INNOVATIVE METHODS FOR WORKING WITH PEOPLE WITH NEURO-COGNITIVE DISORDERS

The project is co-financed by the Governments of Czechia, Hungary, Poland and Slovakia through Visegrad Grants from International Visegrad Fund.
The mission of the fund is to advance ideas for sustainable regional cooperation in Central Europe.

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ABOUT TRITIA

The leader of the project is the European Grouping of Territorial Cooperation TRITIA. This is the first organisation in Poland, Slovakia, and the Czech Republic with regional governments as its members: the Moravian-Silesian Region (CZ), the Silesian Voivodeship (PL), and the Žilina Self-Governing Region (SK). TRITIA was founded to facilitate and promote cross-border, supra-national, and interregional cooperation among its members. Its goal is to enhance economic and social cohesion, in particular through the implementation of common projects aiming to improve the daily life of the people residing in the Polish-Czech-Slovak cross-border region and to support the development of this region.

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Educator in the field of **dementia-related neurological disorders**. She promotes the need for change in care culture and approach to care. Her main area of interest is **early diagnostics** and her goal is to debunk the stereotypes of "this is what old age is like" and "memory disorders".

She is a certified consultant and coach in the Positive Approach to Care educational programme. Educated in the UK and the US (2015 and 2017), she runs training workshops for residential homes and adult day care facilities as well as meetings for family caregivers. She is a lecturer for **post-graduate students** at the Wrocław Medical University and the SWPS University in Sopot.

Marlena Meyer draws satisfaction from her work with people with various types of dementia. She emphasises, however, that such work is virtually impossible without appropriate preparation – the course of disease is too complex. She believes that the **Montessori** approach to children's independence is one of the best tools for training people whose close ones develop dementia. In 2016, she received the **Montessori Teacher Certification**. In her therapeutic practice, she adapts Canadian and Australian solutions using this approach in care for people who experience neurodegenerative changes. Currently, two of her family members live with dementia-related diseases: Alzheimer's and vascular dementia.

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She is the author of publications about **individual mental training for people with cognitive deficits** and co-author of scripts for group mental training for elderly people (silowniapamieci.pl). She offers psychotherapy for older adults, neuropsychology diagnostics and therapy for persons with dementia, and psychological counselling for people taking care of their aged family members. She runs professional courses in psychogeriatrics, activation of elderly people, counteracting violence directed at elderly people, and other **comprehensive areas of care and therapy for persons with dementia**.

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She is a co-creator of a **social innovation** referred to as the **Reminiscence Theatre,** directed to people with cognitive disorders. She cooperates with the Psycheland Centre of Psychotherapy and Self-Development in Wrocław. **She is a co-initiator, co-founder, and President of "Sztukowanie Pamięci" Foundation,** whose work is addressed to elderly people and people with cognitive disorders as well as their families.

Agnieszka Żelwetro is also the **Deputy Chairperson** of the Wrocław Branch of the Polish Psychologists' Association.

In her free time, she coordinates volunteers at the Monte do Gozo hostel in Spain. She loves cycling and is fascinated with Iberia and the phenomenon of the Camino de Santiago.

Monika Stroińska

Gerontopsychologist, certified **Montessori Senior** and Spaced Retrieval consultant and coach, founder of the Montessori Senior Centre. She graduated from the University of Geneva and the Montpellier III University with a master's degree in **psychopathology and neuropsychology** of ageing.

Drawing from her long experience as a psychologist at the Cognitive and Behavioural Ward of Centre de Gérontologie Clinique Antonin Balmès in Montpellier, she specialises in **non-pharmacological methods of coping with reactive behaviours** and in interventions which facilitate the activities of daily living for people with neurocognitive disorders.

Monika Stroińska is a co-author of a series of books titled **Montessori Senior,** addressed to senior citizens with cognitive dysfunctions. The books have received acclaim in France, Switzerland, and Belgium.

INTRODUCTION

We are happy to present our latest publication created as part of the project "V4 for the development of common Social Europe".

The authors of the articles are **outstanding Polish specialists** working with people with dementia. With this publication, we wish to share the best practices in this area with our partner organisations and social workers from the Czech Republic, Serbia, and Slovakia. This is why the book has been translated from Polish **into the languages of our partner organisations** – Czech, Serbian, and Slovak – as well as into English, so that it could reach a wider audience in Europe and beyond.

The publication consists of four articles about **methods of working with elderly people**, including people with dementia. The authors of the subsequent articles are: **Marlena Meyer** – certified consultant and coach in the Positive Approach to Care educational programme; **Maria Jarco-Działak** – psychologist, neuropsychologist, and gerontotherapist, leader of social projects addressed to senior citizens; **Agnieszka Żelwetro** – specialist in clinical psychology and neuropsychology; co-creator of the Reminiscence Theatre; and **Monika Stroińska** – certified consultant and coach in the **Montessori Senior** and Spaced Retrieval methods, **gerontopsychologist**, and founder of the Montessori Senior Centre. In their education process as well as in educating others, all the authors draw inspiration from approaches successfully implemented in other countries across the globe.

All the articles contain **detailed activity plans for practical use** in social care centres, residential care homes, and other institutions focused on sustaining physical and mental abilities of elderly people and their relationship building capacity. The articles are addressed to families of people with dementia as well.

The first article presents the main principles and **practical applications** of the **Positive Approach to Care** educational programme developed by occupational therapist Teepa Snow. Marlena Meyer defines various forms of dementia and the spectrum of symptoms and brain changes that occur in people living with dementia. The author of the article outlines the characteristics of the Positive Approach to Care approach in neurodegenerative care. She proposes **recommendable work methods** and debunks harmful stereotypes about dementia.

The second article **describes forms of group activities** for older adults based on the reminiscence method. Maria Jarco-Działak talks about the power of memory, memory exercises, and recollecting past events and sensations in therapy activities addressed to elderly people, including **persons with dementia**. The author presents tools, topics, and methods for such activities and valuable guidelines for **instructors and therapists**.

In the third article, the **phenomenon of reminiscence** is presented as the foundation for the author's original method – the Reminiscence Theatre. In her approach, Agnieszka Żelwetro combines methods of **reminiscence therapy** with drama therapy and art therapy. In this model, **theatre-related activities** incorporating memory work bring positive results to participants: they improve memory, communication, and concentration, and they **increase overall satisfaction**. Thanks to the detailed activity plans, instructors, caregivers, and therapists can easily introduce the **Reminisce Theatre tools** in their practice – in a variety of conditions and for a variety of patients.

The final article is a presentation of another valuable method of working with older adults – **Montessori Senior (Montessori Lifestyle®)**. Monika Stroińska shows how it can be adapted for therapy work with persons with neurocognitive disorders. In this approach, a person and their needs are the focus rather than the disease and its symptoms, whereas forms of support are based on preserved skills rather than deficits, in line with the motto **"Help me to do it myself"**. The author outlines practical applications and positive benefits of the Montessori method for senior citizens.

We hope that our publication will **reach numerous centres** and individuals that take care of elderly persons, also those with dementia. The methods presented in the articles are useful and effective – by promoting them widely, we can make actual positive difference in the **general attitude of society** and institutions towards elderly people and people with dementia in Poland and in other countries. We expect that through this publication, we will contribute both to systemic changes connected with the introduction of tangible measures and to changes in **the way people perceive and think about dementia**.

POSITIVE APPROACH TO CARE.
COMPREHENSIVE EDUCATION ABOUT DEMENTIA-RELATED DISEASES

Marlena Meyer

The Positive Approach to Care (PAC) educational programme was developed by an American occupational therapist Teepa Snow.[1] It responds to the lack of holistic care for people suffering from a range of dementia-related neurological conditions. As Snow says, **"dementia is an umbrella term"**. The concept of dementia as an umbrella term is currently often applied in educational discourse in English-speaking countries and it is a very accurate depiction of what dementia-related changes actually are.

At the onset of the first visible symptoms, the patient has probably developed the disease for 15 to 20 years.[2] This means that for a person aged 65, the disease has developed since their 45th–50th birthday. If the symptoms occur in a person aged 85, it may be assumed that the disease began to develop when the person was 65–70. Statistically, **nearly 50% of people aged 85 have neurodegenerative disorders.** This situation is becoming even worse, because the number of dementia patients is **growing drastically also in younger age groups**.

Dementia is a condition in which changes in the brain are irreversible, leading to disability and dependence. For the past 20 years, the attempts to invent a remedy for dementia have been unsuccessful: researchers have been unable to find any particle that could modify the neurodegenerative process in a positive way. Why is there no medicine that could effectively solve the problem of dementia and why is it unlikely to be invented within the next decade, or even two decades? The answer to this is short, yet difficult: brain diseases are extremely varied and studies on them are complicated and terribly costly. Moreover, it is hard to find volunteers to take part in such studies. We have already experienced something similar as society. In the 1970s, the situation in oncology resembled the current situation in dementia. Back then, we would ask the same question: why is there no cure for cancer?

[1] www.teepasnow.com

[2] *Preclinical, Prodromal, and Dementia Stages of Alzheimer's Disease*, 2019. Douglas W. Scharre, MD: https://practicalneurology.com/articles/[3] 2019-june/preclinical-prodromal-and-dementia-stages-ofalzheimers-disease

[3] https://toolbox.eupati.eu/resources/tworzenie-lekow-etap-3-i-4-wybor-czasteczki-lub-zwiazku-wiodacego/?lang=pl

Half a century later, we already know the answer: **there are many types of cancer**, each type has its own causes and its own method of treatment, prognosis, and survival rate. The same **applies to dementia:** this broad term covers a number of neurological diseases, each with its own dynamics and complex mechanisms. Theses mechanism have not been fully explored yet but one aspect is certain: **they lead to brain dysfunctions and eventually to its complete insufficiency.**

The chemical and **structural changes** that occur in the brain as part of dementia affect all body systems. To invent an effective remedy, scientists need to understand the nature, causes, and course of all these changes. **Perhaps dementia is like cancer** and we are going to walk the same road in this process?

In the scientific world, **dementia is a relatively new object of study**. For years, it was either wrongly diagnosed or treated as a regular stage of ageing. As such, it was beyond scientists' interest. The past decade and the development of **diagnostic nuclear medicine**, neurology, and neuropsychology have shown us that this attitude is wrong.

WHAT IS DEMENTIA?

Dementia is a syndrome – a compound of symptoms that occur as part of neurodegenerative diseases. In dementia, changes affect at least two brain regions (although normally, the damage is more extensive). In the pathological process, **brain tissue becomes damaged**, which results in changes in the following areas:

- **LANGUAGE** (PROBLEMS WITH SPEAKING, READING, UNDERSTANDING);
- **SENSORY** (SEEING, HEARING, TACTILE, OLFACTORY, GUSTATORY);
- **MOVEMENT** (MOBILITY, WRITING);
- **BEHAVIOUR** (PERSONALITY);
- **CODING NEW INFORMATION** (AFFECTING THE ABILITY TO LEARN NEW CONCEPTS AND SKILLS);
- **COMMUNICATION BETWEEN VARIOUS BODY SYSTEMS** (ATYPICAL DEVELOPMENT OF REGULAR INFECTIONS, DEREGULATION OF MEDICATION THAT WAS CAREFULLY SELECTED FOR THE PATIENT AND USED TO FUNCTION CORRECTLY, UNUSUAL REACTIONS TO SOME SUBSTANCES, INCLUDING THOSE USED IN ANAESTHESIA).

As the damage grows, all of the above-mentioned symptoms may occur simultaneously. In Polish language, there are two words used for dementia: *demencja* and *otępienie.* This way, this phenomenon is split into two. Patients have been divided into those that have *demencja* (which is associated with old age) and those with *otępienie.* This dualism has disastrous social consequences. Moreover, patients with **Alzheimer's** are perceived as yet another group. As a result, in the Polish healthcare and social care system, there are three separate groups of patients: those with *demencja,* those with *otępienie,* and those with Alzheimer's. This approach is simply erroneous. In fact, every person with Alzheimer's has a set of certain symptoms related to this disease, which are identified as *dementia* (or, in Polish, also as *otępienie*). On the other hand, the same set of symptoms displayed by another person might have different causes. In short, dementia is a collection of symptoms that may accompany a number of specific diseases and syndromes.

VARIOUS FORMS OF DEMENTIA

To describe the causes of this spectrum of symptoms, we use the term **"forms of dementia"**. The most common **forms of dementia are the following**:

- **ALZHEIMER'S DISEASE (AD);**
- **LEWY BODY DISEASE (LBD) AND ITS TWO TYPES: DEMENTIA WITH LEWY BODIES (DLB) AND PARKINSON'S DISEASE DEMENTIA (PDD);**
- **VASCULAR DEMENTIA (VaD);**
- **FRONTOTEMPORAL DEMENTIA (FTD);**
- **RARE FORMS OF DEMENTIA.**

Every person with Alzheimer's has a certain set of symptoms that are collectively referred to as dementia. However, a person may display the same set of symptoms without having Alzheimer's.

The same happens in the case of oncology: every cancer is a type of neoplasm, but not all neoplasms are cancerous. There are different treatment methods and different prognoses. There are many neoplasm types that have been harnessed by medicine: we live with them but they do not destroy us. There are also those that people have not yet learned to combat.

EARLY SYMPTOMS AND THE TRAP OF "NOT REMEMBERING"

The stereotypical ways of thinking and talking about Alzheimer's disease reduce it to "problems with memory". In fact, Alzheimer's disease does not mean that a person "forgets" things: the actual problem is that **the brain stops "recording" things.** This is related to hippocampus damage: this part of the human brain is responsible for our knowledge of things that have taken place. As the disease develops, the hippocampus suffers more and more damage. Consequently, permanent "recording" of new data becomes technically impossible (this results, among others, in multiple repetitions of identical questions, because the brain seeks information but is unable to register it). **Tissue damage affects other brain structures as well,** although this does not happen overnight. Alzheimer's disease develops over the years; with the use of suitable rehabilitation and compensation strategies, the adverse symptoms can be controlled to improve the quality of life of persons living with this disease.

In Alzheimer's disease, a typical utterance would be "I have never seen this film"; in vascular dementia (caused by cerebrovascular diseases), it would be "I don't know, I guess I haven't seen this film" or "I might have seen this film, I'm not sure". This results from the complicated processes that occur **in the brain to extract information** at a given moment rather than because that information has not been "recorded". In dementia with Lewy bodies, the symptom of the inability to "record" data may be absent; there will be other symptoms. The matters become even more complicated if a person has **several forms of dementia** at the same time.

EARLY SYMPTOMS OF BRAIN CHANGE COLLECTIVELY REFERRED TO AS DEMENTIA INCLUDE:

- considerable personality changes;
- problems with counting and money management;
- problems with driving (inability to recognise roads signs, manoeuvres that are inadequate in a given situation on the road, incorrect parking, etc.);
- quitting hobbies;
- inability to recognise letters or words (or sign language in the case of persons who are hard of hearing or deaf), difficulty in following the thread of a conversation or text;
- difficulties with decision-making;
- difficulties with critical thinking;
- visual hallucinations.

Early changes refer to a variety of situations which are new phenomena, i.e. a given person did not behave this way in the past.

THE PROGRESSIVE AND IRREVERSIBLE NATURE OF NEURODEGENERATIVE CHANGES

The way the changes develop **depends on a given form of dementia.** The changes occurring at the **early stage of Alzheimer's** do not take place in dementia with Lewy bodies, and vice versa. As the disease develops, most patients display the **following symptoms:**

- critical changes in processing all sensory stimuli;
- spatial disorientation;
- changes in the ability to communicate using formal language;
- problems with using objects as intended;
- problems with performing various activities in the right order;
- motor strip damage and deactivation.

Many patients display hypersensitivity to sounds in their surroundings: the brain is in a way unable to turn them down in the background. Such patients hear sounds of booming, gurgling, and squealing. **High notes** (including high female voices) may affect their behaviour and lead to agitation, anxiety, and frustration. Excessive noise may end up in aggression; however, aggression as such is not a primary symptom: it is a secondary symptom which occurs as a result of unmet needs.

Patients retain certain right hemisphere skills: they may be unable to speak and understand their interlocutors, but they recognise the **rhythm of language**, song lyrics, prayers, poetry, speech automatisms, and so-called special words (swear words, racist phrases, sexual language). **Care should be constructed around these preserved skills**: this is the focal point of the PAC programme.

Music is an essential element of care in this approach. Patients should have regular access to music: twice a week is not enough; twice a day is the recommended minimum. Music considerably reduces the use of neuroleptics, whose unwanted side effects may lead to **pseudoparkinsonism:** a set of symptoms which resemble **Parkinson's disease** but have different causes. Humans move using muscles stimulated by impulses coming from the nervous system: music reduces muscle tension and lowers agitation caused by other factors; it also stimulates salivary secretion, which facilitates swallowing. As music stimulates movement, it has a positive impact on peristalsis and, as a result, it can reduce constipation, which is a **huge challenge in elderly care**.

THE IMPACT OF NEW PATIENT ORGANISATIONS ON CHANGES IN THE APPROACH TO CARE

There are **several examples of modern systems of care** for people with neurodegenerative diseases developed in the United States, Australia, and Great Britain which can be recommended as model solutions to follow. In 2014, patient organisations were launched in these countries, comprising people with various forms of young onset dementia, **aged 50 to 55 on average**. Members of these organisations take active part in all the important events connected with the creation of public space and therapy and care programmes. **This is a brand new stage in education**.

In Poland, we are faced with an urgent task: we must effectuate change to modify the existing patterns of conduct in terms of care and rehabilitation. **Dementia-related diseases** are terminal but in Polish conditions, the stereotype reducing dementia to **"memory disorders"** is still common. In the light of the information provided by the above-mentioned patient organisations, this approach is unacceptable and socially harmful. It trivialises the seriousness of this type of diseases, **stigmatising patients** and depriving them of the right to therapy, pain treatment, and a decent life.

Neurodegenerative changes are irreversible and life with dementia requires compensation strategies, including the process of transition from verbal communication to **non-verbal communication**, which must be gradually spread over time. Without the knowledge of changes and proper preparation of space, **care in dementia is doomed to failure**.

The stereotypical perception of dementia as a natural part of ageing is the key reason why dementia-related diseases do not get diagnosed in their early stages. A common image of a person with Alzheimer's is someone in a very late stage of the disease. In Poland, dementia-related diseases are usually diagnosed at a stage where the patient requires 24-hour comprehensive care rather than supervision. **The changes are so complex** that an interdisciplinary approach is necessary: patients need, above all, neurological assistance, as well as geriatric, cardiological, laryngological, and diabetes care, internal medicine, pain management, and other medical and non-medical types of treatment. **Why is that the case?** The brain is the central and superior part of human body. **Any neurochemical and structural change** that affects it has an impact on the skills and abilities of a given person. The changes in the brain are fundamental to the disabilities characterising dementia-related diseases. Currently in Poland, decisions that are crucial for patients' future are made based on knowledge that relies on stereotypes and outdated information. **Patients function in spaces which are not adjusted to their changing needs,** which leads to a number of surprising and dangerous situations. Meanwhile, properly adjusting public and domestic space could prolong their independence by many years: in fact, in favourable conditions, **a patient with dementia might never become fully dependent**.

The situation is also serious when it comes to family care. In Poland, 95% of care is provided by the patient's family.[4] **The powerlessness of family caregivers** is a consequence of the lack of access to basic knowledge. Normally, a single person is fully in charge of providing care to a sick family member. Other relatives steer clear of the responsibility because they do not understand the ongoing changes and, as a result, they are unable to cope with their intensity. However, the complexity and **severity of neurodegenerative diseases** and the resulting changes in the brain mean that it is virtually impossible for a single person to provide care to a patient without risking the care partner's own health.

THE PARADIGM SHIFT

Care in dementia is often oppressive. This results from education system deficiencies, which are a problem in all the continents. **In Anglo-Saxon countries**, there is a fierce debate on change in care culture. One of the subjects of the debate is the paradigm shift with regard to the perception of people diagnosed with dementia: from "95% of people with dementia will experience psychotic disorders in the course of their illness" to "95% of people with dementia will not receive adequate support to improve their wellbeing".[5]

Dementia is a huge challenge in terms of health and care, as there are two generations suffering from it currently: the pre-war and the post-war. Never before have so many people suffered from dementia-related diseases. Moreover, as **new generations are less numerous,** we are faced with unprecedented health and care difficulties. The only solution lies in early diagnostics and in **supporting the patients' independence at home for as long as possible.** This, however, means that educational changes are called for and that there must be more room for cognitive disabilities, not only physical disabilities – and that is more problematic. **However, this challenge can be overcome**.

Undoubtedly, the upcoming years will also see changes in terminology: the words like "dementia", "brainsickness", or "Alzheimer's" bear a lot of social stigma, which is unlikely to be overcome in a couple of years. Moreover, **terms such as "neurocognitive disorders" are difficult and imprecise**. Hence, we are faced with plenty of work as society. One thing is for sure, though: if we do not involve the patients themselves in the **educational process**, we will not get any closer to **understanding this disease and its processes**.

[4] *Sytuacja osób chorych na chorobę Alzheimera w Polsce. Raport RPO,* 2016. Redaktor raportu: prof. dr hab. med. Andrzej Szczudlik: https://bip.brpo.gov.pl/sites/default/files/Sytuacja%20os%C3%B3b%20chorych%20na%20chorob%C4%99%20Alzheimera%20wyd.II_.pdf

[5] Cytat z wystąpienia dr. Allena Powera na konferencji poświęconej demencji, która odbyła się w 2019 r. w Stanach Zjednoczonych. Źródło: archiwum własne autorki.

MUSIC THERAPY

ACTIVITY SCENARIO

I.

WHEN DESIGNING SUPPORT ACTIVITIES FOR PEOPLE WITH DEMENTIA, REMEMBER ABOUT SIX CRUCIAL ELEMENTS:

1. the patient's life story and habits,
2. knowledge about the patient's brain state (what form of dementia the patient has, how advanced the changes are),
3. knowledge about the patient's underlying health conditions,
4. adaptation to the surroundings,
5. education of all the participants of the support system,
6. time.

II.

EQUIPMENT:

1. headphones for the patient and the care partner,
2. a smartphone,
3. a playlist adjusted to the patient's preferences.

III.

TASKS FOR THE THERAPIST:

1. Find out what kind of music your therapy partner used to enjoy and what kind of music s/he tolerates now; make sure if there are any kinds of music that might evoke negative memories or associations in your partner; create a playlist.
2. Find out what form of dementia your partner has: in the case of dementia with Lewy bodies, you need to consider the high dynamics of changes throughout the day, as your communication possibilities may change from hour to hour; on the other hand, the changes occurring in vascular dementia will depend on a given day rather than an hour; in Alzheimer's, there are usually no fluctuations of this kind.
3. Find out if your partner is hypersensitive to sounds; if so, find out what might alleviate this; find out if your partner has problems such as hearing loss, headaches, or infections that might affect their wellbeing during the session.
4. Prepare your surroundings: a familiar place, comfortable furniture (if the activity is static), or a safe surface (if the activity is dynamic).
5. If there are any other people around, ask them in advance to avoid creating any other stimuli during your music activity (e.g. ask them not to hoover).
6. Based on previous observations, choose the right duration for the music activity (e.g. 5 or 15 minutes).

IV.

TECHNICAL REQUIREMENTS:

The headphones must cover the entire auricle. Earbuds and on-ear headphones are not recommended – the latter do not isolate the surrounding noise, they press on the ear, and they might irritate the skin. Oval over-ear headphones can cover and enclose the whole ear. The foam should be covered with an **easily disinfectable material**. Wireless headphones are definitely recommended.

V.

HOW TO WORK?

1. Adjust the volume of the track and the headphones **before** the activity begins.
2. If the activity is static and you are going to sit, sit perpendicularly to the patient (do not sit opposite the patient). Why is that recommendable? In dementia, the field of vision is limited, so if you sit right next to your partner, you will be out of sight. Once you touch your partner unexpectedly, s/he might be taken aback and react violently. If you sit facing your partner, you will obscure the central field of vision and s/he might feel uncomfortable.

3 Put on your headphones first and touch them; next point to the patient's head phones, hand them over, and suggest that you start listening to music together, e.g. by saying, "Jesse, do you know this song?".

4 If your partner has late dementia symptoms, you can enact your movements so that your partner could imitate them and put the headphones on without your help.

5 Watch the facial expressions and body gestures of your partner – relaxed move ments and regular breathing normally mean that s/he feels comfortable. In the case of parkinsonism, reading facial expressions may be difficult: the patient's eyes may be closed, but this does not mean the person is sleeping – the brain often closes the lids to limit the stimuli and concentrate on the task at hand; for other patients, a music video may serve as an additional stimulus and watching a YouTube video with the therapist will be enjoyable to them.

6 Look out for verbal and non-verbal signals from your partner suggesting that the session should end – everyone has their own sensitivity and needs. Observation is the key.

Music can soothe or excite; it can stimulate people to do something or stop them from doing it. In the case of diseases in which previous forms of verbal communication are no longer applicable, rhythmic or march music can set the body in a swinging motion and helps in standing up, starting to walk, or going downstairs, **in rhythm with the melody**. Music can be used for singing instructions, e.g. for getting up from a chair, because this is where the frontal lobe plays a key role: "Move your feet under the chair, grab the armrest, lean forwards, and raise your head. Now, one, two, three, up you go!". Why does this happen? The procedure of getting up from a chair is built of a sequence of steps which **reflect the neurophysiology of human body**.

THE THERAPEUTIC POWER OF REMINISCENCE IN GROUP ACTIVITIES FOR OLDER ADULTS

Maria Jarco-Działak

Self-awareness, the inner sense of continuity between yesterday and today, between the past and the present, is mostly composed of what we have been through and what we have preserved in our memory.

Ewa Woydyłło

What seems to be a casual "same old story" repeated in regular conversations might become an effective identity-preserving tool for an elderly person, supporting integrity, self-connection, and relationships with others. Recalling stories is a method of helping elderly persons in working through difficult past experiences and conflicts and enhancing their internal resources to help them become reconciled with the increasing dependence and awareness of upcoming death. For reminiscing to be successful, two sides must be equally involved in the dialogue: the teller and the listener.

ON THE REMEMBRANCE OF THINGS AND MATTERS PAST AND THE RESULTING REFLECTIONS

Reminiscence is based on **autobiographical memory**. It consists in recalling meaningful personal experiences and sensations from the past. It may be an involuntary or intentional act of remembering oneself from the past. Reminiscence may include detailed memories of particular occurrences or more **general references** to past episodes, also those that have been **forgotten previously**. By reminiscing, people get insight into the past from a different perspective (the passing of time, more mature and in-depth approach, the context of later experiences and events). This way, **their perception may change:** they may be filtered through the present and reinterpreted.

Reminiscences accompany us throughout our lives but they become more significant as we advance in years and get more mature. **Looking back** on our past becomes more natural and satisfactory then. At the final stage of human development, the reminiscence effect occurs (also called "the reminiscence bump"): **older adults** tend to remember distant past events more clearly than might be expected from the general deterioration of memory over time (Maruszewski, 2005). This particularly refers to events that took place **between ages 10 to 30** (Rubin & al., 1998). Memories that re-emerge as a result of the reminiscence effect are usually positive.

THE THERAPEUTIC POWER OF REMINISCENCE

Reminiscence may be used as a method of therapeutic intervention. According to Dochtermann & al. (2005), it consists in **using memories of past events**, feelings, and thoughts to achieve pleasure, improve quality of life, and adapt to present circumstances. Reminiscence therapy is defined as an **activity or method of thinking** about something or connecting to past experiences, especially those most personal and meaningful (Szulc, 2021). In such processes, reminiscence usually performs an **informative function** (recalling for the pleasure of reliving and retelling) or a **qualitative function** (recalling for analysis and judgment).

In its most popular form, reminiscence therapy is understood simply as recollecting, where participants share their personal memories and stories. It is an opportunity to tell one's life story simply for pleasure or to **share one's life experience** with other people. This form of reminiscence therapy is most common in various care institutions for elderly persons. Memories serve as a crucial factor in improving patients' **mental state:** they help older adults to shift their consciousness **from the frequently depressing present state** and go back to the times when their life possibilities and perspectives were unlimited. People who recollect good moments and feel heard are more likely to accept ageing and **less likely to despair**.

In therapy practice, there are also more structured and evaluative forms of reminiscence. The **Life Review method** described by Butler (1963) is usually practised at individual sessions, in which the therapist supports the patient in chronological exploration of his/her **life experiences** (both positive and negative). A similar approach, referred to as **Life Review Therapy**, is aimed at re-evaluating negative memories and reformulating them into a more positive image. Another popular form of therapy using narrative and reminiscence techniques is **Life Story Work.** In this approach, emphasis is placed on creating a biographical narrative, which is then expressed in so-called **memory books or life-story books** (Woods & al., 2018).

REMINISCENCE THERAPY TOOLS

In reminiscence therapy, we can use a number of tools which support reminiscing. They may be various **objects from the past** (e.g. photos, postcards, letters, songs, daily-use objects) which carry stories that are relevant to patients. Moreover, it is a good idea to use a variety of stimuli, as they enable patients to retrieve more memories than techniques based simply on unassisted recollecting (Maruszewski, 2005). In fact, **anything can be used** (also tastes, smells, and textures), as long as it facilitates reminiscing oneself and past situations.

For instance, old photos can be used for recalling the situations in which they were taken or the people depicted in them, or for reviving a specific event. Frequently, one memory leads to another, which makes it possible to recreate the patient's full life story. While looking at objects such as old phones or coffee makers, patients automatically **return to memories connected with performing certain tasks and they recall various stories and anecdotes.**

(source: author's own work)

SAMPLE TOOLS IN REMINISCENCE THERAPY:

- old photos (of the participants, their homes and hometowns, pictures, actors, artists),
- old newspapers, brochures, books, poems, articles, documents, diplomas, medals, trophies,
- musical pieces from the participants' youth, recordings of old radio broadcasts,
- sounds from the past: cuckoo clock, whistle, traditional school bell,
- stamps, letters, postcards,
- museum objects, paintings, sculptures,
- old daily-use and household objects: cameras, clocks, gramophones, washboards, iron mortars, irons, nutcrackers, scales,
- vinyl albums, old films, archive materials, slides, TV shows,
- smells of the forest, garden flowers, freshly baked bread, favourite perfumes,
- old packaging and other objects or photos of them,
- biographical and documentary films,
- trips to places from the young days of the participants: the village or town they grew up in or previous apartments.

The starting point for **reminiscence therapy** is the diversity of subjects which can elicit memories. Therefore, **a therapy meeting** may cover the subject of the first day at school, first love, old music hits, family celebrations, etc. **Therapy sessions** can be built around films, theatre plays, seasons of the year, or festivals and holidays. When preparing the activity, the therapist should think about the themes which might inspire the participants as well as about those which might block their engagement (potentially sensitive, difficult, and irritating subjects). For this reason, it is necessary to know the group well, including the individual stories of each patient. **The participants' associations and memories must be positive.**

SAMPLE SUBJECTS
OF REMINISCENCE ACTIVITIES

PLACE OF RESIDENCE	my family home, my village / town / city, my childhood bedroom, places I moved to, my favourite places.
PROFESSION (STUDIED AND PRACTISED)	my profession / my work, my first job, the first money I earned, my colleagues.
FAMILY	my family (parents, siblings, spouses, children, grandchildren), family duties, childhood games, family traditions.
HOBBIES	my passions / interests / hobbies, my free time activities and pastimes, scouting, communities, choirs, clubs, stamp collecting.
MY FAVOURITE THINGS	music, film, sport, food, leisure activities.
IMPORTANT LIFE ROLES	parent, daughter / son, expert, achievements I am proud of.

IMPORTANT LIFE MOMENTS (MILESTONES)	the happiest moment in my life, my first boyfriend / girlfriend, engagement / wedding, the birth of my children.
HOLIDAY	my favourite holiday activities, trips, summer activities, childhood holiday adventures, holiday friends.
FOOD	my favourite dishes, the best recipes (my mum's apple pie, my go-to salad).
SCHOOL	my favourite subject at school, my favourite teacher, my school beau / belle, playing truant, school trips, school assemblies, my way to school, school traditions, school uniform and badge.
IMPORTANT POLITICAL AND SOCIAL EVENTS	the outbreak / the end of World War II, life in an underground organisation, clandestine classes, the communist era, ration cards, strikes, riots, manifestations, the pontificate of John Paul II, the end of the communist era.

(source: author's own work)

THE ART OF REMINISCENCE

One of the **best practices** is to combine reminiscence with other forms of therapy: bibliotherapy, music therapy, and other art therapy methods. **Art therapy** provides a wide range of non-verbal communication techniques to persons who are unable to express their emotions, feelings, and thoughts verbally, or find that difficult. **By becoming involved in art activities** (dancing, movement, music, visual arts, literature, or performative arts), they may be additionally inspired towards creativity and reminiscence. The main idea behind combining reminiscence therapy with art therapy is the focus on enhancing participants by enabling them to share their memories through a series of artistic means and offering them space for positive relationships with other people. **Art therapy combined with reminiscence** allows the participants to express the inexpressible and to describe the indescribable, with the use of art media, movement, and sounds. This is especially important in therapy addressed to persons who struggle with neuropsychiatric disorders.

THE MEANING OF REMINISCENCE THERAPY IN DEMENTIA

Reminiscence therapy is one of the most frequently used methods of non-pharmacological support for people with dementia. Tackling the challenge of dementia symptoms is a demanding task. **Dementia, contrary to common misconceptions, is not a trait of old age:** it is a serious neuropsychiatric disorder which manifests itself in a broad spectrum of symptoms. While providing care for patients with dementia, we must bear in mind that each person has a specific background and life story, individual habits and preferences. Hence, therapy classes for such patients should include diverse tools and props that might induce the **reminiscence process:** this means that therapists must know their patients very well. Reminiscence therapy has a huge impact on dementia symptoms: it relieves stress, provides opportunities for contact with other people, improves wellbeing and self-esteem, and helps maintain a sense of identity despite the memory deficits experienced by patients. **Therapy interventions based on reminiscences** compensate for the skills lost by patients with dementia as a result of neurodegenerative processes and they may be implemented **until the last days of the patient's life**.

INSTRUCTORS

Reminiscence therapy in care facilities is usually provided by **psychologists, occupational therapists, art therapists, health care assistants, or nurses**. However, from the perspective of therapeutic effectiveness, what matters more than formal education or professional role is the person of the instructor as such: their attitude and methods of communication with the participants. **The most important aspect is** the ability to listen attentively, embrace the story of the patients, and react in a way which makes them feel heard, acknowledged, respected. The instructor must adopt a non-judgmental approach of empathy and respect towards the patient's experience, thoughts, and emotions, and remain open and flexible when it comes to the changeable **needs of the interlocutor**.

SAMPLE SCENARIOS FOR GROUP ACTIVITIES USING ELEMENTS OF REMINISCENCE THERAPY

A. MUSICAL CHARADES

This is an idea for a group class with elements of music therapy and cognitive training. It can be modified, extended, and adjusted to a given group.

1. PREPARATION

When preparing for the session, find out **what you know about the participants:** about the music they like best and find meaningful. If you don't know what their favourite songs are, use the hit songs from the times of their youth (when they were 10 to 30 years old). The session itself is also an opportunity to learn about their musical preferences. You can ask them directly about their favourite and dearest songs and use them during the meetings to come. **Create a playlist consisting of 5–10 tracks**. Make sure all the participants have their **necessary personal equipment with them:** prostheses, glasses, hearing aids.

2. INTRODUCTION

Start the meeting by playing a selected song (one that all the participants will know for sure, e.g. from the 1960s). Begin to move in rhythm with the music (the participants may remain seated). **Shape your movements**, adding arms, hands, head, legs. Your involvement is very important, as it will give encouragement to the participants and help them overcome shyness.

3. WARM-UP

Ask the participants about the song: about its author, title, or release year. Ask what period they associate it with. At this point, the participants often spontaneously **begin reminiscing** and talking about their personal associations with the song, e.g. "I remember going shopping to the market with my brother".

4. MAIN TASK

Start playing the other songs from your playlist and ask the participants about their associations with them: where they were when they heard the song for the first time and when that happened; **what memories the song brings back**; what associations they have with it. **Make sure you listen to the participants carefully** and acknowledge what they say. The activity can also take the form of a guessing game.

5. WRAP-UP

Collect and discuss the thoughts and ideas that have turned up in the activity and seem important and meaningful to you and the participants. You can refer to the participants' reflections or yours, or **emphasise what the participants have in common**. To end the meeting, you can also sing one of the songs together. **Thank the participants for the time you have spent together**.

The class can be extended by a group singing activity using songbooks with well-known folk and pop songs.

>> B. DRIVEN BY SENSES

This is an idea for a class combined with a cooking course. The participants and the instructor work together to prepare a snack or a cake (e.g. apple pie or brownie).

1. PREPARATION

Prepare the ingredients necessary to make the selected snack or cake. **Make sure that the conditions in the institution make it possible to cook or bake.** You can also ask kitchen staff for their assistance in the activity. Make sure all the participants have their **necessary personal equipment with them:** prostheses, glasses, hearing aids.

2. INTRODUCTION

Ask the participants to help you in preparing the room **for the cooking class.**

3. WARM-UP

Ask the participants about **their favourite and well-tested recipes** for the snack or cake selected by the group. Ask everyone about their individual food preferences.

4. MAIN TASK

Work with the group to prepare the dish **according to the selected recipe**. As you do this, ask the participants about their associations and **memories connected with homemade snacks,** baking, or their favourite cakes made by their mothers or grandmothers.

5. WRAP-UP

Collect and discuss the thoughts and ideas that have turned up in the activity and seem important and meaningful to you and the participants. **To end the meeting**, you can enjoy eating the snacks and cakes you have prepared together or share them with the persons who could not take part in the activity. **Thank the participants for the time you have spent together**.

C. CURRENT MEMORIES

Reminiscence may refer to both distant and recent events. Older groups may benefit from activities referring to the latest events which are important for them: celebrations of special occasions, dances, trips, or meetings with special guests.

1. PREPARATION

For this activity, you will need a suitcase or a box, postcards, magnets, and other souvenirs from the **events that the participants have shared:** celebrations, trips. You can also prepare a slide show with photos from these events. If you don't have a suitcase, you can build it together with the group, using cardboard, some veneer, and wrapping paper. By creating a unique model of a suitcase in cooperation with the group, you will strengthen their involvement in the meeting. Make sure all the participants have their **necessary personal equipment with them:** prostheses, glasses, hearing aids.

2. INTRODUCTION

Start the session by playing a **selected song related to the community** or a trip they have shared. **Begin to move in rhythm** with the music (the participants may remain seated). Imitate movements of driving a car, riding on a train, or strolling. Your involvement is very important, as it will give encouragement to the participants and help them overcome shyness.

3. WARM-UP

Tell the participants that the main subject of the meeting is their common history. Ask them about the first or latest trip / dance / celebration they have shared. **When did that happen?** Who took part? What nice and interesting things happened during that trip or meeting?

4. MAIN TASK

Invite the participants to talk about their associations and memories connected with the objects hidden in the suitcase. Alternatively, you can show them a presentation with the photos from the events they have shared. **Their task is to say what event comes to their minds** when they see a given object or photo. When did that happen? Who took part? What nice and interesting things happened during that trip or meeting? **Ask them auxiliary questions**. In this task, the participants are not expected to recreate the exact details of the event but to **reminisce together** and recall positive moments in their life as residents of the same institution.

5. WRAP-UP

Collect and discuss the thoughts and ideas that have turned up in the activity and seem important and meaningful to you and the participants. **You can refer to the participants' reflections** or yours, or emphasise what the participants have in common. Thank the participants for the time you have spent together.

SOURCES:

Butler, R. N. (1963). The life review: An interpretation of reminiscence in the aged. *Psychiatry*, 26, 65–76.

Dochterman, J., Titler, M., Wang. J., Reed, D., Pettit, D., Mathew-Wilson, M., Budreau, G., Bulecheck, G., Kraus, V., & Kanak, M. (2005). Describing use of nursing interventions for three groups of patients. *Journal of Nursing Scholarship*, 37, 57–66.

Janus, E., Bac, A., Kulis, A., & Smrokowska-Reichmann, A. (2017). *Terapia zajęciowa w geriatrii*. Warszawa: PZWL.

Macleod, F., Storey, L., Rushe, T., & McLaughlin, K. (2021). Towards an increased understanding of reminiscence therapy for people with dementia: A narrative analysis. *Dementia*, 20(4), 1375–1407.

Maruszewski, T. (2005). Pamięć autobiograficzna. Gdańsk: Gdańskie Wydawnictwo Psychologiczne.

Orzechowski, R. (2019). Zastosowanie terapii reminiscencyjnej u osób starszych w turystyce medycznej. *Folia Turistica*, 52, 189–202.

Rubin, D. C., Rahhal, T. A., & Poon, L. W. (1998). Things learned in early adulthood are remembered best. *Memory & Cognition*, 26(1), 3–19.

Samela, K. Terapia reminiscencyjna. From: www.artefakt.arnev.net/files/terapia_reminiscencyjna.pdf

Szulc, W. (2021). Opowiadanie historii życia jako biblioterapia aktywna: terapia narracyjno-reminiscencyjna. *Przegląd Biblioterapeutyczny 2021*, vol. XI, 48–59.

Wehner, L., & Schwinghammer, Y. (2017). *Aktywacja sensoryczna. Holistyczna koncepcja wsparcia osób w podeszłym wieku i cierpiących na demencję*. Gdańsk: Harmonia.

Woods, B., Spector, A., Jones, C., Orrell, M., & Davies, S. (2005). Reminiscence therapy for dementia. *Cochrane Database of Systematic Reviews*, 2.

HOW TO SHOW MEMORIES?

THE REMINISCENCE THEATRE AS A METHOD OF WORKING WITH PEOPLE WITH COGNITIVE DEFICITS AND DEMENTIA

Agnieszka Żelwetro

All sorrows can be borne if you put them into a story or tell a story about them.

Karen Blixen

CONTENTS

1. ABSTRACT

The article presents the **main concepts of the Reminiscence Theatre** as an innovative method of working with elderly persons and persons with cognitive problems.

Its central subject is the **huge problem of the absence of elderly persons** and persons with dementia in social life, especially in art and culture, both as recipients and creators. The elements of modified **therapeutic methods** presented here (gerontological drama therapy and reminiscence therapy) are based on scientific data from the fields of dementia neuropsychology and non-pharmacological treatment.

The Reminiscence Theatre model is described here with respect to its **main ideas**, goals, methods as well as the characteristics of instructors, benefits to participants, and the conditions of implementing the innovation in an institution.

Moreover, the article includes **practical guidelines** for persons who would like to base their work on the Reminiscence Theatre model or its parts as well as sample activity scenarios.

2. INTRODUCTION

The aim of the article is to present the author's original model of work with elderly persons and persons with dementia and to describe the conditions of implementing this model in clinical and therapeutic practice and in theatre activities. **The Reminiscence Theatre** model was invented, developed, and tested as part of the project "Generator Innowacji. Sieci Wsparcia" [Innovation Generator. Support Network] implemented by Towarzystwo Inicjatyw Twórczych "ę" [The "ę" Association of Creative Initiatives]. It targeted the needs and social and clinical situation of elderly dependent **persons with dementia-related diseases**.

Persons with cognitive disorders are rarely present in the area of theatre activities. The authors of the innovation wished to demonstrate the opportunities for involving such persons in drama therapy in order to include them in creative art activities, based on current scientific knowledge concerning the **ageing process and dementia** as well as the authors' long experience in clinical observation. The model is also a response to the insufficient number and value of non-pharmacological **treatment methods** directed to people with cognitive disorders.

3. THE MAIN PREMISES BEHIND THE REMINISCENCE THEATRE. WHAT DO YOU NEED TO KNOW BEFORE ADOPTING THIS METHOD?

The Reminiscence Theatre is addressed to elderly persons and persons with dementia as well as persons with cognitive disorders which are not caused by neurodegenerative diseases (e.g. after brain injuries or strokes, and with mild cognitive disorders) and to healthy **elderly persons**. The model combines **theatre with therapy** and rehabilitation activities. It makes use of the potential of art and culture and of the cognitive and emotional resources of persons with cognitive deficits as well as the current state of knowledge about dementia. It connects artists, psychologists, and people representing various generations and professions. **The Reminiscence Theatre** does not approve of cripping up, i.e. of enacting roles of disability. Instead, disability is a simple, casual element of the setting and the story, which helps in presenting the experience of being excluded.

Research on cognitive **neuropsychology**, in particular on cognitive functions and processes such as memory, language, and executive functions, serves as the basis for the creators of the model and it should be the **main point of reference** for anybody willing to put the model into practice. The awareness of the existence of separate neuropsychological profiles related to different dementia-related diseases and the knowledge of **how dementia progresses** help in ensuring a sensitive and open-minded approach to involving persons with cognitive disorders in creative activities, taking their **difficulties and deficits** into account, while also relying on their preserved assets and abilities.

4. INSPIRATIONS BEHIND THE REMINISCENCE THEATRE

The Reminiscence Theatre model draws from a number of inspirations:

- the growing number of elderly persons in the population, including persons with dementia;
- the needs of people with cognitive disorders concerning non-pharmacological support;
- the subjects of conversations suggested by elderly persons and persons with dementia (including: a sense of loss; experience of despair and grief; longing for a deceased close person; a sense of loneliness; social isolation and rejection; experience of fear, especially fear of being dependent on others, of weakening physical and mental condition, and of losing one's possessions and health; a sense of being useless and left out; focus on the past and review of life traumas; successes and effective steps taken in various walks of life);
- the stereotypical perception of people with cognitive disorders, especially from the perspective of suffering and loss (loss of intelligence, identity, and all cognitive, emotional, and creative resources);
- the dominating problems of people with dementia (fear, anxiety, shame, cognitive deterioration and impairment, loss of independence and self-reliance, physical discomfort, aches and pains, limited mobility, loss of control over one's body, sensory deterioration, experience of social isolation);

- the concepts of cognitive ageing; the individual differences in the ageing process; the different neuropsychological profiles of dementia, also regarding the preserved cognitive, creative, and emotional assets;
- the needs of elderly persons that are often ignored, unheard, and – consequently – neglected and underestimated, also typically filtered through stereotypes, the media, and various misconceptions;
- the power of being interested in new things and curious about novelty, especially in the context of other cultures and languages;
- the storytelling inclinations of older people.

5. TECHNIQUES, METHODS, AND TOOLS OF THE REMINISCENCE THEATRE APPROACH

According to the **recommendations of IGERO** (International Group of Experts in Dementia Diagnostics and Treatment), non-pharmacological methods are recommended for most patients with cognitive disorders (Szczudlik & al., 2013). Such methods constitute a crucial element of treatment as they complement pharmacological interventions.

For **non-pharmacological methods** to be effective and relevant, they must be based on reliable data and preceded by psychological assessment. Moreover, they must respect particular patients' needs. Therapists and instructors need to know the objective of the undertaken activities and applied therapeutic methods and to be aware of their own fears, concerns, beliefs, memories, ideas, needs, and roles. **Their approach** to persons participating in therapy activities should be **characterised by respect, sensitivity, and calmness**.

THE REMINISCENCE THEATRE METHOD CAN INVOLVE:

A) ELEMENTS OF REMINISCENCE THERAPY:

- sharing memories within a group; the memories are evoked by a variety of stimuli, such as objects, sounds, images, photos, smells (i.e. memory anchors);
- bringing up associations and memories that improve verbal and non-verbal communication skills;
- listening to and extracting memories as a connecting factor: common memories from the past (collective memory);
- the tendency to go back to one's past to protect oneself from critical judgment, also to acknowledge one's sense of identity and self-worth;
- life review that leads to the reintegration of the Self and creates a sense of one's dignity;

- transfer of social, spiritual, religious, moral, or tradition-related messages (Steuden, 2011);
- the tendency to ruminate, common among elderly persons with dementia;

B) ELEMENTS OF VALIDATION THERAPY (A METHOD PROPOSED BY NAOMI FEIL, CURRENTLY CONTINUED BY VICKY DE KLERK AND OTHER MEMBERS OF THE VALIDATION TRAINING INSTITUTE (VTI):

- concentrating on attentive listening and understanding the utterances and behaviours of the patient;
- listening to, acknowledging, and articulating the intentions of persons with cognitive disorders by the therapist;
- relying on respect and empathy towards elderly persons who struggle with unsolved life problems, as opposed to lies, confusion, and disorientation;
- ensuring appropriate distance and closeness, respecting the boundaries,
- focusing on a person, maintaining eye contact and an adequate tone of voice; flexibility and openness of instructors and other people who are in touch with the patients;

C) ELEMENTS OF GERONTOLOGY DRAMA THERAPY:

- talking about memories and working through them while preparing a theatrical performance;
- life stories becoming art material, which can be transformed into a performance, staged for the audience by the patients;
- openness to new forms of expression and communication;
- the use of metaphors for revealing undisclosed emotions and events from the past;
- focus on the process rather than the result;
- creative improvisation that stimulates and enlivens a person through the power of imagination and memory;

[6] For more information see: http://vfvalidation.org/

D) ELEMENTS OF ART THERAPY:

- based on two equal elements: art (creativity) and therapy;
- the use of music therapy, dance therapy, film therapy, visual arts, and verbal arts;
- egalitarian approach in which every person, including elderly persons and persons with dementia, has art potential (Kulczycki, 1990, 7–19);
- participation in creative activities as a form of communication and a method of establishing and nurturing social relationships as well as multisensory stimulation (Sacks, 2009);

E) ELEMENTS OF SOCIAL AND PSYCHOLOGICAL SUPPORT:

- opportunity to do a life review, completing unfinished situations, and symbolic solving of past problems in the old age;
- contact with people, sharing experiences and memories;
- being around people;
- listening, speaking, and being heard;

F) COGNITIVE RESOURCES OF ELDERLY PERSONS, INCLUDING THOSE WITH COGNITIVE DISORDERS:

- narrative intelligence;
- sense of humour;
- interests and hobbies;
- life experience and wisdom;
- knowledge;
- ability to use and understand metaphors;
- individuality;
- unmeasured and undiscovered cognitive, emotional, and creative assets.

6. THE REMINISCENCE THEATRE MODEL DESCRIPTION – HOW DOES IT WORK?

The Reminiscence Theatre model was created to implement a specific idea, out of the need to help persons with dementia express their memories, sometimes hard, painful, and exhausting, often the only ones they have. This is its main objective: to help people represent their memories, episodes from their lives, their knowledge, passions, and dreams – in a safe and creative manner. **This is a symbolic fusion** of the realm of culture and the medical world.

Patients' stories are collected, analysed, and processed. Based on them, a script is prepared including elements of the stories and creating a single, coherent, shared story. Then, the script is used to prepare and **stage a theatre play,** performed by persons with cognitive disorders, the staff of a hospital or a cultural institution, and volunteers (senior citizens and students of art or psychology).

A model of the Reminiscence Theatre

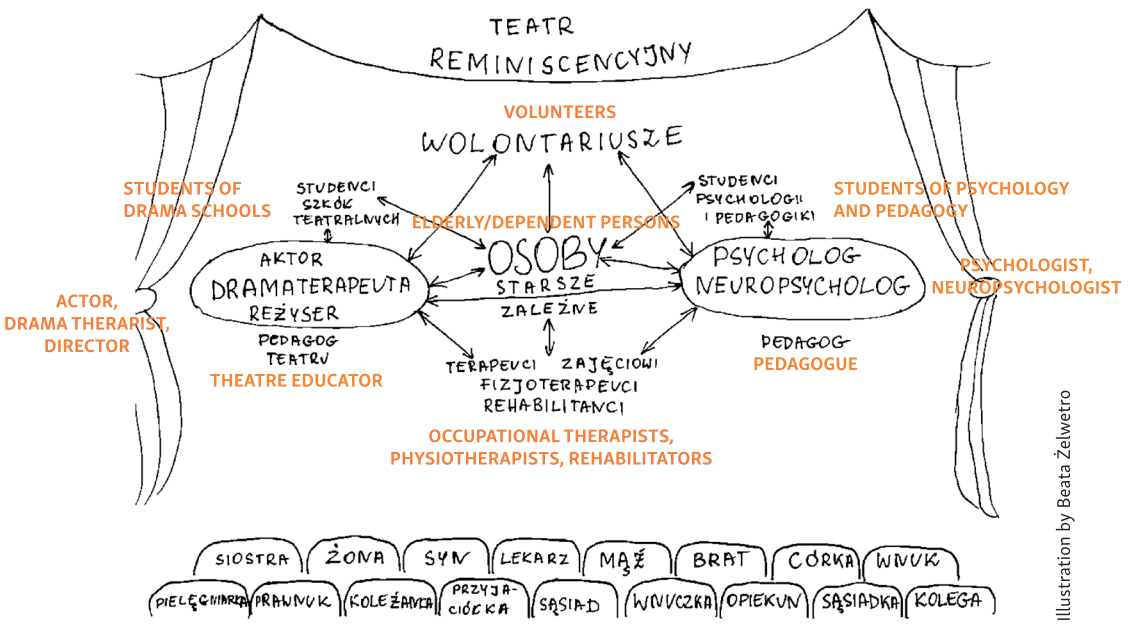


Illustration by Beata Żelwetro

The Reminiscence Theatre process is divided into two parts: psychological (narrative and therapeutic) and theatrical (focused on artistic expression).

THE FIRST PART

This part is focused on **exploring the participants' needs, abilities, and problems.** It is meant to create a safe space for self-expression: for telling one's life story and sharing one's experiences, memories, and dreams.

In this part, most of the time should be devoted to identifying, naming, and expressing feelings as well as relating them to the evoked memories and sharing personal impressions, reflections, and other memories.

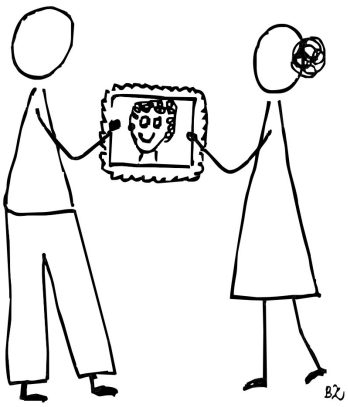


Illustration by Beata Żelwetro

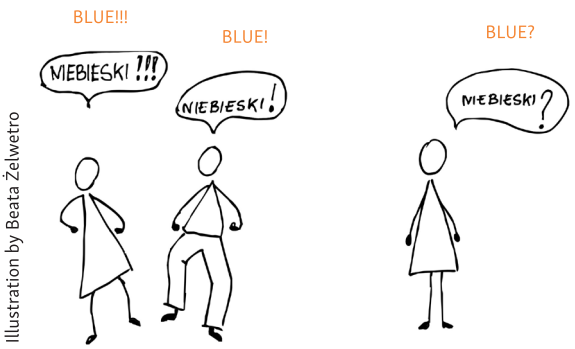


Illustration by Beata Żelwetro

Using theatre techniques and art therapy methods, the instructors and the participants can prepare a short performance featuring elements of the participants' biographies. The story can be based on popular fairy tales and folk tales, making use of the power of fiction and fantasy, and on other commonly known motifs. Improvisation can also be applied in the performance.

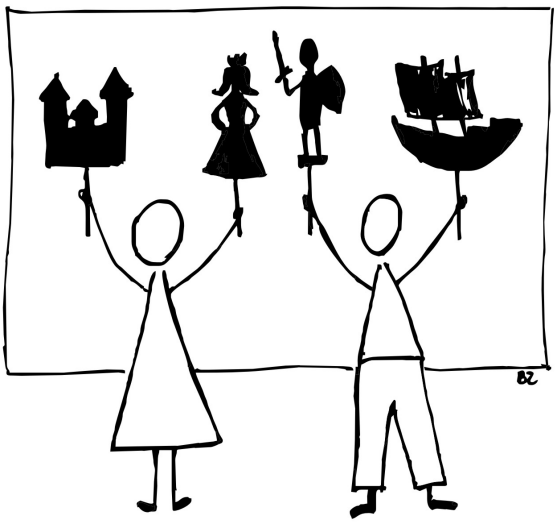


Illustration by Beata Żelwetro

The meetings can take place daily or follow another schedule, agreed upon by the participants and the team of therapists. **The authors** of the model have developed special scenarios (see Attachments) which can be used as a reference but the instructors are free to create their own activity plans which correspond with the **current problems** of the participants and their preferred subjects.

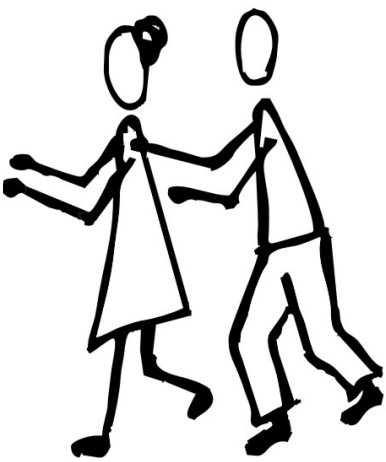


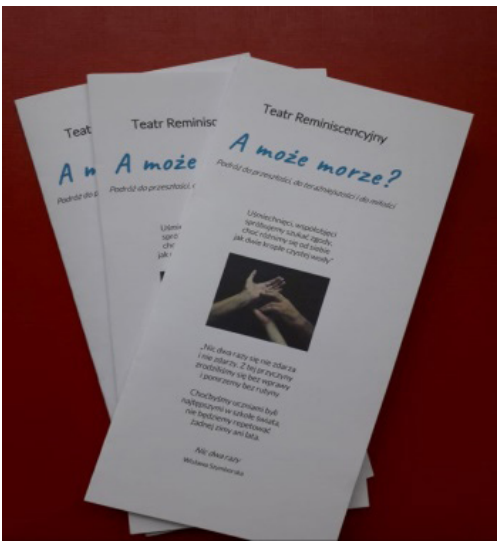
Illustration by Beata Żelwetro

Single activity sessions following the prepared scenarios take up to three hours each. The scenarios can be easily modified, depending on the participants' condition and abilities, on the current circumstances, and on the new themes which arise during meetings. **This part** should be concluded in the atmosphere of respect, joy, and **mutual attachment**. The group may develop their own rituals during meetings. For the instructors, this part provides a **complete set of materials** to be further developed and reworked into a play script.

THE SECOND PART

This is the theatrical part of art expression, based on the completed script, built on the materials gathered in the first part: including and **recreating the stories and memories** that were presented during therapy meetings in the first part. Its main goal is to produce a final play. **The assignment of roles and functions should be a common decision of the participants,** corresponding with their skills, abilities, and competencies, in cooperation with the team of therapists. What is particularly important here is that the patients **should not act out their disabilities**: any instances of cripping up should be avoided. The work on particular roles should be focused on employing preserved skills of the participants; it does not require any processes of intentional learning and memorising. The rehearsals should be planned and carried out in accordance with the developed plan, observing the manners and principles agreed upon by the group. **The costumes**, props, stage design, music, sounds, and lighting should be prepared in cooperation with the whole group **during therapy sessions**, if possible (see examples in Pic. 1 & 2). What is more, the group should cooperate and design a poster and leaflet for the performance together.

Pic. 1. Poster for a show titled *A może morze?* implemented as part of the model tests
Photo by Beata Żelwetro



Pic. 2. Performance programme leaflets
Photo by Beata Żelwetro

On the day of the premiere, the patients and the guests are taken from the hospital to a place where the performance is going to be staged. This is meant to function as a symbolic and real transition from the world of medicine and illness to the world of art and culture: the patients and other **persons transform into creators and actors.** The audience consists of the invited care partners, family members, friends, neighbours, medical and care staff, **and other persons interested in gerontology**.

After the performance, it is a good idea to organise a panel discussion with the performers. **The audience** will have an opportunity to ask questions and talk to all the participants.

The Reminiscence Theatre

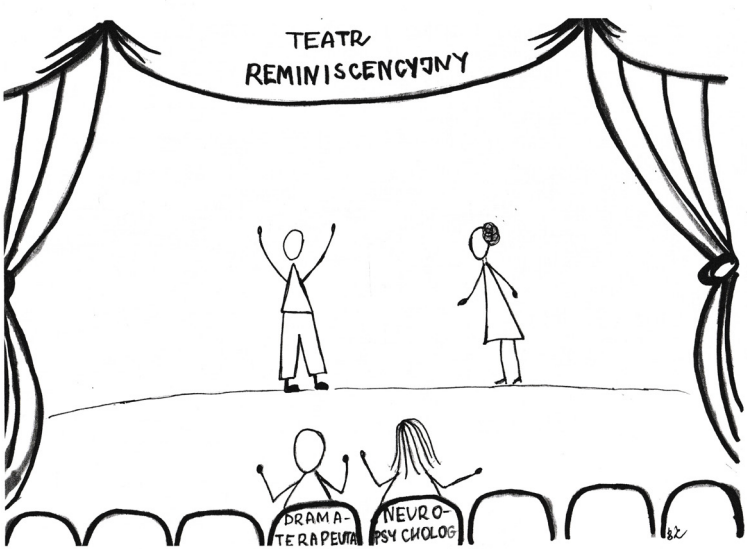


Illustration by Beata Żelwetro

DRAMA THERAPIST NEUROPSYCHOLOGIST

7. WHAT TO PREPARE IN ADVANCE? HOW TO PUT THE MODEL INTO PRACTICE?

The Reminiscence Theatre model is based on a detailed process. The activities are implemented in accordance with the following steps:

- build a team of therapist based on mutual cooperation between psychologists and theatre instructors; prepare detailed descriptions of the roles and tasks of every person in the team;
- discuss the idea of the Reminiscence Theatre;
- establish common principles of work; control and review them regularly;
- get to know the participants / patients; describe them diagnostically, considering their difficulties, deficits, resources, needs, emotional reactive patterns, interests, hobbies, motor and physiological limitations;
- plan the activities in detail;
- create a detailed programme of activities;
- choose the date and location for discussing your current work, intentions, processes, and outcomes;
- sum up and evaluate your actions systematically;
- make sure the team has time for themselves, without the participants; provide opportunities for generating new ideas and discussing the current doubts and problems;
- register the course of work.

8. HOW AND WHERE TO IMPLEMENT THE REMINISCENCE THEATRE MODEL? WHO ARE THE PERSONS INVOLVED?

The Reminiscence Theatre model can be implemented in a variety of places, the participation of a variety of patients and instructors:

A) PLACE:

- hospitals, social care centres, residential care facilities, long-term care homes, healthcare institutions, and other places which can implement new ideas or improve their existing programmes;
- cultural institutions, e.g. theatres, cultural centres, theatre clubs.

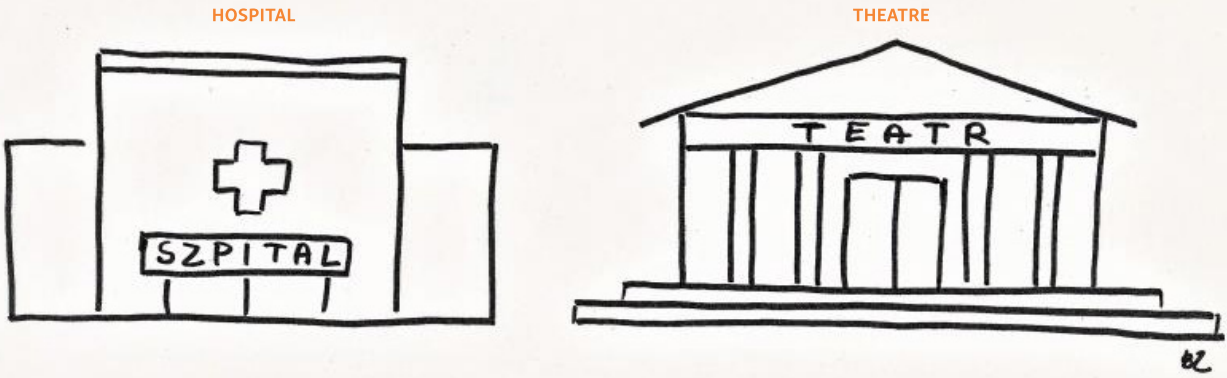


Illustration by Beata Żelwetro

B) INSTRUCTORS:

neuropsychologist / psychologist / psychotherapist:
The main initial role of a psychologist is to establish a neuropsychological diagnosis for persons with cognitive disorders, defining the current level of cognitive activity, briefly characterising the course of cognitive processes, determining cognitive deficits and their degree, and describing their individual neuropsychological profiles (or using an existing one). During the activities, the psychologist must monitor the cognitive and emotional functioning of the participants, sharing ongoing observations with the team and ensuring cognitive and emotional comfort to the participants.

actor / theatre director / theatre instructor / drama therapist
This is person with a knowledge of theatrical and drama therapy: methods and experience in arts; a person willing to work with elderly people and people with cognitive disorders; interested in the process of ageing and old age; open to sharing knowledge, ideas, impressions, feedback; making use of the knowledge and experience of other team members; a person with advanced organisational skills, ready to work in an interdisciplinary team; flexible, open-minded, and attentive. This person's main role is to draw on his/her skills and artistic experience in the cooperation with other team members and – above all – in the work with people with cognitive disorders.

C) PARTICIPANTS: HEALTHY OLDER ADULTS, PERSONS WITH MILD COGNITIVE IMPAIRMENTS, PERSONS WITH DEMENTIA, PERSONS WITH OTHER COGNITIVE DEFICITS.

D) TEAM OF THERAPISTS: SPECIALISTS IN VARIOUS FIELDS FOCUSED ON PSYCHOGERIATRICS (PSYCHOLOGIST, PHYSIOTHERAPIST, OCCUPATIONAL THERAPIST, PEDAGOGUE, DOCTOR; – STUDENTS OF PSYCHOLOGY AND ART ACADEMIES, OTHER OLDER ADULTS).

9. WHO BENEFITS FROM THIS MODEL?

The persons taking part in activities based on this model are able to fulfil their need for contact and self-expression. **They become involved in physical activity and reminiscence.** Intensive stimuli animate memory and other cognitive processes. Verbal expression drives the ability of finding the right words and using them correctly. Thus, the participants learn new methods of communication. **They experience joy and satisfaction from performing a task and being heard,** understood, acknowledged, and accepted. **As a result, they feel that they are important.** They have an opportunity to show their inner assets and unique experience, life stories, valuable and difficult life events, skills, and talents. They are engaged in the activities and interested in new stimuli and situations.

The variety of outcomes concerning a number of sensory, perceptual, cognitive, and emotional areas helps in rebuilding and stimulating cognitive and motor activity. **The methods** used for the stimulation of all the senses provide new possibilities of holistic support.

The model helps caregivers and family members of persons with cognitive disorders in finding some time for themselves. **They learn new methods** of working with persons with dementia and, above all, they see their patient or relative in a better mood, more expressive, and happier. They begin to notice the patient's **skills and capabilities**, which are seldom visible – these qualities often remain forgotten or concealed by deficits and difficulties. What is more, care partners and family caregivers have an opportunity to experience the power and sense of art, culture, and creative endeavours in human life.

The team of therapists gains a new experience of cooperation with patients. They learn new skills and expand their knowledge on a variety of subjects. **The team members** learn from one another; **the synergy of their knowledge** allows them to make better use of patients' abilities and personal resources. Moreover, they are able to see patients from different perspectives: they are not limited to their individual perceptions.

An institution which implements a project **based on the Reminiscence Theatre model** (a cultural institution or a healthcare centre) can use it to demonstrate the value of art and culture from both an **individual and a social perspective**.

10. ABOUT THE PROJECT AND ITS CREATORS

The Reminiscence Theatre model was developed as part of the competition **"Generator Innowacji. Sieci Wsparcia"** [Innovation Generator. Support Network] organised by Towarzystwo Inicjatyw Twórczych "ę" [The "ę" Association of Creative Initiatives] as a social innovation addressed to dependent older persons. Its authors are **Agnieszka Żelwetro, Domingo Ferrandis, and Beata Żelwetro.** Agnieszka Żelwetro is a Polish specialist in clinical psychology and neuropsychology who works with cognitive, emotional, and personality ageing-related problems; Domingo Ferrandis is a Spanish actor, drama therapist, theatre director, and university lecturer whose therapeutic work is directed to persons from excluded social groups, such as the elderly or persons with disabilities; Beata Żelwetro is a Polish psychogerontologist, teacher, biologist, and occupational therapist. **Their model was based on analysis of available clinical and research data** concerning physiology and pathology of ageing, dementia profiles, accessible non-pharmacological interventions, and the therapeutic impact of theatre activities. The innovation was tested at the Alzheimer's Centre in Ścinawa in 2018 and 2019 with the participation of its residents. The instructors were Agnieszka Żelwetro and Domingo Ferrandis in cooperation with Beata Żelwetro. **The activities were conducted in Polish and Spanish** with the support of an interpreter. The therapy team was built of the employees of the Alzheimer's Centre (educator, occupational therapists, rehabilitator, massage therapist, and physiotherapist), the patients' families and carers, and volunteers (students of psychology at the University of Wrocław, students of pedagogy, students of a theatre school, and a retired person). **The therapy activities** were organised on the premises of the Alzheimer's Centre, while the rehearsals and the premiere of the show as well as a training comprising **lectures and workshops** took place at the Centre for Tourism and Culture in Ścinawa.

11. ATTACHMENTS: ACTIVITY SCENARIOS

ATTACHMENT 1 / ACTIVITY SCENARIO: "HAND CONVERSATION. TOUCH ME"

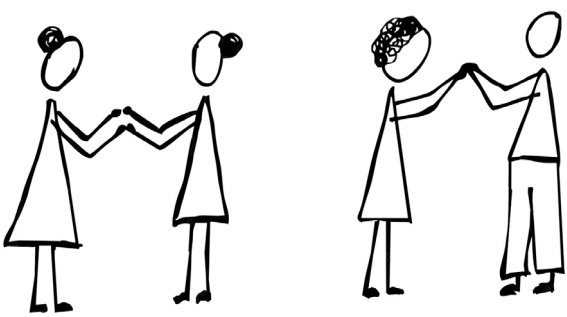


Illustration by Beata Żelwetro

INTRODUCTION:

Everyone feels the **need for self-expression**. This is not always possible with the use of words, though. **This exercise is meant to show another way of talking.** People can communicate through touch, hugs, and kisses: their type and intensity can tell a lot about the emotions a given person feels and about the intended message. **Touch is a form of non-verbal interpersonal communication** – it occurs as an interaction between human movements and senses. Touch is also the first sensation of a newborn person – **and the last sensation a person forgets**.

PARTICIPANTS:
patients with dementia, persons with mild cognitive disorders, elderly people without any disorders

INSTRUCTORS:
drama therapist / actor, psychologist

NUMBER OF PARTICIPANTS:
max. 14

FORM:
groups or pairs

VENUE:
a spacious room where participants can move easily

DURATION:
90 minutes

DIFFICULTY LEVEL:
medium / low

OBJECTIVES AND METHODS:

GENERAL OBJECTIVE
- demonstration of other, non-verbal forms of communication

SPECIFIC OBJECTIVES
- establishing interaction and dialogue using touch and gestures
- shaping and using touch to express oneself
- stimulation of sensory perception and a sense of one's body

METHODS OF WORK
- drama therapy

TEACHING AIDS AND PROPS

- CD player / audio equipment
- internet access
- a bedsheet torn into pieces, or scraps of fabric: 1 m long and 40 cm wide

REQUIREMENTS FOR INSTRUCTORS

- As the exercise involves the intimate sphere of body contact and touch, be careful and react if someone's personal space is overstepped or if some vulnerable areas are threatened (e.g. eyes).
- Make sure there is enough space for the participants so that they do not get hurt or bump into each other.

WHAT TO OBSERVE:

- difficulty in establishing conscious, intended contact based on touch,
- signals of shyness, embarrassment, or shame once the barriers are overcome and boundaries are crossed, as well as other emotional reactions to the touch (to touching and being touched),
- intensity and quality of the movements.

EXPECTED OUTCOMES:

- increased openness and reduced distance between participants,
- a wider range of various forms of non-verbal communication,
- experience of pleasure.

ACTIVITY PLAN:

1. Say hello to the participants and tell them about the objectives of the class.
2. Start with a warm-up using opera music, e.g. *Madame Butterfly.* Place the scraps of fabric in the middle of the room. Ask every participant to get up and choose one. Turn on the music and ask the participants to listen to it carefully and to start moving just the way they feel like, using the piece of fabric they have (continue for 10–15 minutes). Finish the activity by highlighting the ways in which emotions can be expressed using movement without words.
3. Tell a story related to the music you play, e.g. about the life of Maria Callas or about the plot of *Madame Butterfly.* In your story, emphasise the variety of ways in which emotions can be expressed: one of them is touch.
4. Divide the group into pairs. Ask the pair members to stand facing each other and holding one another's hands. Ask them to communicate only through touch and movement, without letting go of one another's hands. Watch the time and the way the activity evolves (15–20 minutes).

5. Ask the participants about their feelings and sensations.
6. Finish the class with your group ritual.

SUMMARY (MAKE NOTES):

- Observations
- Recurring themes

ATTACHMENT 2 / ACTIVITY SCENARIO: "REFLECTIONS"

INTRODUCTION:

A mirror can reflect both human face and entire human body: each stir, each movement. When looking in the mirror, you can see and understand emotions expressed through gestures, face expressions, and body language. Everyone has some **form of memory** of movements, gestures, sounds, and words.

Maintaining face-to-face contact is one of the **most difficult and intimate situations** in human life. A face can express anything and anything can be read from a face. By watching carefully and imitating every movement, you can feel like another person – the one reflected in the mirror.

People with the Alzheimer's disease may have difficulties with initiating movement as well as with expressing, reading, and interpreting emotions.

In this activity, a person playing the role of a mirror imitates the partner's movements, gestures, and face expressions. **The activity stimulates procedural memory**, concentration, and processes of learning and memorising.

PARTICIPANTS:

patients with Alzheimer's or other types of dementia, elderly people without any disorders, persons with mild cognitive disorders

INSTRUCTORS:

drama therapist / actor, psychologist

NUMBER OF PARTICIPANTS:

max. 14

FORM:

groups or pairs

VENUE:
a spacious room where participants can move easily and work in pairs

DURATION:
90 minutes

DIFFICULTY LEVEL:
medium

OBJECTIVES AND METHODS:

GENERAL OBJECTIVE
- becoming sensitive to other people
- stimulation of procedural memory
- focus and concentration practice

SPECIFIC OBJECTIVES
- expressing feelings and emotions using gestures, movements, and other non-verbal signals
- reflecting other people's feelings and emotions,
- reinforcing a relationship with a partner
- presenting non-verbal methods of communication

METHODS OF WORK
- observation
- modelling
- experience
- conversation

TEACHING AIDS AND PROPS
- AV equipment / computer with internet access
- small daily-use objects (mirror, comb, pen, lipstick, cup, cigarette, ruler, pencil sharpener, scissors, lotion, toothbrush, teaspoon)

REQUIREMENTS FOR INSTRUCTORS
- Make sure that the room is convenient for the activity.
- Remain attentive and focused.

WHAT TO OBSERVE:

- ability to reflect movements / praxis and dexterity,
- ability to initiate movements / praxis,
- ability to reflect and express emotions,
- ability to demonstrate actions and combine sequences of movements,
- ability to use abstract thinking,
- changes in the mood and emotional state.

EXPECTED OUTCOMES:

- improved visuomotor coordination,
- enhanced procedural memory,
- satisfaction derived from the ability to memorise and recreate sets of movements,
- improved concentration and alertness.

ACTIVITY PLAN:

1. Say hello to the participants and tell them about the objectives of the class.
2. Start with a warm-up, e.g. talk about the current weather and season. Ask the participants to give 4 associations with the current season and to show gestures or actions connected with these associations. Enact these movements and use them to create a choreography. Choose music or specific sounds to accompany it. Practise the choreography with the participants several times or as needed.
3. Divide the groups into pairs. Decide who is going to play a mirror and who is going the be the person looking in the mirror and performing gestures. The person playing the mirror should imitate the partner's movements and try to express similar emotions. This part should take 3 to 4 minutes. Then the roles are swapped. The other person presents emotions, gestures, and actions, enacting them and using objects, if necessary (e.g. joy, anger, fear, surprise, sadness, drinking coffee, brushing hair, buttoning a shirt), and the reflecting person imitates all the movements.
4. Alternative version:
If the participants have advanced stages of the Alzheimer's disease, one person in every pair should be a therapist (or another person without Alzheimer's) to show the gestures, while the person with cognitive disorders reflects the movements.
5. Talk about the impressions the participants have about this exercise. What was difficult? What was surprising? What was pleasant?
6. Finish the activity, asking the participants about their feelings and sensations. If you have a special group ritual, use it to wrap the meeting up.

SUMMARY (MAKE NOTES):

- Observations
- Recurring themes

12. SOURCES

1. Błędowski, P., Szatur-Jaworska, B., Szweda-Lewandowska, Z., & Kubicki, P. (2012). *Raport na temat sytuacji osób starszych w Polsce*. Warszawa: Instytut Pracy i Spraw Socjalnych.
2. Brzezińska, A. I., Appelt, K., & Ziółkowska, B. (2016). *Psychologia rozwoju człowieka.* Gdańsk: Gdańskie Wydawnictwo Psychologiczne.
3. Brzezińska, M., & Graczkowska, M. (2012). *Zaradnik terapeutyczny.* Warszawa: Difin.
4. Byczewska-Konieczny, K. (2017). *Jak starzeje się umysł? O funkcjonowaniu poznawczym osób starszych i jego zróżnicowaniu indywidualnym.* Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego.
5. Coni, N., Davidon, W., & Webster, S. (1994). *Starzenie się*. Warszawa: Wydawnictwo Naukowe PWN.
6. Czapiński, J. (2009). *Dobrostan psychiczny i społeczny Polaków w wieku 50 i więcej lat na tle wybranych społeczeństw europejskich.* CenEA Centre for Economic Analysis.
7. Erikson, E. (2004). *Tożsamość a cykl życia.* Poznań: Zysk i S-ka.
8. Feil, N., & de Klerk-Rubin, V. (2012). *The validation breakthrough: simple techniques for communicating with people with Alzheimer's and other dementias.* Baltimore-London-Sydney: Health Professions Press.
9. Feil, E. G. (2016). *Summary of validation research.* From: https://vfvalidation.org/wp-content/uploads/2015/07/SummaryValidationResearch_April_-2016-1.pdf
10. Feil, N. (2016a). *What is validation.* From: https://www.youtube.com/watch?v=NPsTZUTqUFw
11. Ferrandis, D., & Motos Teruel, T. (2015). *Teatro aplicado: Teatro del oprimido, teatro playback, dramaterapia.* Barcelona: Ediciones Octaedro.
12. Glińska-Lachowicz, A. (2016). *Arteterapia w działaniu.* Warszawa: Difin.
13. Janus, E., Bac, A., Kulis, A., & Smrokowska-Reichmann, A. (2017). *Terapia zajęciowa w geriatrii.* Warszawa: PZWL.
14. Kielar-Turska, M. (Ed.). (2019). *Starość. Jak ją widzi psychologia.* Kraków: Akademia Ignatianum w Krakowie, Wydawnictwo WAM.
15. Klawiter, A. (Ed.). (2009). *Formy aktywności umysłu. Ujęcie kognitywistyczne. Ewolucja i założone struktury poznawcze, t. 2.* Warszawa: Wydawnictwo Naukowe PWN.
16. Kulczycki, M. (1990). *Arteterapia i psychologia kliniczna. Arteterapia III. Zeszyt Naukowy Akademii Muzycznej we Wrocławiu,* 57, 7–19.
17. Leszczyńska-Rejchert, A. (2007). *Człowiek starszy i jego wspomaganie – w stronę pedagogiki starości.* Olsztyn: Wydawnictwo Uniwersytetu Warmińsko-Mazurskiego.
18. Lis-Turlejska, M. (2002). *Stres traumatyczny. Występowanie, następstwa, terapia.* Warszawa: Wydawnictwo Akademickie „Żak".
19. Malchiodi, C. A. (2014). *Arteterapia.* Gdańsk: Harmonia.
20. Marek, E. (2004). In: Knapik, M., & Sacher W. A. (Ed.). *Sztuka w edukacji i terapii.* Kraków: Oficyna Wydawnicza „Impuls", 105.
21. Muñoz Marrón, E. (Ed.). (2009). *Estimulación cognitiva y rehabilitación neuropsicológica.* Barcelona: Editorial UOC.
22. Modrak, M. (2018). *Porozumienie ponad pokoleniami.* Gliwice: Helion.
23. Morgan, A. (2011). *Terapia narracyjna. Wprowadzenie.* Warszawa: Wydawnictwo Paradygmat.
24. Morgulec-Adamowicz, N., Rutkowska, I., & Rekowski, W. (2011). Zajęcia aktywności fizycznej w Uniwersytetach Trzeciego Wieku w Polsce. *Gerontologia Polska,* 19(3–4), 190–198.
25. Nawrot, A. (2013). *Jesień życia to czas na żniwa. Diagnoza partycypacyjna potrzeb osób starszych i prezentacja modelowych rozwiązań.* Ruda Śląska: Proethica.
26. Nęcka, E. (2018). *Trening poznawczy. Czy umysł można trenować, tak jak trenuje się mięśnie?.* Sopot: Smak Słowa.
27. Nęcka, E., Gruszka, A., Orzechowski, J., & Szymura, B. (2019). *Trening twórczości.* Sopot: Smak Słowa.
28. Puszczałowska-Lizis, E., Biała, A. E. (2014). *Terapia osób o specjalnych potrzebach.* Warszawa: Wydawnictwo Fraszka Edukacyjna.
29. Rembowski, J. (1984). *Psychologiczne problemy starzenia się człowieka,* Warszawa – Poznań: Wydawnictwo Naukowe PWN.
30. Rzecznik Praw Obywatelskich. (2012). *Prawa człowieka. Poradnik dla osób starszych.* Warszawa: Biuro Rzecznika Praw Obywatelskich. From: https://www.rpo.gov.pl/sites/default/files/BIULETYN_RPO_Materialy_nr_72_Prawa_czlowieka_poradnik_dla_osob_starszych.pdf
31. Sacks, O. (2009). *Muzykofilia. Opowieści o muzyce i mózgu.* Poznań: Zysk i S-ka.
32. Steuden, S. (2011). *Psychologia starzenia się i starości.* Warszawa: Wydawnictwo Naukowe PWN.
33. Strelau, J., Doliński D. (Ed.). 2014. *Psychologia. Podręcznik akademicki, t. 2.* Gdańsk: Gdańskie Wydawnictwo Psychologiczne.

34. Szarota, Z. (2004). *Gerontologia społeczna i oświatowa. Zarys problematyki.* Kraków: Wydawnictwo Naukowe Akademii Pedagogicznej.
35. Szczudlik, A., Liberski, P. P., & Barcikowska, M. (Ed.). (2004). *Otępienie.* Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego.
36. Szczudlik, A. (Ed.). (2013). *Diagnostyka i leczenie otępień. Rekomendacje zespołu ekspertów Polskiego Towarzystwa Alzheimerowskiego.* Warszawa: Medisfera.
37. Szulc, W. (2011). *Arteterapia. Narodziny idei, ewolucja teorii, rozwój praktyki.* Warszawa: Difin.
38. Szulc, W. (2001). *Sztuka w służbie medycyny od antyku do postmodernizmu.* Poznań: Wydawnictwo Naukowe UM.
39. Tomasik, E. (1999). *Biblioterapia reminiscencyjna dla osób starszych.* In: Jankowski, D. (Ed.). Edukacja kulturalna w życiu człowieka. Kalisz: UAM, IPA.
40. Quinodoz, D. (2014). *Starzenie się – przygoda życia, która trwa.* Warszawa: Oficyna Ingenium.
41. Wehner, L., & Schwinghammer, Y. (2017). *Aktywacja sensoryczna, Holistyczna koncepcja wsparcia osób w podeszłym wieku i cierpiących na demencję.* Gdańsk: Harmonia.

OTHER ONLINE SOURCES:

1. http://sieciwsparcia.pl/project/teatr-reminiscencyjny/
2. https://www.facebook.com/groups/2025443191093953

THE MONTESSORI SENIOR – MONTESSORI LIFESTYLE®

METHOD AS AN EXAMPLE OF PERSON-CENTRED APPROACH IN ELDERLY CARE

Monika Stroińska

HELP ME TO DO IT MYSELF

These words are the foundation of **Maria Montessori's educational approach,** developed over a century ago. Her ideas changed the perception of education and children's needs. Nowadays, this sentence becomes relevant also in relation to elderly persons with neurocognitive disorders: "Stop doing everything in my place but don't expect me to do something on my own if I can't do this". **The Montessori Senior – Montessori Lifestyle® method** is aimed at supporting independence and self-reliance of people with cognitive disabilities. It is intended to acknowledge the elderly persons' need to exert control over their life, become involved in activities which they find relevant, and remain active members of their communities. **The method** was developed in **the 1990s** by **Dr Cameron Camp** (Camp, 2009; Camp, 2010). Initially, it was known as Montessori-Based Dementia Programming®. Currently, it is popularised as **Montessori Inspired Lifestyle®** (Montessori Approach for Dementia or Montessori Method for Dementia). It has become an inherent element of the life of numerous older adults across the globe (Antenucci & Roberts, 2017; Bourgeois & al., 2015).

In Poland, there is also **another adaptation of the Montessori method** to the needs of senior citizens, which refers to the M3L model. It was developed by Christine Mitterlechner and Beatrix Dangl-Watko in Austria in the first decade of the 21st century. **This adaptation is not a subject of this article. For more information about this particular method,** you can consult Małgorzata Miksza's publication from 2014.

HUMANS AND THEIR NEEDS

Do we treat adults like children by applying the Montessori method to them? **Maria Montessori** treated every child as a human being. Hence, by using the Montessori Senior method, we do not treat adults like children: instead, we treat them like human beings, respecting their needs and rights. **Both Montessori approaches** (for children and for the elderly) are deeply rooted in the values of respect, dignity, equality, and trust towards every person, regardless of their physical or cognitive condition.

An approach focusing on particular **persons and their individual needs** is an alternative to the biomedical model which dominates eldercare (Camp & al., 2018; Douglas & al., 2018). In the latter, the emphasis is placed on the illness itself: on its symptoms and the related deficits. In their nature and organisation, care facilities for persons with neurocognitive disorders resemble patient hotels rather than homes – and home is what every person needs (Ducak & al., 2018; Van der Linden & Van der Linden, 2014). **Daily schedules** are mostly concentrated on fulfilling residents' physiological needs and monitoring their health. The activities offered in such institutions are usually presented as therapy sessions for sick residents. In many places which are based on this model structurally, the needs of persons with neurocognitive disorders, such as the need for love and belonging, safety (disturbed by the sense of loneliness or helples-

sness), esteem, freedom, or self-actualisation (Maslow, 2006), remain unmet. **This may lead to a number of reactive behaviours** (Moniz-Cook & al., 2003; Stokes, 2017). In the biomedical model of eldercare, such reactions are interpreted as behavioural disorders and as **symptoms of neurodegenerative diseases**. As a result, medication is frequently used to relieve such symptoms, whereas the use of alternative solutions based on psychological and social activities is much less common, despite the official recommendations (Banerjee, 2009; de Santé, 2009).

The Montessori Senior method is in line with the trend of person-centred care (Kitwood, 1997; Camp, 2018). The adaptation of the Montessori method developed by Dr Camp is not a form of occupational therapy: it is a holistic approach aimed at supporting self-reliance and independence of persons with neurocognitive impairments, bolstering their sense of control over their own life, and facilitating **their active engagement and social inclusion**.

A SENSE OF CONTROL OVER ONE'S LIFE

We all need a sense of control. **Dr Camp explains** that it is strictly related to the possibility of making independent decisions and choices. As cognitive disability develops, patients are gradually losing this possibility, because more decisions concerning their life are taken by other people. The loss of control becomes even deeper in the institutionalised context, where a person has no possibility of making decisions even about the basic aspects of daily life: what time to wake up, what to wear, what time to have lunch. **Cognitive deficits** make communication difficult, so it is also hard to execute one's needs. Furthermore, other people may fail to identify and understand these needs. A person who expresses objections is often considered as **"uncooperative"**. A refusal to wash, put on clothes, or perform other activities of daily living and hygiene is frequently perceived from the perspective of dementia-related behavioural disorders.

If similar situations are analysed in the light of the **Montessori Senior method**, any objections or lack of cooperation are read as an expression of the need to decide about oneself. The best method of soothing such reactions is by boosting the sense of control. In the Montessori Senior practice, a person gets to choose, in a way which is adjusted to his/her abilities and preserved skills. **The caregiver or therapist** should avoid open-ended questions (such as "What would you like to do?"); instead, they should offer two specific possibilities. In fact, almost every life situation is an occasion to give a patient choice. Both in home care and institutional care, this principle can be easily adapted to existing conditions. The decision-making opportunities may refer to simple life activities (e.g. asking residents at breakfast to choose between tea or coffee, or asking them to choose if they would like to put jam on bread on their own or not).

On a larger scale, the act of giving choice and empowering the decision-making abilities of persons with cognitive disabilities means that care staff need to change the way they perceive elderly persons and their own work. The most common obstacles are old habits and the conventional work systems. For example, institutions which have become accustomed to the Montessori Senior method **gradually extend** the practice of decision-making among residents. Some care

centres have **replaced fixed meals with a buffet,** where residents, discreetly assisted by their care partners, can decide themselves what they feel like having on a given day. The care staff's creativity shows that this solution can also be adjusted to the needs of patients who are confined to bed and have breakfast in their rooms. In Belgium, there is a care home whose residents **take part in job interviews and in other decision-making processes which affect their lives**.

PRESERVED SKILLS

Deficits and lost skills are what stands out from the very moment of giving a diagnosis. To a large extent, they are the point of reference to differentiate between various neurocognitive disorders or identifying the stage of a disease. Furthermore, the system of financing healthcare services is often based on the degree of disability. **All of these factors highlight the aspect of disability** (Gil & Poirier, 2018). Similarly, exercise books and activity scenarios aimed at activating cognitive functions usually focus on the damaged brain areas and the tasks proposed in them are based on asking a patient to name and memorise something or concentrate to find a certain detail. **In the Montessori Senior practice**, we learn to identify and employ the preserved skills of patients, regardless of the degree of their cognitive disabilities. **Dr Camp lists four basic areas:** sensory skills, motor skills, social skills, and cognitive skills. With the use of a simple questionnaire, a caregiver can mark the observed skills, which facilitates the work of the care staff in general. There is also an extended tool called **MAS (Montessori Assessment System)**. It is used for evaluating the preserved skills of persons with mild and advanced neurocognitive disorders (Erkes & al., 2019). By shifting the focus on the skills which are still functional, caregivers can employ them and stop concentrating on the deficiencies. Consequently, **they support the self-reliance** and independence of persons with neurocognitive disabilities.

Let us present this concept in a practical example: the same activity (such as creating a photo album) will take a different course when performed with a person who has perfectly preserved motor skills but weakened **language skills** than with a person who has **motor difficulties** but is able to speak fluently. When activities are based on the preserved skills, not only do we alter our perception of the patient's abilities but we also contribute to the patient's active engagement and **reduce avoidance and unwillingness to perform the task** (without proper preparation, a task unsuited to the patient's skills may turn out to be overly difficult and generate stress and a sense of failure).

Apart from discerning preserved skills in the above-mentioned areas (sensory, motor, social, and cognitive), the **Montessori Senior method relies on in-depth knowledge of the other person** and his/her life, dreams, and the accomplishments s/he takes pride in. It is also essential to learn about the person's old competencies and habits. Another fascinating area of commonly underestimated skills is the use of the potential of implicit (procedural memory), which makes it possible for persons with neurocognitive disorders to acquire **new information and skills** despite the

deficits in declarative memory. **By supporting persons** with neurocognitive disabilities on the basis of the Montessori Senior method, **we apply the technique** of errorless learning. Other aids used in this approach include cognitive prostheses and templates which help elderly persons in retrieving the necessary information despite their explicit memory disorders (Brush & al., 2015).

NORMALISATION

Maria Montessori claimed that a disturbed environment meant a disturbed child. Hence, she placed a lot of emphasis on **creating an environment which would help children** in becoming involved in learning and realising their potential (Montessori, 2018). In the process of normalisation, by impacting the environment, we impact a person. **The concept of normalisation** adapted to the needs of people with cognitive disabilities is one of the pillars of the Montessori Senior method. As cognitive deficits increase, the surrounding world and everyday situations become more and more complicated and difficult to handle. In Dr Camp's approach, **the problem does not lie in the person:** it is connected with interactions, environments, and materials which are not adjusted to this person's abilities and needs. Therefore, we must create conditions which allow people with cognitive difficulties to make use of their potential and support their independence and autonomy. From this perspective, normalisation refers to multidimensional impact: it involves the adjustment of both the physical environment (surroundings, materials) **and the human environmen**t (attitude, speech, behaviour, communication).

Apart from the ideas described in the first part of the article, the adjustment of activities, interactions, and materials is also **based on twelve principles** of the Montessori Senior method. They are simple guidelines which combine elements of Maria Montessori's educational approach with the ideas of psychological models of learning. One of the most interesting examples of normalisation is **the concept of Montessori Senio**r booklets developed by Dr Camp accompanied by reading club meetings referred to as Reading Roundtable®. People with Alzheimer's disease or other neurocognitive disorders often quit reading books. This is not because they no longer know how to read but due to increasing deficits which make reading difficult: forgetting what has just been read, problems with focusing attention, or poor eyesight. **Based on the Montessori normalisation concept**, Dr Camp and his colleagues developed the Montessori Senior booklets which are written in a way that circumvents such deficits and draws on preserved skills. This approach has already helped numerous elderly persons around the world in finding the pleasure of reading on their own again. **The Montessori-based Reading Roundtable®** makes use of external cues and the techniques of learning through practice, so it can be successfully applied by persons with cognitive problems (Camp & al., 2005; Skrajner & Camp, 2007).

THE MEANING OF ACTIVITIES

When a person is diagnosed with **neurocognitive disorders or dementia**, the society begins to look at this person from a different point of view. This change has a direct influence on the daily life of people with cognitive deficits. Activities that used to be common for them before the diagnosis, such as listening to music, playing with their pets, or watering their plants, are gradually becoming perceived from the angle of therapy. This is particularly noticeable in the context of institutions, where activities for residents are often the responsibility of a team of cultural workers or **occupational therapists** and they take place at particular times of the day. Elderly persons in care centres have limited possibilities of performing tasks such as making their own bed, setting the table for dinner, or peeling vegetables for soup: this is caused both by sanitary regulations and by the requirement of impeccable tidiness, which is often imposed on the staff. One may be under the impression that carrying out some ordinary daily life activities by elderly persons with neurocognitive disorders in a care home becomes an extraordinary phenomenon.

In the Montessori Senior approach, all activities, including activities of daily living, become extremely important. **Dr Camp says that activity cannot be limited to occupational therapy** and cultural classes: all the things that a person does throughout the day should be understood as activities. Therefore, involving residents in daily tasks is just not a role of occupational therapists and cultural workers: it is a duty of everyone in the facility. In the context of neurocognitive disorders, the issue of being involved in activities becomes particularly relevant because, as a number of studies have shown, participation in activities improves sleep quality and mental state, lowers agitation and other reactive behaviours, and enhances independence and general quality of life (Richards & al., 2005; Edvardsson & al., 2014; Gitlin & al., 2008; Van Haitsma & al., 2015). **Thanks to the Montessori Senior approach**, the involvement of patients in recreational activities and activities of daily living as well as their participation in the life of the community can be easily adjusted and increased. From this perspective, our target is not therapy for patients with dementia and other neurocognitive disabilities but normalisation and providing them with access to both old and new activities, **taking their choices, preferences, and values into account.**

Research into the outcomes of activities based on the Montessori Senior method as compared to habitual activities at aged care centres shows that the former increase active engagement of persons with neurocognitive disorders (Jarrott & al., 2008; Judge & al., 2000; Lee & al., 2007) and improve their ability to eat on their own (Lin & al., 2011). Moreover, the Montessori Senior approach helps in lowering agitation (Yuen & Kwok, 2019). De Witt-Hoblit & al. (2016) analysed the effects of implementing the Memory in Rhythm® programme, which includes elements of Dr Camp's Montessori adaptation, in 16 long-term care centres in Ohio within one year. Among the observed **beneficial effects**, the researchers reported reductions in medication use intake, lower agitation and wandering, and decreased employee turnover, accompanied by increased sleeping time at night among residents, improved eating abilities, and better capacity for other **activities of daily living**.

PRACTICAL APPLICATIONS OF THE MONTESSORI SENIOR METHOD – EXAMPLES

I. Assistant: Ewa Kociołek, neurological speech therapist, certified Montessori Senior instructor

CONTEXT:

Jane suffered an extensive ischaemic stroke over a year ago, which resulted in right-sided paresis and mixed aphasia with the dominance of motor disorders. She uses a tripod walking stick and she needs assistance in activities of daily living (dressing, personal hygiene). **What frustrates her most** is the inability to communicate with her loved ones through speech (her spontaneous speech is scarce). Thanks to intensive **work with her neurological speech therapist** and her own commitment, Jane's speech has improved; however, the obstacles include the time that has already passed since the stroke and the size of the brain structures damage. The woman displays reactive behaviours such as crying, which is the expression of her frustration. She is irritated and upset because she cannot use speech to communicate her needs and feelings and because she is not as active and independent as she used to be before the stroke. Moreover, she lost the ability to read and write.

1. WHO IS THIS PERSON?

Jane used to be a popular hairdresser and she took care of her home. She was actively involved in the life of her community. She ran her own hair salon for years. Now she bursts into tears whenever she sees scissors and other hairdressing accessories. **She used to be a great housekeeper,** too, and she enjoyed cooking for her family. Currently, she lives with her husband, their adult son, and his wife. During the day, she is accompanied by a distant relative, who is her caregiver. **Jane can count on the support and understanding of her close ones**.

2. WHAT SKILLS HAS THIS PERSON PRESERVED?

Jane can move around and eat on her own. She participates in food preparation and uses her healthy left hand. She understands speech relatively well: she can grasp easy verbal messages. She is intelligent, clever, and motivated to take part in therapy work. **She will not give up**. If she has trouble doing something, she tries until she succeeds. She is very cheerful and she laughs a lot. **She has an enthusiastic attitude towards new challenges**.

3. WHAT ACTIVITIES CAN BE SUGGESTED TO JANE BASED ON HER PRESERVED SKILLS AND INTERESTS?

>> EXAMPLE 1

The therapist suggested cooking together. Jane decided that she would like to cook her favourite barley soup (enhancing decision-making – the assisting person following the Montessori Senior principles offers choice instead of imposing anything). The therapist and the patient created a list of ingredients together ("Help me to do it myself"). With the help of illustrations and visual aids (following the principle of basing on preserved skills and using external prompts and manipulatives), Jane prepared the list of ingredients and the assistant wrote them down. Then, Jane was asked to practise the names of the ingredients for the next meeting (instead of revising random words out of context selected by the therapist, the patient works on a meaningful set of vocabulary).

The next meeting took place two days later in Jane's kitchen. The therapist asked Jane to teach her how to cook her favourite soup (asking the patient for help and emphasising the preserved skills). Jane showed her what dishes to use. She washed vegetables on her own and the assistant peeled them. Jane herself put the ingredients in a pot and she seasoned the soup. While performing one step after another, the women talked about what was being done. Janina tried to name the ingredients and her actions. As she can read a clock (use of preserved skills), she was asked to mark the cooking time on a printed clock face (use of external aids and cues). When the soup was ready, Jane gave it to her husband and her caregiver (the activity was relevant for her and supported her role in the community: in this case, the household members).

>> EXAMPLE 2

Jane celebrated her nameday. There were lots of flowers in her home because of that. Some of them wilted in their vases and had to be tidied. The assistant suggested that the fresh flowers should be separated from those that were withered, and rearranged in the vases. This task was a great opportunity for Jane to name colours and flowers. It served as a meaningful activity based on preserved skills, allowing the patient to take care of the surroundings and referring to the pre-disease habits of housekeeping – also enhancing the sense of being needed. She could show her independence: she decided which flowers should be gone and how to arrange the other flowers (she was given choice and her decision-making was enhanced).

4. DID THE ACTIVITY FOLLOW THE PRINCIPLES OF MONTESSORI SENIOR?

Yes.
Jane was asked **if she was willing to participate** in the suggested activities. The purpose and meaning of the activities were explained to her right in the beginning, referring to her preserved skills. Before the activity, the assistant prepared the necessary materials and space. While performing her tasks, Jane could watch the therapist's face all the time and follow the visual cues of articulation movements, which made communication considerably easier. **The illustrations** were another form of support. **Jane received help in the actions** which she was unable to do on her own due to her right arm paralysis (e.g. peeling), but she performed all the actions that involved her preserved skills on her own. **The activities were divided into stages:** the patient performed one task at a time.

5. WHAT ARE THE EFFECTS OF THE SESSION?

Despite her increased weariness caused by the severe brain damage, Jane was deeply engaged in the activity most of the time. She was visibly enthusiastic about the actions she performed. As a result of the performed tasks, she began to be more actively involved in preparing meals for herself and her family. What is more, **she had a very positive reaction** to a suggestion that she could start watering and caring for her house plants regularly. With her caregiver, Jane marked the flower care days in a calendar. **The family appreciated her actions** and her independence, which made her feel even better.

Although **there are some tasks that Jane is rather unlikely to be able to perform on her own,** the activities described here allowed her to focus on her strengths rather than her weaknesses. Consequently, her reactive behaviours (i.e. frequent crying) – which were a response to her feeling of frustration and helplessness – were gradually reduced to a minimum. **Thanks to the use of the Montessori Senior approach**, she was able to transform her helplessness into satisfaction derived from the tasks she could carry out on her own.

II. A shop project implemented in a residential home in France: EHPAD Mathilde Laurent in Villeneuve-lès-Maguelone

EHPAD Mathilde Laurent has applied the principles of Montessori Senior for years. The idea of creating a shop turned up in conversations with the residents. They noticed that some of them were unable to go to nearby shops (the project was a response to the residents' needs, a result of taking their ideas into account and listening to them carefully – in accordance with the Montessori Senior principles: they find it relevant). **A shop committee was established**: thematic committees are an important element of the Montessori Senior approach – thanks to them, the residents are actively involved in the decision-making process concerning a variety of causes that are relevant to them personally. **The committee members** met once a week to work on the idea and implement it. With the aid of special materials and following the principles of the Montessori Senior method, the residents made their own decisions about the products that should be available in their shop, the way it should be organised, and the opening days and hours.

A group of volunteers accompanied by some staff members purchased the listed products. They were funded by Les Amis de la Maison de Retraite Mathilde Laurent association. The bills were then analysed during another meeting of the shop committee. **The residents made decisions about the products' prices together.** All the payments were transferred to the above-mentioned association and the money was later used to organise other events and activities for the care home.

The next important stage was to arrange the shop interiors together (in accordance with the Montessori Senior principles, **every involved person can choose what kind of activities they wish to take part in)** – they sorted and the named products and created price tags for them. The cash register and the sales register were also adjusted to **enhance the residents' independence** and agency.

The project was actively developed. The residents decided that some of the works they created as part of art classes could be sold in the shop as well: scarves, ceramic decorations, or fragrance sachets with lavender from their garden (i.e. the project made their actions meaningful and helped increase their engagement). **The shop turned into an interesting spot for the families and friends visiting the residents.**

The shop committee is still active – its members cooperate to make decisions concerning a number of questions: e.g. who prefers to work in the shop individually, and who would rather have company. The participants talk about their preferences concerning the opening days and hours of the shop.

This project is a great example of a successful application of the Montessori Senior method: the shop was created with the active participation of the residents of the care home and developed on the basis of their decisions. It became part of their everyday life and they are involved in relevant social roles. It is their pride and it gives them an opportunity to implement other ideas or organise community outings. The creation of this place and the support provided to the elderly residents of the institution in its organisation is absolutely in line with the main motto of the Montessori Senior method: **"Help me to do it on my own"**.

SOURCES

Antenucci, V., & Roberts, A. (2017). The Montessori method applied to dementia: An international perspective. *Montessori Life*, 29(1).

Banerjee, S. (2009). The use of antipsychotic medication for people with dementia: Time for action.

Bourgeois, M. S., Brush, J., Elliot, G., & Kelly, A. (2015). Join the revolution: How Montessori for aging and dementia can change long-term care culture. *Seminars in speech and language*, 36(03), 209–214. Thieme Medical Publishers.

Brush, J., Camp, C. J., Bohach, S., & Gertsberg, N. (2015). Developing a signage system that supports wayfinding and independence for persons with dementia. *Canadian Nursing Home,* 26(1), 4–11.

Camp, C. J. (1999). *Montessori-Based Activities for Persons with Dementia. Volume 2.* Myers Research Institute and Menorah Park Center for the Aging.

Camp, C. J. (2010). Origins of Montessori programming for dementia. *Non-pharmacological therapies in dementia*, 1(2), 163.

Camp, C. J., Bourgeois, M. S., & Erkes, J. (2018). Person-centered care as treatment for dementia. In: G. E. Smith & S. T. Farias (Eds.), *APA handbook of dementia*, 615–629. American Psychological Association.

Camp, C. J., Skrajner, M. J., & Kelly, M. (2005). Early stage dementia client as group leader. *Clinical gerontologist*, 28(4), 81–85.

Cook, E. D. M., Swift, K., James, I., Malouf, R., De Vugt, M., & Verhey, F. (2012). Functional analysis-based interventions for challenging behaviour in dementia. *Cochrane Database of Systematic Reviews*, 2(2).

Douglas, N., Brush, J., & Bourgeois, M. (2018). Person-centered, skilled services using a Montessori approach for persons with dementia. *Seminars in speech and language*, 39(3), 223–230. Thieme Medical Publishers.

Ducak, K., Denton, M., & Elliot, G. (2018). Implementing Montessori Methods for Dementia™ in Ontario long-term care homes: Recreation staff and multidisciplinary consultants' perceptions of policy and practice issues. *Dementia*, 17(1), 5–33.

de Santé, H. A. (2009). Maladie d'Alzheimer et maladies apparentées: prise en charge des troubles du comportement perturbateurs. *Recommandations de bonnes pratiques*, 2009-07. From: http://www.has-sante.fr/upload/docs/application/pdf/2009-07/alzheimer_troubles_comportement_perturbateurs_synthese.pdf

Edvardsson, D., Petersson, L., Sjogren, K., Lindkvist, M., & Sandman, P. O. (2014). Everyday activities for people with dementia in residential aged care: Associations with person-centredness and quality of life. *International Journal of Older People Nursing*, 9(4), 269–276.

Erkes, J., Camp, C. J., Raffard, S., Gély-Nargeot, M. C., & Bayard, S. (2019). Assessment of capabilities in persons with advanced stage of dementia: Validation of The Montessori Assessment System (MAS). *Dementia*, 18(5), 1840–1857.

Gil, R., & Poirier, N. (2018). *Alzheimer: de carpe diem à la neuropsychologie.* Editions érès.

Gitlin, L. N., Winter, L., Burke, J., Chernett, N., Dennis, M. P., & Hauck, W. W. (2008). Tailored activities to manage neuropsychiatric behaviors in persons with dementia and reduce caregiver burden: a randomized pilot study. *The American Journal of Geriatric Psychiatry*, 16(3), 229–239.

Jarrott, S. E., Gozali, T., & Gigliotti, C. M. (2008). Montessori programming for persons with dementia in the group setting: An analysis of engagement and affect. *Dementia*, 7(1), 109–125.

Judge, K. S., Camp, C. J., & Orsulic-Jeras, S. (2000). Use of Montessori-based activities for clients with dementia in adult day care: Effects on engagement. *American Journal of Alzheimer's Disease*, 15(1), 42–46.

Kitwood, T. M. (1997). *Dementia reconsidered: The person comes first*. Open University Press.

Lee, M. M., Camp, C. J., & Malone, M. L. (2007). Effects of intergenerational Montessori-based activities programming on engagement of nursing home residents with dementia. *Clinical Interventions in Aging*, 2(3), 477.

Lin, L. C., Huang, Y. J., Watson, R., Wu, S. C., & Lee, Y. C. (2011). Using a Montessori method to increase eating ability for institutionalised residents with dementia: a crossover design. *Journal of clinical nursing*, 20(21–22), 3092–3101.

Maslow A. (2006). *Motywacja i osobowość*, Warszawa: Wydawnictwo Naukowe PWN.

Miksza, M. (2014). Wartości ważne w moim życiu. Model zajęć z seniorami w oparciu o zasady pedagogiczne Marii Montessori. In: *Edukacja w systemie Marii Montessori. Wychowanie do wartości*. Łódź: Wydawnictwo Palatum.

Moniz-Cook, E., Stokes, G., & Agar, S. (2003). Difficult behaviour and dementia in nursing homes: five cases of psychosocial intervention. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 10(3), 197–208.

Montessori, M., & Camarda, S. (2018). *Sekret dzieciństwa*. Warszawa: Wydawnictwo Naukowe PWN.

NHS Foundation Trust (2019). *Guidelines for the management of Behavioural and Psychological Symptoms of Dementia* (BPSD). From: http://www.oxfordhealthformulary.nhs.uk/docs/OHFT%20BPSD%20Guideline%20May%202019.pdf

Richards, K. C., Beck, C., O'Sullivan, P. S., & Shue, V. M. (2005). Effect of individualized social activity on sleep in nursing home residents with dementia. *Journal of the American Geriatrics Society*, 53(9), 1510–1517.

Skrajner, M. J., & Camp, C. J. (2007). Resident-assisted Montessori programming (RAMP™): Use of a small group reading activity run by persons with dementia in adult day health care and long-term care settings. *American Journal of Alzheimer's Disease & Other Dementias®*, 22(1), 27–36.

Stokes, G. (2017). *Challenging behaviour in dementia: a person-centred approach*. London: Routledge.

Van der Linden, M., & Van der Linden, A. C. J. (2014). *Penser autrement le vieillissement. Pour une approche humaniste du vieillissement cérébral*. Mardaga.

Van Haitsma, K. S., Curyto, K., Abbott, K. M., Towsley, G. L., Spector, A., & Kleban, M. (2015). A randomized controlled trial for an individualized positive psychosocial intervention for the affective and behavioral symptoms of dementia in nursing home residents. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 70(1), 35–45.

Yuen, I., & Kwok, T. (2019). Effectiveness of DementiAbility Methods: The Montessori Way on agitation in long-term care home residents with dementia in Hong Kong. *International Journal of Geriatric Psychiatry*, 34(9), 1352–1358.

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