Journal of Psychiatric and Mental Health Nursing, 2000, **7**, 59–67

Anti oppressive practice: a route to the empowerment of people with dementia through communication and choice

GEOFFREY W. MARTIN RGN RMN BSC MA & DENNIS YOUNGER RMN BSC
University of Teesside, School of Health, Middlesbrough TS1 3BA, UK

Correspondence:
G. W. Martin
School of Health
University of Teesside
Middlesborough
TS1 3BA
UK

MARTIN G. W. & YOUNGER D. (2000) *Journal of Psychiatric and Mental Health Nursing* 7, 59–67

Anti oppressive practice: a route to the empowerment of people with dementia through communication and choice

This short study looks at the issue of anti oppressive practice and the way that it relates to the care of people with dementia. In particular it considers ways in which people can be empowered and given choices around aspects of day-to-day living in a care setting. The study took place over a period of 6 months and utilized the Dementia Care Mapping (DCM) observation process to assess the level of well being of residents in the setting studied. The results can only be seen as a first stage in the process of understanding ways in which people with dementia may be empowered. It is demonstrated that a change of practice developed over the 6 months between the two observation periods. Areas such as communications and day-to-day activities are examined to identify both problems and strategies for such change. The conclusion highlights the need to continue the mapping exercise as a way of ensuring that change is not only maintained but also advanced.

Keywords: anti oppressive practice, care mapping, dementia, empowerment, observation, research

Accepted for publication: 12 November 1999

Introduction

This study, part of work in progress, examines the concepts of anti oppressive practice and empowerment as related to the care of people with dementia. The literature around this area of care has, until recently, largely ignored the rights of people with dementia to any form of autonomy and it is to this omission that the paper is addressed. In recent years we have seen a body of work building up around the rights and 'personhood' of people with dementia (Kitwood 1995, Kitwood 1997, Marshall 1997, Rafferty 1997) and there is a growing body of work which highlights the role ageism plays in the care of older people (Bytheway 1995). A number of research papers have used a similar DCM method to good effect (Brooker & Payne 1995, Wilkinson 1995 and Williams & Rees 1997). Each uses a behavioral analysis approach in different care settings. Brooker & Payne (1995) looks at both in patient and day patient settings and highlights some problems of using the technique as an audit tool. Wilkinson's (1995) pilot study points the way to further research in the area and Williams & Rees (1997) demonstrate a clear link between DCM and improving quality of care. It is important that we now consider ways in which the concepts discussed can bring about change in nursing practice, particularly with a view to the promotion of anti oppressive practice. There has been a few studies that have looked at empowerment and dementia (Chapman 1993, Goldsmith 1996), and this paper seeks to add to this work.

The model of anti oppressive practice discussed in this study relies, in the main, on the interpersonal communication processes which arise between the nurse and the patient/resident as reflected in the results of a Dementia Care Mapping exercise. The objective of the study is to see if a DCM exercise can bring about improvements in practice, related to patient choice and control, in one particular care setting. Communication, according to Killick (1997), must take pride of place in our design and delivery of care for persons with dementia.

For nurses to act as empowerers, a new approach must be adopted. This approach depends for its success on the capacity of nurses to be prepared to work with patients at an empathetic, anti oppressive level that overrides aspects both of paternalism and rigid professionalism. Nurses must attempt to overcome disempowering situations, despite the pressures imposed upon them to conform to the traditional definition of their roles. The nurse, patient and other health care professionals are faced with a complex set of interlocking relationships within which communication takes place. The extent of control will depend very much on their relative status. For anti oppressive practice to become possible the balance will have to shift in favor of the patient. It is the nurse who is most able to bring about this shift, by insuring the patient's boundaries of knowledge and control are extended. This shift can be seen as a cultural change, similar to that outlined by Kitwood (1995) for people with dementia where the emphasis is placed on valuing the 'personhood' of the patient. The discussion should be focused on this change of culture and routes to change developed (Martin 1997). Issues of communication cut across all these concepts and will be addressed in the light of the research results. The discussion will highlight both barriers and strategies, in an effort to move the debate forward towards an empowering cultural change. It is important to address not only the ways that change is prevented from happening but also the ways that change may begin to occur.

Anti oppressive practice

Oppressive practice is not just the lot of specific groups, such as people with dementia, it is more useful to think of oppression in general terms, as the ability of a powerful group (health care professionals) to make decision for, and possibly against the wishes of a less powerful group (patients/clients) (Mullender & Ward 1991). With this in mind there are certain well defined sections of the community who face oppression in situations both related, and not related, to health care. These groups could be seen to be doubly oppressed within the health care system. Groups such as women, black and Asian people, disabled people and lesbian and gay people all face forms of oppression, which are sometimes hidden and therefore difficult to identify (Mullender & Ward 1991). These areas of oppression are central to any discussion of anti oppressive practice.

The term empowerment is an ideological concept. It could be said to remain the property of the holder of power and therefore defined and manipulated in the interests of that group alone. The relationship between the health professional and the patient is double edged, consisting of elements of care and control, both potentially empowering and potentially oppressive (Thompson 1993). Ideologies which maintain the responsibility for patent empowerment solely on professionals may serve to legitimate the status quo in the unequal balance of power, and so justify, protect and reinforce current social arrangements of power. One means by which this can happen is by the establishment of 'norms' which construct a notion of the 'normal', so establishing a standard to measure deviance from that norm. The terms 'normal grieving', 'normal relationships', 'normal behavior', for instance, act as powerful ways of legitimating practice. Stereotypes of the 'abnormal' are therefore powerful tools of ideology and are thus significant obstacles to anti oppressive practice (Thompson 1993). It is through medical nursing discourse that power relations are constructed which have the ability to create an 'outgroup' of people, be they black, homosexual men or lesbians, old, demented, etc., defined in negative terms and assigned an inferior status. By way of example, Thompson points to the use of the terms 'dependency' and 'frailty', to describe older people. Such terms imply a medical model which focuses on physical incapacity, decline and dysfunction of the person rather than their social diversity. Anti ageist practice, he maintains, should focus instead on empowerment through advocacy rather than adjustment to infirmity. Thompson (1993) concludes that,

> 'Oppression is both a social injustice and a barrier to self realization and, as such, the removal, reduction and prevention of oppression are valid and legitimate aims . . .'

However, it is possible that people with dementia will not have the resources to bring about change which results in their self empowerment and it is for this reason that Dalrymple & Burke (1995) believe that it is important to interrogate rigorously liberally generated values by using principles, such as empowerment and partnership, that inform anti oppressive practice. In this way we can take into account the power differentials involved in moving forward; change is then more likely to occur.

Empowerment

A disempowering culture would be one that maintained a task orientated, paternalistic approach to care, remaining caught in a rigid hierarchical structure. The potential for devolved decision making, and a holistic approach to patient care, would therefor be impossible. Moves to reduce the disempowerment of residents would be difficult in such a culture, as individual nurses would be unable to take control of the work environment. Day-to-day working practices, within this culture, need to be examined therefore to ensure that old attitudes do not undermine moves towards a participatory approach.

Kieffer (1984) conceptualizes empowerment in a developmental sense that includes both macro and micro considerations. He defines the stages as follows:

- *era of entry*; when the individual's participation remains unsure and unknown, even though authority and power structures at the macro level are becoming demystified;
- *era of advancement*; when mentorship relationships begin to emerge and collaboration and mutually supportive problem solving is possible. An understanding of the situation is gained and mechanisms for action and choices occur;
- *era of incorporation*; when the permanence and painfulness of structural or institutional barriers to self determination are confronted, and organizational, leadership and survival skills are developed.
- *era of commitment*; when the interaction of new personal knowledge and skills become part of the reality and structure of the day-to-day situation.

From this we can see that empowerment is just as much a process of helping individuals to develop some autonomy of decision making, as it is a process of changing the culture and organization of the care setting. A readiness to act to facilitate and engage in the process of the redistribution of power is central to this awareness. As Gibson (1991) puts it, 'a revolutionary rather than a reformist approach to problem solving' is needed which changes the structure of society rather than integrating change into the existing structure. Gibson concludes that intervention needs to take place at the macro level to the conditions that control, influence and produce health or illness in human beings. Nurses must be prepared, as part of this process, to facilitate empowerment within the context of equal partnership with patients. They must become a 'resource mobiliser and advocate' to ensure that access to resources are available, and the patient is enabled to make use of them (Gibson 1991).

It is, according to Foucault (1984), 'specific intellectuals' who have the power to either benefit or destroy life. The nurse is part of this group, able to determine a person's choices as well as allocate resources. This power that nurses have, in itself, can hold the potential to become empowering. Gilbert (1995) gives a number of examples where popular knowledge may be used to confront existing discourse. People with dementia or other mental health problems may require the nurse's support to form alliances with others to challenge prevailing forms of truth. Foucault (1980) therefore proposes that the analysis of the effect of power should focus on:

- local forms of decision making and the techniques involved;
- the identification of the processes of ongoing subjectification;
- the identification of individuals as the vehicles of power;
- the use of a bottom up rather than a top down approach.

It may be true to say that the powerful are not going to relinquish their power voluntarily; pressure to effect this will need to come from other sources. 'Specific intellectuals', such as nurses, social workers, pressure groups and teachers would be central actors in any such process of change.

There must be a clear understanding of the ways in which power operates coupled with the realization that the nurses' culture is the product of power structures both hidden and overt. Only through this understanding will the hegemony of the present cultural rationality be broken. This study seeks to identify some of the routes to anti oppressive practice that nurses can adopt in order to begin the process of change and so make the empowerment of people with dementia a possibility. To this end a 'feedback' session is included in the exercise which gives the care staff the opportunity to discuss the results of the mapping and plan improvements to care where problems are identified. Very often, once the careers are aware of their potentially disempowering practice, the process of change can start with the feedback discussion and develop into a momentum which brings about a change of culture almost overnight (Moyes & Christie 1998).

Method

Design

A mixture of quantitative and qualitative research based on a nonparticipatory observation method designed by the Bradford Dementia Group (1997), has been used. This research tool has been discussed favorably in a number of recent papers (Brooker 1995, Williams & Rees 1997). The quantitative method, called Dementia Care Mapping is a data gathering tool which gives a clear picture of activity or nonactivity of the people observed over a given period. Each activity is divided into behavior categories (BCC) and given a code (Table 1) for each 5 minute time frame. A separate score is also given ranging from –5 to +5 according to the level of ill being or well being (WIB Score) demonstrated by the resident during the time frame. Total WIB scores are shown in the form of a graph (Figures 1, 2, 3).

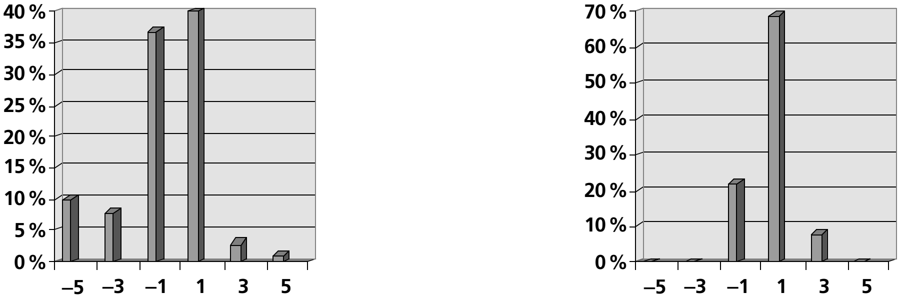

Figure 1
Ted's WIB Value Profile January and July.

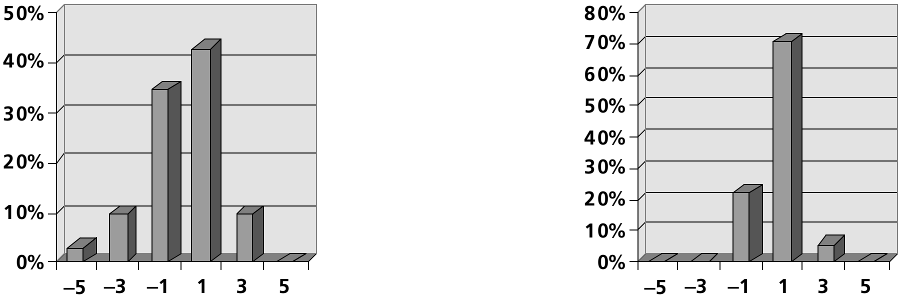

Figure 2
Hatty's WIB Value Profile January and July.

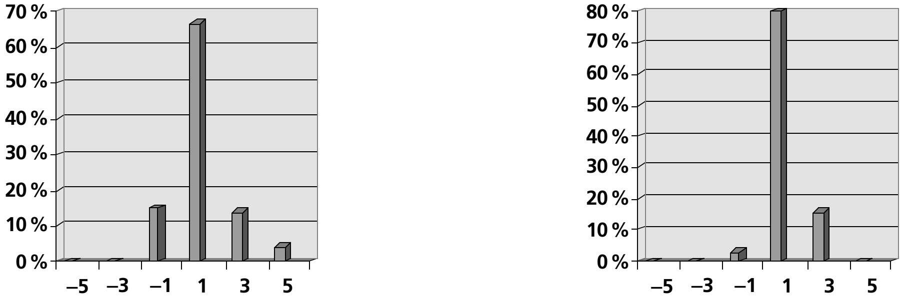

Figure 3
Alice's WIB Value Profile January and July.

Table 1
Behavior categories (Bradford Dementia Group 1997)

A	Articulation	Interacting with others, verbally or otherwise
B	Borderline	Passively, socially involved
C	Cool	Socially uninvolved, withdrawn
F	Food	Eating or drinking
K	Kum and go	Independent, walking, standing or wheelchair moving
L	Labour	Performing work or work like activity
M	Media	Engaging with media
N	Nod, land of	Sleeping, dozing
P	Physical Care	Receiving practical, physical or personal care
X	X-cretion	Episodes related to excretion

The qualitative aspect of this method relates to analysis of individual 'personal detractors' or 'positive events' observed during the DCM process. Personal detractors relate to ways in which care staff and colleagues can routinely 'put down' people with dementia, and are therefore central to any discussion of oppressive practice (Beavis 1998). Examples may include infantalization, stigmatization or mockery (Bradford Dementia Group 1997), these are noted on the data sheet and included in the feedback sessions. At the same time positive events are recorded if care staff show particular skills in communications or crisis management. These also formed part of the feedback session to balance any negative reaction to personal detractors identified.

Collation of the data was in accordance with the recommendations set out in the DCM guidelines and included

Table 2
Behavior category grid – January

	A	B	C	F	K	L	N	P	X
Category	Articulation	Borderline	Cool	Food	Kum & Go	Labour	Nod	physical	x-cretion
Ted	4	1	41	9			75	9	1
Kath	6	24	32	17	11		18	4	4
Hatty	8	10	60	25			23	5	1
John	17	3	8	19	50	14	1	2	3
Alice	18	68	19	15			2	6	2
Totals	53	106	160	85	61	14	119	26	11

Table 3
Behavior category grid – July

	A	B	C	F	K	M	N	P	X
Category	Articulation	Borderline	Cool	Food	Kum & Go	Media	Nod	physical	x-retion
Ted	13	31	26	24	1		33	6	3
Ben	9	28	5	23	23	4	4	2	7
Hatty	11	58	21	27	3		9	4	3
Victor	29	23	3	18	35	3	7	3	4
Alice	28	47	1	18	3	22	5	5	1
Totals	90	187	56	110	65	29	58	20	18

total amount of time patients spent in each behavior category and the overall well being/ill being score for each patient (Tables 2, 3, Figs. 3–6).

Participants

Five residents, one third of the unit's population, were observed initially over two days and a follow up visit was carried out 6 months later when three of the original residents plus two others, were observed for a further 2 days. The observation took place in a villa situated within a complex of similar units. All residents were diagnozed as 'suffering' from dementia.

Procedure

Observers positioned themselves in day areas of the unit and completed raw data sheets with the BCC and WIB score, for each of the five residents observed, in every 5 minute time frame. Care staff were involved in the process initially at a briefing session and after 1 week to discuss the results. Two mappers were involved to ensure reliability of data. Results should be viewed in the light of the small sample and cannot be said to represent other care facilities. Clearly further work is necessary to include a larger sample and further mapping is needed to assess if trends highlighted by this work are maintained over time.

Ethical considerations

The unit manager and the ward manager's permission was obtained before the observation commenced and the ward staff were briefed to allay their fears. Any staff not happy with the procedure were allowed to opt out of the exercise. In the event nobody did. The staff then obtained permission from either the resident or a relative of the resident, if the resident were unable to give informed consent. The ethics of carrying out research on people who are unable to give informed consent were taken into account and any resident who objected to being observed during the research process would immediately be omitted from the exercise. In the event no objections were made. Observation of physical care was not made and public areas only were observed. Bedrooms, bathrooms, etc. were excluded. The Bradford Dementia Group (1997) guidelines state

> 'In fact, very few difficulties have arisen, from an ethical point of view, when dementia care mapping is carried out in a person-centred way. . . . In itself DCM might be viewed as a moral instrument that works towards raising the quality of life of people who have dementia'.

Results

The results are based on observation of seven patients identified as Ted, Kath, Hatty, etc. (Tables 2 and 3). The results will be discussed in relation to the predominance of various behavior categories for these patients shown in Tables 2 and 3. Their level of ill being and well being will also be considered and the implications for anti oppressive practice in this setting discussed in the light of such findings (Figs 1–3). Personal detractors will also be highlighted when relevant and examples of positive events will also be discussed when related to the subject matter of the study.

The behavior category codes discussed are found in (Tables 1–3).

For the purposes of data presentation, only the top nine, of the 24 categories included in the original category coding list, have been included. The figures shown representing 5 min of activity, so, for example Alice spent 1 h 15 min eating and drinking during the January observation period (Table 2 category 'F').

The resident's well and/or ill being values (WIB value) are important when assessing the overall value of the behavior observed. Each 5 minute time frame included an assessment of the patient's well or ill being for that behavior category on a scale from + 5 to – 5, and the overall results for each 12 h period can be shown in graph form for the three participants who were available for both observation sessions (Figs. 1, 2 and 3). The WIB score was recorded along with the BCC so that a complete picture can be achieved. The two sets of coding being shown separately and analyzed separately. It is important to note that if a behavior remained in – 1 for more than half an hour without interruption then it would drop to – 3 and – 5 after a further half hour. 'N' (Sleep) follows a similar rule but allows for an initial 1.5 h in + 1 before the degeneration occurs.

These graphs give a clear indication that + 1 is the predominant level of well being. According to the Bradford Dementia Group (1997) this should equate to 'coping adequately with present situation; some contact with others; no signs of ill being observed.'

The levels of well and/or ill being can be linked to behavior demonstrated on the grids (Tables 2, 3) and some idea of behavior which demonstrates ill being identified. For example high levels of categories 'C' (Socially uninvolved) and 'N' (Sleep) may indicate that attention should be given to include more stimulating activities in the patients day which may produce an improved WIB score. On the basis of this data and the behavior categories identified as significant, we can now consider the potential for a culture of anti oppressive practice.

Discussion of results

According to Goldsmith (1996) people with dementia are disempowered in two ways. Firstly by the illness itself and secondly by other people's reactions to the illness. We are concerned mainly with the latter in this paper although the persons cognitive ability is also important. It will be easier to involve people in decision making if they have some understanding of the situation they face. This is not to say that people with poor cognitive function should be excluded from the process, but different factors such as nonverbal clues or verbal sounds of ill or well being will have to be carefully monitored by the carer. The failure to hear the voice of the person with dementia, however, that is communicated, is an important consideration when looking at routes to empowerment. The person with dementia may become treated as an 'object' which needs only to be kept clean, tidy and sitting quietly. Consultation, participation and individualized care are ignored in an effort to get the job done. At best the carer gets caught up in making choices and decisions based on assumptions about what the person with dementia wants or needs (Chapman 1993).

January observation

If we consider some of the behavior categories in Table 2 we can, perhaps, see this process at work. The highest incidence of observed behavior falls within category 'C', 'being socially uninvolved or withdrawn'. It could, of course, be argued that this is predominant because of the level of dementia demonstrated by the residents, but the coding system takes account of this and includes category 'A', 'interaction with others, verbally of otherwise'. Even interactions with someone who is not able to communicate fully can be coded under this category. The low level of such interactions, particularly with Ted and Kath, who have the highest level of category 'C' (socially withdrawn) and 'N' (sleep) may indicate that they are seen not as individuals with diverse needs but 'objects' that have minimal needs based mainly around physical care. It is not possible to get a clear picture of the level of physical care, given that observation took place in public areas only, but from the data it can be seen that Ted received 45 min of physical care during the first period of observation the highest recorded. Ted's WIB value is fairly evenly spread between + 1 and – 1 (Fig. 1 – January) indicating that he may show signs of well being for a time but, because of the lack of interaction, this tends to decline to ill being as the day progresses.

John shows an interesting pattern of behavior. His WIB value is predominantly + 1 which indicates a reasonable level of well being but if we consider his behavior categories (Table 2) it becomes clear that much of this well being is self generated. Categories 'F' (Food) and 'K' (Kum & Go) are the highest recorded and during the observation it was clear that he enjoyed his meals without involvement from care staff and appeared to get some satisfaction from walking up and down the unit's corridor and round the day rooms usually alone. He would interact with others when approached and sat for sometime with another resident who talked to him. His other main + 1 category was 'L' (Labour) when he would move furniture around or rub the carpet. This was seen as a problem by carers who continually replaced the chairs in their original position. One personal detractor was observed during this process when a carer called him a 'pest' without further interaction occurring. His behavior was seen as a nuisance rather than demonstrating a need by John for some form of activity. If an anti oppressive culture had been in place the need may have been identified and some stimulation given to John during the day. It is important to point out that personal detractors were few and, in the main, minor in nature. The one described about was the most serious observed.

The culture of care at the first observation period (Table 2) is clearly demonstrated by the high level of 'B' (Borderline), 'C' (Socially withdrawn) and 'N' (Sleep) categories which are unlikely to include input by care staff. Certain residents were allowed to sit without stimulation or sleep undisturbed for long periods of time during the day. The other main category relates to food and drink demonstrating the importance of this activity and was the central activity of care staff during the observation period. Certain other categories showed results of less than 10 units of time, or none at all and they include; engaging in expressive activity, games, handicraft and exercise, which may indicate the low priority given to these activities or worse the low value placed on such activities when caring for people with dementia.

It should be possible to bring about a measure of empowerment in all manner of small ways (Goldsmith 1996). They may include games, exercises or handicrafts for those who are able to participate but should always include verbal and nonverbal interaction even if the response is limited. These interactions need not happen independently of care but could become part of the care process. Given the high score that category 'F' (Food) obtained, this could be one area where anti oppressive practice could be developed, leading to some small measure of empowerment by giving residents choices around menu, where they sit, how long they remain at the table. During the observation, morning and afternoon drinks were brought round on a trolley, people were left with their tea or coffee and then the cups were collected with barely a word spoken to the residents involved. Could not this activity be made into an event which included choice of drinks interaction by grouping residents and talking to them during the time it takes them to drink their tea. People who needed feeding could be allowed to sit with others so that the carer could involve them in a group situation. During the observation there were several incidents of 'positive events' recorded revolving around feeding, these could be built on to develop a greater degree of integration and social involvement. As stated by Littlewood *et al.* (1997), 'all wards caring for older people [should] try to alter their perception of meal times from that of a busy practical task to that of a possible time for therapeutic interaction'.

Social interaction which did occur was usually fragmented in nature. Positive event recording contains a few examples of this, just one is considered here by way of example. It was felt that Alice enjoyed listening to music and she was placed beside a record player, which remained on for most of the day. At one point on the second day a carer asked Alice if she still wanted the music as she was looking agitated; rocking and mumbling. Alice, who was unable to communicate verbally, appeared to shake her head and the carer turner the music off. Alice almost immediately looked more relaxed, stopped rocking and sat back in her chair. The significance of this observation rests in the carers interpretation of Alice's nonverbal clues. The carer showed empathy for Alice by communicating with her and assessing her reaction to her environment. As a result Alice was given some control over her life and her care. Alice's WIB value is predominantly + 1 (Fig. 3) owing, largely to her ability to remain in category 'B' (Borderline) without signs of ill being. This situation could be used by the carers to provide a more diverse range of activities and social interaction for Alice. By the time of the second observation a small television had been placed near Alice and its use was monitored to ensure that Alice wanted to watch it. This change is reflected in the higher level of category 'M' (Media) in Table 3.

Once the process of change starts, hopefully, it would encourage further change both during and outside the care giving routine. It may be these care routines and rituals which reduce communication with residents (Martin 1998). Change may help to undermine such a culture of oppressive practice and give people with dementia choices about day-to-day activities as well as care outcomes.

July observation

It is, perhaps too big a jump to link small changes to empowerment but examination of the July results does show that following the feedback session in January improvements began to take place. Examination of Table 3 gives the clearest indication of this change. One obvious example is the lower category 'C' (Socially withdrawn) and the increase in categories 'A' (Articulation) and 'B' (Borderline), which could indicate that a higher level of communication between care staff and residents was observed. Categories 'E' (Expression), 'G' (Games) and 'M' (Media) are much more in evidence as a result of a programme of morning activities and this has shown improvements in a number of other areas. If we examine Ted's graph (Fig 1) we can see that + 1 value has increased from 49% of the time to 69%. From Tables 2 and 3 we can see that the time he is sleeping has dropped from 75 units to 33 units and category 'B' (Borderline) has increased from just 1 unit to 31. Some of the improvement may be as a result of the extra time spent during the lunch period (up from 9 to 24 units). He is no longer fed quickly by the care staff in his chair in the day room but is now brought to the table, given special utensils and allowed to feed himself. Even though he tends to drop food and use his hands, the care staff monitor his progress and encourage him to use a spoon or to place food so that he can reach it. When he spilt his pudding during the observation period, the care staff remarked that he was having a 'custard day', tidied him up and gave him more to replace the spilt food. On both Ted and Hatty's chart – 5 and – 3 no longer appear (Figs. 3, 4 – July). These were due, in January, to the 'degeneration rule' where behavior which lasts for a given length of time is classified at a lower level. The improvement in the July results show that interaction is now more regular and well being is, as a result enhanced. The three July graphs (Figs. 1–3) make it clear that + 1 remains the predominant WIB state but to a higher degree. This does not mean that there is no room for further improvement, but it gives a clear indication that there have been moves in the right direction by careers in this care setting. It is significant to note that no personal detractors were observed during this second set of observations.

Use of this observation tool and subsequent feedback session after each period of observation, may have highlighted the need to change the culture of care towards a more person centred approach. The 'Hawthorne effect' (Bradford Dementia Group 1997) cannot be ignored however, but as stated in the DCM manual this can be seen as a positive effect, 'the experience may provoke a care team to discover something of its hidden capabilities' (Bradford Dementia Group 1997). During the second period of observation residents were much more involved in the decision making, being offered a choice at lunch time or being allowed to opt out of activities if they wished. These small moves toward autonomy are signs that the practice is becoming less oppressive and the residents are empowered despite problems they may have with understanding and memory.

Conclusion

It is not possible to arrive at a conclusion which applies to diverse care settings given the sample size, however, it is clear from the results that a change of culture is underway in this care environment. If one compares the results from the July observation to those obtained in January a number of differences are evident, giving weight to this conclusion. To what extent this can be said to be lasting change is more difficult to assess. However, a further mapping completed the following January demonstrated that the improvements were maintained at that time. This will form part of an ongoing study to include larger samples in a variety of care settings. The DCM process, including the feedback sessions to the care staff, may have helped to bring about a refocusing of practice from one of mainly physical care to one which values the broader concept of 'person centred' care. The examples highlighted have served to link this change of emphasis to the level of communication and choice. This, it is argued, relates to resident empowerment by allowing a greater degree of participation in decision making, even if it means that the resident chooses not to participate. An understanding by the care staff of the ways that residents are able to make such choices has to take into account both verbal and nonverbal means of communicating. It can never be right to use the excuse of an oppressive culture of care to justify non participation by residents. Neither is it right to argue that people with dementia are unable to become involved in decision making because of their poor cognitive function alone. Careful assessment of need, involving the resident, utilizing such skills as empathy, advocacy and patience, can, if the result of this study are to be accepted, bring about an anti oppressive environment which is also, potentially an empowering one and this exercise could be seen to be the catalyst which brought about these improvements. Once the concept of change had been grasped by the care givers then a paradigm shift can occur in which carers, almost overnight, begin to see their practice differently (Moyes & Christie 1998). The important task now is to maintain the momentum for change by ongoing mapping exercises and staff education programmes to ensure that change is not only reinforced but also advanced. Oppressive practice will then, hopefully, become a thing of the past and empowerment of people with dementia enhanced as a result.

References

Beavis D. (1998) Personal detractions – a personal account. *The Journal of Dementia Care* **6**, 24–25.

Bradford Dementia Group (1997) 7th edn. The DCM Method. University of Bradford, Bradford.

Brooker D. (1995) Looking at them, looking at me. A review of observational studies into the quality of institutional care for elderly people with dementia. *Journal of Mental Health* **4**, 145–156.

Brooker D. & Payne M. (1995) Auditing outcomes of care in in-patient and day patient settings using Dementia Care Mapping. Can it be done? *PSIGE Newsletter* **51**, 18–22.

Bytheway B. (1995) *Ageism*. Open University Press, Buckingham.

Chapman A. (1993) Empowerment. In: *Dementia: new skills for social workers* (eds Chapman, A. & Marshall, M.), pp. 110–124. Kingsley, London and Bristol.

Dalrymple J. & Burke B. (1995) *Anti-oppressive practice: social care and the law.* Open University Press, Buckingham.

Foucault M. (1980) Two lectures. In: *Michel Foucault: Power/Knowledge, Selected Interviews and Other Writings 1972–77* (ed Gordon, C.), pp. 78–108. Harvester Press, London.

Foucault M. (1984) Nietzsche, genealogy, history. In: *The Foucault Reader: an Introduction to Foucault's Thought* (ed Rabinow, P.), pp. 76–100. Penguin, Harmondsworth.

Gibson C.H. (1991) A Concept analysis of empowerment. *Journal of Advanced Nursing* **16**, 354–361.

Gilbert T. (1995) Nursing: empowerment and the problem of power. *Journal of Advanced Nursing* **21**, 865–871.

Goldsmith M. (1996) *Hearing the voice of people with dementia: opportunities and obstacles.* Kingsley, London and Bristol.

Kieffer C. (1984) Citizens empowerment: a developmental perspective. *Prevention in Human Services* **3**, 9–36.

Killick J. (1997) Communication: a matter of life and death of the mind. *The Journal of Dementia Care* **5**, 14–16.

Kitwood T. (1995) Cultures of care: tradition and change. In: *The New Culture of Dementia Care* (eds Kitwood, T. & Benson, S.), pp. 7–11. Hawker, London.

Kitwood T. (1997) The concept of personhood and its relevance for a new culture of dementia care. In: *Care giving in dementia: research and applications*, vol. 2. (eds Miesen, B.M.L. & Jones, G.M.M.), pp. 3–13. Routledge, London.

Littlewood S., Saedi S. & Williams C. (1997) Mealtimes: a missed opportunity? *The Journal of Dementia Care* **5**, 18–20.

Marshall M. (1997) *The state of art in dementia care.* Centre for policy on ageing, London.

Martin G. (1997) Changing the culture of care for dying patients. *Professional Nurse* **12**, 498–500.

Martin G.W. (1998) Ritual action and its effect on the role of the nurse as advocate. *Journal of Advanced Nursing* **27**, 189–194.

Moyes M. & Christie H. (1998) Focus on each individual's experience and emotions. *The Journal of Dementia Care* **6**, 16–18.

Rafferty M. (1997) Mental health and the elderly. In: *Mental health nursing: from first principles to professional practice.* (eds Wright, H. & Giddey, M.), pp.177–190. Stanley Thornes, Cheltenham.

Mullender A. & Ward D. (1991) *Self-directed groupwork: users take action for empowerment.* Whiting and Birch, London.

Thompson N. (1993) *Anti-Discriminatory Practice.* Macmillan, Basingstoke and London.

Wilkinson A.M. (1995) Dementia care mapping: a pilot study of its implementation in a psychogeriatric service. *International Journal of Geriatric Psychiatry* **8**, 1027–1029.

Williams J. & Rees J. (1997) The use of 'dementia care mapping' as a method of evaluating care received by patients with dementia – an initiative to improve quality of life. *Journal of Advanced Nursing* **25**, 316–323.