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What Drama Therapy Core Processes Can Be Observed in a TimeSlips Session with Residents in Dementia Care Units?

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Drama Therapy

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Abstract

Despite the arrival of the person-centered movement in dementia care, biases continue in caregiving around ageism, cognitive disability, and pharmacological interventions to mitigate behavior issues. This paper underscores the efficacy of drama therapy as a non-pharmacological intervention in dementia care practices, directing focus on drama therapy core processes and how to utilize them to meaningfully engage with persons with dementia. In this phenomenological study, run over a four week period, I facilitated group interventions using TimeSlips with residents from two memory care units at separate assisted living facilities in New England. TimeSlips is an established program, specifically created for persons with dementia, with the same roots in theater improvisation as drama therapy. The participants ($N = 68$) were White older adults who came on a voluntary basis, were predominately cis-gender female, had varying degrees of dementia, and ranged in age from 75+. The most cited core processes were engagement in dramatic reality and dramatic play, demonstrating drama therapy's ability to bridge differences in cognitive abilities between persons with dementia and their caregivers and improve needed social connections. As sole participant observer of the sessions, the results are limited by my singular interpretation of the still evolving definitions of drama therapy core process.

*Key words:*dementia, caregivers, drama therapy, core processes, bias, non-pharmacological intervention, TimeSlips

Author Identity

I acknowledge my bias as an able bodied, cognitively intact, older adult who identifies as an American cis-gender female of Korean-Italian descent and whose early developmental years were influenced by the cultural biases of White Protestant New England.

What Drama Therapy Core Processes Can Be Observed in a TimeSlips Session with Residents in Dementia Care Units?

Drama therapy is a promising nonpharmacological intervention for persons with dementia, mitigating the behavioral and psychological symptoms of dementia and improving quality of life through creative engagement (Jaaniste et al., 2015; Lin et al., 2022; Novy, 2018; Smith, 2000). A review of academic literature, however, produces limited empirical research regarding drama therapy's effectiveness with this specific population (Feniger-Schaal & Orkiki, 2020; Frydman et al., 2022). de Medeiro and Basting (2013) wrote that this was due to the very nature of expressive arts interventions in dementia care practices where imagination is the distinguishing process of these interventions. They proposed that the expressive arts are incompatible with quantitative research methods at present. These questions regarding visibility and evidence-based research are addressed in Frydman et al.'s (2022) Delphi study codifying drama therapy's core processes to promote quantitative research and support drama therapy's efficacy as a therapeutic intervention. In a limited phenomenological study, I hoped to observe the presence of drama therapy's core processes, as defined in the Delphi study, while facilitating TimeSlips, an expressive arts dementia program (Basting, 2022). As participant observer with residents at two New England memory care units, I was able to share the experience of dramatic play with these residents, i.e., the imaginative process, as we co-created stories from photo prompts. Positive observation of the core processes in my capstone project strengthened my understanding of how drama therapy may be utilized in dementia care practices from concept, to application, to operationalization.

The word dementia historically carries a stigma that continues today, conjuring images of the elderly isolated in cognitive and physical disability. Dementia is the common term for the

neurocognitive disorders whose main features, loss of memory and coherent language, severely impact the day to day living of the person experiencing the disorder (Alz.org, 2022; American Psychiatric Association, 2013; Graff-Radford & Lunde, 2022; World Health Organization, 2022). Dementia is not a disease, but a syndrome of symptoms whose underlying cause may include the following: Alzheimer's disease (which accounts for 60% or more of dementia cases), cerebrovascular disease, Lewy body disease, Parkinson's disease, frontotemporal lobar degeneration, hippocampal sclerosis, and mixed pathologies (Alz.org, 2022, p. 5-7). The World Health Organization (WHO) (2022) reported that there are approximately 55 million people around the world living with dementia and that this number will grow to 78 million by 2030 and 139 million by 2050 (para. 10).

Advanced age does not cause dementia, but is a primary risk factor for the syndrome (Alz.org, 2022; WHO, 2022). There is no cure at present. Recent medications approved by the FDA specifically for Alzheimer's disease dementia can only slow its progression in early stages with limited success (Graff-Radford & Lunde, 2022). While medical research continues, the behavioral and psychological symptoms of dementia (BPSDs) remain a major focus of dementia care. Antipsychotics have limited effect in managing these symptoms, (e.g., depression, agitation, anxiety, aggression), and pose serious side effects as medications for comorbidities may result in contraindication (Austrom et al., 2014; Backhouse et al., 2016). With half the residents in long term care facilities in the United States diagnosed with dementia, the Centers for Medicare and Medicaid Services (CMS) have committed to ensure the quality of life for these residents with person centered care and nonpharmacological interventions as first line interventions to address BPSD's (Brandburg & Tombrella, 2021; cms.gov, 2022). Drama

therapy, as a nonpharmacological intervention, is poised to offer a unique lens in dementia care to understand and connect with persons with dementia.

One prominent intervention in assisted living and dementia care, life review, touches upon my personal stake in these populations. My choice to work in dementia care began with my own life review and confrontation with E. Erikson's (2020) final psychosocial stage of development: integrity versus despair. After much self-debate, I chose integration. Further, per J. Erkison's (2020) addition of a ninth stage advancing a gerotranscendent perspective, I chose to "seek a new life – a new self" (p.126). I decided to repurpose my life experiences and theater skills into mental health counseling and drama therapy. Tackling a master's degree as an able-bodied, cognitively intact older adult proved not as easy as when I was in my 20's. The effects of primary aging and Covid isolation on my semantic memory and self-doubts from internalized ageism has given me a glimpse into the lived experience of my companions in aging and my own possible future. My very first academic paper in graduate school was titled *Transformation through Relationship: Drama Therapy's Use of Improvisation in Alzheimer's Care.* This paper continues that first foray into drama therapy theory and synthesizes theory and clinical application through an experiential understanding of drama therapy's core processes.

Literature review

The North American Drama Therapy Association (NADTA) (2021) defines drama therapy as "an embodied practice that is active and experiential" (nadta.org). The NADTA further wrote that drama therapy "can provide the context for participants to tell their stories, set goals and solve problems, express feelings". Pertinent to my capstone project is NADTA's further assertion that "through drama, the depth and breadth of inner experience can be actively explored

and interpersonal relationship skills can be enhanced". These descriptions offer a process and outcome relavant to therapeutic interventions in dementia care.

To explore drama therapy's relevance in dementia care practices, I began with current issues in research regarding the interpersonal relationship between professional caregiver and person with dementia. Next I examined what is only now emerging in drama therapy research with persons with dementia. How drama therapy can be effective with this population required an exploration into drama therapy's core processes with Frydman et al.'s (2022) Delphi study. Insight into the lived experience of patients with dementia was found through arts based research. Finally two research articles on TimeSlips, the dementia program used in this capstone project, examined its efficacy as an intervention in dementia care.

Dementia care

Personhood is not lost in dementia, but is present throughout each stage of the syndrome (Brandburg & Tombrella, 2021). Kitwood's (1997) *Dementia Reconsidered, The Person Comes First* greatly contributed to the person-centered movement in dementia care and was recently republished in 2019, *Dementia Reconsidered, Revisited: The Person still Comes First,* with commentary from contemporary professionals in dementia care. Kitwood's definition of personhood altered our perspective of (dis)ability from the "person-with-Dementia" to the "Person-with-dementia" (p.6). Personhood, according to Kitwood, is "a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being"; further, this relational context is "empirically testable" (p.7). Two research studies, some twenty years after Kitwood, offered evidence of how the personhood of the resident with dementia may be upheld or undermined.

Gerristen et al.'s (2019) cross-sectional study of 15 long care facilities in the Netherlands examined the relationship between caregiver ($N = 291$) attitudes and residents ($N = 239$) well-being. The researchers found a significant difference between two subscales when added separately into the study: "hope" and "person-centeredness" (p.1520). Residents with dementia whose caregivers had a more hopeful attitude toward them ($p = <0.05$) "experienced higher social well-being and less challenging behavior" (p.1520). This correlation was not present when "person-centeredness" alone was entered. Gerristen et al. (2019) encouraged that future research into caregiver attitudes include the examination of the causes that underlie their attitudes.

Kunz et al. (2022) applied mindset theory to analyze the individual factors underlying caregivers' attitudes toward patients with dementia and how these factors impact caregivers' emotional responses to daily care situations. Two cross-sectional studies with caregivers ($N = 370$) in long term facilities in the Germany were used to understand what factors facilitate person-centered care. Using the Dementia Mindset Scale, created by Kunz et al. (2020), caregivers' responses placed them either in the fixed or malleable mindset category. The fixed mindset holds the belief that neither symptoms of dementia nor quality of life can be changed, a malleable mindset holds the belief that change can happen for these patients. The results showed that while both mindsets can be held at the same time, one mindset will be more dominant (Kunz et al., 2022). Higher scores were reported on the malleable dementia mindset than the fixed mindset ($p = <0.1$) The researchers questioned whether the fixed dementia mindset demonstrated an inability to react differently, to improvise and find a new option to a care situation.

Discussion thus far has centered on if and how caregivers acknowledge the personhood of patients with dementia and how these impact patients' quality of life. Schweighart et al. (2022) interviewed nursing home residents with depressive symptoms, an issue occurring to half of

residents in nursing homes, to assess what were their perceived needs and barrier to needs. Though dementia was not mentioned specifically in the study, the researchers stated cognitive and functional impairment as risk factors for depression in nursing home residents. Schweighart et al. conducted a qualitative, cross-sectional study of participants (N=11) in three nursing homes in Germany. The semi-structured interviews revealed the following themes in perceived needs: being care for, wanting to die, better health, continue hobbies, loss of independence and autonomy, returning home, social needs. Barriers to needs being met were largely expressed as staff not taking their needs seriously and having no confidants with whom to talk. The researchers concluded that successful communication of needs between patients and caregivers resulted in higher quality of life.

Drama therapy in dementia care

As a hospice intern working predominantly with residents with dementia, integrating drama therapy into my visits with residents in memory care units was initially daunting. My on-site supervisor was unsure of how to explain my presence. Artist was easily understood, but would these residents understand the term drama therapy? Descriptions, such as creative arts, arts and crafts, student or intern, were used as introduction. I experienced the limited visibility of drama therapists as described in Frydman et al.'s (2022) Delphi study. I continued researching dementia and dementia interventions, attended virtual sessions on dementia caregiving, but found little in drama therapy research to guide me with this specific population.

Feniger-Schaal and Orkibi's (2020) integrative review of drama therapy intervention research found only two studies examining drama therapy's efficacy with older people with dementia, though no specific techniques were described. In Mechaeil et al.'s (2009) quantitative study, residents with dementia from a care home in the UK were randomly assigned to a control

($N = 4$) or an experimental ($N = 4$) group. Mean age range for both groups was approximately 85 years old. Over a 12-week period, the control group went to regularly scheduled activities and the experimental group went to drama therapy sessions. Pre and post assessment were conducted for each session of the 12 sessions, rating each participant on eight factors that included anxiety, happiness, social contact, body posture, confidence, energy, attention and engagement. Results from the trial indicated cumulative improvement in well-being for the drama therapy group, as well as being able to maintain the improved states of being. Attention and engagement were the factors most positively affected.

The other dementia study found by Feniger-Schall and Orkibi (2020) came from Australia. Jaaniste et al. (2015) conducted a five-month pilot study of older adults ($N = 16$) with mild to moderate dementia, using a mixed methods (quantitative and qualitative) approach. To determine if drama therapy improves quality of life for this population, nine participants ($N = 9$) were assigned to a weekly, 1.5-hour drama therapy session and seven participants ($N = 7$) were assigned to weekly movie watching. The structure of the drama therapy sessions remained the same, i.e., warm-up, activity, and reflection, while using different techniques. A phenomenological method was used in the qualitative investigation of the study which included recording and transcribing body language and dialogue. Themes that emerged in analysis were anger and frustration, family, memory loss due to dementia, and grief.

Jaaniste et al. (2015) concluded that the qualitative data supported the quantitative results that drama therapy can improve the quality of life of persons living with dementia. This methodological triangulation enhances this study's validity and credibility. Further, prolonged engagement with the participants deepens the study's credibility per its weekly drama therapy sessions over a five-month period. Thick descriptions of the participants experiences living with

dementia and the consistency of the drama therapy sessions provide high transferability. The emergent themes from the sessions demonstrated the participants ability to express self-knowledge regarding their diagnoses, sharing their anger, frustration, and humor with others.

Just one year after Feniger-Schall and Orkibi's (2020) review, nine articles were published in a special issue of *Drama Therapy Review* (*DTR*) (2021) on emerging drama therapy research with older adults. Editors Smith-Peers and Gaines (2021) acknowledged the previous lack of research on drama therapy with older adults and with older adults with dementia. Research included in this issue were articles on acting training and dementia (Noice & Noice, 2021), life review enhanced by drama therapy (Harel & Keisari, 2021), short-term drama therapy with patients with Parkinson's disease, neuro-dramatic play and dementia (Holmwood, 2021), witness theater with Holocaust survivors(Grazi-Shatzkes et al., 2021) and a review of Basting's (2022) *Creative Care.* Basting devoted several chapters regarding her journey in creating her TimeSlips dementia program. Smith-Peers and Gaines (2021) also posed an important question regarding bias, whether the presence of systemic bias had influenced drama therapy research with these populations. A significant distinction must be noted here between between older adults and older adults with dementia. There is no clear distinction. The boundary between primary aging and mild neurocognitive disorder is arbitrary (American Psychiatric Association, 2015). One study in this *DTR* issue was of particular interest to me as a drama therapist given drama therapy's roots in theater processes.

Noice and Noice's (2021) 35-year study examined how the cognitive learning strategies of professional actors could lower the risk of dementia in older adults and to improve the cognitive health of adults with dementia. Pertinent to drama therapy research were the executive function processes actors use to memorize lengthy scripts and attain a goal: immediate word

recall, delayed word recall, verbal fluency, and means-end problem solving. Using control versus intervention groups, the researchers found improvement in episodic memory in their older adult parciticpaants who underwent training in acting. Decline in episodic memory is a first indication of dementia. These results were still evident in participants four months after the study and confirmed by functional magnetic resonance imaging study.

Finally, the most recent research I found was a quantitative study sponsored by the Taiwan Nurses Association that first brought me to my thesis question: how can drama therapy's core processes be observed? Lin et al. (2022) examined the use of drama therapy as a nonpharmaceutical intervention for persons with dementia to mitigate depression, increase attention, and improve quality of life. Jones' (1996) five step drama therapy model provided the framework for weekly 90-minute sessions over 12 weeks with themes ranging from TV reminiscing to marriage stories. Participants ($N = 42$) who met inclusion criteria from four daycare centers were randomly divided into an experimental group ($n = 23$) who received drama therapy and a control group ($n = 19$) who received routine activities.

Lin et al.'s (2022) pre-test and post-test design compared changes in depressive symptoms, attention, and quality of life between the drama therapy and the control groups. Though the study lacks strong external validity due to small sample size ($N = 42$), the results showed improvement in all drama therapy participants with significant improvement ($p < .01$ to $p < .001$) after eight and 12 weeks. There were no significant changes in the control group across the domains. The researchers suggested that more studies are needed with larger sample sizes, using a mixed method design, and recommended that drama therapy modules be incorporated into nursing students' geriatric curriculum. This was the study that fueled my desire to more fully understand *how* drama therapy can work within dementia care practices.

Core Processes in Drama Therapy

Limited visibility in empirical research around the core processes was the impetus for Frydman et al.'s (2022) Delphi study to codify drama therapy's core processes toward a specific drama therapy measurement that may promote evidence-based research. Since Jones (1996) first identified core drama therapy concepts, various modalities of drama therapy have resulted in differing perspectives of these concepts and how they are therapeutic (Frydman et al., 2022). Through client vignettes and conversation analysis, Jones (2007) described nine core elements of drama therapy instrumentally therapeutic: dramatic projection, dramatherapetuic empathy, distancing, role playing and personification, interactive audience and witnessing, embodiment, playing, life-drama connection and transformation. Operationalizing the core processes from drama therapy theory became the focus in further research to empirically validate drama therapy core processes. Armstrong et al. (2016) explored two of these core processes, dramatic projection and embodiment, from the perspective of three approaches to drama therapy- role theory, developmental transformation, and psychodrama -and determined that these core processes were observable.

Frydman et al.'s (2022) investigation and collection of academic literature, followed by rounds of feedback from drama therapists, resulted in a tripartite schematic of drama therapy's core processes. These core processes represent a North American perspective of its definitions of seven core processes: *engagement in dramatic reality, dramatic play, active witnessing, distancing, dramatic projection, embodiment, and multidimensional relationship* (see Appendix A). Each core process was articulated by its concept, its application, and its operationalization, i.e., what it is, what it does, and what is observed during the process. These descriptions were

used to identify core processes emerging in my TimeSlips group sessions for this capstone project.

TimeSlips

Though not specifically a drama therapy intervention, TimeSlips evolved from the same roots in theater processes as drama therapy, namely improvisation. I trained as a facilitator through timeslips.org (2022) and have used this program weekly for the past year at my assigned assisted living facilities. This improvisational format, described further in the methods section, was my entry point in linking concept, application, and operationalization of drama therapy's core processes. The following two studies examined TimeSlips' efficacy as a nonpharmacological intervention in dementia care.

Researchers in the United States (Fritsch et al., 2009) assessed the impact of TimeSlips (TS), described here as a creative arts dementia program, to improve the quality of life and care of persons with dementia in long term care settings. The researchers chose non-profit nursing homes *(N* = 20) in Wisconsin (*n* = 10) and North Carolina (*n* = 10) as care settings to be assessed for improvement. No significant difference ($p < .109$ - .340) in basic characteristics between the nursing homes was determined. The nursing homes were paired in each state by location with one randomly assigned to receive the TS program and the other serving as the control. The TS groups involved 10-12 residents plus staff meeting weekly for 10 weeks.

A covert observational study was employed two weeks after TS was introduced in the nursing homes. Researchers (Fritsch et al., 2009) coded the type and frequency of resident affect and staff-resident interactions observed in public areas. The study concluded that residents were more alert t ($p < .05$) in the TS settings than the control settings where more neutral or other affect was observed. Staff-resident interactions were more frequent and more socially oriented in

the TS settings ($p < .01$), while resident-staff interactions in the control setting ($p < .001$) were related to daily care. Though protocols were specified for coding accuracy, internal and construct validity are threatened due to the researchers' inability to differentiate only those residents and staff within a TS setting who participated in TS. There were no pre-test observations to establish norms.

A later study assessed the benefits of TimeSlips this time for individuals with varying degrees of dementia (Vigliotti et al., 2018). A mixed methods approach was used to observe participants ($N = 22$) with mild to severe dementia over a six-month period in a dementia care unit in Pennsylvania. The study had three objectives: to determine TimeSlips impact on quality of life, to determine the impact of TimeSlips on resident-caregiver interactions, and to determine if TimeSlips was beneficial across all levels of dementia. Participants attended weekly, one-hour long TimeSlips sessions. The Mini-Mental State Examination was used to determine the severity of cognitive impairment pre-test and three times during the course of the study. The Greater Cincinnati Chapter Well-Being Observation Tool assessed the participants for well-being. A final interview was conducted at the end of the study with two of participating residents and two participating caregivers for their understanding of TimeSlips. Three qualitative themes of bonding, reminiscence and laughter were observed across all levels of dementia. The researchers determined that participants with mild to severe dementia experienced improved quality of life from the TimeSlips sessions, while participants with mild to moderate dementia were more likely to demonstrate improvement in resident-caregiver interactions.

The Arts and dementia

The concept of time as linear influences our experience of identity as linear. Klein (2014) explained this as "personal diachronicity" which is "our belief that we have an identity that

originated in our past and will follow us into our future" (p.4). Dementia impairs personal diachronicity by fragmenting the memories of the past self, thereby disrupting the future self. This disruption gives rise to the perception that the individual with dementia has lost their identity, is unreachable. Brown (2017) challenged the significance placed on continuity for the individual negotiating dementia, emphasizing their reality of navigating "an experiential self rather than an accumulation of shared experiences and histories" (p.1009).

Arts based research in dementia care augments our textbook knowledge of the lived experience of individuals with dementia. The articles discussed below examine assumptions regarding the personhood of these individuals and demonstrate how meaningful understanding between all stakeholders may be created through artworks. Arts-based research methods offer an understanding of the experience of dementia that goes beyond pragmatic science. High quality art, whether music, dance, or poetry, has the ability to connect those living in the linear world to those living in the non-linear world of dementia.

Canadian researchers (Jonas-Simpson et al., 2022) employed a phenomenological methodology to explore the experience of relational caring and how it is collectively experienced at an arts-based academy for persons living with dementia. Members ($N = 25$) from the academy included persons living with dementia, family members, staff, professional artists, one personal support worker and two volunteers. All participants were regular attendees of the academy. In-depth face-to-face interviews asked open-ended questions and were conducted individually and in small groups. In-depth interviews using open-ended prompts were audio- or video-taped and transcribed for detailed analysis. Three thematic patterns emerged: freedom and fluid engagement inspire a connected spontaneous liveliness, embracing differences invites discovery with generous inclusivity, and mutual affection brings forth trust and genuine expression.

Jonas-Simpson et al. (2022) concluded that the experience of arts-based practices when embedded in relational caring improved quality of living for persons with dementia and their social contacts. While the study provides thick description, the researchers admit to issues with transferability. The academy's unique arts-based environment engenders free exploration that may not work with long-term care facilities that must comply with regulatory restrictions and medical care practices.

Swinnen's (2016) research utilized an ethnographic approach to study the use of oral poetry as an embodied, social dialog between a poet-performer and people with dementia. As a participant observer and later as a poet-performer, Swinnen collected data from 19 poetry interventions over six months from the Alzheimer's Poetry Project at the New York Memory Center. Each session was one hour in length with the groups ranging between 15 – 35 people. All participants were at different stages of dementia. Data collection consisted of detailed description of the researcher's observations, audio recordings with verbatim transcriptions, fieldnotes of the poet-performer training caregivers, photographs, and semi-structured interviews with the poet-performer. Analysis of the data was through "close listening" to the exchanges between the poet- performer and the participants and accompanying observational notes of those embodied encounters.

While Swinnen's (2016) study provides a thorough examination of the processes within oral poetry tradition that offer an effective, pan-cultural intervention in dementia care, absent from the study is the researcher's own reflective, inner dialogue as a participant observer. A non-native English speaker, Swinnen initially made many mistakes during the "call and response" part of the live poetry session, opening a significant enquiry that was not followed (p.1390). Also not included in self-reflection was Swinnen's experience within the group as the researcher

moved from the role of participant to poet-performer. This study followed ethical procedures, obtaining informed consent from group participants. Feedback from the group participants was not solicited.

Moss and O'Neill (2019) arts-based approach helped to educate stakeholders in dementia care regarding the experience of patients with dementia in a hospital setting. The researchers collaborated with a composer, artist, and dancer who immersed themselves in the lives of the patients, their caregivers, and hospital staff over a twelve-week period. This included art-making with the patients and accompanying the patients throughout their medical journey, i.e., attending MRI scans, receiving diagnoses, physical, speech and language therapy sessions, visitations by family. Observational and narrative data from all stakeholders informed the culminating chamber music performance, art exhibition, and original dance performance.

The researchers (Moss & O'Neill, 2019) conducted a highly ethical and substantive study that sensitively portrayed the experience of living with dementia through the arts. Each artist was acclaimed in their respective modalities and was experienced in working in healthcare systems. Ethical approval was obtained from the hospital ethics committee and the entire arts project was overseen by the hospital arts committee. Informed consent was obtained for all participating patients and hospital staff. The culminating artworks were presented first to the patients, their families and hospital staff before presentation to the general public. In post-performance forums audience members and medical professionals alike were affected by the artworks' emotional communication of living with dementia. Requests for repeat performances gained traditional media and social media interest, increasing public awareness and understanding of dementia.

Apparent in this literature review is the impact of bias regarding caregivers' interpersonal relationship skills with individuals with dementia. The belief in the personhood of those with

dementia and that they can experience quality of life is increasingly important as nonpharmacological interventions become first line interventions to address BPSD's. More research is emerging regarding the efficacy of drama therapy's core processes to mitigate BPSD's. Evolving efforts in the operationalizeation of the core processes are key to this endeavor. Drama therapy and the expressive arts have the ability to reach beyond linear interactions and connect with the lived experience of the person with dementia.

Methods and Materials

In September of 2021 I began my first placement drama therapy internship with a hospice organization in Northeastern United States. I trained in facilitating TimeSlips via online modules through TimeSlips.org (2021) in December, 2021 and in January, 2022 received permission to facilitate TimeSlips group sessions from the activity directors at two of my assigned assisted living facilities with memory care units. Data were collected from four consecutive weekly sessions in November and December of 2022.

The residents who participated in these sessions included persons of mixed levels of dementia. The participants' diagnoses were unknown to me, as were their ages which I estimated at 75+ years. Gender was approximately 85% female at both sites and the cultural backgrounds of participants was White. At facility A the sessions were held in the morning and at facility B the sessions were held in the afternoon. The same photo prompt, chosen by me, was used at both facilities each week. Each session lasted approximately 30 minutes. The first week's photo was an old photograph album, unopened and worn, and with three skeleton keys tied together with a piece of twine. A kitten raised up on its hind legs at a dog with its head on the couch comprised the second week's photo. The third week's photo offered an bearded, gray haired older man

holding a small girl on his hip, standing in a field. The final week's photo was a winter scene with two nuns about to go down a hill on a sled.

Residents were brought into the activity room for the TimeSlips sessions by facility staff on a voluntary basis and the number of participants varied each week. Upon arrival I set up my computer and speaker for the opening warm up and greeted each resident as they arrived. At each facility a white board with markers was available to me and the participants' seating arranged into an open semi-circle. I followed a basic drama therapy sequence of warm-up, activity, and closing. Each warm up consisted of music that encouraged the group to join together in voice and movement. Each activity portion consisted of the TimeSlips session, per timeslips.org (2022). The session concluded with music as celebration of the story that was created.

Before each session, I re-familiarized myself with the Delphi study definitions of drama therapy's core processes, per Frydman et al. (2022) (Appendix A), with special attention to the definitions under "here is what is observed while the process is taking place" (p. 8). After the warm- up, I read to the group the story from the previous week, first showing them the previous weeks' photo. A new photo was then handed out to the participants by me and activities personnel. The participants were instructed that this was a group creation and each contribution would be honored and written by me on the board. I reminded the participants that there were no wrong answers.

Following TimeSlips training, open ended questions were asked to invite the participants into dramatic reality (timslips.org, 2022). Ex: What is going on here? Who are these people? What are their names? Where are they? What season is this? Sensory based questions were especially encouraged for this population (Bastings, 2020; Emunah, 2020). What might they see,

hear, smell, feel, taste? All responses were written on the white board to verify to the participants that their contributions were included in the story. If needed, I recapped the story expressed thus far to help participants regather the threads. I relied on an organic sense of conclusion to prompt the group to create a title to their story, then read the final draft of the story. The session concluded with a closing song.

After each session, I took a photo of the story on the white board with my phone. I quickly wrote key impressions in a notebook which were expanded upon later at home. This included what core processes I observed, those I did not observe, and any core processes whose emergence I questioned. The stories were later typed with that sessions' photo and given to the staff to display in the unit or include in a newsletter to family members, per facility protocols. Once this sequence was completed all stories were then deleted from my phone, a practice to which I adhered from the beginning of my internship.

Limitations and biases

As sole facilitator and participant observer, I was limited in my ability to give full attention to non-verbal responses (or quiet responses that I didn't hear) of each individual in the group. I relied on my interpretation of observed core processes and did not have the benefit of an additional facilitator with whom to corroborate observations. I acknowledge my own biases as an older adult with a graduate school level education.

Results

I chose to report the results from each facility separately, as there was a discernable difference in culture between the two facilities. This enabled me to better scrutinize the variables influencing the sessions, i.e., number of participating residents, differing levels of dementia, amount of daily activities and types of activities at each facility, how close residents interacted

with each other on a daily basis. Another factor that may have influenced each session was the photo prompt chosen.

I realized from the outset that my open ended prompts about the photos clearly invited participants into *engagement in dramatic reality* per Frydman et al. (2022). Participant responses to these prompts were evidence of *dramatic play*. I included myself as *active witness* in each session. If one participant was stirred by another participants' response, I recorded this as *active witnessing* per the Delphi definitions. This was observed in week one sessions at both facilities and in week four at facility B. At this point in the research process there is not enough information about observable qualities of distancing to notate when it was happening. I did not observe *dramatic projection* other than the use of the photo as a prop. I observed participant *embodiment* in weeks one, two and four at facility A and in weeks one and four at Facility B. Notably, all participants at facility B in week one were observed to make connections between dramatic reality and real life, defined in the core process *multidimensional relationship*.

Facility A Core processes observed	Week 1 No. Participants: *13	Week 2 No. Participants: *11	Week 3 No. Participants: *14	Week 4 No. Participants: *6
Engagement in Dramatic reality	4	6	9	10
Dramatic play	12	12	17	17
Embodiment	1	1	Not observed	1
Dramatic projection	**	**	**	**
Active witnessing	3	1	1	1
Distancing	**	**	**	**
Multidimensional relationship	2	Not observed	Not observed	Not observed

*I included myself, as participant/observer, in number of participants.

**Not observable based on available research.

Facility B Core processes observed	Week 1 No. Participants: *10	Week 2 No. Participants: *8	Week 3 No. Participants: *7	Week 4 No. Participants: *7
Engagement in Dramatic reality	7	5	13	7
Dramatic play	25	14	19	13
Embodiment	2	Not observed	Not observed	1
Dramatic projection	**	**	**	**
Active witnessing	1	1	1	3
Distancing	**	**	**	**
Multidimensional relationship	10	Not observed	Not observed	Not observed

Four of the seven drama therapy core processes were observed within the group sessions: *embodiment, active witnessing, multidimensional relationship, engagement in dramatic reality, dramatic play.* The most cited core processes throughout all group sessions were *engagement in dramatic reality* and *dramatic play*; the interaction between the invitation into play and the acceptance by the participants to play.

Artistic response to observations and journal highlights

I chose to use the poetic form of haiku for my artistic response to each week's sessions. In limiting my verbal fluency to this structure, I sought to understand the lived experience of my participants with dementia. I chose key moments from the sessions to explain my experiential response.

Week One.

Carefully held words

Unbruised by expectation

Not one left behind

Facility A. I felt fully present in the dramatic space, connected, in relationship. Was this due to the heightened context of the capstone project? Responses off the bat were remarkable. One participant's response, interepreting the photo as a loss of memory, resonated with others in the group. Another participant who never spoke in session before responded to this with an embodied description of loss in just three words.

Facility B. This group imagined a story very different from the first group. It threw me at first. I later realized how my expectations, in that instant and in general, can impact relationship. This group is also much more cohesive in their relationships than facility A. These residents engage in more activites together during the day. A theme of safety emerged with this group: keeping possessions safe, keeping family safe, keeping oneself safe. These were definite connections between the dramatic play and real life concerns.

Week Two.

Disconnected from

Here and now our hands struggle

To hold each other

What a difference between week one and week two at both facilities. Everything felt wobbly. Both groups were rather subdued, sleepy. The weather was gray and Thanksgiving weekend at just ended. I felt that I started to emphasize content versus process in my sessions, trying to get things going. I observed two quiet groups, but, did I take this in fully, actively witness? Expectation rearing it's head again? Later, I recalled from the *DvT Text for Practioners*

(2013) that the playspace must be continually created moment to moment. Despite this uncertainty on my part, there were still a number of core processes observed.

Week Three.

A flower, hidden,

Unseen amongst the many,

Rises to offer.

I had been aware of the physical spaces that were used for the TimeSlips sessions. In the course of this project I was able to examine this further. My modality supervisor had shared that when she entered the room for group sessions she took time to greet and shake everyone's hands. In facility A the room was quite large. In order to make a circle with the 14 participants, the distance between myself at the white board and those farthest away from me was large. (In facility B the room is much smaller, half the size.) During the session, I decided to take the time to leave the white board and be closer to various participants who had never offered a response. I crouched down to be on the same level of this one participant. They responded with a smile and a single word reply. Physical distance affected the psychological distance between us.

Week Four.

How they all laughed, 'cept

One. Who never looked, never

Spoke - but - moved closer.

Here was more evidence of the effect of a participant being in a big group versus a small group; responding to a personal invitation versus group invitation. At facility A group size was half of what it normally was. The room was still set up for a large group and that day's participants were seated farthest away from me. I then brought myself and all equipment closer

to the participants. As I did this, a participant who never spoke nor accepted a photocopy during sessions moved closer. I was very surprised by this choice to be a part of the group. From previous attempts by me to include them, I had incorrectly assumed their disinterest in the activity. At facility B five of the usual group who always engaged in the storymaking had gone to mass. Of those remaining, one participant led the responses with much humor, while another participant, who was a newer resident and who always declined to respond, actively laughed throughout. That participant offered one truly embodied response to a moment in the dramatic play.

Discussion

Drama therapy is an emerging nonpharmacological intervention for persons with dementia as described in the literature review (Grazi-Shatzkes et al., 2021; Harel & Keisari, 2021; Holdwood, 2021; Jaaniste et al., 2015; Lin et al., 2022; Noice & Noice, 2021; Novy, 2018). How and why drama therapy can be implemented in dementia care practices begins with its unique foundation in dramatic reality. Pendzik (2006) described this as bringing "together the imaginary and the real in the here and now" (p.273). At this crossroad, linear and non-linear experience can genuinely encounter each other, express feelings, and create moments of meaning making throughout a person's journey with dementia. Personhood is not lost in dementia, nor the need to meaningfully connect with others (Brandburg & Tombrella, 2021).

Main Takeaways from Results

Engagement in dramatic reality and *dramatic play* were the two most cited core processes in this research project and key to my understanding of how drama therapy practices can engender meaningful relationships with persons with dementia. Basting (2020) described the invitation to play, i.e., *engagement in dramatic reality*, as asking the "beautiful question" (p.76).

It is an open-ended question that "gives the creative power to the listener, not the asker" (p.79). This is analogous to J. Erikson's (2020) description of "maintenance touch versus communicative touch" in assisted living care (p.126). In my internship I have seen the difference between disengaged caregivers who do the minimum and the engaged caregivers who meaningfully connect with their patients with dementia.

Engagement in dramatic reality provides the bridge where therapist/caregiver and person with dementia can meet. The therapist's or caregiver's mindset about behavioral and psychological symptoms of dementia can support or cancel this meeting (Gerristan et al., 2019; Kunz et al., 2022). Meeting the needs of the person-with-Dementia requires meeting the Person – with-dementia, genuinely acknowledging their personhood (Kitwood, 2019). I discovered my own implicit bias as a cognitively intact person during my research with my clients. I also found that the actual physical space between myself and my clients could be a literal obstacle in this invitation to meet. I discovered the necessity to balance a genuinely open mindset and the physical space between myself and my client to complete this agreement to meet and to move into *dramatic play.*

Dramatic play, i.e., improvisation, creates a flexible play space. Basting (2020) and Brown (2017) challenged the significance placed on continuity for the person with dementia. Fragmentation of memory, the hallmark of dementia, requires a flexible therapeutic space that is inclusive, as in improvisation's rule of "yes, and". The Delphi study (Frydman et al., 2022) describes *dramatic play* as "co-created" and an "environment for cognitive, emotional, developmental and interpersonal flexibility" (p. 8). The obstacle of memory impairment is negated in this space of spontaneous, imaginative play. Pendzik's (2006) stated that "dramatic reality is not ruled by the laws and limitations that govern actual living" (p.274). It is important

to encourage the preserved cognitive abilities of the person with dementia and equally important not to shame or demean that person with corrections. *Dramatic reality* provides an equitable space for creative interactions between persons with dementia and therapist/caregiver.

A *multi-dimensional relationship* becomes possible as the person with dementia accepts the therapist's invitation to play. The core processes overlap and build upon each other, expanding therapeutic results. An example of this occurred at the first session at Facility A. A resident offered an embodied expression of fear and loss. I actively witnessed this, repeated their words and wrote them on the board. Another resident actively witnessed the expression of fear and loss and offered their understanding in a few words. There was a shared experience about the photo via dramatic reality that included active witnessing and embodiment, within a span of a minute. Multidimensional connections were made between the imaginal realm and real life concerns regarding these residents' lived experience with dementia.

There is a limitation to observing the core processes as they occur because they do overlap and become hard to differentiate. When one core process is in activation, often other core processes have also been activated. My project would have benefited from an additional researcher co-collaborating to confirm observation of the core processes. Research is still evolving regarding these definitions and continues to move toward operationalization. My one recommendation is to build this evolving research into our present curriculum. I believe this can only strengthen student understanding of drama therapy's core processes, as it did mine, and can clarify their efficacy in dementia care practices.

Conclusion

Drama therapy's core processes are observable and headed toward operationilzation to meet the needs of drama therapy's visibility in empirical research. Observation of drama

therapy's core processes demonstrates to me how I can engage with persons with dementia to improve quality of life by genuinely acknowledging their personhood. In this capstone project I have been using haiku to artistically reflect my allyship with my clients with dementia. Recently I was reminded of another poetic structure, iambic pentatmeter, used by Shakespeare. His use of iambic pentamenter though was not rigid. Deviations from the rhythm reflected an emotional change in the character who was speaking. This final haiku likewise deviates from structure and rhythm to reflect my clients' continuing transformations, and my own.

Words vibrate upon
My skin, constant, powerful.
Hallelujah.....

References:

Alzheimer's Association. (2022). *2022 Alzheimer's Disease Facts and Figures, Special Report.* https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5)*. American Psychiatric Association. http://dx.doi.org/10.1016/j.aip.2016.05.007

Armstrong, C. R., Rozenberg, M., Powell, M. A., Honce, J., Bronstein, L., Gingras, E. H., & Han, E. (2016). A step toward empirical evidence: Operationalizing and uncovering drama therapy change processes. *The Arts in Psychotherapy. 49(*2016), 27-33.

Austrom, M. G., Boustani, M., & Lamantia, M. A. (2018). Ongoing medical management to maximize health and well-being for persons living with dementia. *Gerontologist*, *58*(2014), S48–S57. https://doi.org/10.1093/geront/gnx147

Backhouse, T., Killett, A., Penhale, B., & Gray, R. (2016). The use of non-pharmacological interventions for dementia behaviours in care homes: finding from four in-depth, ethnographic case studies. *Age and Ageing. 45*, 856-863. doi: 10.1093/aging/afw136

Bastings, A. (2020). *Creative care: A revolutionary approach to dementia and elder care*. Harper One.

Brandburg, G. & Tombrella, J. (2021). Person-centered care and dementia: Best practices for residents living in long term care. *American Nurse Journal. 16*(8), 16-19. https://go-gale-com.ezproxyles.flo.org/ps/retrieve.do?tabID=Journals&resultListType=RESULT_LIST&searchResultsType=MultiTab&hitCount=1&searchType=AdvancedSearchForm&currentPosition=1&docId=GALE%7CA691982403&docType=Article&sort=Relevance&contentSegment=ZHRC-

MOD1&prodId=HWRC&pageNum=1&contentSet=GALE%7CA691982403&searchId=R2&userGroupName=les_main&inPS=true

Brown, J. (2017). Self and identity over time: Dementia. *Journal of Evaluation in Clinical Practice*, *23*(5), 1006–1012. https://doi.org/10.1111/jep.12643

Center for Medicare and Medicaid Services. (n.d.). National Partnership to improve dementia care in nursing homes. CMS.gov. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes

de Medeiros, K. & Basting, A. (2013). "Shall I compare thee to a dose of donepezil?": Cultural arts interventions in dementia care research. *The Gerontologist. 54*(3), 344-353. doi:10.1093/geront/gnt055

Emunah, R. (2019). *Acting for Real: Drama Therapy Process, Technique, and Performance* (2nd ed). https://doi.org/10.4324/9781315725406

Feniger-Schaal, R., & Orkibi, H. (2020). Integrative systematic review of drama therapy intervention research. *Psychology of Aesthetics, Creativity, and the Arts, 14*(1), 68-80. https://doi-org.ezproxyles.flo.org/10.1037/aca0000257

Frydman, J. S., Cook, A. Armstrong, C. R., Rowe, C., & Kern, C. (2022). The drama therapy core processes: A Delphi study establishing a North American perspective. *The Arts in Pscyhotherapy.(80).* https://doi.org/10.1016/j.aip.2022.101939

Fritsch, T., Kwak, J., Grant, S., Lang, J., Montgomery, R. R., & Basting, A. D. (2009). Impact of TimeSlips, a creative expression intervention program, on nursing home residents with dementia and their caregivers. *Gerontologist*, *49*(1), 117–127. doi:10.1093/geront/gnp008

Graff-Radford, J. & Lunde, A. M. (Eds.). (2022). *Mayo Clinic. Understanding Alzheimer's. Your Guide to Brain Health.* Dotdash Meredith Premium Publishing.

Gerristen, D. L., van Beek, A. P. A., & Woods, R. T. (2019). Relationship of care staff attitudes with social well-being and challenging behavior of nursing home residents with dementia: A cross sectional study. *Aging & Mental Health. 23* (11), 1517-1523. DOI: 10.1080/13607863.2018.1506737.

Grazi-Shatzkes, S., Asch, J. & Udesky, E. (2021). Thank you for telling-thank you for listening: The witness theater model. *Drama Therapy Review. 7*(1), 77-94. https://doi.org/10.1386/dtr_00062_1

Harel, D. & Keisar, S. (2021). Drama therapy in late life: Taking life-story work one step further. *Drama Therapy Review*. *7*(1), 23-36. https://doi.org.ezproxyles.flo.org/10.1386/dtr_00059_1

Holmwood, C. (2021). Older people, dementia and neuro-dramatic play: A personal and theoretical drama therapy perspective. *Drama Therapy Review. 7*(1), 61-75. https://doi.org/10.1386/dtr_00061_1

Jaaniste, J., Sheridan, L., Ollerton, R. L., & Slewa-Younan, S. (2015). Drama therapy with older people with dementia-Does it improve quality of life? *The Arts in Pschotherapy, 43*, 40-48. http://dx.doi.org/10.1016/j.aip.2014.12.010

Johnson, D. R. (2009). Developmental transformations: Towards the body as presence. In D. R. Johnson & R. Emunah (Eds.), *Current approaches in drama therapy* (pp. 89–112). Charles C. Thomas.

Johnson, D. R. (2013). *Developmental transformations: Text for practitioners, number two*. New Haven, CT: Institutes for the Arts in Psychotherapy.

Jones, P. (2021). *The arts therapies. A revolution in healthcare.* (2nd ed.). Routledge.

Jonas-Simpson, C., Mitchell, G., Dupuis, S., Donovan, L. & Kontos, P. (2022). Free to be: Experiences of arts-based relational caring in a community living and thriving with dementia. *Dementia, 21*(1), 61-76. DOI: 10.1177/14713012211027016

Kitwood, T. & Brooker, D. (2019). *Dementia reconsidered, revisited. The person still comes first.* Open University Press.

Klein, S. B. (2014). Sameness and the self: Philosophical and psychological considerations. *Frontiers in Psychology*, *5*(JAN), 1–15. https://doi.org/10.3389/fpsyg.2014.00029

Kunz, L. K., Scheibe, S., Wisse, B., Boerner, K., & Zemlin, C. (2022). From dementia mindsets to emotions and behaviors: Predicting person-centered care in care professionals. *Dementia. (21)*5, 1618-1635. DOI: 10.1177/14713012221083392.

Lin, L. W., Lu, Y. H, Chang, T. H., & Yeh, S. H. (2022). Effects of drama therapy on depressive symptoms, attention, and quality of life in patients with Dementia. *The Journal of Nursing Research, 30*(1), 1-9. DOI: https://doi.org/10.1097/jnr.0000000000000468

Mechaeil, R., Graybow, A., & Cobham, P. (2009). Towards a purposeful ending: A study exploring the impact of dramatherapy on the quality of life of people suffering from dementia. *Dramatherapy. (31)*2, 27-34. https://journals-sagepub-com.ezproxyles.flo.org/doi/pdf/10.1080/02630672.2009.9689775

Moss, H. & O'Neill, D. (2019). Narratives of health and illness: Arts-based research capturing the lived experience of dementia. *Dementia. 18(*6), 2008-2017. DOI: 10.1177/1471301217736163

Noice, T. & Noice, H. (2021). A theatrical evidence-based cognitive intervention for older adults. *Drama Therapy Review. 7*(1), 9-22. https://doi.org/10.1386/dtr_00058_1

North American Drama Therapy Association. (2021). What is drama therapy? NADTA.org. https://www.nadta.org/what-is-drama-therapy

Novy, C. (2018). Life stories and their performance in dementia care. *Arts in Psychotherapy*, *57*. https://doi.org/10.1016/j.aip.2017.12.003

Pendzik, S. (2006). On dramatic reality and its therapeutic function in drama therapy. *The Arts in Psychotherapy. 33*(2006), 271-280. DOI: 10.1016/j.aip.2006.03.001

Schweighart, R., Klemmt, M., Neuderth, S., & Teti, A. (2022). Needs and needs communications of nursing home residents with depressive symptoms: A qualitative study. *International Journal of Environmental Research and Public Health. (19)*3678, 1-12. https://doi.org/10.3390/ijerph19063678

Smith, A. G. (2000). Exploring death anxiety with older adults through developmental transformations. *Arts in Psychotherapy*, *27*(5), 321–331. https://doi.org/10.1016/s0197-4556(00)00074-5

Smith-Peers, J. & Gaines, A. M. (2021). Drama therapy and older adults: From waiting in the wings to crossing centre stage. *Drama Therapy Review. 7*(1), 3-6. https://doi.org/10.1386/dtr_00057_2

Swinnen, A. M. C. (2016). Healing words: A study of poetry interventions in dementia care. *Dementia. 15*(6), 1377-1404. DOI: 10.1177/1471301214560378

Vigliotti, A. A., Chinchilli, V. M., & George, D. R. (2018). Evaluating the benefits of TimeSlips creative storytelling program for persons with varying degrees of dementia severity. *American Journal of Alzheimer's Disease & Other Dementias. (34)* 3, 163-170. https://doi.org/10.1177/1533317518802427

World Health Organization. (2022, September 20). *Dementia.* https://www.who.int/news-room/fact-sheets/detail/dementia

Appendix A

Definitions of Drama Therapy Core Processes

Table 5
Drama therapy core process schematic.

Core Process	Here is what the process is:	Here is what the process does:	Here is what is observed while the process is taking place:
Active Witnessing	The process by which participants notice aspects of themselves, others in a group, or the drama therapist. At the same time, participants are seen by the drama therapist, other group members, or an invited audience.	Active witnessing may create a heightened experience. For those in the role of witness to oneself or others, active witnessing helps create perspective and is a forum for the offering and receiving of supportive feedback when relevant. For those being witnessed, active witnessing promotes the experience of being supported, acknowledged, validated, and helps develop perspective or new understanding.	While the participant(s), therapist(s), or audience member(s) is/are involved in a drama therapy process, they demonstrate active witnessing by watching, listening, reflecting, interacting, engaging emotionally, demonstrating empathy, and/or providing feedback to others and/or oneself.
Distancing	A process of titrating emotion and cognition through engagement with dramatic media.	Allows the participant(s) to move between feeling and thinking, helping participant(s) to fully feel, express, and tolerate emotions and/or expand perspective, awareness, and capacity for self-regulation.	There is a noticeable shift from a place of emotional flooding or intellectualizing; the participant(s) move(s) or is/are guided along a continuum of emotional and cognitive expression.
Dramatic Play	Engagement in a co-created improvised relationship with reality, utilizing imagination and spontaneity. Typically, there is a sense of experimentation, and an engagement in experiential processes that are expressive and collaborative.	Allows the participant(s) and drama therapist(s) to explore aspects of reality (such as time, place, events, consequences, attitudes, actions, and held ideas). It creates an environment for cognitive, emotional, developmental, and interpersonal flexibility and generates new possibilities and empowerment without real-life consequences.	Mutual participation in imaginative and spontaneous activity within various degrees of structure.
Dramatic Projection	The process of outwardly expressing and representing aspects of oneself, others, social forces, feelings, and experiences onto dramatic material (e.g., puppets, props, masks, text, role, story) and engaging with that material.	Achieves aesthetic distance away from or toward the dramatic material; externalizes inner experiences, dynamics, or other issues and creates dialogue between internal material and external expressions; the external expression and exploration of personal material helps participants to develop parts of self, insight, perspective, and behavioral change.	Dramatic material is brought into action or expression. The participant(s) may also identify a life-drama connection.
Embodiment	A physical, vocal, or emotional inhabiting of the body; attending to sensations; touch; the spectrum of physicalized expression of emotions, thoughts, reactions, impulses, and inner experiences.	Supports an intentional sense of presence and immediacy, and a connectedness between (or reintegration of) mind, body, emotion, and/or a heightened awareness of transpersonal and intersectional identities. The individual takes on a bodily identity, resulting in expanded kinesthetic awareness, insight, or perspective; release; and/or new behaviors. The participant (s) might explore the personal, social, ecological, and/or political forces that influence one's experience of the body, including how the body may be socialized, racialized, gendered or otherwise viewed in specific contexts.	The participant(s) is/are engaged in a dramatic activity that is physical or vocal, with the primary focus of the activity being the body and its range of abilities; a heightened or altered use of the body for the task of expression and/or awareness of senses or behaviors.
Engagement in Dramatic Reality	Participating in a transition from external reality to a liminal state, bringing the imaginal realm into outward expression; an in-session departure from ordinary life.	Allows the participant(s) a flexible space to express and explore their inner and external experience and to review past experiences and rehearse future possibilities for real life within an imaginative reality; it brings together the imagined and the real.	An offer/invitation is made by a drama therapist or participant(s), there is an agreement to participate, and then a transition into a dramatic reality; something from the imaginal realm is made concrete; inner experience is made visible, tangible, and/or audible.
Multidimensional Relationship	The inter-relationship between participant(s), drama therapist(s), and dramatic reality.	Participant(s), drama therapist(s), and group interactions are mutually and dynamically influenced by what takes place within and outside of dramatic reality.	The participant(s) engage(s) with the drama therapist, other group members (when applicable), and the dramatic reality. Spoken and unspoken connections between what takes place in dramatic reality and real-life concerns and goals may be observed.

Note. From Drama therapy core processes: A Delphi study establishing a North American perspective by Frydman et al., 2022, p.8. Copyright 2022 Elsevier Ltd.

THESIS APPROVAL FORM

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Date of Graduation: _____May 5, 2023_____
In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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