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Title: Using the Embodied Self Methodology to Address Intersectionality through the Discharge of a Patient with Young Onset Dementia

Abstract

Background: Teaching nursing students to fully empathise with the important principles of diversity and intersectionality can pose a challenge for nurse educators. **Aim:** To improve student nurse's communication skills during complex discharge planning. **Method:** Through an interactive multi-professional team (MPT) role play, nurse educators incorporated principles of Cultural Safety, Embodiment, and Humanistic Learning Theory to draw students in a Return-to-Nursing Programme into fully participating in an experiential session to plan the discharge of a patient with Dementia. **Results:** Intersectional revelations which came to light included causation of moral distress, language usage, assumptions being made about the patient and carer, lack of inclusivity which students were then able to analyse further. **Conclusion:** Evoking compassionate leadership through this type of simulation supports students to learn and improve the care of vulnerable patients.

Keywords: Embodiment, Intersectionality, Dementia, Discharge Planning, Interprofessional Simulation, Cultural Safety.

Background: *Inclusion and Intersectionality*

Intersectionality underpins our understanding of cultures, other cultures and our own cultural beliefs and values, and it can lead to more targeted treatment interventions and policy changes (Wolf, 2017). Intersectionality can comprise some of the various social categorisations listed under the Equalities Act (2010) and more. Rather than considering social characterisations in isolation, intersectionality is interwoven and links to or several

features together. For examples; age with gender and race, ethnicity with disability and sexuality. Class, religion, and transsexualism. There are often wider intersectional features to an individual's identity and their lived experience which overlap. For more understanding behind the concept in relation to power and privilege dynamics, see Figure 1.

Figure 1: The Intersectionality Wheel (Simpson, 2009).



It is widely accepted that patient care should be person-centred and inclusive (Nursing and Midwifery Council, 2018). Therefore, incorporating sensitive conversations exploring the

intricacies of intersectionality within healthcare curricula is important, but lacking within the literature. Nursing students often struggle to integrate theoretical 'taught' knowledge with real life experiences or unconscious bias related behaviour when dealing with diversity in clinical practice (Arveklev et al. 2015). Norms that perpetuate exclusion can predominate within healthcare settings (Okenwa-Emegwa and Eriksson 2020) and this can lead to the formation of culturally and psychologically unsafe discriminatory attitudes amongst healthcare professionals (De et al. 2022). This unique paper contributes to the nursing literature by incorporating the embodied self-methodology into clinical simulation.

The true origins of intersectionality are rooted in black feminism and Critical Race Theory. In 1989, Kimberlé Crenshaw introduced the term intersectionality to address the marginalization of black women within not only anti-discrimination law but also in feminist and antiracist theory and politics. The way in which a Black, Asian and Minority Ethnic (BAME) individuals experience prejudices and how they disaggregate race from other characteristics such as their age or being female, however, is unique, as well as multifactorial. Intersecting what information is helpful to improve understanding of race is highly complex. It would be advantageous for health care students to become more self-aware of where potential biases exist. Hence, protected characteristics cannot be simply considered in isolation, but more holistically and intertwined. An example of this would be an older, black woman who has a disability. Similarly, in the case discussion of this paper, the corresponding intersectionality features include the presence of young onset Dementia as a diagnosis that caused disability, within the context of a mixed heritage and same sex partnership.

Intersectionality serves to highlight how the classifications can overlap, be layered and lead to varying, but unique degrees of marginalisation, discrimination, and oppression. As such, intersectionality is the opposite of privilege. Those experiencing intersectionality can be prone to vulnerabilities and microaggressions due to assumptions being made about them which restrict care options available (Cousins and Diamond, 2021). These biases can be witting, unwitting biases or institutional and impact on a patient's overall health outcomes. The authors felt, there needed to be better recognition of this by student nurses, especially those who had (in some cases) had a significant hiatus from clinical practice and were now Returning to Nursing Practice¹(RTP). These students might not have had exposure to People Living With Dementia (PLWD) or Young Onset Dementia (YOD) before their career break. It was therefore important that in line with the Healthcare Simulation Standards for Best Practice (INACSL Standards Committee et al. 2021) that the authors planned a learner-centred facilitative approach driven by the programme objectives. This was to promote confidence and regain competence based upon previous skills, knowledge, level of experience and anticipated learning outcomes. Research by the UK Council of Deans of Health, in collaboration with Anglia Ruskin University (2024) has highlighted how simulation in nurse education could transform learning in practice. Therefore, one such way of improving understanding by student nurses around intersectionality could be through such

¹ *Return to Nursing Programmes (RTP) are PSRB accredited level 6 programmes which feed into the UK Government's agenda around improving workforce planning and development. Compared to the cost and length of fully training a student nurse, RTP Programmes are shorter, cost-effective method of re-recruiting experienced nurses back into the profession by building back-up their confidence and clinical competence.*

pedagogy. This can involve methods such as the use of roleplay, actors, immersive room, manikins, virtual reality (VR) and computer programmes.

Aim: To improve student nurse's communication skills during complex discharge planning.

Dementia and Young Onset Dementia

Dementia is a progressive condition characterised by symptoms including memory loss, difficulty expressing language, impaired communication, and ability to reason effectively (Alzheimer's Society, 2023). It is estimated that there are 55 million people living with dementia worldwide (World Health Organisation, 2023). This number is predicted to reach 153 million in 2050 (Collaborators G.B.D.D.F, 2022). PLWD who are admitted to hospital are vulnerable due to increased cognitive impairment and confusion and are at heightened risk of morbidity and mortality. Caring for a person with dementia requires a patient, sensitive and emotionally intelligent approach (Sheard, 2015). However, poor outcomes could be influenced by negative stereotyping and inaccurate assumptions. Patients and carers can sometimes feel minoritized and outnumbered by the vast numbers of inter- health professionals involved in their care.

Dementia is a disability and hence is subject to the Equality Act (2010). Dementia is legislated as a cognitive disability (Lynch, 2020). Discharging a PLWD from hospital can sometimes feel premature, unsuitable, or unsafe if it is not to a place other than their own home (Alzheimer's Society, 2023). A significant number (16% of people with dementia in comparison with 1% people who do not have a dementia diagnosis) are discharged to a care

home (Bu and Rutherford (2018). As such, discriminatory practices are regulated against by the The Equality Act (2010) and the Human Rights Act (1998). Despite this, PLWD often do not have their disability rights met¹ and dementia stigma remains a global concern (Lynch, 2020).

Most people with dementia are aged above 65 years and as a result, it tends to be older PLWD who commonly feature as cases to study in nurse education (Adewuyi et al 2022). The authors however recognised that YOD in those below the age of 65 was often overlooked or attributed to something other/or rare. Nevertheless, YOD presentations are increasingly being seen clinically and it is estimated that people with YOD represent 10% of all dementia cases (Tan et al, 2019). Supporting people with YOD differs from the way in which older people with dementia receive care and support for their condition (Wong et al. 2020). To better equip families to enable people living with dementia to remain in their own homes through choice, a social and cultural shift by commissioning services is necessary. Healthcare professionals who advocate on behalf of PLWD who lack the mental capacity to consent, need to be educated appropriately to ensure decisions are made in the person's best interests (Mental Capacity Act, 2005). Moreover, PLWD might also be subject to other forms of intolerance secondary to other aspects of their identity such as race, sex, age, or sexual orientation. The World Health Organisation Global Action Plan (2023) for dementia stipulates that dementia care needs to be culturally sensitive, and required to address age, gender, and disability factors. The authors recognised the need for nurse education to incorporate the aspects of cultural safety and a scenario was created to support such.

Method: Centring Learning Upon Dementia Care and Management

The authors incorporated the principles of the embodied-self pedagogy to promote deeper appreciation of the multifaceted concept of intersectionality, using experiential methods to create a virtual multi-professional case conference. Absence of a male facilitator set to play the patient's husband left the remaining two female facilitators with a void to fill. This provided the opportunity to review and contemporise a written scenario to promote intersectionality, yet still maintain the original learning outcomes of students facilitating a safe discharge. Challenging stereotypes, professional attitudes, discriminatory behaviour, and language nuances formed the basis of the learning objective. The authors embarked upon adapting an existing traditional family set up to create (through a peer review process) an emotive and contemporary simulated case conference scenario. It involved a modern family that would challenge assumption that care should not be the same for all. Instead, a more person and family centred outcome was envisaged for students to reach. A 'traditional' family scenario was adapted to portray a younger, mixed race, same sex couple. The couple, one of whom was living with YOD, faced an uncertain discharge from hospital. To support student learning and guide professional decision making, the following discharge outcomes were provided to the students to select which would in Jenny and Carlinda's best interest. Students unanimously opted for Jenny to be set up with below option 1.

1. The service user remains in their own home, and people visit on a regular basis to undertake a range of adaptations and tasks. In the UK, this is called **domiciliary care**.
2. The service users' home is adapted and remains in their own home, and their significant other takes on caring responsibilities as a **full-time paid carer**.
3. The service user remains in their own home, but other people move in to help look after them on a rota basis of 2 - 4 carers. This is called **live in care**.

4. The person goes into a care home, where they have their own room, and the staff provide all care and all services such as meals and laundry. This is called **residential care**.

5. The person lives independently with security of tenure and have care services arranged according to need. This is called **housing with care**.

Both authors are active members of the Diversity, Equality, and Inclusion (DEI) Committee, so they were able to draw upon their own intersectional attributes and build-in to the scripting and improvisation. A traditional heterosexual couple scenario was then adapted to portray a younger, mixed heritage, same sex couple that did not have any access to support from family living nearby. Challenging stereotypes, professional attitudes, discriminatory behaviour, and language nuances formed the basis of the learning objectives. Enhancing emotional intelligence and compassionate leadership was achieved through supporting a vulnerable patient, as well as their exhausted partner and carer.

Outcomes

Student Engagement

As is often the case with participatory learning, there was some initial reluctance to the idea of simulated role play by the students. Nonetheless, the roles of a meeting Chairperson, nurse, doctor, dietician, physiotherapist, social worker, fall prevention team representative were eventually taken up. Again, the Healthcare Simulation Best Practice Standards (INACSL Standards Committee et al. 2021) emphasis on pre-briefing proved instrumental with this. A live boardroom discharge planning meeting then ensued. Topics such as employer harassment, carers rights, financial constraints and dealing appropriately with witting and

unwitting prejudice uncovered a host of additional considerations that the small groups of learners could explore. As the MPM ensued, emotional intelligence and compassionate leadership naturally evolved between all the participants, and not just for the Chairperson. This surpassed what the facilitators set out to achieve alongside better appreciation of intersectionality.

Table 2

Stanislavsky's method of embodiment

The session facilitators desired to create an authentic experience for the students to embolden them to fully engage in the role play. Had the facilitators simply recited from a script from the perspective of 'educator', the students would respond from the viewpoint of being a 'student'. To enhance understanding through experience, the aim had to be different so students could embrace the role 'as if' they were a qualified healthcare professional, who were part of a MPT. Konstantin Stanislavsky, actor, and theatre practitioner's method involves internalising the motivations and emotional states of the character (Clare, 2017). Actors envisage themselves in the circumstances of the person they portray, responding authentically to the context of the setting and to those around them. This involves using their own inherent attributes; physical, mental, and emotional, encouraging them to draw on their own personal experiences or 'emotional memory' to create a transitory 'situational self' (Kemp, 2013). The facilitators adopted the role of a same sex, mixed race couple, one of whom was living with YOD, using principles of Stanislavsky's seminal method (Clare, 2017).

In this case, the facilitators were able to employ their own intersectional attributes (as mixed race) as well as their affective memory of experiences, to respond emotionally and

184 authentically as 'Jenny' and 'Carlinda'. They immersed themselves in the inner world of the
185 character, 'embodying' their roles rather than 'performing' them. Moulage and appropriate
186 attire for Jenny and Carlinda were sensitively incorporated to enhance authenticity. For
187 example, Jenny had sustained a broken hip from a fall in her garden. She was in the hospital
188 at the time of the MPT meeting and she wore a good quality nightgown. As she was slightly
189 older than the actor playing her character, a tasteful and realistic wig was worn in addition
190 to dark colour make-up applied under the eyes to depict someone who was more tired than
191 usual. This, in turn, helped the facilitator to embody the role more effectively. It was
192 important that any enhancements avoided being excessive or exaggerated, as this would
193 have been indelicate and considered 'poor taste'. Furthermore, it would have perpetuated
194 stereotypes and homogeneity about people with dementia all being a certain age. Hence,
195 going against what the facilitators set out to achieve.

196 'Jenny' had the experience of confusion, sadness, and frustration throughout the meeting.
197 As a librarian who normally interacts with people daily, she felt somewhat marginalised by
198 the discussion going on around her and intimidated by the unfamiliar faces and articulate
199 expressions. Use of 'jargon' from the healthcare professionals in the meeting caused her to
200 misinterpret what was being said. There was an overwhelming feeling of not being
201 'present'. She was distracted from the conversation and became disengaged. Momentarily
202 she would feel part of the discussion, if a member of the group addressed her by name and
203 invited her to comment. Otherwise, there was the general feeling of being disregarded,
204 despite the meeting being about her. 'Carlinda' on the other hand was much more astute
205 and wary of the MPT and their lines of questioning. However, she was also self-conscious
206 about her overseas accent, skin tone and history of previous mental illness being brought
207 up. 'Carlinda' frequently became overprotective of Jenny and was often defensive about

208 their relationship, finances, her immigration status being checked, and their social situation.
209 As a proud career driven engineer, with good economic earnings, Carlinda was experiencing
210 guilt of not being able to fully care for her partner. As the scenario ensued, 'Carlinda'
211 divulged this toll of working late and long hours and the imbalance between this and being a
212 full-time carer (with little to no support). By the close of the scenario, Carlinda became
213 receptive and warmed to the idea of supplementary services being offered. Eventually,
214 implementation of a home assessments was agreed to.

215 Students responded to 'Jenny' and 'Carlinda' in different ways. Stanislavsky's method asks
216 the question: 'What would I do if...?' (Moschkovich, 2023). This is addressed by
217 corresponding action as opposed to descriptive accounts of an abstract scenario. Within the
218 session, students were asked to respond physically and verbally 'as if' they were actual
219 members of the MPT, in the presence of the patient and family, discussing the safe
220 discharge of the person. This involved employing the use of appropriate non-verbal
221 communication such as gestures, posture, non-threatening body language, active listening,
222 and polite inclusion of the patient in the discussion. Students were able to draw on their
223 own skills in emotional intelligence to tactfully respond to some of Jenny's
224 misinterpretations and to Carlinda's sometimes exasperated demeanour.

225 Clare (2017) likens the Stanislavsky method to the more recent theory of embodied
226 cognition, which denotes that human thoughts are shaped by the body's physical
227 interaction with our surroundings. Cognition is determined by the setting or context (Gomez
228 et al. 2017). The way we think, and process information involves conceptual simulations that
229 include sensory and motor mechanisms (Robinson and Thomas, 2021). In relation to the
230 MPT session, students were not asked to merely discuss the factors that 'might' be present

231 in relation to the hospital discharge scenario, as would be a traditional classroom format.
232 Rather, students were asked to take on the roles and participate in what 'was' happening in
233 real time. A valuable component to the session was the debriefing that followed afterwards,
234 with Jenny and Carlinda shedding their embodied persona, to share with the group their
235 thoughts and feelings in relation to their lived experience in the moment. The authors
236 acknowledge that Return to Practice nursing cohorts tend to be low and with current
237 recruitment being an issue, low numbers may impact upon being able to cover all the roles.
238 On the other hand, staffing resources might prove difficult with larger cohorts of learners.
239 One of the main biases from the scenario was that students were familiar with the staff
240 member playing Carlinda. Nonetheless, the debrief included students disclosing that the use
241 of 'jargon' was confusing and that 'talking about but not with' Jenny led to the feeling of
242 exclusion and subsequent disengagement. One student expressed their concern that Jenny
243 should not have been present during the MPT. Or at least, should have remained for only a
244 short duration due to them witnessing episodes where Jenny clearly became distressed. This
245 led to a wider conversation about inclusion, shared decision making and in the point of view
246 held by people with dementia of; 'no decision about me, without me,' (Ong, 2021).

247 ***Student Evaluation***

248 The nine students who participated in the session were asked to provide feedback
249 anonymously via an online survey. In response to being asked the question, "Do you feel
250 that the simulated role-play was a helpful way of learning?", all nine responded "Yes".
251 Participants were also asked, "What new learning did you take away from the session
252 today?". We received rich data in response to the questions, however as no ethical review

253 was sought prior to the session we are unable to include verbatim comments. However, the
254 main learning points reported by students are summarised in the text box below.

255 Table 1: Summary of RTP student feedback

1. It is essential to be organised prior to inviting the patient and Carer into the MDT meeting, ensure they have been introduced to all participants and are informed of what to expect.
2. It is important for members of the MDT to be prepared in advance; and then to communicate and work collaboratively.
3. Patients and family members should be included in all the discussions. Never assume the patient will recognise all the health care professionals in attendance; introductions are necessary.
4. A good understanding of the patient's medical history and mental capacity is essential so communication can be pitched at the correct level to effectively manage pertinent issues.
5. Holistic discharge planning is important.
6. Avoid the use of jargon or abbreviations as this is confusing for non-healthcare professionals. It is essential to minimise potential distress, as the meeting may feel intimidating and overwhelming for patients and families.
7. A person-centred approach is essential. This involves planning for complex discharges with respect for the person involved and ensuring decision-making is shared and informed.
8. Risks should be 'managed' rather than avoided entirely when working with people living with dementia.

9. Inclusion is important; ensure patients and families do not feel overwhelmed by what is happening. Although challenging, we need to try to make the experience for them more positive.
10. The roleplay enhanced understanding of the different professional roles.
11. It is important to respect and seek to understand the perspectives of patients and relatives.

256

257 The question asked was intentionally open, to elicit honest responses from students and to
258 determine what elements they found most useful from participating in the simulated
259 session. Most participants (N=7) mentioned communication in their response. Other
260 responses (N=3) included elements of inclusivity and holistic care/person-centredness.
261 Other learning divulged by students included organisation, discharge planning, managing
262 emotions and managing risk. All responses can be viewed as compassionate, and it was clear
263 to see how the students were able to empathise with Jenny and Carlinda during the
264 scenario.

265 **Limitations and recommendations for Nurse Education**

266 A limitation was that both the actors involved provided the verbal pre-briefing. This meant
267 students were pre-empting involvement by the same staff members once the scenario
268 commenced. In future, the Programme Leader (uninvolved in the scenario) would provide
269 the preamble, so staff playing patient and partner would arrive in character at the start of
270 the meeting. A further limitation is that an understanding of the different multidisciplinary
271 roles relied upon the knowledge of nursing students who had been briefed and asked to
272 explore this prior to the session. One might consider that inconsistencies and errors might

273 result from limited preparation. This may contribute to roles being misinterpreted and
274 misrepresented. The authors propose to explore the interprofessional elements further by
275 inviting allied health care students to take on some of the interdisciplinary scenario roles in
276 the first instance. This would add more authenticity to the scenario.

277 This was the first evaluation of the educational session, which can be amended and
278 improved upon according to feedback. In future it would be helpful to formalise this session
279 as a research study, in which greater depth of qualitative data can be elicited, coded, and
280 thematically analysed. It would be important to consider that there are likely multiple
281 learning outcomes that may be derived from this session. Capturing these more formally
282 would be beneficial to planning future nurse education.

283 There is increasing evidence emerging about the effectiveness of clinical simulation to
284 enhance culturally competent nursing care (Ozkara San, 2015). Professional Statutory
285 Regulatory Bodies are placing more emphasis upon the inclusion of such as in *future nurse*
286 proficiencies as part of contemporary learning (Nursing and Midwifery Council 2018,
287 Okenwa-Emegwa and Eriksson 2020). A didactic pedagogical format would only have
288 offered a verbal description of an abstract scenario which does not offer optimum
289 development of emotional intelligence or interpersonal skills. Interprofessional-simulated
290 learning like this promoted inclusivity yet could be more transformative and culturally safer
291 by including healthcare students from other programmes.

292 Being able to flip the scenario format offered flexibility in learning. Regardless of whether
293 live virtual or face to face student learning was evident, from the engagement with the
294 session and discussion afterwards. It was still possible for all actors to notice subtle
295 expressions and other forms of non-verbal communication and equally detect intonation. In

296 fact, to a certain extent this may have been more heightened when there was closeness of
297 the faces on the screen monitor. The participants in the MPT- both students and educators
298 shared in a values-based 'experience'. When Jenny became slightly tearful during the
299 meeting, students responded authentically.

300 It was recognised that these important considerations were learned through engagement
301 with the role-play, as an experiential exercise, rather than a didactic format that would only
302 offer a verbal description of an abstract scenario. RTP students were able to demonstrate
303 and augment higher level interpersonal interactions by using inter-professional curiosity to
304 ensure the best outcomes for Jenny and her partner were mutually reached. At the same
305 time, it is acknowledged that this type of approach will not be acceptable to all learning
306 styles or groups. According to Kolb (1984), 'convergent' thinkers tend to do well with
307 practical or technical tasks, decision making and problem solving. Hence, students in this
308 category prefer structure and may not necessarily welcome the experiential nature of the
309 session. Likewise, 'assimilators' adopt a clear and logical approach, with a preference for
310 abstract theoretical concepts rather than creating connections with people. This type of
311 learning would more likely be accepted by what Kolb (1984) described as 'divergent'
312 thinkers or those with an 'accommodating' learning style. Divergent thinkers are said to be
313 sensitive and have the capacity to use imagination and consider different perspectives.
314 Likewise, those with 'accommodating' learning styles lean towards the intuitive as opposed
315 to logical, are flexible and adapt well to change. Experimentation and 'learning by doing' is
316 valued. D'Amore et al (2012) found that student nurses are more likely to combine 'diverger'
317 and 'assimilator' and 'accommodating' learning style and are less likely to be 'convergent'
318 thinkers.

Finally, it would be relatively easy for nurse educators to replicate this exact scenario in other institutions and adapting it for different learner groups. As a means of developing emotional intelligence further, it would also be easy for nurse educators to adapt the scenario, choose differing designated roles and incorporating differing overlapping protected characteristics to suit their programmes inter-professional learner's objectives. To draw out more diverse aspects around assumed cultural thinking and cultural safety, the authors have proposed that during the next run, Jenny will be played by a colleague to portray her as a black, female patient with YOD. This, it is felt would make the scenario become more in-line with Crenshaw's (1984) seminal definition of intersectionality.

Conclusion

An innovative simulated multi-professional meeting based upon the principles of the 'embodied self' has been presented. Several intersectional revelations came to light which students were then able to analyse with facilitators more critically. This evoked cultural safety and compassionate leadership in a small group of RTP student to enable a vulnerable patient with dementia to experience a safe discharge back to their family home.

This paper provides guidance for nurse educators who may be interested in implementing similar interventions with learners. The simulation described could easily be replicated, adapted, and applied in different educational or clinical settings. It has been successfully implemented live face to face, within a standard classroom yet works just as effectively via a virtual medium. Depending on staff resourcing, the scenario could also be run simultaneously across several venues to accommodate larger cohorts of students.

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