LISTENING TO THE VOICES OF DEMENTIA

THE THERAPIST’S TEACHING-LEARNING PROCESS THROUGH CO-CONSTRUCTION OF NARRATIVE AND THE TRIADIC RELATIONSHIP WITH ALZHEIMER’S DISEASE SUFFERERS

Ryoko Watanabe
RYOKO WATANABE

LISTENING TO THE VOICES OF DEMENTIA
The therapist’s teaching-learning process through co-construction of narrative and the triadic relationship with Alzheimer’s disease sufferers

Academic dissertation to be presented with the assent of the Doctoral Training Committee of Human Sciences of the University of Oulu for public defence in Kaljusensali (KTK112), Linnanmaa, on 11 March 2016, at 12 noon
Watanabe, Ryoko, Listening to the voices of dementia. The therapist's teaching-learning process through co-construction of narrative and the triadic relationship with Alzheimer’s disease sufferers
University of Oulu Graduate School; University of Oulu, Faculty of Education
University of Oulu, P.O. Box 8000, FI-90014 University of Oulu, Finland

Abstract

In dementia care, it has been widely recognized that not only providing medical treatment, but also building an appropriate care relationship between medical professionals and the persons with dementia is one of the keys for understanding the person’s needs and for developing their residual physical and mental abilities. However, there has been little discussion about the meanings and contexts of the care relationship and the role of the therapeutic tools used and the therapist’s expertise in establishing it. To examine these points, the following research questions were addressed: 1) as a mediating tool in the care relationship, what kinds of narratives were created through everyday interaction between therapists and dementia sufferers? 2) how and why were narratives constructed? 3) what is the teaching-learning process of the therapist through narrative joint formation?, and consequently, 4) what is the relationship in dementia care?

The data was collected from interviews with one experienced occupational therapist and observations of his care sessions with two Alzheimer’s disease (AD) sufferers in a Japanese nursing home for two years. Their interactions and narratives were transcribed and qualitatively analysed based on Vygotsky's cultural-historical approaches and Bakhtin’s theory of dialogue in education as a theoretical framework.

The results have shown that the therapist jointly created narratives and a triadic relationship between the AD sufferers, the narratives, and himself. Using the narratives, he arranged a dialogical environment where the AD sufferers could express their own voices and encounter the voices of others. This enabled them to learn the meaning of their therapeutic activity in connection to their own life experience. As cognitive/psychological tools, the narratives worked towards a teaching-learning process and helped to establish the care relationship.

Through the co-construction of narratives and the triadic relationship, the therapist listened to the AD sufferers’ voices carefully, participated in an open ended and unfinalisable dialogue himself with them, and confronted them as equal respondents. In this sense, the therapist is seen as a dialogic teacher who actively learns knowledge and ideas from the dementia sufferers and unceasingly explores unknown questions in narratives with them.

Keywords: dementia, dialogue, Japan, narrative, nursing home, therapy
Dementian hoidossa on laajalti tiedottettu, että lääkehoidon ohella hyvän hoitosuhteen muodostaminen hoitoenhenkilöstön ja potilaan välille on avainkysymys potilaan tarpeiden ymmärtämiseksi ja käytettävissä olevien fyysisten ja henkisten kykyjen hyödyntämiseksi. Tästä huolimatta on ollut hyvin vähän keskustelua hoitosuhteen merkityksistä ja konteksteista, kuten myös erilaisten työvälineiden roolista ja terapeutin asiantuntijuudesta luoda niitä. Näiden seikkojen tarkastelumiseksi asetettiin seuraavat tutkimuskysymykset: 1) millaisia narratiiveja hoitosuhteen välittävänä työkaluna luotiin terapeutin ja dementiapotilaiden päivittäisessä vuorovaikutuksessa, 2) miten ja miksi narratiiveja konstruoitiin, 3) millainen on terapeutin opettamis- ja oppimisprosessi yhteisessä narratiivin muodostamisessa ja näin ollen, 4) millainen on dementian hoitosuhde?

Aineisto koottiin haastattelemalla kokenutta toimintaterapeuttia ja havainnoimalla hänen terapiaistuntojaan kahden Alzheimer-potilaan kanssa japanilaissessa hoivakodissa kahden vuoden ajan. Heidän vuorovaikutuksensa ja narratiivinsa transkriptoitiin ja analysoitiin laadullisesti teoreettisena viitekehyksenä Vygotskin kulttuuri-historiallinen lähestymistapa ja Bahtinin dialoqin teoria.


Narratiivien yhteiskehiteltä ja kolmenvälinen suhde autoivat terapeuttia kuuntelemaan huo-lella potilaiden ääniä, osallistujiin hänen avoimena jatkuvaan dialogiinsa ja asetti heidät yhdennvertaisiksi osapuoliksi. Tässä mielessä terapeutti nähdään dialogisena opettajana, joka aktiivisesti oppii dementiapotilaita ja joka jatkuvasti tutkii heidän kanssaan narratiivien tunte-mattomia kysymyksiä.

Asiasanat: dementia, dialogisuus, hoitokodit, Japani, narratiivisuus, terapia
To Professor Pentti Hakkarainen who has trusted me and my work. To Hilkka, Riitta-Liisa, Sanni, all my friends in Finland who have supported me. To Kouyou, Aino, and my mother who have always lightened my heart. To Kiyo who has inspired me from the very beginning. Most warmly to Mr Kawaguchi and all the research participants including the dementia sufferers in the nursing home. To my father who did not allow me to stand aloof from dementia and has shown me the way to see it. I have learnt a great deal from the dialogues with all of the people mentioned above.
Acknowledgements

This research project was funded by the Japan Society for the Promotion of Science (JSPS) Grant-in-Aid for Young Scientists (B) Grant Number 16730314, a Finnish Government Scholarship in 2006, the Univers Foundation Research Grant in 2008, and a working grant in the University of Oulu in 2015.

11th March 2016

Ryoko Watanabe
Contents

Abstract
Tiivistelmä
Acknowledgements

9

Contents

11

1 Introduction

13
1.1 What is dementia? ................................................................. 13
1.2 Caring and being cared for: Exploring the relationship between
sufferers and therapists in dementia ........................................... 14

2 Approaches to the relationship in dementia care (1): Literature
review with new models

17
2.1 Towards a categorisation of dementia relationships: The
application of three models and two perspectives ....................... 17
2.2 The therapist-centred model: The therapist as a medical authority .... 20
2.3 The sufferer-centred model: The therapist as a passive supporter ...... 23
2.4 The dyadic relationship model: Therapist as a collaborator ............ 26
2.5 What is missing in the literature on the dementia relationship?
Issues with the three models ...................................................... 28

3 Approaches to the relationship in dementia care (2): Literature
review of cultural-historical approaches, narrative studies and
pedagogical theories

31
3.1 Vygotsky’s cultural-historical approach and defectology ............. 31
3.1.1 The mediation of tools ......................................................... 31
3.1.2 The mediation of others: General genetic law of cultural
development and zone of proximal development ....................... 34
3.1.3 The theory of defectology .................................................. 39
3.2 Narrative as a psychological tool and therapists as dialogic
learners ...................................................................................... 42
3.2.1 What is narrative? .............................................................. 42
3.2.2 The construction of narrative: Mediation of others ................. 43
3.2.3 Narrative as a tool for sense-making and self-making in a
therapy situation ..................................................................... 45
3.2.4 Narrative research in dementia .......................................... 47
3.2.5 Narrative as a pedagogical tool: Narrative learning and
Egan’s theory of cognitive tools .............................................. 49
3.2.6 Miyazaki’s theory of teachers’ expertise and learning ............ 53
3.3 Why a pedagogical approach in dementia relationship? Narrative as a psychological tool and therapists as dialogic learners.................... 58

4 Research questions 61

5 Methodology 63

5.1 Research strategy: Interpretative study ..................................................... 63

5.2 Research methods .................................................................................... 64

5.2.1 Participant observation ........................................................................ 64

5.2.2 Interview survey .............................................................................. 66

5.2.3 Methodological triangulation: Combination of observation and interview .............................................................. 68

5.3 Research Procedures ............................................................................... 69

5.3.1 Research site and participants............................................................ 69

5.3.2 Data collection.................................................................................... 70

5.3.3 Setting out the analytical framework ............................................ 75

5.3.4 Ethical considerations........................................................................ 79

6 Results 81

6.1 Sowing the seeds of narratives: The arrangement for story development by the therapist.......................................................... 81

6.1.1 Coordinating the activity: The use of turn-taking.............................. 81

6.1.2 The suggestions of topics by the therapist........................................ 82

6.2 Case studies of two AD sufferers .......................................................... 83

6.2.1 Case 1: Narrative co-construction with Mrs N............................... 83

6.2.2 Case 2: Narrative co-construction with Mrs O.............................. 101

6.3 Interviews with the therapist ................................................................. 112

6.3.1 Interpretations of the cases of Mrs N and Mrs O........................... 112

6.3.2 The therapist as the creator of a triad relationship and dialogue .............................................................. 119

7 Conclusions and perspectives 139

7.1 As a mediating tool, what kinds of narratives were created through the everyday interaction between therapists and dementia sufferers? How and why were narratives constructed?........ 139

7.2 As a dialogic teacher, what is the teaching-learning process of the therapist through the co-construction of narratives? .................... 141

7.3 What is the relationship in dementia care?............................................ 145

7.4 Implications for dementia care research............................................ 148

7.5 Limitations of the study and needs for further research...................... 149

References 153

Appendix 165
1 Introduction

This chapter begins with a brief definition of dementia and describes the importance of the relationship between dementia sufferers and therapists, based on previous studies. It then examines theoretical and methodological issues with these studies.

1.1 What is dementia?

Dementia is a multiple cognitive impairment that causes serious behavioural and psychological changes. There are many types of dementia including Alzheimer’s disease (AD), vascular dementia, front temporal dementia, semantic dementia and dementia with Lewy bodies. AD is the most common form and accounts for about 50% of all cases.

According to the definition of the American Psychiatric Association (2007), dementia is a set of multiple cognitive deficits such as memory impairment, aphasia (language disturbance), apraxia (inability to perform motor activities despite intact motor function), agnosia (inability to recognise or interpret objects despite intact sensory function) and disturbances in executive functioning (e.g. planning, organising, sequencing, and abstracting)\(^1\). Moreover, these cognitive deficits continue to decline with significant impairment in social or occupational functioning.

The number of people who have dementia has been increasing rapidly all over the world. According to the WHO, the number of persons with dementia is currently estimated at 35.6 million and the number will triple by 2050 (World Health Organization 2012). In Japan, where I conducted this research, the Ministry of Health, Labour, and Welfare survey has shown the number of people with dementia had reached 4.62 million in 2012 with the rapidly growth of old population (Ministry of Health, Labour, and Welfare 2013). It is about 15 per cent of the total elderly Japanese population and dementia is one of the leading causes of death in modern society. In this sense, living with dementia is one of possible life stages in old age and it is crucial to explore the nature of the sufferers’ experiences and how to support their lives.

\(^1\) The American Psychiatric Association has recently published the latest version of the book (DSM-5) and the definition of dementia has slightly changed. For example, the term, dementia has been replaced with major or minor neuro-cognitive disorder (Rabins et al. 2014).
1.2 Caring and being cared for: Exploring the relationship between sufferers and therapists in dementia

Since dementia is a progressive physical and psychological disturbance, the people with dementia need support to live not only from their families, but also from health and social care professionals. That is, the person with dementia becomes the one who is cared for by medical specialists. The professionals here refer to the doctors, nurses, caregivers working at the homes for the elderly, and therapists such as physical or occupational therapists, etc.

This change means a lot to dementia sufferers and their lives, because they have to learn how to build and develop new relationships with others. For example, when they move to a home for elderly, establishing a ‘good’ relationship is one of the keys to living comfortably. Furthermore, it is known that dementia sufferers are sensitive to relationships with others and susceptible to social interventions (Adams & Gardiner 2005, Ota 1994, Killick & Allan 2001, Kitwood 1997b, Sabat 2001).

In the field of dementia studies, many researchers have explored the relationship between dementia sufferers and healthcare professionals as a counter to the stress in biomedical treatment that existed in the 1990s. Kitwood is the one of pioneers to acknowledge the value of social relationships in psychology. He criticized the medicalization of dementia care as ‘the standard paradigm’ (Kitwood 1989) and suggested that dementia should be seen as a dialectic between the personal, social and neurological model (Baldwin & Capstick 2007, Kitwood 1996). While ‘the standard paradigm’ or technical frame is based on medical science with a linear causality, focuses only on deficit and ignores the individual differences and complexity of the dementing process, he considered dementia as a summation of a variety of factors in neuropathology and social psychology (Kitwood 1996). Moreover, he proposed an alternative theory called the person-centred approach, which focuses on the self and the uniqueness of the sufferers as a social being and their interaction with the caregivers (Kitwood 1997b). In his writings (Kitwood 1993a, Kitwood 1997b), he described the structure of interpersonal processes in dementia care and suggested that caregivers require personal and moral development.

In accordance with Kitwood’s arguments about the social constructionist view of dementia, the relationship between care professionals and sufferers has been frequently investigated in not only psychology but also in various fields of science, such as sociology, nursing science, linguistics, cultural anthropology, among others. For instance, some sociological researches have examined interchanges between
sufferers and caregivers as being a power structure between two persons, by using Foucauldian theory (e.g. Brijnath & Manderson 2008, Dunham & Cannon 2008). Nursing researches categorized the types of interaction with nurses or home caregivers during their conversations (Ota 1994, Richter et al. 1995, Roberto et al. 1998, Tappen et al. 1997). Linguists have described the structure of everyday conversation in detail and revealed the interactional difficulties between sufferers and caregivers (e.g. Chatwin 2013, Ramanathan 1997). Anthropologists have regarded dementia as a social and cultural constituent and have compared the meaning and experience of dementia among cultures (e.g. Pollitt 1996, Traphagan 1998). Furthermore, there are many interdisciplinary studies using specific theoretical frameworks (e.g. symbolic interaction, phenomenology, narrative approaches, a grounded theory approach, etc.) and in multidisciplinary academic fields (e.g. gerontology, social welfare studies, etc.).

Although they have different theoretical and methodological backgrounds, many researches have built some consensus among the notions of the relationship or the interaction between care professionals and sufferers that mentally and physically affects the sufferers’ performance and the quality of care. For example, after experiencing negative interaction in which therapists neglect the sufferers’ reactions and requests, the sufferers cease to talk or act much, while positive interaction leads to improved speaking and action (Onodera 2002, Ota 1994).

However, on the other hand, research on the dementia relationship faces some common and basic issues with the accumulation of study results. For example, what is the dementia relationship? What exactly does it mean? In other words, how is the concept of the dementia relationship theoretically defined? As I mentioned above, many researchers have conducted their own studies based on different conceptualizations of relationship according to their different academic or theoretical stances. Consequently, the concept of the relationship between dementia sufferers and therapists has a variety of meanings in research literature. Sometimes, the relationship in dementia care consists of some individual factors such as a loss of the sufferers’ working memory (Bayles 2003) or the care professionals’ attitudes towards the sufferers (Norbergh et al. 2006). Meanwhile, as Kitwood and his followers of the person-centred approach emphasized, it is philosophically identified or idealized as the ‘I–Thou’ mode which Buber (1923/1978) proposed (Kitwood 1997a, Mills 2003). Here, the ‘I–Thou’ mode implies self-disclosure and spontaneity in relating to another person as Thou, as opposed to the ‘I–it’ mode which contains coolness, detachment and instrumentality (Kitwood 1997b).
Moreover, this unresolved question of what the relationship is leads to the next question in research methodology. That is, how can the relationship be described and analysed? Some researchers have used standardised tests to measure the sufferers’ communication and language abilities on the hypothesis that the individual residual abilities contribute to the formation of the relationship with others (Bayles et al. 2000, Bayles 2003). On the other hand, other researchers have thought that there has not been enough discussion about the process and quality of the relationship and therefore have utilised video and ethnographic observation to capture the interaction dynamics between therapists and dementia sufferers (Bohling 1991, Chatwin 2013, Ericsson et al. 2011, Richter et al. 1995). In sum, many researchers have applied different kinds of methods or research tools on the basis of a variety of concepts of the relationship and theoretical backgrounds without their being a general consensus on the nature of the dementia relationship.

With this situation in mind, I think it is necessary to make the concept of the relationship clear in order to answer those questions. For this purpose, I will overview the major concepts of dementia relationships by briefly reviewing previous studies in the next chapter. Using three relationship models, I will discuss what kind of dementia relationship has been created by researchers in the past and what is missing in those views and then I will provide possible answers to the questions.
2 Approaches to the relationship in dementia care (1): Literature review with new models

In this chapter, I will specify the main concepts of dementia relationships in previous studies using three models and two perspectives. Next, I will discuss the neglected issues in the literature and propose alternative approaches to solve them.

2.1 Towards a categorisation of dementia relationships: The application of three models and two perspectives

On reviewing and distinguishing the perspectives of the dementia relationship in previous studies, I take a historical approach by examining the chronological changes or trends in the theoretical discussions regarding who is responsible for the relationship and how the relationship is established. To see the relationship in dementia care as a power structure between therapists and sufferers does not simply mean that I rely on a sociological framework. The main reason I take this viewpoint is the fact that many studies on the dementia relationship have focused on the tension between therapists and sufferers along with its formative process to clarify the degree of freedom and control in the caring and the quality of care. It also reflects that recent research trends such as a person-centred approach and social constructionism have paid close attention to the subjective experience of the sufferers and the quality of the interaction with others, because dementia is a part of a social construct. (Ericsson et al. 2011, Killick & Allan 2001, Kitwood 1997b, Sabat 2001, 2002, Sabat & Harré 1994, Örulv 2008).

To examine the dementia relationship, I created three relationship models from the point of view of how to facilitate the relationship (instigated by the therapists, sufferers, or through dyadic engagement) in connection with two perspectives on a person’s abilities (individualised abilities or shared specific competencies). Both of these are conceptual frameworks on the relationship and the models are based on the perspectives (and vice versa). Practically, the models can be seen in the theoretical background and methods in each of the previous studies, while the perspectives on ability can be drawn from the models. That is, the previous research was conducted based on the models and the models are based on the perspectives. I mean that the researchers on dementia relationships explicitly or implicitly premised the models and the perspectives. In other words, it is still unclear that each researcher was aware of these models and perspectives, but I think they can be categorized from their theoretical backgrounds and methodology.
On building the models and the perspectives, I drew upon discussions on the
teaching-learning process and the relationship between students and teachers in
education and psychology, which I will discuss later (Ishiguro 1998, Resnick 1987,
Rogoff et al. 1996). Perhaps, there are some arguments that it is not appropriate to
apply the models and perspective on the teaching-learning process for teachers and
students to those on the caring for a person with dementia. However, I think there
are commonalities between them, especially from the perspective of the structure
of the activity and the relationship between two people (teacher and student, or
therapist and sufferer). First, both schooling and caring at a nursing home are
institutionalised and reciprocal activities which aim at achieving a certain
(educational/caring) goal with help from an expert. Regarding the socialized and
goal-oriented nature of the activity in schooling and nursing caring, a Japanese
feminist sociologist, Ueno (2011: 134) defined care as being “the interactional
activities to meet dependent others’ needs and to that end, the actors including care
recipients and givers share the time and space”. Although she warned against the
theoretical difference between childcare, including education, and nursing care and
recommended empirical demonstration to prove her hypothesis, she claimed that
we could adopt her definition of care as a broader concept in both areas, because
geriatric care (including dementia sufferers) and child care consist of asymmetrical
interaction which is socially constructed and both of them can be called as a labour
from the standpoint of Marxist feminism.

The second reason why schooling and caring for dementia sufferers have
similarities comes from the caring theory (ethics). Many theorists of caring pointed
out that caring is essentially the relationship between a carer and the cared and this
relationship can be seen in various situations such as in school education and in
nursing care (Mayeroff 1971, Noddings 2003, Watson 2008). One of the original
leaders of the caring theory, Mayeroff (1971: 1–2) defined care “as helping another
grow and actualize himself, is a process, a way of relating to someone that involves
development”. For him, caring is the relationship to make each other’s growth
possible over time and this relationship can be found “among a parent caring for
his child, a teacher caring for his pupil, a psychotherapist caring for is patient, of a
husband caring for his wife”, because “they all exhibit a common pattern”
(Mayeroff 1971: 2). He argues the basic pattern as a set of characteristics that a
caring person possesses such as patience, honesty, trust and hope.

Based on Mayeroff’s idea, Noddings developed the caring relationship as being
a reciprocal and educational one. She revealed the essential characteristics of caring,
such as receptivity, engrossment, motivational displacement, sympathy and
responsibility and actively extends the concept of the caring relationship to the teaching-learning relationship. Though the meetings between teacher and student are generally unequal, the teacher as one-caring works with the student as the one being cared-for on behalf of the enhancement of the student’s ethical ideal (the ideal image as one-caring). The teacher primarily sees the student not just as a learner but a person to be cared for. She also distinguished two forms of caring (“care about” or “care for”) corresponding to the different modes of knowing (a rational, objective and general understanding or a sympathetic, responsive and receptive one) and acknowledges the interrelationship between them (Ikuta 2010). It means that she regards the establishment of the caring relationship not as having a desirable attitude or a personal trait, but as acquiring some sort of knowledge.

Like Mayeroff and Noddings, Watson (1999, 2008) placed the relationship between the carer and the cared at the centre of caring and called her nursing approach a transpersonal caring relationship. Although she gives various kinds of definitions to it later on, in her earlier writings, she explains the transpersonal relationship as “an intersubjective human-to-human relationship in which the nurse affects and is affected by the person of the other” (Watson 1999: 82) to sustain human dignity. She developed her theory rooting philosophical considerations such as existentialism and phenomenology and extended this concept of the relationship from nursing to human caring (Watson 1999). One of her unique contributions to the caring relationship is to focus on the teaching-learning process in it as Noddings did. Particularly, she is interested in how to develop ‘an authentic caring relationship’ for professional nurses and develops her own pedagogical curriculum for this purpose.

She believes that “learning is more than receiving information, facts, or data” (Watson 2008: 125) but holds intellectual, symbolic and cultural meanings for the learner. Teaching (and learning) is also not “an authoritarian approach to control and power over another”, but is “relational, trusting, exploratory, engaging, and ultimately liberating for patient and another” (Watson 2008: 126). To promote the teaching-learning process, she proposes to “stay within the other person’s frame of reference” (Watson 2008: 127) as one of the core skills for a nurse. In the end, the experience of the teaching-learning process results in becoming their own best teacher who has a sense of self-knowledge, self-caring, etc. For Watson, self-growth and self-actualization are goals for human and nursing practice and again, this view of caring seems quite similar to the ones from Mayeroff and Noddings.

So far, I have briefly reviewed the similarities in the concept of the relationship in caring and teaching-learning contexts from the theoretical point of view.
However, in the research into dementia, few studies have been focused on this relatedness. Onodera (2002) analysed the relationship between caregivers and dementia sufferers in a nursing home as a teaching-learning process and found four interactional and instructional patterns, but except for this, many researchers seem not to regard the caring relationship as a teaching-learning process.

With this in mind, I think there are some advantages in applying the research findings of the teaching-learning process to the dementia relationship so that we can focus on the reciprocal nature of the caring relationship, the active role of therapists as teachers and the meaning of therapeutic tools used in the relationship. These points have been missing in the previous studies into the caring relationship, and using the three models and two perspectives, I will discuss these points in detail with the research review in the next chapter.

2.2 The therapist-centred model: The therapist as a medical authority

Two models, the therapist-centred model and the sufferer-centred model share common ground in the understanding that one person is responsible for the relationship, while the other is passive or exclusive to it. Both of them rely on the theoretical assumption that dementia care is a one-sided (therapist-run or sufferer-run) action and the other’s contributions are less appreciated or neglected. In this context, a person’s ability is regarded as individual and inherent, and is less affected by others or various situations and can be measured by certain standardised tests.

In the therapist-centred model, the relationship between therapists and sufferers is considered in terms of the therapist’s decision-making or instruction process towards dementia sufferers. While the sufferer is viewed as a fragile, disabled and abnormal person who is losing physical and mental ability and social skills, the therapist is regarded as the expert who has the medical ‘knowledge’ and instructive strategies for caring. This model widely prevails not only in the research literature but also amongst medical professionals. For example, with a criticism against the behaviouristic approach on dementia caring, Kitwood (1993b: 146–147) describes this situation as follows:

“The dementing person was taken as being in many respects, like a child; the task was to keep that person, as far as possible, in good physical health, fed, toileted, clean and comfortable, protected from harm. … On the professional level – in the work of nurses, care-workers, occupational therapists, clinical
psychologists and others – another subsidiary discourse took form. It was that of ‘behavioural management’ … The strongest emphasis was on things done by dementia sufferers that were troublesome for caregivers … The general aim was to re-shape behaviour into a more acceptable mould, through methods derived from operant conditioning.”

In this context, therapists are seen as being responsible for controlling dementia sufferers using medical knowledge based on behaviourism. The sufferers are treated as recipients of medical control but not as active participants in caring. They have little role except to be receptive, following the therapist’s directions.

The therapist-centred model has roots in the biomedical view in dementia care. Lyman (1989) suggests that the biomedical view has three features: firstly, dementia is pathological and individual; secondly, it is somatic or organic in etiology, caused by progressive deterioration of the brain; and thirdly it is to be diagnosed, treated and managed according to medical authority. Like ‘the standard paradigm’ by Kitwood (1989), dementia is seen not as a normal part of aging, but as a subject of medicalization, and thus medical control over sufferers and paternalism by medical professionals is legitimated. According to Kitwood (1997b), the biomedical view of AD became popular as a result of the financial and political decisions made regarding dementia such as those instigated by the Alzheimer’s movement in the early 1970s in the USA.

Lyman (1989) also clarifies the characteristics and problems of the biomedical view on the caregiving relationship. For example, he writes, “If dementia is viewed only as a biomedical condition, the behaviour of the demented person is individualized and power relationship involving the elderly and their caregivers are depoliticized” (Lyman 1989: 602). In his words, the biomedical view considers the changes in the caregiving relationship in connection with the deterioration of the sufferer or the rationalized treatment strategies by caregivers, which can be explained by the progression of the dementing illness. For that reason, he claimed that “people with dementia are largely invisible in most of this literature; they are merely disease entities, independent variables” (Lyman 1989: 603).

In the psychological and gerontological literature, this model appears in distinctive ways. The division of labour between dementia sufferers and therapists is clear. The dementia sufferer’s role is to be involved in the inquiry and simply follow the therapist’s instruction rather than to share or create the inquiry with others. The therapist’s role is to control sufferers with their intervention strategies or motivate them to make themselves receptive. The researchers in this model
mainly set two kinds of research objects. Firstly, they measure therapists’ individual abilities and characteristics, the cognition of the sufferers, or communication strategies using some standardised tests or researcher-defined questionnaires (Kuremyr et al. 1994, Norbergh et al. 2006, Turner et al. 2004, Yamada & Nishida, 2007, Åtrom et al. 1990). These measured abilities tend to be explained in relation to the therapists’ background such as their age, work experience, medical knowledge, or types of the job, while the sufferers’ contribution to the relationship is completely ignored or discussed in relation to their problems. Another way to approach to the therapists’ abilities was to conduct interviews (Dunham & Cannon 2008, Haggstö & Norberg 1996, Hellner & Norberg 1994, Kuremyr et al. 1994, Richter et al. 1995, Zingmark et al. 2002). To determine the therapists’ experience and build an understanding of their relationship, the researchers organised un/semi-structured interview sessions and were apt to find the positive attitudes or strategies towards sufferers such as ‘respecting sufferers’ dignity’ (Dunham & Cannon 2008, Hellner & Norberg 1994, Zingmark et al. 2002), ‘seeing the sufferer as a unique individual’ (Haggstö & Norberg 1996, Richter et al. 1995), or ‘using imagination, power of insight and the institution as the expert’ (Hellner & Norberg 1994). In these studies, the sufferers were seen as a positive source of the therapists’ discourses on the relationship, but the therapists seemed to have the initiative to control the relationship as a medical and caring authority.

Secondly, as a result of test performance by sufferers, some researchers introduced intervention strategies to therapists for the purpose of improving their communication skills with sufferers or for the settlement of the sufferers’ behavioural problems (Bayles 2003, Carozza 2012, Dijkstra et al. 2002, Tappen et al. 1997, Watamori et al. 1989, Yatomi 1996). For example, after pointing out working memory deficits in dementia sufferers, Bayles (2003: 214) suggested “techniques for facilitating communicative functioning of individuals with Alzheimer’s dementia”, such as manipulating linguistic variables to simplify language, reducing cognitive load, etc. In this context, it became clear that the therapists were persons who could control and promote the relationship and correct the sufferers’ problematic behaviour with their biomedical knowledge. The sufferers were seen as helpless or incompetent and receivers of this professional knowledge.

From the standpoint of the teaching-learning relationship, it is useful to discuss the kind of knowledge used by the researchers and therapists to control the relationship in this model. Here, the therapists heavily rely on biomedical knowledge as I mentioned before. According to Dunham and Cannon (2008: 48),
“medical knowledge was used by caregivers to manage the caregiving relationship and the person with dementia” and “plays a major role in establishing the differentiation between competent and not competent care recipients and helped them to make sense of the changes in the family member”. The therapists use the medical knowledge to explain the caregiving activities and to control the sufferer by dividing some communication strategies into small units and by providing incentives for sufferers. The sufferer learns how to follow the therapist’s guidance and strategy, but not how to manage themselves or collaborate with others. Medical knowledge is prepared and possessed only by the therapist and the researcher, while the sufferer is alienated from its creation and sharing. In this sense, learning is viewed as a product of the therapist’s provision of information with this model (Rogoff et al. 1996).

2.3 The sufferer-centred model: The therapist as a passive supporter

The sufferer-centred model is a counterpart to the therapist-centred model and the biomedical and pathological view on dementia and has been actively proposed since the 1990s by scholars and practitioners. In the sufferer-centred model, the relationship between therapists and sufferers is considered as the sufferer’s self-determination and self-actualization in caring. The sufferer is expected to be the active agent in spite of physical and mental problems, while the therapist is seen as a passive supporter or even a potential impediment, which may have a negative influence on the sufferer’s activity and the relationship. Like the therapist-centred model, there is the theoretical presupposition that the caring relationship is one-sided process.

The idea of the sufferer-centred model arose from the debate with the advent of Kitwood’s concept of ‘personhood’ which challenged the biomedical view. He used this concept for the promotion of his ‘person-centred care’ (Kitwood 1997b) which was not only for academics but also for practitioners (Baldwin & Capstick 2007). He gives varied definitions of personhood but one of the most famous versions is: “It (personhood) is a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust.” (Kitwood 1997b: 8). Although the notion of personhood originally implies the person as a social and psychological being, it triggered two kinds of standpoints on dementia: “those who believe that individuals are persons because of some capacity or capacities they possess and those who
contend that being human is the same as, or at least equivalent to, being a person” (Baldwin & Capstick 2007: 176). Being a person means to be made a member of a moral community. Fleischer (1999) pointed out that these different visions sometimes caused a conflict between personalism and physicalism or vitalism. Furthermore, the idea of personhood was supported by other positive viewpoints of the elderly, such as successful aging (Baltes & Baltes 1990) and the discussion surrounding quality of life (Lawton 1997) both of which became popular in the 1990s.

Based on Kitwood’s formulation of personhood and person-centred care, as well as other related perspectives, several studies have been conducted to measure the sufferer’s residual abilities, or to find their subjectivity, or to study the uniqueness of the person in the relationship. Regarding the former, researchers have evaluated sufferers’ interactional abilities using researcher-defined instruments (Ettema et al. 2005). For example, sufferers were asked to show some interpersonal behaviours like a greeting, to answer cognitive examinations, and to rate their feelings (Wells & Dawson 2000, Zucchella et al. 2014). While these studies emphasised the possibility of retained abilities in severe dementia, there was the criticism that many tasks and the instruments defined and introduced by the researchers were normative and not tailored to measure the sufferer’s subjective meaning and experience (Ettema et al. 2005). On the other hand, in the latter studies, researchers aimed to describe the sufferer’s experience and the cognition of the self in the relationship by conducting interviews (Clare 2003, Cohen et al. 1984, Harman & Clare 2006, Proctor 2001, Sabat & Harré 1994, Werezak & Stewart 2002). They made the assumption that the sufferer was an agent who could discover the meaning of their lives and manage the disease on their own or through interaction with others. For example, Sabat and Harré (1994: 145) suggested that Alzheimer’s sufferers are semiotic subjects “for whom meaning is the driving force behind their behaviour” and demonstrated that they could interpret their situations, act and plan using their existing conceptual schemas, while caregivers did not recognise their conditions. Other researchers described the sufferers’ recognition of the disease or of the relationship with others (Clare 2003, Harman & Clare 2006, Proctor 2001, Werezak & Stewart 2002). Werezak and Stewart (2002) studied the process of adjusting to the early-stage dementia by the sufferers and reported that towards the assimilation process of dementia, it is important for the sufferers to learn from other dementia sufferers in a support group, and health care professionals should not harm the sufferer’s feelings with insensitivity.
In the above studies, it is notable that the sufferers were expected to be central to the caring and its relationship, while those persons who cared for the dementia sufferers were treated as a secondary. Similarly to the criticism of Kitwood that his theory of personhood is overly individualistic and only counts the person with dementia (Baldwin & Capstick 2007), in this research the role of the therapists were minimized. The therapist’s interventions may affect the sufferer’s performance and cognition but in a negative or limited way.

In a teaching-learning process, knowledge that the sufferer’s possess and the researchers postulated is regarded as the intact remaining abilities in this model. Because of the protest against the biomedical viewpoint and because of respect for the sufferer’s potential, the subject of the sufferer’s self and experience is often taken up for discussion. Terms such as the sufferer’s ‘self-respect (esteem)’, ‘lived-experience’ and ‘sense of identity’ have been used to describe this and it has been assumed that these abilities were retained to some extent (Clare 2003, Harman & Clare 2006, Proctor 2001, Sabat & Harré 1994, Wells & Dawson 2000, Werezak & Stewart 2002). For example, Clare (2003: 1017) investigates awareness in early stage AD sufferers and concludes: “(the AD sufferers’) responses formed a continuum running from ‘self-maintaining’ to ‘self-adjusting’. A self-maintaining stance related to attempts to normalise the situation and minimise the difficulties, thus maintaining continuity with prior sense of self, while a self-adjusting stance related to attempts to confront the difficulties and adapt one’s sense of self accordingly.” Here, she applied the notion of the AD sufferer’s sense of self as a source of knowledge about the management of the disease.

Although the notion of the AD sufferer’s self and experience is a broad and ambiguous concept, which can be differently evaluated by authors or situations, the researchers seem to see the AD sufferer’s self as the main force for acting on caring and the relationship. In this sense, depending on their sense of self, AD sufferers have the potential to learn how to solve the physical and mental difficulties caused by their dementia and to accommodate environments on their own or through interaction with peers. The job of the therapist is to support their learning activities by giving a minimum amount of advice or making preparation for the environment and staying out of the AD sufferer’s way. Thus, in this model, learning is seen as the process of the AD sufferer’s active production of self and knowledge or perhaps the reproduction of a pre-existing self or knowledge.
2.4 The dyadic relationship model: Therapist as a collaborator

Both the therapist-centred and the sufferer-centred models are based on a “one-sided philosophy of instruction” (Rogoff et al. 1996: 395) in which sufferers and therapists are seen as striving for freedom and control in the relationship. The two models are considered as alternatives to each other. The dyadic relationship model is a conciliation of the two models and brings a mutual coordinating process within the relationship into focus. The relationship is no more a one-sided action governed by the other, but a co-construction process. The sufferer and the therapist are responsive to and both more or less have an influence on each other. The role of the sufferer and the therapist is to engage in a shared activity. In this sense, each person’s ability to perform successfully depends on what the other does and how to get along with others. Their ability is socially distributed in the situation where the reciprocal relationship occurs (Hutchins 1995).

Attention to the dyadic relationship has stemmed from the criticism of the literature on the caring relationship. For example, Graham and Bassett (2006: 336) pointed out the research problems as follows:

“The complexity of care-giver/care-receiver relationships, especially in the context of dementia, prevents an easy operationalisation of definitions for research purposes. The false dualism of a simple carer–receiver relationship prevents interpretation beyond a reductionist economic exchange argument … Although much of the literature acknowledges the relational character of caregiving, researchers provide little evidence of relational interaction and instead focus predominantly on the caregiver.”

They emphasised the reciprocal relations in caregiving and cautioned the unidirectional relationship used in the research literature. Also, many researchers mentioned that in spite of a plethora of studies related to the relationship or interaction in dementia care, the process of how the relationship is established is still unclear because of the inadequate conceptualisation of the relationship (Graham & Bassett 2006, Onodera 2002), the lack of the appropriate theoretical background (Ota 1994, 1996), the lack of sufficient empirical data (Horiuchi 2010, Normann et al. 2002, Ward et al. 2008), methodological limitations (Bohling 1991, Chatwin 2013), the difficulty of the relationship with severe dementia (Ericsson et al. 2011), etc. Thus, the authors in this model questioned the existing research approaches and proposed alternatives to capture the ‘process’ or ‘patterns’ of communication in the actual situations where the career-receiver relationship
occurs. As a theoretical framework, many researchers drew on the “constructivist paradigm” (Denzin & Lincoln 2011: 13) which assumes the co-creation of understandings between a knower and a respondent in the natural world. They applied qualitative research methodologies such as the grounded theory method (Ericsson et al. 2011, Horiuchi 2001, Ota 1994), content analysis (Graham & Bassett 2006, Graneheim et al. 2001, Normann et al. 2002, Ward et al. 2008), conversation analysis (Chatwin 2013, Ramanathan 1997), phenomenological-hermeneutic analysis (Kihlgren et al. 1994), and Goffman’s frame analysis (Bohling 1991).

In this model, the findings are usually categorised as the strategies or schemas which the participants used to (dis)continue their relationship or the distinctive structures which the interaction process contained. For example, Ericsson et al. (2013) discovered the ‘opening up’ process to establish the relationship with the sufferers and towards that process, the caregivers adopted strategies such as ‘assigning time’, ‘establishing security and trust’ and ‘communicating equality’. Bohling (1991: 262) reported that caregivers used a variety of listening strategies in their interaction such as “joining the patient’s frame (reality)”, or “staying partially within the patient’s frame”, or “staying primarily within the caregiver’s frame”, and examined their effects on the sufferer’s reaction.

Although, these studies presented varying descriptions and conceptual models to capture the dementia relationship as a system of mutual influence, there are some criticisms of this approach. For instance, Charmaz’s discussion (1990: 1164) on the problems with the grounded theory method and qualitative studies, argues that “the relation between subjectivist and objectivist realities and levels of explanation remain unspecified.” Since the term ‘relationship’ is inherently ambiguous, if the authors are not fully aware of their decisions about the levels of abstraction, it causes the over-production of jargon describing the participants’ strategies and the interaction structures without relation to other theories.

Another criticism comes from the stance for individual uniqueness. The research in the dyadic relationship model emphasizes the process itself in the relationship, but it rarely questions the participants’ intentionality towards the relationship or their backgrounds such as their knowledge, prior experiences, or the self, which to a greater or lesser degree influence the relationship. This may be because of the methodological character of those interaction studies. For example, conversation analysis is “one of the few naturalistic qualitative approaches which routinely incorporates large sets of data ... the influence of individual participants communication styles, or their particular psychological disposition is effectively
removed.” (Chatwin 2013: 739–740). The categorisation of the relationship sometimes masks the personhood (Kitwood 1997b) of the sufferer and the therapist in a systematic way.

Furthermore, these issues become clearer from the perspective of the teaching-learning process. In the dyadic relationship model, many questions arise related to undisputed elements in the description of the interaction process. For example, what is the therapist’s and sufferer’s intention to change or sustain the relationship? What is the therapist’s expertise and responsibility? Moreover, the learning goals and contents come into question, because the researchers in this model are concerned not with what is learned through the relationship, but rather how the relationship is jointly constructed. That is, the goal of learning here is defined as the establishment of the ongoing relationship, rather than as the acquisition of certain knowledge or skills through the relationship. In this sense, the therapist and the sufferer may interchangeably learn how to manage the relationship but they seem not to care about the aim or quality of their relationship after all.

2.5 What is missing in the literature on the dementia relationship? Issues with the three models

In this chapter, I have examined how the relationship between therapists and dementia sufferers has been analysed and considered in the gerontological literature applying the three models described. With these three models, I think the researchers’ epistemological premises in the concept of the relationship such as the degree of freedom and control and the person’s ability became clearer. There is both a binary opposite or a balanced agreement about the relationship between therapists and sufferers and the two viewpoints of the person’s ability to support them. The one-sided (therapist and sufferer centred) relationship is concerned with individualised abilities, while the dyadic relationship depends on shared specific competencies.

On the other hand, the neglected issues become more obvious based on the three elements of the person’s ability, knowledge, and the role of the therapist. It is these aspects which the educational research has also focused on in the teaching-learning process (Ishiguro 1998, Rogoff et al. 1996). I have partially mentioned these aspects in the previous discussions but now again, argue these points clearly.

First, in the one-sided models, the ability of the sufferer or the therapist is personalised and decontextualized. The socio-cultural background such as the contribution of others and the influence from the care settings are minimised and
independent abilities are often investigated using researcher-defined measurements. In contrast, in the dyadic model, the person’s ability is viewed as being relational and situated and works successfully depending on what others do. The researchers describe the participation process and the contribution in the relationship using qualitative and interpretative methods. In this sense, the dyadic model seems to cover the shortcomings of the one-sided models. However, the acquired abilities or cognitive abilities constituted through the relationship, such as how the participants understand and interpret their relationship, should be questioned.

Second, the theoretical stance of the knowledge seems problematic. The one-sided models are based on a notion of ‘learning as transmission of knowledge by an expert or acquisition of knowledge by a novice, with a passive role assumed for people other than the one responsible for learning’ (Rogoff et al. 1996: 409). In the therapist-centred model, therapists build and manage the relationship with their medical knowledge, while the sufferer is amenable to following their guidance. In the sufferer-centred relationship, sufferers act spontaneously in the relationship, while therapists remain on the sidelines or provide a comfortable environment. Meanwhile, the dyadic relationship is based on an idea of learning in terms of the shared and co-constructed knowledge between therapists and sufferers. In other words, the three models have different assumptions: in the one-sided model, the knowledge is individual and sometimes generalised, but in the dyadic model, the knowledge is shared and contextualised among people. Here again, the dyadic model seems to provide a good alternative for the one-sided models, but the model is limited to the knowledge of a given relationship rather than the participants’ experience and expertise.

These inadequacies in the three models also bring up the question of the therapist’s role. In the three models, the responsibility and job of therapists still appears unclear. For example, in the sufferer-centred relationship, the contribution of the therapist is marginalised. In the dyadic relationship, the therapist’s experience and expertise are undiscussed. In the therapist-centred relationship, the therapist’s role is recognised not as a creative and collaborative learner working with the sufferer, but merely as a medical authority. Although there is much criticism and discussion about the sufferer’s role and ability in the previous studies (Kitwood 1997b, Sabat 2001, 2002, Sabat & Harré 1994), the therapist’s active and positive role seems rarely examined (Onodera 2002).

Thus, it seems that all three models have some limitations in their conceptualisation of the relationship. This raises the questions of what is missing in the research on the dementia relationship, and what lies behind these limitations?
Again, I think the theoretical perspectives and discussions on the teaching-learning process also show us a way to reconsider these issues. For example, the critical review of psychology and education by Ishiguro (1998) provides a clue. Examining the gap between psychological research and educational practice, he points out the three problematic theoretical and instructional assumptions about the person’s ability as being ‘non-mediated’, ‘decontextualized’ and ‘non-negotiated’ and that these resulted in the individualistic ‘person-centred ideology’ (Caplan & Nelson 1973). In his criticism (1998: 126), ‘non-mediation’, ‘de-contextualisation’, and ‘non-negotiation’ mean that nothing or no-one influences human activity, and that people’s knowledge is not situated, and that meaning and value are fixed. Then, he applied the situated cognition theory to revise these perspectives emphasising the role of tools (artefacts) and others embedded in each situation.

Based on Ishiguro’s critiques, the issues surrounding the dementia relationship can be paraphrased as being problems of mediation, context, and negotiation. In the one-sided models, the relationship between therapists and sufferers is seen as being ‘non-mediated’ by tools, and as being ‘decontextualized’ from the situation or participants’ background and ‘non-negotiated’ by others. In the dyadic model, the relationship is regarded as mediated, contextualised and negotiated, but only by others. That is, the role of mediating tools seems overlooked in the models. As many researchers have recognised (Hutchins 1995, Resnick 1987), tools are created, used and shared among people and helped to shape our cognition in practice. Ishiguro (2004: 14) suggests that learners have a twofold connection between tools and others (teachers) and it is important to examine how they relate to each other in the teaching-learning context. In other words, to study the relationship between therapists and dementia sufferers is equal to questioning the relationship between therapists and sufferers and how the mediating tools come into play. The focus on the relationship should change from the dyadic to triadic. Taking tools into consideration, a person’s ability is defined as a competency for tool use, where knowledge is embodied in the tools, and the therapist becomes an expert who knows how to use the appropriate tools in the relationship.

Therefore, what kinds of tools are used in the dementia relationship? What kinds of characteristics do they have? As a teacher or a user of tools, how does the therapist work with them? To answer these questions, in the next chapter, firstly, I will review the role of tools in the teaching-learning process from the psychological and educational points of view and secondly, discuss their meanings and the role of therapists.
3 Approaches to the relationship in dementia care (2): Literature review of cultural-historical approaches, narrative studies and pedagogical theories

In this chapter, I will examine the role of mediating tools and others (mainly, teachers) in the teaching-learning process based on cultural-historical approaches originating from the Russian psychologist, Vygotsky. I will then discuss narrative studies from the perspective of a narrative being a psychological tool and I will then go on to explore pedagogical theories viewing the therapist as a dialogic learner in relation to Bakhtin’s theory of dialogue. After reviewing these matters, I will rethink how to better understand the significance of mediating tools and the role of the therapist in a dementia caring relationship.

3.1 Vygotsky’s cultural-historical approach and defectology

One of the key concepts in any cultural-historical approach is the social origins of human psychological processes (Cole, 1998). As I will explicate below, cultural-historical approaches emphasise that humans have developed their psychological processes through the mediation of tools and others from their birth, which is why all human mental activities and artificial tools (artefacts) are essentially social. The concept of social origins of mental processes can be seen in many of Vygotsky’s works and the following chapters shed light on his ideas of the roles of tools and others in human development, education, and defectology.

3.1.1 The mediation of tools

One of the pioneers who highlights the importance of mediating tools in everyday practice and the teaching-learning process is a Russian researcher, Lev Vygotsky. He proposes that human action and higher mental functioning are mediated by tools (‘technical tools’) and signs (‘psychological tools’) (Wertsch 1991). Vygotsky (1981a: 140) explains the difference between technical tools and psychological tools, as follows:

“The most essential feature distinguishing the psychological tool from the technical tool is that it directs the mind and behaviour, whereas the technical tool, which is also inserted as an intermediate link between human activity and
the external object, is direct toward producing one or another set of changes in the object itself. The psychological tool changes nothing in the object. It is a means of influencing oneself (or another) – of influencing the mind or behaviour; it is not a means of influencing an object. Therefore, an instrumental act results in activation in relation to oneself, not in relation to an object.”

While the technical tool directly changes the object, the psychological tool “alters the entire flow and structure of mental functions” (Vygotsky 1981a: 137). For instance, Vygotsky (1981a: 137) illustrates psychological tools as being “language; various systems for counting; mnemonic techniques; algebraic symbol systems; works of art; writing; schemes, diagrams, maps, and mechanical drawings; all sorts of conventional signs; *etc.*” Although he considers that any tool contributes to develop human mental functioning, his main concern was with psychological tools, because it caused a semiotic meditation (Wertsch & Tulviste 1992). In his account, human natural language is the most important form of mediating tool because it makes social relationships with others and one’s own thought possible at the same time.

“Specifically, the initial and the primary function of speech is communicative. Speech is a means of social interaction, a means of expression and understanding.” (Vygotsky 1987: 48).

Language works as a tool for communication with others and as a form of intelligence. It helps us to enter our cultural and historical practices through communication and creates and structures abstract thought beyond the ongoing situations and times. In Wertsch’s words (1991: 93), within natural human language, Vygotsky “recognised the possibility of de-contextualization as manifested in scientific concepts and the possibility of linguistic conceptualisation as manifested in inner speech.”

Meanwhile, this structure of mediating tools is often depicted as a triangle by Vygotskian researchers. Figure 1 shows the relation between the subject, object, and mediated tools. In natural processes, the subject and object are seen as directly connected, but in instrumental processes, the subject and object are indirectly connected through tools. Cole (1998: 119) points out that through the meditation of tools, a new structural relation appears as “a triadic relationship of subject-medium-object”. That is, the mediated (cultural) path and the unmediated (natural) path interact not separately but synergistically. This triangular relationship makes two ways possible for reaching one’s objective as both a “‘direct, natural, phylogenetic’
and as an ‘indirect, cultural’ aspect of experience” (Cole 1998: 119). For Vygotsky, the dual approaches to the object also show two lines of human development: natural and cultural. In the natural course, people react to objects in the way they are biologically or reflexively programmed, while in the cultural course, people respond consciously or intentionally. As he states, “the two lines of psychological development (the natural and the cultural) merge into each other in such a way that it is difficult to distinguish them and follow the course of each of them separately” (Vygotsky 1929: 418). Human development is always mediated by tools and “the central thesis of the Russian cultural-historical school is that the structure and development of human psychological processes emerge through culturally mediated, historically developing, practical activity.” (Cole 1998: 108). The activity theorists, especially, who derived their stance from the cultural-historical approach, have promoted research into everyday actions and tools as the first step forward in forming human mental functioning (Engeström 1987, Leont’ev 1978)². Thus, if the mediation of tools is necessary for development and the teaching-learning process, how is this possible? In the next chapter, I will illustrate another important element for the mastery of tools: the mediation of others.

² In contrast to the activity theorists who regarded the role of actions and tools as a primary motive for humans, some researchers have pointed out that Vygotsky put great value not only on activities and tools but also on higher mental functioning such as human consciousness as a central force in human development (Morioka 2001, Nakamura 2004, 2010).

Fig. 1. Vygotsky’s triangle.
3.1.2 The mediation of others: General genetic law of cultural development and zone of proximal development

As an innovator of the cultural-historical approach, Vygotsky takes the role of others as seriously as he does the role of tools. His emphasis on the mediation of others is seen in his famous formulation of ‘the general genetic law of cultural development’ and the well-known ‘Zone of Proximal Development (ZPD)’.

In the ‘general genetic law of cultural development’ Vygotsky asserts that interpersonal processes precede individual processes and that individual processes emerge after the establishment of the interpersonal processes.

“Any function in the child’s development appears twice, or on two planes. First it appears on the social plane, and then on the psychological plane. First it appears between people as an inter-psychological category, and then within the child as an intra-psychological category. This is equally true with regard to voluntary attention logical memory, the formation of concepts, and the development of volition ... It goes without saying that internalisation transforms the process itself and changes its structure and function.” (Vygotsky 1981b: 163).

“Any higher psychological function was external; this means that it was social: before becoming a function, it was the social relation between two people. This means of acting upon oneself is first a means of acting on others and the action of others on one’s personality.” (Vygotsky 1989: 56).

For Vygotsky, the inter-psychological category means the collective mental functioning which people collaboratively carry out using tools such as ‘socially distributed consciousness’ (Bruner 1985), or ‘socially distributed cognition’ (Hutchins 1995). The intra-psychological category is the individual psychological functioning which people can achieve alone with the aid of various mediating tools.

To illustrate the process of internalisation, Vygotsky gave the example of language. First, language is introduced by others and becomes a tool for communication with others (external speech) on the social plane. Later, with expertise in it, it evolves into a tool for self-regulation and thinking (inner speech) on the psychological plane. That is, language is a socio-historical tool and supports the development of mental functioning from the inter-psychological to the intra-psychological category.

This process of the internalisation can be depicted as shown below in Figure 2. At the left of the figure, the subject (S1) indirectly enters the two kinds of relationships: one is the system of the subject (S1) – tools (X) – object (O) and
another is the one of the subject (S1) – experienced other (S2) – object (O). Through the mediation of tools and the experienced other, the subject achieves the object on the social plane. After interaction with the experienced other and the mediating tools, the subject appropriates the system that the experienced other has (S2–X–O) and intentionally uses it for attaining the object on the psychological plane. The experienced other now becomes a part of the subject (S1’) and the subject’s inner speech.

Fig. 2. The process of internalisation.

The general genetic law of cultural development clearly shows Vygotsky’s idea of the “social origins of mental functioning in the individual” (Wertsch 1991: 25). Similarly, the ZPD demonstrates the social nature of developmental potential and the significance of pedagogical practice. One of the standard definitions of the ZPD written by Vygotsky is as follows:

“… the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance, or in collaboration with more capable peers.” (Vygotsky 1978: 86).

Although the ZPD is widely used to indicate the relationship between instruction and development, there have been many interpretations among researchers because of its equivocal terms (Chaiklin 2003, Hakkarainen & Bredikyte 2008, Lave & Wenger 2002, Okahana et al. 2009, Valsiner & Van der Veer 1993, Zuckerman 2007). Chaiklin (2003) points out three common conceptions of the ZPD and three associated problems, which he describes as the generality assumption, assistance assumption, and potential assumption. With the first assumption, the ZPD is applicable to any kind of learning, but misses the relation to human development. The second assumption emphasises the contribution of competent others, but lacks
any relation to a child’s learning and development. The third assumption underscores “a learner’s potential and/or readiness to learn” (Chaiklin 2003: 42) as a property. However, the potential is essentially not a property of the learner but “simply an indication of the presence of certain maturing functions” (ibid.: 43). To solve these problems, Chaiklin proposes to define two kinds of ZPDs: a subjective and objective zone of development. The ZPD “is a way to refer to both the functions that are developing ontogenetically for a given age period (objective functions), and a child’s current state of development in relation to the functions that ideally need to be realized (subjective functions). In this respect, the zone of proximal development is both a theoretical and an empirical discovery.” (Chaiklin 2003: 50).

Chaiklin’s views on the conceptualisation of the ZPD seem partly similar to what Valsiner and Van der Veer (1993) suggest as the three main uses of the ZPD. In their terms, the ZPD has historically been applied in three ways: (1) as a dynamic measurement of learning abilities (assisted vs. individual problem solving), (2) as the scaffolding concept in interactive learning, and (3) as a component in contemporary psychological theories. In the first application, children’s ability and readiness is seen as a property and measured by testing problem solving using given hints. In the second application, scaffolding metaphors (Wood et al. 1976) which “explicitly provide support for the initial performance of tasks to be later performed without assistance” (Lave & Wenger 2002: 150) match the nature of children’s guided learning according to the ZPD. However, it does not fully capture the development of psychological functions. Thus, as with Chaklin’s assistance and potential assumption, both of the first and second applications focus on the social context, but lose the interdependence of the context and the personal developmental processes. To overcome these issues, Valsiner (1987) proposes two additional zones termed the Zone of Free Movement (ZFM) and the Zone of Promoted Action (ZPA) in addition to the ZPD. While the ZFM includes “the child’s freedom of choice of action (and thinking) it is limited by a set of constraints” (Valsiner 1987: 97). The ZPA is the “set of activities, objects, or areas in the environment, in respect of which the child’s actions are promoted” (ibid.: 99–100). Two zones jointly interact and create child development (ZPD).

On the other hand, some researchers have arrived at other understandings of the ZPD. Hakkarainen and Bredikyte (2008) examine the interpretations of the ZPD by Chaiklin, Valsiner, Zuckerman and Del Rio et al. and the original texts by Vygotsky and criticised that they miss the play activity that Vygotsky emphasised as the context for the development of “imagination, intentions, life-plans, motivation and will” (Hakkarainen & Bredikyte 2008: 3). Focusing on the
development of personality in play and differentiating the contexts between school learning and play activities, they point out that sense making and emotional experience (perezhivanie in Russian) of children are the key to creating a ZPD in play. To expand the concept of the ZPD into the development of children’s psychological functions, they define the two definitions of the ZPD as two distances: “1) between individual action and joint higher level potential, and 2) between joint higher level potential and qualitative change in personality” (ibid.: 10).

Similarly, Zuckerman (2007) also focuses on the child’s personal development and describes the ZPD as a multi-dimensional concept which aims to achieve harmonious development of the child’s potentialities. She criticises the definition of the ZPD as being a linear and one-dimensional concept which depicts the child’s transition from his current potential to further development in near future in schooling, because the child’s development is judged by specific task performance in a classroom and is not always supported by the teaching. To promote the child’s development in all directions, she suggests to prepare an educational and creative environment and to foster initiative using cultural and psychological tools. In this sense, the ZPD is described as being “a special form of interaction in which the action of the adult is aimed at generating and supporting the child’s initiative” (Zuckerman 2007: 43). Unlike the scaffolding model, the relationship between the child and adult is equal and they find something new that is interesting, unexpected, and notable for each other. By experiencing something new together, the child can master affective-semantic and conceptual content of activity, while the adult can encourage his/her initiatives.

In connection with Zuckerman’s negation of linear and causal development and learning in the ZPD, Holzman (2006, 2009) proposes a dialectical relationship between learning and development where learning and development are intertwined and emergent as a whole unity. She describes the ZPD as a “process-and-product” which is an “ever emergent and continuously changing ‘distance’ between being and becoming” (Holzman 2006: 257). That is, she sees the ZPD as a creative and improvisational group activity where people jointly achieve what they do not yet know how to do (ibid.: 257). Learning and development in this context means “participating in creating the performance ‘stage’ and performing on it is how we can go beyond ourselves to create new experiences, new skills, new intellectual capacities, new relationships, new interests, new emotions, new hopes, new goals” (ibid.: 258).

While these researchers mainly interrogate children’s personal development, the social context, and the relationship between learning and development in the
ZPD, others raise questions about the structure of the ZPD. Okahana et al. (2009) critically review recent discussions on the ZPD and the scaffolding metaphor and conclude that the ZPD and scaffolding can be considered not as a dyadic relationship between a teacher and a child but as a triad relationship such as a child-teacher-object system. Based on some developmental theories applying the triad relationship (Tomasello et al. 2005, Trevarthen & Hubley 1978), they suppose that we can capture the child’s initiative, motivation, and the sociocultural background as the object. Shoy (1995) also supports the idea of the triad relationship in the ZPD indicating that subjects are reciprocally changing due to the mediation of tools.

From these perspectives, it seems clear that the recent studies on the ZPD highlight how to identify the zone in which a learner actually and potentially develops through joint activity with peers or experienced others. Consequently, towards the identification of the individual ZPD, it seems important to take into account the nature of social practice where the ZPD actually takes place. Because of the difference in the ZPD between schooling and play (Hakkarainen & Bredikyte 2008) and the emergent and improvised nature of the ZPD (Holzman 2006, 2009), we need to consider the components of social practice such as settings, participants, tools, (educational) goals and participants’ development on the basis of Vygotsky’s original theory. Moreover, the current interpretations of the ZPD seems to mainly focus on the learner’s (child’s) ability and potential rather than on the active roles and learning of an adult (a teacher). This concept go against the prevailing belief of instructionism that “learning as a product of teaching or an adult’s provision of information” (Rogoff et al. 1996: 391) and the re-evaluation of Vygotsky’s works from the socio-cultural approaches which put much emphasis on the shared social activity among participants in recent years (Cole 1998, Lave & Wenger 1991, Rogoff 2008). However, it is known that Vygotsky seriously concerns the role of instruction with development in the concept of the ZPD (Nakamura 2004). He suggested the importance of instruction in the ZPD as follows:

“It is important to determine the lower threshold of instruction. The issue is not exhausted by this question however. It is equally important to determine the upper threshold of instruction. Productive instruction can occur only within the limits of these two thresholds. Only between these thresholds do we find the optimal period for instruction in a given subject. The teacher must orient his work not on yesterday’s development in the child but on tomorrow’s. Only then will he be able to use instruction to bring out those processes of development that now lie in the zone of proximal development.” (Vygotsky 1987: 211).
Thus, in the context of the dementia relationship, it seems meaningful to explore Vygotsky’s theory of defectology, because we can see his views on the nature of the development and pedagogy including the role of mediating tools and others towards the disabled. Unfortunately, Vygotsky does not mention dementia itself much, but his idea of defectology seemingly gives us many hints to explore the role of teachers (therapists) towards disability and how they can create a ZPD in their pedagogy.

3.1.3 The theory of defectology

For Vygotsky, the development and education of the disabled was one of his central research concerns throughout his life and he contributed to the field of special education (Vygotsky 1993, 2006). His term, defectology means, “studies of the disabled, their development, teacher training and methods” (Vygotsky 1993: 1). He formulated and elaborated many major theoretical concepts with the data on defectology (Gindis 1995, 1999) such as the above ideas on the mediation of tools, general genetic law of cultural development, and the ZPD.

Shiyo (2010) marshals three aspects in Vygotsky’s defectology based on the works by Gindis (Gindis 1986, 1995, 2003, Kozulin & Gindis 2007): (1) the socio-genetic process of the disability rather than the biomedical one, (2) disability as being dynamic and developmental rather than static and unchangeable, and (3) special education as inclusion rather than integration. On the first point, Vygotsky argued that a disability should be considered “not as a ‘biological impairment having psychological consequences’, but as a socio-cultural developmental phenomenon” (Gindis 1999: 334). He thought disability is only problematized according to the social contexts where the disabled child develops and emerges differently in the cultural and social setting. To illuminate the socio-cultural nature of disability, he introduced two concepts of ‘primary’ and ‘secondary disability’. With primary disability he referred to biomedical impairment, while secondary disability refers to distortions of higher mental functions, caused by socio-cultural conditions. Vygotsky himself explains the two disabilities as follows:

“Two basic factors shape this social conditioning of a handicapped child’s development. First, the effect of the defect itself invariably turns out to be secondary, rather than direct. As we have already said, the child is not directly aware of his handicap. Instead, he is aware of the difficulties deriving from the defect. The immediate consequence of the defect is to diminish the child’s
social standing; the defect manifests itself as a social aberration.” (Vygotsky 1993: 35).

The primary disability is insusceptible to a pedagogical approach and independent of social interventions because of its organic nature, but the secondary disability is socio-culturally constructed and responsive to educational efforts. For this reason Vygotsky believed that it was urgent to promote the development of higher mental functioning in special education, because in his view the secondary disability was amenable to the teacher’s instruction. This search for the positive aspects of the disabled child’s abilities shows Vygotsky’s hallmark that he views the disability not as a weakness but as a strength (Gindis 1999).

On the second point, the understanding of the socio-cultural nature of disability (the second disability), Vygotsky considers the disability in the process of the child’s development and falling under the influence of education. He believes that education guides development, internalising one’s culture and social relationships through the mastery of mediating tools. In this way development becomes a complex process integrating both natural and cultural processes. To approach these two lines of development, Dynamic Assessment (DA) is used as “an interactive procedure that follows a test-intervene-retest format focusing on the cognitive processes and meta-cognitive characteristics of a child” (Gindis 1999: 337). In comparison pre-test and post-test performances by a child, an experimenter obtains the information on the “effective remediation” for the child including “cognitive modifiability, his/her responsiveness to an adult’s mediation, and his/her amenability to instruction and guidance” (ibid.: 337). The idea of the DA is built on the concept of ZPD containing two kinds of zones: one is the child’s individual and actual level of development and the other is his/her joint higher level potential. Although Valsiner and Van der Veer (1993) point out that the DA is limited in several respects that the child’s learning only occurs during the problem-solving situation and that his/her ability is seen as being individual. This is because the role of the instructor becomes a part of the test setting and the individual differences become a central concern for researchers. The original concept of the DA aims to measure the achievement process in joint activities which traditional standardised assessment has ignored (Gindis 1999).

On the third point, Vygotsky develops his perspective on special education as “inclusion based on positive differentiation” (Gindis 2003: 211), not as normalisation. In his early years, Vygotsky (2006) encourages normalisation through inclusion of all disabled children, but later he explains that a differentiated
learning environment can fully develop higher psychological functions and the overall personality of a child with a disability (Gindis 1999, 2003). In sum, special education needs a special method to provide alternative means of development and compensation for disabilities. Inclusion for disabled children should be constructed by utilising specialised cultural tools, trained teachers, and other children. As the special tools in this case, Vygotsky proposes the use of ‘psychological tools’, because they help to control behaviour, to construct higher mental functioning, and to accelerate cultural development for the disabled children. As he states, “mastering a psychological tool and, by means of it, one’s own natural psychological functions generate an artificial development, as it were; that is, it raises a given function to a higher level, increases and expands its activity.” (Vygotsky 1993: 45). Concretely, he mentions sign systems as psychological tools including language in general, braille and sign language, math, etc. (Vygotsky 1993). In addition to psychological tools, Vygotsky also regards peer support as an important element in special education. He emphasises organised group education among disabled children and believes that peer relationships stimulate the disabled child’s motivation to learn and to develop their higher mental functioning. The role of schools is to form not only spontaneous notions but also scientific concepts, because the development of abstract and logical thinking can overcome disability. Vygotsky sets a positive and creative vision of disabilities focussing on residual and potential abilities in the disabled.

According to Shinjo’s outline of Vygotsky’s defectology, disability is seen as a socio-cultural process mediated by the use of psychological tools and others and special education aims to change higher mental functioning of disabled children. However, it seems that he does not mention concrete methods of instruction or roles of the teachers much in his theory of defectology. In relation to the dementia relationship, his viewpoint on disability as a socio-cultural process seems to have much in common with Kitwood’s arguments on social constructionist view. On the other hand, Vygotsky’s emphasis on the development of higher mental functioning and the use of psychological tools seems original. Then, what are psychological tools and how do therapists find and devise them in their therapies? In the next chapter, I will cover narratives as a useful psychological tool and discuss their significance for the teaching-learning process in dementia.
3.2 Narrative as a psychological tool and therapists as dialogic learners

In this chapter, I will define what is narrative including its structure and formation process and then discuss its roles and meanings as a psychological tool in therapy, dementia care, and pedagogical situations. Especially, I will focus on how teachers or therapists can enhance their expertise using narratives.

3.2.1 What is narrative?

As discussed in the previous chapter, Vygotsky points out the importance of mediated tools and others in the teaching learning process especially focusing on psychological tools as sign systems. With the use of psychological tools, he thinks people master mental and behavioural processes of their own or someone else’s (Vygotsky 1981a). He illustrates the acquisition of language as a typical example of the use of mediating tools several times and narrative is one of the common forms of language which people mundanely use every day. However, what is narrative?

When we think of narrative, we often imagine literary works such as a novel or a folk tale, but actually, we engage in narrative discourse not only intentionally but also unintentionally every day. For example, we use narrative or story forms, when a child wants to describe what was happened in her kindergarten, a student tries to explain his exciting experiences during the summertime to a classmate, or a grandmother looks back at her past with her grandchildren. In this sense, narrative seems a “distinctive human trait” (Abbott 2008: 1) and making narrative is a common and ubiquitous phenomena in human life. Due to the pervasiveness of narrative, many researchers have focused on the study of narrative and devised various versions of its definition (e.g. Bruner 1990, Labov & Waletzky 1967, Polkinghorne 1988, Propp 1968). Although it is still not easy to obtain a single, simple and elegant definition, Abbott (2008) gives us one of the most informative and integral interpretations of narrative after reviewing several of its conceptualisations. In contrast to the researchers who equate a story with narrative, he defines narrative as “the representation of events, consisting of story and narrative discourse”, while “story is an event or sequence of events (the action) and narrative discourse is those events as represented” (Abbott 2008: 19). In this interpretation, an event is a basic component of narrative and includes a sequence of “mental states and happenings involving human beings as characters or actors”
(Bruner 1990: 43). In other words, to understand narrative, it is important to cover “the overall configuration of the sequence as a whole – its plot or fabula” (*ibid.*: 43). Moreover, in structuring the narrative scheme, we can create meanings for each event and comprehend individual experiences and the experiences of others within the narrative framework. Polkinghorne (1988: 18) writes on this point as follows: “In summary, narrative is a meaning structure that organizes events and human actions into a whole, thereby attributing significance to individual actions and events according to their effect on the whole.” That is, narrative is a basic tool for making meanings to frame our activities and experiences.

### 3.2.2 The construction of narrative: Mediation of others

Narrative depicts events with characters and conveys the understanding of happenings, but the narrative construction process also has another important role: the mediation of others including characters, readers and authors. For example, Asano (2001: 62) summarises three main structural features of narrative as follows: (1) selective structuring of events with a temporal order, (2) creating two perspectives of an author and a character, and (3) co-authoring with a reader. As I mentioned above, the first function means that people organise events based on some criteria and make a link between them in a narrative form. The link, a succession of events, creates a chronological order (Abbott 2008) and gives an appropriate meaning to the narrative as a whole. Secondly, a narrative portrays a perspective of the character, while the author has his/her own. The perspective means how the character or the author sees events in the narrative. In other words, a narrative expresses consciousness and feelings forming the self. Especially, when the author tells the audience something about his/her life story (*e.g.* autobiography), the perspectives between the character and the author need to be consistent with each other. Thirdly, narrative always needs someone to tell it and a reader or listener who actively participate in making the narrative as co-creators. Although it seems that the author sometimes produces a narrative alone, narrative is always formulated in response to the reader or listener the author focuses on (Morson & Emerson 1990). In this respect, Russian philosopher, Bakhtin ponders narrative making as a dialogic relationship between an author (a speaker) and a reader (a listener) as follows:

“The word cannot be assigned to a single speaker. The author (speaker) has his own inalienable right to the word, but the listener also has his rights, and those
whose voices are heard in the word before the author comes upon it have their rights (after all, there are no words that belong to no one).” (Bakhtin 1986: 121–122).

Bakhtin thinks that for the active understanding of words (utterances), the author anticipates the reader’s perspective, while the reader anticipates the author’s. His term ‘voice’ indicates “the speaking personality, the speaking consciousness” (Holquist & Emerson 1981: 434) and exists in a socio-cultural context (Wertsch 1991). It means that the interlocutors enter a reciprocal relationship in making words as Bakhtin (1984: 183) says: “Language lives only in the dialogic interaction of those who make use of it.” In fact, Bakhtin did not overtly use the term narrative much in his writings, but his insights into the creation of words and the dialogic relationship in novels seems to be applicable to narrative (Anderson 2008). As a form of meaningful communication, narrative always belongs to (at least) two people, an author and a reader and needs to be negotiated between them. It also means that making narrative is an intersubjective activity (Charon 2006).

This intersubjective and social nature of narrative formation can be depicted applying a Vygotskian triangle as shown in Figure 3. The second feature of narrative described by Asano (2001) is the relationship between the author and a character in a narrative. Here, narrative works as a psychological tool for making meaning and at the same time a character exists in narrative. Moreover, the third feature he describes is the relationship between the author and a reader. Each of participants is directed towards the creation of meaning (O) through narrative. With this triad relationship, an author, a reader and a character interact each other, exchanging and articulating their perspectives and thoughts.

![Fig. 3. A triadic relationship towards meaning-making.](image-url)
3.2.3 Narrative as a tool for sense-making and self-making in a therapy situation

The mediation of others in narrative formation has attracted researchers’ attention in medical and caring fields and narrative is used as a tool for therapeutic communication and making sense (Anderson 2008, Frank 2013, Kleinman 1989, Mattingly 1998, Mattingly & Garro 2000, Noguchi 2002, White & Epston 1990). Narrative opens the opportunity to negotiate and to enrich people’s perspectives and develops their imagination and understanding of others and themselves through it. It helps sufferers and therapists to see the world from others’ points of view and consequently, they can find new meanings for their illnesses, experiences and themselves.

For example, Anderson (2008: 109) characterises the process of psychotherapy as a “dialogical conversation” between and within a client in which “new meanings – different ways of understanding, making sense of, or punctuating one’s lived experiences – emerge and mutually constructed.” The idea of the dialogical conversation is based on the postmodern view which sees humans as intentional and socio-historical entities creating themselves and their environments in dialogue and interaction with others. The aim of therapy is “not to discover knowledge or information, but to create new meaning and understanding mutually” towards “a transformation of the narrating self of the client” (Anderson 2008: 110). In her opinion, the self or the identity is not a stable or fixed entity, but “is an ever-changing expression of our narratives, a being-and-becoming through language and storytelling as we continually attempt to make sense of the world and of ourselves. Self, therefore, is always engaged in conversational becomings, through relationship” (ibid.: 216). Thus, “the purpose of therapy is to help people tell their first-person narratives so that they may transform their self-identities to ones that permit them to develop understandings of their lives and its events, that allow multiple possibilities for ways of being in and acting in the world at any given time and express or execute agency or a sense of self-agency” (ibid.: 234). She also emphasises that in the process of self-narration, both that of a client and a therapist, there is risk a transformation of the self, because therapy is essentially an interpretative and interactive process.

Regarding the idea of narrative as a tool for making sense, a medical anthropologist, Mattingly points out that narrative accounts of illnesses reflect “a cultural understanding about illness – including possible causes, appropriate social responses, healing strategies and characteristics therapeutic alternatives”
(Mattingly & Garro 2000: 26). Stories work as cultural resources for understanding and constructing illness experiences mediating the personal and cultural meaning. With matching or conflicting private experience and cultural knowledge about illnesses, people search for the appropriate narrative for their disrupted lives (Frank 2013). How to tell or listen to a story is a cultural matter which is learned in one’s community. Moreover, as the life history approach shows (Frank 2013, Kaufman 1988, Kleinman 1989), stories about illness often address the process of exploring a person’s sense of identity, because disease such as chronic illness radically affects the way of the sufferers’ life, their visions of the future and their thoughts about themselves (Mattingly & Garro 2000). To reveal the narrative structuring process between therapists and sufferers in practice, Mattingly (1994) conducted fieldwork on occupational therapy sessions and developed the notion of ‘therapeutic emplotment’ (Del Vecchio Good et al. 1994, Mattingly 1994, 1998). It is “the interpretive activity, present in clinical encounters, through which clinicians and patients create and negotiate a plot structure within clinical time, one which places therapeutic actions within a larger therapeutic story” (Del Vecchio Good et al. 1994: 855). Mattingly (2000) also develops the concept of ‘emergent narratives’ which are created in action rather than words in clinical sessions. Both of her conceptualisations on narratives are distinctive from other researchers in that Mattingly sees narrative “not only as told (that is as texts that need interpreting to make sense of situations), but as related to social action (that is as having the potential to create experiences in clinical practice)” (Tropea 2012: 940). Narrative emplots clinical actions to transform the sufferer’s desire for a therapy through the interaction with therapists. There is “a paradigmatic shift from stories ‘as told’ to stories ‘as tools’ in the hands of health professionals to shape therapeutic interactions in clinical situations” (ibid.: 945). That is, narrative works as a tool by being actively involved in the interaction, reflecting and reorganizing the illness experience, reshaping a lost sense of identity, and fostering hope for the therapy between therapists and sufferers (Mattingly 1998, Tropea 2012).

As can be seen in the discussions reviewed, narrative in medicine functions to create new meaning and self-identity embedded in both of socio-cultural and personal contexts. It becomes a therapeutic tool for organising the interaction between therapists and sufferers as a story-like structure and provides an opportunity for clinical reasoning and reflection. In the case of the dementia relationship, how do therapists and sufferers create these narratives in spite of the sufferer’s cognitive and linguistic difficulties? In the next chapter, I will briefly
explore the narrative studies in the field of dementia studies focusing on the above problems.

3.2.4 Narrative research in dementia

In dementia studies, there are growing interests in narrative formation especially from the therapeutic points of view. Killick and Allan (2001) clearly indicated the positive potential of narrative for dementia as a way of maintaining memories, identity and relationships with others. Although dementia is a multiple cognitive disability including memory impairment or aphasia, telling a narrative seems to help sufferers to remember their past experiences and to activate communication with others. Pragmatic approaches, such as reminiscence therapy and life reviews, have been developed as intervention methods to facilitate recall of past experiences and to encourage interaction with others using narratives. Though the empirical evidence for these approaches has been insufficient, mainly because of small sample sizes and post-test design problems (Cotelli et al. 2012, Kasl-Godley & Gatz 2000), these methods have been commonly used among healthcare practitioners.

While reminiscence and life review therapy have mostly emphasised the cognitive changes in individuals as a result of narrative intervention, other researchers have paid attention to the interpersonal exchanges in narrative formation. Some of previous studies have shown that dementia sufferers actively construct narrative with others (Crisp 2000, Kitwood 1997b, Örulv & Hydén 2006). Caregivers and therapists especially provide an important contribution to the co-construction of narratives (Graham & Bassett 2006, Hydén 2011, Ota 1996, Ozawa & Tsuchimoto 2004, Ramanathan 1995, Zgola 1999). For example, Ramanathan (1995) analyses narrative well-formedness in her conversation with a woman with Alzheimer’s disease and finds that the sufferer needed recipient scaffolding to construct a well-formed narrative. Hydén (2011: 341) applies Bruner’s notion of scaffolding to the collaborative storytelling process in AD and explains that persons with AD need “experts” in the storytelling who can interpret the meaning of contributions and find appropriate words or references for them. Scaffolds consist of mutual interpretative processes (repair work) and “lengthy and complex search activities for words and linguistic expressions as well as for references to past events or persons” (ibid.: 342). For successful joint making of meaning, the experienced partner organises the interaction as a narrative scaffolding and the
storytelling becomes a collaborative and moral activity to sustain the personal relationship.

Seeing the narrative formation as a joint activity leads to concerns on the co-construction of meaning and self. Örulv and Hydén (2006) analyse confabulation in AD identifying it as narrative discourse and found three functions: 1) making sense of the current situation, 2) making the sufferer’s self, and 3) making the joint action in the world. They stress that confabulation is a meaning making activity with others and thus embedded in the immediate and life history contexts rather than de-contextualisation. Confabulation is structured to answer those questions such as “where am I?” and “who am I and what am I like?” (ibid.: 668) as a dialogue. They have also studied the formation of autobiographical narratives among persons with AD and found that the evaluation of the story events by the staff plays a central role in it (Hydén & Örulv 2009). In this study, they question the conventional views on narrative as a well-formed autobiography depicting a stable and fixed identity (Usita et al. 1998) and suggest that the self is ‘fragile’ and in need of ‘patching-up’ (Örulv 2008) but maintained through the interaction.

As seen above, these recent narrative studies in dementia have revealed narrative features as a tool for making meaning and interaction, but still, some issues seem to remain. For example, Hydén & Örulv (2009) point out that many researchers have missed the analysis of spontaneous narrative production by persons with AD and the performative aspects of autobiographical narratives, because they have focused on the functional and grammatical characteristics of the sufferers’ narrative in the experimental situations. As other researchers note (Hydén 2011, Ota 1996, Ramanathan 1997), everyday situations and social contexts where the actual narrative interactions between sufferers and therapists occur are not fully discussed in the research literature. On the other hand, Hydén and his research group (Hydén & Örulv 2009, Hydén 2011, Hydén et al. 2013, Örulv & Hydén 2006, Örulv 2008) actively investigate narrative co-construction processes among caregivers, peers and sufferers in a nursing home, but it seems that they have not entirely examined the role of the health professional as a story listener and co-creator with background expertise. Since they mainly study the narrative co-creation process and its structure in a limited time, it seems difficult to take into account the therapist’s developmental process and skills in narrative co-construction. However, in the narrative collaboration, therapists often play a role as “the expert in engaging and participating with a client in a dialogical process of first-person story telling” (Anderson 2008: 95). As an expert, therapists attempt to learn from sufferers, while “the client becomes the teacher” (ibid.: 95) to tell a story.
That is, the therapist’s task seems “to facilitate dialogue, and through dialogue, creates optimal opportunity for newness in meanings, narratives, behaviours, feelings, and emotions” (ibid.: 98), especially in the therapy sessions. Thus, the therapist’s contribution to narrative formation and its progress needs to be considered.

In search of the role of the therapist and the meaning of narrative as a tool for sense making, again, I will focus on the pedagogical approaches to narrative in the next chapter. In educational studies, narrative is widely used to study the meaning making process by both of students and teachers. Although there are variety of narrative inquiries, I will pick out two kinds of narrative studies based on the Vygotskian approach, narrative learning and Egan’s theory of cognitive tools, in order to investigate meaning as a tool and its application in the teaching-learning process.

**3.2.5 Narrative as a pedagogical tool: Narrative learning and Egan’s theory of cognitive tools**

Narrative research in educational science has been very popular as a means to investigate experience in education (Connelly & Clandinin 1990). Narrative is treated as both a “phenomenon and method” (Connelly & Clandinin 1990: 2), namely the human experience as a research subject, and a type of research methodology. While much narrative research has been conducted in the field of teacher education to explore how narrative shapes teachers’ practices and express modes of knowledge (Carter 1993, Bell 2002), researchers adopting a Vygotskian approach view narrative as an essential learning tool for teachers and learners mediated by society and culture. As a pedagogical tool, narrative works not only for the illustration of teachers’ knowledge or the implementation of a school curriculum, but also for the mutual teaching-learning process and development among participants.

One of the implementing approaches to narrative is called ‘narrative learning’ and was developed by a Finnish research group (Hakkarainen 2004, 2006, Hakkarainen & Bredikyte 2010). Narrative learning is based on the theoretical ideas from Vygotsky’s discussion regarding play where play creates a zone of proximal development for children and holds the transitional nature between imaginary and real situations (Vygotsky 1978). The narrative learning approach is also influenced by Lindqvist’s pedagogy of the ‘playworld’ (Lindqvist 1996) which enables the development of joint play between adults and children through “the
creation of a common fiction” (Ferholt 2007: 27). In narrative learning, narrative is seen as “a basic principle of the human mind and a psychological tool formalizing and unifying human thought and knowledge into thematic units” (Hakkarainen & Bredikyte 2010: 60) and adults and children mutually work for the construction of narratives as a drama play. The joint creation of fascinating narratives and the environments in which they are performed by the participants allows the participants to explore the tension or transition between the play world and real life. According to Vygotsky (1978: 100), play creates a zone of proximal development, because during play activity children can create a role that Vygotsky describes as the “fictitious ‘I’,” which fits the, “role in the game and its rules” and emancipate their thoughts from the constraints of the immediate situation. With the development of imagination and self-will in play, children make sense of their imaginary and real worlds and foster abstract and internalised thoughts. Simultaneously, play offers joyful and emotional engagement for the participants. In narrative learning, a problem-solving situation becomes an emotional, voluntary, creative, and joint sense making activity rather than merely the provision of information by adults. Children actively investigate riddles by playing make-believe together in narrative learning and it differs from traditional school learning where students tackle problems independently. That is, narrative learning offers an enjoyable and exciting learning environment where participants meet a challenge and foster self-motivation for learning within the plot of the story. The task of the adults here is to establish and facilitate a peer-oriented story world.

While the concept of narrative learning mainly focuses on the theorization of the child’s development in play using narrative and its implementation as a “genetic experiment” (Hakkarainen 2009: 65) in the field of teacher education, Canadian educational philosopher, Kieran Egan considers narrative an essential teaching material and develops his idea on this pedagogy in practice. In connection with Vygotsky’s theories, Egan (1997, 2005) names narrative as a cognitive tool. Depending on Vygotsky’s notion of tool mediation, he explains that when we master the use of cultural tools which are invented, discovered and accumulated by our ancestors and communities, they become personal cognitive tools (Egan 2005). Through the acquisition of cognitive tools, “each of the elements of our culture can be internalised, in varying ways and to varying degrees, by individuals” (Egan 2005: 8) and helps our intellectual and imaginative development. Thus, the mastery of cognitive tools is important factors for the teaching-learning process and educators need to prepare each of tools according to children’s developmental stages (Egan 1989, 1997, 2005). As a part of cognitive tools, Egan (2005) proposed primary
cognitive tools such as story, metaphor, binary opposites, ‘rhyme, rhythm, and pattern’, mental imaginary, play, mystery, etc. He basically uses the term, story in conjunction with narrative and defined stories as follows:

“... one of the most powerful cognitive tools students have available for imaginatively engaging with knowledge. Stories shape our emotional understanding of their content. Stories can shape real-world content as well as fictional material. It is this real-world story-shaping that promises most value for teaching.” (Egan 2005: 2).

By Egan’s (1989) definition, stories have particular structures including clear beginnings and ends. The story sets up a conflict or sense of dramatic tension at the beginning, “is elaborated or complicated in the middle, and is satisfied in the end” (Egan 1989: 24). He called this story flow “story rhythm” (ibid.: 24) and suggested that the task of teachers was to select and introduce a well-wrought story in the lessons. To choose the appropriate story, teachers need to be conscious about what the most important aspect is about the topic in relation to profound abstract concepts which children can clearly understand. Good stories allow emotional and imaginative engagement with children by “communicating information in a memorable form” (Egan 2005: 10) and shaping the listeners’ feelings about the information. The key of the story in the teaching-learning process is its power to engage children’s emotions.

To make the story emotional, Egan suggests the uses of other cognitive tools as structural components in stories. Binary opposites are one of them and “the most basic and powerful tools for organizing and categorizing knowledge” (Egan 2005: 3). These elements appear as conflict in almost all stories and we use them for all ages. Binary opposites, such as conflicts between good and bad or fear and security, structure story lines from the beginning and organise the following content. They make meanings of the story clearer and are applicable for children in stimulating abstract thoughts. Thus, Egan (1989, 2005) recommends teachers find clear and comprehensible binary opposites to capture the most important aspects of a topic in teaching.

In addition to binary opposites, another cognitive tool for the development of the story is the recognition of mystery. As he describes,

---

5 Actually, Egan differentiated the term, story from narrative in his recent book (Egan 2005). To mention the different level of understandings in ages, he employed story for preschool children, while narrative is used for school-age children.
“Mystery is an important tool in developing an engagement with knowledge that is beyond the students’ everyday environment. It creates an attractive sense of how much that is fascinating remains to be discovered.” (Egan 2005: 5–6).

Egan places great emphasis on mysteries, because they enrich the learner’s understanding with the realisation of the richness of knowledge. Mystery leads the exploration beyond our existing knowledge and he describes this experience as “from the known to the unknown” (Egan 1989: 12). Discovering unknown matters and knowledge in the known world is one of the important purposes of education. He describes this point as follows:

“The educational achievement is not to make the strange seem familiar, but to make the familiar seem strange. It is seeing the wonderful that lies hidden in what we take for granted that matters educationally.” (Egan 1989: 47).

He claimed that the known-to-unknown principle can be suitable for other cognitive tools such as binary opposites. Since our knowledge and experience of the world accumulates from the known to the unknown, Egan (1989) thinks the adoption of the principle is essential to develop abstract concepts and imagination in education. In other words, it means that educators can take ‘known’ knowledge and cognitive tools which children have already mastered as a starting point for their teaching. For the design of a curriculum in practice, teachers need to make the known contents exciting and mysterious to students. To create mysteries using this principle in the classroom, Egan (2005: 53) suggested that teachers “try to re-see the topic through the eyes of the child, to catch what can stimulate the sense of wonder about even the most routine topics” in their planning of lessons. That is, teachers need to identify “sources of wonder” (ibid.: 53) in the topic and emotionally engage in the materials ahead of the children. The “teacher’s own emotional engagement with the content must become central” (ibid.: 214) to allow the students to emotionally engage with the teaching-learning process with narratives and other cognitive tools.

To summarise, the above narrative approaches adopting Vygotskian perspectives seem to share common ground in the following areas: (1) narrative is a cultural and psychological tool for teaching and learning, (2) narrative evokes emotional experience and meaning in story forms and thus, motivates students and teachers and develops their imagination and thoughts, and (3) narrative is also a pedagogical tool which firstly enables teachers to plan and implement the teaching contents in imaginative and collaborative ways. It seems that both approaches make
the role of narrative in educational use clearer, but again, how about the role of teachers, especially in terms of teachers’ expertise with narratives? Inspired by these narrative approaches and other theories, a Japanese psychologist, Miyazaki (2005, 2006, 2009, 2010a, 2010b, 2012, 2013) developed his theory on teachers’ learning process and skills with narratives in the classroom. In the next chapter, I will introduce his pedagogical theory to find the relation and similarity in therapists’ expertise in using narratives.

3.2.6 Miyazaki’s theory of teachers’ expertise and learning

Based on observational data from his fieldwork in classrooms organised by experienced Japanese teachers, Miyazaki (2010b) has investigated the teachers’ expertise and their learning process as a form of dialogic pedagogy. He uniquely extended Egan’s teaching models to the theory of teachers’ strategies in classroom and their learning process making a connection to Japanese pedagogy founded by the elementary teacher, Kihaku Saitou in the 20th century and Bakhtin’s theory of dialogue. In relation to the narrative approach, the points of his theory are: (1) teachers’ exploration of ‘the unknown question’ enriches the understandings of the narrative and teaching materials between students and teachers, and (2) teachers are the dialogic authors who listen and discover various views and voices from the teaching materials and children. The first concept is about the teaching strategy in the classroom and the second relates to the teacher’s active learning behind his teaching.

The exploration of the unknown question in the narrative classroom

Leaning on Egan’s (1989, 2005) approach to teaching as a form of storytelling, Miyazaki emphasises the organisation of teaching content in story form by teachers. What makes Miyazaki’s idea different from Egan’s model is that he thinks teachers' explorations into the teaching content and their initiatives and responsibilities towards the students are vital to the formation of good classroom use of narratives. Egan proposed a general framework for teacher planning with the use of cognitive tools and claimed that emotional engagement with teaching materials was the key, but Miyazaki describes how experienced teachers authentically and emotionally commit to the materials in classrooms and found that their teaching-learning process utilises unknown questions (Miyazaki 2009, 2013).
In his explanation, “an unknown question is one to which the teacher does not know the answer, or the one which the teacher does not know the existence and/or significance of before the lesson starts” (Miyazaki 2013: 112). He argues that teachers normally think that questions in an elementary school curriculum are not worth pursuing much because they seem rather easy for teachers to understand and there are already numerous correctly prepared answers in teaching guidebooks. However, unknown questions exist as “unnoticed puzzles” (Miyazaki 2013: 113) in the questions which teachers believe that they already understand. To discover and develop the unknown question, teachers need to re-examine what they already know in the teaching content including their common sense knowledge. Like Egan’s concept of exploration “from the known to the unknown” (Egan 1989: 12) or with mysteries used as a cognitive tool, the unknown question uncovers the hidden questions behind our existing knowledge. This gives learners the opportunity to make “the familiar strange” (Egan 1989: 47) with feelings of excitement, and supports the development of teaching content as a form of storytelling. Moreover, he argues the similarities between the unknown question and a German philosopher, Gadamer’s, discussion on text understanding. Quoting Gadamer’s (2004: 363) words, “We can understand a text, only when we have understood the question to which it is an answer”, Miyazaki argues that to gain a deeper understanding of the teaching content or students’ perspectives, it is necessary for teachers to discover the questions in those elements, and to understand the formulated question they also need to examine the answer which the question presupposes. In Gadamer’s sense, to understand the examined answer, it is also necessary to discover the question in it, and thus the exploration of the question by teachers can be seen as a never-ending investigation (Miyazaki 2012). The discovery of the unknown question is the starting point of such a process.

To demonstrate these ideas, Miyazaki (2010a, 2013) provided an empirical example of an unknown question, “what is a store?” which was introduced by the teacher and discussed in a social studies class. He presented the idea that this question triggered many new questions and interpretations along with scrutiny with emotional engagement from the teacher and children. He also analysed other lessons and found that children’s erroneous answers produced new lines of inquiry into the unknown question for the teacher (e.g. Miyazaki 2010a, 2010b, 2013). In those cases, both teachers and children brought the unknown questions into the classroom, but Miyazaki considers that the teachers’ initiative and learning on the content is fundamental for finding the unknown question and the development of narratives in lessons.
Teachers’ expertise as dialogic author

If the unknown question offers the chance to deepen the comprehension of the teaching materials as a narrative, how can teachers recognise and practise this in the class? Miyazaki also provided some insights into this question. The first point is the teacher’s pursuit of knowledge of the teaching content in advance of the lesson. With the examination of learning methods developed by teachers practicing a form of Saitou pedagogy called Kyouzai-Kaishaku⁴, he pointed out that three kinds of knowledge are crucial for the understanding of teaching materials (Miyazaki 2010a). Teachers need to have general knowledge as a sort of common sense, professional knowledge applying both the children’s point of view, and the specialised knowledge that experts possess. The last two kinds of knowledge especially are important to go beyond the boundaries of conventional thinking and to discover the unknown question. One type of professional knowledge that teachers have is that teachers know and imagine how children think and they understand how to respond them. In other words, teachers can learn and are able to comprehend the teaching material as a child. To acquire specialised knowledge, teachers need to meet many experts who have useful knowledge related to the teaching material and receive the information from them as field research. The learning from experts leads to a re-examination of their existing knowledge and the realisation of more accurate answers in the material. To meet and organise knowledge and ideas, teachers can utilise cognitive tools such as binary opposites and mysteries. In other words, in this learning process, teachers emotionally re-encounter the cultural resources related to the teaching content with the discovery and creation of unexpected, varied and new findings and problems (Miyazaki 2009, 2010b).

The second point is Bakhtin’s notion of polyphony. Miyazaki applied Bakhtin’s idea on voice and polyphony and proposed the teacher as the author of a polyphonic novel. As previously mentioned, Bakhtin emphasised the dialogic relationship between authors and readers in a narrative (novel) and actively discussed the authors’ job in creating polyphony in his essay on Dostoevsky (Bakhtin 1984). Bakhtin distinguished two types of novels as monologic and polyphonic by comparing both the novels of Tolstoy and Dostoevsky. While only “the author’s voice controls all” (Miyazaki 2010a: 43) and the author’s own ideology dominates

⁴ Miyazaki explains that Kyouzai-Kaishaku means that “the process of learning the relevant knowledge of the teaching material and preparing it for the lesson”(Miyazaki 2010a: 34).
in the monologic (Tolstoy’s) novel, the author takes “a fully realised and thoroughly consistent dialogic position, one that affirms the independence, internal freedom, unfinalizability, and indeterminacy of the hero” (Bakhtin 1984: 63) in the polyphonic (Dostoevsky’s) novel. Miyazaki applied the above Bakhtin’s views on the author and the novel to the teacher and their work in a classroom and suggested that children can be seen as the heroes in the Bakhtian sense because the author (teacher) takes the ethical responsibility for listening and creating various voices from the heroes (the children). Moreover, “thoughts, views and interpretations in the teaching content” (Miyazaki 2010a: 42) can be seen as heroes, too. As Miyazaki wrote, although they do not seem to be characters as such, Bakhtin regarded the hero as “a particular point of view” (Bakhtin 1984: 47) in a novel. Miyazaki suggests that teachers as monologic authors presume that they fully understand the teaching content and the children’s thoughts and simply use the already acquired teaching methods and knowledge without new discovery and exploration in the teaching material. In such a class, children just follow their point of view in pursuit of the ‘correct’ answers. On the other hand, the teachers as polyphonic authors search for new thoughts about the teaching content to relativise their acquired knowledge in the process found in Kyouzai-Kaishaku. They meet many different and fresh thoughts and voices related to the teaching material and enrich their knowledge. In the lesson, the teachers set the arena for dialogue among heroes (children and thoughts from the teaching material) and themselves and participate in the process not as the facilitator or ‘third-person’ but as a person who confronts children as equals. Thus, the teachers listen to the children’s possible voices carefully, discover various and meaningful ideas from them in relation to the teaching material, and make the differences and similarities clearer using cognitive tools and revoicing (Wells 1993) to raise a conflict. Through this endeavour, children “confront with the teacher, present their views as having equal right to the teachers, find out new, unexpected views in themselves and experience themselves ‘unfinalizable’” (Miyazaki 2010b: 202) as polyphonic heroes.
The above analysis leads to the third point: the triadic relationship between teachers, children and the teaching material in the formation of the dialogic classroom (Miyazaki 2012). Based on the research on infant intersubjectivity in developmental psychology (Tomasello et al. 2005, Trevarthen 1998) and Saitou pedagogy, Miyazaki argued that triadic engagement is the key to understanding the teaching-learning process as a dialogue. As Figure 4 shows, in dialogic learning, firstly, teachers interact with the teaching material as the polyphonic author finding new ideas and the voices of the characters (1), secondly with help from the teachers, children communicate with the teaching material as polyphonic heroes confronting the various views (2), and thirdly, teachers and children contest their own viewpoints and thoughts with each other (3). During the whole process, teachers mediate the teaching content and the children and make them confront another point of view. Miyazaki suggests that by seeing the teaching-learning process as a triadic relationship, we could understand the teachers’ expertise both as in terms of learning from the children and the teaching contents.

![Fig. 4. The triad relationship in the teaching-learning process.](image)

In Miyazaki’s conceptualisations, teachers are active learners who explore the teaching material in advance of the children. Miyazaki called this type of teacher the “proto-learner” (Miyazaki 2005) because the teachers’ learning process serves as a prototype (model) of the children’s learning in the sense that they experience how to explore the teaching content as a whole person before the lesson. With the teachers as the proto-learner, children not only learn about the study materials but also know how to learn. Teachers act as a pioneer of the learning.

From this point of view and the above discussions, I think teachers can also be seen as dialogic actors in that they interact with the teaching material and learn the
cultural sources with others as proto-learners. They prepare and author the dialogue between the children and the teaching material polyphonically and themselves join in the dialogue as the polyphonic author. As Miyazaki noted, the classroom dialogue is not just an activity to explicitly exchange opinions or information among participants, but to rediscover the new thoughts and even find “the still weak voices, the not-yet fully emerged ideas, the voices latent as potentialities” (Miyazaki 2013: 117). The creation of dialogue requires teachers’ work and thus, their learning of the teaching material and children are essential for the construction of the dialogic environment. In sum, Miyazaki’s theory of teachers’ expertise provides a clue to explicate the characteristics of knowledge, strategies and professional development in elementary teachers.

3.3 Why a pedagogical approach in dementia relationship?

Narrative as a psychological tool and therapists as dialogic learners

In this chapter, first I explored the idea of the mediating tool and others in the teaching-learning process and socio-cultural nature of the disabled by Vygotsky. From a Vygotskian perspective, it seems comprehensible that the mediation of psychological tools and others are important for the development of higher mental functioning and compensation for the handicap. Then, to scrutinize the use of mediating tools and the contribution of the others, I focused and reviewed narrative research examining the meaning of narrative and its co-construction process. As a result, it seems clear that narrative is a psychological tool which we use to make sense of our experience and the self. It is socially and culturally mediated by others and thus, it consists of the perspectives of authors, readers, and characters. In therapy, the creation of new meaning and mutual understanding through narrative co-construction is the key for caring. In this respect narrative works as a therapeutic tool to shape motivation for treatment, clinical reasoning, and reflection between therapists and AD sufferers. In the context of dementia studies, narrative also works as a tool for sense making and interaction while others play a significant role in creating it using scaffolding frameworks. I also addressed, some research problems such as the lack of the therapists’ expertise in the formation of narrative. For further consideration, I investigated educational studies on narrative and found that narrative is one cognitive tool to emotionally engage with the teaching material and to develop the imagination and thoughts for both of children and teachers. To carry out teaching as story-telling and make it intriguing, teachers use other
cognitive tools such as including conflict or mysteries in the narrative and explore unknown questions in the teaching materials in advance of the children. The inquiry into the unknown question also requires the teacher’s effort to learn the teaching content emotionally as a proto-learner, and to discover the (possible) voices and viewpoints from children and in the teaching material as the author of a polyphonic novel. Based on their deep understanding of the teaching material, teachers mediate and create the dialogue between children and the teaching material and in that context, can be seen as dialogic teachers.

From the above literature review, how can I answer my initial questions which were formulated in chapter 2 including: “What kinds of tools are used in the dementia relationship?”, “What kind of characteristics do they have?” and, “As a teacher or a user of tools, how does the therapist work with them?” First, as socio-cultural entities, AD sufferers and therapists seem to jointly construct narratives in their therapy or everyday situations. Second, narrative works as a psychological tool in that it makes sense of the sufferers’ experience in story form and provides sufferers with an understanding of the real-world, their motivation for treatment, and it provides reflection on the therapy and the sufferers lives with emotional engagement. Third, in the same way that the dialogic teacher does, therapists listen to sufferers’ voices, find viewpoints in narratives, and create dialogue to confront unknown questions. Therapists’ learning prior to meeting the sufferers especially is crucial for deepening their understanding of the sufferer, their narratives, and caring, and thus, in this way therapists try to explore the unknown questions.

Based on these hypotheses about the use of narrative as a psychological tool and the therapists’ expertise as the dialogic teacher, I think that the issues related to the studies into the dementia relationship can be considered from new perspectives as a teaching-learning process. As I discussed in chapter 2.5, some of the existing conceptualisations of the dementia relationship hold the problematic premises of being ‘non-mediated’ by tools, ‘decontextualized’ from the situation or the participants’ background and ‘non-negotiated’ by others”. However, these issues are replaced by the new viewpoints in my hypothesis regarding the mediation of socio-cultural tools, the narrative co-construction as the socio-cultural context, and others’ negotiation in the dementia relationship. From this point of view, I think that we can shed light on the real process of the dementia relationship and the therapists’ contribution, and provide appropriate engagement with persons with dementia.
4 Research questions

In this research, to clarify the relationship between therapists and sufferers and the role of mediating tools and therapists in dementia care, I will consider the relationship in dementia care as a teaching-learning process with narratives and will examine the following questions using the theoretical frameworks of Vygotsky’s socio-cultural approaches, narrative studies, and pedagogical research related to Bakhtin’s theory of dialogue.

The questions are: (1) as a mediating tool, what kinds of narratives were created through everyday interaction between therapists and dementia sufferers?, (2) how and why were narratives constructed?, (3) as a dialogic teacher, what is the teaching-learning process of the therapist through joint narrative formation?, and consequently, (4) what is the relationship in dementia care?

To solve these questions, I conducted field research in a Japanese nursing home and analysed the data with an interpretative study including observations and interviews. In the following chapters, I will report my research process and results in detail.
5 Methodology

In this chapter, I will describe the methodology of my study, consisting of the theoretical presuppositions of the research methods or techniques, descriptions of research procedures for the data collection including the setting, the participants, the positioning of the researcher, analytical framework, and other related matters.

5.1 Research strategy: Interpretative study

In this study, I will examine the process of narrative formation and the therapist’s learning, but how can this be approached? Recently, as I mentioned in chapter 3, narrative approaches have become a widespread trend across various disciplines and multiple methodologies have developed based on the different epistemologies of narratives. On the other hand, since narrative is a tool for sense making, Polkinghorne (1988: 6) notes that “the aim of the study of narrative meaning is to make explicit the operations that produce its particular kind of meaning, and to draw out the implications this meaning has for understanding human existence”. That is, narrative research deals with the realm of meaning in which the narrative operates.

To investigate human meaning and sense, I applied interpretative study as a research strategy. Although the word, interpretative represents many aspects, Erickson (1985b: iii) writes, “the central questions of interpretative research concern issues of implicit and explicit choice and meaning from the points of view of actors in social life, regarding the actions they take in everyday life”. While some researchers prefer to use the term “qualitative” for sketching their methods regarding meaning-making by local people (Gergen & Gergen 2000, Denzin & Lincoln 2000) or others pointed out that all research is essentially interpretative (Schwandt 2000), Erickson (1985a: 119) clarifies his reasons of the application of the term ‘interpretative’ as follows: “(a) it is more inclusive than many of the others (e.g. ethnography, case study); (b) it avoids the connotation of defining these approaches as essentially nonquantitative (a connotation that is carried by the term qualitative), since quantification of particular sorts can often be employed in the work; and (c) it points to the key feature of family resemblance among the various approaches – central research interest in human meaning in social life and in its elucidation and exposition by the researchers”. Thus, in this way interpretative research is defined as an inductive and deductive practice carried out by the researcher to consider the distinctive local meaning that actors have in their cultural
and historical background. This standpoint originates from the ideas of post-modernism or social constructionism that human reality is not positive, but constitutive through an unceasing social interaction or so-called ‘narrative turn’ (Riessman 2008).

From this perspective, I designed my research methods and analytical framework. To capture the immediate and local meanings from the participants’ point of view, Erickson (1985a) proposed long-term participant observational fieldwork in the settings where the face-to-face interaction takes place. Based on his discussion, I conducted the fieldwork including participant observations and interview surveys in a nursing home for two years.

5.2 Research methods

Interpretative study contains several research methods such as ethnography, participant observation, case study, interview surveys, etc. In my research, I adopted participant observation and an interview in relation to the research strategy and the research situation. In my research setting, both of these methodologies seemed more natural and practical to apply because of some of the following reasons. First of all, few studies have been done on narrative construction with therapists in dementia care so that an exploratory study was primarily needed to grasp their actual interaction and the therapists’ learning process. As Erickson (1985a) points out, the local meanings and research problems are unknown in the beginning, and fieldwork is necessary. Second, as I elaborate later, my research had been done with occupational therapists and elderly people with dementia in a nursing home. Thus, it was very important not to interrupt their daily care activities as far as possible and develop an acquaintance with the local people, especially the dementia sufferers, to lessen their anxieties about my existence as a stranger, because it is known that sufferers are very sensitive to the reaction of others (Ota 1994, Zgola 1999). I will explain each research method in this chapter.

5.2.1 Participant observation

Participant observation has been developed mainly among anthropologists and sociologists. The process of participant observation has been depicted as a process where “an ethnographer lived in a society for an extended period of time, learned the local language, participated in daily life, and steadily observed” (Tedlock 2000: 465). Through this process, researchers produce documentary data called
ethnography that reflects the actors’ own perspectives about reality (Tedlock 2005, 2000). In the beginning, ethnography was seen as subjective or objective accounts of the research field, but recently, under the influence of post-modernists and social constructionists, it has been considered as a form of developmental documentation including a variety of voices of the self and others (Tedlock 2000). The work in participant observation is to capture these voices and to actively enter the cultural, social and personal dialogue.

Some researchers have described three types or levels of observation carried out during the research process as descriptive observation, focused observation, and selective observation (Angrosino & Mays de Pérez 2000, Werner & Schoepfle 1987). Descriptive observation is to observe everything as much as possible assuming that a researcher knows nothing. Focused observation is more selective in choosing research objects and a researcher gains an understanding of the participants by conducting interviews. Selective observation is more attentive to each activity in the field and enables a researcher to compare the differences and similarities among them. Angrosino and Mays de Pérez (2000) also recommend applying selective observation to “maximize the efficiency of the field experience, minimize researcher bias, and facilitate replication or verification by others, all of which make the findings more objective” (Kawulich 2005: 46). In their view, objectivity means the agreement between the researcher and participants on the research findings.

Other researchers regard the establishment of rapport with the participants as crucial in the process. As Bernard (2006: 344) notes, “establishing rapport and learning to act so that people go about their business as usual when you show up” is very important. To gain rapport and trust in the research community, participant observation usually requires a long time for settling in, learning a local language, and knowing how to ask the questions in the right place and time.

Not only the process, but also the researcher’s positioning is another index for discerning how the researcher is being involved in the field activities. Kawulich (2005: 21) notes that the stance of researcher “makes a difference in the quality and amount of data he/she will be able to collect”. For example, Gold (1958) characterises four ethnographer's roles according to their influence on the setting such as the complete participant, the participant-as-observer, the observer-as-participant, and the complete observer. In the first role, the researcher becomes a member of the community without notice of the disclosure of doing research. In the second role, the researcher becomes a part of the group being studied with the given role acknowledged by it. The group members know the research activity. The
third role involves a small amount of involvement in the community. The members recognise the research work and the researcher participates in their activity as desired, but mainly conducts his/her investigation. In the fourth role, the researcher does not take part in the activities at all and the members do not realise that they are being observed. Although this type of stances aims to measure ‘observer’s bias’, it is difficult to maintain the membership as a constant in practice and this role misses the interactive context of fieldwork. Thus, nowadays researchers affirm or develop a membership role in the communities with the conscious adoption of “a situational identity” (Angrosino & Mays de Pérez 2000: 678). The situational identity is a process of ‘role making’ and therefore, the process of the acquisition of such an identity is taken into consideration and described.

Although participant observation is a useful research strategy to approach the participant’s lives and their meanings, several researchers have pointed out disadvantages such as the problem of establishing ‘limits to participation’ and the researcher’s bias (DeWalt et al. 1998). To manage the researcher’s bias, they recommended to train the researchers in their writing and field note reflexivity, to use other research methods in addition to participant observation, and to collaborate with other researchers to build the appropriate generalisations. In my research, I applied both methods of participant observation and conducted an interview survey to reflect my research understandings and asked my Japanese supervisor to check the research data together. I will describe the detailed process in the following chapters.

5.2.2 Interview survey

An interview has been typically described as the way “two people, often relative strangers, sit down and talk about a specific topic” (Rapley 2004: 15). Since interviewing is the interaction between the informant and the interviewer, it is a highly contextual act embedded in cultural, historical, and social processes. Thus, there are many epistemological issues surrounding interviewing as an interpretative activity, but I will centre on a brief introduction of the interview survey with its classification, characteristics, advantages, and disadvantages here.

Many researchers have illustrated different types of interviews according to the research conditions such as the research purpose, the interview settings, the question format, the roles of the interviewer, etc. Among these, Fontana and Frey (1994) depict a comprehensive forms of interviewing as being structured, semi-structured, and unstructured. In their model, the degree of control by the interviewer
makes a difference among the three types. First, structured interviewing means the situation where “an interviewer asks each respondent a series of pre-established questions with a limited set of response categories” (ibid.: 363). While the advantage is to lessen errors by providing the same questions in the same process towards various interviewees, the disadvantage is that the process minimises flexibility and variation in response (Punch 2009). Second, in semi-structured interviewing, the interviewer and the informant engage in a formal interview using guidelines including the interview topics and questions, but the interviewer can change the flow of the interview in response to the informant’s reaction. It is beneficial for informants to express their opinion more freely by keeping flexibility in the interview, but the interviewer’s interpretation of the ongoing interview situation impacts the data and process. Third, unstructured interviewing includes a variety of types such as “the non-standardised, open-ended, in-depth interview, sometimes called the ethnographic interview” (Punch 2009: 147). The interviewer has the plan and goals to ask, but takes little control over the informant’s responses. With this amount of flexibility and interactivity, it is useful to explore and gain an understanding of the unknown meanings regarding the informants, the community and local culture (Ritchie & Lewis 2003). However, the quality of the data collected using this method greatly depends on interviewer’s communication skills and the relationship with the informants.

As with participant observation, establishing “balanced rapport” (Fontana & Frey 1994: 364) is a key because the goal of interviewing is to achieve understanding. Balanced rapport refers to a relationship with the informants which is friendly and relaxed, but keeps social distance from them so as to be neutral and objective. To maintain good rapport, Ritchie and Lewis (2003) suggest demonstrating a real desire to understand things from the informant’s perspective, to convey confidence as a professional researcher, and display interest and respect towards the informants.

In this study, I applied a semi-structured interview with the therapist in mind as the main research tool, but also used unstructured interviews when I had conversations with other people including dementia sufferers and care workers during my observations. I will describe the process in detail and the main questions which I asked in the interviews later.
5.2.3 Methodological triangulation: Combination of observation and interview

As an interpretative study, I carried out participant observation and an interview survey. The use of two research methods is usually referred to as ‘triangulation’ in social sciences. Triangulation means “the use of more than one approach to the investigation of a research question in order to enhance confidence in the ensuing findings” (Bryman 2004: 1142). Denzin (1989) categorises types of triangulation and defines methodological triangulation as the use of more than two methods for gathering data. He distinguishes two forms of methodological triangulation as the ‘within-method’ and the ‘between-method’. The former refers the use of multiple techniques in the same method, while the latter means the application of contrasting methods. For example, participant observation could be described as ‘within-method triangulation’ when it takes multiple comparison groups (Jick 1979) or implements a variety of data collection techniques such as interview surveys, document analysis, and multiple types of observations within one paradigm. The merit of the ‘within-method’ is “cross-checking for internal consistency or reliability while ‘between-method’ triangulation tests the degree of external validity” (Jick 1979: 603). On the other hand, Flick (1999) notes that Denzin’s idea of triangulation first appeared as a strategy for validating results. However, after critical and epistemological examinations from the viewpoint of social constructionists and interactionists, it seems to “produce knowledge on different levels, which means this goes beyond the knowledge made possible by one approach and thus contributes to promoting quality in research” (Flick 2009: 445). Thus, triangulation is seen as the tool for “theory construction” (Denzin 1989: 236) by researchers for examining different perspectives rather than focusing on validation and reliability.

When we use triangulation in our research, Flick (2009) stresses to clarify when and why to use it in connection with the research question, the field, and participants. In my research, since the research aim is to clarify the relationship between therapists and sufferers focusing on the role of the mediating tools and the therapist, firstly, I conducted participant observation of occupational therapists to obtain a comprehensive picture of their everyday activities. With the accumulation of knowledge about their interaction processes and the research finding of narrative as a therapeutic tool, I was interested in the therapist’s job in creating a therapeutic environment for the sufferers. To examine their subjective experience and insights into occupational therapy and the related narrative, I conducted interviews with
experienced occupational therapists. Therefore, there were two levels of analysis: (1) a narrative analysis of therapeutic interactions and how and why narrative was co-produced between sufferers and therapists, and (2) professional perspectives of the sufferers, practices, and expertise. To make the links on the different levels of the data, I mainly focused on the cases of two dementia sufferers in the observations and asked the therapist about the knowledge and experiences related to them in the interviews. At the same time, from the perspective of narrative formation, I checked the therapist’s accounts of their own experience and expertise to locate similarities and differences between their observed practices and their talks. Although both of research methods were basically qualitative and interpretative, they seemed helpful in exploring the dementia relationship from the viewpoints both of social structure and the subjective meaning of the therapist.

5.3 Research Procedures

This chapter describes the processes of data collection and analysis through participant observation and an interview survey to explore the research questions mentioned in chapter 4.

5.3.1 Research site and participants

The research site was a public nursing home for the elderly situated in a small town in the north of Japan. The home was established in 1997, accommodates about 100 elderly residents, and provides short-term rehabilitation for them. Three occupational therapists and one care worker simultaneously provided therapy for residents and visitors in a therapy room. The therapy room was organised as an open space of two intersecting corridors on the first floor of the institution, so people are easily able to see what is happening.

One of the occupational therapists was the Vice Director of the home, Mr. Kawaguchi Junichi, who had been employed by the home for nine years. He was also renowned for organising drama plays with people with special needs. He facilitated interaction with his dementia sufferers through group and face-to-face activities during his therapy sessions. As an expert, he also regularly worked as an instructor on training programs including communication skills for the

---

5 As Mr. Kawaguchi strongly requested, I describe his autonym rather than make him anonymous or use a pseudonym in this paper.
occupational therapists and published a book about his practice (Kawaguchi 2006). The researcher observed his activities all day and met several clients including AD sufferers through his introductions.

After observing many therapy sessions, the sessions of two female AD sufferers (Mrs N and Mrs O) over 85-years-old were particularly focused upon and compared. Both were provided short-stay care from one to two weeks in length. They both had problems with their legs and difficulties in communication\(^6\). They needed daily rehabilitation to exercise their legs because they could not walk by themselves and were not willing to try it. In their therapy sessions, Mr Kawaguchi was the main therapist but other occupational therapists (Mr D and Ms I) and the care worker (Ms P) often helped and joined them. Table 1 shows the average time of each sufferer per interlocutor. These sufferers were selected mainly for three reasons. Firstly, they both suffered from similar health conditions such as Alzheimer's disease and difficulties in walking. Secondly, they were not so-called ‘regular clients’ who were familiar with the care professionals and the home, but the ones who occasionally stayed at the home for few days and had experienced occupational therapies a few times only before my observations. Thirdly, their interactions and conversations with the therapists were observable in series without being interrupted by other care workers or sufferers. Consequently, it was possible to observe the whole processes of their narrative formations.

Table 1. Time of sufferers’ interaction per interlocutor (minutes).

<table>
<thead>
<tr>
<th></th>
<th>occupational therapist</th>
<th></th>
<th></th>
<th>researcher</th>
<th>no interaction</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mr Kawaguchi</td>
<td>Mr D</td>
<td>Ms I</td>
<td>Ms P</td>
<td>student</td>
<td>other</td>
</tr>
<tr>
<td>Mrs N</td>
<td>21</td>
<td>3</td>
<td>0.5</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mrs O</td>
<td>18.5</td>
<td>1</td>
<td>0.5</td>
<td>2</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

5.3.2 Data collection

This chapter first presents the methodologies how the data was gathered from the research participants and how it was represented for qualitative data analysis. Then,

\(^6\) According to Mr Kawaguchi, their cognitive abilities were measured according to the Alzheimer's disease scale, HDS-R (Hasegawa Dementia Scale-Revised) during their stays. HDS-R consists of nine questions with the score ranging from 0 to 30 and is one of the most popular scales in Japan. Both Mrs N and Mrs O scored 0 on the HDS-R. Those who score less than 4 are diagnosed as having severe dementia.
to consider the researcher’s roles, memberships, and reflections during data collection, it illustrates the developmental process of researcher’s positioning.

Data from participant observation

The data was collected from participant observation of the occupational therapies organised by Mr Kawaguchi and the other experienced occupational therapists. Their care sessions were observed for 28 days over two years from 2004 to 2006 (see Table 2). Interaction between the caregivers and sufferers was videoed and overall, the videotapes consist of about 150 hours of observation data.

In addition to the videotaped recordings, I wrote field notes during my observations to record the contextual information and my impressions or interpretations on each activity. I also kept notes about the situations where filming was prohibited or impossible such as in staff meetings in the morning and in informal conversations with the sufferers and care workers. The field notes were used to develop my understanding of their activities and supplement the videotaped data.

Table 2: Outline of the observations.

<table>
<thead>
<tr>
<th>Date and period</th>
<th>Main observed activities</th>
<th>Research participants in target</th>
</tr>
</thead>
<tbody>
<tr>
<td>26th - 29th, November, 2004</td>
<td>occupational therapy sessions, daily activities, play activity with children</td>
<td>Mr Kawaguchi, Mrs N</td>
</tr>
<tr>
<td>4th, December, 2004</td>
<td>Family party (fashion show)</td>
<td>Mr Kawaguchi</td>
</tr>
<tr>
<td>24th - 27th, November, 2005</td>
<td>occupational therapy sessions, daily activities, communication workshop for young occupational therapists</td>
<td>Mr Kawaguchi</td>
</tr>
<tr>
<td>24th -27th, January, 2005</td>
<td>occupational therapy sessions, daily activities, group activities</td>
<td>Mr Kawaguchi, Mrs O</td>
</tr>
<tr>
<td>27th, March - 12th, April, 2006</td>
<td>occupational therapy sessions, daily activities, group activities, tea party</td>
<td>Mr Kawaguchi, Mrs O</td>
</tr>
</tbody>
</table>

Data from interviews

The semi-structured interviews were conducted mainly with Mr Kawaguchi five times and around eight hours (see Table 3). The interviews were recorded both by video camera and audio recording device. The interviews were conducted in the room for the care workers or the outside the cafeteria or restaurants as Mr Kawaguchi requested. During the interview sessions, other occupational therapists
sometimes joined us to listen to what we talked about and sometimes answered questions together. The open-ended questions were mainly asked in relation to the therapist’s views, knowledge, and experiences about the AD sufferers and his practice. For example, questions such as “How about your sessions today?” or, “What do you think of the sufferers?” or, “Why did you interact with them like that?” or, “What was the best/worst experiences in your career?” and, “What is the most important in doing your job?” were presented and the therapist expressed his opinions freely. Only in the second interview, the therapist watched some video material of his session with Mrs N and was asked some questions about her. The display of the video material was used to stimulate recall and to reflect on his therapy sessions which were organised almost a year ago. In other interview sessions, the video materials were not presented, because the interviews took place soon after his sessions with the sufferers.

In addition to the formal interviews, informal interviews were occasionally carried out during my observations. I sometimes asked the AD sufferers, other care workers, and the sufferers’ families about their information, impressions, feelings or thoughts related to their activities, situations and backgrounds. For example, I sometimes asked questions such as “How’s it going?” or “How do you feel?” to the AD sufferers immediately after the therapy sessions. These interviews were usually short but helped to understand their perspectives on the therapy and on others including the therapists.

Table 3. Outline of the interviews with the therapists.

<table>
<thead>
<tr>
<th>Date</th>
<th>Participants</th>
<th>Length of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>26th, November, 2004</td>
<td>Mr Kawaguchi and Ms I</td>
<td>1.5</td>
</tr>
<tr>
<td>24th, November, 2005</td>
<td>Mr Kawaguchi and Ms I</td>
<td>1.5</td>
</tr>
<tr>
<td>7th, December, 2006</td>
<td>Mr Kawaguchi</td>
<td>1.5</td>
</tr>
<tr>
<td>4th, April, 2006</td>
<td>Mr Kawaguchi</td>
<td>1</td>
</tr>
<tr>
<td>10th, April, 2006</td>
<td>Mr Kawaguchi</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Data transcription

Video data was transcribed with the inclusion of conversation and body movements such as gestures, gaze, posture, etc. The software, InqScribe and CotEditor were used for the transcription. Especially, the interactions among two AD sufferers (Mrs N and Mrs O) and Mr Kawaguchi were transcribed in detail applying the transcription conventions of conversational analysis (Goodwin 2003) and a
narrative approach (Ochs & Capps 2001) as reference. Appendix shows the transcription conventions applied in this study. All interview data was also transcribed in a similar way.

All transcriptions were written in Japanese at first and then, selected excerpts were translated into English. However, direct translation often faced difficulties because of the linguistic features in Japanese such as the grammatical order in sentences as subject-object-verb, the omission of subjects and objects, the variety of personal pronouns, honorifics, etc. Especially, due to Asian tradition to show respect for the elderly, the therapists and care workers often used a variety of honorifics to address their attitude towards the sufferers, but these nuances were difficult to duplicate in English. As a general policy for translation, I tried to follow the original sentence order and meanings as much as possible receiving advice from English proof-readers, and if the translations were lacking significant implications that existed in the original texts because of the linguistic and pragmatic features of Japanese, I added the annotations to the excerpts.

Researcher's positioning

Illustrating the researcher’s positioning in the field research is strongly connected to the post-positivistic thought that research is one interpretative act embedded in a social, cultural, and historical background (Denzin & Lincoln 2000). This means that modern researchers need to consider their relationship with the research participants and their organisations. To clarify the developmental process of my field understanding and analytic focus, I will briefly state my positioning in the field here.

1. The beginning: The researcher from the university

In the beginning of my research, I did not have much knowledge and experience in dementia care or occupational therapy. I made a contact with Mr Kawaguchi, because he was the vice president and famous for his approach using drama. After getting his permission for the implementation of the study, I started my observation and Mr Kawaguchi and other therapists introduced me to every person in the home as a researcher from the university in Tokyo. Since the nursing home was located in a rural area, many people showed surprise by my information and I had been recognised as ‘the researcher from the university’ for a few days. Mrs O, especially, was happy to talk about my university, because she said that she used to live in...
Tokyo in her youth and knew it well. She always smiled at me and was supportive of my observations.

2. The midway point: The photographer in the home
A few days after my arrival, many elderly people forgot the introduction by the therapists and asked the reason for my visit. Since I always carried a video camera, many people naturally believed that I was a professional photographer and was there to take their photos. Actually, the therapists and I sometimes explained that I was not a photographer, but the researcher or a person who videotaped. However, the idea of a researcher and a videotaping were not common to the elderly people and therefore, they continued to call me a photographer. Moreover, on the AD sufferers’ request, I sometimes printed their photos from video material and handed these to them as a present. That is, I recognized myself as a photographer there. To some extent, it made my observation smoother and it was easier to remain in the therapy room for long times without raising people’s suspicions about me as a stranger and this allowed me to record their activities as much as I could. On the other hand, this role limited my observations in a few cases as some AD sufferers eagerly asked me to take their photos while I was concentrating on videotaping other sufferers.

3. The final phase: The friend
While many people knew me as a photographer, some female patients who were not dementia sufferers talked to me as “a friend”. For example, I was invited to visit their private rooms and had conversations for an hour after my observation. During our conversations, I did not videotape and we talked about our hopes, worries, life histories, etc. After my observations, we sometimes exchanged cards a few times. Similarly, Mr Kawaguchi sometimes introduced me as “a friend from long ago” to other therapists during my observations. We often had dinner together with other visitors and therapists he invited. In Japanese communities, it is common to get acquainted at after-hours drinking parties or at dinner and it also happened to me. We could exchange our opinions about care, life and many other matters and this experience seemed to develop my understanding of his professionalism and the occupational therapist as a whole person.

Through these three stages, I think my situational identity had moved between the observer-as-participant and the participant-as-observer. First, I participated in the therapy sessions as a researcher who was videotaping all the time and was
recognised such a person by many of members in the home. After several observations, I gradually acquired my role as a photographer and then could form a friendship with some of the residents. Although it is recommended to be a neutral and objective as a researcher conducting surveys (Ritchie & Lewis 2003), I shared my thoughts with other after working. To reflect my positioning and degrees of commitment as much as possible, writing field notes and keeping the time intervals of my observations seemed to help me. To their merit, informal conversations with the members provided opportunities to learn about their culture and values which they had built over time and in that sense, my situated identity can also be seen as ‘a student’ in the field7. Without the relationship as a friend and by learning from the participants, I think I could not have been able to understand their teaching-learning process at all.

5.3.3 Setting out the analytical framework

This chapter explains how and why the unit of analysis was selected, with a discussion of the sample selection criteria, and then illustrates two analysis methods each used to interpret both observational and interview data.

The unit of analysis

In my analysis, I focused on the micro-level interactions between AD sufferers and therapists from observations and the therapists’ voices from interviews to answer the research questions. In reality, while conducting my fieldwork and watching the collected video and audio materials, I had to select what was significant data for analysis and identify the reasons why. As an interpretative study, this process was a bottom-up approach where the research questions was explored and constructed through the examination of data. Thus, setting the appropriate unit of analysis was closely connected with the construction of the research questions. While examining the audio and visual data in detail, I focused on the excerpts of narrative formation, checked the development of narrative and the contexts from the field notes, and asked myself what this interaction and narrative meant. On the other hand, it was also necessary to identify the criteria used for the selection of the sample. Ritchie and Lewis (2003)

7 Actually, a few elderly people called me ‘a student’, because some students of occupational therapists or caregivers regularly visited the home as interns.
mentioned four criteria to be considered and explored as (1) identified characteristics from relevant literature, (2) variables to achieve a balanced sample (e.g., age, gender, etc.), (3) hypotheses including the particular subgroups, and (4) unknown subgroups. In dementia research, there were few studies on narrative formation in dementia care and the skill and contribution of therapists especially seemed missing in literature. As a result, the identified characteristics and hypotheses seemed to be still unsettled and thus, I mainly prioritised the criteria according to variables and subgroups. I selected the occupational therapy sessions, because many kinds of interactions, including the joint formation of narrative, were observed compared to the other activities in the home. Then, I chose two female sufferers (Mrs N and Mrs O) as research participants according to common variables such as age, gender, health condition, symptoms, and the therapy attendance. Additionally, I decided on Mr Kawaguchi as a main research participant to explore the therapist’s expertise, because he had long years of experience compared to the other occupational therapists and was skilled at organising his job. When I checked the video material, Mr Kawaguchi usually had longer interactions with old people including Mrs N and Mrs O than other therapists and caregivers. Consequently, the narrative sequences which were produced between Mr Kawaguchi, Mrs N, and Mrs O in the occupational therapy sessions during my observations and Mr Kawaguchi’s accounts of his strategies, experiences and thoughts on dementia care from the interviews became units of analysis.

The narrative cases illustrated as four excerpts in this paper were deliberately selected because they seemed to represent particular features of the dementia relationship. As is often the nature of interpretative study, the cases were not statistically representative, but demonstrated typicality to some extent in subgroups constituted from amongst the participants. However, the cases were not representative in all respects. Although narrative construction seemed often to take place through interactions in spite of the different stages and types of dementia, the frequency was quite different for each individual. Moreover, the ‘successful’ cases of narrative construction were limited in my observations. In fact, many of interactions were often ‘fragmented’ (Örulv 2008) and not fully elaborated or completed in spite of the therapists’ efforts. In this sense, my cases might be ‘successful and special’ examples which contained definitive narrative structures and it may be inadequate to select them as typical. However, I focused on them firstly because they illustrated the whole process of narrative construction and the therapist’s strategies, and consequently, they displayed the potentiality of narrative and the relationship in dementia care which has still largely remained unknown.
Secondly, investigating dementia sufferers who had the similar variables could provide a detailed picture of a particular phenomenon and the local knowledge in a specific context. In other words, although the well-formed narrative interactions were limited, with the control of the sufferers’ variables and the comparison between them, I think that the characteristics of therapist’s strategy can be depicted in detail.

**Methods of analysis**

In this paper, I applied a narrative approach as an interpretative and case-centred research method. From amongst the many narrative analytic methods, I selected a thematic analysis and an interactional analysis categorised by Riessman (2005, 2008). According to Riessman (2008: 53), the primal focus of thematic analysis is content and “narrative scholars keep a story ‘intact’ by theorizing from the case rather than from component themes (categories) across cases”. As she wrote, this method has been adopted to reveal the sufferers’ experiences of illness in many studies on nursing and medical sciences. While this approach has strengths in that it is suitable for a variety of narrative texts, including interviews, and focuses on the informant’s reports of events and experiences, its limitations obscure the researcher’s role in constructing narratives and the particularities of meaning. Meanwhile, interactional analysis concerned with “storytelling as a process of co-construction, where the teller and listener create meaning collaboratively” (Riessman 2005: 4). It is useful for research into relationships among participants and pays attention to both thematic content and narrative structure. The challenge of the method is the representation of narrative including nonverbal behaviour as a constituent element. Moreover, the definition of narrative needs to be articulated in the both of the methods because this depends on the author’s analytic focus.

From the above, I implemented an interactional analysis of the observational data and a thematic analysis of the interview data in this research. The reasons I selected these methods were that both of the data sets were viewed as narratives in terms of extended, nonlinear, and episodic segments of oral discourse made from observations and extended accounts of occupational therapy, the AD sufferers, and the therapist himself during interviews. The idea of narratives as extended accounts of the therapists’ lived experiences and understanding of the world was based on the studies into nurses’ expertise by Benner *et al.* (1996). They analysed nurses’ narratives through observations and interviews to uncover the acquisition of skills and the articulation of knowledge embedded in expert practice in nursing.
on their methodology, I organised the interpretation of the interview data in the following order:

1. Interpreting narratives by naming them to capture examples of patterns of meaning and action (themes) including contexts.
2. Checking the observational data and notes to gain an understanding of the therapist’s work and to reveal the relationship between his accounts and practice.
3. Examining interpretations repeatedly and making public presentations of the interpretations to evaluate the interpretative accounts including their reliability and validity.

During the process of naming narratives, I asked the following questions to scrutinise the meanings of the narratives and my research questions:

1. What was the occupational therapy and the relationship with the AD sufferer for the occupational therapist? How did he explain this?
2. What kinds of unknown questions did he explore? How did he discover and solve them?
3. What did he think of the persons with dementia?

The video data was analysed in reference to the work on narrative co-construction between sufferers and physicians (Clark & Mishler 1992). They investigate how storytelling is accomplished in the context of clinical encounters using video-recorded data. Following their methodology, the data analysis was conducted in the following manner:

1. Identifying major patterns of interaction including narrative formation.
2. Examining differences in interaction with reference to the storytelling process, such as the negotiating of a story topic, setting the scene, and clarifying the action and its results.
3. Exploring possible meaning and outcomes of the relationship in the ending of the interaction.
4. Checking the interpretations repeatedly and making public presentations of the interpretations to evaluate the interpretative accounts including their reliability and validity.

Especially, I asked the following questions in the detailed examinations of the interactions:

1. What kind of narratives were told and why?
2. How were the narratives co-produced between participants?
3. How did the therapist create the contexts to enter into storytelling?
4. What was the meaning of the narratives for participants?

As I wrote in the preceding chapter, although numerous interactions including joint narrative formation between Mrs N, Mrs O, and the therapist were observable in the nursing home, it was not easy to capture the whole process of narrative co-creation. Thus, after examining all the video materials according to the above procedure, I especially selected four storytelling situations demonstrating particular features which enabled detailed descriptions and exploration of the dementia relationship. In other words, while a series of jointly created narratives were relatively clearly recognizable in the four situations, the AD sufferers often introduced and created other narratives, which had similar topics to the ones in the four situations but were not fully developed.

On interpreting narratives, Benner (1994) cautions that we cannot assume that a text is completely coherent and rational and matches the participant’s ideas on their practice and their actual practice. Thus, “the task of interpretation is to bring to light the most coherent and complete story possible” (Benner et al. 1996: 364).

To check the reliability and validity in my interpretation, I made several academic presentations of the research findings and my Japanese supervisor watched the video materials and examined the transcriptions several times together with me.

5.3.4 Ethical considerations

As an ethical consideration, all participants including the therapists, other caregivers, dementia sufferers and their family (if needed) granted permission for the implementation of this study. I handed out consent forms to each research participant. Along with the consent forms were descriptions of the researcher in brief, the research aims and process, the protection of participants’ confidentiality and anonymity, and their freedom to withdraw from the study or to refuse to answer questions or to be videotaped at any time. The occupational therapists also explained to the sufferers that they would participate in the research and be filmed, and asked them directly for permission by showing them my video cameras.

After recording the videos, all tapes were copied and provided to Mr Kawaguchi as he requested. All public reports also received confirmation from him. All the data were stored in a secure place and used by the researcher only.
6 Results

In this chapter, first I will examine the observational data from the therapy sessions with Mrs N and Mrs O focusing on their interactional patterns and the process of narrative co-construction. Then I will explore the interview data from the therapist to shed light on his strategy for forming relationships with the AD sufferers, caring for them and the teaching-learning process.

6.1 Sowing the seeds of narratives: The arrangement for story development by the therapist

Before the co-construction of a narrative, Mr Kawaguchi organised the environment for the storytelling verbally and non-verbally. In general, he used turn-taking during the conversations and suggested the topic several times in response to the sufferers.

6.1.1 Coordinating the activity: The use of turn-taking

Since storytelling is a form of interaction between interlocutors, turn-taking is seen as a component of the narrative to embed it in the local context (Jefferson 1978). In a clinical situation, Clark and Mishler (1992: 352) point out that the story “reflects the interplay of a physician's agenda in assembling relevant clinical facts and a sufferer's efforts to provide a coherent account of his or her experience”. In dementia care, although people with dementia have difficulty with language and cognition, it is known that they actively participate in conversation using turn-taking (Hydén 2011, Onodera 2002, Ripich & Terrell 1988). In this sense, turn-taking seems to indicate the degree of participation in story making.

In my cases, the whole period of interaction was characterised by turn taking. Mr Kawaguchi immediately reacted to the sufferers’ behaviour or utterances to give positive feedback, articulate their meanings, or suggest the new ideas. The responses from the sufferers sometimes incomplete in the sense that were not audible, difficult to understand, or even silent, but the therapist kept offering his interpretation to them. Therefore, it seemed that the storytelling progressed with the interchange between the therapist and the sufferers reflecting their views, feelings, and thoughts.
6.1.2 The suggestions of topics by the therapist

As the trigger for narrative co-construction, Mr Kawaguchi often suggested topics to the sufferers. The sufferers seemed not always to reply in a straightforward manner. For example, after his suggestions, Mrs N often reacted by shouting or making a loud plosive sound and Mrs O sometimes sang or pretended to be asleep in front of him. However, even if the sufferers showed negation with a reaction such as rejection, bringing up another topic (side-tracking), or ignorance, he then paraphrased the topic or created a new one. The contents of his topics mainly regarded the appropriate activities or rules of the session, while the sufferers created their topics based on their private interests. In the case of Mrs N, he suggested the topics 22 times regarding therapeutic activity such as doing stand-up exercises and communication practice, such as showing a fine face, speaking in a low voice, and saying hello to everyone. Meanwhile, Mrs N raised the topics four times including her requests such as “don’t beating me”, “working hard” and “making me pretty”. In the case of Mrs O, the therapist similarly offered the topics of the therapeutic activity such as doing stand-up exercises and communication practice such as showing a fine face and saying hello, but also proposed her favourite topics such as singing, playing, and the stories of her grandchild 18 times. In contrast, Mrs O presented the topics of singing and the stories of her grandchild and son four times. Consequently, the therapists were more active in introducing topics than the AD sufferers and demonstrated the same topics using different expressions. While 75% of the total number of his utterances related to the topic suggestion in the case of Mrs N, 44% of them included it in the case of Mrs O.

Figure 5 shows the transition of main topics which were suggested by Mr Kawaguchi during their interactions. It also indicates that some topics were frequently suggested, while others were fixed or appeared a few times. For example, greeting behaviour such as saying hello was usually introduced at the beginning of the interactions. The frequency of topic appearance seems to reflect the therapist’s care strategy to some extent but I will discuss this later.
6.2 Case studies of two AD sufferers

With the therapist’s preparations and support, two sufferers, Mrs N and Mrs O engaged in the narrative construction. In the following chapters, I will depict their collaborative endeavours to make a narrative focusing on the therapist’s intervention as case studies.

6.2.1 Case 1: Narrative co-construction with Mrs N

In the case of Mrs N, the narrative co-production was observed as a process of topic negotiation with sense-making and exploration of a known or unknown question. I will examine the three parts of their interaction in depth below.

The setting

Mrs N in a wheelchair came to her last session in the therapy room with the care worker. She had been staying at the home for one week. In the room, there were three occupational therapists, one care worker, and ten sufferers. Approximately half of the sufferers were able to do their therapist-tailored exercises by themselves.
Yet, Mrs N could not do the exercises and shouted obscure phrases and made loud plosive noises for 16 minutes while waiting her turn in the corridor. Some sufferers complained or asked the care worker about her behaviour. After Mr Kawaguchi had finished his therapy with the other sufferers, he approached her and pushed her wheelchair to the intersection of the corridors (see Figure 6 and Figure 7). There were two other sufferers (Mrs A and Mrs B) in wheelchairs in front of them and both saw the interaction. Mrs A was a quietly-spoken person and Mrs B had a mild degree of dementia but could still communicate with others. Mr Kawaguchi carried out his therapy with Mrs N for 21 minutes. After finishing the therapy, Mr Kawaguchi moved on to another sufferer, Mr D and Ms P came to talk to him for three minutes. Finally, Mrs N left the therapy room with help from the care worker. The joint formation of narrative took place during the therapy by Mr Kawaguchi.

Fig. 6. The arrangement of a therapy room in case 1.
The negotiation of the topic: Sense making through the sufferer’s negation

As I wrote, Mr Kawaguchi eagerly suggested the topics during his therapy and was often faced with negation by the sufferers. However, the sufferer’s negation seemingly caused to introduce another new topic into their conversation. In the following excerpt from their first interactive session, Mr Kawaguchi suggested her to “show a fine face” through her negation.

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

In Excerpt 1, Mr Kawaguchi asked the sufferer to show her fine face. First, he asked her directly after exchanging a greeting (see Line 7). However, Mrs N immediately replied that she could not show her fine face (Line 8). Mr Kawaguchi then paraphrased his request by asking for a “lovely face” (Line 9). In fact, the word “lovely” was expressed in a dialect characteristic to the local area (see also Line 10 and 26). Mrs N replied with an irrelevant phrase (Line 10) to his request. Her answer literally included the words “lovely face” from Mr Kawaguchi, yet she avoided providing a direct answer to the request and refused to show a fine face to him. Then Mr Kawaguchi started the therapy by massaging her left leg (Line 13), and Mrs N suddenly said that she wanted to laugh (Line 14). Mr Kawaguchi encouraged her to laugh, while showing her how to laugh (Line 17 and 19). But Mrs N rejected his suggestion (Line 20) and explained that she disliked being laughed at (Line 17 and 19). Again, her answer included his word “laugh”, but she changed the context to ‘being laughed at’. Mr Kawaguchi suggested her to smile (Line 23) showing his smile (Line 24), Mrs N did the same (Line 25). While Mrs N smiled, he asked another sufferer, Mrs B if Mrs N was lovely (Line 26). She agreed that Mrs N was lovely (Line 27).

Mr Kawaguchi negotiated the topics of “showing a fine face” in different ways. He paraphrased by saying, “showing a lovely face”, “it’s better to laugh” or “smile”. His expressions of the topic were all different, but followed the same theme, “showing a fine face”. First, he paraphrased using dialect to make it more easily understandable for the sufferer (Line 9). Secondly, according to Mrs N’s comments, he created a new sense that she could laugh as much as she wanted to (Line 17 and
19). Thirdly, in response to her rejection and assertion, Mr Kawaguchi again paraphrased his request, making it “let’s smile” (Line 23) and demonstrated this act of physical behaviour for her (Line 24). The use of bodily movement embodied the contents of the topic. As a result, Mrs N finally followed his movement with a smile and he gave positive feedback to her involving another sufferer (Line 26).

All of his suggestions were created after the negations by Mrs N. She expressed the negations including rejection (Line 8, 20, and 22; underlined) or side-tracking (Line 10) four times in the excerpt and Mr Kawaguchi immediately brought up the ideas about showing a fine face. In this sense, the negations by the sufferer prompted a search for a sharable sense or form of the topic for the therapist. The activity of showing the fine face had changed from following the therapist’s advice to showing a lovely face, laughing, and smiling together acknowledged by others. The series of the negations enabled the sufferer to propose her views towards the therapist and discover another way to join his topic. For the therapist, he could continue the dialogue with the sufferer and achieve the goal of his intervention creating appropriate opportunities for freshness in meanings, behaviours, and emotions in one topic (Anderson, 2008).

The topic negotiations occurred frequently during his session and the same topics appeared several times throughout the process (see Figure 5). In relation to this excerpt, a similar topic of “smiling is lovely” appeared in their conversation once again later on. Especially, when the therapist was able to create a sharable topic for the AD sufferer, they occasionally accomplished the therapeutic activity or worked together to create sense making in a narrative form. The following section will depict the process of narrative formation after the negotiation.

Narrative co-construction (1): Creating the known question

The following example was observed 11 minutes later than Excerpt 1. After the negotiation where they spoke in a low voice, Mr Kawaguchi jointly constructed the story of the letter from her son.
Excerpt 2: Letter from her son
1 Thermist: *By the way, your ...*
2 Mrs N: [nods 8]
3 Thermist: *{the son} living in Rokugo*
4 Mrs N: [nods] Yeah.
5 Thermist: *From your son ...*
6 Mrs N: [bends over to Mr Kawaguchi] Yeah?
7 Thermist: *{we} received a letter.*
8 Mrs N: *Oh!*
9 Thermist: *{the letter says} “How is my mother getting along?”*
10 Mrs N: [nods] Yes.
11 Thermist: *Stand-up*
12 Mrs N: [nods]
13 Thermist: *{the letter says} “Has she done her stand-up exercises?”*
14 Mrs N: *The child ...*
15 Thermist: *{points at Mrs N} Yes, your son and...*
16 Mrs N: *Ah, my child is great.*
17 Thermist: *Yes. [nods] He was so concerned about you...*
18 Mrs N: Yes.
19 Thermist: *So, he sent me the letter.*
20 Mrs N: [loudly] *THANK YOU! THANK YOU!*
21 Thermist: *Then ...*
22 Mrs N: *Yeah.*
23 Thermist: *Then your mother ...*
24 Mrs N: [nods] *Yeah.*
25 Thermist: *I said to him your mother definitely does stand-up exercises every day!*
26 Mrs N: [nods] *Yeah.*
27 Thermist: *So he was pleased*
28 Mrs N: [smiles and nods] *Yes.*
29 Thermist: *{smiles} He was pleased*
30 Mrs N: *He was pleased and ...*
31 Thermist: *Yeah.*

8 For the Japanese, head nodding generally shows the agreement and encouragement by the listener and is frequently used in the conversation.
9 Rokugo was the name of her hometown.
32 Mrs N: He cried.
33 Therapist: He cried.
34 Mrs N: Yes.
35 Therapist: So to avoid telling a lie
36 Mrs N: Yeah.
37 Therapist: I suppose we should do the stand-up exercises.
38 Mrs N: Oh, great!
39 Therapist: [smiles] Shall we do them together?
40 Mrs N: Yes, I will.
41 Therapist: [nods] Yes.
42 Therapist: [looks back at Mrs B] Well, we will do the stand-up exercise for a while.
43 Mrs B: Yes.
44 Therapist: Please cheer us on for it!
45 Mrs B: [nods]
46 Therapist: [looks at Mrs A] Please!
47 Mrs A: [nods]
48 Mrs N: [starts to stand up with a help from the therapist]

In this excerpt, firstly Mr Kawaguchi introduced Mrs N to the story of the letter sent to him by her son (Line 1, 3, 5, and 7) inquiring about her condition (Line 9) and whether she had done her stand-up exercises (Line 11 and 13). In fact, this was a fantasy, since her son did not send her a letter when she was in the home. But she gladly accepted his topic and expressed appreciation of her son saying “my child is great” (Line 16). Following her utterance, He elaborated the story of her son detailing how her son cared about her and that this was the reason he had sent the letter (Line 17 and 19). She appreciated this very much (Line 20) once again. Then, he developed the story adding that he had promised her son that she would do her exercises every day and that her son was pleased (Line 23, 25, 27, and 29). She repeated his phrase and added another detail to the story about her son (Line 30 and 32). He also repeated her phrase (Line 33). Finally, he suggested that they do the stand-up exercises in order to avoid telling her son a lie (Line 35 and 37). She accepted the suggestion smoothly (Line 40) and they started to do the exercise (Line 48). Before doing the exercise, he asked Mrs A and Mrs B to cheer them on and she acquiesced (Line 44, 45, 46, and 47).

This excerpt was formally organised as a perceivable and temporally ordered narrative. It included orientations of place and persons (Line 3 and 17),
complications of the action (Line 17, 19, 25, 27, 30, 32, 33, 35, 37, and 39), an evaluation (Line 8, 16, 20, and 38), and a resolution (Line 48) (Labov & Waletzky, 1967). It consisted of three developmental topics. The first topic was the content of the letter from Mrs N’s son. The second was the interchange between Mr Kawaguchi and her son about her execution of the exercises and her son’s reaction. The third was the suggestion of doing the exercises then and there. The story contains the binary opposite structure of doing the exercise in the letter vs. not doing the exercise now. The binary opposite worked as a cognitive tool (Egan 1989, 2005) to make the story and the therapeutic situation more easily understandable for the AD sufferer.

Mr Kawaguchi improvised the basic story line, while reacting to the sufferer’s speech and actions. This is a similar phenomenon to what Mattingly called therapeutic emplotment (Mattingly 1994, 1998). In her research of occupational therapists, therapists created improvisational and embodied narratives with sufferers to create meaning during their therapy time. During this episode, Mr Kawaguchi also created a sense which was significant to the sufferer to make her do her stand-up exercises, using a narrative. At first, she had no interest in doing her stand-up exercises. He introduced the topic and provided a sense to the exercises through the narrative, in that they were for her son. Although the medical meaning of doing the exercise was clear to the therapist, it was difficult for her to comprehend the medical or therapeutic aspect of the activity. Thus only jointly sharable senses were negotiated through the narrative construction.

Mrs N also actively reacted to the story (Line 8, 14, 16, 20, and 38) and sometimes participated in making further sense (Line 30 and 32). One of the main reasons she joined in the sense and story making process is because the story concerned her son. As her reactions demonstrated, this situation caused her emotional involvement, which is crucial to story making (Egan 1989, 2005, Hakkarainen 2009). She also became involved because the narrative was constructed collaboratively. Although the basic storyline was fed by Mr Kawaguchi, and despite her cognitive illness, he always waited for her reactions and elaborated her utterances (e.g. Line 15 and 17) as we observed in Excerpt 1. Thus the story became authentic to Mrs N and affected her motivation to do her exercises in a positive way.

From the teaching-learning point of view, the therapist’s involvement of narrative production with the AD sufferer seems like a creation of a known information question. Unlike the unknown question, a known information question is one which the asker already knows the correct answer to and has been previously
investigated by educational researchers (Hicks 2008, Miyazaki 2005, 2013). In this excerpt, Mr Kawaguchi created the narrative with the question consisting of a binary opposite which was whether Mrs N did the stand-up exercise or not. As the goal of the occupational therapy and for her personal interest, the suitable answer was doing the exercise to avoid telling her son a lie and probably Mr Kawaguchi expected her to choose the answer and therapeutic activity when he set the question. In this sense, this narrative contains a known information question which was formulated by the therapist and reflected his care strategy to make the therapeutic activity more understandable and desirable for the AD sufferer. Narrative worked as a therapeutic tool to emplot clinical action with the AD sufferer’s personal sense.

On the other hand, narratives were not always constructed with a known question by the therapist and sometimes therapists and the AD sufferers jointly form narratives in the exploration of an unknown question, especially when the therapist does not know the correct answer. The following excerpts depict the process in which they mutually produced narratives including unknown questions.

The narrative co-construction (2): Exploring an unknown question

Soon after the Excerpt 2, Mr Kawaguchi and Mrs N jointly did the stand-up exercise once again. After that, Mrs N complained that the exercise hurt her and she hesitated to do it again for five minutes. Then, Mr Kawaguchi proposed doing the stand-up exercise again using a different version of the story. Their process of narrative co-construction was not well-crafted and coherent like Excerpt 2, but included many queries, side-tracks and deliberations on alternative perspectives which are also the characteristics of a living narrative (Ochs & Capps 2001).

Excerpt 3.1: Reward for the exercise (1): The negotiation of the topic

1    Therapist: One more time [touching her lap]
2    Mrs N: Yes. [nods]
3    Therapist: If you do the stand-up exercise.
4    Mrs N: Yes.
5    Therapist: I think your son will become happier.
6    Mrs N: [tilts one's head to the left]
7    Therapist: What do you think?
8    Mrs N: I DON’T HAVE MUCH MONEY.
9    Therapist: [waves his left hand] Well, you don’t need money.
10   Mrs N: THERE IS NOTHING TO DO WITHOUT MONEY.
Therapist: You know
Mrs N: Yeah.
Therapist: Later ...
Mrs N: [nods]
Therapist: I will come to pick up your radish.
Mrs N: [tilts one's head to the left]
Therapist: You know, the radish
Mrs N: [nods]
Therapist: You have many of them, don't you?
Mrs N: I think so.
Therapist: [laughs and puts his head down]
Mrs N: [smiles]
Therapist: Well [puts his right hand on her lap] well, the radish seems OK.
Mrs N: Well, so.
Therapist: For me, yes, now vegetables are expensive.
Mrs N: Yes. [nods]
Therapist: Since {I} can't buy {them}
Mrs N: Yes. [nods]
Therapist: [nods] In exchange for doing the stand-up exercise
Mrs N: Yes.
Therapist: Later.
Mrs N: [leans forward towards him]
Therapist: Your vegetables
Mrs N: [nods]
Therapist: Please give me a little bit. [cups his hands and makes a bow to her]
Mrs N: [nods]
Therapist: Is it OK? [looks closely at her]
Mrs N: [nods]
Therapist: Are you all right?
Mrs N: [nods] Just a small amount, please.
Therapist: Yes. [laughs] You are mean, aren't you?
Mrs N: Yes.
Therapist: [laughs]
Mrs N: [I'm] not mean.

Bowing indicates showing one's appreciation in Japanese communication.
In the first part of their interaction, Mr Kawaguchi suggested doing the stand-up exercise to make her son happy (Line 1, 3, and 5). However, she did not reply to his suggestion (Line 6) and said that she did not have any money (Line 8). Although he told her that she did not need money for the exercise (Line 9), she did not accept his idea (Line 10). Then, he made another suggestion that he would come to pick up her radish instead of taking money (Line 15, 27, 29, and 35). At first, she seemed to wonder about his suggestion (Line 16), but joined the conversation about the radish with affirmative responses (Line 18, 20, 22, and 24). He also provided information about the reason he picked up the radish with the explanation of the expensive prices of vegetables (Line 25). With his gestures, he asked her to give her radish in small amounts (Line 35) and she accepted it (Line 36). When he asked her if she agreed with his suggestions (Line 37 and 39), she stressed that she would give a small amount of the radish to him (Line 40). He accepted it laughing and made a joke about her comment (Line 41). She replied it both positively (Line 42) and negatively (Line 44).

Like all cases, the topic negotiation continued after her responses. When she showed negation by side-tracking (Line 8 and 10) to his first topic of making her son happy by doing the exercise, he quickly introduced another topic by asking for vegetables as a reward for the exercise (Line 15). The first topic was similar to the previous one in the Excerpt 2, but because of her opinions on money (Line 8 and 10), he created a second one. In this sense, the second topic reflects both views of the AD sufferer and the therapist to some extent, although the therapist mainly elaborated the topic compared to the sufferer who gave short replies to him.

After setting the topic, Mr Kawaguchi continued to develop the narrative by asking Mrs N to look for the appropriate reward for the exercise as follows.

**Excerpt 3.2: Reward for the exercise (2): An unexpected turn of the narrative**

45 Therapist: *Will you give me some more?* [opens his arms to Mrs N]
46 Mrs N: *Closer, I’ll take a closer look and give you.*
47 Therapist: *Yeah.* [nods] *a radish and.* [claps his hands together and counts one using his fingers]
48 Mrs N: *Yes.
49 Therapist: *A carrot and.* [claps his hands together and counts two using his fingers]
50 Mrs N: *Yes.
51 Therapist: *A tomato and.* [claps his hands together and counts three using his fingers]
Mrs N: Yes.

Therapist: *A cucumber and.* [claps his hands together and counts four using his fingers]

Mrs N: *Yeah.* [nods]

Therapist: *A Chinese cabbage and.* [claps his hands together and counts five using his fingers]

Mrs N: *Yeah.* [nods]

Therapist: *A lettuce and an eggplant.* [claps his hands together and counts seven using his fingers]

Therapist: *That's it.* [shows his hands to Mrs N] *please give me.*

Mrs N: *I don't quite follow you.*

Therapist: *Well ...*

Mrs N: *It was hard to count.* [straightens up in her seat]

Therapist: *I see.*

Mrs N: *YES, YES, YES, YES.* [makes plosive noise]

Therapist: *Well, what do you give, Mrs N?* [takes her hand and strokes it gently]

Mrs N: *[continues to make plosive noise]*

Therapist: *Mrs N.* [waves his right hand in front of her]

Mrs N: *What?*

Therapist: *What kinds of vegetables will you give?*

Mrs N: *[nods] An apple.*

Therapist: *AN APPLE!* [laughs and dabs his head] *I said, vegetables.*

Mrs N: *[smiles] Vegetables?*

Therapist: *Yes.* [nods]

Mrs N: *Are vegetables different from an apple?*

Therapist: *Vegetables ...* [tilts his head] *an apple seems a fruit.*

Mrs N: *That's because ...*

Therapist: *Yes.* [nods]

Mrs N: *I can't.*

Therapist: *Oh, I see.*

Mrs N: *Yes.* [nods]

Therapist: *Well, it's no problem.*

Mrs N: *Let it go at this.*

Therapist: *Yes.* [nods]

Mrs N: *THANK YOU, THANK YOU, THANK YOU SO MUCH.*
At his request in the previous excerpt, Mr Kawaguchi continued to ask Mrs N about if she could give him her vegetables again (Line 45). Mrs N promised that she would give them to him after looking at them carefully (Line 46). Thus, he started to suggest the kinds of vegetables providing their names (Line 47, 49, 51, 53, 55, and 57). She gave him affirmative answers (Line 48, 50, 52, 54, and 56), but when he counted up five kinds of vegetables and asked her to give them (Line 58), she told him that she could not understand and count them (Line 59 and 61). Then, she started to shout “yes” repeatedly and made a plosive noise, which she often did (Line 63 and 65). In response to her reaction, Mr Kawaguchi asked her what kinds of vegetables she would give him (Line 64) and paraphrased his question again (Line 68). Mrs N said “an apple” (Line 69) to his astonishment (Line 70). He explained that he had said, “vegetables” (Line 70 and 72), so she asked him if vegetables were different from an apple (Line 73). He answered that an apple belonged to fruit (Line 74). She tried to explain why she thought an apple was a vegetable (Line 75), but because of the ambiguity in her utterance (Line 77), it seemed difficult to grasp her meaning for the others. In spite of that, Mr Kawaguchi quickly and positively accepted her (Line 78 and 80). She agreed with his view (Line 81) and expressed her gratitude to him in a loud voice (Line 83).

In this excerpt, Mr Kawaguchi continued to ask the question of what vegetables he could receive from Mrs N as the reward for his therapy. By suggesting concrete ideas with the names of vegetables and receiving positive evaluations from the AD sufferer, they searched for suitable vegetables to exchange together. Also, the story of the reward for the therapy had developed with the elaboration of the setting with listing the names of vegetables by the therapist. However, when the AD sufferer became confused (Line 59 and 61) and showed some irrelevant responses such as making noises (Line 63 and 65), the therapist abandoned his idea of suggesting vegetables and created another question to let her decide what she could give him (Line 64 and 68). Although her answer, “an apple” seemed unexpected to him and he firstly tried to elucidate the difference between vegetables and fruit, he immediately accepted it and she was satisfied with his reaction (Line 83). That is, by changing his questions and the object of reward from vegetables to fruits, he could elicit positive responses from her and could continue to form the narrative of asking for a reward for the therapy. The co-construction of the narrative continued further in the next excerpt and again, the therapist’s reactions played a crucial role in the process.
Excerpt 3.3: Reward for the exercise (3): The development of the narrative

84 Therapist: [looks at Mrs B] Well ...  
85 Mrs N: THANK YOU, THANK YOU, THANK YOU SO MUCH.  
86 Therapist: [touches her lap] Do you harvest strawberries?  
87 Mrs N: Yeah.  
88 Therapist: Strawberries.  
89 Mrs N: Where?  
90 Therapist: Well, in a field.  
91 Mrs N: On your land?  
92 Therapist: [points at Mrs N] No, on Mrs N's land.  
93 Mrs N: Oh! My...it is impossible.  
94 Therapist: Straw... Do strawberries grow there?  
95 Mrs N: [tilts one's head to the left] I don't know.  
96 Therapist: You don't know. Around Rokugo [turns back to Mrs B], there is someone who harvests strawberries, isn't there?  
97 Mrs N: [nods and looks at the therapist and Mrs B]  
98 Mrs B: Where?  
99 Therapist: Around Rokugo or Furebetsu\(^{11}\), someone harvests strawberries, doesn't he?  
100 Mrs B: [I] rarely see {someone}.  
101 Therapist: Oh, really?  
102 Mrs B: Yes. [nods]  
103 Therapist: [nods and turns his face to Mrs N]  
104 Therapist: [turns back to Mrs B] What is good? A tomato, after all.  
105 Mrs B: Yes, there are tomatoes.  
106 Therapist: [turns his face to Mrs N] There are tomatoes.  
107 Mrs N: [smiles]  
108 Therapist: Tomatoes seem good.  
109 Mrs N: Tomatoes?  
110 Therapist: Yes. [nods]  
111 Mrs N: You think so. [nods]  
112 Therapist: [nods] I love tomatoes.  
113 Mrs N: [bows deeply] Thank goodness.  
114 Therapist: Yes.  
115 Mrs N: I'm grateful.

\(^{11}\) Furebetsu was one of the neighbouring towns to Rokugo.
Therapist: [touches her lap] *But, well, an apple is OK, too.*

Mrs N: *I see.* [nods]

Therapist: *Yes.* [nods]

Mrs N: *I will give an apple.*

Therapist: *Yes.* [nods]

Mrs N: *I will share an apple.*

Therapist: *Yes.* [nods]

Mrs N: *I put it in.*

Therapist: *You put it in.*

Mrs N: *Yes.*

Therapist: *Oh, you’re kind.*

Mrs N: *YES.*

Therapist: *OK. I’ll get the apple.* *Yes.* [stretches both of his arms to pretend to hold apples]

Mrs N: *Yes.* [laughs] *Thank you. Thank you.*

Therapist: *[stands up and holds her arms under his arms] Let’s go. Yes, let’s stand up.*

Mrs N: *Thank you. My rice field is sleeping.*

Therapist: *[returns a greeting to other sufferers] Yes, thank you.*

Mrs N: *My rice field is sleeping. Ah, ah, ah:::*

Therapist: *Well, I suppose your son will be pleased. One, two, three! [assists her in standing]*

Mrs N: *Yes, yes.* [voluntary stands up with a help from the therapist]

Therapist: *Oh, you can stand up!*

Mrs N: *Yes.*

Therapist: *Mrs N, you can stand up well and will reach up the apple tree!*

In the beginning of the excerpt, Mr Kawaguchi asked Mrs N if she harvested strawberries (Line 86). Although she continuously shouted out (Line 85), she stopped, answered yes (Line 87) and asked questions about the land where strawberries were harvested (Line 89 and 91). He explained that the land was at Mrs N’s (Line 92) but she responded negatively (Line 93). Thus, he asked her if strawberries grew there (Line 94) but she replied that she did not know (Line 95). He accepted her response (Line 96) and quickly asked another sufferer, Mrs B, if there was someone who harvested them (Line 96 and 99). Mrs B answered that she rarely saw anyone (Line 100). Therefore, he raised another question, “what was good?” to Mrs B and suggested tomatoes (Line 104). Mrs B agreed with his idea...
(Line 105), so he told Mrs N about tomatoes (Line 108 and 112). While Mrs N showed her appreciation towards him (Line 113 and 115), he suggested her that an apple was also OK (Line 116). She positively accepted his offer (Line 117 and 119) and actively talked about the way of giving it to him (Line 121 and 123). He replied affirmatively to her suggestions (Line 120, 122, and 124) and gave a positive evaluation (Line 126). When he told her that he would get the apple with bodily movement (Line 128), she showed her appreciation to him (Line 129). Then he suggested that she do the stand-up exercise (Line 130) but she suddenly talked about a different topic and started shouting (Line 131 and 133). Thus he gave positive feedback regarding her son (Line 134) and she followed him to stand up together (Line 135). When she could stand up, he again gave positive feedback regarding the apple tree (Line 138).

During this excerpt, they still discussed the topic of the reward for the therapy. First, Mr Kawaguchi questioned whether she grew strawberries on her land presumably because he counted them as another reward for the therapy (Line 86 and 94). Since Mrs N showed negative responses, he asked the same question to Mrs B who was familiar with the local area where Mrs N lived. After the exchange of information about the fruits with Mrs B, he decided to choose tomatoes as the reward and told Mrs N. Since she showed appreciation of his offers, he again suggested an apple as the reward. After deciding the reward, Mrs N was eager to explain how she would give it to him and actively formed the narrative articulating her actions. The therapist positively agreed with her accounts and mentioned the action in the narrative forward (Line 128). Although she seemingly hesitated to participate in the stand-up exercise with talking about an unrelated topic and shouting, they finally achieved the exercise with his encouraging words. Their narrative did not have a clear ending such as the resolution of the problem in Excerpt 3.2 and its connection with doing the exercise seems obscure, but after her participation in the production of the narrative, he introduced the exercise and continued to talk about the topic of the apple related to her exercise. In this sense, he probably intended the joint formation of narrative to achieve the therapeutic treatment.

As a tool for therapeutic engagement, the narrative in these excerpts has two characteristics. First, the narrative enabled the participants to be actively involved in the interaction. Since Mrs N had communication problems such as shouting and making a noise, it seemed difficult for her to exchange long conversations on one topic as Figure 5 shows. However, in these excerpts she could continue the conversation with help from the therapist and sometimes participated in the
narrative production. As Egan (2005) says, the story orients our emotion to the events, settings and characters in particular way. In this case it launched the interlocutors into social and collaborative exchanges. While creating the narrative, the AD sufferer emotionally expressed her feelings and impressions sometimes smiling or showing confusion. The therapist also organised the narrative actively and plainly expressing his feelings and thoughts to them both.

Second, the narrative works as a tool for making sense of the therapeutic situation. By giving possible and positive meanings in the therapy, the narrative motivates the sufferer to participate in the therapy and organises the therapeutic goals in an intelligible way (Mattingly 1998). In this example, the therapist asked the AD sufferer about a food which she could give him several times. To search for what she could provide from her field, he listed many kinds of vegetables and fruit and carefully checked them. Through the process, he created a new meaning for the story of the reward for the therapy, made a connection between the story and the sufferer’s experience of farming, and transformed the exercise into a give-and-take deal rather than a task provided by the authoritative therapist. Since it was not easy to grasp the clinical meaning of the therapy for the AD sufferer because of her cognitive symptoms and leg pain, the therapist crafted a familiar, interesting, and selectable narrative for her and giving fresh meanings to the therapy. Especially, in their conversation about the apple in Excerpt 3.3, the narrative seemed to become ‘authentic’ by the sufferer’s descriptions of her actions and the therapist’s responses with gestures as a drama. Although the contents of the narrative were not achieved in reality, the experience of narrative drama as being vivid and negotiable between the participants enabled the sufferer to orient herself and accept the therapeutic activity.

In addition to the narrative functions, the therapist’s effort played a large role to the narrative co-construction. The therapist took the stance of “responsive-active listening-hearing” which is “actively interacting with and responding to what a client says by asking question, asking comments, extending ideas, wondering, and sharing private thoughts aloud” (Anderson 2008: 153) without control of the conversation. In this case, the therapist always talked in response to the sufferer’s speech, introduced newer ideas to ask for her opinions, and immediately changed and determined the narrative settings and actions depending on her interests or requests throughout the interaction. Thus, the narrative was developed back-and-forth between the AD sufferer who expressed her feelings and desires and the therapist who explored her will and a meeting point where the narrative emplots the therapeutic activity. Applying this stance, the therapist could elicit the “voices”
(Holquist & Emerson 1981) of the sufferer including her own interests, views and background, and fine tune the process of collaborative story making.

As a teaching-learning process, the therapist seemed to explore an unknown question which the therapist himself did not know the answer to at the beginning of their interaction. By questioning, the therapist seemingly concerned himself about how to develop the narrative by collecting the appropriate narrative materials which mattered to the AD sufferer. For example, when he elaborated on the topic of the reward for the therapy, he posed questions such as asking if she had many radishes (Line 19), if she could give him any other vegetables (Line 45), what kinds of vegetables she would give him (Line 64 and 68), and whether she harvested strawberries (Line 86 and 94). All of these questions were connected with the narrative topic and the sufferer’s experience as a gardener at home. When the AD sufferer could not follow the storyline (Line 59 and 61) or showed negative responses (Line 10 and 93), he asked these questions and actively applied her answers to the story. If the AD sufferer could not answer his question (Line 95), he asked another sufferer who had knowledge about her home and the nearest towns (Line 99 and 104), found the possible answers from her, and maintained the narrative construction with them. In this sense, the questions enabled the sufferers to continue to participate in the joint formation of the narrative while they offered a chance for the therapist to learn the sufferer’s background and personality, such as knowledge about her hometown or her interests. Also, through questioning several times, the therapist seemed to explore more appropriate answers from the AD sufferer. For instance, he asked a question related to strawberries in Excerpt 3.3, although they once reached a reasonable answer as “an apple” which was proposed by the sufferer in Excerpt 3.2. It was possibly because the therapist was unsure about her answer at first and needed to check if it was a ‘genuine’ offer from her. Thus, he suggested another fruit and vegetable which seemed to be familiar to her and examined her responses with these narrative materials. After the proposed strawberries and tomatoes, he finally adopted her original idea of an apple because she was seemingly active in responding to him compared to other ones. In sum, to bring out what she was really concerned about and embody it as a narrative form, the therapist continued to ask questions through trial and error until he could reach an appropriate answer or achieve the therapeutic goal.
6.2.2 Case 2: Narrative co-construction with Mrs O

As in the case with Mrs N, Mr Kawaguchi jointly formed the narrative with negotiation of the topics with Mrs O. On the other hand, since she refused to do the exercise several times, he actively shared the formation of narratives and unknown questions with other therapists and AD sufferers and consequently, the AD sufferers spontaneously and collaboratively continued to create the narratives together. To examine these processes, I will describe their interactions in chronological order in the following chapters.

The setting

In the beginning of her occupational therapy, Mrs O, in a wheelchair, stayed at the intersection of the corridors as did Mrs N. There were three occupational therapists, one care worker, one student in practice, and about eight suffers in the therapy room. It was the third day of her stay at the home out of four days. She had undergone treatment with the therapists for two days and had been reluctant to do the stand-up and walking exercise because of her leg pain.

In this session, Mrs O experienced interchanges with all care professionals including Mr Kawaguchi and other sufferers for about one hour, because they tried to let her to do the stand-up and walking exercises in turns. First, when she sat alone, the female occupational therapist, Ms I quickly came to exchange greetings. After Ms I left, the male therapist, Mr D came to sit right next to her bringing Mrs B with him. During their fourteen-minute conversation, he directly or indirectly asked Mrs O to walk five times, but she rejected this idea and ignored the suggestions. After Mr D left to attend another sufferer, Mr Kawaguchi quickly approached to her and chatted for four minutes. When he linked arms with her to let her stand, she immediately started singing showing her rejection. Mr Kawaguchi just told her, “Please sing more”, and went to another sufferer. Mrs B joined in with her singing and the care worker, Ms P, came to engage in conversation for four minutes. During their exchange, Ms P asked Mrs O to do the walking exercise twice, but again she ignored and dismissed the idea. After Mrs B went to the corner of the room to do walking exercise using parallel bars, Ms P made a request for Mrs O to cheer for Mrs B twice but she did not respond. Then, Ms P asked Mrs O to come with them to avoid being lonely and to sing for them. Since she did not show a negative reaction, Ms P took her to the edge of the parallel bars where Mrs B did the exercise by going back and forth (see Figure 8). They started chatting about their ages and
Ms P handed the Japanese flag to Mrs O to cheer Mrs B on. With the flag, Mrs O started singing the Japanese flag song and Mrs B sang in chorus. After their three-minute singing, Mrs B started the walking exercise again. Mrs O and Ms P cheered her on by waving the flag, shouting “banzai”, and raising their arms up in the air\textsuperscript{12}. Mr Kawaguchi, the student and another AD sufferer also participated. While shouting, Mr Kawaguchi and Ms P called Mrs O to come over to Mrs B but she ignored them. Mrs O and Mrs B exchanged a few words about the flag and continued to sing the flag song a few more times together. Mr Kawaguchi again joined in with them and started his intervention for twenty minutes (see Figure 9). Through this interaction with him, Mrs O did the stand-up and walking exercise three times\textsuperscript{13} before leaving the room and the following excerpts were recorded during the process.

\textbf{Fig. 8. The arrangement of a therapy room in case 2.}

\textsuperscript{12} The series of activities consisting of waving the Japanese flag, shouting the phrase, “banzai” and raising the arms up are usually conducted when the Japanese people meet the emperor or cheer someone up collectively. They were especially common in the school during the wartime.

\textsuperscript{13} Mrs O stood up twice with help from Mr Kawaguchi and walked once with help from Mr Kawaguchi and Mr D.
Fig. 9. The face-to-face interaction between Mrs O and Mr Kawaguchi.

The narrative co-construction (3): Sharing activities, narratives and the unknown question with others

When Mr Kawaguchi approached Mrs O, she had just finished singing the Japanese flag song with Mrs B and the male sufferer, Mr T who also had dementia. Mr Kawaguchi squatted down next to her saying, “We heard your singing”. Mrs O asked him to sing the flag song, but he told her that he did not know it. Thus, she sang the song again with Mrs B and Mr T and he gradually unfolded the narrative making a connection between her ongoing activity (singing), her past experience at school, and their future goal (doing the therapeutic exercise).

Excerpt 4.1: “Stand up” in school: The creation of the story and the rejection of its achievement

1  Mrs O: [finishes singing the song]
2  Therapist: Good.
3  Mrs O: Let’s sing like this.
4  Therapist: Well, that song was sung many times in your school days, didn’t you?
5  Mrs O: Yes.
6  Therapist: Yeah.
7  Mrs O: {I} sang.
Therapist: Where...In the schoolyard or the gym?
Mrs O: [put left hand over her mouth] That’s right.
Therapist: Well, was the head teacher, wasn’t there?
Mrs O: Yes, there was the head teacher properly.
Therapist: Yes.
Mrs O: {He} said, “ABOUT TURN!”
Therapist: Oh, I see. “Attention!”
Mrs O: Yeah. [lifts her left hand] “Attention!” [waves her left hand] “Turning right.” We often did it.
Therapist: I see.
Mrs O: The head teacher {said} later, “EVERYONE BECOMES GOOD AT IT”.
Therapist: {You} were praised.
Mrs O: {We} were praised. [smiles]
Therapist: Well, {at first}, that must be “STAND UP”.
Mrs O: Yes, yes.
Therapist: Well, let’s do it!
Mrs O: [looks at the front] I mean, it is missing here because of this.
Therapist: Here is like a gym. [looks around the room and points to the people in the floor] YOU KNOW [nods], EVERYBODY [nods]
Mrs O: [looks at the front]
Therapist: Here [points at the bars] let’s hold the bars and “STAND UP”. [stands up] Let’s try in such a way! [holds her right hand]
Mrs O: No. [draws in her right hand] I dislike that.
Therapist: [laughs with clapping his hands]
Mrs O: Then I don’t want to do that...It turns round to the wrong way.

During their interaction, they talked about a school activity in old times. First, Mr Kawaguchi asked her if she sang the song at school (Line 4) and Mrs O affirmed it (Line 5 and 7). Then he posed a question about the place where the students sang in the school (Line 8) and she showed a positive response (Line 9). Additionally, he enquired about the presence of the head teacher (Line 10) and she agreed with him (Line 11). Since Mrs O mentioned the words of command by the head teacher (Line 13), he suggested another word which was often used by teachers (Line 14). She actively repeated his word with bodily movement and explained what they did in response the teacher’s comments (Line 15 and 17). In response to her explanations, he gave her positive feedback (Line 18) and she seemed happy to
repeat it (Line 19). When he expressed the teacher’s speech as “Stand up” (Line 20), she agreed (Line 21). However, soon she got side-tracked (Line 23) from his suggestion of the stand-up exercise (Line 22). He continued to suggest the exercise finding a similarity in the therapy room and the school gym (Line 24) and explaining the ways of the exercise (Line 26) but she refused the exercise and stopped talking about the school activity (Line 27 and 29).

In this interchange, Mr Kawaguchi and Mrs O collaboratively crafted the story of the school activity. First he introduced the setting where the flag song was often sung (Line 4) and provided some information about it through a series of questions (Line 8 and 10). She engaged in the story making elaborating on the actions by the head teacher and herself as one of the students (Line 13, 15, and 17). Since they replicated the voices of the head teacher through vocal intonation (Line 13, 14, 15, 17, 20, and 26) and with her gestures (Line 15), these scenes were vividly described. He also added a positive meaning to her school activity (Line 18) and she accepted it. Their story clearly contained narrative elements to make the story coherent and understandable (Labov & Waletzky 1967) and a clear narrative had developed. However, when he asked her to do the stand-up exercise in relation to the school activity (Line 22, 24, and 26), she immediately stopped making the narrative. While the therapist tried to place the therapeutic activity within an appropriate narrative form in relation to her current and memorable activity, the AD sufferer concerned herself with expressing her school experience in the narrative and was both sensitive and negative to the therapist’s intention of achieving the exercise. In other words, narrative coherence supported by the therapist did not work for the sufferer’s active participation in the exercise.

After this excerpt, he proposed the exercise again referring to standing up to sing the song like everyone did in elementary school. Since she ignored his comment, he asked her to rearrange her posture. Although she closed her eyes, she stood up following his instructions. The following excerpt depicts their interaction during the exercise.

**Excerpt 4.2: “Stand up” in school: The creation of an emergent narrative by others**

1. Therapist: [helps her up with his hands under her armpits] *Come on!*
2. Mrs O: [holds the bars with her hands and stands up]
3. Therapist: *In this way, yes. [sings] “White” [finishes to sing] did you sing like this, didn’t you?*
4. Mrs O: [looks down at the floor]
Mrs B & Mr T: [continue to sing] “with red spot”

Therapist: [smiles] Ah, the others are singing.

Mrs B, Mr T & Therapist: [sing together] “A rising sun is painted. Ah, how beautiful, the Japanese flag is” [finishes singing]

Mr T: BANZAI! [raises his arms up in the aim]

Therapist: Hey! Mrs O, the cheer followed.

Mrs B: BANZAI!

Mrs O: [stands up closing her eyes]

Therapist: [looks at back, nods, and speaks to Mrs B in a low voice] Come here, come here, come here, come here.

Mrs B: BANZAI!

Ms P: [to Mrs B] Grandma, grandma, grandma, let’s go!

Mrs B: [stands up and walks towards Mrs O]

Therapist: [smiles and lets Mrs O sit in a wheelchair]

Mrs O: [sits down closing her eyes]

Therapist: [sits down in front of her] Since you stood up and sang, everybody said to you, “Banzai!””, you know?

Mrs O: [opens her eyes] Is this OK?

While standing up, Mrs O looked down at the floor without making eye contact or showing any response to Mr Kawaguchi. On the other hand, he started to sing the flag song (Line 3) and other AD sufferers, Mr T and Mrs B, followed him to sing (Line 5 and 7) and shouted, “Banzai” (Line 10 and 13) as they had four minutes previously. He described the situation to Mrs O (Line 6 and 9) and asked Mrs B to come closer (Line 12). Ms P also asked Mrs B to come over (Line 14). After singing and shouting, Mrs O sat down in a wheelchair. He again told her the situation giving a positive meaning to her stand-up action (Line 18). Then Mrs O opened her eyes and asked him if it was OK (Line 19).

As Mr T and Mrs B jointly sang the flag song during their exercise, the situation seemed to be similar to the story which the therapist told before: standing up to sing the song together as they did in school. The scene played by them was improvisational and seemed to embody the part of his story line and thus, it is similar to what Mattingly (1998) termed as emergent narratives14. To let Mrs O participate in this, Mr Kawaguchi talked to her to draw her attention several times,

---

14 Mattingly (1998) defined the concept of emergent narratives as stories created in and through actions rather than through words.
but she ignored these advances. As in the previous excerpt, she showed a negative attitude to the exercise with the actions such as not contributing to the story and passively doing the exercise. In this sense, the narrative of standing up in school was not fully collaborated on or embodied in the clinical action for her in spite of the therapist’s effort.

After this excerpt, they engaged in a short conversation. He told her that her attempt at the exercise was so good that the head teacher was surprised and used this to make the story continue. She agreed with this and he asked her to stand up again. Although she stood up with the therapist’s calls sounding like the school principle, “Stand up!”, she immediately closed her eyes and became totally unresponsive. He quickly stopped the exercise to place her in a wheelchair and asked Mrs B for help who came near with Ms P. The following excerpt shows the therapists’ request to share the problem-solving with Mrs B.

**Excerpt 4.3: Sharing the unknown question with others**

1. Mrs O: [closes her eyes]
2. Mrs B: *She* seems asleep.
3. Ms P: Does she sleep?
4. Mrs B: [nods]
5. Ms P: Does she sleep?
6. Mrs B: [nods]
7. Therapist: [looks back at Mrs B] What shall we do in this case, Mrs B?
8. Mrs B: What?
9. Therapist: What shall we do in this case? [waves his hands] Is it better to wake her up?
10. Mrs B: She is sleeping, isn’t she?
11. Therapist: [waves his hands] Is it better to wake her up or let her sleep?
12. Mrs B: [nods] Letting her sleep is also OK.
13. Mrs O: [opens her eyes and smiles]
14. Ms P: [smiles] Ah! *She* wakes up!
15. Therapist: [smiles] *She* wakes up!
16. Mrs B: [laughs]

When Mrs B recognised that Mrs O’s eyes were closed, she checked to see whether she was asleep with Ms P (Line 2, 3, 4, 5, and 6). Mr Kawaguchi noticed them and asked her what they would do (Line 7). When Mrs B asked what he asked, he repeated the question and paraphrased it as a closed question to probably make it
more easily understandable (Line 9). Since Mrs B mentioned that Mrs B is sleeping (Line 10), he added another choice to the question (Line 11). Mrs B replied that they should let her sleep (Line 12) and with her answer, Mrs O woke up. In a delightful manner, Mrs O smiled and then started to talk mainly with Mrs B.

During this short interchange, Mr Kawaguchi asked for help from Mrs B by questioning how to interact with Mrs O (Line 7, 9, and 11). Before that, the therapists tried to motivate Mrs O to enrol in the exercise using various means such as making suggestions, asking questions, giving positive feedback, and creating narratives. However, when all of their efforts seemed not to be effective for, Mr Kawaguchi stopped taking the initiative in handling the situation and exchanged some new ideas with the other AD sufferers. In this case, he sought help from Mrs B as a partner to share and solve the problem collaboratively. In replying to his questions and interacting with Mrs O, Mrs B partially shared the responsibility for Mrs O’s care. In other words, the therapists hold an enquiry into what they could do for Mrs O and for implementing her exercises as an unknown question and Mrs B also participated in this. It seemed not an abdication of responsibility by the therapist, but the creation of collaborative problem solving.

Actually, Mr Kawaguchi was quite active in sharing the unknown question and the caring responsibility with others in his session. In addition to this excerpt, he had already asked Mrs B for help once. When Mrs O ignored calls to come over by Ms P and himself in their earlier interaction, he told Mrs B, “We failed, because she’s tough. Now {we} must leave the job up to Mrs B, OK?” and she answered yes. He also told other sufferers who did not have dementia about her and that there was one person who was pretty tough and did not say yes to them and thus, he wondered what he could do with her. Thus, one of them frequently and carefully watched Mrs O’s activity. As he talked and asked about Mrs O’s problems, not only the therapists but also the sufferers shared and tackled the issue collectively in the therapy room.

After this excerpt, Mrs O started a friendly conversation with Mrs B sometimes involving Mr Kawaguchi for seven minutes. They spontaneously repeated the topic of the song, sang the flag song together, and then talked about their school days as follows.

**Excerpt 4.4: School day memories: The creation of a story between the sufferers and the therapist**

1 Mrs O: [finishes singing and looks at Mr B] *THE EMPEROR AND THE EMPRESS, BANZA::I* [raises her arms up in the air]
Mr T: [claps his hands]
Mrs B: [laughs]
Mrs O: {You} did it like this. [lowers her hands]
Mrs B: [nods]
Mrs O: Our childhood was fun, wasn’t it?
Mrs B: [nods] Yes.
Mrs O: There were no bad people anywhere as it is now. [smiles]
Mrs B: [nods] Yeah.
Therapist: Exactly. [smiles]
Mrs B: Grandma did you go to the school in Tokyo?
Mrs O: In Tokyo?
Mrs B: [nods] Yes.
Mrs O: Yes. {I} went there for some time.
Therapist: [laughs] Really?
Mrs B: [nods]
Mrs O: Yes, because my father travelled there for his business.
Therapist: Ah, I see.
Mrs B: [nods]
Therapist: The school in Tokyo?
Mrs O: Yes.
Therapist: [smiles and nods] {You} were stylish.
Mrs O: {I} was NOT stylish but just a student, wearing the school uniform decently.
Mrs B: [laughs]
Therapist: I see.
Mrs B: [nods]
Mrs O: You know.
Mrs B: [nods]

When Mrs O said “Banzai” raising her hands (Line 1), everyone in the therapy room paid attention to her, and Mr T and Mrs B especially responded positively (Line 2 and 3). Mrs O mentioned her activity as they had done it at school (Line 4) and actively expressed her school memories (Line 6 and 8). Mrs B and Mr Kawaguchi listened carefully with sympathetic nods (Line 5, 7, 9, and 10). Then Mrs B asked Mrs O if she went to school in Tokyo (Line 11). To the therapist’s surprise (Line 15), Mrs O answered yes and provided the reason (Line 14 and 17). He checked her answer (Line 20) and gave her a positive comment (Line 22). She
denied his comment but explained how she was at the time (Line 23). Compared to the therapist, Mrs O talked in a friendlier manner to Mrs B (Line 27) and Mrs B positively showed her agreement to what Mrs B said (Line 26 and 28).

Within the structure of the narrative, Mrs O presented information regarding her childhood or school days (Line 6, 8, 14, 17, and 23). Since they mainly exchanged views on their names and the flag song mediated by the therapists, it was the first time for her to talk about her school memories to Mrs B. In this sense, Mrs O was interested in the topic of the school day introduced by Mr Kawaguchi in Excerpt 4.1 and developed it in response to questions from Mrs B and the therapist. Through answering the questions, she revealed her past experiences and perspectives on her childhood and school. The plot of their narrative did not encompass a clear beginning, middle, or end but was a work in progress in describing a part of her life. In this sense, the narrative was a tool for sense making of the sufferer herself by presenting her identity: explaining what kind of person she is. The therapist also took part in the process casting a positive image of the sufferer (Line 22).

Moreover, the narrative may function as a tool for emotional engagement with other sufferers as the following episode shows. After this excerpt, Mr Kawaguchi rearranged her posture while she talked about her childhood, but Mrs O started to pretend to sleep by closing her eyes. After changing her posture, he left to attend another sufferer while Mrs O and Mrs B remained there. Mrs O said to Mrs B, “Let’s play!” twice in a childlike tone. After they engaged in a short conversation and sang the flag song for one minute, Mrs B went back to her seat in a wheelchair. The therapist, Mr D came and asked her to do the exercise by saying, ”It’s your turn to walk in return for Mrs B’s activities”. With his support, Mrs O spontaneously stood up and walked to meet Mrs B. When she arrived at where Mrs B was, Mrs B waited for her with Mr Kawaguchi saying how wonderful she was. Mrs O smiled and started to talk to Mrs B. In the process, she seemed to be motivated to do the exercise through the previous interchange with Mrs B using the narrative. For example, before the interaction in Excerpt 4.4, Mrs O did not walk and came in response to the calls from Mr Kawaguchi, Ms P, and Mrs B. Thus, there is a possibility that the shared experience of talking, singing, and creating the narrative continuously caused a change in Mrs O’s attitude towards the exercise and the others. Especially, the telling of first-person narratives by Mrs O in Excerpt 4.4 gave her the chance to express a sense of her self-identity and to develop a friendly relationship with Mrs B who had had similar experiences at school at the same age.
The therapist was seemingly sensitive about her change especially on the point of what she thought really mattered through their interaction. Since the narrative plot of the school activity did not work towards her successful implementation of the exercise, he stopped using the same plot in Excerpt 4.4 and spent some effort to involve Mrs B in her interaction. In other words, first he used the narrative as a therapeutic tool for emploting the narrative meaning in the ongoing interaction in order to carry out the therapy, but then he stopped and focused on the joint narrative construction with Mrs O.

In respect to the teaching-learning process between the therapist and the AD sufferers, firstly all care professionals including the occupational therapists and the care worker faced the unexpected situation that Mrs O did not wish to do the exercise voluntary. It seems that they explored how to construct some form of mutual cooperation in accordance with the intents of both Mrs O and the care professionals towards the implementation of the therapeutic activity. While Mr D and Ms P directly asked and suggested her to do exercise, making a connection with the other sufferers, Mr Kawaguchi was the only one to introduce the narrative and proposed two kinds of unknown questions. In his co-creation of this narrative, he seemed to pursue unknown questions which revealed her school day experiences (Line 4, 8, and 10 in Excerpt 4.1). With these questions, he seemed to look for the appropriate narrative materials which might make her participation in the narrative and therapy possible as with the case of Mrs N. Their conversation also showed that he did not know about her school life before the session, these unknown questions enabled the therapist to learn about her life history. With these findings, he organised the school narrative, her next action, and his intervention. In parallel, he shared another unknown question with other sufferers about what they should do to encourage and implement Mrs O’s exercise (see Excerpt 4.3). Through the introduction of this question, other AD sufferers started to become involved with Mrs O and encouraged and supported her activities. By asking the question, he could find new ideas for interacting with Mrs O as he prepared the collective problem-solving environment. The formation of the environment enabled Mrs O to communicate with Mrs B and provided motivation to complete her exercise. Moreover, since Mrs B and the other AD sufferers did their exercises during the interaction with Mrs O, it also seemed to motivate others to do their exercises in order to encourage Mrs O. In the end, they actively interacted with each other in a friendly atmosphere with much singing, laughing, smiling, and talking earnestly and they collaboratively participated in the activities, which the therapists prepared.
Although these two types of the unknown questions are set in the different contexts, they seem similar in the way that they made the therapy session dialogical. In response to the questions in narrative, Mrs O actively talked about her past experiences, because she was an 'expert' who had knowledge about her childhood. After listening to the question of Mrs O’s problem, Mrs B brought forward her opinion for solving the unexpected situation. By asking the questions and eliciting the answers from the AD sufferers, the therapist encountered new ideas from them about narratives and therapeutic interventions, actively adopted them through trial and error, enabled them to meet another or his own point of view, and managed to share the responsibility for interacting with each other as equals. In this sense, the therapist seemingly worked as a polyphonic author and created a dialogical learning environment (Miyazaki 2012).

6.3 Interviews with the therapist

Personal interviews gave me the chance to see the interactions and cases through Mr Kawaguchi’s eyes and understand his reasoning and thoughts on occupational therapy and the relationship with the AD sufferers. In relation to my research questions, I will analyse his interviews focusing firstly on his interpretations and descriptions of the cases of Mrs N and Mrs O and secondly on his general ideas and reflections on building relationships and narratives, using unknown questions and caring in dementia.

6.3.1 Interpretations of the cases of Mrs N and Mrs O

After his sessions and during watching the video materials together, I could directly ask Mr Kawaguchi about his impressions and ideas on the cases of Mrs N and Mrs O. His comments revealed his understanding of the sufferers’ problems, the strategies he used to interact with the them, and the unknown questions which he pursued.

Main problems of AD sufferers and the goal of therapy

As I wrote in chapter 5, Mrs N and Mrs O had similar physical and social problems as sufferers. Both of them had difficulties to carry out leg exercises and to communicate with others. On the other hand, when Mr Kawaguchi talked about
their illness, he focused on their communication ability and the relationship with others. For example, he explained their problems as follows.

**Extract 1: Mrs N’s problem with communication**
Therapist: *Well, she couldn’t be aware of her situation and ... from this point of view, of course, it seemed impossible to conduct conversational exchanges with her.*
Researcher: *Yes.*
Therapist: *It seemed possible, but*
Researcher: *Yes. I see.*
Therapist: *Well, it was nearly impossible to communicate with her ... Therefore, for example, voices, intonation, words ... a part of words ... she liked to pick up and responded to them, but ... communication with her seemed almost impossible.*

**Extract 2: Mrs N’s problem of shouting**
Therapist: *When she was at home ... though I suppose she did not really want to shout ... because of shouting, she was unwelcome at home and here ... Hmm, she herself was really a lovely person, but ... she couldn’t make friends ...*
Researcher: *Yes.*
Therapist: *Well, she always thought about her beloved son and his wife but they even said, “But when our grandma stayed at home ...” It was just a pity that they even said it like that.*
Researcher: *Yes.*
Therapist: *I think, if she stopped shouting, she could happily live with everyone.*
Researcher: *Yes.*
Therapist: *Yes. I wanted to let her stop it somehow. That’s it.*

In the case of Mrs N, he clearly mentioned that her problem lay in her communication pattern with shouting and he wanted to change that as a goal of the treatment (the underlined text above). Although he introduced the stand-up exercises to her several times, the main aim of her treatment seemed to be to improve her communication with other sufferers at the nursing home and her family at home.

On the other hand, he did not refer to the communication problem with Mrs O much, but he also cared about how others responded to her in the therapy room.
Extract 3: The therapist’s assessment of Mrs O
Researcher: What do you think Mrs O?
Therapist: Mrs O ... Well, I suppose that her speech and voice was clear and fluent. So, I thought that I did not need to encourage the conversation with her because everyone around her listened her speech and smiled to her. I loved it.

Extract 4: Mrs O’s problem with her family
Therapist: Well ... She would be in trouble, if she did not do her exercises. I suppose, if she did not walk hand in hand with her family, they would worry.

As he explained, the walking exercise was prepared not only for reducing her physical symptoms but also for maintaining a good relationship with her family. That is, the restoration of a good relationship with others was a main goal of his intervention for both of the AD sufferers and he seemed to care about it very much during our interviews.

However, why did he put much value on building a better relationship with other sufferers and the families compared to other major goals, such as functional physical recovery in dementia care? Although Mr Kawaguchi did not explain in detail, in my view, there were two possible reasons related to the sociocultural backgrounds of the nursing home and the occupational therapy. First, the nursing home which I observed was a place where people lived collectively and aimed to help sufferers live better at home through the treatment. Like Mrs N and Mrs O, many sufferers normally live with their families and sometimes visit the nursing home to receive treatment and to stay for few days. Thus, the therapists needed to take account of the transition between the nursing home at present and their own home in the future and the quality of their lives with other people. For this reason the therapists most likely placed a great deal of importance on the relationship with others, which would make their communal life more comfortable. Second, it also fits with one of general goals of occupational therapy. The guideline of the Japanese Association of Occupational Therapists (2012) clearly specifies one of the goals of occupational therapy is restoration to social ability including communication and family life. Although there are other abilities as a target for the therapy, it seems reasonable to focus on one of them as a main goal of his therapy.
The unknown questions in the cases of Mrs N

For Mr Kawaguchi, the goal of his treatment was not only to make decisions on the practical exercises in the therapy room, nor to help the sufferer develop good relationships both in the institution and at home. To check the goal of the therapy and to better understand the will of the sufferers, he often mentioned the importance of the pursuit of the sufferers’ reasons behind their problems. For example, he talked about his reasoning on Mrs N as the following extract describes.

**Extract 5: The reasoning behind Mrs N’s problematic activity**

Therapist: *However, there were some reasons why she shouted. Yes, there were reasons why she did it.*

Researcher: Yes.

Therapist: *The reason ... we should establish the possible reasons for ... and if we find a clear reason, the means except for shouting would fulfil her demand ...*

Researcher: Yes.

Therapist: *Yes. 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 to create storytelling with her.*

Researcher: Yes.

Therapist: *That was my view and ...*

Researcher: [nods]

Therapist: *I suppose so. But, we ended up not finding it at all. [looks at Ms I]*

Ms I: Yes. [nods]

During the conversation, he stressed Mrs N had some reasons for her problematic behaviour and the therapists needed to clarify the reasons to provide another way to compensate for her loss. His idea of something missing in the sufferer’s life behind the problematic behaviour was commonly found in his interviews and elsewhere. For instance, he also illustrated this in his book.

“People unconsciously act in search for something missing in themselves (and their lives). I think that there are surely some reasons for their actions. For the persons with dementia, there are certainly reasons other than the symptoms of dementia.” (Kawaguchi 2006: 40).

Compared to doing an exercise and establishing a good relationship with others, finding out what is missing in the sufferer’s life seems more difficult for both the
dementia sufferers and the therapists. Since the sufferers have cognitive and communication problems, it is not appropriate for them to directly ask or straightforwardly express what the matter with them is. In this sense queries such as, “What are the reasons behind this problematic behaviour?” and “What is missing in their life?” can be seen as unknown questions which the therapists did not know the answer to yet as in the case of Mrs N. Thus, they need to tackle the questions in various ways such as interviewing the sufferer’s family and scheduling staff meetings to discuss their problems, which Mr Kawaguchi actually did in the home. Moreover, as an alternative approach, he explained that his quest for what she missed led to some “storytelling” activity with her (the underlined part). In other words, it seemed that he had explored these unknown questions by making narratives, even though the therapists thought that they had been unable to find the possible reasons (answers) for her problems. In this respect his quest to seek the answers to the questions was not so observable in my observations.

The strategy for therapeutic interventions

After setting the therapeutic goals and activities, the therapists usually started their treatment. To achieve it successfully, Mr Kawaguchi described his strategies for the intervention with Mrs N and Mrs O as (1) expanding the sufferer’s range of expression, (2) grasping nonverbal information, and (3) creating the scene.

Extract 6: The expansion of Mrs N’s range of expression

Therapist: *She did not have the ability to respond to our suggestions.*
Researcher: *Yes. [nods]*
Therapist: *After all, we need to expand what came out of her mouth and to return it to her in our approach.*
Researcher: *I see.*
Therapist: *Indeed ... It was just like sweating with nervousness.*

In the above conversation, he described his way of communicating with Mrs N as expanding what she expressed and then returning it to her. Since she could not understand the therapist’s intentions because of her symptoms (see Extract 1), it was challenging for him to exchange words with her and he expressed this as “sweating with nervousness”. To catch and expand their expressions, he argued the significance of their nonverbal communication during the interaction as follows.
Extract 7: The grasp of nonverbal expressions
Researcher: *When you are rejected (by Mrs N) ... what do you care about?*
Therapist: *I don’t want to talk back to words ... as I am.*
Researcher: *Ah.*
Therapist: *Yeah. Basically, I think the information by words is not so meaningful.*
Researcher: *Well ...*
Therapist: *She said, “I can’t show my fine face any more.”*
Researcher: *Yes.*
Therapist: *When I listen to the words, I don’t think that she couldn’t show her fine face any more. [smiles]*
Researcher: *[nods] I see.*
Therapist: *Yes. There should be a reason why she said so.*
Researcher: *Oh, yeah.*
Therapist: *I want to tune in to her feelings behind ... For example, this time, I am really rejected.*
Researcher: *Yes.*
Therapist: *Or she really becomes angry ... in such cases ... I believe the information of facial expressions or intonation rather than words ... yes, because they touched me deeply.*

Although he actively created the conversation including the narratives during his sessions, he stressed that he did not value “the information by words” much, because he paid more attention to the nonverbal information such as the sufferer’s feeling, facial expressions, and tone of voice. Quoting what’s Mrs N said (see Excerpt 1), he explained that because of the weight he gave to nonverbal communication, he could continue the conversation despite the sufferers’ rejections. In other words, he seemed to catch what the AD sufferers expressed beyond mere words and it also gave him the motivation to continue the communication using words and narratives.

Extract 8: The creation of the scene with Mrs O
Therapist: *When persons meet a rehabilitator or an occupational therapist and they get confused, I will pretend to be someone or create some sort of scene in such cases.*
Researcher: *Oh, I see.*
Therapist: *I never introduce myself to Mrs O as an occupational therapist named Mr Kawaguchi.*
Researcher: *Hmm ... How did you introduce yourself to her?*
Therapist: *Young man.*
Researcher: *Young man.*
Therapist: *Your grandson or son.*
Researcher: *OK. Did you play the one 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.*

Another way to catch and expand the sufferers’ reaction is to “pretend to be someone or create some sort of scene”. In the above interview, he stated how to decide and play a familiar person for Mrs O. He explained that he took the position of a close person to the AD sufferers rather than playing the role of a medical expert to make the communication smoother. Of course, it is still unsure whether the AD sufferers really thought of the therapist as a close person, but his role play seemed to provide the opportunity for the sufferers to engage emotionally with the therapist and thus to participate in the therapy easier. In fact, when Mr Kawaguchi impersonated her son, Mrs O became talkative and friendly towards him and did not directly reject his suggestions.

For the therapist, the role play enables some degree of understanding of the sufferers’ relationship with others and makes new sense in the therapy session. For example, when Mr Kawaguchi pretended to be her son, they talked about Mrs O’s feelings for her son and grandson several times. During the session, they rarely discussed her symptoms but exchanged her family affairs. The therapy room became a place for chatting with the family rather than a medical setting authorised by medical professionals. The change of situation can be described in his words as “the creation of some scenes”.

From his comments on both of the AD sufferers, it is clear that the therapist placed emphasis on building the relationship with others, pursued some of the reasons behind the sufferers’ problems by addressing an unknown question, and used some criteria and strategies to create the sufferers’ expressions. To comprehend the background and his view of these findings, I will examine his ideas on the relationship, narratives, and teaching-learning process in detail in the next chapter.
6.3.2 The therapist as the creator of a triad relationship and dialogue

In addition to talking about the cases of Mrs N and Mrs O, Mr Kawaguchi offered extended explanations of his therapeutic practices and ideas behind them during our interviews and in his book. Through his accounts of his intervention and experiences with the dementia sufferers, it was revealed that he tried to establish a triad relationship with dementia sufferers by forming the “scene” and narrative and his efforts towards this end corresponded to some pedagogical theories including Bakhtin’s conceptions of dialogue and the polyphonic author.

The creation of the scene as a triad relationship

In his interviews, when Mr Kawaguchi explained the process and method of his intervention, he sometimes referred to theatrical words such as scene, story, or an improvisation. One of the reasons he used these words was because of his background as the creator of a drama play, but it also meant that he intentionally created a dramatic moment with the sufferers. For example, when the researcher asked what he did in the therapy, he described his work as follows.

Extract 9: The creation of the scene
Therapist: Yes. Well, rather than making a story.
Researcher: Yes.
Therapist: Yes. A scene, as a drama play, one scene.
Researcher: Yes.
Therapist: I created it.
Researcher: I see.
Therapist: It’s probably like that.
Researcher: OK.
Therapist: Today, this morning, well, there was the scene where three people including Mrs Y and Mr T did their exercises for abdominal and back muscles side by side. Two of them were funny and the other almost laughed but tried to be nice. That scene, I created it and because someone, the audience were watching it, well, I had a feeling to make that scene more enjoyable.

In the case of Mrs O, he described creating a scene with the dementia sufferers during his therapy rather than story making. Although he did not explain the scene itself in detail, from his description of the case with the sufferers, it seems that he
regarded it as the situation where the sufferers engaged in therapeutic activity interacting with each other and focusing on what they do as the audience. Moreover, he suggested that he wanted to change the scene to make it more pleasant. He thought that his job is to facilitate the sufferer’s relationships as form of a drama and just after this extract, he provided details of how to form the scene with the sufferers as below.

**Extract 10: The creation of the triad relationship through the scene**

Therapist: *Today, among three people, when Mrs Y and I were together, Mr T was the audience.*

Ms I: *Ah!*

Researcher: *I see.*

Therapist: *But, when another relationship was created [twists his fingers together as showing the relationship between Mr T and himself], the rest of others became the audience. Moreover, I wanted to be the audience, too, so I made a link between two of them occasionally.*

Researcher: *OK, OK.*

Ms I: *Ah!*

Therapist: *At that moment, or every time, it’s fun if something, something dramatic happens there, I suppose.*

With the illustration of the case, he stated how to co-ordinate the triad relationship between three people including his own positioning (see Figure 10). In his account, first he formed the relationship between Mrs Y and himself (1). Then he created the relationship between Mr T and himself (2) and finally he made a link between Mrs Y and Mr T and he became the audience. The scene was constructed through their relationships.

He also mentioned that this process of making relationships was fun because it created a dramatic moment. That is, the therapist valued the construction of the triad relationship and the scene where the participants played the role as both actors and audience.
The creation of the roles in the scene

When the therapist creates the scene and the relationship, what kind of the preparations are necessary? In his interview, Mr Kawaguchi suggested that he produced some roles in their interactions as he did with Mrs O.

**Extract 11: Creating the role of the therapist**

Therapist: *Without regard to their cognitive status, just treating the dementia sufferers as clients and behaving as myself as an employee here seems nonsense to me. After all, to set up a comfortable environment where the sufferers recognise us easily, and to offer good care service in the home, we should change ourselves and play each role for each sufferer. In some cases, my role seems impolite, while it seems formal in other cases. But, you never know if your idea fits with their perspectives of their world.*

Researcher: *That’s true.*

Therapist: *Yes. Just after experiencing many interactions with them, I will probably know what will be good for them. In fact, I suppose I make up (my therapy) like that.*

Here, he denies a relationship with the dementia sufferers which would treat them just as his clients without consideration for their cognitive skills and he suggests that the therapist should create a role which is suitable for each sufferer. Through many interactions with the role-play, he believed that he could understand what was good for them. For him, to play the appropriate role for a dementia sufferer is a way
of changing himself, to make the communication flow smoothly, and to provide better care.

On the other hand, Mr Kawaguchi also believed that creating a role for the sufferer was also necessary. When he talked about a dementia sufferer who was bedridden and could not speak much, he stressed creating a situation where she could play the role of a mother.

Extract 12: Creating a role for the sufferer
Therapist: So, when someone cares about her
Researcher: Yeah.
Therapist: *When someone cares about her, it results in a situation where her family happily come and see her, they warmly welcomes her at home, and she can live as their mother. I think, that is her primary role, of course. When her children visit, she welcomes them without words but not without happy expressions. Such situations, well, though she lives in the nursing home, we should create the situations that she lives as an ordinary mother. Therefore, we should create a fascinating world as an impetus for her to care about others.*

In this conversation, he emphasized the importance of caring about others for the sufferer and creating situations where she fulfils her primary role as a mother in the nursing home. He used the term, the situation(s) rather than the scene here but both words seems to have similar meanings in the point that the sufferer can actively interact with others and they pay attention to her. Even though she could not move or speak well because of her symptoms, the therapist hoped the sufferer would live as their mother, because she had been living as one all her life. In this sense, her role stemmed from her socio-historical background and the therapist tried to restore it in the nursing home. In contrast to what he described as “sufferers as clients” in Extract 11, he wanted to treat the sufferers as persons who had their own lives and histories outside the nursing home. For example, in the cases of Mrs N and Mrs O, the therapist often tried to assign a role as a mother to each sufferer by introducing the story of Mrs N’s son and pretending to be Mrs O’s son through their interactions. By providing familiar roles to the sufferers, he provided another meaning for the therapeutic situation as a place where the sufferers can live as they used to.

From the viewpoint of the narrative formation, the therapist’s efforts to set up the scenes and the roles for the participants seems a meaningful way for structuring the therapy. Bruner noted that the narrative contains a sequence of “mental states and happenings involving human beings as characters or actors” (Bruner 1990: 43)
and the therapist seemingly prepares happenings as a scene where the participants mutually interact and the characters or actors have their own roles, and consequently, this triggers the narrative or a dramatic moment. Thus, when the therapist prepares the scenes, what kinds of mental states and happenings were aimed for in the interactions? In the next chapter, I will explore his purpose behind the creation of the scene and the relationship between the dementia sufferers.

*The backgrounds to the creation of the scenes*

When Mr. Kawaguchi explained why he was concerned with the sufferers’ relationships and introduced the scenes to them, it seemed that he mainly focused on two points: creating spaces for their normal life in the therapy room and raising the awareness of others among the sufferers. For example, when I asked him about the reason he gave the sufferers the roles, he pointed out the peculiarity of the care institution and the need for the restoration of their normal lives there.

**Extract 13: Creating space for the sufferer’s normal life**

Therapist: *Regarding providing the rehabilitation exercises, if things go wrong, it establishes hierarchy more easily than providing nursing care, I suppose.*

Researcher: *Yes.*

Therapist: *Well, obviously, {during exercises} there is the expert who knows about physical matters or body functions and for example, with his expertise, he can simply move the sufferer’s joints.*

Researcher: *I see.*

Therapist: *So, from the very beginning, I have the idea to create a situation without hierarchy.*

Researcher: *OK.*

Therapist: *Then, another point is, in this place as a closed institution, we need at least one place to go out. When you have a place to go out, you will look in a mirror and brush your teeth. Without such a place, hmmm ... it seems hard to live. But of course, here is the care institution, so it’s difficult to go out. Going out freely seems difficult from the security point of view.*

Researcher: *Yes.*

Therapist: *So, I think that’s why the therapy room works. As a world for them, this room is so limited compared to our everyday world, but that’s why we need to simulate some spaces we normally have in our daily lives.*
In this conversation, first he mentioned the existence of the hierarchy between the sufferers and the therapists who hold the authority as caring experts in the nursing home and he hoped to dissolve it. Second, he said that he wanted to make the therapy room similar to the place where the sufferers used to live. Since life in the nursing home is very different from their normal lives, he argued that he wanted to restore their familiar places in the therapy room.

His idea of changing the therapy room into a place familiar in the sufferers’ normal lives seems similar to what Egan (2005) wrote when he discussed making the familiar seem strange. In his theory of education, Egan suggested that the teachers’ effort in making the familiar seem strange is important in creating a mystery and thus encouraging students’ emotional engagement in a classroom activity. In finding out about unknown aspects of the known world, the teachers can elicit “an attractive sense of how much that is fascinating remains to be discovered” (Egan 2005: 5–6) for the students. Similarly, the therapist also tries to make the familiar therapy room seem strange for the sufferers and himself for their emotional engagement. Of course, by most definitions, the therapy room can be viewed as a strange place and their accustomed sites can be taken as familiar ones for the sufferers. However, as long as the sufferers stay in the nursing home, they usually miss their familiar settings and the nursing home turns into another place for their daily living. In this sense, providing familiar roles and the everyday environment seemingly enables the sufferers to discover new contexts and meanings for the therapeutic activity in connection to their familiar ones and provides them with motivation to join in with the activity.

For the therapists, since they usually do not know the sufferer’s background at first, it becomes a challenge to create such an environment in their therapy room. It means that while they know the therapy room and their activities well, they need to pick up quickly on the known and unknown matters for the sufferers through their interactions and they need to consider what is strange and how to connect life in the therapy room with the one at home. To pick out unknown matters, Egan (2005: 53) recommended that teachers “try to re-see the topic through the eyes of the child”, and the therapist’s trials such as playing the role of familiar persons (see Extracts 8 and Extract 11) may be one approach to knowing more about their ordinary lives and to finding out what matters for them from their points of view. For example, in the case of Mrs O, the therapist introduced a school-like setting to her (see Excerpt 4.1), imitated the voice of the head teacher, and posed questions and made suggestions in relation to the school activities. While asking questions, he seemed to collect information about her school days which were unknown
matters for him and continued to create the school-like situation as an unusual situation in the therapy room. This case seemingly indicates his thought of enactment concerning their familiar places and his efforts to make the therapy room strange for both of them.

Another purpose for creating the scene is to build consciousness in the sufferers of others. In his accounts of creating the scene, Mr Kawaguchi described how to develop a third-person-perspective for the sufferers.

**Extract 14: Creating a third-person-perspective**

**Therapist:** So, when two people exist, they don’t just share the same space, but they are aware of others who watch their performance as a third person and see themselves from the other’s point of view.

**Researcher:** Yes. In fact, Mrs Y looked around many times.

**Therapist:** Yes. I think, that it is important to develop their social abilities. Well, while spending a lot of time alone in the nursing home, they need to interact with someone with an awareness of others watching them. It can be an advanced social skill.

**Researcher:** Yes.

**Therapist:** In fact, they are doing the same as care professionals do.

**Researcher:** I see.

**Therapist:** Yeah. Showing what they are doing to others ... This is like developing sense as a performer.

In Extract 10, he explained how to construct a triad relationship between two sufferers and the therapist by becoming the audience. Here again, he indicated the triad relationship between two sufferers and a third person. He places much value on the creation of the self-awareness about how one looks to others in the relationship as the “sense as a performer” because he believes that it develops their social skills.

As the therapist illustrated, showing their performances towards others was connected with the acquisition of two perspectives namely seeing others and being seen by others. Bakhtin discussed this state of consciousness in terms of the ‘surplus of vision’ (Morson & Emerson 1990) in relation to his theory of dialogue. Since “one always sees something in the other that one does not see in oneself” (ibid.: 153) in the surplus of vision, we need others’ perspectives to understand not only others but also ourselves and our surroundings. In other words, we can comprehend each other when we share our surplus of vision by viewing the world
from others’ points of view. Moreover, Bakhtin thinks that it is the polyphonic author’s work to let the characters see the others’ surplus of vision. In doing so, they can encounter all other consciousness equally including the author’s and he can open up the dialogue where many disparate points of view exist as equals. That is, from the Bakhtinian perspective, the therapist’s attempt to introduce the third-person-perspective seemingly enables the sufferers to understand others’ views, their settings as the scene, and themselves as a performer for others. By becoming conscious of others, there was an opportunity to make their relationship dialogical or non-hierarchical, as he stressed in Extract 13.

Furthermore, the relationships including both seeing others and being seen by others seemed to connect with the caring about others and being cared about by others. In his following comments, Mr Kawaguchi considers the meaning of the third-person-perspective and suggests it causes a relationship of caring about each other.

Extract 15: Creating a relationship of caring about others
Therapist: Well, interacting with others leads to being cared about by others or ... it creates another communication or ... Yes. Whether they have dementia or not, elderly people can care about others. But even so, they tend to judge others as right or wrong, yes or no, or in terms of like or dislike. Actually, that should be mixed feelings towards others. Also, even if you don’t like others in your heart, it’s important to care about them somehow. This often happens at home and these sufferers will return home and there will be their families including their daughters-in-law, of course. It means they live with somebody else who did not use to be a member of their families. Moreover, their grandchild sometimes invites his wife to their home. When the family, the members of the families increase, they need to care about others immediately. Otherwise they can’t get on well at home.

In the beginning of his comments, he states that the relationship with others causes being cared about by others. Then, he states that the sufferers are capable of caring about others regardless of their symptoms and the ability to care about others is important to have a good relationship with others including the members of their own families at home. Since his comments were made in answer to why the third-person-perspective was crucial in his therapy, it seemed that he regards the third-person-perspective in the triad relationship to cause a caring relationship among the sufferers and their close persons.
The therapist’s intention of making the elderly people, including dementia sufferers, care about and be cared about by others seems to be directed at offering new roles to them and at restoring their normal lives in the nursing home and their homes. Normally, the elderly residents and sufferers are seen as the ones who are cared for by the therapists in care institutions, but the therapist hoped to give them a role as a person who cares about others, because he believes that caring about others is common in their lives with their families. By changing their roles, the relationship between the sufferers and the therapists also turns into one of being cared for and caring about to some extent. At least, it seems that the relationship between the dementia sufferers clearly changed into a reciprocal and active one, exchanging their positions as caring and being cared for. For example, when the therapist interacted with Mrs O, he involved Mrs B in their relationship by asking her for help and sharing an unknown question. After his inclusion, they started to care about each other by asking questions and singing together related to their school day experiences and did the walking exercises in return in Excerpt 4.4.

In terms of the construction of the triad relationship, his comments so far show how the therapist tries to create a triad among the dementia sufferers, the scene, and himself (see Figure 11). As a process, first the therapist introduces each role of the participants (S2 and S3) with the preparation of the scene (X) which they are familiar with. Then, while the sufferers participate in the scene or watch it as an audience, a triad relationship is created between the sufferers, the scene, and the therapist. Actually, as Extract 10 shows, the therapist regarded the triad relationship as being between the two sufferers and himself, but the scene is necessary as the place for their interaction. A triangular relationship mediated by the scene seems to be established. When others (S4) such as elderly residents or care professionals watch the scene, they also can become the audience or a potential participant in the scene and thus their relationship expands. Through this relationship, they can interact, do their exercises, realise other’s perspectives and care about each other. Moreover, as the cases of Mrs N and Mrs O demonstrated, if the scene developed in the sense that the participants jointly described, evaluated or explained a certain event or situation, it gave rise to a narrative. In each case, the therapist seizes the initiative to construct the relationship and with the formation of the triad relationship, he expects to broaden it not only as between the therapist and the sufferers, but also the relationship between the sufferers. Furthermore, he hopes to unfold it between the sufferers and their families in the future, while simulating home-like scenes with the sufferers.
The triad relationship between the therapist, the sufferers, and the scene.

**The therapist’s efforts to create the relationship**

When the therapist intentionally forged a relationship with the dementia sufferer, what kinds of strategies did he adopt? When Mr Kawaguchi described how to form the relationship, he highlighted the importance of catching and making the sufferers’ reactions, confronting them, and collecting the case descriptions as follows.

**Extract 16: The dementia sufferer as a person who can respond to others**

Therapist: *Well, the dementia sufferers can care about others by nature. Yes, probably. Also, they can show signs and sorts 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. I believe so. Well, how to say, in reality, I saw such cases many times, so … On last Friday, Mr I joined in the group activity, but he can’t speak and it was hard to know if he could hear our chat from his facial expressions. But when it counted, to my surprise, he shook his head intensely [shakes his head] and looked at us.*

Researcher: *He was looking at you.*
Therapist: Yes. For him, those actions were probably his expressions such as his voices, shouts, and laughs ... I want to give them back as much as possible. Not only satisfying myself with his actions and saying, “Oh, he's laughing”, but reacting to him is needed. If I can do it, something wonderful may happen next. This is what I have learned from many cases.

From his experiences and learning with the dementia sufferers, he said that each sufferer had his/her own expression towards others and the therapist needed to catch and respond to them continuously. In his account of Mr I who had dementia, although he could not talk, the therapist thought that his body movement showed his expressions, such as his voice, shouts, and laughs. While recognising and reacting to them, the therapist believed that the dementia sufferer gradually became more active in responding to him and consequently, something new might happen between them. Also, he regarded the sufferer as a person who is capable of responding to others.

His opinions regarding the sufferers being active respondents towards others, and the therapist’s own activity in noticing and responding to their reactions is also reflected in his career view as an occupational therapist. In the following excerpt, he specifies the therapist’s work in reacting to the sufferers.

**Extract 17: Occupational therapy as the job of reacting to the sufferers**

Therapist: What we can give back to the sufferers is the key. It's the job of reacting. It's not anything like the job of taking action but the job of offering reactions.

Then, what shall we do for the people with no response. Well, if they don’t react at all.

Researcher: OK.

Therapist: I think if you look closely at them, they surely express something. The sense you can realise it matters ... I hope the therapists can develop it. Because these people are alive and breathe, or, at a minimum, the respiration rate, heart rate, and blood pressure can be their expression.

Researcher: Yes.

Therapist: In fact, some people can only express themselves in such ways.

Researcher: Oh, yeah.

Therapist: During a lifetime, they can express. They are alive. Even a person in silence can express himself and you can see it. Still, in human communication, people demand words. That’s why they see no reaction and no expression in
sufferers, but … I want, I feel compelled to catch, interpret, and verbalise them, because they can’t speak.

Here, he defines his profession as the job of reacting to the sufferers. As his first comment demonstrated, reacting means giving something back to the sufferers. As he mentioned in Extract 16, he thought that the sufferers were capable of responding and expressing themselves as long as they live. Thus, he assumed that the therapists should cultivate the sense of noticing the sufferers’ expressions and putting them into words on behalf of the sufferers who could not talk.

His perspectives on the sufferer as an active respondent in both interviews seem similar to Bakhtin’s discussion on dialogue. Bakhtin presented the term dialogue in various senses, but in the first sense, he thinks that “every utterance is by definition dialogic” (Morson & Emerson 1990: 131) and any utterance “always has an addressee” (Bakhtin 1986: 126) as a listener. Since Bakhtin thinks meaningless words, tones, and gestures are highly expressive as utterances, the actions by the dementia sufferers can be seen as their utterances. That is, the sufferers are speakers who have their own utterances and the therapist is the listener who captures their utterances or expressions. When the therapist responds to the sufferers, he also becomes a speaker or an author who creates his utterances in relation to them and the sufferers become listeners who can be attentive to his words. Through this process, both parties engage in a joint endeavour in dialogue to express their ideas and feelings.

Moreover, Bakhtin particularly emphasises the role of the author in dialogue, because dialogue does not just consist of verbal exchanges between people but also consists of encounters with different perspectives. In his book of Dostoevsky (Bakhtin 1984), he examined two roles of the polyphonic author in creating “a world in which many disparate points of view enter into dialogue” (Morson & Emerson 1990: 239) and himself participating in that dialogue. In contrast to the monologic author who manipulates his characters and their voices, the polyphonic author can hear “both the loud, recognised, reigning voices of the epoch, the reigning dominant ideas (official and unofficial), as well as voices still weak, ideas to yet fully emerge, 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 characters as Dostevsky did. For Bakhtin, the polyphonic author is the one who can listen and create possible voices which are not fully emerged (Miyazaki 2012, 2013). From this point of view, the therapist’s accounts show a close similarity to the work of the polyphonic author. For example, in his explanation of Mr I, the
therapist explicitly stated that he needed to take the sufferer’s unspoken expressions such as his “voices, shouts, and laughs” and react to them not just as commenting in the third person such as “Oh, he’s laughing” but by creating their own expression giving them back to the sufferer. As another example in my observation (see Excerpt 1), when Mrs N mentioned that she wanted to laugh, he immediately repeated it and suggested various ways of laughing, demonstrating how to laugh, proposing to smile, and showing the physical movement by smiling. This also seems to represent the therapist’s effort to listen to the sufferer’s voice as being ideas or desires which are not fully emerged or expressed, and that’s why he developed them with some suggestions and new meanings. In this sense, the therapist can be seen as a polyphonic author who listens and elicits the possible voices from the dementia sufferers and constructs a dialogic relationship where the sufferers and the therapist become both listeners and speakers.

To capture and listen to the voices of the dementia sufferers as a polyphonic author, Mr Kawaguchi also suggested confronting them. For him, a confrontation is the means to elicit responses and to express oneself in earnest as the following extract indicates.

**Extract 18: Confronting the dementia sufferers**

Therapist: *Being a therapist or a care professional, it is believed that they want to control or manipulate a person at any rate, but …*

Ms I: *Hmmm.*

Therapist: *It’s totally wrong. Yeah. After all, expressing, catching, and reacting. That’s all.*

Researcher: *Yes.*

Therapist: *In doing so, the unexpected happens, but we also accept such unexpected and react to it again. It’s just like a real fight or and one-to-one fighting … One mistake and it would be all over … Without expressing ourselves, we can’t elicit what they have in themselves.*

Ms I: *Yes, that’s right.*

Therapist: *Yeah. We need to confront to them with our own naked selves.*

Researcher: *Yes.*

Therapist: *Otherwise, they don’t express themselves. That is human nature, isn’t it?*

In this conversation, first the therapist illustrates his work as not controlling the sufferers but “expressing, catching, and reacting” to them as he stated in Extract 16 and Extract 17. Although the unexpected happened in their interchanges, he thought
that it was important to accept it and react to it. Moreover, he called this process of his intervention as “a real fight” between the dementia sufferers and the therapist. In his context, this fight means to confront the sufferers in person to draw out their expressions while the therapists express themselves straightforwardly. He believes that without a confrontation like this, the therapist could not elicit the expressions from the dementia sufferers.

On the dialogic relationship, Bakhtin believes that the polyphonic author confronts his characters as equals (Morson & Emerson 1990). In the work of the polyphonic author, the author “sets the stage for these contests he is not pre-ordained to win and the outcome of which he does not foresee” (ibid.: 239) and characters “partially escape his control and prevent him from knowing in advance how they will answer him” (ibid.: 240). In the interview above, it seems that the therapist avoided controlling the sufferers, accepted unexpected situations in which he did not anticipate, and encountered them as whole persons and as equals, as Bakhtin wrote. To make their relationship equal, the therapist introduced roles and scenes to confront each other, and actively adopted their ideas which he had not expected before. For example, in the case of Mrs O, the therapist introduced a head teacher as a character in the narrative and offered the role as a student to her, while forming a triad relationship between the head teacher, her and himself. In their joint formation of the narrative, Mrs O confronted the therapist who expected her to do the stand-up exercise several times and rejected many of his suggestions. While Mrs O voiced her opinions including rejections and side-tracks freely, the therapist actively listened to them, reacted to them by taking the position of a conversational partner and as a head teacher, and arranged the setting where she could meet other voices not only from the head teacher but also from other dementia sufferers including Mrs B and Mr T later.

Another of the therapist’s efforts as a polyphonic author is to see caring as unfinalisable. In his accounts of the relation to other therapists, he described that what is right was decided by collecting not the right answer but as many individual cases as possible.

Extract 19: Collecting not the correct answers but the descriptions of the cases

Therapist: *What is right is, you know, only the elderly people themselves know, so among three or four of us, we can’t offer the right answer. In my opinion, it’s important not to figure out what a correct answer is as the proper way. So, how to care for someone can be seen as one of the cases. Something like one of the ways that went well.*
Researcher: OK.

Therapist: *When we look for the correct answer or, well, when things went wrong, it was decided by seniority, by the person who had a long career in the home.* But, for example, by discussing how he reacted when I talked with him, we can collect a number of his cases.

Researcher: I see.

Therapist: *Then we will gradually know what is better for him as we become a high-average hitter ... It naturally unfolds. In order to keep it, we don’t negate the care workers, even when their batting average is so low. Do not say, “OK, he showed a fine face, but it just happens by chance”. We have to interpret it as one result of the case, because it’s also dangerous to standardise it immediately.*

In his account of the judgment of good caring, he proclaims that since the dementia sufferers only knew what was right for them, the therapists could not decide on it and it was better to leave it unanswered. Instead of finding the correct answer, he recommends collecting many cases and believes that the therapists gradually and naturally understand what is good for the dementia sufferers through the process. To keep collecting the cases, he thinks that the therapists should neither reject others who report their cases nor standardise them as being correct. In sum, the therapist’s concept of good caring is not deciding or searching for one correct answer but creating and sharing a collection of several case reports by the therapists.

In his Dostevsky book, Bakhtin analysed two kinds of author’s approaches to the truth (Morson & Emerson 1990). While the monologic author only has authority to express the truth and refuses other truths as being non-essential or partial, the polyphonic author perceives the truth as dialogic and unfinalisable in terms of interacting with several consciousnesses or unmerged voices (Morson & Emerson 1990: 236). He does not extract a single proposition, but meets the combination of individual views (ibid.: 237). Like the polyphonic author’s viewpoint on the truth, the therapist regarded what was right in caring as the collection of others’ opinions and did not seek correctness as a single, right answer. For him, it seems important to engage in a dialogic relationship with others’ ideas and open to multiple possibilities of caring rather than synthesise these as a certain method. In seeing the caring as an unfinalisable endeavour, it seems that he operates as a polyphonic author who listens to various voices from care professionals and positions himself as an equal member of the case reporters. Moreover, by thinking about what is good in caring as being undecidable and unpredictable by the therapist, he views the dementia sufferer as a person who is free from his control. Actually, when he
described the case of Mrs O, he concluded it as follows: “Today it (their interaction) went well, but tomorrow it probably won’t work. What is good is not to be manualised. It was suitable for Mrs O today. That’s it.”

The therapist as a dialogic learner of the sufferers

Through the analysis of his interviews, it was clear that the therapist expected to build a triad relationship with the sufferers introducing the scene and the roles that seemed to trigger the narrative construction. Moreover, the construction of the triad relationship was directed to simulate places in the sufferers’ normal lives and to develop their consciousness towards others as a dialogue. To form the relationship, the therapist worked as a polyphonic author eliciting their reactions by listening and authoring their voices, confronting the sufferers, and viewing caring as unfinalisable. Overall, it was found that his thoughts on the relationship and caring resembled to Bakhtinian concepts.

On the other hand, when I asked him how he developed his expertise as an occupational therapist, he rarely mentioned any particular persons or methodologies but liked to cite particular cases. For example, in Extract 16, he explained Mr I’s case and added, “This is also what I have learned from many cases.” He explicitly stated that he had learned to see the sufferers as active respondents and to actively react to them through their interactions. Similarly, when he talked about the creation of the roles for the dementia sufferers, the places of their everyday life experiences, and their consciousness of others, he often commented that he had learnt it from the sufferers themselves using expressions such as, “They taught us”, or “Many cases demonstrated it.” In this way, he regards himself as a person who learns with the dementia sufferers. However, how can he continue and develop his learning in practice?

The continuous process of his learning with the elderly sufferers seems clearly stated in his book. For example, in relation to his experience with a sufferer with terminal cancer, he writes his thoughts on the role of the occupational therapist and his learning from the sufferers he met as follows.

“After working as an occupational therapist in the nursing home, I’ve been thinking on one question. In contrast to a midwife, is it our job to assist the elderly people in dying? Is it the job to help them go and die while letting them feel things such as ‘I’m happy to live’ or ‘I’m happy to born as I am?’ I’m not sure if we can help them like that. What we can do may be limited. However,
occupational therapy will make it possible, because it aims to create a human relationship which enables people to end their day off in a happy way and to have a peaceful death surrounded many friends and family … I experienced several partings with elderly people. I remember all of their faces but forget some of their names. However, I want to keep writing down what I’ve learned from each person, never forget it, apply it to my job, and give it back to others whom I will meet in future. I think this is the occupational therapist’s way to show his appreciation for the departed people.” (Kawaguchi 2006: 163–164).

Here, he asks himself about the role of the occupational therapist for elderly people including terminal sufferers and concludes that by creating a human relationship, the occupational therapy makes their lives and deaths meaningful and provides a happy ending. He expresses that he has learned these ideas from the sufferers and will carry them out with other sufferers. For him, what he learned from the sufferers in the past makes up a part of his ongoing job and for the future.

Moreover, his learning is seemingly achieved by entering a dialogic relationship with the sufferers. When he explains his ideas about occupational therapy, he often quoted various conversations with the sufferers. In the following excerpts, first he wonders what the occupational therapy is in response to his mother’s question in his early years as a therapist and then quotes the words from Mr S who had a problem with his legs and whom he met in his first year of working as an occupational therapist.

“After all, what is your job?” my mother asked me … My work is providing so-called rehabilitation. It is my job to let the sufferers endure the severe pain to regain the use of their limbs. But, my work is more than this. I did not explain it with such a word. So, I gave other explanations again and again. Consequently, my attempts ended in emptiness with full of vague and meaningless words … Without giving a clear explanation to my mother, as what I am doing as an occupational therapist.” (Kawaguchi 2006: 8).

“He said, ‘I talked about many stories with my wife. If you give people sadness, you will receive it. If you won’t receive it, your children will receive it. But, if you give happiness to people, you will receive it, too. If you won’t receive it, your children will receive it. Like this. I’m just an ordinary fellow but I’m quite sure of that in all my 90 years of life … Doctor, that’s why you chose a good job.’ After saying these words, Mr S leaned back against my arms. I never
forget this conversation with him. When I have failed, been worried, been happy with sufferers and my company, hurt someone, thanked someone, or when someone has said to me, “Thank you”, his words come into my mind, gave me the motivation to work, and connect to my first question. For decades, I am still searching for my words with which I can describe it (what the occupational therapist is) to others.” (Kawaguchi 2006: 9–11).

Remembering the sufferer’s words in many emotional situations later, Mr Kawaguchi continues to think about his long-standing question, what is occupational therapy. In the beginning, he thinks that it is not enough to merely illustrate the therapist’s work such as providing limb training. Then he introduces the sufferer’s words that show the sufferer’s values of human nature and evaluation of the occupational therapy as “a good job”. He writes that he still looks for the appropriate words to describe his job for decades and the sufferer’s words inspire him to work and tackle the question. He does not make a conclusion of the sufferer’s words and his question but keeps it as a trigger to deal with the question.

From Bakhtinian point of view, the therapist works as a polyphonic author listening to the sufferer’s voices and constructing a dialogic relationship between them. The therapist actively joins in the dialogue not just by passively remembering things, but through actively posing questions using the sufferer’s words to consider his question. Moreover, as he describes his experience, the sufferer’s voice seems to become his inner voice and it enables him to continue the dialogic relationship in his mind.

Although he does not directly mention that he learned something from the sufferer’s words here, the engagement in the dialogical relationship with the sufferer is seen as his learning process in two respects. First, as Anderson (2008: 101) noted, when learning between the therapist and the client occurs, “It involves multiple, mutual reflecting conversations with myself, clients, colleagues, students, and others” and transforms the therapist as a professional and a private person. She thinks that these interactive reflections are a “part of a generative learning process that is broader than simply learning a client’s story and broader than the therapy experience itself” (ibid.: 101), because it causes the therapist to change himself including an examination of his ethics, morals, and values. From her point of view, through the conversation with the sufferer, Mr Kawaguchi engaged in the learning process by continuously reflecting on the sufferer’s words and his own values and goals for occupational therapy. Moreover, since his learning is seen as the process of looking for the possible answers and testing his ideas against the sufferer’s it
forms an unfinalised dialogue as praxis. It resembles what Matusov called as the ontological learning (Matusov & Miyazaki 2014: 4).

Second, he seems to seek an unknown question through the dialogue with the sufferer. Miyazaki (2005, 2013) describes an unknown question as one which the teacher does not know the answer to or its significance before the lesson. Here, the therapist also does not know the correct answer to what occupational therapy is because the concept of occupational therapy is broad in general, and as the excerpt shows, he is not satisfied with the answer as a methodological description and thus, continues to look for better expressions. Miyazaki (2010a, 2010b) also points out that the teacher explores and discovers the unknown question by encountering various voices from children and experts as everyone may have useful knowledge related to the problem. He implies that by listening to different voices of children and experts, the teacher learns diverse thoughts co-exist in his mind and becomes a polyphonic author who can generate new and unexpected questions for the children (Miyazaki 2013). From his viewpoint, the therapist listens to the sufferer’s voice as an expert’s opinion. To the therapist this represents the value of human life and of occupational therapy and is forged by the sufferer’s 90 years of experience. By encountering such sufferer’s voices, the therapist actively and continuously forms his own thoughts or philosophy of work and life as a polyphonic author.

Moreover, the dialogue with Mr S seems to continue and influence his recent views to some extent, although the therapist left Mr S several years ago. For example, in Extract 17, he described his work as “the job of reacting” and its key was “what we can give back to the sufferers”. Such explanations seemingly resemble what Mr S means in their dialogue on the point that he sees the human relationship as give and take and it connects to occupational therapy. It does not imply that the therapist found a correct answer to his question of what occupational therapy is after their dialogue, because he showed different interpretations and accounts of his job in other interviews, such as when he described it as “a real fight” in Extract 18. Instead, it possibly means that after listening to the voice of Mr S, the therapist might cultivate one of his views on the work according to Mr S’ voice and express it as his own voice during our interview.

Another example of his exploration of this unknown question again appears in his book. He describes the case of Mr I who had dementia and received occupational therapy recently. He quotes Mr I’s words, “Yes, I responded to you”, and speculates its meaning. In response to the therapist’s question, “When I talked to you, you did not respond to me at all, did you?” (Kawaguchi 2006: 165). Mr I suddenly spouted these words and they surprised the therapist. After reflecting on
other experiences and interactions with Mr I, the therapist raises two questions: “What can we (occupational therapists) do to support people who can’t express themselves easily?” (*ibid.*: 166) and “Do Mr I’s words represent other sufferers’ voices who can’t express themselves?” (*ibid.*: 171). Then, he concludes that occupational therapists are people who can catch small signs from the sufferers’ by observation and deal with their difficulties, and thus he wants to continue to “reply to them” (*ibid.*: 171) in his job. Here, his definition of the therapist’s work is similar to what he said in Extract 17 as the job of responding to the sufferers and his question becomes more specific compared to his first question of “What is occupational therapy?” not just literally but qualitatively. Inspired by Mr I’s unexpected words, he poses the question of how to help the sufferers who cannot express themselves easily but have their voices and he explores the meaning of his job. In other words, while he focuses on the explanatory words of his job to people who can express themselves such as his mother and Mr S in the original question, he pays attention to the sufferers who have weak voices and how to act for them in the latter case. When encountering Mr I’s voice, the therapist reformulates other forms of his unknown question (e.g. what is occupational therapy) and elaborates his view of the job as continuously catching and responding to the sufferers’ voices. In this sense, the therapist again engages in the polyphonic work of listening to the multiple voices of the sufferers, confronting them by raising unknown questions, and to trying to explore them. Through this process, it seems that he learns and (re)creates new perspectives which he did not possess before and his dialogue and his learning process with the sufferers become unfinalisable as long as he continues to catch and reply to their voices in his work as an occupational therapist.
7 Conclusions and perspectives

In this final chapter, first I will briefly answer my research questions regarding the functions of narrative, the role of the therapist, and the meaning of their relationship that I formulated in chapter 4. Then I will discuss future perspectives on this research including the implications for dementia care research, limitations of the study, and needs for further research.

7.1 As a mediating tool, what kinds of narratives were created through the everyday interaction between therapists and dementia sufferers? How and why were narratives constructed?

Brief answers: The therapist and the AD sufferers jointly produced narratives regarding their past experiences and familiar people. The therapist delicately introduced the narrative topic by creating the narrative roles and settings for them. The narratives functioned as a psychological tool for mediating their perspectives, making new sense of the situation and human relationships, their teaching and learning as a form of collaborative problem solving, and changing the AD sufferers’ behaviour and higher mental functioning. The reason why narratives were formed was to make positive sense of the therapeutic activities, to restore good relationships with others, and to search for the reason behind the AD sufferer’s problems.

From the analysis of the observational data in chapter 6, it was shown that the therapist and the AD sufferers jointly created the narratives. The therapist crafted the story of a letter from the son of one of the sufferers and of gaining a reward for the therapy with Mrs N, and the story of a school activity with Mrs O. In the process of narrative formation, first the therapist introduced the topic by creating roles for the AD sufferers and himself and preparing the settings that were familiar to them. He negotiated this between them, and if they accepted it they continued to develop it. These narratives often had structural elements such as description, evaluation, and resolution or explanation by the interlocutors. Especially, while the AD sufferers talked about their feelings, desires, evaluations, and old memories in the story, the therapist listened to their utterances carefully, gave positive feedback to them, suggested or modified the stories to create new meanings which complied with their point of view and oriented them to the implementation of therapeutic
exercises. Through their negotiation, two perspectives of the AD sufferers and the therapist were intertwined and crystallised in the narrative form and thus, the narrative seems to function as a tool for mediating their ideas and perspectives. Moreover, since they created the narrative plot to embed the ongoing activities in the therapeutic story, their interchange is viewed as therapeutic emplotment (Del Vecchio Good et al. 1994, Mattingly 1994, 1998). That is, the narrative worked as a tool for therapeutic sense-making.

Also, the narrative can be seen as a tool for their teaching and learning. During the narrative co-construction, the therapist often posed questions both as known and unknown and explored them with the AD sufferers. While the therapist knows the correct answer to the known questions, he does not know the answer or its significance before the therapy to the unknown questions. Setting a known question as a binary opposite, which is a kind of cognitive tool (Egan 1989, 2005), the therapist clarified the narrative situation and made the therapeutic activity more understandable and desirable for the sufferer. When the therapist and the sufferer reached the ‘desirable’ answer to the known question, they stopped exploring it and conducted the therapeutic activities because the known question was directed towards the implement of the exercise as its solution. On the other hand, in pursuit of unknown questions, the therapist seemed to look for the appropriate narrative materials in relation to what really mattered to the AD sufferers or what they liked to talk about. While he could elicit possible answers from the AD sufferers, he embodied them in the narrative form. If he could not find any answers, he sometimes shared the unknown question with other AD sufferers seeing them as experts who had knowledge of the question or as partners who could deal with it together. By creating an environment for collaborative problem solving, the AD sufferers could jointly participate in the story telling, express possible answers or their opinions, and finally achieve the therapeutic activity. This means that the exploration of both of known and unknown questions in the narratives enabled the AD sufferers to complete the therapeutic activities that they were reluctant to do in the beginning of their interactions. That is, the AD sufferers could learn the meaning of the therapeutic activities and were motivated to achieve them, while they could teach the therapist things based on their personal knowledge about their home environment or past experiences like childhood. At that point, the narrative seemed to function as a psychological tool affecting the sufferers’ behaviour and higher mental functioning in a Vygotskian sense. By higher mental functioning, I mean their abilities for telling and listening to narratives and exploring questions with others. Of course, it can be regarded that they may already have had potential
to achieve such communication and narratives with others before the therapy sessions, but the therapist’s support using narrative seemingly contributed to helping them do this in the therapy room.

The reasons the therapist introduced the narrative to the AD sufferers were investigated with the aid of observational and interview data. During my observations, since the therapist proposed to do the exercise through narrative co-creation, he seemingly aimed to accomplish the therapeutic activities with creating positive senses of the AD sufferers’ current activities and the implementation of the therapy. On the other hand, the therapist himself explained other reasons for his intervention, including narrative production, mainly regarding two points: the restoration of a good relationship with others and the search for the reason behind the AD sufferer’s problematic behaviour. To (re)establish a good relationship with their families at home and other sufferers in the nursing home, the therapist continued to communicate with the AD sufferers using the narratives whose topics were connected to their families or experiences with others. In other words, the narrative became a tool for making actual relationship between the AD sufferers, the therapist, and other people in the nursing home and fostered the AD sufferer’s consciousness towards the possible relationship with their families at home.

7.2 As a dialogic teacher, what is the teaching-learning process of the therapist through the co-construction of narratives?

Brief answers: The therapist’s teaching-learning process through narrative co-construction was interpretable from both Vygotskian and Bakhtinian perspectives. In terms of Vygotskian views, the therapist seemed to arrange a Zone of Proximal Development (ZPD) for the AD sufferers. Here, the ZPD refers to joint higher level potential as the possible therapeutic goals or narrative endings. With the creation of the ZPD, the therapist could teach the AD sufferers how to solve their problems, to achieve the therapeutic activities, and to communicate with others. From the Bakhtinian approach, the therapist's role is seen as a dialogic teacher in that he created a dialogic environment encountering many voices from dementia sufferers, exploring known/unknown questions with them, discovering knowledge about their historical and cultural backgrounds learning from them, and continuing his open-ended dialogue with their voices.

During my observations, the therapist always introduced the narratives to the AD sufferers according to their responses, and therefore his role was particularly crucial
in the process of its construction. With the narrative formation, he actively listened
to the sufferers’ voices, finding their viewpoints in their utterances and narratives.
He created the dialogue between them by asking questions, and taught them how
and why they did the occupational tasks, which they were unable to do by
themselves. From Vygotskian and Bakhtinian perspectives, such therapist’s acts are
seen as a teaching-learning process and as one that the dialogic teacher possesses.

In the light of Vygotskian approaches, the therapists seemed to create a Zone
of Proximal Development (ZPD) for the AD sufferers during the narrative co-
construction. By making fascinating narratives, the therapist and the AD sufferers
played their roles, set free from the constraints of immediate situation and explored
the tension between the narrative world and real life. Especially, the therapist tried
to make positive and attractive senses for both the narratives and therapeutic actions
to achieve his therapeutic goals, such as doing an exercise and facilitating
communication with others. In this sense, as Mattingly (1998) noted, the therapist
“sees backwards” from a future endpoint or “an array of possible endings” to
practical action in a story-making venture. In other words, the therapist sees two
zones during his intervention and makes a connection between them. The zones are:
the one of the AD sufferer’s individual and actual level of activity and the other
zone of her joint higher level potential as the ZPD and possible therapeutic
activities. During the narrative formation or before then, the therapist grasps the
AD sufferer’s personal conditions including her will, hopes, and physical and
mental problems and elaborates the narrative context which is relevant to the
subsequent possible actions. For the therapist, it is necessary to predict or imagine
the ZPD as possible therapeutic goals or narrative endings although the future is
unknown, because it orients the AD sufferer and himself to form the ongoing and
future therapeutic activities together. If the prepared narrative did not fit with his
imagined ending, he immediately changed the topic or shared it with other sufferers.
That is, through the co-creation of the narrative, the therapist expressed both the
actual problems at present as well as possible and happy narrative endings in the
future, and helped the AD sufferers to learn how to solve their problems, to achieve
the therapeutic activities, and to communicate with others actively.

On the other hand, while the notion of the ZPD is applicable to analysing the
teaching-learning process by the participants, it also sheds light on the relation
between learning and development. In this context, what sort of development
occurs with the AD sufferer’s through their learning? The concept of development
often refers to ‘the gradual growth of abilities’ in the field of the developmental
psychology. With such a perspective, development can be considered doubtful in
dementia sufferers, because they are seemingly in the process of losing their ability and capability. However, using the narrative as a tool for their teaching and learning, the AD sufferers could remember their past experiences and restore their capacities to perform socially appropriate activities. In sum, although their physical ability may be diminishing, their social and emotional abilities, which have developed throughout their lives, still remain or can potentially be rehabilitated or developed. In addition, if we take Holzman’s perspectives on the ZPD as the dialectical relationship between learning and development and the changing distance between being and becoming, it is considered that the AD sufferer could learn and develop the new capacity in themselves such as creating a new experience (e.g. talking about their past experience with others and doing the stand-up exercises with the therapist) and new relationship with others while performing their roles in the narrative. In Holzman’s terms, collective “performing is a way of taking ‘who we are’ and creating something new … through incorporating ‘the other’” (Holzman 2006: 257).

Furthermore, it becomes clear that the therapist was also aware of these developmental goals for the AD sufferers. As the therapist himself mentioned the goal of the therapy in the interview, and the guidelines of the Japanese Association of Occupational Therapists (2012) define it, he aimed at not only facilitating the sufferer’s immediate learning on the spot, but also reviving their past experiences and developed capabilities. In this sense, as Zuckerman (2007) points out, the therapist sees the ZPD in the AD sufferers not as a linear and one-dimensional one which aims at the development of single skill but as a multidimensional one which leads to her holistic development in the community.

While Vygotskian theories mainly focus on the teaching-learning process by the participants as being socially and culturally developed, Bakhtinian approaches provide more detailed descriptions of the role of therapists as polyphonic and dialogic teachers. In my observations, the therapist jointly produced the narratives by listening to the AD sufferers’ utterances, adopting their ideas, intertwining them into narrative forms, posing known and unknown questions, and sharing them with others. In his interviews, he explained his intervention as the creation of the scene and the roles for the restoration of the sufferers’ normal lives and of their relationship with others and illustrated his job as continuously catching, responding, and confronting the sufferers’ various voices, including the ones yet to emerge. In those findings, the therapist was active in eliciting the AD sufferers’ voices, preparing the setting where several voices could meet and contest each other, and in establishing positive relationships among the participants in the nursing home.
and their families at home using their voices. Here, the voice means not just an utterance but a perspective which reflects the interlocutor’s idea and personality (Holquist & Emerson 1981), such as the AD sufferer’s opinions of other’s comments and the talk of her past experience. To arrange the dialogical environment, the therapist used narrative as a tool for creating several roles and characters and examining their ideas, hopes, and problems. Moreover, to develop the narrative, he often raised known and unknown questions. Unlike the known question, the unknown question needs continual modification and reformulation of the question, because it leads to a new and unexpected question derived from the original question. Miyazaki (2005, 2010a) indicates that for the discovery of the unknown question, the teacher needs to encounter many voices from the experts and children in advance as a proto-learner. In my research, the therapist firstly set the unknown question such as what really mattered to the dementia sufferers. Although only they knew the correct answer, they often could not straightforwardly answer it because of their symptoms. To find the correct or possible answers to the question and to form an appropriate narrative, the therapist took multiple points of views as he himself played another role which was familiar to them such as their son or the head teacher, adopted other sufferers’ voices asking and sharing the questions, or assigned his role as therapist, leading the narrative construction and the implementation of the exercise to another sufferer. In doing so, he could encounter many voices from the dementia sufferers sometimes to his astonishment (e.g. He was surprised at Mrs N’s answer of “an apple” in Excerpt 3.2). He could also learn knowledge about their historical and cultural backgrounds, comprehend the narrative from their perspectives, and craft a more appropriate narrative which reflected others’ voices. As Egan (2005) highlights, such a therapist’s trial to “re-see the topic through the eyes” of the dementia sufferers makes the narrative more attractive and enables them to be emotionally involved in the narrative construction. In other words, while he encountered the sufferers as experts who have knowledge about their own narratives, he himself became the learner trying to discover what was new, important, and meaningful for them towards the narrative formation and the therapy. Moreover, as he clearly stated in his interview, he continued his learning by remembering the dementia sufferers’ voices and questioning them in reference to his unknown questions. In this sense, his learning process seems unfinalisable.
7.3 What is the relationship in dementia care?

Brief answers: A triad relationship was formed between the narrative, the dementia sufferer, and the therapist in the therapy room. The therapist intentionally created the triad relationship and had expertise in it as a dialogic teacher. Since the triad relationship is mediated, contextualised, and negotiated by involving a variety of tools and engaging with the participants, the ideas of a person’s ability, knowledge, and the role of the therapist in the triad relationship are viewed as interpersonal, collaborative, and dialogic ones.

While the literature review shows that the relationship between the therapist and dementia sufferers has been widely studied as a one-sided or dyadic relationship, this research indicates that the relationship in dementia care is seen as a triadic relationship between the dementia sufferers, the therapist, and the narrative. As Mr Kawaguchi explained, he intentionally formed a triadic relationship between the dementia sufferers and himself constructing the scenes in my interviews. Moreover, since the development of the scene resulted in narrative creation, this consequently formed a triadic relationship between the narrative, the dementia sufferer, and the therapist in my observations (see Figure 12). As an expert on narrative formation, the therapist intentionally introduces narratives to the dementia sufferers while creating the voices of narrative characters such as their familiar people and themselves. Then, with support from the therapist, the dementia sufferers express their own voices (perspectives) and communicate with others’ voice through the joint formation of the narrative. Consequently, the therapist and the dementia sufferers can continuously interact and contest their own views through narrative production and this creative and reciprocal process is also described as a dialogic relationship between them.
Fig. 12. The triad relationship among the therapist, the sufferers, and the narratives.

In this paper, I have used the term, “relationship” in a different way between my analysis of observational and the interview data. In my observations, it means something that was socially and locally created through the participants’ interactions and was a way of relating to each other for the purpose of the achievement of the therapeutic activities. On the other hand, in my interviews, it reflects the therapist’s personal interpretations and reflections of his caring interventions with the dementia sufferers. In other words, there were differences between what the therapist demonstrated and what he said. However, as I discussed in chapter 5.2.3, these different levels of data and analyses were basically used to cross-check the research question and internal consistency or reliability of the phenomena. From this point of view, at least it seems clear that the therapist put the emphasis on the formation of the triadic relationship, was aware of how to create it, and put it into practice using narratives as a tool.

In relation to the discussion in chapter 2.5, the triadic relationship is also defined as one which is mediated, contextualised, and negotiated by utilising various tools and the participants. Thus, three elements in the teaching-learning process including the person’s ability, knowledge, and the role of the therapist seem to be interpersonal and contextualised in the triadic relationship compared to other caring relationships such as the one-sided models in the following respects.

First, the person’s ability is seen as a relational, situated, and collaborative achievement. As Vygotskian approaches emphasise, it is socially, culturally, and historically mediated by tools and others. For example, since the narrative co-construction often made the dementia sufferers’ achievement of the therapeutic activities possible, the therapist’s intervention with narratives had an impact on
their performances. As a tool for their communication, teaching and learning, the narrative created a social relationship between the dementia sufferers and the therapist and changed their activities. Moreover, since the narrative is a cognitive tool which is culturally and historically invented and accumulated by one’s communities (Egan 1997, 2005), the dementia sufferers’ narratives are embedded in a certain culture and history. For instance, the main reason why Mrs O’s talk of her autobiographical memories, such as her school days, was emotionally shared with other sufferers was because they belonged to the same age and cultural group who had almost same experience. That is, communication with dementia sufferers is promoted by the appropriate narratives and interlocutors who can share personal, cultural, and historical backgrounds and their performances is strongly linked to these mediation. Thus, it is crucial to consider the residual ability of dementia sufferers as the skills to interact with mediating tools and others such as the ones how to participate in the narrative co-creation and how to craft the narrative with others.

Second, the knowledge was mutually produced and shared among dementia sufferers and the therapist through the co-production of narrative. Knowledge here refers not to medical knowledge but to personal and local knowledge that the sufferers possessed and the therapist discovered. For instance, the therapist asked the AD sufferers questions and collected information on their past experiences or values to find the appropriate narrative materials. He rarely gave a medical explanation to them during his sessions and mainly focused on discovering the subjective experiences and senses such as their life experiences rather than demonstrating the objective and biomedical meanings which the health professionals possessed in advance. Using the narrative as a tool, the therapist enriched his understanding of their backgrounds, preferences, and thoughts and crystallized what he had listened and learned from them into narrative forms or restored them as their voices in his mind. In parallel, the dementia sufferers could collaboratively and emotionally join in the therapy by presenting their knowledge about their lives. During the narrative formation, both the therapist and the dementia sufferers seemed to become informants who had knowledge as an expert in their own fields and were in an equal position. Of course, as the therapist took the initiative to guide the therapy by making comments and posing questions, their positions were not always totally equal, but they brought different expertise to the therapy. While the therapist “brings expertise in the area of process” (Anderson 2008: 95), such as creating and participating in the dialogical process of narrative formation, the dementia sufferers “brings expertise in the area of content” (ibid.:
95), such as knowing their life experiences and the main characters and details of their narratives. In other words, the joint creation of the narrative contributed to discovering knowledge from the AD sufferers.

On the therapist’s side, as he explained how to create the triadic relationship in his interviews, he had knowledge of how to orient the process of narrative formation, and how to build their relationship, and to organize the therapeutic activities. Moreover, his medical knowledge seemed to play an important role in handling the situation, because he basically arranged his activities to fit the general goals of the occupational therapy, as I wrote in chapter 6.3.1. While the therapist has this special knowledge, he continuously creates and explores the knowledge about the dementia sufferer and his therapeutic activities through the narrative formation. In this sense, unlike one-sided relationship models, knowledge is not simply transmitted from the therapist to the dementia sufferers or acquired only by the therapist but discovered, negotiated, and created between them.

Third, the role of the therapist is regarded as a dialogic teacher as I discussed in chapter 7.2. Through the co-creation of narrative, the therapist played an active role in encountering various voices from the dementia sufferers, and their families, learning knowledge and ideas from the dementia sufferers, and teaching them the meaning and the way of carrying out their therapeutic activities for the purpose of rehabilitating their developed capabilities and building better relationships with others. In other words, he varied his positions not only as a therapist (teacher), who supports the dementia sufferers’ exercises, but as a listener, a narrator, a spokesperson, and a co-creator of their voices and as a learner from them. As he changes his positions, he distributed the responsibility for creating the narrative and for participating in the therapeutic activities to the dementia sufferers, confronted them as active and equal respondents, and became not authoritative but dialogic. Furthermore, compared to the sufferer centred relationship and the dyadic relationship models in chapter 2, the therapist’s expertise seems crucial in forming the relationships and interactions with the dementia sufferers, because he specialised in it.

7.4 Implications for dementia care research

First, as a conceptualisation of the relationship in dementia care, the previous studies on the relationship in dementia care, which I categorised as three models, seems to lack sufficient discussion on the triadic relationship consisting of the sufferers, the therapist, and a mediating tool. Most studies in gerontology,
especially, have not focused on the meaning of tool meditation, while narrative studies tend to pay overly much attention to them with fewer concerns about the therapist’s contribution. What is evident from this paper is that the relationship is mediated both by narratives used as a therapeutic tool and by the therapist as an expert in using the tool and that they have a great impact on its formation. Thus, the relationship is considered as a complex and socio-cultural process of how the subjects and mediating tools interact and influence each other, and the application of theories in educational research is seemingly meaningful in clarifying the connections between them and the therapist’s expertise.

Second, taking into consideration what was learned by both the AD sufferers and the therapist from educational point of view, the goal and the outcome of the relationship seems clearer compared to the previous research. With the descriptions of the creative process of the narrative and the relationship, it is obvious that the therapist and the AD sufferer can interchangeably teach and learn certain knowledge related to their past experiences or the meaning of therapeutic activities through narrative. The idea that both the therapist and the sufferer can be an active teacher and learner in the process of collaborative narrative formation also provides a positive standpoint on the potential of dementia sufferers in relation to some existing theories in gerontology such as Kitwood’s (1997b) person-centred approach and the social constructionist’s view (Clare 2004, Graham & Bassett 2006, Sabat 2001, Örulv 2008) which regard them as people who can maintain a sense of self, actively make senses of their experiences, and manage with their difficulties caused by disease through interpersonal relationships.

7.5 Limitations of the study and needs for further research

Several factors possibly impacted the transferability of these findings. First, as a case study, the sample size was only two sufferers due to the homogeneity of the sample including similarities in their age, sex, the length of time staying at the nursing home, physical and mental problems, and the score on the Alzheimer's disease scale. In particular, I relied on their physical and mental symptoms and the test scores to judge their severity of dementia, but as the research findings paradoxically demonstrated, their abilities changed depending on the relationship with others, the therapeutic tools used, and situations. Thus, the research results call into question the sampling criteria using medical diagnosis or measurement and my decisions on their symptom progression. In other words, it seems necessary to reconsider the impact of these medical factors on the dementia relationship and
narrative co-construction and it may be effective to check it further in comparison with the performances of other elderly persons with different diagnoses in the same group.

Second, the methodological triangulation is problematic. Especially, since the term, ‘relationship’ is ambiguous and equivocal, a researcher needs to grasp the levels of abstraction and his/her interpretation of both the observational and the interview data. In this study, I described the relationship as the interactional patterns, including the joint formation of narrative in my observation data. I approached it in terms of the therapist’s accounts of the relationship and of his interaction with the dementia sufferers in the interview data. Although I re-examined my interpretations and conversational contexts of his explanations and practices with help from other researchers, it seems still unclear whether his interpretations of the relationship are equivalent with what I observed and heard. For example, when he said, “I created the relationship between people”, it generally indicated that he arranged the situation where the sufferers communicate with each other, but in different contexts, it sometimes meant the particular activity in which he promoted the conversations between them. Moreover, the implementation of one research method may influence another. Since the interviews were repeatedly conducted during or after my observations of the therapy sessions and thus, the therapist gradually enriched his understanding of my research purpose. It was helpful for establishing a cooperative working relationship with him and listening to his frank opinions, but on the other hand, it may have caused him to formulate his answers in response to the researcher’s expectations.

Third, the cultural-historical background of occupational therapy as ‘the third voice’ needs further consideration. As Mattingly (1998: 151–152) noted, the history of occupational therapy indicates, "a long-standing tension between a collaborative, individually focused and highly inventive therapy that encourages the production of powerful therapeutic plots as part of the healing experience and a practice that gains its power and legitimacy by standardizing interventions to conform to medically defined conditions and goals”. To protest medical and the physiologically centred approach, the occupational therapy movement started and the occupational cure underscored the adaptation to the sufferers’ “real world” (Mattingly 1998: 152) by offering complex, meaningful and socially appropriate tasks to them, such as the co-creation of drama with therapeutic plots (Mattingly 1994, 1998). Thus, the joint formation of narrative with the sufferers is also viewed as a part of the therapist’s “work that is socio-historically embedded.
In Japan, occupational therapy was introduced in the 1960’s on the recommendation of World Health Organization (Yamane 2006) and embodies the basic principles that the occupational therapy is intended to help people with special needs to adapt their social and physical environment with providing appropriate occupations (Japanese Association of Occupational Therapists 2012). Occupation here indicates all the activities to which people personally and culturally dedicate themselves and find their meanings and values (Japanese Association of Occupational Therapists 2012: 2). In this sense, narrative co-creation is also regarded as the one of the therapist’s endeavours to produce significant meanings for the occupations and this is institutionally legitimated. To clarify the expertise of the therapists and their teaching-learning process in the joint construction of narrative, I believe that the cultural-historical contexts of occupational therapy require further exploration in relation to its history, concepts, and educational systems such as school curriculums.

Forth, further exploration is required into the therapist’s skill in narrative use. As a tool for teaching and learning, this study demonstrates that co-construction of the narrative enabled the sufferers to perform therapeutic activities, but it did not work well in some cases, especially when other therapists and care workers tried to introduce the narratives which Mr Kawaguchi produced. For example, in my observations, one occupational therapist (Mr D) and one care worker (Ms P) sometimes suggested the narratives forming the scene and the roles to Mrs O and acting like Mr Kawaguchi. However, they often failed in these attempts due to her rejections or side-tracks. It might because the use of narrative requires not only an appropriate plot consisting of roles, scenes, and events, but also the performative aspects of how it is told including voice tone, rhythm, tempo, and gestures by the therapist. Furthermore, since Mr Kawaguchi had a long career in drama play with the people with special needs, he probably developed special expertise in narrative formation compared to other therapists. For example, the exploration of the unknown question seems distinctive in his narrative construction and practices and other therapists and care workers rarely raised such a question during their sessions. As Miyazaki mentioned, the inquiry of the unknown question is closely connected with the teacher’s learning and the story’s development in the dialogic classroom (Miyazaki 2005, 2012) and thus, it is seemingly important to re-examine the narrative fashion in terms of each therapist’s strategy in terms of how to create, use, and unfold the narrative.

A final possible limitation concerns the forms of narratives, especially their non-verbal aspects. To describe narratives, I used spoken and written discourse.
including interviews and video transcripts, field notes, and documents. Although the video transcripts described the gestures and body movements of the participants as much as possible, my analysis was mainly based on sense-making processes via speech and language. On the other hand, it is known that narrative inquiry applies other representations (e.g. images, movies, sound, and music) as research subjects (Abbott 2008, Riessman 2008), because some means of expression precede language in human development and play important roles in communication. Moreover, some researchers point out that shared bodily experience is essential in self-expression and interaction of AD sufferers (Baldwin 2006, Kontos 2004, 2005, 2012) and narrative production with them (Hydén & Örulv 2009, Örulv 2008). In fact, as the results of the case analysis demonstrated, non-verbal communication, such as nodding and smiling often triggered or facilitated the narrative formation in various ways. Further, it was obvious that the therapist himself placed great emphasis on the embodied expressions, as he stated in Extract 7, “I think the information by words is not so meaningful.” To elucidate essential and meaningful components of narrative in dementia care, further research needs to be done on this issue.
References


Bakhtin MM (1986) Speech genres and other late essays. Austin TX, University of Texas Press.


Lindqvist G (1996) The aesthetics of play: a didactic study of play and culture in preschools. Early Years 17(1); 6–11.


Örulv L (2008) Fragile identities, patched-up worlds: dementia and meaning-making in social interaction. Doctoral dissertation. Linköping University, Department of Medical and Health Sciences.


Appendix

Transcription conventions

The following conventions were used in the transcripts in this study.

.   A period indicates a falling or final intonation, not necessarily the end of a sentence.

?  A question mark indicates rising intonation, not necessary a question.

!  An exclamation mark indicates an animated tone, not necessarily an exclamation.

:::  Colons indicate stretching the preceding sound.

wOrd  Upper case indicates loudness.

…  Series of periods indicate pauses.

[ ]  Square brackets indicate descriptions of conduct.

( )  Empty parentheses indicate unheard words.

{ }  Braces indicate the words complemented by the researcher to fill a gap between English and Japanese.

“ ”  Double quotation marks indicate singing or imitating someone’s voice by changing the pitch, speed, and tone of the speech.
147. Suorsa, Teemu (2014) Todellisuus on mahdollinen : systeeminen ja subjektiiviställinen näkökulma kasvatustyöskentelemiseen kokemuksen tutkimukseen
150. Rantanen, Antti (2014) Development of methodology for assessing counseling interactions : developing the Counselor Response Observation System and assessing applicability of heart rate variability to the measurement of client emotions during verbal reporting
157. Sotomäki-San, Johanna (2015) Fabricating the teacher as researcher : a genealogy of academic teacher education in Finland

Book orders:
Granum: Virtual book store
http://granum.uta.fi/granum/
LISTENING TO THE VOICES OF DEMENTIA

THE THERAPIST’S TEACHING-LEARNING PROCESS THROUGH CO-CONSTRUCTION OF NARRATIVE AND THE TRIADIC RELATIONSHIP WITH ALZHEIMER’S DISEASE SUFFERERS