

# "You speak all your part at once, cues and all": Reading Shakespeare with Alzheimer's Disease

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## Abstract

This is the story of reading an abridged script of *Twelfth Night* with a support group for early stage Alzheimer's disease patients. Though the reading was difficult in many ways, the result was a tremendous boost to the self-esteem of the participants because they did something perceived as difficult and worthwhile. The paper looks at why this was such an unexpected success, examines the readers and their challenges, and concludes with the recommendation that Shakespeare or other literature be studied as a therapy for people with Alzheimer's disease.

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## Introduction

"We did Shakespeare!"

This statement was made by at least a half-dozen dementia patients to their caregivers after the meeting of an early stage Alzheimer's support group.<sup>1</sup> This paper tells the story of how these patients came to read an abridgement of one of Shakespeare's plays, discusses why they spoke of their reading with such enthusiasm, and concludes by asking whether literature might be used as a therapy to improve the lives of people with Alzheimer's disease.

I wear two hats in life. Under the Shakespeare hat, I have been adjunct faculty and lectured in several academic and popular venues. I edit the "Talking Books" column in *Shakespeare Newsletter* and have published more than forty articles, reviews, and chapters in books about Shakespeare and the writers of his era. Switching to my Alzheimer's hat, I was a secondary caregiver to my wife's father and step-father during their struggles with Alzheimer's disease and was motivated by the second of these experiences to co-author *Alzheimer's: The Answers You Need* (Elder Books, 1998) with Helen D. Davies, co-director of the Stanford/VA Alzheimer's Research Center. Ours was the first book to help newly diagnosed patients get through the next few years of their lives. Davies talked me into revising our book in the late 2000s. While I was in her office for that first

revision meeting, Davies asked, "Do you want to work here?" I worked at the clinic for about a year and a quarter, fulfilling a variety of low-grade duties. One was to serve as co-facilitator of an early stage support group, the target readership of our book. Early stage Alzheimer's patients were once considered too impaired to be helped by support groups. While counseling patients, Davies found a complex emotional life under the muddiness of the way in which early stage patients expressed themselves, an emotional life that could benefit from therapy. With the support of Jared Tinklenberg, Primary Investigator for Alzheimer's research and the clinic's Director, Davies's first Alzheimer's support group started in the early eighties. It was a success because the group helped patients express their concerns and frustrations and taught them coping mechanisms that would, at least for a time, make their lives better. Group meetings are places where patients and their caregivers learn about resources they may not find on their own, and the sessions give patients an opportunity to be with people who experience life much as they do, people who understand their concerns and fears. The group is a place where patients can make mistakes without embarrassment, and importantly, gives patients an opportunity to socialize, which helps them continue to function. Not all the patients in the group had Alzheimer's. Some suffered from other dementias, but most were Alzheimer's patients. This group was later split into two: one group for patients and one for their caregivers. The patient group had different goals in different weeks. These included building self-esteem, coping with frustration, improving communication, and helping patients accept their limitations and thrive within them.

### Doing Shakespeare

I was introduced to the group as a Shakespeare scholar and co-author of Helen Davies's book; everybody knows Helen, and two or three members asked if the group could do something with Shakespeare. I gave a non-committal "Great idea, we'll try to figure something out," knowing that these decisions are made by the three co-facilitators, in collaboration with Davies. One objective of the group is to give the members activities at which they can succeed, since the disease has brought so much failure to their lives. I was not inclined to act on the request at first because I had no idea what activity a group of people with early stage dementia could do successfully with Shakespeare.

It was expected that some group members would not remember me the next week, so I was introduced again. Requests to do something with Shakespeare were repeated. I then realized that we should take this request seriously. The three co-facilitators had our regular meeting with Davies after that second session to discuss what happened in the group, and what, if anything, we could do with Shakespeare. Three assumptions were unspoken, but shared by members of our group: Shakespeare is hard, Shakespeare is rewarding, and Shakespeare is worth doing. His place as a

pillar of modern culture was assumed. Nobody questioned Shakespeare's status or how he came to his cultural preeminence. People in an early stage support group are not interested in deconstructing Shakespeare with the tools of French philosophy and cultural studies, nor for that matter are they able to. These three assumptions were exactly what made a Shakespeare project desirable.

The only activity that seemed feasible was to have those who could still read perform an abridged script, and I knew where to find one. From 1951 to 1974 in the U.S., the Oregon Shakespeare Festival (OSF) had a half-hour annual radio show for the National Broadcasting Company (NBC).<sup>2</sup> Two minutes of each broadcast usually were taken up with credits and plugs for the Festival. The rest of the program was an excerpt or abridgement from one of the plays performed by OSF that year. I chose the script for a 1964 production of *Twelfth Night*, in part because of the larger than usual number of female parts that survived the abridging, and to avoid turning the group's thoughts towards death, which might happen if we performed a tragedy or history. After a quick OK from OSF Publicist Amy Richard, lots of photocopies, and the use of a highlighter to mark different parts in different scripts, we scheduled the reading as one activity in a series on building self-esteem. I prepared topics for the group to discuss between the end of the reading and the break that usually came after one hour. Discussion topics would include how it feels when others look down on you, how it feels to be the butt of a joke and the best way to speak to the jokers, and how many of the problems in the play and in life could be fixed with better communication. These are not the issues scholars usually discuss when working on the play, and were not intended to be. The goal was to find analogues between the play and life as Alzheimer's patients experience it, especially experiences that contribute to or damage self-esteem. It was down to me to tell the group about the OSF radio show and that we would reenact the broadcast, then give a synopsis of the play and assign the roles.<sup>3</sup>

I cast the reading rather badly. The ability of an Alzheimer patient to speak well does not necessarily indicate an ability to read well, since reading engages somewhat different parts of the brain and those parts may not be impaired to the same degree.<sup>4</sup> Though aware of this, I had nothing else to go on and so gave the most able conversationalists the largest parts, with the exception of the part of Viola. The reason is given below. Half of the readers struggled, while some who could be unfocused in conversation benefited from the concentration that reading an assigned part gave to them. I was able to suggest afterwards that one man might be a better communicator when reading written responses, though I was not able to follow up to learn if this tactic was tried.

The script was originally written for a twenty-four minute broadcast. I edited it to eliminate the plugs for OSF and the closing credits. Professionals could probably have performed our version

in about twenty-two minutes. It took our group an hour and a quarter due to false starts, the need to prompt some group members that it was their turn to read, and the general slowness of the poorer readers struggling with their lines and sometimes reading another character's lines, which half reminded me of Peter Quince's "You speak all your part at once, cues and all" (*A Midsummer Night's Dream* 3.1.93-94).<sup>5</sup> Despite my own reading disability — I am mildly dyslectic — I appointed myself to read the narrator's part. OSF's adaptor for this script, Carl Ritchie, used a narrator to explain the cuts in the abridgement, and reading this part gave me the chance to add even more clarification when needed and then cue the next speaker without seeming to interrupt the reading. I rehearsed my part privately so as not to stumble too much when I read with the group.

Among the revelations of our reading was how well an Irish accent works for Sir Andrew Aguecheek. Our Sir Andrew is low functioning in some areas, but speaks and reads very well. Andrew's first line came out in a brogue, and at the end of the line he asked me, "Do you like him Irish?" I did not at first, but my feelings mattered less than his, so I told Sir Andrew to have fun with it. Sir Andrew is an outsider in Olivia's household, and the accent marked him so. This gave our reader, who has a bit of an imp in his personality, the chance to feel different and interesting, and this exercise was intended to build self-esteem. Though Sir Andrew is clueless and not an imp, our reader's impishness enlivened the character's boast about dancing (Ritchie 1964, 7) and gave the reading energy throughout.

I chose for Malvolio a reader whose personality in some ways matched that character. He was fairly high functioning and for this reason, often stayed aloof from others in the group. He said privately that he looks down on the other group members and only attends as a way to gage how well he is doing compared to them. Surely, this offers some sort of analogue to Malvolio's personality, perhaps is an aspect of it, and while his reading lacked the distain most actors give it, our Malvolio's natural character was in the right direction. Choosing our Sir Toby Belch was another attempt at creating a personality analogue. A boisterous former professional athlete read the part, but his reading was so inhibited by the disease that he struggled to recognize and then say each word, which came out one word at a time with pauses in between. This kept our reader's personality from coming through. Because Fabian has only short lines in this abridgement, I gave the part to a very nice man with Lewy bodies, one of several non-Alzheimer's dementias. He was from a privileged background and once had a very demanding job, but at this point he was so unfocused that he often fell asleep in our meetings. As I had hoped, reading a script aloud helped our Fabian stay awake that week. Maria was an excellent conversationalist with a terrible short term memory. She remembered much from her past, including her professional education, but often forgot what

she had done twenty minutes before. Though anxious to participate, her reading was painfully difficult, and while she read most of the words correctly, she did not read with comprehension. She was an excellent listener, however. Maria understood the portions of the script read by others. Her education and former profession gave Maria an above-average understanding of human needs and fears. When we finally took our break, Maria spoke to me about the other characters, quickly summing up the psychological problems of three or four of them and indicating what they should do to function better in the story. These comments came from a very modern understanding of human psychology, of course, one that was probably not shared by Shakespeare, but it was interesting to see her apply what she had learned in the past to these characters and their problems.

While the biggest disappointment was that some group members had lost their ability to read aloud smoothly, the best surprise was how well Viola read. The woman I asked to take the role of Viola/Cesario was fairly new to the group and had resisted our encouragement to participate meaningfully. She claimed that she did not have dementia, though she clearly did. Viola only attended because her family insisted, and only spoke when asked a direct question. Typically sitting with legs and arms crossed for the length of the two hours, she primarily gave one and two word answers when possible, a full sentence only if necessary, and never a second sentence. Casting her was calculated to get her to participate in some way. She refused to read at first and then surprised us by changing her mind when I began to ask Maria to read the part. Viola commanded the room with her clear, bold, well-spoken reading. It was a marvelous cold reading, and not just by the standard of Alzheimer's patients. Her family later told us that Viola had been a professional actor decades before, but retired to raise her family. Our angry Viola became the functioning Cesario, sitting forward in her chair, eyes on her script, both the reader and the character doing the best they could under difficult circumstances.

Because the reading lasted so long, we took our break late and had no time to discuss personal issues related to the play that I had prepared. We stuck to the plan for a different self-esteem related activity during the rest of our session. Participants usually speak of the last activity after these meetings, not the first. They have not necessarily forgotten what they did earlier, but more recent activities dominate. Not this week. When they joined their caregivers in the hallway after the sessions, our participants mentioned the Shakespeare reading. These brief hallway conversations are usually of a "What did you do?" type, answered with "We talked," or a similar line, as everyone heads for the exit. This week, "We did Shakespeare" was said by one patient after another in my hearing. "We did Shakespeare."

"What do you mean, you did Shakespeare?" asked one caregiver, and others asked this in their own ways. The patients usually replied that they had read a Shakespeare play, though I needed to

remind them which play, and the facilitators tried to answer caregiver questions in ways that did not violate patient privacy.<sup>6</sup> Patients and caregivers lingered in the hall for several minutes, some for ten and fifteen, as we answered questions and many patients gushed about their accomplishment.

Fabian took my arm as we walked out and began reciting the "quality of mercy" speech from *The Merchant of Venice*. He forgot it after a few lines and indicated some frustration over this: I believe the lines that he remembered were these:

The quality of mercy is not strained.  
It droppeth as the gentle rain from heaven,  
Upon the place beneath.  
It is twice blessed.  
It blesseth him that gives and him that takes.  
T'is mightiest in the mightiest. (*The Merchant of Venice* 4.1.181-86)

Then he told me about a time he acted up in class and was forced to stay after school. The schoolmaster — his word — forced him to memorize Portia's speech during that detention. "I've remembered those words ever since," he said, forgetting that he had just forgotten much of the speech. I did not feel the need to remind him.

Patients also spoke of the experience at home between meetings, so part of Davies's next caregiver group was given to answering questions about why we had read Shakespeare in the patient group, though she could not comment on specific patients both because Helen was not with us during the reading and because of HIPAA rules. The patients also brought the reading up in our meeting, which took place at the same time. It is rare for group members to mention the activities of the previous session, but several mentioned reading Shakespeare. The heady feeling of accomplishment presumably made the reading more memorable than most other activities. It did not matter that the script had been difficult to read, that some of our readers lost their place when reading, read the wrong part, missed their cues, or read the cues of others. Most seemed to forget the negatives to revel in the accomplishment, and they wanted to do it again. Some patients still remembered doing Shakespeare in the meeting following that, which was without precedent in my experience, and some asked when we could do Shakespeare again. Viola's husband cornered me at the clinic holiday party and suggested *King Lear* for our next reading; they had once appeared in the play together. I thanked him for the suggestion, but gave a non-committal response because of my continuing concern that the discussion following might go in the wrong direction.

Alas, a second reading was not to be. I spent another week in Ashland soon after our reading, tasked to get another script. I chose a *Taming of the Shrew* script from 1967 because it fit the most

needs and because the treatment of women in the script could be turned into a group conversation about self-esteem issues, settling family strife, feelings of power and powerlessness, and other useful topics. This time, the discussion would be planned for after the break so that we would be sure to get it in. During my absence, Davies had brought in a new co-facilitator who worked very well with the group. Since people with memory problems often have difficulty adjusting to change, Helen did not want to change back, which saddened me, but the needs of the patients were more important than mine. Without me to direct the reading and the following discussion, further Shakespeare readings were not considered practical.

### Coda

A few months later, I asked my former co-facilitators how some members of the group were doing. Because part of my job was to chart the progress or decline of patients, this is not a HIPAA violation. Everyone had declined, of course, since Alzheimer's is a degenerative disease. At the time of that conversation, Sir Andrew was still an imp, just a slower imp. Malvolio still felt superior to everybody, but had less cause. Sir Toby had declined to the point that his natural boisterousness became distracting. Asking him to leave the group was being discussed, perhaps putting the co-facilitators in the position of Malvolio inviting Sir Toby to leave if he could not separate himself from him misdemeanors. Fabian continued to sleep at meetings. Since he received little benefit from attending, he was asked not to return, in order to make space for someone who would benefit more from the group. Maria declined rather quickly. The exercise was of the most benefit, perhaps, to Viola. Her arms and legs are permanently uncrossed. She became one of the most active and vocal participants in the Early Stage Support Group. I am sure she has declined since, but her story demonstrates a point that Helen Davies and I made again and again in our book. You will probably live with Alzheimer's for many years. You should make those years as rich as you possibly can.

I am glad that Shakespeare helped enrich the lives of the people in our group and wonder if the creative use of Shakespeare as a therapy might help other Alzheimer's patients. Music and the visual arts have received multiple studies and encouraging results as therapies.<sup>7</sup> The Museum of Photographic Arts in San Diego, California recently began a program of docent-led tours tailored for dementia patients, with a course to teach patients digital photography. This is not currently being studied by researchers, but I hope that will follow.<sup>8</sup> Patients are encouraged to express themselves in writing, especially autobiographical writing, and many have learned to keep journals to exercise long-term memory and to help them recall recent events.<sup>9</sup> The arts, generally defined, do seem to have some therapeutic value for Alzheimer's patients.

More specifically with literature, there are scholars working with Shakespeare and other literature directly with Alzheimer's patients: Katharine Craik at Oxford Brookes University, Matt Kozusko at Ursinus College, and Amy Scott-Douglass at Marymount University. On the less scholarly front, for several years in Brooklyn, the poet Gary Glanzer has been using poetry as a therapy for people who have dementia. I have not, however, found a proper scientific or cognitive study on the benefits of reading or listening to literature as therapy. I hope this short, anecdotal, unscientific article will put this topic into conversation in the Alzheimer's care community with the result that a longer, non-anecdotal scientific study of the benefits of Shakespeare or other literatures will be undertaken to ascertain their therapeutic efficacy.

### Notes

1. I did not decide to write about this experience until recently, so notes were not taken at the time. This account, therefore and ironically, relies more than I would like on my imperfect memory. I believe everything is accurate, but some specifics have been forgotten and so are omitted. I realize that some things may be remembered as I wish to remember them, but this was not done deliberately. I am grateful for the support of a number of dedicated and caring professionals during my time at the Stanford/VA Alzheimer's Research Center, including Helen D. Davies, MS, APRN, BC, Psychiatric Clinical Nurse Specialist; Jerry Tinklenberg, MD, Professor of Psychiatry and Behavioral Science at the Stanford School of Medicine; my direct supervisor, Program Manager Pauline Luu; Research Assistant Christine A. Coughlin; and especially my co-facilitators, Clinical Research Coordinator Virginia L. Dao and Clinical Nurse Specialist and Research Assistant Christiane Baker Pitts, MA, RN, BSN.
2. The program ran for sixty minutes in 1953 and 1954, then reverted to the shorter time slot. In 1957, NBC changed the length to twenty-four minutes to accommodate network announcements and news. For a history of the program and its impact on the town of Ashland, Oregon, see the somewhat mistitled article by Michael P. Jensen, "*A Midsummer Night's Dream* on Radio: The Oregon Shakespeare Festival's Radio Series" (2012). I also describe most of the episodes in "Radio: Entries by Play" (Jensen 2007).
3. This paper has elements in common with the "feel good" newspaper and magazine stories that are usually accompanied by photographs of happy participants, the use of first names, and some background on the lives of the patients involved. Quite rightly, the Stanford/VA Alzheimer's Research Center holds patient privacy as the highest priority after patient care. It would be a violation of doctor/patient privilege for me, as a former agent of physician Jared Tinklenberg, to give any clue that could lead to the identification of the patients involved. It is also against

the U.S. Health Insurance Portability Accountability Act (HIPAA) of 1996. I could be fined or put in prison for merely giving enough information for a clever person to figure out who the patients are. This is why I did not specify the year of this exercise in my second paragraph. I shall identify each patient only by the role he or she played in the reading.

4. I am not an expert, but as I understand it, reading and speaking are both two-part processes. The optics of reading goes to the Visual Cortex, and the words read are then understood in Wernicke's area. Conversation is a combination of Wernicke's area, where ideas are generated as well as understood, and Broca's area, which produces speech. Degeneration in Wernicke's area will tend to affect both reading and speech. If Wernicke's area is free of plaque and tangles inside of nerve cells, but the Visual Cortex is affected, it is difficult to read. If Wernicke's area is normal but Broca's area is affected, patients will have difficulty expressing thoughts that may be clear in their heads. Reading aloud involves all these areas, and so is a three-part process. If degeneration has not yet affected these centers, or not affected them very much, then reading aloud is usually fairly fluid.
5. All references to Shakespeare's plays are to the Oxford *Complete Works*, second edition (2005).
6. What happens in each group stays in that group. It is a HIPAA violation to tell a caregiver what a patient did or said in our group, and vice versa. Patients and caregivers may, of course, reveal these things to one another and give us permission to comment.
7. See Koger, Chapin, and Brotoms 1999; Kumar, Tims, Cruess, et al. 1999; and Britons and Marti 2003. For art therapy, see Sterritt and Pokorny 1994; Rentz 2002; and Abraham 2004.
8. *Perspectives: A Newsletter for Individuals with Alzheimer's or a Related Disorder* (2012): 6.
9. Two recent articles are Ramanathan 2009; and Ryan, Bannister, and Anas 2009. A published journal by an Alzheimer's patient is Cary Smith Henderson, *Partial View: An Alzheimer's Journal* (1998).

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