Ageing & Society (2019), **39**, 2653–2670
doi:10.1017/S0144686X18000685

ARTICLE

How figurative language may be related to formal care-givers' person-centred approach toward their patients with dementia

Miriam Ethel Bentwich[1]*, Ya'arit Bokek-Cohen[2,3] and Nomy Dickman[1]

[1]Faculty of Medicine, Bar-Ilan University, Safed, Israel, [2]Academic College of Administration, Rishon Le-Zion, Israel and [3]Mofet Institute, Tel-Aviv, Israel
*Corresponding author. Email: Miriam.Bentwich@biu.ac.il

(Accepted 18 May 2018; first published online 17 July 2018)

Abstract
Person-centred care that respects a patient's personhood is the gold standard in dementia care, which is often difficult to achieve given the complexity of caring for people with dementia. This article delves into the narration style of formal care-givers from a variety of ethno-cultural backgrounds in search of linguistic cues that may be related to their emphasis on a person-centred approach to care. A qualitative study, using a discourse analysis of semi-structured interviews with 20 formal care-givers in an institutional setting, was employed. The care-givers fell into three groups: Arabs, immigrants from the former Soviet Union (IFSU) and Jews born in Israel (JBI). Our results show 20 figurative language expressions (FLEs) in the narratives of the JBI care-givers and 11 among the IFSU care-givers. In contrast, the Arab care-givers conveyed 48 FLEs. Many of the Arab care-givers' FLEs were not associated with the 'regular' domains articulated by other care-givers (family, children, militaristic language) and were primarily individual-focused, emphasising the personhood of the patient. These findings, together with relevant theoretical literature, suggest that the extensive use of figurative language by Arab care-givers may be a possible tool assisting these care-givers to employ a person-centred approach, manifested in their stress on the personhood of the patient. Such tools may be useful for better achieving person-centred care for these patients.

Keywords: person-centred care; dementia; figurative language; personhood; formal care-givers

Introduction

Recent decades have witnessed a growing number of patients with dementia, attributed with heightened dependency, as well as an increase in the complexity of their care (Baillie *et al.* 2009; Cohen-Mansfield, Garms-Homolová and Bentwich 2013; Kada *et al.* 2009; Örulv and Nikku 2007). Patients with an advanced stage of dementia often cannot recognise others and therefore are reluctant to co-operate with them (Simard and Volicer 2010). Accordingly, The World Health Organization (WHO

2012) has declared, as a public health priority, attending to these patients in a professional manner that is respectful of their personhood and dignity.

The employment of multicultural care-givers who are responsible for older adults in need of care is increasingly prevalent. In Europe and Canada, for example, the population of home attendants is comprised mainly of labour immigrants from Africa, Eastern Asia, the Middle East and Eastern Europe (Cohen-Mansfield, Garms-Homolová and Bentwich 2013; Ireland 2011; Martin *et al.* 2009; O'Shea and Walsh 2010; WHO 2012). Yet, much of the literature on the human dignity of older adults and of older adults with dementia has either overlooked possible cultural differences between formal care-givers or denied the existence of such differences (Ariño-Blasco, Tadd and Boix-Ferrer 2005; Tadd, Vanlaere and Gastmans 2010; Woolhead *et al.* 2006).

Against this backdrop, we have already published a mixed-methods study that probed whether or not formal care-givers from a range of cultural backgrounds differ in their respect for the dignity of patients with dementia. The study emphasised the potential Arab formal care-givers may have for demonstrating care of patients with dementia that is more respectful of these patients' human dignity, especially compared with care-givers from the former Soviet Union (Bentwich, Dickman and Oberman 2016). It was argued that stronger support for the different attributes of human dignity and autonomy reflected a more holistic viewpoint of patients with dementia, depicting them as whole human beings by acknowledging their personhood, manifested in their own wishes, perceptions and emotions, which should be respected to the greatest extent possible. We have, therefore, suggested that Arab care-givers' emphasis on the dignity and personhood of patients with dementia may be interpreted as reflecting a person-centred approach, thus laying the groundwork for person-centred care (PCC).

Thus, *personhood*, particularly in patients with dementia, was presented by Tom Kitwood as 'imply[ing] recognition, respect and trust' (1997: 8), which has much to do with acknowledging the uniqueness of persons (1997: 20). In a similar vein, based on a recent literature review regarding PCC, its six main components were identified, amounting to setting the focus of care on the person being treated, thereby necessitating the need to know and empower, as well as forming a relationship of trust and respect with this person (Sharma, Bamford and Dodman 2015). These components also imply the need for giving primary attention to the subjective perspective of the person living with the disease, by establishing a therapeutic relationship based on shared power and responsibility between the care-giver and the patient, which is achieved through open communication between them (Edvardsson, Fetherstonhaugh and Nay 2010). Therefore, PCC, setting the focus on the person being taken care of and his or her subjective perspective, is based on respecting the patient's personhood. In other words, PCC is based on a *person-centred approach*, placing the patient with dementia's personhood at the centre of the care-giver's attention and focus of care.

However, in our previous study, we were unable to suggest explanations for the differences between the care-givers from different cultural backgrounds. Furthermore, in the absence of possible explanations, our ability to identify differences in the conceptualisation of dignity among these care-givers is rather limited. In contrast, the ability to understand the possible source underlying the more robust perception of Arab care-givers regarding the human dignity of their patients with dementia, which is manifested by an emphasis on their personhood, may apply to all care-givers of people with dementia.

A possible source for the differences we found between the varied ethno-cultural groups of care-givers could be related to the link between the use of figurative language and empathy. Some studies associated the existence of an imaginative capacity and the ability to enhance the capacity to imagine with the use of *figurative language*, both of which are mainly manifested in the use of metaphors and similes (el-Aswad 2014; Lakoff and Johnson 1980; Nelson 2012; Ryman, Porter and Galbraith 2009). A metaphor is 'the application of a word or a phrase to an object or concept it does not literally denote, in order to suggest comparison with another object or concept' (Urdang and Flexner 1969: 840). The imagination in human thought provides a fertile breeding ground for the evolution of stable knowledge structures (*i.e.* metaphors, similes), thereby depicting the use of figurative language as reflecting the capability to imagine (Lakoff and Johnson 1980). Similarly, the capability to imagine has been found to be enhanced through the use of figurative language, as in the case of using similes and metaphors while writing essays, which has been shown to kindle a writer's imagination (Nelson 2012).

At the same time, the ability for empathy may be related to an enhanced imaginative capacity. *Empathy* is the ability to genuinely understand someone else's personal experiences, emotions and view of the world; the ability to empathise is thus grounded in cognitive and emotional competencies (Davis 1994). The care-giver should have empathy for the patient by understanding the situation, perspective and feelings of the patient, communicating that understanding and verifying its accuracy with the patient, as well as acting on that understanding toward the patient in a helpful way (Hojat 2016; Mercer and Reynolds 2002). In other words, the empathetic care-giver of patients with dementia may be said to respect the personhood of each of those patients. What is common to most definitions of empathy is the focus on the *empathiser's ability to imagine* either the patient in another mental and/or medical condition or him- or herself in the patient's situation. This view corresponds to the teachings of Titchener, the British psychologist who introduced the term 'empathy' to English (Titchener 1909). Hence, an enhanced capacity for imagination among care-givers of patients with dementia may be an important tool that enhances the ability of these care-givers to empathise with and respect the personhood of patients with dementia, manifested by a person-centred approach, leading to PCC.

Purpose and scope

In the current study, we returned to the qualitative portion of the research, in which 20 care-givers from a variety of ethno-cultural backgrounds were interviewed (in Hebrew; *see* further details in the Design section that follows): immigrants from the former Soviet Union (IFSU), Jews born in Israel (JBI) and Arabs. We searched the care-givers' verbal patterns for potential links between respect for the personhood of patients with dementia and the care-givers' use of figurative language.

The focus on these particular ethno-cultural groups of care-givers stems from two reasons. First, the three ethno-cultural groups we chose to focus on constitute the majority of care-givers within institutional settings in Israel. Second, and no less important, these groups appear to exhibit different cultural attributes potentially pertaining to the current study. A culture consists of sets of values, beliefs and habits constructed and reconstructed in social interaction, which form the worlds of ideas, perceptions and decisions, as well as how individuals act. Hence, each care-giver has his or her own collection of cultural values, which is brought into the caring interaction with the patient (Doswell and Erlen 1998; Rassin 2008). Notice that this definition does not imply that the cultural values a care-giver carries with him or her are static. Indeed, culture is regarded as a dynamic construct that changes with time, whether on the macro- or micro-level (Boyd and Richerson 1985; Henrich and McElreath 2003; Inglehart and Baker 2000; Kashima 2008, 2014).

Historically, the Arab community in the country is a traditional society based on the principles of kinship and respect for older adults as wise and valuable community members (Al-Haj 1995). In contrast, Israeli Jews are characterised by Western individualistic values that tend to marginalise older adults (Al-Haj 1995; Lavee and Katz 2003). Indeed, it seems that the important familial role and the satisfaction of older adults with their status and care in this sector are still more pronounced than in the Jewish society (Katz and Lowenstein 2012). A more recent study, regarding nursing students in Israel, revealed that, in comparison with their Israeli-Jewish counterparts, Arab nursing students are more willing to take care of older adults in need of care (Zisberg, Topaz and Band-Wintershtein 2015). Finally, another interesting study, with respect to hospital nurses caring for older adults who were bedridden, revealed that Israeli-Jewish nurses who immigrated from the former Soviet Union reported using more physical restraints than other Israeli-Jewish nurses (Iecovich and Rabin 2013). Hence, nurses who immigrated from the former Soviet Union were less concerned with respecting the autonomy of these older adults, entailed in acknowledging their humanness.

Design and methods

Design

We embarked on a qualitative research study that explored the attitudes of informants toward the human dignity of patients with dementia using semi-structured interviews (Lincoln 1995; Miller and Crabtree 1994). The informants were presented with two vignettes about care-givers and asked to express their opinions about the behaviour of those care-givers. We used the 'one shot case study' in which 'a group is studied only once, after some agent or treatment presumed to cause change' (Campbell and Stanley 1966: 6–7). All interviews, which were conducted in Hebrew, were audiotaped and transcribed; however, the interviewers also spoke the native language of their informants. This way, if the informant did not understand some sentences or words in the interview guide, the interviewer could immediately translate them into the informant's first language.

It should be emphasised, though, that in general, the interviews did not require translations, *i.e.* there were few instances in which the translation was required, and even then, it was mainly regarding a single phrase/word. In this respect, it should also be noted that the interviewers were specifically instructed to probe for implied difficulties in language expression by the informants. In cases where the

Table 1. Occupational/cultural background of informants

Cultural group	Fictional name	Profession	Gender	Institution type	Years in job
Arab	Muhamad	Nurse	Male	Hospital	13
Arab	Amir	Nurse	Male	Hospital	11
Arab	Juwaher[1]	Nurse	Female	Nursing home	8.5
Arab	Rulla	Nurse's aide	Female	Hospital	6
Arab	Jasmin[1]	Nurse's aide	Female	Nursing home	30
Arab	Christine	Occupational therapist	Female	Hospital	3
Arab	Ahmad	Physiotherapist	Male	Nursing home	13
IFSU	Mira	Nurse	Female	Hospital	8
IFSU	Ina	Nurse	Female	Nursing home	16
IFSU	Oxana	Nurse's aide	Female	Hospital	10
IFSU	Yivgenia	Nurse's aide	Female	Nursing home	20
IFSU	Svetlana	Nurse's aide	Female	Nursing home	20
IFSU	Ana	Occupational therapist	Female	Nursing home	17
JBI	Liat	Nurse	Female	Hospital	12
JBI	Noa	Nurse	Female	Hospital	23
JBI	Isaac	Nurse	Male	Nursing home	26
JBI	Shani	Nurse's aide	Female	Hospital	10
JBI	Neta	Nurse's aide	Female	Nursing home	22
JBI	Merav	Occupational therapist	Female	Nursing home	30
JBI	Shoshana	Occupational therapist	Female	Nursing home	15

Notes: 1. Arab care-givers who are Christians; the rest are Muslims. IFSU: immigrants from the former Soviet Union. JBI: Jews born in Israel.

interviewers sensed such difficulties, they were directed to encourage the informants to express their thoughts using their native language, and the interviewer will also serve as a translator. However, as noted above, there were only scarce instances where the informants wished to use this option and, even then, mainly with respect to a single phrase/word. Furthermore, as Table 1 shows, most of the interviewed care-givers had more than five years of work experience, with the majority having tten years or more. This fact is particularly important regarding care-givers who were immigrants from the IFSU, most of whom had ten or more years of experience (with only one having eight), as it means that they were hardly 'new immigrants' to the country. Finally, turning to the Arab care-givers, as our results show, despite the fact that Hebrew is not their native language, their use of figurative language surpassed the Jewish care-givers who were born in Israel (JBI) and for whom Hebrew was actually the native tongue.

Sample

We applied stratified purposeful sampling (Onwuegbuzie and Collins 2007), by which we divided the sampling frame into strata of types of persons providing patient care, in order to obtain relatively homogeneous sub-groups. We recruited 20 experienced care-givers attending to patients with dementia. These care-givers were nurses, nurses' aides, occupational therapists and physiotherapists, employed either in nursing homes or hospitals in the northern region of Israel. The ethno-cultural background of the informants was diverse: seven were Arabs, six were IFSU and seven were JBI. Table 1 presents their demographic and professional information.

The process of recruiting these care-givers included two stages. First, either the head nurse or the facility's manager was asked to provide a list of care-givers who fit the professional and ethno-cultural profile we were looking for and have had at least three years of experience in the job (and preferably above five years of experience). In the second stage, we approached these care-givers directly, without the presence of any administrator or other authority figure, and asked for their permission to be interviewed, after explaining our research goals. Overall, we reached approximately 25 potential informants, of whom 20 gave their consent to participate. While the interviews were conducted at the workplace and during the working hours of the care-givers, they took place in a private room that was designated for this purpose, so that, during the time of the interview, only the interviewer and the informant were present.

Method

This study offers a *secondary analysis* of the data gathered in the interviews, focusing on the figurative language employed by the care-givers in the course of the interviews, in order to reveal possible differences in their narration styles. Accordingly, the data analysis technique used here is based on *discourse analysis*. *Discourse* is conceptualised here as a set of meanings, metaphors, similes, representations, images and stories (Burr 2015). Discourse analysis offers a way to scrutinise the 'orderly ways of talking, with which individuals account for and make sense of themselves and their social worlds' (Shotter 1993: 35). A key concept of discourse analysis is that human beings use language to build versions of their social world. This language does not merely revolve around neutral means by which people express themselves but is constitutive (Davies and Harré 1990; Wetherell 1998). Hence, by focusing on discourse components such as metaphors and similes, discourse analysis may reveal how complex identities are constructed and reconstructed through the use of language. In other words, discourse analysis may reveal more hidden layers of identity that are not communicated in an explicit verbal manner but rather in an implicit manner through the particular use of lingual expressions chosen by the speakers (or interviewees in our case).

The interviews were designed to assess the care-giver's perspective on human dignity indirectly, to minimise the chances of social desirability. Hence, each informant was presented with two typical but detailed vignettes describing everyday situations faced by care-givers of patients with dementia (*e.g.* bathing patients or helping them to do so, administering medicines to patients, taking them to the dining hall). This method also follows previous research aimed at exploring the concept of autonomy among formal care-givers of older adults in need of care (Collopy 1988; Mattiasson and Andersson 1994; Mattiasson *et al.* 1997). After each vignette was presented, the informant was requested to share his or her impression of the hypothetical care-giver and to express an opinion based on one's own experience. Subsequently, the informant was asked to reflect about everything that the care-giver in the vignettes had said and done.

To expose the metaphors and similes in the transcribed interviews, as well as extract key themes expressed by these metaphors and similes in a trustworthy manner, a two-layer interactive interpretation exchange process between the researchers was applied. The first layer revealed the metaphors and similes through a constant mutual scrutiny regarding the interpretation offered by the researchers, so that any personal bias of a single researcher would be minimised. When the researchers disagreed over whether or not a certain expression indeed constituted figurative language, the researchers discussed it until they arrived at an agreement. The second layer revolved around examining whether key themes of the figurative language expressions (FLEs) exposed in the first layer could be extracted. In this stage, once again, a mutual scrutiny process was applied. When there was disagreement over the thematic interpretation of the FLEs, the researchers engaged in discussions until an agreement was reached.

Ethical approval

The study was approved by the research ethics committee at the Faculty of Medicine in which the first author is employed (approval #61-2013) and by the research ethics committee of the hospital involved in the study (approval #2013-5671). Ethical standards of conducting social sciences research involving human subjects were followed. We presented the potential informants with an informed consent form, prior to the interview, and verified their willingness to undergo an interview, together with an emphasis that they may refuse to do so, without giving reason for their refusal. We ensured the confidentiality of the informants by using fictional names in the transcriptions and in this paper, by removing any identifying information that could jeopardise the confidentiality of our informants, and by refraining from disclosing the names of nursing homes and hospitals that participated in this study.

Results

Our results show substantial differences among Arab, JBI and IFSU care-givers. In what follows, we highlight the main differences. We begin by asserting the

Table 2. Number of figurative language expressions (FLEs) and number of FLEs in the three domains per informant

Cultural group	Fictional name	Number of FLEs	Number of FLEs in the three domains[1]
Arab	Muhamad	12	0
Arab	Juwaher	10	1
Arab	Amir	8	1
Arab	Rulla	6	1
Arab	Christine	5	0
Arab	Ahmad	5	2
Arab	Jasmin	2	0
IFSU	Mira	1	1
IFSU	Ina	1	1
IFSU	Oxana	6	5
IFSU	Yivgenia	1	1
IFSU	Svetlana	0	0
IFSU	Ana	2	2
JBI	Liat	1	0
JBI	Noa	4	1
JBI	Isaac	3	1
JBI	Shani	1	0
JBI	Neta	3	3
JBI	Merav	3	2
JBI	Shoshana	5	2

Notes: 1. Militaristic language, small children and family. IFSU: immigrants from the former Soviet Union. JBI: Jews born in Israel.

quantitative differences in the use of FLEs among the Arab, IFSU and JBI care-givers and then proceed to the thematic aspects of these differences. The thematic aspects of the differences are then further interpreted in the Discussion section that follows.

The number of utterances reflecting the use of FLEs proved highest among Arab care-givers. Twenty FLEs were found in the narratives of the seven JBI care-givers, 11 appeared in the narratives of six IFSU care-givers but there were 48 among the seven Arab care-givers. As Table 2 shows, among JBI care-givers, the instances of FLEs per care-giver range from one to three, and the highest number of FLEs per care-giver reached five (in the case of Shoshana). Among the IFSU care-givers, the number of FLEs per care-giver ranges from one to two, with only one care-giver (Oxana) having six FLEs. In contrast, among Arab care-givers, except for a single care-giver (Jasmin), all of them had at least five FLEs; four care-givers had six or more. Hence, four of the seven Arab care-givers exhibited at least as many FLEs as the single-most-expressive care-giver in each of the other groups.

Table 3. Examples of use of figurative language expressions (FLEs) in the three main domains by all cultural groups

Domain	Cultural group	FLEs
Family	IFSU	PWDs should be treated '*like a family*' (Oxana)
	JBI	Treat the patients as if they were their family relatives (Isaac and Merav)
	JBI	Treated the old ladies here '*like grandmothers*' (Shoshana)
	Arab	The care-giver should treat the patient 'as if he was his *father*'
Small children	IFSU	PWDs 'have [to have] limits, *like small children*' (Mira)
	JBI	'It [the use of the word 'sweetie'] *infantilises* [them] … I call them "mama" … as if I was saying "my mother"' (Shoshana)
	Arab	They are '*like small children* who just began to discover their world' (Juwaher)
Militaristic language	IFSU	'*it's a war*' (Inna reflecting on interactions with resistive PWDs)
	IFSU	'There needs to be *a revolution*' (Yivgenia)
	IFSU	'We are not *in the police, not in prison, and not in the ghetto*' (Oxana)
	JBI	'Are they [PWDs] currently in a *military boot camp*?' (Merav)
	JBI	'I *fight, I fight* every day in order for the old persons to feel good' (Neta)

Notes: IFSU: immigrants from the former Soviet Union. JBI: Jews born in Israel. PWD: patient with dementia.

These quantitative disparities are most pronounced when attention turns to the uncovered themes of FLEs. Hence, our analysis shows that almost all FLEs used by immigrant care-givers and nearly half of the FLEs employed by their Jewish colleagues are limited to three domains of discourse: militaristic language, small children and family (10/11 and 9/20, among IFSU and JBI care-givers, respectively). In contrast, while two of these domains (small children and family) are shared by the Arab care-givers, they articulate FLEs that mostly go beyond the three domains (43/48 FLEs).

Accordingly, Table 3 shows key examples of FLEs within each of three domains, as they are employed by care-givers from each group. Table 4 displays key examples of FLEs articulated by Arab care-givers as well as examples of such expressions used by JBI care-givers, which are beyond the domains of family, small children and militaristic language. While JBI care-givers, except for Noa and Shosha, used fewer expressions beyond these domains, all Arab care-givers extensively used expressions beyond the domains of family, small children and militaristic language. These extensively used expressions by Arab care-givers covered themes as varied as food, blue-collar workplaces, flora, fauna and anthropomorphism.

For example, Ahmed, referring to the care-giver behaviour described in the vignette, says, 'You cannot treat him [the patient] as if he was a *sack of potatoes*',

Table 4. Examples of use of figurative language expressions (FLEs) *outside* the three main domains

Cultural group	FLEs
Arab	'You cannot treat him as if he was a *sack of potatoes*…' (Ahmad reflecting on the care-giver described in the vignette)
	'It is *not a dog*! He is a human being!' (Mohamad reflecting on the same scenario)
	'I cannot yell here as if it were a *construction site*' (Rula, stressing the PWDs' privacy)
	'[The nursing home] here it is not a *factory*…' (Amir relating to the importance of personal treatment to each PWD)
	The need not to treat PWD as if they were *objects or stuff* (Amir, Muhamad, Juwaher)
	'Human dignity is the *food*, the *bread and water* of the patient…' (Amir)
	'I tried to *survive* under the *rain drops* … I merely *extinguish fires*' (Rula reflecting on the difficulties of her job)
	'When I arrive at work, I *throw out my own problems*, and then when I go home, I *take my own package*…' (Jasmin)
	'They come and visit [the patient] and it *empties* them…' (Amir relating to the experience of the PWD's family)
	'This person is completely *wiped out*' (Christine)
	'She treated him [the PWD] as if he were *a person who knows everything*' (Jasmin)
JBI	'I do not take care of them [the PWDs] as if they were on a *moving assembly line*' (Noa)
	PWDs 'should not be treated like they were *a tablecloth taken off the table*' (Noa)
	PWDs are 'like *flowers on the wall*' (Shoshana)

Notes: JBI: Jews born in Israel. PWD: patient with dementia.

while Amir uses another simile related to food when reflecting on the concept of human dignity for patients with dementia, as he equates the latter to 'the *food*, the *bread and water* of these patients'. When Amir and Rulla reflect upon the environmental nature of the institution they work in, they contrast it with blue-collar workplaces such as a *factory* and *construction site*, while Rulla also uses metaphors related to flora, when she states that 'I tried to survive under the *rain drops*'. Muhammad, on the other hand, refers to the animal world (fauna) in order to stress the humanness of a person with dementia, by stating that 'it is not a *dog!* He is a human being!'

In other words, the FLEs used by Arab care-givers mainly go beyond the 'regular' expressions of figurative language used by their colleagues, thus intensifying the imaginative nature of the metaphors and similes used by this group of care-givers. Moreover, as will be further elaborated upon and discussed in the next section, the intensified imaginative nature of the FLEs used by Arab care-givers seems to express an emphasis on the individuality of their patients. In contrast, their IFSU and JBI colleagues, mainly focusing on FLEs that are limited to three domains of family, small children and militaristic language, tend to capture persons with dementia in a collectivist manner.

Discussion

Our results show that Arab care-givers' narration style is characterised by highly figurative language, reaching beyond the usual domains of FLEs, as identified among their colleagues. In the current section, we discuss further the Arab care-givers' narration style in comparison with their IFSU and JBI colleagues, and explain how the use of figurative language by Arab care-givers reflects a more person-centred approach, emphasising the personhood of patients with dementia. Then, by linking our findings to the relevant literature, we propose that the use of figurative language by these care-givers may be understood as (a) having cultural underpinnings among Arabs, in general, and Muslims, in particular; and (b) forming the foundation for their person-centred approach due to the theoretical linkage among figurative language, imagination capacity and empathy. We also suggest that the Arab care-givers' emphasis on a person-centred approach may be understood as laying the grounds for PCC.

Thus, Arab care-givers not only tend to use the most extensive and varied FLEs, but the latter emphasise the individuality and uniqueness of patients with dementia. As shown in Table 4, Rulla uses the metaphor of a '*construction site*' to emphasise the *privacy* of the patients with dementia, while Amir uses a similar metaphor (*factory*) to reiterate the importance of *personal treatment*. Amir compares the human dignity of the *individual* patient to a necessity like *bread and water*. Three of the Arab care-givers (Amir, Muhamad and Juwaher) cited the need *not* to treat patients like *objects*, thereby affirming their humanity. In a similar vein, Muhamad was appalled by the treatment given to one patient in the vignettes, declaring that the patient 'is *not a dog*. He is a *human being!*' Finally, Jasmin referred to a patient with dementia as a 'wiped-out *person*'; she complained about the care-giver in the vignette who raised her voice toward the patient with dementia only because the patient wished to pray, instead of bathing as the care-giver planned. Commenting on the fictional care-giver described in the vignette, Jasmin says: 'She treated him [the patient with dementia] as if he were *a person* who knows everything.' Hence, Jasmin shows an awareness for the mistreatment of the patient with dementia in the vignette, while emphasising the humanness or personhood of this patient.

In contrast, as Table 3 shows, JBI and IFSU care-givers' use of figurative language when referring to patients with dementia depicted the latter in *a group-wise manner*, thereby circumventing the personhood of the patient with dementia. They depicted patients with dementia as if *they* were their *grandmothers* or *other relatives*. Some spoke about these patients as if they were *small children*, while others mentioned not treating *them like in a kindergarten* or *infantilising them* by calling them 'sweetie', yet again reflecting on these patients collectively rather than individualistically. When using metaphors reminiscent of a militaristic language, it is not to emphasise the individuality or privacy of patients with dementia (as used by the Arab care-givers with similar 'civil' metaphors like 'construction site' and 'factory'). Instead, militaristic language is used as a rhetorical vehicle that relegates patients with dementia to a group. Merav (a JBI care-giver) said that patients with dementia should not be forced to take a shower or submit to other non-medical procedures, rhetorically commenting: '*Are* they currently in a *military boot camp*?' Neta (also JBI) says: 'I *fight*, *I fight* every day … for the *old persons* to feel good.' Even

Oxana, the care-giver who is an immigrant from the former Soviet Union with the highest number of FLEs in her ethno-cultural group, repeatedly uses para-militaristic language (*police*, *prison*, *ghetto*) to make the same point that Merav does: not forcing patients with dementia as a group. Similarly, Noa and Shoshana, the only JBI care-givers referring to FLEs outside the main three domains, used such FLEs solely with respect to patients with dementia as a group (*see* Table 4).

In fact, note that, even when these care-givers had presumably presented opposite stances regarding people with dementia, these care-givers nonetheless referred to the patients in a collective manner rather than individualistically. One example for such opposite stances while sharing a similar collectivist approach to people with dementia concerns whether or not they should be treated as small children. Another example relates to the use of militaristic language. While content-wise, Neta (JBI care-giver) uses such language in order to stress her devotion to patients with dementia ('I fight, I fight every day … for the old persons to feel good'), Inna (IFSU care-giver) employs militaristic language to emphasise the hardship in coping with resistive patients ('It's a war'). Yet in both care-givers' use of militaristic language, the reference to people with dementia is done in a collective manner, namely group-wise instead of individually focused.

Differently from JBI and IFSU care-givers, then, Arab care-givers tend to employ a more extensive and varied figurative language, in which the personhood and the uniqueness of patients with dementia are reflected precisely by these care-givers' use of individualised references to their patients. In doing so, the Arab care-givers express a more holistic and person-centred approach acknowledging the patient's *personhood*, manifested in the patient's *own* wishes, perceptions and emotions. Such emphasis also appears to echo Kitwood's definition of personhood specifically in the context of caring for persons with dementia as stressing the acknowledgement of the uniqueness of persons (Kitwood 1997: 20).

At the same time, such an extensive use of figurative language by Arab care-givers appears to be aligned with past studies emphasising the cultural underpinnings of FLEs among Arabs, in general, and Muslims, in particular. Thus, it has been claimed that the Qur'an's narrative is charged with many metaphors, and the Muslims commonly accept the belief that typically language fails to express the essence of God. Therefore, much metaphoric imagery is used in order to convey the nature and essence of God (Ahammed 2010). Consequently, the Arabic language is made up of metaphors, and the Qur'an verses include many metaphoric directives (Hourani 1983, 1991). Dwairy (2006) also calls attention to the unique Muslim thinking style, which is characterised by imaginary language, symbols and metaphors termed *Qeyas*. Hence, it is customary among Muslims to utilise indirect and figurative language when describing and evaluating problems. Finally, a more recent study found that most Arab women use metaphors extensively in as varied realms as marriage, food and nourishment, rootedness and authenticity, covering and protection, as well as patience (el-Aswad 2014: 39). Therefore, our study's findings regarding the extensive use of figurative language particularly by Arab care-givers may not be a mere coincidence but rather a reflection of deeper cultural context embedded in this ethno-cultural group.

Interestingly, previous research depicted figurative language as reflecting the capability to imagine and enhancing this capability. On the one hand, research suggests that human imagination is the basis for conceptual metaphors because the imagination is a fertile breeding ground for the evolution of stable knowledge structures (*i.e.* metaphors, similes) (Lakoff and Johnson 1980; Ryman, Porter and Galbraith 2009). On the other hand, the use of figurative language may enhance the capacity to imagine. For instance, Nelson (2012) found that using similes and metaphors while writing essays kindles the writer's imaginative capability. Another study suggests that figurative language is based on imagination and creativity, and recommends the development of students' imagination by encouraging them to think of new metaphors (Ryman, Porter and Galbraith 2009). It follows that one may interpret the extensive and varied use of figurative language by the Arab care-givers as both reflecting a higher imaginative capacity and perhaps as enhancing this capacity.

Moreover, the idea that the use of figurative language may enhance the imaginative capacity is further supported, once the extensive use of figurative language by Arab care-givers is linked to empathy and personhood. Recall that empathy is the ability to understand someone else's experiences, emotions and worldview; hence, the ability to empathise is grounded on cognitive and emotional competencies (Davis 1994). As already noted in the Introduction, what is common to most definitions of empathy is the focus on the *empathiser's ability to imagine* either the patient in another mental and/or medical condition or him- or herself in the patient's situation. In fact, some later studies, focusing on family care-givers of patients with dementia, showed that these care-givers tend to use metaphors to make sense of their loved one's health (Golden, Whaley and Stone 2012; Mastergeorge 1999). Hence, by using metaphors, which can be seen as reflecting an imaginative capability, family care-givers were able to empathise with what their relatives with dementia were going through.

Yet the ability to empathise with patients with dementia requires acknowledging their personhood and uniqueness, in other words a *person-centred approach*. That is, in either version of empathy (cognitive or emotional), the care-giver is required to relate to the *individual* and *specific* experience that the patient with dementia undergoes. In the cognitive version, the care-giver needs to *understand* this experience from the outside; in the emotional or affective version, he or she is supposed to join the patient's experience, at least up to a point. In fact, one study precisely found that 'achieving person-centred dementia care is dependent upon health practitioners' imagination to recognize that selfhood persists despite the presence and progression of cognitive impairment' (Kontos and Naglie 2007: 565).

Therefore, from this perspective, if the Arab care-givers in our study were found to exhibit an extensive use of FLEs, associated with imaginative capacity, and these FLEs mainly stress the individuality of patients with dementia, then these results may be interpreted as possibly depicting the imaginative capacity of these care-givers as being enhanced by the extensive use of FLEs. Hence, by stressing the individuality of these patients, Arab care-givers may be understood as fostering an empathic stance to these patients, which is associated, in turn, with an enhanced imaginative capacity supposedly triggered by the extensive use of FLEs.

Finally, PCC in the context of dementia is particularly geared toward shifting the focus from the disease to the person and from the objective interests of medical and nursing professions to the subjective perspective of the person suffering from the disease (Edvardsson, Fetherstonhaugh and Nay 2010; Kitwood 1997; Sharma, Bamford and Dodman 2015). Furthermore, implementing PCC is particularly significant in nursing homes, as the idea of PCC had been contemplated due to the observed tendency among long-term care facilities to de-humanise their residents (Chenoweth *et al.* 2015; Cornelison 2001; Kitwood 1993, 1997; Ronch 2004; White, Newton-Curtis and Lyons 2008). Consequently, emphasis on the personhood of persons with dementia, as it was reflected and possibly enhanced through the extensive use of FLEs by Arab care-givers, may be depicted as potentially laying the grounds for PCC; the latter setting the focus on the person with dementia as being first and foremost a person, thereby acknowledging this person's humanness and uniqueness.

Theoretical and practical implications

The above discussion reveals a possible tool assisting Arab care-givers to foster a more person-centred approach, as demonstrated by their stress on the personhood of the patient with dementia. This tool is the extensive use of figurative language, which, according to the analysis, may be related to a greater ability to empathise. Based on *this interpretation* of the data, we propose that a more extensive use of figurative language *may* provide a tool assisting care-givers of different cultural backgrounds in offering the much-desired PCC for patients with dementia.

Researchers from several disciplines recommend the incorporation of metaphors in training programmes for care-givers and therapeutic counselling (*cf.* Ahammed 2010; Berdes and Eckert 2007). Such recommendation introduces the potential importance of incorporating figurative language within the training of care-givers. Our results and their discussion, in turn, suggest that figurative language may be a tool assisting care-givers of patients with dementia to show empathy and implement a person-centred approach toward these patients. Based on the aforementioned recommendation, together with the suggested insights from our study, one possible practical implication might relate to the training of care-givers for patients with dementia. Such training programmes may encourage figurative thinking in order to provide these care-givers with a more fruitful ground for showing empathy and implementing PCC toward patients with dementia.

Conclusions and limitations of the study

The study revealed substantial differences in the narration style of Arab, JBI and IFUS care-givers attending to patients with dementia. Our study found that, in comparison with their JBI and IFSU colleagues, Arab care-givers of patients with dementia tended to use a more figurative language. The study also showed that the figurative language of Arab care-givers especially emphasised the personhood of these patients. Against this backdrop, further literature ascribing the use of figurative language to a greater capacity for imagination and associating this latter capacity with the ability for empathy was presented as well. Based on the study's results and the presented literature, we suggest that Arab care-givers' stronger emphasis on figurative language may have enabled them to empathise more with patients with dementia, subsequently leading them to stress a person-centred approach. Future studies should explore the extent to which these findings are found in other cultural groups and whether programmes for care-givers of patients with dementia may be enhanced by the introduction of figurative language as one tool that is expected to improve the quality of the care given to these patients.

Some study limitations bear mentioning. The first is the undefined generalisability of the findings to other ethno-cultural groups. It is reasonable to suspect that care-givers working in other countries and originating from different ethno-cultural backgrounds may have different ideas about personhood and human dignity, which may correspond to different levels of figurative language usage than those employed by the care-givers in our study. Therefore, we hope our study will lead to future research in other countries, both qualitative and quantitative, which can further corroborate or alternatively dispute or test our findings. Such future research may also widen the thematic scope of the current study by presenting and examining additional perspectives regarding the use of figurative language by care-givers of persons with dementia. These perspectives may include (but are not limited to) issues such as which dominant discourses of dementia and ageing are reflected in the care-givers' narration as well as how do the FLEs reflect or contribute to negotiate counter-discourses of dementia and ageing?

The generalisability of the study's finding is also limited due to its *qualitative* nature, which by design is not supposed to demonstrate statistically significant causality between relevant variables. As such, the study did not include examining alternative factors that may explain our results, other than FLEs. Future *quantitative* studies may wish to do so, thereby either further corroborating our findings or refuting them.

We are also aware that a social desirability effect might have been at work, where care-givers tried to appear more ethical and more devoted to their job in their responses to the interviewer. Understandably, most studies that use face-to-face interviews are vulnerable to this bias. However, it is precisely due to the social desirability factor that we have used vignettes, as have other studies in the health domain.

Finally, it might be argued that, because the interviews were conducted in Hebrew, the results are biased in favour of native speakers of this particular language. Nevertheless, as discussed already in the Design section, this concern appears to be less substantiated. To begin with, overall, there was (almost) no need for translations, even though the interviewers were specifically instructed to probe for implicit difficulties in language expression by the informants and to offer them the option to speak in their own native language in such cases. In fact, when retrospectively going through the audiotaped interviews, the authors did not find any spots in the interviews in which the informants seemed to have difficulties in expressing themselves without being given the opportunity to use their own native language by the interviewers. We explained this lack of need for translation by the fact that the IFSU informants were hardly 'new immigrants', given their years of work experience in the country. In addition, Arab care-givers whose native language is not Hebrew actually exhibited the most extensive use of

FLEs, thereby suggesting that these care-givers also apparently did not have significant difficulties in expressing their thoughts in Hebrew. Still, we acknowledge the possibility that, theoretically, there might have been a few instances in which neither our interviewers nor the authors (retrospectively) had been sensitive enough to implicit difficulties in language expression experienced by informants for whom Hebrew was not their native language.

Acknowledgments. Above all, we are indebted to all the participants in the study. We are also grateful for the very helpful comments and suggestions for improvements offered by the two anonymous reviewers who read the previous versions of the manuscript. An initial draft of the study's findings was presented at the 2015 Oxford-Mt. Sinai Consortium on Bioethics Meeting. The helpful comments offered by the participants of these conferences, particularly the comments and suggestions made by Professor Michael Weingarten and Professor Rosamond Rhodes, have likewise significantly contributed to the study.

Funding. We wish to express our gratitude to the Israel National Institute for Health policy research for its funding of the research.

Ethical approval. The study was approved by the research ethics committee at the Faculty of Medicine in which the first author is employed (approval #61-2013) and by the research ethics committee of the hospital involved in the study (approval #2013-5671).

References

Ahammed S (2010) Applying Qur'anic metaphors in counseling. *International Journal for the Advancement of Counselling* **32**, 248–255.

Al-Haj M (1995) Kinship and modernization in developing societies: the emergence of instrumentalized kinship. *Journal of Comparative Family Studies* **26**, 311–328.

Ariño-Blasco S, Tadd W and Boix-Ferrer J (2005) Dignity and older people: the voice of professionals. *Quality in Ageing and Older Adults* **6**, 30–36.

Baillie L, Ford P, Gallagher A and Wainwright P (2009) Nurses' views on dignity in care: an RCN survey offers valuable insights into the challenges of providing dignified care to older patients. Lesley Baillie and colleagues assess the responses. *Nursing Older People* **21**, 22–29.

Bentwich ME, Dickman N and Oberman A (2016) Human dignity and autonomy in the care for patients with dementia: differences between formal caretakers from varied cultural background. *Ethnicity and Health*.

Berdes C and Eckert JM (2007) The language of caring: nurse's aides' use of family metaphors conveys affective care. *The Gerontologist* **47**, 340–349.

Boyd R and Richerson PJ (1985) *Culture and the Evolutionary Process*. Chicago: University of Chicago Press.

Burr V (2015) *Social Constructionism*. Routledge: New York.

Campbell DT and Stanley JC (1966) *Experimental and Quasi-experimental Designs for Research*. Boston: Houghton Mifflin Company.

Chenoweth L, Stein-Parbury J, Lapkin S and Wang YA (2015) Organisational interventions for promoting person-centred care for people with dementia. *Cochrane Library of Systematic Reviews* **11**, CD011963.

Cohen-Mansfield J, Garms-Homolová V and Bentwich M (2013) Migrant home attendants: regulation and practice in 7 countries. *American Journal of Public Health* **103**, e30–e39.

Collopy BJ (1988) Autonomy in long term care: some crucial distinctions. *The Gerontologist* **28**, supplement 1, 10–17.

Cornelison AH (2001) Cultural barriers to compassionate care – patients' and health professionals' perspectives. *Bioethics Forum* **17**, 7–14.

Davies B and Harré R (1990) Positioning: the discursive production of selves. *Journal for the Theory of Social Behaviour* **20**, 43–63.

Davis MH (1994) *Empathy: A Social Psychological Approach*. Boulder, Colorado: Westview Press.

Doswell WM and Erlen JA (1998) Multicultural issues and ethical concerns in the delivery of nursing care interventions. *Nursing Clinics of North America* **33**, 353–361.

Dwairy MA (2006) *Counseling and Psychotherapy with Arabs and Muslims: A Culturally Sensitive Approach*. New York: Teachers College Press.

Edvardsson D, Fetherstonhaugh D and Nay R (2010) Promoting a continuation of self and normality: person-centred care as described by people with dementia, their family members and aged care staff. *Journal of Clinical Nursing* **19**, 2611–2618.

el-Aswad e-S (2014) Metaphors Arab women live by. *Hawwa* **12**, 36–48.

Golden MA, Whaley BB and Stone AM (2012) 'The system is beginning to shut down': utilizing caregivers' metaphors for dementia, persons with dementia, and caregiving. *Applied Nursing Research* **25**, 146–151.

Henrich J and McElreath R (2003) The evolution of cultural evolution. *Evolutionary Anthropology: Issues, News, and Reviews* **12**, 123–135.

Hojat M (2016) *Empathy in Health Professions Education and Patient Care*. Cham, Switzerland: Springer International.

Hourani A (1983) *Arabic Thought in the Liberal Age*. Cambridge: Cambridge University Press.

Hourani A (1991) *A History of the Arab Peoples*. Cambridge, MA: Harvard University Press.

Iecovich E and Rabin B (2013) Practices used in Israel by nurses who care during hospitalization for older patients with dementia or who are bedridden. *American Journal of Alzheimer's Disease and Other Dementias* **29**, 166–176.

Inglehart R and Baker WE (2000) Modernization, cultural change, and the persistence of traditional values. *American Sociological Review* **65**, 19–51.

Ireland PR (2011) Female migrant domestic workers in Southern Europe and the Levant: towards an expanded Mediterranean model? *Mediterranean Politics* **16**, 343–363.

Kada S, Nygaard HA, Mukesh BN and Geitung JT (2009) Staff attitudes towards institutionalised dementia residents. *Journal of Clinical Nursing* **18**, 2383–2392.

Kashima Y (2008) A social psychology of cultural dynamics: examining how cultures are formed, maintained, and transformed. *Social and Personality Psychology Compass* **2**, 107–120.

Kashima Y (2014) How can you capture cultural dynamics? *Frontiers in Psychology* **5**, article 995.

Katz R and Lowenstein A (2012) Solidarity between generations and elders' life satisfaction: comparing Jews and Arabs in Israel. *Journal of Intergenerational Relationships* **10**, 5–21.

Kitwood T (1993) Towards a theory of dementia care: the interpersonal process. *Ageing & Society* **13**, 51–67.

Kitwood T (1997) *Dementia Reconsidered: The Person Comes First*. Buckingham, UK: Open University Press.

Kontos PC and Naglie G (2007) Bridging theory and practice: imagination, the body, and person-centred dementia care. *Dementia* **6**, 549–569.

Lakoff G and Johnson M (1980) *Metaphors We Live By*. Chicago: University of Chicago Press.

Lavee Y and Katz R (2003) The family in Israel: between tradition and modernity. *Marriage & Family Review* **35**, 193–217.

Lincoln YS (1995) Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry* **1**, 275–289.

Martin S, Lowell BL, Gzodziak E, Bump M and Breeding A (2009) *The Role of Migrant Care Workers in Aging Societies. Report on Research Findings in the United States*. Washington DC: Institute for the Study of International Migration, Walsh School of Foreign Service, Georgetown University.

Mastergeorge AM (1999) Revelations of family perceptions of diagnosis and disorder through metaphor. In Kovarsky D, Duchan J and Maxwell M (eds), *Constructing (In)competence: Disabling Evaluations in Clinical and Social Interaction*. Mahwah, New Jersey: Lawrence Erlbaum Associates, pp. 245–256.

Mattiasson AC and Andersson L (1994) Staff attitude and experience in dealing with rational nursing home patients who refuse to eat and drink. *Journal of Advanced Nursing* **20**, 822–827.

Mattiasson AC, Andersson L, Mullins LC and Moody L (1997) A comparative empirical study of autonomy in nursing homes in Sweden and Florida, USA. *Journal of Cross-cultural Gerontology* **12**, 299–316.

Mercer SW and Reynolds WJ (2002) Empathy and quality of care. *British Journal of General Practice* **52**, supplement, S9–S12.

Miller W and Crabtree BF (1994) Qualitative analysis: how to begin making sense. *Family Practice Research Journal* **14**, 289–297.

Nelson A (2012) Cultivating writers: figurative language in the developmental class. *Teaching English in the Two Year College* **39**, 388–397.

O'Shea E and Walsh K (2010) *The Role of Migrant Care Workers in Ageing Societies: Report on Research Findings in the United Kingdom, Ireland, Canada and the United States*. Geneva: Migration Research Series, International Organization for Migration.

Onwuegbuzie AJ and Collins KM (2007) A typology of mixed methods sampling designs in social science research. *The Qualitative Report* **12**, 281–316.

Örulv L and Nikku N (2007) Dignity work in dementia care: sketching a microethical analysis. *Dementia* **6**, 507–525.

Rassin M (2008) Nurses' professional and personal values. *Nursing Ethics* **15**, 614–630.

Ronch JL (2004) Changing institutional culture: can we re-value the nursing home? *Journal of Gerontological Social Work* **43**, 61–82.

Ryman JA, Porter TW and Galbraith CS (2009) Disciplined imagination: art and metaphor in the business school classroom. *International Journal of Education & the Arts* **10**.

Sharma T, Bamford M and Dodman D (2015) Person-centred care: an overview of reviews. *Contemporary Nurse* **51**, 107–120.

Shotter J (1993) *Conversational Realities: Constructing Life Through Language*. London: Sage.

Simard J and Volicer L (2010) Effects of Namaste Care on residents who do not benefit from usual activities. *American Journal of Alzheimer's Disease and Other Dementias* **25**, 46–50.

Tadd W, Vanlaere L and Gastmans C (2010) Clarifying the concept of human dignity in the care of the elderly: a dialogue between empirical and philosophical approaches. *Ethical Perspectives* **17**, 253–281.

Titchener EB (1909) *Lectures on the Experimental Psychology of the Thought-processes*. New York: Macmillan.

Urdang L and Flexner SB (1969) *Random House Dictionary of the English Language*. New York: Random House.

Wetherell M (1998) Positioning and interpretative repertoires: conversation analysis and post-structuralism in dialogue. *Discourse & Society* **9**, 387–412.

White DL, Newton-Curtis L and Lyons KS (2008) Development and initial testing of a measure of person-directed care. The Gerontologist *48, supplement* **1**, 114–123.

Woolhead G, Tadd W, Boix-Ferrer JA, Krajcik S, Schmid-Pfahler B, Spjuth B, Stratton D and Dieppe P (2006) 'Tu' or 'vous?': a European qualitative study of dignity and communication with older people in health and social care settings. *Patient Education and Counseling* **61**, 363–371.

World Health Organization (WHO) (2012) *Dementia: A Public Health Priority*. Geneva: World Health Organization.

Zisberg A, Topaz M and Band-Wintershtein T (2015) Cultural- and educational-level differences in students knowledge, attitudes, and preferences for working with older adults. *Journal of Transcultural Nursing* **26**, 193–201.

Cite this article: Bentwich ME, Bokek-Cohen Y, Dickman N (2019). How figurative language may be related to formal care-givers' person-centred approach toward their patients with dementia. *Ageing & Society* **39**, 2653–2670. https://doi.org/10.1017/S0144686X18000685