

Authoring the Narrative Self in Dementia Care. A Bakhtinian Perspective

This article examines the co-creation of narrative self in dementia care and the therapist's expertise in the process. Applying Bakhtin's theory of dialogue as the analytical framework, videotaped data were collected through interviews with an experienced occupational therapist as well as direct observation of his care sessions with two women with Alzheimer's disease in a Japanese nursing home, before they were qualitatively analysed. The result indicated that the therapist created three kinds of voices: the voice of the person's self, the voices of the actual others, and the voices of the imagined others towards the person. The women actively responded to the voices, jointly created possible and positive selves, and were able to achieve therapeutic activities. As a polyphonic author, the therapist intentionally produced the voices for therapeutic engagement thereby giving appropriate meaning to the therapy, building relationships with others, and expressing the persons' hope for the therapy, for others, and for themselves.

1. Introduction:

Perspectives on Narrative Collaboration in Dementia

Narrative is one of the most ubiquitous and powerful discourse forms for making sense, structuring action, and constructing self-identity (cf. Bruner 1990, Polkinghorne 1988). Although dementia is a multiple cognitive impairment including difficulty with language and memories, previous studies have shown that persons with dementia and conversational partners such as their spouses can jointly create various narratives (cf. Hydén 2011, 2013, Hydén et al. 2013, Kemper et al. 1995, Mok / Müller 2014, Ramanathan 1997, Usita et al. 1998) along with construction of the persons' selves (cf. Hydén / Örluy 2009, McLean 2006, Ramanathan 1997). These studies shed light on the collaborative creation of narrative, the effect of interlocutor's scaffolding, and the potential for supporting the persons' well-being and identities (cf. Kindell et al. 2017) which are embedded in their social lives.

On the other hand, less research has been conducted on the therapist's expertise in creating narratives and the person's sense of self. For example, "to keep patient talk on track" (Ramanathan 1997, 123), Ramanathan suggested "some interventionist strategies" (ibid., 121) of caregivers such as "developing listening skills" (ibid., 121), "learning to ask open-ended questions" (ibid., 123) and "monitoring one's uses of continuity / discontinuity elements" (ibid.) such as affirmations and newsmarkers or extended pauses. Based on the sociolinguistic point of view, Hamilton (like Ramanathan) mentions the importance of caregivers' "scaffolding" including "guiding questions, cooperative overlap

(Tannen 1989), or completed utterances” (Hamilton 2008, 79) to extend narrative in Alzheimer’s care. Both of them focus on the caregiver’s verbal feedback as means to facilitate the conversation with the persons with Alzheimer’s Disease (AD) but as a narrative joint formation, it is still unknown how these practices contribute to the actual conversation between the persons and the therapist. With this regard Hydén (2011) analyses the conversation between a person with AD and his partner and identifies the process of collaborative storytelling as “narrative scaffolding” based on the idea of Jerome Bruner (cf. Wood et al. 1976). In narrative scaffolding, “two tellers contribute to the story, although one of the storytellers assumes more responsibility both for elaborating and pursuing the storyline as well as for organizing the interaction” (Hydén 2011, 346). For example, when the person with AD faces difficulties solving the narrative tasks given by the interviewers, his partner helps him using verbal ‘repair’ (cf. Schegloff et al. 1977) strategies such as paraphrasing, repetition and clarification of his utterances or visual cues such as gestures (cf. Hydén 2011, 2013). However, these studies are applied in contexts in which one of the interlocutors is a family caregiver and the interviews are prepared by the researchers, like in the cases of Ramanathan and Hamilton. In the nursing homes, health professionals care for and interact with the persons with dementia every day, but the impact of therapists’ intervention and expertise is seemingly still unexplored in the literature. In Hydén and Örvu’s study of narrative interaction (2010), they analyse the conversation between the residents with AD and the assistant nurses in a Swedish elder centre. Although they demonstrate the contribution of scaffolding from the nurses in the residents’ storytelling, they mainly focus on their narrative structures and thus, the nurses’ expertise and knowledge of narrative co-construction is left undiscussed. Some researchers have also described narrative joint formation between health professionals and the persons with AD using positioning theory as an analytic framework and found the importance of the professionals’ roles in the co-construction of narrative self (e.g. Hedman et al. 2014, Hyvärinen / Watanabe 2017). Still, the professional expertise in narrative use is not fully discussed because of the emphasis on the self-positioning of the persons with dementia themselves.

2. Bakhtin’s Theory of Dialogue and Polyphonic Authorship: Its Contribution to Care Relationship

To bring the professionals’ expertise in narrative co-construction to the fore, this paper focuses on Bakhtin’s dialogism. Bakhtin’s theory of dialogue is widely and variously argued in many scientific contexts and it has also been applied to the storytelling activity between the health professionals and patients (cf. Bowers / Moore 1997, Seikkula 2011, Puustinen 1999, Anderson 2008). One of the key points in his dialogism is that dialogue represents “a special sort of interaction” (Morson / Emerson 1990, 49), where both of the speaker and the

listener (or the writer and the reader) encounter several internal or external voices and jointly create the meaning of the world. Dialogue reflects many disparate ideas and thoughts and the self is crafted through the dialogue (cf. Morson / Emerson 1990).

In caring situations, Bakhtin's theory of dialogue "illustrates one of the most central features of nursing practice: the collaborative nature of self-other interaction" (Bowers / Moore 1997, 75). When the patient enters into dialogue, "the nurse is in a unique position to hear" the patient's story, "to hear what is spoken and unspoken, in body language, context, and configuration of meanings" (ibid.). That is, health professionals take a responsibility to create dialogue by listening and responding to the patients' voices as one of the authors of their story. Moreover, creating dialogue connects with self-construction, because dialogue contains various voices such as "another character, a conscience, one's inner thoughts, or an imagined other" (Anderson 2008, 225). Here, "the self is not a single entity, one voice or one position, but a multiplicity of each" (ibid.).

Bakhtin, in his essay on Dostoevsky (Bakhtin 1984), defines the role of the author as either monologic or polyphonic. When the monologic author controls the characters, they can't express their own thoughts and ideas free from the authorial discourse and nothing new will be discovered in their dialogue. By contrast, a polyphonic author doesn't control the characters and their "several consciousnesses meet as equals and engage in dialogue that is in principle unfinalizable" (Morson / Emerson 1990, 238-239). As a result, "a polyphonic author engages in dialogues that can always potentially create something genuinely new" as a "surprisingness" (ibid., 244).

In therapeutic context, while a monologic therapist becomes the only one who controls the interaction with patients and reduces their voices, a polyphonic therapist and patients mutually and equally participate in the dialogue. In a polyphonic interaction, the therapist encourages patients to speak in their own unique voices and also interweaves "the story of treatment" (Seikkula 2011, 183) into the narrative. To construct dialogic environment, the polyphonic therapist puts lots of effort into listening and responding to facilitate external and internal dialogues in a clinical situation (cf. Anderson 2008, Puustinen 1999). As patients and the polyphonic therapist actively engage in a dialogue, they can find new voices, unexpected potentials, or the self of the patients that was never expressed before, and consequently, they open a new direction in their communication. Thus, the dialogue becomes an open and changing process with help from the polyphonic therapist.

With the Bakhtinian idea of dialogue and a polyphonic author or therapist, health professionals can be seen as active respondents to patients' voices and creators of a dialogic environment. But how is this possible in dementia care? How can therapists achieve dialogic encounters with self-construction in storytelling activities as a part of their regular job? To examine this point, the following research questions were addressed: 1) What kinds of narratives were created in care sessions? 2) Regarding the person with AD, what kind of voices

and sense of self appeared in the narratives? and 3) What professional expertise did the therapist use to support the self-construction through narrative?

3. Methods

Observations and interviews were implemented to illuminate the narrative co-construction between the persons with Alzheimer's disease and their therapists. The study was carried out from 2004 to 2006 at a Japanese nursing home for elderly, which offered short-time rehabilitation for about 100 residents and visitors. Three occupational therapists and one care worker simultaneously provided care for the clients in the open-space therapy room and one of the therapists and research targets, Junichi Kawaguchi, the chief therapist, actively organized face-to-face and group interactions with them. The researcher mainly observed and videotaped his activities for 28 days (about 150 hours of videotapes) and interviewed him for eight hours.

Being an expert occupational therapist, Mr Kawaguchi worked for more than ten years as a therapist in the home and functioned as its Vice Director. He was widely known for creating plays with handicapped children and elderly people based on their life histories. After initial observation of his sessions, the researcher focused on two women with AD (Mrs N and Mrs O) because of their similarities concerning age, health conditions, and therapy exercises. Both Mrs N and Mrs O were diagnosed with advanced AD, had difficulties in communication and walking, lived out of a wheelchair, and regularly stayed at the home for two-week periods. They routinely underwent leg exercises including massages and walking exercise, and moreover, sometimes joined in the social activities such as group singing and conversations, but often refused to participate in them because of their symptoms and unfamiliarity with the situations.

The data were transcribed with the inclusion of utterances and body movements (gesture, eye gaze, etc.). The key interactions were collected from the transcripts and qualitatively analysed in reference to Bakhtinian approaches to narrative analysis (cf. Riessman 2008, Wortham 2001). One of the reasons why the researcher applied these methods is because they reveal how narrative is dialogically produced and especially, how narrative can interactively represent the self with respect to other voices. Although the persons with dementia are often at risk of being viewed as an incompetent storyteller because of lack of coherence and cohesion in speech (cf. Hydén 2011), narrative is considered as an unfolding storytelling activity including brief fragments from interlocutors in these approaches.

With the analysis, the selected cases were translated into English by the researcher. The linguistic and cultural characteristics of Japanese language such as elliptical expressions and connotations were repeatedly checked with another Japanese researcher and English proofreaders.

For the ethical perspectives, all participants, including the therapists and caregivers, elderly clients, and (if needed) their families granted permission for the implementation of the study. The researcher directly asked each participant of the study for permission and the occupational therapists also explained the research details to them every time. Since the research ethics committee wasn't established yet, the researcher directly got permission from each participant with the informed consent document (for more information about the study, see Watanabe 2016).

4. Results

4.1 Three Types of Voices

The result indicated that the therapist and the persons with AD jointly created multiple voices and narratives based on the voices in the sessions. Especially, Mr Kawaguchi improvisationally produced three kinds of voices: the voice of the person's self, the voices of the actual others, and the voices of imagined others in response to the persons' reactions. To demonstrate this, a twenty-minute long session with Mrs N taken from the data corpus will be examined and compared with one with Mrs O. The two cases are relatively similar in the length of their interactions and the main goal of the exercises, i.e. walking.

The voices were identified in reference to Bakhtin's idea of three categories of the self (cf. Bakhtin 1990, Morson / Emerson 1990). To describe the process of the self-construction in art and life, Bakhtin proposed three kinds of selves including "I-for-myself (how my self looks and feels to my own consciousness)" (Morson / Emerson 1990, 180) and "two categories of outside-ness and otherness, I-for-others (how my self appears to those outside it) and the reverse, the-other-for-me (how outsiders appear to my self)" (ibid.). In this study, the researcher categorized the voice of the person's self in reference to Bakhtin's idea of "I-for-myself," while the voices of the actual others and the ones of imagined others were based on "I-for-others" to see how the selfhood is established in relation to the voices of him / herself and others.

4.2 The Voice of the Person's Self

Among the three types of voices, the voice of the person's self express the person's perspectives on him / herself. They indicate the person's own feelings or ideas to him / herself. For example, from the beginning of their session, Mr Kawaguchi and Mrs N actively create the voice of the self in response to their utterances as below.

Excerpt 1: Showing a fine face¹

- (1) Therapist: Hello
- (2) Mrs N: Hello
- (3) Therapist: How are you?
- (4) Mrs N: Yes, I am fine
- (5) Therapist: Well, please show your fine face
- (6) Mrs N: I can't show my fine face any more
- (7) Therapist: Well [says gently; in local dialect] please show your lovely face
- (8) Mrs N: Oh it is a very lovely face
- (9) Therapist: [starts to massage her left leg]
- (10) Mrs N: {I}² want to laugh
- (11) Therapist: [looks at her] {You} want to laugh
- (12) Mrs N: {I} want to laugh
- (13) Therapist: When you want to laugh
- (14) Mrs N: Yes?
- (15) Therapist: It's better to laugh like this ha ha ha [demonstrates laughter]
- (16) Mrs N: No
- (17) Therapist: Well, smile ...
- (18) Mrs N: I dislike being laughed at very much
- (19) Therapist: Do you? Well, let's smile
- (20) Therapist: [leans his head to the right and left with a smile]
- (21) Mrs N: [leans her head to the right and left with a smile]
- (22) Therapist: [looks back at Mrs B.] Isn't she lovely?
- (23) Mrs B: [looks at the therapist and nods] She's lovely

As soon as Mr Kawaguchi comes to sit in front of Mrs N, he starts their interaction with exchanging daily greetings and with asking her condition (line 1 and 3). Mrs N has been sitting alone and shouting several times before he comes but quickly replies to him with positive answers (line 2 and 4). When he asks her to show her “fine face” (line 5), she immediately rejects it (line 6) and thus, he negotiates it with a different tone of voice including her local dialect and expressions as “lovely face” (line 7). She replies to him mentioning the “lovely face” (line 8) and suddenly tells him that she wants to laugh (line 10 and 12) when he massages her leg. Mr Kawaguchi repeats her words to clarify what she means (line 11) and suggests to laugh by practically showing how to laugh (line 15). She strongly rejects the suggestion because she takes his action as being laughed at (line 16 and 18) so he proposes another suggestion of “let's smile” (line 19) and they smile together with same bodily movement. Mr Kawaguchi also asks Mrs B, another woman with AD who is sitting next to them, about Mrs N's loveliness and Mrs B affirms it.

Throughout this excerpt, Mr Kawaguchi repeatedly tries to suggest that Mrs N shows a fine face. He asks it at least four times with different forms (line 5,7,15 and 19) according to her reactions. For example, when she rejects his comments, he immediately stops suggesting or changes it into other expressions (line 7,17 and 19). Meanwhile, when she suggests her idea (line 10 and 12), he immediately adopts and embodies it as a possible activity (15, 19 and 20). In other words, when Mrs N expresses her hope to laugh as the voice of

the person's self, the therapist immediately reacts and supports it. As a result, her image of the self changes from the negative person who doesn't express "a fine face" to the positive one who wants to smile. That is, Mrs N gradually changes her attitude from negation to acceptance of his suggestion and they create the voice of the person's self together. Moreover, the therapist continues to support it by eliciting the positive comments from another resident.

4.3 The Voices of the Actual Others

After Excerpt 1, the therapist tries to keep this positive image of herself using the voices of actual others in addition to the voice of the person's self. The voices of actual others express the perspectives of the others who exist here, such as other elderly residents and therapists in the room. In the following episode, right after the excerpt 1, the therapist picks up on Mrs B's comment about Mrs N.

Excerpt 2: Being lovely

(24) Mrs N: [shouts]

(25) Therapist: Mrs N

(26) Mrs N: Yes

(27) Therapist: {She said you} are lovely [in a local dialect]

(28) Mrs B: [smiles to Mrs N]

(29) Mrs N: WOW! GOOD [nods] THANK YOU! THANK YOU! THANK YOU SO MUCH! I'M GLAD! I'M GLAD! [nods³]

(30) Therapist: {You} are glad, aren't you?

(31) Mrs N: Yes, I'm glad [nods]

(32) Therapist: [nods]

(33) Mrs N: [blows raspberries]

Mrs N starts shouting as she did several times before the interaction with Mr Kawaguchi (line 24). Mr Kawaguchi calls her name and explains that Mrs B tells him that Mrs N is lovely when she smiles (line 27). He expresses it by imitating Mrs B's voice in a local dialect and it seemingly works out as the voices of actual others. At his words, Mrs N tells her appreciation to him in a loud voice (e.g. capitalized letters in line 29) and expresses her joyful feeling as the voice of the person's self. Mr Kawaguchi asks an affirmative question as to her feeling repeating her word, "glad" (line 30) and she confirms it by nodding.

Here, the voices are used to maintain Mrs N's positive image of herself. The lovely image of Mrs N is firstly suggested by the therapist (excerpt 1, line 22) but he presents it to Mrs N quoting Mrs B's voice. Since Mrs N positively accepts the voice, the therapist confirms her feeling using Mrs N's words, "glad", and again she describes herself as "glad". Thus, the positive self-image of Mrs N as a smiling and lovely woman is maintained and shared with others and Mrs N herself.

In other words, the therapist offers the affective relationship between two women with the voices of actual others. Before and in the beginning of the session, Mrs N and Mrs B sit separately and never talk to each other. However, the emergence of both of voices mediated by the therapist gives them a chance to meet and communicate with each other and turns the session into a multi-voiced environment.

The therapist continuously endeavours to preserve the positive and possible image of Mrs N using the voices. After excerpt 2, Mr Kawaguchi says to her, “Everyone here says, ‘they love you so much when you talk in a small voice’”. He suggests it three times using the voices of actual others, “everyone” (other residents in the same room), whenever Mrs N starts shouting. In this sense, the voices of “everyone loves quiet Mrs N” are created to inform the positive self of Mrs N without her behaviour problems. On the other hand, Mrs N reacts to his suggestions, saying “Oh! Do I?” and keeps shouting during their conversation. Then, she talks about few topics such as “keep going after failure” and “losing her hands”. Mr Kawaguchi listens attentively and tries to add a positive ending to each topic such as “let’s keep going” and “your hands have grown and turned back”. After the exchanges, Mr N shouts again and so he introduces the voices of “everyone” again as the following excerpt 3 shows.

Excerpt 3: Being loved by everyone

- (1) Mrs N: [shouts]
- (2) Therapist: [touches her right foot and smiles] Your voice
- (3) Mrs N: Yeah
- (4) Therapist: {Your voice} seemed loud [smiles]
- (5) Mrs N: The voice is loud
- (6) Therapist: [nods and smiles]
- (7) Mrs N: Sometimes I am loud and sometimes quiet
- (8) Therapist: [nods] In a small voice
- (9) Mrs N: Yes
- (10) Therapist: {If} Mrs N talks
- (11) Mrs N: Yes
- (12) Therapist: I heard that everyone loves you so much
- (13) Mrs N: Oh!
- (14) Therapist: What will you do?
- (15) Mrs N: I see
- (16) Therapist: Yes. What will you do? Of course...
- (17) Mrs N: [leans forward] {I} want to talk in a small voice.
- (18) Therapist: Yeah [nods]
- (19) Mrs N: In a small voice [nods] properly...
- (20) Therapist: {I} want to talk
- (21) Mrs N: Yes. Yes, yes, yes
- (22) Therapist: You want, after all, to be loved by everyone, don’t you?
- (23) Mrs N: Yes! Yes! [nods]
- (24) Therapist: Yes!
- (25–27 Therapist starts to mention her homecoming.)
- (28) Mrs N: Everyone, please love me!

- (29) Therapist: [smiles] Everybody, please love me!
 (30) Mrs N: Everyone, please love me!
 (31) Therapist: Yes, a smiling person is loved [smiles]
 (32) Mrs N: [smiles]

At first, Mr Kawaguchi addresses her problematic behaviour with physical contact (line 2 and 4). Mrs N stops shouting and paraphrases his words (line 5) and describes herself as “sometimes I am loud and sometimes quiet” (line 7) using the voice of the person’s self. To focus more on her loud voice, Mr Kawaguchi brings the voices of actual others into use again and suggests speaking in a small voice (line 12). Mrs N is surprised at his words (line 13), so he asks her what she will do about that (line 14). To his question, she expresses her will to “talk in a small voice” quoting his words (line 17) as the voice of the person’s self. Mr Kawaguchi replies affirmatively (line 18) and puts her requests into words (line 20). Mrs N gladly accepts it (line 21), so he paraphrases the topic that she wants to be loved by everyone, to clarify her motivation to talk in a small voice (line 22). Mrs N strongly agrees with it (line 23) and states her hope as “Everyone, please love me!” (line 28). The therapist repeats her words (line 29) and mentions that a smiling person is loved with a smile to embody her hope (line 31). Finally, Mrs N smiles together with him (line 32).

The first part of this excerpt displays some narrative structural elements (cf. Labov / Waletzky 1967). In the beginning, Mr Kawaguchi describes Mrs N’s problem providing information about a character (“your voice”) and situation (“loud”) in past tense (orientation, OR). According to his description, she positions herself as the neutral person between “loud” and “quiet” (evaluation, EV). The therapist adds another character (“everyone”) and situation (“loves you”) (OR). She reacts to it (EV), and they find the way to solve her problem by talking in a small voice (resolution).

In the latter part, the therapist focuses on Mrs N’s hope for being loved by everyone. The therapist originally introduces the idea of being loved by everyone as a paraphrased form of “everyone loves you”, but Mrs N puts it into words as her own request for everyone around her. It is the first time for her to comment on everyone during the session and in this sense, it seems that she becomes conscious of others’ points of view through the exchanges of the voices of actual others. Put differently, responding to the therapist’s voices, she constructs her ideal image as the person who talks quietly, smiles, and is being loved by everyone.

Her hope of being loved by everyone has been taken up by herself after excerpt 3. For example, she starts singing one traditional Japanese song, titled “Please love me” and Mr Kawaguchi joins in it. After singing, when he asks her to show a gentle face, she answers, “Please love me happily, when my face looks beautiful”. He agrees with her request and asks her to show a beautiful face, smiling. In both cases, Mrs N doesn’t directly mention the word “everyone” anymore but she actively expresses her hope of being loved to the thera-

pist for a certain period and he connects it with the collaborative activities such as smiling at each other.

4.4 The Voices of Imagined Others

After the communication with Mrs N using two kinds of voices, Mr Kawaguchi introduces the voice of Mrs N's son as the voice of an imagined other: the voice of someone not present. Like the voices of the actual others, it is used to exhibit others' points of view and give positive feedback to the person's appropriate activity. At first, Mr Kawaguchi applies the voices of her son to describe the son's positive reactions to her performance of the stand-up exercise in the story world. In the voice of her son, she faces the gap between the story world (doing the exercise) and the present situation (not doing the exercise) and decides to engage in the exercise to respond to the son's voice (for more detailed analysis of the case, see Watanabe 2016). After doing the exercise together, Mr Kawaguchi again introduces the son's voice to tell her the son's reactions to her implementation of the exercise in the real world in excerpt 4.

Excerpt 4: Being great

- (1) Mrs N: [blows raspberries]
- (2) Therapist: Mrs N [touches her left foot]
- (3) Mrs N: [blows raspberries]
- (4) Therapist: if you do such an exercise
- (5) Mrs N: [nods]
- (6) Therapist: Your son will be happy, surely
- (7) Mrs N: Is that so?
- (8) Therapist: {The son} says, "My mother is great!" [nods and smiles]
- (9) Mrs N: [smiles] "My mother is great!"
- (10) Therapist: [smiles and points at her with his finger] {He} says, "My mother is great!"
- (11) Mrs N: THANK YOU! THANK YOU! ANTS SLEPT IN THE RICE FIELD!
- (12) Therapist: [laughs]
- (13) Mrs N: [laughs]

When Mr Kawaguchi calls her name and told her son's happy reaction (line 2, 4 and 6), Mrs N stops making noise and listened carefully (line 5). She asks about the son's response to make sure of it (line 7) and the therapist answers to praise her in her son's voice (line 8). Mrs N happily repeats his words (line 9) and then the therapist tells it to her again with bodily movements (line 10). She shows her gratitude to the therapist or her son and mentions the ants in the rice field⁴ (line 11). In reaction to her sudden words, the therapist laughs and she sympathetically laughs, too (line 12 and 13).

Here, the voice of her son helps her to make sense of the therapeutic activities. She usually isn't willing to do the stand-up exercise because of the foot

problem and cognitive impairment but the use of his voice motivates her to participate in the treatment⁵. Although her son doesn't make a comment on her activity at that time, the therapist creates his possible voice based on the interview with her family and her attitude towards the son⁶. In this sense, the voices of imagined others are the therapist's invention but seemingly reflect the person's and her family's hopes to some extent.

4.5 Co-Creation of the Voices by the Participants

Overall, the uses of three kinds of voices are found in sessions with both Mrs N and Mrs O (Table 1). The two women actively create the voices of their respective selves and Mr Kawaguchi tends to repeat them to clarify what the respective person with AD wants to say. Regarding the voices of actual and imagined others, he introduces these voices according to the persons' utterances or therapeutic activities and then Mrs N and Mrs O repeat or re-create them. While the therapist frequently forms the voices of actual others (11 times for Mrs N and six times for Mrs O), the persons themselves create the voices of imagined others by responding to their familiar person in the story world or remembering their past experiences. In every case, the therapist creates the voices according to the reactions of the persons with AD. Therefore, the use of these voices seems to be a joint endeavour between the therapist and the persons to create dialogical sessions with multiple voices.

Voices		Session 1		Session 2	
		Mrs N	Therapist	Mrs O	Therapist
The person's self		20	9	10	3
Actual others	Resident	0	4	1	3
	Everyone	0	7	0	3
Imagined others	Son	2	4	0	0
	Grandchild	0	0	0	1
	Head teacher	0	0	3	3

Table 1: Number of the voices in each session

4.6 Behind Co-Creation of the Voices: The Therapist's Expertise in Creating Coices and Narrative

What ideas or reasoning does the therapist have concerning the co-creation of the voices? In the interviews with Mr Kawaguchi, some of the therapist's thoughts are presented. To gain knowledge about each person, the therapist

firstly collects the person's background information from the social worker, the caregivers, and their family, including their medical history, life history, and the relationship with their family, and other residents, before the session. Based on the information, he sets various goals or questions for his therapy. In the case of Mrs N, when the researcher asks him about the impression that Mrs N makes to him, he mentions her shouting behaviour as the target of his treatment as follows:

Extract 1: Mrs N's shouting problem⁷

Therapist: Her [Mrs N's] peripheral symptom was shouting [...]. When she shouted, her family probably told her, "Be quiet!" [...]. Other residents were annoyed with her, but they didn't know how to stop it except for being angry at her. At this rate, she will get on the residents' bad side. Moreover, she could be aware of their reactions. But, there were some reasons why she shouted. Yes, there were reasons why she did it [...]. Perhaps, it [her problematic behaviour] was an activity to make up for what's missing in herself but ... I hoped that we could find another means to make up for it. That was my underlying idea for creating storytelling⁸ with her.

In the earlier part of his comment, he describes her shouting in relation to her family and other residents and sees that it is a problem to be dealt with by the therapist. That is, he intends for Mrs N to stop shouting so that she can live happily with her family and other residents through therapeutic interventions. In practice, the therapist's intentions are partly observable in the excerpts above. For example, when she shouts or makes a noise, Mr Kawaguchi starts the conversations with her by suggesting that she show her fine face (excerpt 1) and talk quietly (excerpt 3), or by giving her positive feedback on her smile (excerpt 2); therefore, she can express her hopes and stop or change her problematic behaviour by seeing it from other people's point of view.

Later, he mentions the need to find out why Mrs N shouts and the intention of making the stories for her. He says that he creates the stories so that he can determine her problematic behaviour and find a solution for her problem. Right after this comment, he tells the researcher that he can't discover her reasons after all, but at least, he seems to apply narrative co-creation as one of his strategies to unearth them.

In addition to the joint narrative formation, Mr Kawaguchi reports that he employs other strategies for the ongoing therapeutic interventions (Watanabe 2016). One of them is to create characters that are familiar to the persons, and in extract 2, he explains how he introduces the characters and himself.

Extract 2: Creation of characters for the person with AD

Therapist: I never introduce myself to Mrs O as an occupational therapist named Kawaguchi.

Researcher: Hmm... How did you introduce yourself to her?

Therapist: Young man.

Researcher: Young man.

Therapist: Your [her] grandson or son

Researcher: OK. Did you do it from day one?

Therapist: Because she called me like this, I switched to it, became the person who was close to her, and started to make contact.

Researcher: Oh, yeah.

Therapist: But, I did it on purpose.

Mr Kawaguchi states that he intentionally plays the characters to make the communication smoother. In fact, he often uses the voice of Mrs O's grandson in the beginning of her session, and she starts to talk with a smile. For Mrs N, he applies the son's voice, as mentioned in excerpt 4. In this regard, his roleplay seemingly triggers the use of voices of imagined others in their interactions and makes the therapy session dialogical. Moreover, he changes the therapist's position from a medical authority to a familiar person who can interact with them as equals. In another interview, he gives an example of one elderly woman with AD called "Mum" by all therapists and happily accepts her role in the home. He acknowledges: "To call our residents 'Mum' is kind of a 'Don't' in our job". However, "to make her situation comfortable and understandable and respond to her family's request", he believes that changing himself by playing various roles and assigning the familiar roles to the persons with AD is meaningful with regard to having a better relationship with them.

With these strategies, the therapist enables the persons with AD to meet others' voices and to create their own ones. To create such situations, he also holds strong views on his role in reacting to persons with AD:

Extract 3: Reacting to persons with AD

Therapist: Also, they [the persons] can show signs and kinds of actions towards others. But because of the weakness of their signs and signals, no one can notice them. So I want to notice them. When I notice and react to them, they probably become happy and repeat it [my response]. I believe so [...]. In reality, I saw such cases many times [...]. Sometimes {their expressions} may include voicing, shouting in some cases, or laughing heavily. I want to react to them as much as possible. It's not like the situation that we just enjoyed it saying, "Oh, she's laughing!" But if we genuinely react to her, well... something may happen next. I have learned it from many cases.

Here, Mr Kawaguchi talks about his perspective on the expressions in persons with AD and the importance of reacting to them as a therapist. He sees the persons as active respondents to others with their own expressions, and that's why he hopes to realise and react to them. Concerning reacting, he later rephrases it as the activity "to catch, interpret, and verbalise" (Watanabe 2016, 130) the persons' reactions in the interview. In this regard, his idea of reacting to the persons with AD seems to correspond to the idea of a polyphonic author creating several voices by listening and responding to the characters' voices and engaging in a dialogue.

During the observation, the therapist quickly reacts to the persons' each utterance or action, and, therefore, most of their interactions are identified as a form of turn-taking. In the process of turn-taking, the persons can have longer interactions with Mr Kawaguchi, compared to those with other therapists in each session.

5. Conclusions and Discussion

It was shown that the therapist introduced multilevel voices towards the persons with AD, such as the voice of the person's self, the voices of actual others, and the voices of imagined others. In response to the voices, the persons actively positioned themselves in their familiar social roles, played roles in the narratives, constructed possible and positive selves, and achieved therapeutic activities that they were not capable of before the sessions. From a Bakhtinian perspective, the therapist, as a polyphonic author, continuously responded to the persons' voices and actions and created voices for therapeutic engagement in order to give appropriate meaning to the therapy, to build relationships with others, and to express the persons' hopes for the therapy, others, and themselves. The therapist produced the voices based on the persons' background information and on his intentions to create the characters and react to them.

In a polyphonic work, the therapist himself participates in the dialogue and encounters the person's new voices. To discover the voices, the polyphonic author listens to the "voices still weak, ideas not yet fully emerged, latent ideas heard as yet by no one but himself, and ideas that were just beginning to ripen, embryos of future worldviews" (Bakhtin 1984, 90). In the case of Mrs N, Mr Kawaguchi stated that he wanted to notice her weak signs, so he carefully listened to and elaborated on her voices and found new ones indicating the need to be loved by everyone. In other words, he listened to her hidden but possible voices and made them explicit in order to share them with others and to portray her ideal image that was embedded in social relationships in the past and present. Compared to other strategies for facilitating a conversation, such as narrative scaffolding (cf. Hydén 2011) and revoicing (cf. O'Connor / Michaels 1993), the therapist's discovery of unexpected voices is one of the distinct features.

Focussing on the therapist's role as a polyphonic author has much potential towards elucidating the therapist's expertise in the co-creation of a narrative about the person's self. It also facilitates a shift from viewing persons with AD as silent and voiceless patients to seeing them as active participants who have their own unique voices in the session. Applying Bakhtin's dialogical approach, dementia care can be seen as a creative and collaborative process in which the person's new voices are mutually explored and constructed.

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¹ This excerpt was already analysed by different research approaches (Hyvärinen/Watanabe 2017, Watanabe 2016).

² Braces are used to indicate the omitted subject in the sentence.

³ Nodding normally means positive affirmation in Japanese.

⁴ Her comments on "ants" ("ari" in Japanese) may come in association with the word "thank you" ("arigatou") because of phonetic similarity in Japanese. Also, her words "rice field" may reflect her past identity as a farmer (Hyvärinen/Watanabe 2017), but there is not enough evidence for that in this study.

⁵ In the session, Mrs N did the stand-up exercise twice after the co-creation of narratives about "the letter from her son" and "the negotiations on vegetables and fruits" including the voice of her son.

⁶ In the interview, the therapist told her that he knew that her son cared about her and that she loved her son and daughter and thought about them so much through the communication with them.

⁷ All extracts in this section (extracts 1, 2, and 3) were studied from a different viewpoint in Watanabe (2016).

⁸ In this interview, his "storytelling" basically means the co-creation of two narratives of "the letter from her son" and "the negotiations on vegetables and fruits."