and sustaining engagement with participants are part of the real world context of research which introduces new practice to clinical settings which are beset with change and instability. It was the contextual data which led to the emergence of the theoretical ideas about the factors which mediate the use of contact work. The knowledge generated was ongoing and arose through cyclical reflexive engagement with self, others and the expert community. Through this research process three key areas of knowledge have been generated:
i) The potential for Pre-Therapy Contact Reflections to add to the range of approaches in dementia care

ii) The slight variations in how contact reflections are used with people with dementia

iii) The underlying social process of the management of emotions in interactions.

The discussion took the model of emotional management further. The proposal is that the mechanism of emotional management of interactions may help us understand the difficulties of using approaches which lean towards engaging with the subjective experience of a person with dementia. These might form the basis for future work.
Conclusion

The research question asked *What happens when staff learn and use Pre-Therapy contact reflections with people with dementia?* The question existed in relation to existing therapeutic approaches in dementia care, a drive to improve emotional care that is inherent in policy and a national training agenda for staff. The research process demonstrated that with some adaptations contact work may be another approach which can be incorporated into the existing repertoire of therapeutic approaches which facilitate staff engaging with the subjective world of the person with dementia. Prouty's approach offers practical guidance about how to engage.

However, it was through the introduction of Pre-Therapy Contact Work there emerged the possibility that dementia care practice is underpinned by a social process of the management of emotions in interactions. The emotional management of interactions involves staff managing their own emotions and those of the person with dementia. This helps towards an understanding of why the translation of Pre-Therapy to the dementia care context was not straightforward.

It was the exploration of Pre-Therapy contact work that led to the proposal that we embrace a more honest acceptance that some of our practices are based on a position of emotional custodianship (positive and negative). The social process of emotional management may help us understand why it may be difficult to introduce approaches which foster relationships which are attentive to the subjective world of the...
person with dementia. This may hold wider implications for how we strive to improve communication in dementia care in general and how training needs to consider this as a barrier to improving care.

**Locating Pre-Therapy in dementia care**

Pre-Therapy requires staff to be ready and able to manage the range of emotions which arise. Pre-Therapy is Person Centred in the theoretical sense as it directly addresses the subjective embodied experience of the world of the person with dementia. In this way the person with dementia determines the interaction. This differentiates Pre-Therapy from other approaches which may take greater responsibility for the emotional tone of interactions by instilling positive emotions, leading activities and prompting communication which is led and directed by the worker. These approaches are not Person Centred in the theoretical sense, rather person-focused. This leads to the conclusion that there is some confusion in the field of dementia care about what is meant by person-centred practice. This confusion arises from the use of the term 'person-centred' as an umbrella term for a variety of approaches in dementia care and as a generic term in policy.

The exploration into the use of contact reflections demonstrated that over time and to varied extent staff could use contact work to facilitate interactions which were more attentive to the subjective experience of the person, less directive and inherently more person-centred. Contact work has value in providing a method of communicating which can be used alongside the practical care tasks that are part of everyday care.

The specific application of contact work to dementia care showed that, whilst there are slight adaptations, contact work has the potential to contribute to raising the quality of interactions, promote empathic and compassionate care and help staff engage on an emotional level. This helps move communication in dementia care towards the theoretical
humanistic principles of Person Centredness. This is already evident in the work of John Killick and his descriptions of how he engages with people. Prouty adds to this by providing very concrete and tangible advice on how a worker might achieve this.

By clarifying the purpose of approaches and interactions it becomes clearer whether our intentions are to hear the experience of the person or to direct it. Prouty's approach offers a way to hear and witness the experience. It provides an approach which facilitates the person expressing their experience of the world.

Killick, Kitwood and Prouty's approach require workers to have the capacity to manage themselves in the emotional engagement. Emotional engagement requires workers to safely hold and contain their own responses to the experience of the person with dementia. This differs from other approaches (such as initiating activities, singing, reminiscing) where the worker is actively taking responsibility and some control over the emotional world of the person with dementia. Taking responsibility may be positive - staff steer the person with dementia to experience positive emotional states through activities or interactions which actively promote happiness, joy and pleasure. Approaches which are more directive steer an interaction away from the experiential world of the person. In concrete terms this may manifest itself in diverting people away from their experience by providing positive alternatives or by overriding it.

However, this deviates from the tradition of Person Centredness as the subjective world of the person with dementia is not leading the interaction. This thesis argues that approaches which are less intent on engaging with the subjective experience are taking emotional control and are forms of emotional custodianship. Emotional custodianship has two functions. First, it protects people with dementia from their own (difficult) emotions. Second, it protects staff from their own response to more difficult emotions of the person with dementia.
The exploration of Pre-Therapy has been valuable in drawing attention to the minutiae of interactions. It exposed the choice made when responding to a person with dementia. The choice involves deciding when we engage with the subjective experience of the person, providing safe containment of their experience, and when we adopt emotional custodianship and navigate away from the emotional subjective experience presented to us. Both approaches have value. At times it may be useful for staff to engage and attune, at other times it may be more beneficial to offer diversion, reassurance or other interactions to steer a person away from their experience. The model of emotional management provides a framework to help understand these choices.

If we choose to engage in the subjective world we can use contact work or ways of communicating which meet the person on a deeper empathic level; if we choose to be more directive we can use a variety of approaches which, to some extent, avoid a level of contact which may be uncomfortable. People with dementia present us with these choices in the minutiae of everyday social contact.

The choice is illustrated by an interaction which lasted less than a minute. I was early for a meeting on one of the research sites and used the time to eat my sandwich with the residents of a unit. I seated myself at a table with a gentleman who was presented with a pleasant smelling lunch of steak and kidney pie. I said 'hello' and said that his meal looked 'nice', trying to initiate a conversation around the pleasure of eating. He looked at me, his eyes damp and beseeching. He simply said 'I'm lost'.
Glossary

**Action Research**
Research approach which emphasises the introduction of change or innovation.

**Affective contact**
Awareness of moods, feelings and emotions.

**Agency Staff**
Nursing staff employed on a casual basis via an employment agency. They are not part of the permanent staff team.

**Anchoring**
Anchoring is a term used by Dion Van Werde where the contact reflections are used to help ground or maintain a person in an expressive state, rather than slipping back into their 'psychotic' or pre-expressive state.

**Anti Dementia Drugs**
A generic term for medication which is designed to slow cognitive deterioration. This helps delay the decline in functioning which arises from the dementing process.

**Bodily Reflection**
Reflecting verbally or non-verbally the gestures, movements and postures of the client.

**Communicative contact**
The symbolisation of the world and self through words or other ways of conveying meaning to another.

**Contact behaviours**
The behavioural response to contact reflections, indicative of an increase in contact functioning.

**Contact functions**
The prerequisites of being in contact with oneself, the world and being able to communicate with others. There are three contact functions: affective, reality and communicative.

**Contact impairment**
The term used by Prouty to indicate diminished state of emotional contact in the client. Contact Impairment involves reduced contact functioning.

**Contact reflection**
The action of the therapist. There are five types of reflection: Word for Word Reflection (WWR), Bodily Reflection (BR), Facial Reflection (FR), Situational Reflection (SR), Reiterative Reflection (RR).

**Counterpoint**
Two contrasting or interacting elements which occur simultaneously.

**Dysphasia**
Impairment of language common in dementia or strokes. Types of dysphasia include: difficulty expressing speech (expressive dysphasia); difficulty comprehending speech from another (receptive dysphasia); and difficulty naming items correctly (nominal dysphasia).

**Elite bias**
Elevation of status of a participant due to factors such as status or level of articulation.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Experiential Psychotherapy</td>
<td>A discipline of psychotherapy, commonly associated with Eugene Gendlin. The focus of this approach is the internal sense of experiencing and focusing.</td>
</tr>
<tr>
<td>Expressive functioning</td>
<td>Requires a person to have all contact functions. A person is in touch with themselves, the world and can communicate this to others.</td>
</tr>
<tr>
<td>Facial Reflections</td>
<td>Reflecting verbally or non-verbally the facial expressions of the client.</td>
</tr>
<tr>
<td>Gatekeeper</td>
<td>A person who has influence on the research, for example, who can sanction access to a research site or participants or who holds power in relation to the progress of the research.</td>
</tr>
<tr>
<td>Grey zone functioning</td>
<td>Fluctuation between an expressive and pre-expressive state.</td>
</tr>
<tr>
<td>Lecturer Practitioner</td>
<td>Occupational role combining an academic position with a clinical role.</td>
</tr>
<tr>
<td>Malignant social psychology</td>
<td>Social interactions and social processes which are detrimental.</td>
</tr>
<tr>
<td>Person-centred (not capitalised)</td>
<td>A generic term used to indicate having a focus which values the individual as opposed to a task, institution or need of another.</td>
</tr>
<tr>
<td>Person-Centred Psychotherapy</td>
<td>A discipline of psychotherapy, commonly associated with Carl Rogers. The focus of this approach is the use of the therapeutic relationship and the use of empathy, acceptance and positive regard for the client by the therapist.</td>
</tr>
<tr>
<td>Positive Person Work</td>
<td>Ways of interacting which contribute to the well-being of people with dementia. Devised by Tom Kitwood.</td>
</tr>
<tr>
<td>Pre-expressive functioning</td>
<td>An individual is not able to be in contact with themselves, the world or communicate this to others. The person has capacity for contact but is unable to make contact.</td>
</tr>
<tr>
<td>Reality contact</td>
<td>Awareness of 'the world', specifically people, places, things and events.</td>
</tr>
<tr>
<td>Reiterative Reflections Reminiscence therapy</td>
<td>Repeating reflections which have been shown to make contact.</td>
</tr>
<tr>
<td>Validation therapy</td>
<td>Therapeutic method of communication focused on the resolution of the past; emphasis is placed on working with the reality presented by the client. Specific techniques are used to validate the person's experience.</td>
</tr>
<tr>
<td>Videography</td>
<td>The use of video recording as more than a method, whereby the act of video becomes part of the social drama of the research process.</td>
</tr>
</tbody>
</table>
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Well-being/ill-being</td>
<td>Phrase used to indicate the relative subjective state of a person with dementia.</td>
</tr>
<tr>
<td>Word for Word Reflection</td>
<td>Repetition of words, sentences or fragments of speech</td>
</tr>
</tbody>
</table>
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**Appendix 1**

**Literature search checklist**

Key texts in the field of
Dementia
Person centred care or approaches in dementia
Pre-Therapy

**Data base searches:**
Psychology (PsychINFO)
Education – ERIC
Social Science – BIDS
Health – CINAHL and BNI
ISI Web of Science
ZEOTEC

**Key words (full and truncated) single and in combinations**
Dementia
Staff
Training
Learning
Communication
Person-Centred (capitalised),
'person-centred' (not capitalised)
Person centred (no hyphen)
Pre-Therapy
Empathy
Nurse
Patient
Relationship
Action Research

**Auto Alerts**
ZEOTEC
OVID/DIALOG
CEBMH (e-CAB). This provides a fortnightly bulletin for mental health. This includes clinical news, health and social care guidance, policy and publications. Also available on the Web
http://www.psychiatry.ox.ac.uk/cebmh/dissemination_cab.htm

**Grey literature:**
Conference papers
Unpublished text from Pre-Therapy Network Members
Editorials from journals specific to Dementia, Older Persons Mental Health, Aging, Gerontology.
Journals (not peer-reviewed)

**Personal Journal subscriptions**
*Dementia: the international journal of social research and practice.*
*Journal of Dementia Care.*
Information Sheet – Staff participants/Professionals
Version 1. 25.5.04

You are being invited to take part in a research study. It is important that you know what is involved. Before deciding if you want to take part please read the following information and discuss it with others if you wish.

You do not have to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. Even if you consent at the beginning you may still decide to withdraw at any time.

You may contact me (Penny Dodds, researcher) if you want to talk about it. My mobile number is 07989 XXXXX.

Name of Project: Pre-Therapy and Dementia: An Action Research project on the introduction of the techniques to nursing staff working with people with dementia.

Researcher: Penny Dodds, Lecturer Practitioner Old Age Mental Health, [Name of Trust]/University of Brighton.
My background is working with older people with mental health problems. I have worked as a nurse specialist in dementia and have 16 years' experience of working with people with dementia. I am a part time Nurse Lecturer at the University of Brighton, and I work part time with staff to support them and help them develop their practice.

What is the research looking at?
The research is looking at the use of a particular way of communicating by staff who work with people with dementia. The aim is to improve the quality of care. The techniques are called Pre-Therapy techniques.

What are Pre-Therapy techniques?
Pre-Therapy techniques are a way of communicating with people who may have difficulties with language and speech due to a psychological or organic illness. The techniques are simple. They involve a staff member or carer 'reflecting back to a person' their own words, their movements, their facial expressions and their surroundings. This enables the patient/client to have greater opportunity to express their own ideas, thoughts and feelings. This can help improve the communication between staff and patients. The techniques are called 'contact reflections'. The contact reflections enhance the potential for staff to be able to communicate with patients and to provide better care and understanding of the patient's experience. This has the potential to improve the quality of care that patients receive.
What is the aim of the project? To find out how Pre-Therapy techniques can be learnt by staff and used in every day interactions with people with dementia.

Outline of the project
The research project will involve:
- A presentation and discussion with nursing staff on the use of the techniques and the research project.
- An observation of the clinical setting/ward/patient by Penny Dodds (researcher).
- Staff will receive training in the Pre-Therapy techniques (1-2 hour teaching session)
- Staff will try using the Pre-Therapy techniques in their day to day interactions with a patient/s. Staff may make notes on the use of the Pre-Therapy techniques. Penny Dodds will not be there, staff do this in their own work.
- Staff will receive further training and supervision from Penny Dodds on the use of the techniques (1 hour).
- Two video recordings of staff using the techniques in an interaction with a patient/s will be made. Each recording will be about 15 mins. They will be about one month apart.
- Staff will be interviewed about their experience of using the Pre-Therapy techniques (1 hour)
- The total time involved for each staff member will be approximately 3 months.

This research process is called Action Research and involves the researcher looking at the effects of introducing a new technique or interventions. This involves finding out from staff the effect of the training and the implementation of the techniques.

Is anything else expected of staff?
Staff will not be expected to travel, Penny Dodds will do the teaching, videoing and interviewing in the staff members workplace.

How will staff learn the Pre-Therapy techniques?
The techniques will be introduced to staff in a teaching session in their own workplace. Staff will then practice the techniques in their work. The video recording and the interview provide further opportunities for the staff to continue discussing and learning about using the techniques.

Who else is being asked to take part?
It is hoped that 10 staff and 10 people with dementia will take part in the research.
Staff who work with people with dementia are invited to take part and receive training in the techniques. This project is designed for staff who work in units/wards, not in the community.
Patients who have dementia and have difficulty with their language and communication are being invited to take part or being invited via their patients representative and the clinical team who work with them.
Confidentiality – will the research Identify me?
All audio tapes, video tapes and notes written by Penny Dodds will be her property. No patient or staff member will be identified in the research report. Video and audio tapes will be coded so that no person can be identified. The video tape recording may be shown to a member of the International Pre-Therapy Network for an expert opinion. This may involve sending the video tape abroad. Members of the Pre-Therapy Network will sign a confidentiality agreement and will not copy or distribute any video recordings. They will then return the video tape to Penny. Audio tapes and video tapes will be kept for 20 years by the Trust. Access to the tapes will be through Penny Dodds.

Will the video be shown to anyone else?
Penny would like to use examples of good practice from staff for educational and training purposes. At least three months will elapse before staff and patients/patients representatives are asked if any video tape recording made during the research may be used for further education and training purposes. Only examples of good practice will be used for this. Consent for using video recordings for educational purposes will be sought separately.

Video Tape Recording – what is involved and how will Penny make sure that it does not cause distress?
To ensure that video recording does not cause any distress to the person with dementia Penny will do the following:

- Introduce the video camera to the patient and obtain consent to use the camera.
- Monitor any interaction during video tape recording for any signs of distress that may be caused by the presence of the camera and the researcher.
- Penny will use her clinical expertise and judgement to monitor the well-being of the patient throughout the video recording.
- Video tape recording will only take place in communal areas and the patients privacy and dignity will be of primary importance
- The processing of the video tape will hide the identity of patients or staff who are not part of the research process.
- Video recording will not continue if either the staff member or the patient indicate they wish the recording to stop.
- Once the tape is made it will be coded so that no one can be identified.
Audio tape recording – what is involved?
- Penny will interview staff and make an audio tape recording of the interview
- The tape will be given a code so that the member of staff cannot be identified
- Staff will be invited to read the transcript of the interview. Comments and corrections will be made by the researcher.

How will people get information about the research?
- Patients representatives, members of the Multi-Disciplinary Team and staff are welcome to contact the researcher to find out how the research is progressing and discuss any findings. A written summary will be available.

Are there any risks?
It is not anticipated that the techniques will cause any distress. The idea is that the person with dementia is given more chance to communicate what they want to say and this improves communication. However people with dementia do sometimes get distressed due to the illness. The techniques themselves do not cause distress but may allow a person with dementia to voice their distress. The techniques are not designed to provoke distress.

What if there is distress?
In the event of any distress Penny will do the following:
- If patients express distress during the video recording Penny will end the video recording and attend to the patient's distress.
- The video camera will be placed somewhere that is unobtrusive
- Penny will show the camera to the patient and judge if the patient is upset by this. If so the video recording will not take place.
- Penny will offer additional time with the patient, inform the nurse in charge and the multi professional team.
- The patient representative will be informed if the use of the Pre-Therapy techniques causes distress.
- If staff become distressed they will be offered supervision by their manager
- Penny is a registered nurse and will follow the NMC Code of Professional Conduct. Any disclosures of malpractice or practice which is not in the interests of patients safety cannot be kept confidential and will need to be reported to the staff member's line manager.
Appendix 2

What are the benefits of taking part?
Staff will receive training in the use of the techniques which will help them communicating with people with dementia. It is hoped that the research will help understand if the Pre-Therapy techniques can be used by staff and if so, how they change or improve the communication between staff and patients.

How will patients continue to benefit after the research?
If the research shows that the patient benefits from the use of the Pre-Therapy techniques, staff will be encouraged to continue using them in their day to day work. The research findings will be presented to Trust staff and if they are useful then further teaching sessions will be offered to staff to enable other staff who did not take part in the research to learn the techniques.

Will medical staff be aware of the research?
The General Practitioner and The Consultant in Old Age Psychiatry, who has day to day responsibility will be aware of the research.

Will I have to sign anything?
You will be asked to sign a consent form. You will keep a copy of this form and Penny will keep a copy. This consent form shows that you have volunteered to take part.

What if I decide to withdraw from the research?
Taking part in the research is voluntary. You may withdraw from the research at anytime. Withdrawing consent will not affect your employee status.

Who is overseeing the research?
The research is being conducted for Penny's PhD degree and is supervised by the Nursing Research Department at the University of Brighton. The research project will be monitored by the Trust Research Governance Committee. It has been approved by the Worthing and Southlands Research Ethics Committee.

If you want to discuss any of this information further please contact me. My mobile number is 07989 534414

Thank you for taking part.
Penny Dodds (Lecturer Practitioner Old Age Mental Health)

One copy of this Information Sheet is to be kept by the staff member, one copy kept by Penny Dodds, one copy in the patients notes.
### Extract of log of activity to access staff.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Issues/thoughts/reflective diary entry about:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7.04</td>
<td>Phone conversation with D1 re using Site D – later email to say can’t at moment</td>
<td>gatekeeper</td>
</tr>
<tr>
<td>2.7.04</td>
<td>Phone call to C4i re using site C</td>
<td>gatekeeper</td>
</tr>
<tr>
<td>7.7.04</td>
<td>Meeting with new manager of (B1 off sick) – she agreeable, I need Criminal Records Check</td>
<td>Dealing with gatekeepers</td>
</tr>
<tr>
<td>July 2004</td>
<td>Meeting with Research site A gatekeepers – set time for staff teaching and appearance at carers meeting</td>
<td>Memo on gatekeepers</td>
</tr>
<tr>
<td>23.8.04</td>
<td>One hour teaching at research site A wing – presentation and recruitment of participants</td>
<td></td>
</tr>
<tr>
<td>31.8.04</td>
<td>Letter faxed to A2 asking her to distribute the formal invitations to which people will reply. Suggesting outlines of next teachings</td>
<td>Accessing staff memo 31.8.04</td>
</tr>
<tr>
<td>2.9.04</td>
<td>Meeting with B3 – new acting senior nurse at Research site B – B1 Left -</td>
<td>Turnover of staff</td>
</tr>
<tr>
<td>20.9.04</td>
<td>Meeting with research site A carers group</td>
<td></td>
</tr>
<tr>
<td>14.9.04</td>
<td>Received letters back from 4 at Research site A – asked A2 to think how she wants training to happen – suggested half day with those interested</td>
<td>Me needing to push – limitations of democracy and empowerment in AR</td>
</tr>
<tr>
<td>21.9.04</td>
<td>Went to site B to teach – nothing happened – see reflective diary</td>
<td></td>
</tr>
<tr>
<td>22.9.04</td>
<td>Phone call to manager at Site B – to talk about yesterday. Told her what happened, me said I’d like help promoting it for next week. Sent poster and hoping she’ll make staff attend, and generate interest</td>
<td>More direct approach getting gatekeepers to stimulate interest, outsider researcher</td>
</tr>
<tr>
<td>28.9.04</td>
<td>No news from Research site A – A2 now on leave – need to pester her to arrange training</td>
<td>In action in action research, problems with access, ENTROPY</td>
</tr>
<tr>
<td>28.10.04</td>
<td>1 hour session delivered twice to staff site B. See reflective diary notes – 11 staff in total attended</td>
<td></td>
</tr>
<tr>
<td>13.10.04</td>
<td>P/call to site A arranging session</td>
<td></td>
</tr>
<tr>
<td>13.10.05</td>
<td>Sent certificates to Site B</td>
<td></td>
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<tr>
<td>?oct</td>
<td>A2 arranging of duty to free 4/5 staff for 3 hour training off site</td>
<td>Action learning theory says best off site, action research best to do in situ?</td>
</tr>
<tr>
<td>29.nov.04</td>
<td>4 hour session with site A group 1 -</td>
<td></td>
</tr>
<tr>
<td>Dec 04</td>
<td>Phone calls to ward manager site a to arrange getting site a group 1 together, and recruiting more staff from site A – ward manager suggesting others to join in</td>
<td>Keeping gatekeepers on board. Using key staff member (deputy ward manager as key link by including them in group 2</td>
</tr>
<tr>
<td>Dec 04</td>
<td>Thanking unit manager for cooperation – group 2 from site A identified</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Activity</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
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<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>29.12.04</td>
<td>Follow up session with site A group 1</td>
<td>Action learning principles – differences between interviewing and action learning – I seemed to be doing both simultaneously</td>
</tr>
<tr>
<td>7.1.05</td>
<td>Session with group 2 on site A – including A7 – deputy ward manager also included as linking person, video did not work, see teaching reflections. Phoned on the morning to check still on.</td>
<td></td>
</tr>
<tr>
<td>12.1.05</td>
<td>Phone call to site B – told that as I had not heard anything I'd come and see her, appt arranged for 14.1.05</td>
<td>Consider reasons and features of site B that mean it has not happened so far.</td>
</tr>
<tr>
<td>14.1.05</td>
<td>Meeting with manager site B plus enrolled nurse – reflective diary</td>
<td></td>
</tr>
<tr>
<td>15.1.05</td>
<td>Letter sent to site B following meeting yesterday – offered 8 dates for doing the three hour training</td>
<td></td>
</tr>
<tr>
<td>17.1.05</td>
<td>Phone call to A2 re checking arrangements for next meetings with staff</td>
<td>Following up gatekeeper</td>
</tr>
<tr>
<td>17.1.05</td>
<td>Unexpected event – one of my personal students put me onto C6, introduced me, I spoke to her about the project</td>
<td></td>
</tr>
<tr>
<td>18.1.05</td>
<td>Posted project outline and info to C6, happened to bump into her at (XXXXXX Ward) again</td>
<td>Impromptu contacts with subjects and potentials by my presence around the unit</td>
</tr>
<tr>
<td>10.2.05</td>
<td>9-5 at Site A</td>
<td></td>
</tr>
<tr>
<td>??</td>
<td>Discussion with C6 about project</td>
<td>Impromptu gate crashing of quality group meeting Site C to raise topic of research</td>
</tr>
<tr>
<td></td>
<td>Impromptu corridor conversation with consultant covering site A</td>
<td>Initial presentation at arranged meeting site C</td>
</tr>
<tr>
<td>26.2.05</td>
<td>Impromptu corridor conversation with consultant covering site A</td>
<td></td>
</tr>
<tr>
<td>26.2.05</td>
<td>Interview with C6</td>
<td></td>
</tr>
<tr>
<td>26.2.05</td>
<td>Impromptu visit to site C</td>
<td></td>
</tr>
<tr>
<td>1.3.05</td>
<td>Phone call from relative from patient at site A</td>
<td></td>
</tr>
<tr>
<td>2.3.05</td>
<td>Information sent to relative, letter to consultant</td>
<td></td>
</tr>
<tr>
<td>9.3.05</td>
<td>Phone call to site A to arrange seeing more staff – she not there</td>
<td></td>
</tr>
<tr>
<td>14.3.05</td>
<td>Phone call to ward manager site A arranged to go see her on 17\textsuperscript{th}, and maybe see A5 on 18\textsuperscript{th} (he's been off sick)</td>
<td></td>
</tr>
<tr>
<td>15.3.05</td>
<td>Phone call from relative of patient saying she has been on leave and will deal with consent form</td>
<td></td>
</tr>
<tr>
<td>15.3.05</td>
<td>Received consent back from A13 (patient consultant) for patient P1</td>
<td></td>
</tr>
<tr>
<td>17.3.05</td>
<td>Phone call from B15 has set up date for 3 hour workshop 4 people including him</td>
<td></td>
</tr>
<tr>
<td>17.3.05</td>
<td>Initial teaching workshop at site B (B15, B16, B17 - 3 hours, video discussion at end of</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
<td></td>
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</tr>
<tr>
<td>17.3.05</td>
<td>Visit to manager A2 at site A.</td>
<td></td>
</tr>
<tr>
<td>18.3.05</td>
<td>Interview and modelling at site A – A5.</td>
<td></td>
</tr>
<tr>
<td>18.3.05</td>
<td>Corridor conversation with A14 – telling her about what I was doing with staff, said that if I do a mini conference with participants I would invite her.</td>
<td></td>
</tr>
<tr>
<td>22.3.05</td>
<td>Interview with C6, ideas arising – see reflective diary. Ideas sharing, me talking aloud to share thoughts, collaborative.</td>
<td></td>
</tr>
<tr>
<td>22.3.05</td>
<td>Popped onto site C, saw deputy ward manager C11 – C7 there too, C11 leaving in two weeks – he knows about pre-therapy as did my dementia module some 3 or 4 years ago.</td>
<td></td>
</tr>
<tr>
<td>29.3.05</td>
<td>Phone call to site A – no staff participants on apart from A9.</td>
<td></td>
</tr>
<tr>
<td>29.3.05</td>
<td>Phone call to site C – no staff participants on.</td>
<td></td>
</tr>
<tr>
<td>30.3.05</td>
<td>Visit to site C – saw C6 – ward manager not on.</td>
<td></td>
</tr>
<tr>
<td>31.1.05</td>
<td>Phone call from B17 – arranged to see tomorrow.</td>
<td></td>
</tr>
<tr>
<td>31.3.05</td>
<td>Saw C5 at meeting about something else – reminded her I would be in touch to sort out dates for staff training.</td>
<td></td>
</tr>
<tr>
<td>1.4.05</td>
<td>Arranged to see B15, B16, B17 there too – group interview and modelling on unit, P3 saw relative and tried techniques out with her husband – possible subject.</td>
<td></td>
</tr>
<tr>
<td>22.4.05</td>
<td>Interview C6 for site C.</td>
<td></td>
</tr>
<tr>
<td>6.5.05</td>
<td>Arranged to see Site A staff in afternoon – A5 with P1 – video work, him watching himself – didn’t get chance to see A9 as he was busy with NVQ assessor, Did witness testimony for his NVQ file and spoke to his assessor.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doing unexpected other activity for A9 – being helpful to participants,</td>
<td></td>
</tr>
<tr>
<td>15.5.05</td>
<td>Arranged to go to site A on Sunday as staff on – worked with A10, modelling and videoing her with P1. Sought consent from P2 wife, she’s happy and I need to get consent form to her.</td>
<td></td>
</tr>
<tr>
<td>16.5.05</td>
<td>Spoke to B15 about arranging times – see him tomorrow, B17 on leave for one week, will sort out dates for B17 and B16 tomorrow.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Using B15 as access to others, affirming his leader role.</td>
<td></td>
</tr>
</tbody>
</table>
Invitation to participate in the research

Thank you for attending the presentation of Pre-therapy techniques and dementia.

At the presentation you were invited to participate in the research project. This letter is to provide a summary of what would be involved if you wished to participate. There is no payment for being a participant. You will not be expected to do this in your own time, but as part of your work.

Summary –
1. Staff are invited to join in the research looking into the use of Pre-Therapy techniques with people with dementia.
2. Penny Dodds (the researcher) will visit your work place and spend about one hour in your work place, she will make some research notes and observation
3. You will receive training in the use of the Pre-Therapy techniques. This training has been devised with the help of the person who invented the Pre-Therapy techniques.
4. You will be asked to consider a patient that you are working with who has a dementing illness and has difficulty communicating.
5. You will try using the Pre-Therapy techniques with the patient in your everyday work.
6. Penny Dodds will video you using the Pre-Therapy techniques with the person with dementia (15 mins).
7. Penny Dodds will interview you about your experience of using the Pre-Therapy techniques. This interview will be tape recorded and last an hour.
8. Steps 5 and 6 will be repeated to give you a chance to learn more about using the Pre-Therapy techniques.
9. Penny Dodds will use the Video and Audio recording and any other comments you wish to make as research data.

I also enclose the Information Sheet that gives more information about the project. Please contact me if you would like to discuss the project or have any questions.

Thank you in advance for your participation.

Penny Dodds - Lecturer Practitioner Old Age Mental Health.

REPLY SLIP

<table>
<thead>
<tr>
<th>Penny Dodds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institute of Nursing and Midwifery</td>
</tr>
<tr>
<td>University of Brighton</td>
</tr>
<tr>
<td>Westlain House</td>
</tr>
<tr>
<td>Falmer BN1 9PH</td>
</tr>
<tr>
<td>I would like to participate in the research</td>
</tr>
<tr>
<td>Name (please print):</td>
</tr>
<tr>
<td>Contact address:</td>
</tr>
<tr>
<td>Phone number:</td>
</tr>
<tr>
<td>email</td>
</tr>
</tbody>
</table>

Letter of invitation. Version 1.24/2/04
<table>
<thead>
<tr>
<th>Date/when</th>
<th>10.2.05</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where</td>
<td>Site B</td>
<td></td>
</tr>
<tr>
<td>What happened</td>
<td>Spent the day at the site. Aim was to—do further teaching in situ, support and be a ‘presence’ collect video data. Originally 5 staff who were participating were due to be on duty, in the end Alison, Ayline, Andy were there. Spent the day working alongside, teaching and joining in, observing. Spent time with relatives, gave info to patients’ wife, (need to follow this up and ask consultant)—</td>
<td></td>
</tr>
<tr>
<td>Thoughts about the event</td>
<td>Ward environment is psychologically bleak, using DCM principles there is much walking, sleeping, tasks, patients seeking contact of some sort. Patient to patient contact is often disruptive to pwd. Little positive patient to patient contact is facilitated. Patients that seek some contact are responded to, some patients likely to get little uninitiated attention if quite and then mainly in response to either tasks, care or due to danger—eg walking unsafely. Staff—undeniably busy—4 staff 15 patients, high level of physical dependency, chair bound, hoists. Depressing environment which may be easy to become naturalized to—difficult to maintain objective approach and I could see myself becoming similar to staff in the non proactive approach. Staff viewed very well by relatives—said to be kind, flexible and very good. One patient who the techniques are being used is being assessed to move—I must hurry on getting him on video. Modeling techniques—showed, Andy me using the techniques with AS. Episode in the corridor—my sound bite on video tape about episode. Benefits of demonstrating—can explain as I go along, show the subtle of the techniques, the low key nature of them, using situational reflections. I feel they are using much word for word and mirroring of movements—their application of techniques crude. Time is a real barrier but in the way that they maybe do not have their own head space to be reflective in action, they can do reflection on action, but thinking whilst doing is difficult. Are their heads too full, are they working on too many things at once. I found I did want to distance myself from patients, partly as extra on ward and not having other ‘things to do’ I wonder if this is linked to needing to have ‘things to do’—if so then maybe point to staff being able to think—I’ll go and do some contact work. Modelling to Alison and Ayline—Ayline is going to carry on—now that she sees the contact reflections can be used with a lighter touch. I modeled using AS.</td>
<td></td>
</tr>
<tr>
<td>Feelings</td>
<td>Miserable environment, Andy doing a bit of showing off—more brusque and loud around me and other patients. Can identify how staff can be affected by the environment.</td>
<td></td>
</tr>
<tr>
<td>Beliefs</td>
<td>Value in working alongside people, fits with not disrupting work, rather offering something. Teaching approach of modeling, reinforcing does values staff, this can be seen in their response to me. By reinforcing practice, they are getting something from the research process itself, regardless of what they are learning.</td>
<td></td>
</tr>
<tr>
<td>Change</td>
<td>Possibly greater explanation to other staff about the research, which may have generated more interest and possibly gained new participants.</td>
<td></td>
</tr>
<tr>
<td>Ideas</td>
<td>Teaching in situ, related to doing AR in context of work world—do memo. Observation of ward—do memo. Role of researcher in field—strategies I used to gain acceptance and compliance. How much teaching is enough—difficult to quantify as I cannot log hours etc as I am working in context.</td>
<td></td>
</tr>
</tbody>
</table>
Pre-Therapy and Dementia: Research Project

Information sheet for patients' representatives

Researcher: Penny Dodds
Lecturer Practitioner
(Mobile number: 07989 XXXXXX)

University of Brighton
And
(Trust Name)
Information Sheet for Relatives/Patients Representatives

Your relative/the person you represent is being considered to take part in a research project. It is important that you know what is involved. Because of their health it is important to consult you about whether they can take part. Before deciding if you agree for them to participate please read the following information and discuss it with others if you wish.

If you agree they can take part you will be asked to sign a consent form. Even if you consent at the beginning you may still decide to withdraw at any time.

You may contact me (Penny Dodds, researcher) if you want to talk about it. My mobile number is 07989 XXXXXX.

Name of Project: Pre-Therapy and Dementia: An Action Research project on the introduction of the techniques to nursing staff working with people with dementia.

Researcher: Penny Dodds, Lecturer Practitioner Old Age Mental Health, (Name of Trust)/University of Brighton.

My background is working with older people with mental health problems. I have worked as a nurse specialist in dementia and have 16 years experience of working with people with dementia. I am a Nurse Lecturer at the University of Brighton, and I work with staff to support them and help them develop their practice.

What is the research looking at?
The research is aiming to train staff in a particular way of communicating with people with dementia. The aim is to improve the quality of care. The techniques are called Pre-Therapy techniques.

What are Pre-Therapy techniques?
Pre-Therapy techniques are a way of communicating with people who may have difficulties with language and speech due to a psychological or organic illness. The techniques are simple. They involve a staff member or carer 'reflecting back to a person' their own words, their movements, their facial expressions and their surroundings. This enables the patient/client to have greater opportunity to express their own ideas, thoughts and feelings. This can help improve the communication between staff and patients.
The techniques are called 'contact reflections'. The contact reflections enhance the potential for staff to be able to communicate with patients and to provide better care and understanding of the patient's experience. This has the potential to improve the quality of care that patients receive.

What is the aim of the project? To find out how Pre-Therapy techniques can be learnt by staff and used in every day interactions with people with dementia.

Outline of the project. The research project will involve:

- Staff will receive training in the Pre-Therapy techniques (1-2 hour teaching session)
- Staff will try using the Pre-Therapy techniques in their day to day interactions with a patient/s. Staff may make notes on the use of the Pre-Therapy techniques. Penny Dodds will not be there, staff do this in their own work.
- Staff will receive further training and supervision from Penny Dodds on the use of the techniques (1 hour).
- Two video recordings of staff using the techniques in an interaction with a patient/s will be made. Each recording will be about 15 mins. They will be about one month apart.
- Staff will be interviewed about their experience of using the Pre-Therapy techniques (1 hour)

This research process is called Action Research and involves the researcher looking at the effects of introducing a new technique or interventions. This type of research is used to look at ways of improving care.

How will staff learn the Pre-Therapy techniques?
The techniques will be introduced to staff in a teaching session in their own workplace. Staff will then practice the techniques in their work. The video recording and the interview provide further opportunities for the staff to continue discussing and learning about using the techniques.

Who else is being asked to take part?
Patients who have dementia and have difficulty with their language and communication are being invited to take part or being invited via their representative and the clinical team who work with them. It is hoped that 10 staff and 10 people with dementia will take part in the research.
Confidentiality – will the research identify my relative/the person I represent?
It is important that the privacy and confidentiality of your relative/the person you represent is maintained. All audiotapes, videotapes and notes written by Penny Dodds will be her property. No patient or staff member will be identified in the research report. Video and audiotapes will be coded so that no person can be identified. The video tape recording may be shown to a member of the International Pre-Therapy Network for an expert opinion. This may involve sending the videotape abroad. Members of the Pre-Therapy Network will sign a confidentiality agreement and will not copy or distribute any video recordings. They will then return the videotape to Penny Audio tapes and videotapes will be kept for 20 years by the Trust. Access to the tapes will be through Penny Dodds

Will the video be shown to anyone else?
Penny would like to use examples of good practice from staff for educational and training purposes. This is important if the research proves that the techniques help improve communication between staff and people with dementia. At least three months will elapse before you and the staff are asked if any video tape recording made during the research may be used for further education and training purposes. Only examples of good practice will be used for this.

Video Tape Recording – what is involved and how will Penny make sure that it does not cause distress?
To ensure that video recording does not cause any distress to the person with dementia Penny will do the following:
- Introduce the video camera to the patient and obtain consent to use the camera. Penny will show the camera to the patient and judge if this upsets the patient. If so the video recording will not take place.
- The video camera will be placed somewhere that is unobtrusive
- Monitor any interaction during video tape recording for any signs of distress that may be caused by the presence of the camera and the researcher.
- Penny will use her clinical expertise and judgement to monitor the well being of the patient throughout the video recording.
- Video tape recording will only take place in communal areas and the patients privacy and dignity will be of primary importance.
Appendix 6

Page 4

- The processing of the videotape will hide the identity of patients or staff who are not part of the research process.
- Video recording will not continue if either the staff member or the patient indicates they wish the recording to stop.
- Once the tape is made it will be coded so that no one can be identified.

How will people get information about the research?
- You are welcome to contact Penny to find out how the research is progressing and discuss any findings. A written summary will be available.

Are there any risks?
It is not anticipated that the techniques will cause any distress. The idea is that the person with dementia is given more chance to communicate what they want to say and this improves communication. However people with dementia do sometimes get distressed due to the illness. The techniques themselves do not cause distress but may allow a person with dementia to voice their distress. The techniques are not designed to provoke distress.

What if there is distress?
In the event of any distress Penny will do the following:
- If patients express distress during the video recording Penny will end the video recording and attend to the patient's distress.
- Penny will offer additional time with the patient, inform the nurse in charge and the multi professional team.
- You will be informed if the use of the Pre-Therapy techniques causes distress.
- Penny is a registered nurse and will follow the NMC Code of Professional Conduct. Any disclosures of malpractice or practice which is not in the interests of a patient's safety cannot be kept confidential and will need to be reported to the staff member's line manager.
What are the benefits of taking part?
It is hoped that the research will help understand if staff can use the Pre-Therapy techniques and if so, how they change or improve the communication between staff and patients.

How will patients continue to benefit after the research?
If the research shows that your relative/ the person you represent benefits from the use of the Pre-Therapy techniques, staff will be encouraged to continue using them in their day-to-day work. If the research proves the techniques are useful then further teaching sessions will be offered to staff to enable other staff who did not take part in the research to learn the techniques.

Will medical staff be aware of the research? The General Practitioner and The Consultant in Old Age Psychiatry, who has day-to-day responsibility, are aware of the research.

Will I have to sign anything? You will be asked to sign a consent form. You will keep a copy of this form and Penny will keep a copy. A copy will be held in the patient's notes. This consent form shows that you have agreed for your relative/the person you represent to take part.

What if I decide to withdraw my agreement for my relative/the patient I represent to take part in the research?
You may withdraw from the research at anytime. Withdrawing consent will not affect the care that your relative/the person you represent currently receives.

What if something goes wrong during the research?
If you feel the Pre-Therapy techniques are causing psychological harm to the person you represent you can contact Penny direct to discuss your concerns. You may withdraw your consent at any time. This will not affect the care that the patient receives. There are no special compensation arrangements. If the person you represent is harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

If you have concerns about any other aspect of their care that is outside the research project, then you will need to contact the unit manager who will inform you of the usual Trust complaints procedure. The techniques are called 'contact reflections'. The contact reflections enhance the potential for staff to be able to communicate with patients and to provide better care and understanding of the patients' experience. This has the potential to improve the quality of care that patients receive.
Who is overseeing the research?
The research is being conducted for Penny's PhD degree and is supervised by the Nursing Research Department at the University of Brighton. The Trust Research Governance Committee will monitor the research project. The Worthing and Southlands Research Ethics Committee have approved it.

If you want to discuss any of this information further please contact me. My mobile number is 07989 XXXXXX

Thank you for taking part.
Penny Dodds (Lecturer Practitioner Old Age Mental Health)

One copy of this sheet is to be kept by the relative/patient representative.
Appendix 7

(Form to be on headed paper)

Centre Number:
Study Number:
Staff Identification Number for this trial:

CONSENT FORM (staff consent for patients representative to view video recording)

Title of Project: Pre-Therapy and Dementia: An Action Research project on the introduction of the techniques to nursing staff working with people with dementia

Name of Researcher: Penny Dodds, Lecturer Practitioner Old Age Mental Health, (Name of Trust)/University of Brighton.

Please initial box

1. I confirm that I give permission for the patient representative to view the video recording of me using Pre-Therapy techniques with the person with dementia they represent.

2. I understand that they will sign a statement of confidentiality and may not show, copy or distribute the video recording to anyone else.

Name of Staff Member______________________________________________
Signature_________________________________________________________
Date_____________________________________________________________

1 copy to Staff member, 1 copy to researcher;

Consent Form – Staff consent for patient representative to view video recording. Version 1.24.2.04
Statement of confidentiality by Patients Representative.

Title of Project: Pre-Therapy and Dementia: An Action Research into the introduction of the techniques to nursing staff working with people with dementia.

Name of Researcher: Penny Dodds, Lecturer Practitioner Old Age Mental Health, (Name of Trust)/University of Brighton

1. I understand that I have been given permission by the staff research participant to view the video tape recording (code) which shows the person with dementia I represent.

2. I understand that I may not copy, distribute or use the video for any purpose.

Name

Signature

Date

24.2.04
Appendix 9

(Form to be on headed paper)

Centre Number:
Study Number:
Staff Identification Number for this trial:

CONSENT FORM (staff)

Title of Project: Pre-Therapy and Dementia: An Action Research project on the introduction of the techniques to nursing staff working with people with dementia

Name of Researcher: Penny Dodds, Lecturer Practitioner Old Age Mental Health, (Name of Trust)/University of Brighton.

Please initial box

1. I confirm that I have read and understand the information sheet dated ......................... (version ............ ) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. An integral part of this research is the use of video and audio recordings. I agree to participate in these recordings.

4. I understand that the video recordings may be viewed by another member of the Pre-Therapy Network. They will sign a statement of confidentiality.

I agree to take part in the above study.

Name of Staff Member
Signature
Date

Name of Person taking consent
Signature
Date
(if different from researcher)

Researcher
Signature
Date

1 copy to Staff member, 1 copy to researcher;

Consent Form – Staff. Version 1.24.2.04
ASSENT FORM (patient's representative)

Title of Project: Pre-Therapy and Dementia: An Action Research project on the introduction of the techniques to nursing staff working with people with dementia

Name of Researcher: Penny Dodds, Lecturer Practitioner Old Age Mental Health, (Name of Trust)/University of Brighton.

Please initial box

1. I confirm that I have read and understand the information sheet dated .................. (version ............) for the above study and have had the opportunity to ask questions.

2. I confirm that I know of no reason why my relative/the person I represent would object to being approached to take part in the study.

3. I confirm that I know of no reason why my relative/the person I represent would object to taking part in the study.

4. I understand that the researcher will speak to my relative/the person I represent about taking part and that their consent and willingness to take part will be ongoing.

5. I understand that video recording is part of this research project and I agree for the person I represent to participate in this.

6. I understand that the video recording is the property of the researcher and will be made anonymous, be confidential and be held securely in the Trust for 20 years.

7. I understand that the video recording may be viewed by another member of the Pre-Therapy Network who will sign a statement of confidentiality.

Name of Patient's Representative Signature Date

Relationship to patient

Name of Person taking consent Signature Date
(if different from researcher)

Researcher Signature Date

1 for patient/patients representative, 1 for researcher; 1 to be kept with hospital notes

SDS0210M Assent Form – Patient Representative. Version 1. 24.2.04
Consent to use video tape recording for training purposes.

Title of Project: Pre-Therapy and Dementia: An Action Research into the introduction of the techniques to nursing staff working with people with dementia.

Name of Researcher: Penny Dodds, Lecturer Practitioner, Old Age Mental Health, (Name of Trust)/University of Brighton.

1. I confirm that three months has elapsed since the video recording and this has given me time to consider if I wish video recording number ( ) to be used for educational purposes.

2. I understand that the use of the video for training has the intention to show good and effective practice in the use of Pre-Therapy techniques.

3. I understand that I may withdraw consent for the video to be used for training purposes at anytime without giving a reason.

4. I understand that both the staff member and the patient/patients representative must give consent for the video to be used for educational purposes.

5. I understand that the video will not be used for commercial purposes.

<table>
<thead>
<tr>
<th>Name of Staff</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Patient/Patients Representative</td>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

Consent to use video for training. Version 1. 24.2.04
Episodes of Validation

1. Conducting an exercise with Pre-Therapy Network Members to validate my understanding of Pre-Therapy and contact work.

**Description of activity with Network - 2005**

In 2004 I took written accounts by 4 students (not participants) who produced written accounts of using contact reflections. The Network members were informed that I wanted to use their expertise and conduct an exercise which would validate my own understanding in relation to their expertise. The exercise was structured in a way to triangulate opinions of network members by gleaning different people's opinions on the same work.

**The exercise**

The network members were divided into 4 teams (of between 4-6 people), each team reviewed two accounts. Therefore each account received the views of eight to twelve members of the Pre-Therapy network (including Garry Prouty). After reviewing the accounts the ideas were compared, and each account had written notes from the network members. There was a high inter-group reliability between teams, and Network members made similar comments on the transcripts. The comments by Network members matched closely my own notes. For example, there was agreement where staff described accurate use of contact reflections and agreement where the transcripts showed either a mis-understanding or inaccurate use of contact reflections. The exercise validated my own knowledge and ability to read a transcript and interpret the use of contact reflections with a degree of accuracy.

2. Validation of my understanding of contact work from a video extract - 2005

**Description:** With consent, two members of the network (Dion Van Werde and Dave Deady) were shown an extract of a video. The video was shown as part of a Pre-Therapy workshop of approximately 25 health professionals. This confirmed emerging ideas about the differences between mechanical replication of contact reflections and the art of doing contact reflections which show a more empathic and relational quality to the interaction. Their response and the response of the workshop attendees was overtly critical of the performance of Adam, and more bluntly critical than my response.

**Thoughts arising** This indicates two things. First the possibility of my perspective being distorted with a degree of 'going native' as I had built a relationship with Adam as a participant and to some extent felt defensive on his behalf. Second, my interpretation of his performance compared to their perception of his performance was informed by my involvement in the research, which meant I had historical, contextual knowledge about the situation which was being shown on the video.
Appendix 13

Subdivision of research questions.

1. Staff
   a. Can staff learn contact reflections
      i. Can staff identify contact reflections in a demonstration
      ii. Can staff name the contact reflections after an initial teaching session
      iii. Can staff demonstrate an understanding of the difference between contact reflections and other ways of communicating
      iv. What level of knowledge can staff demonstrate about contact reflections
   a. Can staff use contact reflections
      i. Can staff use contact reflections in a simulated role play
      ii. Can staff use contact reflections in their communication with people with dementia in their day to day work
      iii.
   b. What is the staff's experience of using contact reflections
      i. What accounts can staff provide of using contact reflections
      ii. How do their accounts relate to theoretical ideas of the use of the use of contact reflections
      iii. What accounts for a variation in their reported use of the contact reflections and the observed experience – (something about them thinking they are using them and not really doing so)

2. People with dementia:
   a. What happens when people with dementia receive contact reflections from staff
      i. What is observed when contact reflections are used with people with dementia

3. using Pre-Therapy techniques in the clinical context
   a. what is the impact of the clinical context on staff using contact reflections
      i. what is the response of other staff who don't use contact reflections or are not participating in the research
      ii. what influence does the clinical context have on the use of contact reflections
   b. what is the impact on the clinical context of staff using contact reflections
      i. is there any other effect of either the research process or the clinical context and care

   c. What is the impact of the clinical context on staff learning the contact reflections
      i. What influence does the clinical context have on the learning of contact reflections

4. the action researcher introducing Pre-Therapy techniques to staff.
   This begins with my own knowledge and skill base
   a. how can I learn and use Pre-Therapy
      i. how do I go about gaining expertise
ii. how do I verify my knowledge

b. what is my own experience of using Pre-therapy techniques
   i. what accounts and thoughts do I have on the use of the techniques with people with dementia

This leads to the introduction of the techniques via the Action research and action learning process

c. how do I teach staff to use contact reflections
   i. what methods of teaching and learning do I use
   ii. how do I assess their learning?
   iii. How do I use the action learning process

d. What are the ongoing developmental processes involved in the learning
   i. what do staff describe in the learning process
   ii. what do I observe in the learning process over time

5. the application of the techniques in relation to dementia care
   a. how does the use of Pre-Therapy contact reflections with people with dementia relate to the literature
      i. what differences and similarities are there
      ii. how do the clinical features of dementia affect the use of contact reflections
      iii. what deviations from the literature arise
      iv. 

b. what does the application of Pre-Therapy contact reflections contribute to the literature on Pre-Therapy
   a. how does my ideas arising from the research contribute to expanding the knowledge and theoretical base of dementia

c. What does the application of Pre-Therapy contact reflections contribute to the dementia literature
   i. how does my knowledge from the research contribute to expanding the knowledge and theory within the dementia field

d. What does the application of Pre-Therapy contact reflections contribute to care for people with dementia
   i. what are the implications for practice
   ii. what are the implications for teaching staff
   iii. what are the implications of the findings on the clinical context
   iv. what are the implications for organizations
   v. what are the implications for introducing new ideas
   vi. what are the implications for instigating change in practice.
<table>
<thead>
<tr>
<th>Pwd reaching out/seeking</th>
<th>Nature of work - aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic nature of dementia</td>
<td>Pwd relational seeking</td>
</tr>
<tr>
<td>Expressiveness speech organic</td>
<td>Doing - CR or other</td>
</tr>
<tr>
<td>Reaching out (pwd)</td>
<td>Group learning - not alone</td>
</tr>
<tr>
<td>Organic expressiveness</td>
<td>Combing : cr and other</td>
</tr>
<tr>
<td>Guessing, not knowing</td>
<td>Using - confidence</td>
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<tr>
<td>Alternative approaches - constructive directive</td>
<td>Noticing self</td>
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<tr>
<td></td>
<td>Noticing pwd</td>
</tr>
<tr>
<td></td>
<td>Using - accuracy</td>
</tr>
<tr>
<td></td>
<td>Difficult to do - awkward</td>
</tr>
<tr>
<td></td>
<td>Supervision</td>
</tr>
<tr>
<td></td>
<td>Knowledge of PT</td>
</tr>
<tr>
<td></td>
<td>Trial and error</td>
</tr>
<tr>
<td></td>
<td>Doing - practicing</td>
</tr>
<tr>
<td></td>
<td>Doing - familiarity</td>
</tr>
<tr>
<td></td>
<td>Using - experimenting</td>
</tr>
<tr>
<td></td>
<td>Speculating</td>
</tr>
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**Organic Nature of Dementia**

**Staff Learning, Skill and Competence**

<table>
<thead>
<tr>
<th>Unexpected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw emotion</td>
</tr>
<tr>
<td>Making contact</td>
</tr>
<tr>
<td>Facilitating expression</td>
</tr>
<tr>
<td>Distress</td>
</tr>
<tr>
<td>Expressiveness - limits of</td>
</tr>
<tr>
<td>Response - negative</td>
</tr>
<tr>
<td>Response ambiguous</td>
</tr>
<tr>
<td>Unpredictability</td>
</tr>
<tr>
<td>Circular</td>
</tr>
<tr>
<td>None rapid emotive</td>
</tr>
<tr>
<td>No response</td>
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**Response from Person with Dementia**

**Experience of Staff**

**Context**

<table>
<thead>
<tr>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing - avoiding</td>
</tr>
<tr>
<td>Balancing doing</td>
</tr>
<tr>
<td>and being</td>
</tr>
<tr>
<td>Engaging - difficult</td>
</tr>
<tr>
<td>Response - fear</td>
</tr>
<tr>
<td>the response - hesitancy</td>
</tr>
<tr>
<td>Using: reluctant</td>
</tr>
<tr>
<td>Response - fear anticipation</td>
</tr>
<tr>
<td>Can of worms</td>
</tr>
<tr>
<td>Inciting pain</td>
</tr>
<tr>
<td>Fearful of distress</td>
</tr>
<tr>
<td>Dementia</td>
</tr>
<tr>
<td>Avoiding pain</td>
</tr>
<tr>
<td>Overwhelmed</td>
</tr>
<tr>
<td>Response: distressing</td>
</tr>
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<table>
<thead>
<tr>
<th>Emotional labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combining - doing</td>
</tr>
<tr>
<td>and being</td>
</tr>
<tr>
<td>Relationship - bridge (not)</td>
</tr>
<tr>
<td>Building bridges</td>
</tr>
<tr>
<td>Normalising</td>
</tr>
<tr>
<td>Being there with them</td>
</tr>
<tr>
<td>Witnessing</td>
</tr>
<tr>
<td>Being present</td>
</tr>
<tr>
<td>Satisfaction</td>
</tr>
<tr>
<td>Hope</td>
</tr>
<tr>
<td>Containing</td>
</tr>
<tr>
<td>Self protection</td>
</tr>
<tr>
<td>Using - reluctance</td>
</tr>
<tr>
<td>Seeing the person</td>
</tr>
<tr>
<td>Entering their</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Getting somewhere</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makes life easier</td>
</tr>
<tr>
<td>Not knowing</td>
</tr>
<tr>
<td>Taking the micky</td>
</tr>
<tr>
<td>Mockery</td>
</tr>
<tr>
<td>Role: not qualified</td>
</tr>
<tr>
<td>Doing: avoiding</td>
</tr>
<tr>
<td>Relevance of cr to staff</td>
</tr>
<tr>
<td>Role - not qualified</td>
</tr>
</tbody>
</table>

| Role nurse - instinct to make it better |
| Make it better |
| Protection Role - usual work |
| Role concept - engaging |
| Role concept: being a nurse |
| Moving it on |
| Role concept: making happy |
| Not nursing |
| Role concept nurse |
| Role - comforting |
| Tasks |

<table>
<thead>
<tr>
<th>Context - resources</th>
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</thead>
<tbody>
<tr>
<td>Time</td>
</tr>
<tr>
<td>Context: other people</td>
</tr>
<tr>
<td>In front of others</td>
</tr>
<tr>
<td>Self conscious</td>
</tr>
<tr>
<td>Juggling</td>
</tr>
<tr>
<td>Role nurse - conflict</td>
</tr>
</tbody>
</table>
Appendix 15

Refined Codes

DOING-TECHNIQUE
DOING-BEHAVIOURAL
DOING-ENVIRONMENTAL CONDITIONS
DOING-SOCIAL CONTEXTUAL INFLUENCES
DOING-SELF PERCEPTION AFFECTING DOING
DOING-ROLE PERCEPTION AFFECTING DOING
DOING-MEANING OF CARING AFFECTING DOING
DOING-BARRIERS TO DOING
DOING-CHALLENGE POSED BY DOING
DOING-IN RELATION TO THEORY

RESPONSE-PWD
RESP-POSITIVE PERCEPTION
RESP-NEG/OTHER PERCEPTION
RESP-UNUSUAL RESPONSE OR REACTION TO RESPONSE
RESP-ENABLING PERSON WITH DEMENTIA

THEORETICAL COMPARISONS
CONTACT-EVIDENT
CONTACT-NOT EVIDENT
CONTACT FUNCTIONING
CONTACT BEHAVIOURS
LEVEL OF EXPRESSIVENESS
WWR-STAFF
BR-STAFF
FR-STAFF
SR-STAFF
RR-STAFF

LEARNING-PROCESS
LEARN-ERRORS
LEARN-ACCURACY OF KNOWLEDGE
LEARN-LEARNING THROUGH USING
LEARNING-SOCIAL ACTIVITY
LEARNING-BARRIERS

STAFF RESPONSE
S-RESPONSE-DISCOMFORT
S-RESPONSE-SOCIAL PROCESSES
S-RESPONSE-EMOTIONAL

NATURE OF DEMENTIA
NOD-ORGANIC
NOD-COMMUNICATION
NOD-PITHEORETICAL (nature of dementia in relation to Pre-Therapy theory)

RELATIONSHIP WITH PERSON WITH DEMENTIA
REL-CARING
REL-PROTECTION
REL-LOOKING AFTER?
REL-DISTURBANCES

RESEARCH PROCESS ACTIVITY
R/PROCESS-CONTEXTUAL ASPECTS OF RESEARCH ACTIVITY
R/PROCESS-HELPING FACTORS
R/PROCESS-HINDERING FACTORS
R/PROCESS-RESEARCHER/PARTICIPANT RELATIONSHIPS
R/PROCESS-ORGANISATIONAL
Effects of contact reflections

Positive

Seeing the person
Building bridges
Expression
Communication

Negative

Can of worms
Helplessness
Absence of response
Agitation

Nurse

Person with dementia

Positive

Negative
Appendix 17

I Social rules of interaction

Empathy

Role concept

Self-concept

Perspective of a caring relationship

Relational autonomy

Social and cultural norms of care

Organisational structures and values

Nurse

Person with dementia

Organic nature of dementia

Dysphasia

Emotional expressiveness

Social isolation

Relationship seeking
Staff use contact reflection

Primary Mediators
Learning, skill
Organic nature of dementia

Continue contact reflections

Response to contact reflection

Useful
Not useful

Continue contact reflections

Secondary mediators (staff)
Intra personal
Inter-personal contextual

Response to contact reflection

Useful
Not useful

Discontinue contact reflections

Positive/negative, helpful/not helpful, beneficial/not, productive/counter productive, effective/ineffective,
PROCESS OF USING CONTACT REFLECTIONS – MAR 07

RELATIONSHIP

MEDIATING FACTORS:
- INTRAPERSONAL
- INTERPERSONAL
- CONTEXTUAL
- LEARNING, SKILL AND KNOWLEDGE
- ORGANIC NATURE OF DEMENTIA

FILTERS

POSITIVE / NEGATIVE

FILTERS AFFECTING STAFF PERCEPTION OF POSITIVE OR NEGATIVE RESPONSE
View of the needs of the person with dementia
Staff experience of response
Staff expectation of purpose of their role

FILTERS AFFECTING THE PERCEPTION OF POSITIVE OR NEGATIVE RESPONSE IN THE PERSON WITH DEMENTIA
Contact behaviours
Absence or presence of distress
Effect on relationship with staff

Key features affecting the filters
RELIANCE
CONTROL
PROTECTION
‘CARING ROLE’
EXTRACT FROM AN EPISODE OF WRITING FOLLOWING SUPERVISION.
Expectations and role concept
This rests on key themes from the data. The first of these is 'we are here to help'. Where participants discussed their experiences they illustrated their self concept of what they see as the role of the nurse. This includes ideas of helping, reassuring, offering comfort and helping. In this way they are showing their expectations of the purpose of their communication with the person with dementia. where the expectation is to help, comfort and reassure, the contact reflections challenge this expectation. This is particularly evident where the contact reflections facilitate a person with dementia expressing fear, anxiety, sorrow. By feeling that they have somehow 'made the person feel difficult emotions' the staff's self concept of helper, comforter is contradicted. This results in discomfort for staff. Indeed, the impotence experienced by staff can simply by being in extended eye contact with a person with dementia. Again this taps into the staff self concept of needing to 'do something' or 'offer something' to the person with dementia, rather than simply be with them. Where staff feel that their role is to allow and hear a range of emotional states, staff seem to show a greater ability to contain the emotions of the person with dementia, rather than feel that they have somehow failed if the person with dementia is not happy.

It is possible that positive approaches in dementia care have contributed to the internalised self concept of taking responsibility in the relationship. Positive approaches frequently advocate taking responsibility for providing and assuming responsibility for creating positive emotional states in people with dementia and opportunities for people with dementia to experience joy, laughter. I whole heartedly support these approaches, but wonder how much this contributes to creating expectations in staff that they will be making people feel happy. This point can be extended. Current directions in dementia care have called for an end to a warehousing model of care. In this model, relationships are distanced; people with dementia are housed, cleaned and fed. By promoting a more nurturing 'horticultural' model we are encouraged to engage more with the humanness and person-hood of people with dementia. Whilst this is completely in line with the philosophical origins of Pre-Therapy, Person centred philosophy, there has been an emphasis on the social interactionist perspective, which has led to workers needing to assume greater responsibility for the relationship and the impact of the relationship between themselves and the person with dementia. Again, this has contributed to greater emphasis on constructive activities. However, if we interpret this with an emphasis on determining the experiences for people with dementia maybe there is a danger that we can over-determine their experiences at the expense of improving our engagement on a phenomenological level with the world of the person with dementia. If we replace an old culture of care with an approach which takes over, then we need to be mindful that we do not replace physical warehousing with emotional warehousing which is the determining of the emotional experiences for the person with dementia. It would be a shame if newer approaches to dementia care replaced one form of custody for another.

Where staff assume the responsibility for the emotional direction in interactions with people with dementia, they are less likely to feel comfortable with the contact reflections which require noticing, focusing on and reflecting the bodily experience, the facial expressions, the physical situation and the words and sounds of the person with dementia. The very nature of the contact reflections are non-directive. The worker follows the embodied experience of the person.
Appendix 20

There is no sense of leading the person with dementia into a different emotional state, rather using their own world as the starting point for engagement.

Reciprocity
Another way that the contact reflections challenge the concept of the ‘normal’ relationship. Reciprocity involves both parties gaining something from the interaction. Within the model of emotional custodianship the need for staff to gain some satisfaction from the interaction means that where staff feel that they are achieving something, they experience a sense of pride in the job. In relation to the contact reflections this is where staff feel that their contact with the person with dementia was beneficial to them, or they gained pride by seeing something ‘work’. This is reflected in the category/code of ‘getting somewhere’. They get something from seeing the person with dementia experiencing something. Again we can link this to the emotional custodian model, where there is a tendency for staff to view positively either getting somewhere or seeing that their intervention somehow did something, even if that was perceived as eliciting a difficult emotion. It is also perhaps an explanation of why sometimes people tended to not do contact reflections as the staff perceived them as not having a result, or there was no response from the person. ‘the window’ built is the category used to describe moments when staff felt the saw the person within which is built by ‘bridging’, and this could be seen as moments where emotional reciprocity and giving of the worker of their own presence is present in that moment. In these moments staff have moved from emotional custody of the person or themselves to emotional containment where the emotion within the contact is safely contained.

Feels different – not the normal rules of conversation
The data shows that contact reflections challenge normal rules of conversation.

Reliance –
the nature of the relationships between people with dementia and nursing staff is based on a relationship of reliance. The person with dementia is reliant on the those around them. On a basic level, they are reliant for the very basic functions of having food provided, keeping clean, being dressed. On an environmental level, people with dementia are reliant on others for helping them find out where they are, helping them find somewhere comfortable or safe to be, and staff have the responsibility for the environment. In social terms, the person with dementia is reliant on others to provide opportunities for social interaction as the dementing process restricts their opportunities to reach out and engage in social contact with others in a way that results in reciprocal meaningful social interaction. Where people with dementia seek out social contact with others in a way that results in reciprocal meaningful social interaction. Where people with dementia seek out social contact with others, their overtures may not been recognised and the person with dementia is reliant on the staff or others to respond to them in a way that recognises any needs they present to another. In the same way, staff are reliant on the person with dementia fitting in with the role concept of carer. Therefore mutuality in the relationship of reliance is most comfortable for staff when the response of the person with dementia fits with the role concept of helper, comforter, carer. Where a person accepts physical care, engages in a social contact which reinforces the role concept, the relationship feels more comfortable for the staff. Staff also rely on understanding the needs or actions of the person with dementia. this is difficult as many times the carer is left not knowing what it is the person with dementia wants, needs or is doing and the code which frequently occurs for staff is ‘not knowing’. The contact reflections offer a direct challenge to the comfort of a relationship based on reliance. This is by staff needing to adopt a position of not being in a position to know what is best for
the person or what they need. They have to abandon their own frame of reference and enter into the frame of reference of another. This means that they need to stop and notice the world of the person with dementia rather than acting immediately based on the idea that the person with dementia is reliant on them to do something. Or assume responsibility for the person with dementia being reliant on them to feel better.

This is again complicated by the nature of dementia. People with dementia are reliant on us. We cannot neglect the person with dementia who is about to fall over, the person with dementia who is roaming a ward. But it maybe that the instant response of wanting to intervene, interpret their behaviour or try and provide an answer or reassurance is based on an internalised concept of the person with dementia being reliant on us. Therefore to incorporate contact reflections requires a re-balancing of reliance. Yes the person with dementia is reliant, but first we enter their world, make contact in order to further try and understand what it is the person with dementia is reliant on us for. This is uncomfortable when we find out that we cannot meet the emotional needs of the person with dementia. If they are reliant on us for security and we cannot offer it, the staff are left feeling hopeless unless we can safely contain the emotional impotence that may arise.

Hope and hopelessness and helplessness – (Is this a part of the findings rather than a construct of emotional custody- or part of protection)
Core to emotional custodianship is its relationship to hope and hopelessness. Custodianship in staff involves the avoidance of feelings of helplessness and hopelessness. Job satisfaction, gained by adhering to the internalised self concept of offering help and feeling hope. This means that where contact reflections engage staff in being attuned to the helplessness and hopelessness of the situation of the person with dementia they experience discomfort (shown in the categories of 'can't make it better' 'can't help'). Also staff are less inclined to see their role as incorporating the witnessing of hopelessness and helplessness. The contrast between the research subject in a non nursing role who is a qualified person centred therapist, illustrates how her witnessing of hopelessness, or pain, or despair was part of her role concept. Therefore the nursing role is seen to include the avoidance of facilitating expressions of emotions which place them in a position of feeling helpless and hopeless. This points to one of the dangers of using contact reflections. They open staff to an attunement with the person with dementia which exposes staff to greater feelings of hopelessness and helplessness, and the pain and despair of the world of the person with dementia.

This is counteracted by hope. Where contact reflections engendered hope, this came from where staff expressed hope that they were 'getting somewhere' with the person with dementia via the contact reflections. Again we can see this in relation to the role self concept of somehow making it better for the person with dementia. Hope for the staff arises if the contact reflections or other types of interventions seem to result in a person with dementia being able to do something that they were not usually able to do, or express something that was not uncomfortable to the staff member, or respond in a way that they seemed 'happier'. With contact reflections there is no guarantee that being in contact with the person with dementia will result in a happier patient, there is a real risk that they may meet a human who is far from happy. In relation to safe containment, the requirement of the staff is to engage with the person and be able to contain in themselves hopelessness as well as be faced with the hopelessness of the person with dementia.
Protection

Emotional custody places staff in the role of protector. People with dementia are protected from their own emotional states (good or bad). In particular the difficult emotions are diverted or overridden by the staff in attempts of staff protecting themselves. This protection is lowered where people with dementia are in positive states. Staff respond to the person who appears happier. Where the contact reflections are seen to potentially 'open a can of worms' staff may respond in a protector role, again wanting to soothe or reassure. Lessening the protector role, requires a model of containment rather than custody. There is a strong argument for offering protection. The organic nature of the dementing process means that higher cognitive functions which allow a person to mobilise coping strategies begin to disappear. This leads to less ability for the person with dementia to self control their own emotional states. As a result, to some extent, part of the role of the worker is to act and provide these for the person with dementia, sometimes diverting people away from emotional states that are painful either to witness or experience, to ones which are more pleasurable. This still feeds the idea of custodianship and containment. Where we over protect people with dementia from their own emotional states, we are in fact invalidating their emotional world in the guise of offering protection. Thus protection is one of the roles assumed by the worker—offering the person with dementia protection from their own emotional experiences. However, we know that these painful, often strong emotions do not simply go away. The person seeking their mother, may be distracted for a few moments, but will quickly return to seeking one the worker has finished trying to offer protection from the feelings of loss.

Control

Within relationships with people with dementia staff offer control. In physical and temporal terms, staff determine when things happen. This may be inevitable because the person with dementia is reliant on staff. In relation to emotional control, staff assume can assume the control over the emotional flavour of an interaction. They may initiate an interaction in a cheerful way, thus offering an opportunity for the person with dementia to get in step with the cheerfulness of the staff member. Again this is not necessarily a bad thing. Because people with dementia are reliant on others, and because they may respond well to the emotional states of others there is something rather satisfying initiating and offering a positive emotional state to a person with dementia because they may respond well and be cheerful in return. However, for a person with dementia who is in a pre-expressive state and is not in contact with another person, the staff offer an interruption to their world rather than joining them in it, and this results in the person with dementia not having a say in determining the emotional direction of an interaction. Contact reflections challenge the act of exerting emotional control. By simply reflecting and starting with the world of the person with dementia and their experience of it, staff have to relinquish control, waiting for the contact with the person with dementia which then gives the person with dementia the possibility to have some control in the emotional direction of the interaction. Again, this requires staff waiting and containing their own responses to wait to see what the person with dementia expresses. By relinquishing some control, staff are further exposed to anxiety relating to the possibilities of helplessness, hopelessness and other things which counter their role expectation as a carer.

However, safe containment, may mean getting engagement then using a positive emotional controlling of the relationship. This is using contact reflections in a light way, rather than opening the can of worms.
To: Members of the Pre-Therapy International Network
From: Penny Dodds (UK)
Date: Nov 2006

Dear All,

Following the discussion at the network meeting last month, I have put down my thoughts about training and education in relation to Pre-Therapy.

I have tried to approach this in a way that appreciates the difference between course outcomes that are about contact reflections and contact work, and courses that have more depth and a psychotherapeutic aim.

I am aware that I am not a therapist and that the depth of knowledge and experience for non-therapists is vastly different. I have approached this from an educational perspective, applying the educational principles to the idea of developing training standards for contact work and pre-therapy. I would not see that I can teach anything other than very basic information about contact reflections and how these might relate to the practice of non-psychotherapists and contact work in relation to a nursing role.

I have tried to provide a hierarchy which reflects the different levels of knowledge and awareness of Pre-Therapy. I have produced four course outlines — although there could be others.

I think there is a fundamental problem with 'teaching people to be person centred' and that this is unrealistic in short courses. This is not the aim of short or basic courses. I do see that there is a place for standardizing or creating a baseline for what is included in delivering knowledge of basic contact work. A baseline then allows for greater recognition of contact work.

I recognise the paradoxes

1. Contact reflections require a person centred approach, yet we cannot teach people to be person centred in a few hours.
2. Some people are more naturally person centred than others and are able to incorporate contact work with more ease after a basic introduction.
3. Pre-Therapy involves the art of being and standardized 'training' involves doing.
4. Basic assessments address knowledge and behaviour, rather than attitude.
5. Training and education require some standardization but there is a variance that is likely to exist between countries, people who may deliver training, organisational requirements for accreditation.
6. Training and education often do not address the issue of change in practice and implementing change in practice.
7. There is no automatic link between a person teaching and a student learning. However, an assessment of learning does then sanction that the person has learnt something. This provides change in knowledge but not change in attitude or presentation of self to others (although written work, change and attitude in often implicit in what people write, especially if they are required to write reflectively.)
The different courses vary in level (level 0) being education speak for a low level. Level 1 – certificate level, level 2 – diploma level etc. The levels reflect the academic ability or expectations. Level 1 students are only expected to describe and understand. Level 2 – students are also expected to analyse. Level 3 – students have to critically analyse. Level 4 (masters level) students have to synthesise.

We mark work according to marking criteria for each level which divides the assessment of work into the use of supporting literature, knowledge understanding and analysis, application to practice and presentation of work. Each section has its own weighting. I am happy to share these if people want.

In terms of the courses below, I would see that only the diploma level and any other courses at diploma and above would require accreditation with an institute of Higher education and would have to go through local procedures for having courses accepted. In relation to my own university, there is no guarantee that organisations simply say yes to courses as they have to be marketable and cost effective for universities to run, and they would also have to link to existing courses and qualifications, for example degree pathways that are already in place.

At the other end, the courses which are level 0 and level 1 would be run (in my case) outside of higher education or university establishments, and would not carry any formal or academic credit. The result of achieving the course outcomes would have to be in the form of some sort of certificate from either an organisation or trainer who was approved by the PT network to deliver that level of training, or from the PT network or PT Institute?

I would be interested to hear from people who work in university departments which focus on psychotherapy courses, (I am within a faculty of health, not psychology or counselling), as for higher level courses, I imagine this would be where they sit.

The courses below are in outline form. There are many problems with what is written below, but I hope this can add to the discussion.

Penny
<table>
<thead>
<tr>
<th>Title</th>
<th>Certificate of Attendance (Pre-Therapy Contact Reflections)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry requirements</td>
<td>none</td>
</tr>
<tr>
<td>Level</td>
<td>1</td>
</tr>
<tr>
<td>Credit rating</td>
<td>0</td>
</tr>
<tr>
<td>Course length or equivalent</td>
<td>6 hours or less</td>
</tr>
<tr>
<td>Method of delivery</td>
<td>One day</td>
</tr>
<tr>
<td><strong>Aim</strong></td>
<td>To introduce basic concepts of Pre-Therapy with a focus on the use of contact reflections</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>The course will &lt;ul&gt;&lt;li&gt;Introduce central concepts of Pre-Therapy: levels of expressiveness, contact functions, contact reflections and contact behaviours&lt;/li&gt;&lt;li&gt;Allow participants an opportunity to discuss the potential use of contact reflections in their own practice&lt;/li&gt;&lt;li&gt;Enable participants to locate Pre-Therapy contact reflections in relation to the person centred philosophy&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td><strong>Learning Outcomes</strong></td>
<td>Participants will be able to: &lt;ul&gt;&lt;li&gt;Demonstrate an understanding of the differences between expressive and pre-expressive states&lt;/li&gt;&lt;li&gt;Demonstrate an ability to use contact reflections&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>&lt;ul&gt;&lt;li&gt;Origins of Pre-Therapy&lt;/li&gt;&lt;li&gt;The Pre-Expressive self, expressive self and grey zone functioning&lt;/li&gt;&lt;li&gt;Contact functions&lt;/li&gt;&lt;li&gt;Contact reflections&lt;/li&gt;&lt;li&gt;Contact behaviours&lt;/li&gt;&lt;li&gt;Basic principles of the Person Centred Approach&lt;/li&gt;&lt;/ul&gt;</td>
</tr>
<tr>
<td><strong>Teaching and learning strategies</strong></td>
<td>&lt;ul&gt;&lt;li&gt;Presentation of theoretical material&lt;/li&gt;&lt;li&gt;Demonstration of contact reflections&lt;/li&gt;&lt;li&gt;participation in role play&lt;/li&gt;&lt;li&gt;Group discussion&lt;/li&gt;&lt;/ul&gt; Teaching and learning strategies may vary according to local delivery</td>
</tr>
<tr>
<td><strong>Method of Assessment</strong></td>
<td>none</td>
</tr>
<tr>
<td><strong>Indicative Reading</strong></td>
<td></td>
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</tbody>
</table>

Appendix 21
<table>
<thead>
<tr>
<th>Title</th>
<th>Basic certificate (Pre-Therapy contact reflections)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry requirements</td>
<td>People will normally be working in a health or social care setting working with people with mental health issues, learning disabilities, or physical care needs</td>
</tr>
<tr>
<td>Level</td>
<td>1</td>
</tr>
<tr>
<td>Credit rating</td>
<td>0</td>
</tr>
<tr>
<td>Course length or equivalent</td>
<td>6-12 hours or equivalent</td>
</tr>
<tr>
<td>Method of delivery</td>
<td>This course will be delivered on more than one day. This allows the participant to use contact reflections in their own practice prior to the follow up session.</td>
</tr>
<tr>
<td>Aim</td>
<td>To introduce basic concepts of Pre-Therapy with a focus on the use of contact reflections and how these relate to the participants own work</td>
</tr>
<tr>
<td>Objectives</td>
<td>The course will</td>
</tr>
<tr>
<td></td>
<td>• Introduce central concepts of Pre-Therapy: levels of expressiveness, contact functions, contact reflections and contact behaviours</td>
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<tr>
<td></td>
<td>• Allow participants an opportunity to discuss the potential use of contact reflections in their own practice</td>
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<tr>
<td></td>
<td>• Enable participants to locate Pre-Therapy contact reflections in relation to the person centred philosophy</td>
</tr>
<tr>
<td></td>
<td>• Provide participants with an opportunity to discuss and reflect on their use of contact reflections in their own practice.</td>
</tr>
<tr>
<td>Learning Outcomes</td>
<td>Participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Demonstrate an understanding of the differences between expressive and pre-expressive states</td>
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<tr>
<td></td>
<td>• Demonstrate an ability to use contact reflections</td>
</tr>
<tr>
<td></td>
<td>• Reflect on their experience of using contact reflections in their own practice</td>
</tr>
<tr>
<td></td>
<td>• Report on their experience of noticing contact behaviours in response to contact reflections</td>
</tr>
<tr>
<td>Content</td>
<td>Origins of Pre-Therapy</td>
</tr>
<tr>
<td></td>
<td>The Pre-Expressive self, expressive self and grey zone functioning</td>
</tr>
<tr>
<td></td>
<td>Contact functions</td>
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<td></td>
<td>Contact reflections</td>
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<tr>
<td></td>
<td>Contact behaviours</td>
</tr>
<tr>
<td></td>
<td>Basic principles of the Person Centred Approach</td>
</tr>
<tr>
<td></td>
<td>Differentiating between contact reflections and other interventions or ways of communicating</td>
</tr>
<tr>
<td>Teaching and learning strategies</td>
<td>Presentation of theoretical material</td>
</tr>
<tr>
<td></td>
<td>Demonstration of contact reflections</td>
</tr>
<tr>
<td></td>
<td>Participation in role play</td>
</tr>
<tr>
<td></td>
<td>Group discussion</td>
</tr>
<tr>
<td></td>
<td>Teaching and learning strategies may vary according to local delivery</td>
</tr>
<tr>
<td>Method of Assessment</td>
<td>Students are invited to complete a multiple choice questionnaire.</td>
</tr>
<tr>
<td>Indicative Reading</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Extended Certificate : Pre-Therapy contact reflections</td>
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<tr>
<td>Entry requirements</td>
<td>People will normally be working in a health or social care setting working with people with mental health issues, learning disabilities, or physical care needs</td>
</tr>
<tr>
<td>Level</td>
<td>Level 1</td>
</tr>
<tr>
<td>Credit rating</td>
<td>0</td>
</tr>
<tr>
<td>Course length or equivalent</td>
<td>18+ hours or equivalent</td>
</tr>
<tr>
<td>Method of delivery</td>
<td>This course requires a minimum of two periods of practice between the taught content.</td>
</tr>
<tr>
<td>Aim</td>
<td>To introduce basic concepts of Pre-Therapy with a focus on the use of contact reflections and how these relate to the participants own work</td>
</tr>
<tr>
<td>Objectives</td>
<td>The course will</td>
</tr>
<tr>
<td></td>
<td>• Introduce central concepts of Pre-Therapy: levels of expressiveness, contact functions, contact reflections and contact behaviours</td>
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<tr>
<td></td>
<td>• Allow participants an opportunity to discuss the potential use of contact reflections in their own practice</td>
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<tr>
<td></td>
<td>• Enable participants to locate Pre-Therapy contact reflections in relation to the person centred philosophy</td>
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<td></td>
<td>• Provide participants with an opportunity to discuss and reflect on their use of contact reflections in their own practice</td>
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<tr>
<td></td>
<td>• Allow participants to receive feedback</td>
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<tr>
<td>Learning Outcomes</td>
<td>Participants will be able to</td>
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<tr>
<td></td>
<td>• Demonstrate an understanding of the differences between expressive and pre-expressive states</td>
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<td></td>
<td>• Demonstrate an ability to use contact reflections</td>
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<tr>
<td></td>
<td>• Report on their experience of noticing contact behaviours in response to contact reflections</td>
</tr>
<tr>
<td></td>
<td>• Reflect on their experience of using contact reflections in their own practice</td>
</tr>
<tr>
<td>Content</td>
<td>• Origins of Pre-Therapy</td>
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<tr>
<td></td>
<td>• The Pre-Expressive self, expressive self and grey zone functioning</td>
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<td></td>
<td>• Contact functions</td>
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<td>• Contact reflections</td>
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<td></td>
<td>• Contact behaviours</td>
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<tr>
<td></td>
<td>• Basic principles of the Person Centred Approach</td>
</tr>
<tr>
<td></td>
<td>• Differentiating between contact reflections and other interventions or ways of communicating</td>
</tr>
<tr>
<td>Teaching and learning strategies</td>
<td>• Presentation of theoretical material</td>
</tr>
<tr>
<td></td>
<td>• Demonstration of contact reflections</td>
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<tr>
<td></td>
<td>• Participation in role play</td>
</tr>
<tr>
<td></td>
<td>• Group discussion</td>
</tr>
<tr>
<td></td>
<td>Teaching and learning strategies may vary according to local delivery</td>
</tr>
<tr>
<td>Method of Assessment</td>
<td>• Students are invited to complete a multiple choice questionnaire.</td>
</tr>
<tr>
<td></td>
<td>• Participants will provide a reflective account of their use of the contact reflections</td>
</tr>
<tr>
<td></td>
<td>• Participants will be observed in practice by a colleague or peer</td>
</tr>
<tr>
<td></td>
<td>• The colleague or peer will provide the participant with a written account of the observation</td>
</tr>
<tr>
<td>Indicative Reading</td>
<td></td>
</tr>
<tr>
<td><strong>Title</strong></td>
<td>Diploma in Pre-Therapy (contact reflections)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Entry requirements</strong></td>
<td>People will normally be working in a health or social care setting working with people with mental health issues, learning disabilities, or physical care needs</td>
</tr>
<tr>
<td><strong>Level</strong></td>
<td>2 (undergraduate level)</td>
</tr>
<tr>
<td><strong>Credit rating</strong></td>
<td>60</td>
</tr>
<tr>
<td><strong>Course length or equivalent</strong></td>
<td>30 days + or equivalent</td>
</tr>
<tr>
<td><strong>Method of delivery</strong></td>
<td>This course will normally be delivered over 1 year. This course requires a minimum of two periods of practice between the taught content.</td>
</tr>
<tr>
<td><strong>Aim</strong></td>
<td>The course will allow participants to develop their skills in contact reflections and their knowledge of Pre-Therapy in relation to their own practice</td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>The course will:</td>
</tr>
<tr>
<td></td>
<td>• Provide an outline of Pre-Therapy in relation to other approaches in psychotherapy practice</td>
</tr>
<tr>
<td></td>
<td>• Enable participants to locate Pre-Therapy contact reflections in relation to the person centred philosophy</td>
</tr>
<tr>
<td></td>
<td>• Introduce central concepts of Pre-Therapy: levels of expressiveness, contact functions, contact reflections and contact behaviours</td>
</tr>
<tr>
<td></td>
<td>• Provide participants with an opportunity to discuss, reflect and analyse their use of contact reflections in their own practice</td>
</tr>
<tr>
<td></td>
<td>• Allow participants to receive feedback</td>
</tr>
<tr>
<td></td>
<td>• Provide the participant with the opportunity to integrate theoretical knowledge of the person centred approach to their own practice</td>
</tr>
<tr>
<td></td>
<td>• Provide participants with an opportunity to discuss how they can introduce contact reflections to others in their work setting</td>
</tr>
<tr>
<td><strong>Learning Outcomes</strong></td>
<td>Participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Locate Pre-Therapy in relation to existing approaches in psychotherapeutic practice</td>
</tr>
<tr>
<td></td>
<td>• Demonstrate an understanding of the theoretical foundations of Pre-Therapy</td>
</tr>
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<td></td>
<td>• Demonstrate an understanding of the differences between expressive and pre-expressive states</td>
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<td></td>
<td>• Demonstrate an ability to use contact reflections</td>
</tr>
<tr>
<td></td>
<td>• Reflect and analyse their experience of using contact reflections in their own practice in relation to contact functions, contact behaviours</td>
</tr>
<tr>
<td></td>
<td>• Reflect and analyse their experience of differentiating between using contact reflections and other therapeutic approaches</td>
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<tr>
<td></td>
<td>• Provide information about the use of contact reflections in relation to the specific clients/client groups.</td>
</tr>
<tr>
<td></td>
<td>• Disseminate information about contact reflections to colleagues</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>• Theoretical foundations of Pre-Therapy</td>
</tr>
<tr>
<td></td>
<td>• Key principles of Rogerian Person centred Therapy and Existential Phenomenology (Rogers, Gendlin, Merleau Ponty, Buber)</td>
</tr>
<tr>
<td></td>
<td>• Pre-Expressive self, expressive self and grey zone functioning</td>
</tr>
<tr>
<td></td>
<td>• Contact functions</td>
</tr>
<tr>
<td>Teaching and learning strategies</td>
<td>Method of Assessment</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| • Presentation of theoretical material to peers  
• Demonstration of contact reflections  
• Participation in role play  
• Group discussion  
• Participant led seminars  
Teaching and learning strategies may vary according to local delivery | • Participants will be observed in practice by a colleague or peer  
• The colleague or peer will provide the participant with a written account of the observation  
• Participants will complete an assessment which demonstrates theoretical knowledge of Pre-Therapy and the application of the contact reflections in practice with a specific client or client group.  
Method of assessment may vary locally. Where the Diploma is linked to an Institution of Higher Education, the assessment will reflect the assessment requirements for an undergraduate diploma. For example in the UK, 60 credits at level 2 are required. Assessments will be marked at academic level and reviewed by someone with substantial experience in Pre-Therapy | Achievement of the diploma will enable participants to deliver the following courses:  
• Certificate of attendance (Pre-Therapy contact reflections)  
• Basic certificate (Pre-Therapy contact reflections) |
<table>
<thead>
<tr>
<th>Title</th>
<th>Advanced Diploma in Pre-Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry requirements</td>
<td>Participants will normally be working in a role that includes psychotherapeutic or psychotherapy practice. Participants will have experience of working from a theoretical perspective of psychotherapy. Participants will be receiving supervision on their psychotherapy or psychotherapeutic practice.</td>
</tr>
<tr>
<td>Level</td>
<td>2</td>
</tr>
<tr>
<td>Credit rating</td>
<td>? (level 3 or Masters level)</td>
</tr>
<tr>
<td>Course length or equivalent</td>
<td>Minimum 1 year. This includes study, practice and supervision</td>
</tr>
<tr>
<td>Method of delivery</td>
<td>extensive</td>
</tr>
<tr>
<td>Aim</td>
<td>This course allows those working in a counselling, psychotherapy, psychotherapeutic role to integrate Pre-Therapy into their existing practice.</td>
</tr>
<tr>
<td>Objectives</td>
<td>The course will:</td>
</tr>
<tr>
<td></td>
<td>• Provide an outline of Pre-Therapy in relation to other approaches in psychotherapy practice</td>
</tr>
<tr>
<td></td>
<td>• Enable participants to locate Pre-Therapy contact reflections in relation to the person centred philosophy and other models of psychotherapy</td>
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<td></td>
<td>• Introduce central concepts of Pre-Therapy: levels of expressiveness, contact functions, contact reflections and contact behaviours</td>
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<tr>
<td></td>
<td>• Provide participants with an opportunity to discuss, reflect and analyse their use of contact reflections in their own practice</td>
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<tr>
<td></td>
<td>• Allow participants to receive feedback</td>
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<td></td>
<td>• Provide the participant with the opportunity to integrate theoretical knowledge of the person centred approach to their own practice</td>
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<td></td>
<td>• Provide participants with an opportunity to discuss how they can introduce contact reflections to others in their work setting</td>
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<tr>
<td>Learning Outcomes</td>
<td>Participants will be able to:</td>
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<tr>
<td></td>
<td>• Demonstrate an understanding of the theoretical foundations of Pre-Therapy</td>
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<tr>
<td></td>
<td>• Demonstrate an understanding of the differences between expressive and pre-expressive states</td>
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<tr>
<td></td>
<td>• Demonstrate an ability to use contact reflections</td>
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<tr>
<td></td>
<td>• Reflect and analyse their experience of using contact reflections in their own practice in relation to contact functions, contact behaviours</td>
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<tr>
<td></td>
<td>• Locate Pre-Therapy in relation to existing approaches in psychotherapeutic practice</td>
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<tr>
<td></td>
<td>• Reflect and analyse their experience of differentiating between using contact reflections and other therapeutic approaches</td>
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<td></td>
<td>• Analyse how contact reflections relate to their existing practice</td>
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<td></td>
<td>• Provide information about the use of contact reflections in relation to the specific clients/client groups.</td>
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<td></td>
<td>• Disseminate information about contact reflections to colleagues</td>
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<tr>
<td>Content</td>
<td>• Theoretical foundations of Pre-Therapy</td>
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<tr>
<td></td>
<td>• Key principles of Rogerian Person centred Therapy and Existential Phenomenology (Rogers, Gendlin, Merleau Ponty, Buber)</td>
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<tr>
<td></td>
<td>• Central concepts of Pre-Therapy: levels of expressiveness, contact functions, contact reflections, contact behaviours</td>
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<tr>
<td></td>
<td>• Research base of Pre-Therapy in relation to different client</td>
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<tr>
<td>Teaching and learning strategies</td>
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<tr>
<td>- Pre-Therapy as contact work and Pre-Therapy as part of a psychotherapy or psychotherapeutic approach</td>
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<tr>
<td>- Presentation of case material to peers</td>
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<td>- Group discussion</td>
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<tr>
<td>- Role play and demonstration of contact reflections</td>
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<td>- Teaching and learning strategies may vary according to local delivery</td>
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<thead>
<tr>
<th>Method of Assessment</th>
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<tbody>
<tr>
<td>- Participants will complete peer and self assessments</td>
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<tr>
<td>- Participants will complete a written case study which demonstrates the integration of Pre-Therapy to their own practice</td>
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<tr>
<td>- Participants will submit a written summary from supervisor</td>
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<thead>
<tr>
<th>Indicative Reading</th>
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<tbody>
<tr>
<td>Additional Information</td>
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<tr>
<td>PERSON</td>
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<td>--------------------------------------------</td>
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<tr>
<td>People with dementia</td>
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<tr>
<td>Staff participants</td>
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<tr>
<td>Relatives</td>
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<tr>
<td>Ward managers</td>
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<tr>
<td>Old Age Psychiatrists (Responsible Medical</td>
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<tr>
<td>Officers)</td>
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<tr>
<td>Shift coordinators</td>
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<tr>
<td>Directorate manager</td>
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<tr>
<td>Service manager</td>
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<tr>
<td>Garry Prouty</td>
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<tr>
<td>Pre-Therapy Network Members</td>
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<tr>
<td>PhD supervisors</td>
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<tr>
<td>University colleagues</td>
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