Is 'elderspeak' always inappropriate? An empirical investigation of the use of elderspeak in dementia care in the acute hospital context

Lauren Bridgstock

Abstract

The acute hospital environment is known to be difficult for people living with dementia (PLWD), and healthcare staff often view communication with this group as challenging (Griffiths et al., 2014). Elderspeak has been defined as a form of communication used towards older people, particularly PLWD. It involves features such as high pitch/tone of voice, simplified sentences/grammar, terms of endearment and excessive praise. It is often assumed to be patronising or infantilising (Ryan et al., 1995; Williams et al., 2017; Shaw and Gordon, 2021). However, prior research has neglected to examine interactional functions of elderspeak style talk in real life interactions with PLWD.

This thesis uses conversation analysis to examine functions of elderspeak style talk within a collection of video data recorded on UK hospital wards during two NIHR funded research projects (VOICE and VOICE2). The data comprise routine healthcare interactions between PLWD and healthcare professionals. Findings suggest that aspects of elderspeak are recurrently used in very specific contexts and appear to fulfil important interactional functions in these contexts. For example, terms of endearment serve mitigating functions and can help orient to conversational closings. Praise works as a supportive action to aid orientation to tasks and activities and has implications for the preservation of agency and face (Goffman, 1955). Finally, prosody (pitch, tone, duration and amplitude of talk) has been shown to systematically draw attention to greetings, convey key messages in talk and add additional layers of meaning to turns. These findings suggest that judgements on elderspeak need to be sensitive to context, as well

as contributing to the empirical literature on interactions with PLWD and healthcare communication more widely.

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Table of Contents

Chapter 1: Introduction to dementia care and elderspeak

1.1 Dementia and Care

Dementia is common, with over 50 million individuals diagnosed worldwide (Alzheimer's Disease International, 2019). Many of these individuals will at some point need to access various forms of formal care. Despite this, there are many misunderstandings and stereotypes about PLWD (Alzheimer's Disease International, 2019) and the condition can be invisible and poorly understood, particularly in hospital settings (Featherstone and Northcott, 2020). This introduction will first consider how dementia is defined, before examining the historical context of care settings. This will lead to an explanation of more recent research and a justification for why this project intends to focus on the use of elderspeak in dementia care specifically.

Gale et al., (2018) define dementia as an acquired syndrome where "*significant decline from one's previous level of cognition causes interference in occupational, domestic, or social functioning*," (2018: 1161). Similarly, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) lists dementia under major neurocognitive disorder, and specifies that for diagnosis, there will be substantial impairment in at least one (or more) cognitive domains, which is sufficient enough to interfere with activities of everyday living. (APA, 2013). Dementia can have many possible causes, although Gale et al. (2018) do note a higher prevalence in older adults, which is often due to neurodegenerative disease such as Alzheimer's, Lewy body dementia or Parkinson's. (See Gale et al. for a wider list of potential causes). With consideration of the wide variety of conditions involved, and the fact that many people struggle to get a correct diagnosis (Featherstone and Northcott, 2020), this thesis intends to focus on dementia as a broad category, rather than concentrating on any single illness.

The field of dementia care has gone through many developments over recent decades. One important consideration is how personhood, or an individual's sense of self, has been dealt with over time. The central idea of Kitwood's (1997) highly influential *Dementia Reconsidered* is the personhood of people living with dementia. Kitwood defined personhood as "*a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust.*" (1997: 8). He examines this concept in comparison to what he terms the 'standard paradigm.' According to Kitwood (1997), the standard paradigm of dementia looks at the condition in a very scientific way (such as in psychiatry). In Kitwood's view, it focuses broadly on medical advancements but neglects to consider the individual people involved. These paradigms are then claimed to translate into different care practices. The standard view leads to what is portrayed as a helpless outlook, with decline inevitable and 'problem' behaviours simply managed (usually with medication). Kitwood's idea of new or person-centred dementia care is portrayed as a much more positive approach. In this version, dementia is conceptualised as a unique experience and care is about looking after the person as a whole, assisting them to maintain their personhood and working with them as a full member of the team. The previously viewed 'problem' behaviours are instead seen as efforts to communicate an issue/need.

A key idea brought forward by Kitwood is that of malignant social psychology. This came from Kitwood (1990) examining the depersonalising tendencies that people can use towards PLWD. In his (1997) book, he expands upon his original list, to name 17 elements of a care environment that are "*deeply damaging to personhood, possibly even undermining physical wellbeing.*" (Kitwood 1997: 46). The elements listed are: treachery, disempowerment, infantilisation, intimidation, labelling, stigmatisation, outpacing, invalidation, banishment, objectification, ignoring, imposition, withholding, accusation, disruption, mockery and disparagement. These elements are not consistent with an environment that Kitwood would say facilitates person-centred care. Kitwood's ideas are of such key significance, due to the influence they have had on dementia care over the last 20 years, that it is of relevance to consider the historical context that led up to their development.

Kitwood was not the first person to consider the detrimental effects of institutionalisation. Goffman's (1961) work, *Asylums*, examines life in various forms of institution. This book describes a bleak setting, in which religious establishments, prisons, concentration camps and mental health institutions are all considered as part of the same institutional context. A key idea discussed by Goffman was that of an individual's sense of self being "*mortified*," (1961: 24) by the institution. This mortification, or loss of self, occurred when a person entered an institution and experienced the loss of the stable social arrangements of their home world. This was then intensified by the individual being forced to adopt potentially demeaning procedures. For example, only being allowed to eat with a spoon, staff discussing the individual as if they were not present, and experiencing a lack of personal privacy. Additionally, the individual's personal sense of responsibility was removed as they were denied their own economy of action. I.e., people had to request permission to do things that, as adults, they would have been free to do outside of the institution (such as using the toilet). For Goffman, it was of interest that this loss of self appeared to be an intentional strategy on the part of the institution. For instance, Goffman noted that patient visitation was discouraged in order to remove outside attachments and aid the loss of self, resulting in further institutionalisation.

The institutional environment described by Goffman (1961) is in direct contrast to what Kitwood (1997) later considered to be good care for PLWD. Kitwood claimed that care should be about the personhood, where the aim is about aiding the person in preserving the self, rather than destroying it. Rather than denying economy of action, the individual with dementia should be assisted so that barriers are minimised. Specifically, Kitwood argued that depersonalising individuals makes their condition worse, whereas if they are empowered, disabling symptoms can be reduced or overcome. Many of the features of institutions discussed by Goffman (1961) are consistent with Kitwood's (1990, 1997) malignant social psychology. Particularly, banishment (from the outside world and wider relationships), objectification (loss of personhood), and disparagement (being subjected to demeaning procedures).

Goffman is writing about institutions in general, including those whose purpose is to punish as well as to care. In *The Myth of Mental Illness*, Szasz (1974) develops a similar critique, but this time with the focus solely on medicine, and specifically the limitations of the medical model of treatment in relation to mental illness. One of the central arguments of the book is that mental illness is a social construction, rather than a medical ailment. When discussing historical approaches to psychiatry, Szasz claims that patients were often simply viewed as objects present for manipulation and study. He states that this continues in more modern times when, for instance, doctors refer to medical "cases," rather than individuals. This negative view toward the medical approach is continued throughout the book. For instance, he compares it to "*a guillotine*" (Szasz 1974: 24) and claims that looking at mental illness though the lens of the medical model has resulted in "*disastrous abuse of patients*," (Szasz 1974: 49) as it leads to social context being ignored. Eventually, this leads him to the conclusion that the medical view of mental illness should be rejected, and other approaches should be considered, which should take into account the "*ethical, political, psychological and social problems from which psychiatric patients suffer*." (Szasz 1974: 79).

Kitwood (1997) later addresses many of these issues in his new model of dementia care. For instance, he discusses some of the psychological needs of people with dementia such as comfort, inclusion, identity, acknowledgement and occupation. In addition, Szasz's claim that patients were simply seen as objects present for manipulation and study is an example of objectification described by Kitwood's malignant social psychology.

Contemporaneous with the work of Szasz is the work of Illich (originally published in 1975 and later reprinted in 1995). In his book, *Limits to Medicine* (1995) he sets out a scathing argument against modern medicine. Whilst Szasz was critical of the medical profession being applied to mental health, Illich makes arguments against the field as a whole. He argues that medicine is practically useless when it comes to dealing with old-age. He claims that other factors determine when people die, and later he suggests that the old are victims, as treatment is given for conditions which cannot be cured. Again, Illich discusses issues which could be seen to prefigure the concept of personhood, or the ways in which it is denied. For example, when discussing the concept of death, he claims that death has lost the dignity it was afforded historically and the person's body has been reduced to an object. Illich also argues that the expansion of healthcare as an industry reduces individual ability to cope with health issues and respond to challenges in life. Again, personal responsibility and agency are removed, as medical professionals diagnose people as "*genuinely sick*," (Illich 1995: 44).

It should be noted that Goffman (1961), Szasz (1974), and Illich (1995) refrain from directly discussing dementia care in specific detail. Goffman perhaps comes the closest, as when defining the total institutions that are the subject of the book, he does include a grouping for institutions whose aim was to care for individuals who might have been considered incapable of looking after themselves, such as homes for 'the aged.' Illich refers to 'the elderly' and those with terminal illness, but again does not actually mention dementia. Szasz is more focused on mental health in general, in particular in relation to what was classed as 'hysteria.' Nonetheless, Kitwood (1997) does reference work by Goffman and given the similarities of his ideas with those discussed, it seems logical to suggest that he was heavily influenced by these works or at least the style of thinking which was prevalent in critiques of medicine in the early to mid-20th century. It can therefore be argued that Kitwood has drawn on broader sociological ideas and understandings and applied them specifically to the field of dementia care.

Kitwood's work has inspired a great deal of research and development in the care system. For example, Brooker (2004, 2007) further developed the idea of person-centred care, and came up with the VIPS framework. This involves four elements: V – a **v**alue base which values all human life, I – **i**ndividualised approach, P – considering the **p**erspective of the service user and S – a supportive **s**ocial environment that meets psychological needs (for further information, see Brooker, 2007:13).

There is evidence to show that the person-centred approach is beneficial and there are many ways to apply it in care settings. For example, a review by Terkelsen et al. (2019) suggests that person-centred care led to increased quality of life and more positive care experiences in Western countries. Additionally, Johnston and Narayanasamy (2016) found that it facilitated meaningful engagement with individuals involved and helped to acknowledge the history and personhood of patients. Furthermore, there is some evidence to show that the approach even influences care choices made by health providers, such as decisions relating to pain management (Hunter et al. 2013).

Nonetheless, research suggests that although improvements have been made, work still needs to be done. A recent ethnographic work by Featherstone and Northcott (2020) explored the experience of PLWD in acute hospital settings. Their book, *Wandering the Wards*, provided a bleak picture of what PLWD can experience when in hospital, suggesting that dementia as a condition is poorly understood by health professionals, and PLWD are often treated as invisible. This can result in very negative outcomes for PLWD when they are admitted to hospital. Some research estimates that someone with dementia is up to twice as likely to die during a hospital admission, compared to someone without dementia admitted with the same conditions (Sampson et al., 2009; Goldberg et al., 2012). These worrying statistics highlight the importance of research in this area.

1.2 Elderspeak

It is generally acknowledged that communication can play a vital part in good person-centred care and helping to maintain a sense of self and connection in PLWD (Williams, et al., 2017; Kitwood, 1997). Despite the importance of communication in healthcare being well-known, HCPs often report finding it challenging in situations which involve PLWD (Griffiths et al., 2014). One particular feature of communication which is very commonly used in healthcare towards PLWD is elderspeak. Shaw et al., (2022) revealed that approximately 97% of interactions between nursing staff and PLWD involve some elderspeak. However, despite its apparently frequent use, elderspeak has been the subject of much debate.

Elderspeak is variously defined in the literature. Some of the first research on the topic began when simplified speech was found to be used towards residents in US nursing homes, but not when staff spoke to their coworkers (Ashburn and Gordon, 1981). In the same year, Caporael (1981) noted “baby talk,” being used towards nursing home residents, and that this style of talk could not be separated from talk that was used towards infants. The term “elderspeak” itself was initially used by Cohen and Faulkner (1986). Although it was initially conceptualised in reference to baby talk, later research began to conceptualise elderspeak as a more patronising phenomena, in relation to speech accommodation theory (see Coupland et al., 1988) with Ryan et al., (1986, 1995) developing the Communication Predicament of Aging Model (CPAM), see figure 1.1 below.

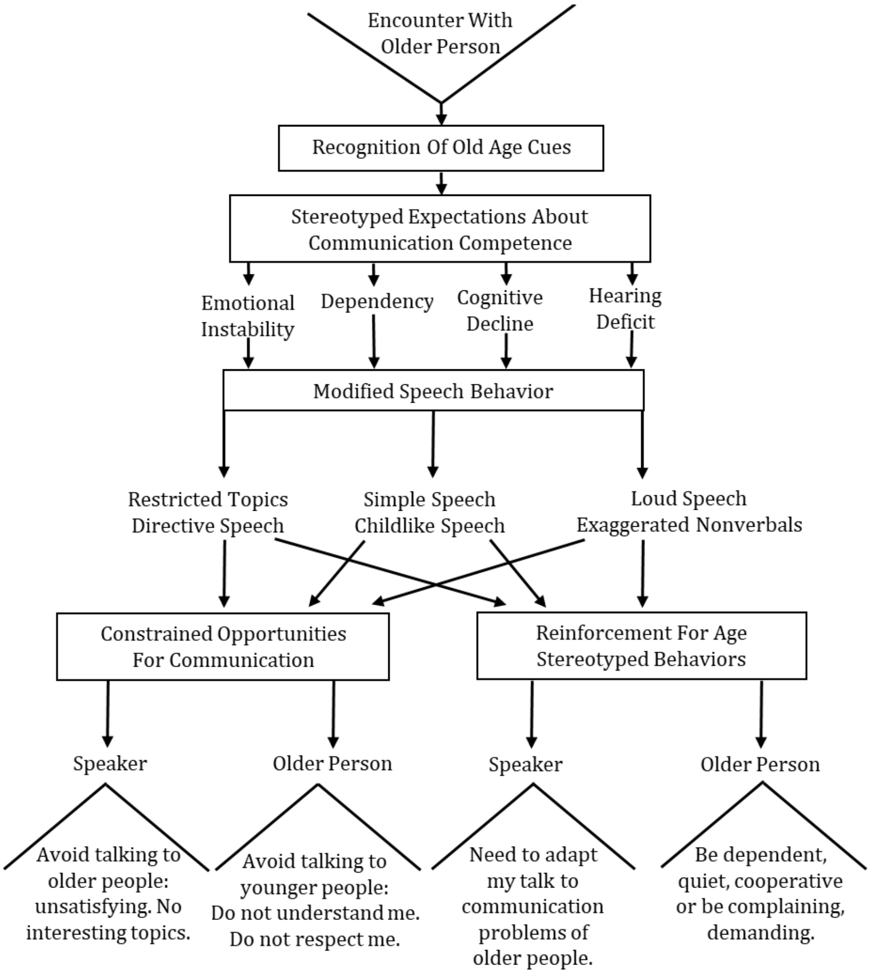


Figure 1.1: Features and functions of patronising communication within the CPAM (Ryan et a., 1995: 147).

The CPAM (Ryan et al., 1995) claims that elderspeak (also referred to as ‘patronising communication’), occurs when individuals over-adjust their communication style towards older adults, based on old-age stereotypes of assumed incompetence or dependence in the individual. These (potentially incorrect) assumptions lead to features such as simplified sentences/grammar, slower or louder speech, higher pitch and the use of terms of endearment which may be inappropriate for the situation (Williams et al., 2017; Ryan et al., 1995). As explained by Ryan et al., (1995), the 'communication predicament' the CPAM model refers to, is the challenge experienced by speakers to find a balance between behaving with respect or being more caring. In other words, treating the older person as capable and making the most of their abilities, whilst also making accommodations that are appropriate for the specific communication challenges they face. In this, there is a difficulty in that by making communication more easily comprehensible (e.g. by speaking more simply or slowly) it might at the same time carry the message that the person being spoken to is less competent or independent.

Ryan et al. (1995) suggest that this speech style can lead to decreased self-esteem, depression and withdrawal in its recipients. Nonetheless, it should be noted that this paper relies heavily on assumptions and evidence based on hypothetical scenarios (e.g., Hummert et al, 1994). This means that there is a lack of grounding in what occurs in actual real interactions, and how recipients of elderspeak themselves respond. Moreover, and notably, the classification of a given communication or event as over-accommodation or patronising is dependent on the interpretation of speakers, listeners or third-party observers (Ryan et al., 1995), demonstrating the subjectivity of this definition, and beginning to raise the question that frames this thesis: “is elderspeak always inappropriate?”

Shaw and Gordon (2021) conducted a more recent review of research in this field, stating at the outset that elderspeak is: “*a simplified speech register used with older adults which sounds like baby talk. It is characterized by a variety of linguistic adjustments in rhythm, sound, sentence structure, and meaning, such as a high-pitched and over nurturing voice, use of inappropriate terms of endearment (e.g., sweetie), and collective pronoun substitution (e.g., we instead of you)*.” (2021: 2). Many of these features are shared with Ryan et al’s earlier categorisations, and still involve assumptions of inappropriateness. See table 1.1 below for a full list of all features of elderspeak identified by Ryan et al., (1995) and Shaw and Gordon (2021).

Broad Category	Specific	In which paper
Vocabulary	Childish Terms	Both
	Simple Vocabulary	Both
	Short Words	Both
	Minimising	Both
Grammar	Simple Sentences	Both
	Short Utterances	Both
	Sentence Fragments	Both
	Repetitions	Ryan et al., (1995)
	Long Pauses/Extra Fillers	Both
	Tag Questions	Both
	Directives/Imperatives	Both
	Collectives	Both
	Reflexives	Shaw and Gordon (2021)
Forms of Address	Diminutives (including T.o.E)	Both
	First Names	Ryan et al., (1995)
	3rd Person References	Ryan et al., (1995)
Topic Management	Exaggerated Politeness	Shaw and Gordon (2021)
	Exaggerated Praise	Both

	Interruptions	Both
	Limited Topic Selection/Reinforcement	Ryan et al., (1995)
	Ignoring/Dismissive	Both
Voice	Raised Pitch	Both
	Excessive Pitch Range/Singsong Intonation	Both
	Excessively Soft Voice	Shaw and Gordon (2021)
	Overly Loud Voice	Both
	Excessively Slowed Speech Rate	Both
	Over Exaggerated Pronunciation	Both
	Overly Exaggerated Stress	Shaw and Gordon (2021)
Gaze	Low Eye Contact	Ryan et al., (1995)
	Staring	Ryan et al., (1995)
	Eye Rolling	Both
	Winking	Ryan et al., (1995)
Proximity	Standing Too Close	Ryan et al., (1995)
	Standing Over	Both
	Standing Too Far Off	Ryan et al., (1995)
Facial Expression	Frowning	Ryan et al., (1995)
	Exaggerated Smile	Ryan et al., (1995)
	Raised Eyebrows	Ryan et al., (1995)
Gestures	Laughing At	Shaw and Gordon (2021)
	Shaking Head	Ryan et al., (1995)
	Shrugging	Ryan et al., (1995)
	Hands On Hips	Ryan et al., (1995)
	Crossed Arms	Ryan et al., (1995)
	Abrupt Movements	Ryan et al., (1995)
Touch	Patting	Both

Table 1.1: elderspeak specifics

Shaw and Gordon (2021) also concluded that many older adults do not find elderspeak to be respectful, and maintain that elderspeak may lead to behaviour in PLWD such as resistance to care and some elderspeak (specifically prosody) may reduce comprehension. Nonetheless, they do also suggest that some aspects of speech accommodation could help to facilitate comprehension (in line with Ryan et al., 1995) and that not all older adults will find elderspeak to be patronising. Overall, these conclusions led them to advocate for an individualised approach to communication, with accommodations being based on the person's specific needs, reflecting the pervasive underlying person-centred ideology of care (Kitwood, 1997; Brooker, 2007).

Williams et al., (2017) further make the point that elderspeak is implicated in person-centred care, although in this case they focus on the idea that that older adults can recognise when elderspeak is being used towards them, and this is a threat to their sense of personhood and self. If this is the case, it is possible that elderspeak is a threat to good person-centred care (as defined by Kitwood, 1997). It should be acknowledged that some features and alleged consequences of elderspeak do align closely with Kitwood's (1990, 1997) malignant social psychology discussed above. For instance, communication based on underlying assumptions of incompetence described by Ryan et al., (1995) would fit with the elements of *infantilisation*, *labelling* and *stigmatisation*. Additionally, the implied threat to personhood could potentially be a form of *disparagement* and perhaps even *mockery* depending on how the communication comes across.

With these ideas in mind, elderspeak can be located within broader sociological theory. For example, Goffman's, (1955) notion of face is relevant here. This theory proposes that face is something that people create like a mask in social situations. People try to maintain their face, both to avoid feeling bad about themselves and also so that others will respond favourably towards them. If something happens in interaction that provides a better level of face than the one the person holds for themselves, then the person will feel positively about themselves. It follows that in relation to elderspeak, if a communication style is used towards an individual that they perceive is patronising, infantilising or otherwise disparaging, then this is a clear threat to face, which may help to explain some of the potential negative consequences of elderspeak suggested by the literature (e.g. lower self-esteem, withdrawal and depression, Ryan et al., 1995). Other literature also portrays elderspeak in a decidedly negative light, highlighting consequences and providing information on how to recognise and avoid it (e.g., McLaughlin, 2020; Williams et al., 2009; La Tourette and Meeks, 2000). Lowery (2013) provides a further review on this topic.

Nonetheless, despite the prevalent view of elderspeak as a negative, a preliminary investigation from Torres-Soto (2019) showed videos of interactions with older adults with cognitive impairment in a care facility and collected self-reports of mood before and after each video, and conducted observations of affect during the viewing. They found that in comparison to a neutral interaction, the older adults showed no behavioural or emotional differences when viewing an interaction containing elderspeak. This is in contrast to the claims of Ryan et al., (1995) and Williams et al., (2017) discussed above. Furthermore, in terms of actual care interactions, it should be noted that despite some negative findings and assumptions, in practice elderspeak can be viewed as a positive or useful thing. Grimme et al. (2015) found that elderspeak was often used with good intentions, with some healthcare professionals viewing it as useful and more appropriate for PLWD. Overall, they found that elderspeak was used with the intention of enabling positive interactions by making PLWD feel more comfortable and making caregivers appear more friendly. It was also intended to improve comprehension and cooperation.

These findings point to a situation, previously identified by some researchers (Lombardi et al., 2014; Hummel, 2012) where context is likely to have a significant influence on the appropriateness of elderspeak. It is likely that the situation in which it is used may affect how individuals respond. For example, research by Yazdanpanah et al., (2019) found that the context in which interactions occur influenced whether some features of elderspeak (particularly sound prolongation) were interpreted as distressing or soothing. These findings may be interpreted in relation to the CPAM model (Ryan et al., 1995), in that there is potential overlap between what is considered helpful and what is considered overaccommodation or patronising talk.

From a conversation analytic perspective (the method used in this thesis, see chapter 4), talk can only be examined as it presents in real life interaction (see Sacks et al. 1974). As has been briefly mentioned here (and will be demonstrated in more detail in the literature review in the following chapter), research into elderspeak has largely been carried out using a priori definitions and assumptions. These assumptions generally include the idea that elderspeak has overaccommodating or patronising functions and should be avoided. However, these assumptions largely appear to be made by researchers themselves, without reference to PLWD themselves or the way in which these features of elderspeak occur in interaction.

We therefore have a list of potential features of talk (e.g. high pitch, simplified speech, terms of endearment etc.) which have been placed together into the category of elderspeak, or patronising communication without any real knowledge of whether they serve any interactional function in interactions with PLWD. In other contexts, these same features may be considered comforting (e.g Proctor et al. 1996), or otherwise beneficial (for example when used towards children, e.g. Saint-Georges et al. 2013; Frank et al. 2020). Although we have some arbitrary 'rules' that classify these features as elderspeak (such as the talk being directed towards an older person), the fact that the basic features of talk remain the same demonstrate that further investigation is needed into exactly how this style talk presents in real life interaction with PLWD, and how it is received by them in different contexts.

The use of CA in this analysis means that these features of talk may be investigated as they appear in interaction without pre-existing assumptions of their purpose. The analysis in this thesis is not intended to evaluate motivations behind talk: for example whether individuals are using higher pitch or a term of endearment because they hold a pre-existing stereotype of the person they are talking to. Instead, the focus is on how the talk is produced treated during the interaction, and how it is responded to. This approach will be further discussed in the methodology section of Chapter 4 and will be revisited during the analysis sections of the thesis.

The accumulation of this background literature led to the following broad research questions which underpin my PhD research.

1.3 Research Questions:

1) In what contexts is elderspeak used in the care of people living with dementia (PLWD), and by whom?

2) How is elderspeak received and responded to by PLWD?

3) What is the impact of local interactional context on receipt or rejection of elderspeak by PLWD? Does activity type (e.g., medical history taking vs assisting someone with eating) affect receipt?

The nature of these questions meant that a method was required with the capability to examine naturally occurring actions in detail, contributing to the decision to use conversation analysis (CA) in this thesis. This will be discussed in much greater depth in chapter 4. Before carrying out my own research it was necessary to more comprehensively identify existing work in this area. Due to the exploratory nature of these questions, the scoping review method was chosen over a systematic review. The aim of this review was to establish a more comprehensive understanding of the existing knowledge in the field of dementia care and elderspeak research, in order to identify gaps and develop directions for future research. This review will be covered in the following chapter.

Chapter 2: The Appropriateness of Elderspeak in Dementia Care: a Scoping Review

The following chapter will cover the scoping literature review which examined the appropriateness of elderspeak used in dementia care. Initially, the design and implementation of the review is covered, followed by the findings which are discussed in relation to the wider research questions of this thesis.

2.1 Protocol Design

The protocol used in the present literature review was based on the guidance set out by Arksey and O'Malley (2005), and the advice provided by Peters et al., (2020) in the Joanna Briggs Institute Manual for Evidence Synthesis. According to these, a scoping review should involve five stages, (with an optional sixth stage). These stages are: firstly, identifying the research question; secondly, identifying relevant studies; selecting studies; charting the data; collating, summarising and reporting the results and lastly, consulting with relevant stakeholders.

2.2 Stage 1: Identifying Research Questions

The objective of this scoping review was to explore what data are currently available relating to elderspeak and dementia care, in order to identify gaps in knowledge and inform future research. The following questions were identified with background theory and literature in mind:

1) In what contexts is elderspeak used in the care of people living with dementia (PLWD), and by whom?

2) How is elderspeak received and responded to by PLWD?

3) What is the impact of local interactional context on receipt or rejection of elderspeak by PLWD? Does activity type (e.g., medical history taking vs assisting someone with eating) affect receipt?

2.3 Stage 2: Identifying relevant studies.

Electronic databases of the published literature in the area were searched to identify relevant studies in the area. These databases included MEDLINE; PubMed; EMBASE; CINAHL and PsycINFO. In addition, resources such as EThOS, OpenGrey and Google Scholar were searched to identify relevant grey literature. The reference lists of relevant studies found were also searched to check for additional studies of relevance.

Based on the initial exploratory research covered in the introduction, the review used the following eligibility criteria:

2.3.1 Participants:

- People living with dementia (PLWD).
    - Note that this makes it likely that the majority of participants may be older adults. However, due to the variability in dementia conditions and diagnosis, no limits were placed on age.
- People working with PLWD.

2.3.2 Concepts:

- The review was particularly interested in the phenomenon of elderspeak, and how it is used in interactions. This includes where elderspeak is used in care of PLWD, how PLWD respond to elderspeak and how different interactional contexts impact how elderspeak is received.

2.3.3 Context:

- Care settings. This could include any setting where PLWD experience care interactions, including healthcare and personal care. Although this thesis will focus on the acute hospital setting, for the purpose of the review context was left intentionally broad, due to its exploratory nature.

2.3.4 Types of evidence sources:

- As this review aimed to explore existing evidence in the field and identify gaps in knowledge, all forms of literature found in the search were considered for inclusion. The search itself was limited to the English language, due to time constraints and potentially differing linguistic and cultural norms around factors such as politeness (e.g., Becker et al., 2020; Wierzbicka 1985) and dementia diagnosis (e.g., Mahoney et al., 2005). No cut-off date was used, since the concept of elderspeak within research is relatively recent. This initial search was conducted between March and May 2021 and then updated between December 2023 and February 2024 to include new literature that had been published during the time period of this thesis.

2.3.5 PCC Summary (as recommended by Peters et al. (JBI) 2020)

	Main concept
Participants	PLWD, people working with PLWD
Concepts	Elderspeak, Interactional Context
Context	Care settings

Table 2.1: PCC Summary

2.3.6 Proposed Search Strategy

The following search terms were created after an initial literature search using the main concepts stated above in the PCC table.

Concept	Search terms
People living with dementia	Dementia* OR living with dementia OR PLWD OR cognitive impair* OR memory loss OR Alzheimer* OR AD
Elderspeak	Elderspeak

Interactional context	Interactional context OR context OR Interaction* OR relation* OR interpersonal OR social*
Care settings.	Care* OR hospital* OR residential OR nursing OR institution* OR eldercare OR Homes for the aged OR retirement communit* OR healthcare

Table 2.2 Literature Review Search Terms

It should be noted that after the initial search was complete, an additional search was run identical to the above, but substituting the term "elderspeak" with "Patronising OR patronizing OR baby talk Or Infantilisation talk OR infantilization talk OR infant* speech". This was done to check for additional papers which may have been published before the term elderspeak became widely known and used. A summary of the development of elderspeak as a concept can be found in Shaw and Gordon (2021).

2.4 Stage 3: Study Selection.

The results of the searches were consolidated, and duplicates were removed. Literature was first reviewed based on the abstract (or similar) provided. Full papers of selected studies were then reviewed to ensure all inclusion criteria were met. This is consistent with the PRISMA process discussed by the Joanna Briggs Institute (Peters et al., 2020).

2.5 Stage 4: Charting the Data/Data collection.

During the full text review, data was collected for each study using a data collection matrix in Microsoft Excel. The chart had the following headings: reference, year of publication, source country, aims/purpose, study population/sample size, methodology, environment, relevant findings, notes, appropriateness of elderspeak (for/against/mixed), and description of elderspeak used. This allowed a brief overview of each paper, enabling easier comparison.

2.6 Stage 5: Data summary and synthesis.

Once the papers were read in full and appropriate data had been extracted, data was then synthesised using thematic analysis to develop a summary of information included. This synthesis is discussed below in terms of the research questions and implications for future study.

After full text review, 47 references were chosen for inclusion in the present review. Sixty-one references were excluded as they did not meet the full inclusion criteria (51) or it was impossible to access the full text (10) with existing University of Nottingham subscriptions. The 47 included studies ranged in date from 1986 to 2022 and were mostly based in the USA (24), followed by Germany (4), Canada (4), Sweden (4) and the UK (3). Single references were also gathered from Australia, Belgium, China, Ireland, the Netherlands, New Zealand, Portugal and Singapore. Of the studies that specified numbers of participants (as opposed to reviews), number of participants ranged from 1 to 188 (mean= 57). The majority of research took place in nursing homes and other long term care facilities, but a small amount did cover other environments such as acute hospitals and home/community settings. Some studies also used laboratory settings.

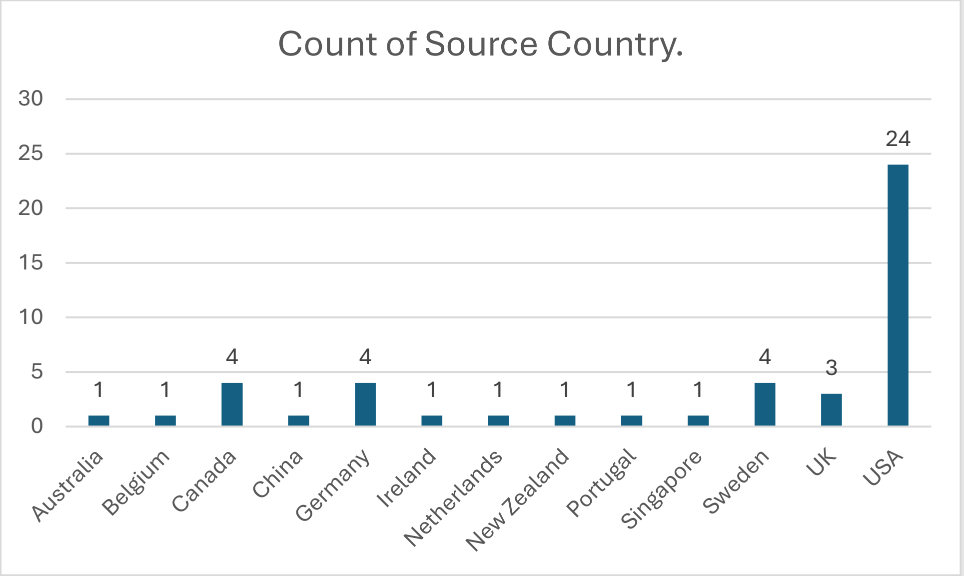


Figure 2.1: Source Countries of Data.

During the examination of the full text, each study was given a preliminary rating regarding whether it was mostly positive or negative towards the use of elderspeak as a whole. A “mixed,” category was added for those which offered both positives and negatives, or remained neutral on the issue. This rating was primarily given based on suggested outcomes or results of elderspeak. For instance, Balis and Carpenter (2005) claimed that elderspeak use is seen as disrespectful, patronising etc. and people elderspeak is used towards are considered to be frustrated, angry, unhappy etc. Balis and Carpenter also specifically use the phrase “*negative effects of elderspeak*…” (pg. 90). Hence, this study was sorted into the “negative,” category. It should be noted that this rating system was purely to allow some initial examination of the data, and should not be taken as an absolute judgement of each paper. Nevertheless, this led to 23 studies being rated as having a negative perspective on elderspeak, 5 having a positive perspective on elderspeak and 19 with mixed or neutral views. These findings demonstrate that the use of elderspeak in dementia care is a controversial topic, over which there is some disagreement.

It is of note that eight papers were almost excluded, as their main focus was not on PLWD, despite discussing elderspeak. (Balis and Carpenter, 2005; Catona 2010; Kemper and Harden, 1999; Marsden and Holmes, 2014; Ryan et al., 1986; Samuelsson et al., 2013; Samuelsson et al., 2015 and Schroyen et al., 2018). After consultation with the supervisory team, it was deemed relevant to include them in the analysis. Although they do not examine elderspeak directly in relation to PLWD, they do look at the use of elderspeak in more general care related settings. They can therefore be used in terms of examining how, where and why elderspeak occurs in more generalised settings, which may then apply to PLWD. Furthermore, although the main focus of the present review is how elderspeak is received and responded to by PLWD, it may be relevant to consider if this response is similar or different to individuals without dementia, and also how attitudes to research in this area have developed.

2.7 Themes

Themes identified within the findings of the included studies will now be reflected on in relation to the research questions.

2.7.1 In what contexts is elderspeak used in the care of people living with dementia (PLWD), and by whom?

As anticipated, elderspeak appears to be widely used in the care of PLWD. Grimme, et al., (2015) claimed that all 26 certified nursing assistants they interviewed (from 4 long-term care facilities) reported either using or witnessing elderspeak. Likewise, when examining hospital interactions between nursing staff and PLWD, Shaw et al., (2022) found that more than one quarter of all speech used by nursing staff towards PLWD was elderspeak, and almost every care interaction (~97%) included at least some elderspeak. Similarly, Willams et al., (2017) reported that elderspeak was a common occurrence in nursing homes (with elderspeak found in 84% of transcripts of staff-resident communication).

In terms of specific contexts, Shaw et al., 2022 recorded hospital care interactions that involved activities of daily living, assessment, medication administration, and procedural care (2022: 3). The more common features of elderspeak they identified included minimising words, mitigating expressions, childish talk and collective pronoun substitution. Williams et al. (2017) found that elderspeak was present in resident-staff interactions during activities such as bathing, dressing and oral care. It should be noted that in this case, the most common form of elderspeak found overall was collective pronoun substitution, (use of “we,”); this was followed by the use of diminutives including terms of endearment (such as” Honey,” “Sweetie,” “Grandma,” “Babe” and “Sunshine.”). Additionally, Carpiac-Claver and Levy-Storms (2007) found that during mealtimes in nursing homes, terms of endearment were used for residents with higher levels of cognitive impairment.

Overall, elderspeak was commonly believed by staff to be more appropriate for PLWD than older people in general (e.g., Grimme et al., 2015; Lombardi et al., 2014; McLaughlin, 2020), and was often seen as an aid or solution to communication difficulties with PLWD (e.g., Grimme et al., 2015; Small et al., 1997; Jansson, 2016; McLaughlin, 2020). Similarly, elderspeak was suggested as a means to aid task completion for PLWD (Lombardi et al., 2014), particularly when care staff were attempting to assist with activities of daily living. It was suggested that the use of elderspeak could potentially help to normalise or make sense of the presence of a carer during activities such as personal care (Jansson, 2016). The assumption that elderspeak may be helpful for facilitating task completion supports the findings of Williams et al. (2017) and Carpiac-Claver and Levy-Storms (2007) discussed above. It would make sense for staff to use a method they believe to be helpful when managing activities that are known to be difficult in many cases with PLWD, such as brushing teeth or assisting with eating.

Interestingly, many researchers mentioned that cognitive impairment (CI) itself appeared to be a trigger for the use of elderspeak, with increased CI leading to more extreme use of elderspeak. This is particularly evident in Cavallaro et al., (2016), where it is noted that the more “incapable” a resident appeared to be, the younger they were treated as. Hence, residents with high CI were spoken to in a manner similar to how one would converse with an infant (as opposed to residents with low CI who were spoken to as children). An increased degree of elderspeak for PLWD was also noted by Kemper et al., (1998) who noted that young adults used elderspeak for both (those that they perceived as) older adults and older adults with dementia. However, for the perceived PLWD, they lowered propositional density, provided more expanded/repeated instructions and increased location checks. This resulted in differences in the amount of information conveyed during a conversation, but not the delivery itself.

It should be noted that although it appears there is a clear link with apparent severity of the individual's dementia, and the use of elderspeak towards them, the situation may not be as simple as it first appears. For example, there is some evidence to suggest that the use of elderspeak was more related to cues of old age or disability in general, rather than dementia specifically. Schnabel et al., (2020) examined interactions between nurses and patients in acute general and geriatric hospital settings. They used naïve raters to judge whether the tone used was either controlling or person-centred (based on impressions of the vocal qualities). Although they found that the nurses did use more controlling tones (defined in relation to elderspeak) in both settings for patients who were cognitively impaired, when the findings were looked at overall, it appeared this behaviour was actually related to lower functional status in general (as opposed to just CI).

Furthermore, Hummert and Shaner (1994) had young adults participate in a role-playing exercise where they were asked to record a persuasive message to an older person. On the basis of their results, they claimed that more elderspeak would be used towards a 'negative target,' compared to a 'positive' one. In this instance, the 'targets,' they used were hypothetical individuals described as having various stereotypical features. Nevertheless, in this situation, the targets did not just differ on level of cognitive impairment/dementia. Although the ‘negative’ person was portrayed as having dementia, the described individuals also differed on a number of other factors such as age and description. (The negative persona was described as “*fragile*,” and “*waiting to die*,” (Hummert and Shaner 1994: 147)). Therefore, comparisons in relation to dementia only are limited, and it is possible that other cues here were just as important for triggering elderspeak.

Further supporting this, Shaw et al., (2022) found a statistically significant increase in the amount of elderspeak used by nurses towards PLWD in hospital where they experienced delirium and/or had longer hospital stays. The fact that all of the patients had dementia, but elderspeak was increased for additional issues further supports the notion that dementia is not the only cue for elderspeak. Arguably, patients who were also experiencing delirium and/or had longer hospital stays were likely to have more serious or extended illness so would also present other stereotypical cues that could trigger elderspeak. Nonetheless, the fact that all the patients had dementia limits comparisons.

Perhaps more compelling evidence for the wider use of elderspeak towards older people in general comes from the subset of articles that did not specifically focus on PLWD (Balis and Carpenter, 2005; Catona 2010; Kemper and Harden, 1999; Marsden and Holmes, 2014; Ryan et al., 1986; Samuelsson et al., 2013; Samuelsson et al., 2015 and Schroyen et al., 2018). Supporting the idea that more general old-age cues can trigger elderspeak, Catona (2010) found that features of care home residents themselves explained the most variance in resident-caregiver interactions. In particular, stereotypes relating to hearing proficiency were most associated with elderspeak.

Samuelsson et al., (2015) is of interest here, as (in conjunction with Osterholm and Samuelsson, 2015), they propose a new concept of "dementia-speak." This is elderspeak directed specifically towards PLWD, which may differ slightly to elderspeak used towards people without dementia. This may be an area that requires further investigation, but it was found that PLWD were socially positioned differently in conversation, compared to people without dementia. In this case, during conversation PLWD were placed in a less competent role than people without dementia. Samuelsson et al., (2015) also suggested that although people without dementia experienced fewer features of elderspeak, its use may be linked to frailty of the individuals involved (since those perceived as more frail were treated as less competent.). This fits well with the other research discussed above. Hence it is possible that elderspeak may be used to different extents, depending on the perceived mental and physical characteristics of the individual it is directed towards. Although Osterholm and Samuelsson, (2015) claim that PLWD receive more features of elderspeak (prompting them to label the more extreme use as "dementia-speak,") it may still be that elderspeak use is based more on stereotypical old-age cues, and PLWD may in general happen to display more of those cues. As Hummert and Shaner (1994) discuss, features of dementia such as forgetfulness are part of the old age "negative" stereotype.

In terms of wider environmental context, the majority of research took place in long-term care facilities, particularly nursing homes. Consequently, the assumption that elderspeak commonly takes place within the context of formal long-term care is well founded. With regards to other environments, the picture is not quite as definitive. Three papers (Shaw et al., 2022; Schnabel, Wahl et al., 2020a and Schnabel, Wahl et al., 2020b) examined hospital settings and found high use of elderspeak features in these environments. Five papers included participants who resided in a home environment (usually with relatives as carers) (Small et al., 2009; Christie 2016; Osterholm and Samuelsson, 2015; Samuelsson et al., 2015 and São José, 2020) which may indicate a wider presence of elderspeak towards PLWD in less formal care settings. Interestingly, elderspeak was also used towards PLWD in studies which used laboratory environments (e.g., Kemper and Harden, 1999; Hummert and Shaner, 1994). Whilst the ecological validity of such studies is often limited due to their nature, the fact that elderspeak still occurred here supports the idea discussed above that use may be triggered more by the characteristics or perceptions of the individuals involved, rather than the specific environment that they are in.

To summarise, elderspeak appears to be used widely in the care of PLWD, particularly during activities of daily living. Evidence is limited, but it is possible that the use of elderspeak may be more related to the individual features of the PLWD themselves, and less about wider environmental context.

2.7.2 How is elderspeak received and responded to by PLWD?

Despite its frequent use, and the common belief that elderspeak is a suitable or useful way to communicate with PLWD, a number of negative reactions were noted. A common finding was that elderspeak was linked to resistance to care

(RTC) in PLWD (e.g., Backhouse et al., 2020; Christenson et al., 2011; Cunningham and Williams, 2007; Herman and Wiliams, 2009; Williams et al, 2017). There was also evidence to suggest that elderspeak led to PLWD being placed in a passive role which resulted in issues such as lower self-esteem, increased dependence, feelings of incompetence, frustration, agitation or depression and potential aggression (e.g., Bugental and Hehman, 2007; McLaughlin, 2020; Salari, 2005).

In addition, there was some suggestion from the literature that elderspeak was actually detrimental to conversations in some cases. For instance, Williams (2016) found that use of elderspeak was correlated with fewer utterances by nursing home residents with dementia. Small et al., (2009) also found that some features of elderspeak (pitch and loudness) were associated with conversations which were deemed unsuccessful in some spouse pairs during daily living tasks at home. Although, conversely, the same features of elderspeak were actually associated with successful conversations with other pairs in the same study, implying conversation success may have been more related to variation in individual situation, rather than elderspeak overall.

Some positive reactions to elderspeak were also observed in other studies. A key theme was improved communication. As mentioned above, Small et al., (2009) found some contrasting links to both conversational success and failure. McLaughlin (2020) suggested that elderspeak does share some features with a style of communication that is considered good or helpful for PLWD, such as the use of short and simple sentences. This assumption may have some merit as

Small et al., (1997) did find some support for the use of simplified grammar, and paraphrased repetitions improving comprehension for PLWD.

Sachweh (1998) observed 70 nursing home residents, and found elderspeak (or as they often referred to it, 'secondary baby talk'), was mostly accepted or even liked by residents. It should be noted that this study did not exclusively focus on PLWD, but a significant proportion of those included in the research did have dementia. Interestingly, the most extreme reactions captured (both positive and negative) were from PLWD. They concluded that where elderspeak is used, the affection and care it signals may outweigh the implied child status, making it a positive thing. Jansson (2016) also noted that if used sensitively, praise (a feature of elderspeak), could aid the provision of person-centred care, as it helps PLWD to stay on task. In addition, Marsden and Holmes (2014) identified some features of elderspeak such as mitigated directives (suggestions, rather than commands) and endearments which they argued resulted in the building of good warm relationships between caregivers and residents. This further suggests that in some cases, elderspeak may in fact be beneficial.

Another area of interest in terms of how elderspeak is received and responded to by PLWD is the presence of potentially protective responses to its use. Regardless of whether elderspeak in the abstract is perceived as positive or negative by the participants of a conversation, PLWD were reported to have the ability to reposition themselves within an interaction. For instance, Osterholm and Samuelsson, (2015) reported that in conversations with social workers and relatives, PLWD were positioned as less competent. However, some PLWD used language which reframed them as capable individuals. This interesting response to elderspeak suggests that it may not always lead to a self-perpetuating negative spiral as is often assumed. Nevertheless, it should be noted that these findings may not apply in all cases, particularly in individuals with more severe dementia.

Salari (2005), whose ethnographic research in adult day centres found largely negative effects of elderspeak and other associated ‘infantilisation’ treatment, also claimed that older people may have the capacity to resist elderspeak. Unlike Osterholm and Samuelsson (2015), however, Salari found that this resistance could lead to an increasingly negative situation. For example, some individuals were reported to adopt what was described as a fight or flight response, which could include sarcastic remarks, verbal attacks, and breaking of institutional rules (particularly when staff attempted reprimands). If this is the case, it may be that a resistive response to elderspeak relates to resistance to care discussed above. It was also suggested by Salari that in terms of wider care, treating older people like infants can create a more restrictive environment which may potentially worsen features of dementia such as agitation.

To summarise this section, it appears that the way PLWD receive and respond to elderspeak has the potential to be highly varied. Reactions range from very positive to very negative, possibly depending on individual situation and context, and this may also be influenced by how PLWD position themselves within a conversation. This highlights the importance of examining the impact of local interactional context.

2.7.3 What is the impact of local interactional context on receipt or rejection of elderspeak by PLWD? Does activity type (e.g., medical history taking vs assisting someone with eating) affect receipt?

From the data available, the above question is perhaps the most challenging to answer at this stage, as little research focused specifically on this issue. Nonetheless, some extrapolations can be made. As already discussed above, it does seem that elderspeak is used more in some situations, particularly when a carer is assisting someone living with dementia with an activity of daily living. It is difficult to say however, whether these situational differences influence receipt of elderspeak as many papers do not specify exactly what reactions occurred in relation to each activity (if indeed the studies were observational). Many more studies do not focus directly on real-time interaction, instead choosing to use hypothetical situations or interview techniques, for example.

Nevertheless, one theme of interest here is the relationship between the carer and PLWD. Lombardi et al., (2014) found that elderspeak was considered to be more appropriate in situations where certified nursing assistants (CNAs) had a familiar relationship with residents of long-term care facilities. Likewise, Sachweh (1998) suggested that nurses used elderspeak towards residents that they liked more. Schnabel et al., (2020b) also specified that appropriateness may depend on familiarity and Cavillaro et al. (2016) noted that a positive or negative response may depend on a resident's relationship with the carer. Hence, it appears that those with higher levels of familiarity with their carer may respond better to the use of elderspeak. Nonetheless, these findings should be interpreted with caution. Not all of the papers considered the direct opinions or reactions of PLWD, and some instead used assumptions from the individuals caring for them.

La Tourette and Meeks (2000) claimed in their study comparing nursing home residents and older adults in the community that there was no influence of living environment on evaluations of elderspeak appropriateness. However, the fact that the five papers classified as positive towards elderspeak in the present review were all based in long term care environments (e.g., nursing homes), may introduce some uncertainty to this claim. On a related note, reconsidering the positive and negative reactions found by Salari (2005) and Osterholm and Samuelsson (2015), it is of interest that Salari's research took place in day centres, whereas Osterholm and Samuelsson examined assessments for short-term care and home situations. It is possible that the difference in environment influenced (at least some of) the variation in reactions to elderspeak. A day centre is an institution (as defined by Goffman 1961); however, if individuals only spend short periods of time there, they may not be fully 'institutionalised', and so may be more resistive to forms of behaviour and interaction which may seem more "normal" for those in longer-term care environments. They may also lack familiarity or ongoing relationships with staff. Osterholm and Samuelsson's research looked at interactions involving family members, suggesting an element of familiarity. Hence, individuals in that instance may have felt more comfortable repositioning themselves in less overt or aggressive ways.

Another potential area of consideration is the sex of individuals within interactions. This area is not always examined, but some papers did note differences within their findings. Cavallaro et al., (2016) noted that what they categorised as negative overaccommodation was only used towards female residents, and Sachweh (1998) also observed elderspeak mainly directed towards female residents. However, it should be noted that, particularly in the paper by Sachweh, a large majority of the residents were female (62 females to 8 males), which limits the sex comparisons that can be drawn.

2.8 Discussion

Overall, this review has aimed to explore the following questions: "In what contexts is elderspeak used in the care of PLWD, and by whom?" "How is elderspeak received and responded to by PLWD?" and "What is the impact of local interactional context on receipt or rejection of elderspeak by PLWD? Does activity type (e.g., medical history taking vs assisting someone with eating) affect receipt?"

In terms of context, it appears that elderspeak is commonly used in a wide variety of situations, particularly where a carer is attempting to help PLWD complete a task, or the PLWD display cues particularly stereotypical of old age or disability. This is especially salient in nursing home environments, where the majority of research was conducted. Regarding responses, it appears that PLWD can receive and respond to elderspeak in both positive and negative ways. This may be influenced by local interactional context, although at present, there is not enough data to predict how this may have an effect.

Despite this review producing some interesting findings, a number of limitations should be noted. For example, there was wide variation in how dementia as a condition was identified and interpreted. Some papers intentionally singled out PLWD for their study or tested for the condition (e.g. Christenson et al., 2011), whereas others noted more vague features such as memory loss or cognitive impairment within their participants (e.g., Bennett et al., 2016). Even within those more formally diagnosed, some focused on dementia as a whole and others focused on particular types of dementia such as Alzheimer's disease (e.g., Small et al. 2009). Hence, it may be difficult to make specific statements about how PLWD respond to elderspeak in all scenarios. On the one hand, the fact that there is such variation in the definitions of dementia, and yet similarities are found within many of the results may suggest some responses to elderspeak could be a more global phenomenon. On the other hand, it is also possible that these discrepancies could also explain some of the variation in how people receive and respond to elderspeak.

Aside from the variation in how dementia was defined, there was also a large amount of variation in how elderspeak was described and operationalised. Elderspeak appears to be a term that has evolved over time (see Shaw and Gordon, 2021). Although it is now commonly used and understood within the literature, earlier papers appeared to focus more on factors such as "baby-talk," "infantilisation," and "patronising talk" (e.g., Anderson et al., 2005; La Tourette and Meeks, 2000; Ryan, et al., 1986; Salari, 2005). The features of talk described in these situations are highly similar to what is now known as elderspeak, which is why these papers were included within this review. Furthermore, not all studies looked at elderspeak as a whole phenomenon, for example, Jansson (2016) just focused on use of praise and some studies mainly focused on "patronising" talk which may be subjective (e.g., Rust, 2013). This further muddles what general extrapolations can be made about how PLWD react to elderspeak in different contexts. In addition, it was noted that some papers (Osterholm and Samuelsson, 2015; Samuelsson et al., 2015) coined a new term, "dementia speak," raising the possibility that even if elderspeak can be considered a whole and coherent phenomenon, some features could potentially differ depending on who it is being used towards (i.e. PLWD or people without dementia).

Another consideration is the possibility of negative bias existing within these findings. It could be argued that terms such as "patronising speech", for instance, may come with negative connotations. A number of the earlier papers (e.g. Balis and Carpenter, 2005; Cunningham and Williams, 2007; Hummert and Shaner, 1994; Ryan et al, 1986; Williams, 2006) provide a fairly negative view of elderspeak in general, and some newer papers appear to have continued this narrative. For instance, many only look for resistance to care in relation to elderspeak, without checking for any more positive or neutral responses. (E.g., Herman and Williams, 2009; Williams et al., 2017 and Williams et al., 2009). This approach is potentially flawed, as often it is impossible to know exactly what has caused the resistance to care and it is perfectly possible the behaviour is in response to some other form of distress, such as confusion or pain from the task being attempted (Kitwood, 1997).

Marsden and Holmes (2014) provide a rarer example of the opposite perspective. They note that previous research had focused mostly on negative aspects of elderspeak such as power and control, and that often social relationships between participants are overlooked. When they took an ethnographic approach to examine talk between care givers and receivers, they found positive effects of elderspeak, highlighting the importance of studying full interactions.

However, even where papers focus mainly on harmful effects, it is worth unpicking the results in more detail. The study by Williams (2006) reports that the use of elderspeak results in less utterances by PLWD. This is framed as a negative, but it is possible this may not show the full picture. For example, the researchers themselves note that the relationship found between more elderspeak and less utterances from PLWD could potentially be due to the staff members in the study simply filling silences that would have already existed. If this was the case, it would fit with other research, which suggests that individuals perceived as less capable are more likely to receive more elderspeak.

Furthermore, the assumption that silence is a negative response is in itself problematic. This may to an extent fit with the narratives of institutions discussed by figures such as Goffman (1961), Szasz (1974), and Illich (1995). In this, individuals such as those living in nursing homes are placed in a position where they lose selfhood and individual agency, and are expected to comply with the rules and authority of the institution. If one views the interaction from this perspective, it could be argued that a lack of response to a staff member may be perceived as a negative. If one adopts a more person-centred view of care, such as that discussed by Kitwood (1997), it could alternatively be posited that a lack of verbal response could mean many things. For instance, the individuals in question could have responded in a non-verbal manner, or they may simply have been unengaged in the conversation. In addition, the fact that fewer utterances also means fewer negative utterances has not been considered. There is no guarantee that if an utterance had been made, it would have been a positive contribution to the interaction, or one that facilitated continuation.

In addition, the fact that most research took place in nursing homes may bias findings further, firstly because they are a specific kind of institutional environment, and so may have developed a specific culture of care that differs from other situations (Goffman, 1961; Kitwood 1997). Secondly, it also stands to reason that many individuals in these long-term care environments are there because they require a level of care that is above what could be given elsewhere. Hence these individuals may experience higher or differing levels of elderspeak to that found elsewhere, due to potentially being perceived as less competent, frailer or more in line with other old-age related stereotypes. These issues highlight the importance of expanding future research to explore interactions in other environments, such as hospitals, which currently have been under researched but have high prevalence and mortality rates for PLWD (Sampson et al., 2009; Goldberg et al., 2012).

To conclude, it appears that some form of elderspeak is likely to be commonly used in the care of older people, and particularly in the care of PLWD. In terms of context, it seems that it may be more common during some activities of daily living, but more data is needed regarding exactly where it is most used and by whom. Likewise, more research is also needed into how elderspeak is received and responded to by PLWD, as at present, the evidence appears to be very mixed and/or grounded in very specific contexts. Some research has highlighted extremely negative consequences for the use of elderspeak, and other research has painted a more positive picture. It appears likely that the use and receipt of elderspeak is very context dependant, and further study is needed to identify whether local interactional context does have an impact, and what exactly that impact may be. Due to the variation in findings and the high reliance on subjective reports, hypothetical scenarios and laboratory studies in the existing literature, it is suggested that future research will need to focus on analysing what actually occurs in real-life interactions, in order to fully answer these questions. By drawing these conclusions, this scoping review has developed an important foundation for future research development.

Chapter 3: Introduction To Communication And The Use Of Conversation Analysis In Research With PLWD.

This chapter will cover background literature on communication involving PLWD, starting with atypical communication more broadly and then considering specific features of interaction with PLWD. Researchers have noted that there is an increasing interest in the use of conversation analysis (CA) as a methodological approach to studying dementia (Lindholm, 2015); Webb (2017) states that examining talk can have profound real-world implications, and that since conversation is a shared experience it needs to be studied as such. Consequently, the majority of the studies discussed in this chapter have utilised CA, although research using other methods has been included where relevant. The practical application of CA to this thesis will be covered in chapter 4.

The nature of dementia means that PLWD may have unique experiences which may help or impede interactions with others. A frequent justification for the use of CA is its ability to examine interactions in the moment as they happen, rather than retrospective accounts of behaviour (Sidnell, 2012). This is particularly useful in interactions with PLWD, as due to the nature of their condition, these individuals will, in many cases, be unable to recount information about interactions that have previously occurred. Whilst generally people may be unable to recall interaction in detail useful to the analyst, this is likely to be exacerbated by symptoms of dementia. Furthermore, as Kindell et al., (2017) assert, research which is able to focus on conversations that occur in natural settings can provide a valuable source of data that can be used to explore both the skills retained by PLWD, and also the challenges they may face within interactions.

It is possible to locate this topic in broader CA literature on ‘atypical’ interaction. According to Wilkinson et al., atypical interaction is “*naturally-occurring conversation or other forms of social interaction where at least one of the participants has a communicative impairment which impacts upon the interaction.” (*2020: 1-2). Examples of conditions or disabilities that may impact upon interaction include autism spectrum disorder, learning disabilities, schizophrenia, dementia, aphasia, developmental language difficulty, stammering, dysarthria and hearing impairments. (Wilkinson et al., 2020).

A lot of research on atypical interaction has focused on healthcare contexts. For instance, Gordon et al., (2009) used CA to look at interactions between nurses and patients who were experiencing communication disabilities after strokes. Antaki and Wilkinson (2012) provide a broad overview of ‘atypical’ interaction and the application of CA. Through a discussion of various issues that could potentially lead to atypical conversation such as speech and hearing disorders, cognitive impairments and atypical beliefs (such as in psychosis), they show how interactional features originally identified in CA work on ‘normal’ talk can be highly useful for studying populations with differences in communication. They claim that many features of interaction are preserved across conditions, such as turn taking and positioning within interaction.

Abbeduto and Rosenberg (1980) conducted one of the original studies on this topic. They examined individuals with cognitive impairments talking amongst themselves, and found that they used a turn taking system that was as ‘efficient’ as turn taking in those without cognitive impairment. Yearley and Brewer (1989) took this further, using CA to map turn taking patterns, adjacency pair responses and how speech is monitored reflexively during interactions in people with cognitive impairments. They found that conversations between residents in day care centres demonstrated many of these features of everyday interaction. However, when residents interacted with visitors from outside, the conversation was influenced by 'stigma' (Goffman 1963) both felt by and enacted towards the residents. In these cases, residents were more likely to provide minimal responses, despite demonstrating, for example, that they were aware of transition relevance places when conversing with each other. It was suggested that when conversing with visitors, residents may have been attempting to hide any communication difficulties they may have been experiencing. Although this research only used a relatively small sample (three hours of recorded material), and focused on one specific type of condition, it does begin to demonstrate how CA can be successfully utilised to unravel the complexities of real-life interactions in this kind of context.

3.1 Research on People Living With Dementia.

Focusing specifically on dementia, there are a number of factors that are likely to make talk by PLWD 'atypical.' Ripich et al., (1991) examined differences in conversational abilities between people living with Alzheimer's disease, and older adults without dementia. Although they recorded and transcribed the conversations, they analysed the data quantitatively to look for significant differences between aspects of conversation (defined by Terrell & Ripich, 1989 and Sacks et al., 1974). They found that the PLWD used significantly fewer words per turn than other older people (who were matched on factors such as age, sex and education). PLWD also used more non-verbal responses and unintelligible utterances. Interestingly, they also measured the speech of the individual conversing with the older adults (referred to as the 'examiner'), and they found that the examiner used more words per turn when speaking to the individuals who did not have dementia, but there was no significant difference in nonverbal responses. The authors concluded that overall, although there were some significant differences in conversations with people with and without dementia, the interactions themselves were still clearly recognisable as conversational exchanges because on the whole, form and communicative intent were maintained.

Perkins et al (1998) used a conversation analytic approach to provide some examples of interactional features which are found to be preserved in PLWD. They observed that most prior research at the time had taken a deficit focused approach, rather than focusing on what abilities are retained in PLWD. They then describe how general turn taking ability often appears to be preserved, even in quite severe cases of dementia. However, this may not always be clear, as the cognitive difficulties associated with dementia may make it challenging to produce a response within the split-second timing typically required in conversation. Perkins et al. point out that this may make it difficult for PLWD to take and hold onto the conversational floor (and so take turns). Nonetheless, it is noted that if the conversational partner is sensitive to these issues and allows the person with dementia additional time to respond, conversations are often successful. In this situation, success is assumed by Perkins et al. if the interaction is able to continue, with responses to turns and no need for repair action to be taken.

The preserved turn-taking action is further supported by Hamilton, (1994) and Hydén (2012), who describe how turn taking is used even in cases where dementia has led to specific communication barriers such as aphasia. In the case of Elsie discussed by Hamilton (1994), despite her speech being mostly limited to utterances such as “mhm,” or “mm,” she is still able to perform actions such as requesting repetition of an utterance, taking turns appropriately and indicating recognition of personally important topics. Hydén (2012) also notes that conversational partners often treat utterances as meaningful, and irrespective as to whether they were intended that way, treating them so and responding can consequently lead to a successful interaction for both participants, if success is considered to involve interactional progressivity.

Schneider et al (2019) used video analysis (including CA) to examine a woman with severe dementia (Suzan) being led around an art gallery by gallery staff. Although Suzan had a very minimal level of speech and restricted mobility, she was able to engage with the art and participate with the aid of the staff members. Suzan was constructed as being an active participant in the interactions, as the staff members left silences where a response would have been (if Suzan was able to respond verbally) and then built upon the conversation as if the response had been given. Suzan’s engagement is evidenced by her gazing at relevant objects of discussion and what was described as her ’unusual’ level of alertness during this activity (she was said to often be disengaged and sleeping in her wheelchair at other times). When Suzan made non-lexical vocalisations, like her silences, these are also treated as a valid contribution to the conversation (rather than being ignored or spoken over, for instance). This research serves to demonstrate that interaction can be validly analysed even in cases with extremely serve communication difficulties, and also shows that it was possible for a PLWD to participate in interaction without using words.

Sabat (1991) investigated abilities that were preserved or reduced in a woman (Dr M.) who suffered from Alzheimer's disease. Like Perkins et al., (1998), Hamilton, (1994) and Hydén (2012), he found that many features of the conversation proceeded as could be considered "normal," although Dr M. did experience some difficulties, particularly around word finding. In his conversation with Dr M. (which centred around finding ways to improve her situation), he notes that it is important to look at the situation from an optimistic perspective – i.e., one should look at what is working well, rather than focusing exclusively on the deficits. This is a similar viewpoint to that expressed by Perkins et al., (1998) and is arguably quite person centred (Kitwood, 1997). Additionally, and similarly, he expresses the importance of the conversational partner being sensitive to the needs of PLWD. In this case, he demonstrates how he allowed longer pauses to occur intentionally, in order to give Dr M. the space to take her turns in the conversation. This enabled her to interact in a more meaningful way, as to an extent she could work around her word finding difficulty if given the time to produce or alter an utterance.

Further evidence for the sensitivity of conversational partners was produced by Young et al., (2016). They examined overlap in talk between PLWD and partners they communicated frequently with. Their findings support the work of Sabat (1991), as they showed that communication partners often yielded turns if they overlapped with those of their partner, in order to give the PLWD more space to communicate.

Wilson et al. (2007) examined how PLWD may use laughter in social interaction and like others above (e.g. Perkins et al, 1998; Hyden, 2012; Sabat, 1991; Young et al. 2016), also demonstrated the collaborative nature of talk. More specifically, they used CA to look at the case of 'M.' Although again this was just one individual, they examined a significant amount of data collected from recorded conversation (558 turns at talk were included in the analysis for laughter), and they found that laughter was actually used in some quite precise ways. In the situation discussed in the paper, they focused on how laughter can be used as an instruction to hear, and also highlighted the reciprocal nature of it in interaction. Using CA, Wilson et al. demonstrate how M. uses laughter in a systematic way, in order to ensure that his conversational partner (B.) is listening and following what he is saying. For example, in one instance, M is attempting to pass on some information he knows about making money to B. His message is not fully clear, but then he laughs, and B laughs in response. This response demonstrates to M that B is likely to be paying attention, and M treats it as such by responding with an acknowledgment ("*oh ya*," pg. 1004) and then continues his speech. Overall, it was concluded that laughter could be a useful strategy used by PLWD to increase communicative access and feelings of competence, which could then improve quality of life and wellbeing. This aligns well with the notions of person-centred care and enabling inclusion of PLWD (e.g. Kitwood 1997; Brooker 2007). It also makes sense in relation to other sociological literature, which has suggested that laughter (and other humour) can serve various purposes in interaction more widely (e.g. Griffiths 1998).

Wilson et al. (2007) chose to use CA in their research, as they claimed that CA allows the complexities that occur in natural conversation to be investigated. They also note that CA allows one to examine data without a great deal of preconceptions. This means that conversation can be examined by how it occurs both socially and contextually. The findings of this study fit well with other research, such as that by Hamilton (1994) and Hydén (2012) who showed that meaningful conversations can still occur without the exclusive use of words. In the case of Wilson et al., they show how laughter can be used to do work in conversations, potentially instead of words. However, overall, it seems likely that PLWD may have a wide range of strategies to compensate for situations where they struggle to find words.

Also utilising conversation analysis to understand differences in interactions with PLWD, Rasmussen et al., (2019) looked at availability in social encounters with PLWD, and found that often, co-present others (such as staff and visitors) are faced with practical difficulties related to establishing whether or not residents with moderate to severe dementia are engaged or unengaged in interactions. They also noted that PLWD are often ‘away’ (e.g., staring into space) during interactions, but individuals trying to interact with them were sensitive to this. Rather than trying to hold attention or repair the interaction with reference to reduced hearing, understanding or agreement, they instead employ continuous monitoring to investigate the potential for interaction at different times. This led to people following a kind of dementia-specific social norm, where residents were not always expected to engage in social interaction.

To summarise this section, it appears that in general, many fundamental interactional abilities such as turn taking are often preserved in PLWD, but it is important for conversational partners to be sensitive to difficulties that do occur, to allow for PLWD to reach their conversational potential (e.g. allowing additional time for them to take their turn if required). The following section (3.2) examines some examples of interactional trouble that may occur in conversations with PLWD.

3.2 Interactional Trouble

Chatwin (2014) used CA to examine an interaction involving a resident called Ted (pseudonym) and two carers. Ted is said to be often confused about where he is, and is found trying to get find his coat and leave. The interaction that follows is used to illustrate that sometimes interactional difficulties that arise are not specifically due to the communication competency of PLWD themselves. In this example, Ted asks about his jacket. The carers assume that Ted is looking for his wallet as he thinks he needs to pay, but this has not been mentioned in this interaction. As Chatwin notes, it is likely that this scenario has occurred in previous similar interactions. However, to Ted who is unlikely to recall this, the topic change from jacket to wallet may seem strange or out of place. (Additionally, topic management is known to often be impaired in PLWD, (Hall et al., 2018)). The mention of his wallet leads to concern on Ted's part that he needs to pay for something, which is never fully resolved. This example further demonstrates the importance of conversational partners being sensitive to the context and needs of PLWD. In this case, Ted may have exhibited regular turn taking and other interactional competencies, but the carers not orienting to his confusion or probable lack of recall of previous encounters leads to trouble.

A great deal of original CA research was done using data produced from phone conversations (Hutchby, 2019). This has produced a large amount of literature on features such as "normal," conversational openings and closings. This provides a unique opportunity to examine communication with PLWD from a different angle. Kitzinger and Jones (2007) looked at telephone openings for family conversations with a woman living with Alzheimer's disease in a care home. A key finding was that the ritualistic opening 'how are you,' sequences (Schegloff, 1968) were fully intact for the individual with dementia (pseudonymised as May). This led Kitzinger and Jones to conclude that May displayed a *"normal range of cognitive and interactional skills required to transact routinized call-openings."* (2007: 191). It is also of note that May was fully capable of intentionally *not* following the how-are-you sequence, to demonstrate urgency in situations where she had a perceived issue that she wished to discuss. These intact abilities are interesting, as to an extent, they reflect some of the findings of Perkins et al., (1998), Hamilton, (1994) and Hydén (2012), in that the more procedural or routine aspects of the conversation appear to be preserved.

However, despite May's intact abilities, as with Chatwin's (2014) data the interactions were not trouble free. Kitzinger and Jones (2007) note that a key difficulty that often arose in conversation was memory (somewhat similarly to Chatwin, 2014). One example of this discussed is May's inability to recall that her daughter (Natalie) had broken her leg. This influenced interactions in very subtle ways. For instance, it is noted that if May had recalled Natalie's injury, she would likely have performed the how-are-you sequence differently, with special emphasis or with reference to the ailment. Instead, she just speaks in a more routine way. Therefore, although her memory loss is not outlined explicitly at this stage, her failure to orient to something she might be expected to orient to has revealed the deficit. A point of concern Kitzinger and Jones identify here is that for PLWD, if they can conceal difficulties such as memory deficits by using routine features of conversation, they may be held accountable for trouble that arises in interactions. For example, in the above situation, if the daughter was unaware of her mother's situation, a lack of consideration for her broken leg may have been perceived as rude or uncaring rather than a memory issue.

It is possible that this type of issue may have negative implications for the individual living with dementia, both in terms of personal relationships, and also in terms of their sense of personhood or self-opinion. Saving face (as defined by Goffman 1955) is mentioned elsewhere in this thesis (e.g. see chapter 1). However, it may also apply here in the kind of situation experienced by May (described by Kitzinger and Jones, 2007), as they do note at times, May appears aware that she has forgotten something, but is unable or unsure of what it was. In one instance, Natalie reminds May of her broken leg, and May acts as if she had been meaning to ask about it all along. It could be argued that this is an example of May saving face (Goffman 1955), as she does not want her daughter to realise that she had forgotten about the injury. This is likely to be a feature that occurs in other interactions involving people without dementia, as people work to preserve face (Goffman 1955) in many situations (and may forget other people's problems for many reasons).

As Lindholm (2015) points out, in the literature, there is increasing interest in using CA to examine how PLWD and their conversational partners collaborate in interactions to construct meaning. Perkins et al., (1998), Sabat (1991a) and Rasmussen et al., (2019) have noted the importance of sensitivity on the part of conversational partners to PLWD. Additionally, Chatwin (2014) and Kitzinger and Jones (2007) provide some useful examples of how seemingly routine interactions between individuals can lead to trouble. However, Lindholm (2015) focused specifically on confabulation (when PLWD unknowingly make statements that are untrue), and the reactions from their conversational partners. A continuum of responses to the confabulations were identified. At one end, the incorrect utterance was challenged with the aim of getting the PLWD to rethink their statement, and at the other the individuals went along with the confabulatory view of the world, and produced confirmatory responses. Despite the potential difference in these reactions, it was found that most people responded somewhere in the middle of the continuum. It was suggested that it is likely that individuals attempted to find balance between trying to respect the PLWD's subjective experience, and trying to be honest and not lie, which could be seen as morally questionable. Current guidance in healthcare recommends against lying to patients, although there is debate around whether therapeutic lying could have a place in the care of people living with more severe dementia. (See Smith et al., (2020) for discussion on this, and Kartalova-O'Doherty et al., (2014) for a fuller review).

A significant component of CA, is establishing what actions conversational turns aim to accomplish (Schegloff, 2007). In this situation, Lindholm (2015) notes that by acknowledging confabulations made by PLWD, conversation partners are doing important work to support them. This is due to the fact that PLWD appeared to use confabulation to promote a positive self-image, and also compensate for their impairments and participate actively in conversation. In this situation, it is noted that *"the confabulating person creates a picture of himself as a person who travels the world, who meets people at the men's club, and who knows famous people."* (2015: 196). Responses could serve various useful functions, such as helping the individual with dementia to exit a confusing situation if they experienced issues when developing their narrative. Lindholm therefore concluded that confabulations should be regarded as important, and sensitive listening, nonverbal attention and time should be given to PLWD in these situations. This again fits well with the notion of saving or maintaining face (Goffman 1955).

The notion of conversational success is worth further considering here, because it is possible that there may be differing ideas around what exactly makes a conversation successful. Different participants may have different motivations, agendas or actions that they are trying to accomplish, and so their talk will work to serve different purposes. Light and Mcnaughton (2014) note that an individual's motivation for communication will be influenced by their desire to communicate during daily situations. For example, is the individual attempting a simple goal (e.g. asking for food), or are they wishing to make friends or have a more in-depth discussion? Webb et al. (2020) looked at quizzes involving PLWD, and noted that staff members running the quizzes used various strategies to fulfil their institutional agenda of "*doing a quiz*," (2020: 20). They showed how the staff would step in to fix or reinstate actions that were counter to the goal of completing the quiz, and also noted how this had the potential to be face threatening for PLWD. Arguably, if the goal of completing the quiz hadn't been the main focus, staff may not have prioritised progressivity of the activity over other less focused talk. In the acute hospital setting (the context of this thesis), it is likely that healthcare professionals (HCPs) will have various agendas behind their talk, since they will be present to do a job and often to accomplish some kind of healthcare task with a patient. Their talk may therefore be designed differently to talk in more relaxed or less institutional settings, demonstrating the importance of the consideration of context, both more widely (e.g. the hospital setting) and at the local interactional level.

An interesting example of differing conversational agendas can be seen in studies of interactions at a memory clinic. Elsey (2021) discusses cases of patients speaking with a neurologist. They are in the process of establishing whether memory difficulties experienced by the patient are due to dementia or functional memory disorder. These are said to follow the typical pattern of many institutional interactions, where the neurologist almost exclusively produces the questions, and the patients and companions provide answers. The analysis focuses on the roles of the patients' companions during the consultations. It was found that the companions worked to accomplish different things with their talk, depending on the situation with the patient themselves. For instance, in a situation where the patient was experiencing some quite severe cognitive issues, the patient reports that they are doing well, and not having problems. The companion (his wife) then disagrees with this, and her talk works to provide examples of her husband experiencing difficulties. In this situation, Elsey claims the companion's underlying motivation is to provide accurate information for the neurologist to give a correct diagnosis. However, this is also an example of where participants within an interaction may potentially have differing motivations. The husband, for instance may be working to give a positive, no problem response he believes will be preferred by the neurologist (see Pomerantz, 1984), or he could also be working to save face (as defined by Goffman 1955) if admitting to the memory problems is viewed as negative or embarrassing in some way.

3.3 Repair

Continuing the theme of interactional trouble, this section focuses specifically on conversational repair. Perkins et al., (1998) also discuss how repair is an important resource in conversations with PLWD. They make the important point that even if errors are made during talk (due to cognitive impairments), these may not necessarily be sources of trouble that will actually need repair work. In some situations, they may be overlooked in the interest of maintaining the conversation. Nonetheless, in many cases, repair will be required. They claim that self-repair is present in PLWD, particularly in the earlier stages of the condition. In the middle stages, more self-repair attempts were likely to be made, but this was accompanied by a higher number of aborted phrases, suggesting that the ability to successfully repair talk may be compromised in later stages of dementia. In these situations, it is possible that difficulties may be overcome if the conversation partner is able to do the repair work instead. Although, ordinarily in conversation not involving PLWD, there is a preference for self-repair (see Schegloff et al. 1977).

One issue that should be considered when it comes to repair, is the feelings of PLWD themselves. It is possible that in situations where the person with dementia could have self-repaired, they may choose not to. This may occur in situations where they are aware that they have made an error, but they do not wish to draw attention to the difficulty they are having (Perkins et al., 1998). In this case, moving past the error may allow them to save face (Goffman 1955), and preserve their sense of self and perceived capability. This may be preferable to some individuals, where the alternative is admitting to or highlighting a memory or other cognitive deficit. Nonetheless, whilst this is a potential consideration relating to the motivations and purposes of conversation, it should be noted that from an analytic perspective, it may be difficult to identify exactly why an individual had neglected to repair at any given point.

Research has shown that in 'normal' conversation, it is possible to observe when an individual is searching their memory for an answer to something. The speaker disengages for a short time, and may take repeated pauses and use hesitation markers during this process (Schrauf, 2020). However, PLWD (specifically Alzheimer's disease), have been shown to use increasingly laboured memory searches. These often trail off, and fail to produce an answer, although those with more severe dementia may avoid searching altogether, and instead provide answers that are wrong (or improbable), but grammatically correct, or answer a question to a previously closed topic (Schrauf, 2020). This is of relevance in relation to the issues discussed above (such as by May's situation described by Kitzinger and Jones, 2007) as Schrauf (2020) observes that PLWD in early and middle stages of the disease appeared to hold themselves accountable for their answers to memory questions. As Schrauf puts it, "*they know they should know*." (2020: 66). This was demonstrated in the research by the increasing conversational trouble caused when the PLWD attempted to engage in a memory search, and the way in which they produced lengthening pauses, and more search phenomena such as hesitation markers, disfluencies, tentative answers, and epistemic self-accounting (such as 'I don't know.'). Schrauf also noted that often, no repair was attempted – the individual would simply disengage until the clinician interacting with them took up the next turn. This fits to an extent with the observations of Perkins et al., (1998), and is potentially concerning in terms of Goffman's (1955) ideas around saving face, as if PLWD are aware and hold themselves accountable for these issues, their sense of their own perceived capability could be threatened.

It therefore seems that the picture when it comes to repair involving PLWD is complex. As a part of the VOICE research (discussed further below in terms of practical applications of research) a recent paper by Pilnick et al., (2021) revisited the idea of maintaining face in the specific context of how health professionals respond to hard to interpret talk from PLWD in acute hospital settings. Using CA, they demonstrated six different approaches that health care professionals could use in response to hard-to-interpret talk produced by

PLWD. The first was other initiated repair, which is mentioned above in relation to Perkins et al., (1998). Perkins et al., (1998) suggested that this type of repair is helpful, as it may allow conversational difficulties to be overcome. Nonetheless, whilst this could be the case in some situations, Pilnick et al. demonstrate that in the majority of cases identified in their data set, this type of repair did not work towards fixing the trouble understanding. Conversely, the attempted repair (particularly with open class repair initiators, such as 'pardon'), was likely to result in unsuccessful and prolonged attempts at clarification. This then led to the question of whether this type of repair was worth the potential delay and also the potentially face threatening (Goffman, 1955) highlighting of trouble PLWD experience in their talk.

Aside from other initiated repair, the other five responses to hard-to-interpret talk Pilnick et al. (2021) identified were: use of non-committal responses; repetition; responding to the emotional tone; closing one topic and shifting to the next; and treating talk as related to the task. Additionally, the data suggested that overall, in comparison to general populations, PLWD were less likely to initiate self-repair when trouble occurred. Examining the concept of preserving face in more detail, Pilnick et al., suggest that by using combinations of the five types of response above, healthcare workers may actually be promoting the inclusion of PLWD in interactions. This may seem counterintuitive, especially with regards to switching topics or treating talk as task relevant. However, it is pointed out that these techniques may avoid exposing wider cognitive changes and difficulties experienced by the PLWD. This allows them to be involved in the interaction taking place, without the possible lack of shared understanding causing ongoing sources of trouble. This provision for inclusion is important, as PLWD are not always included as full participants in interactions (e.g. Lindholm, 2016). As Pilnick et al. (2021) note, this inclusion may then help towards the provision of good person-centred care, as the inclusion of PLWD will support personhood and individual identity. This sense of identity will be further enhanced due to the fact that the avoidance of repair will allow PLWD to save face.

3.4 Practical Applications of Communication Research

CA can also be used to illuminate issues in interactions that may not be obvious. For example, the VOICE research (summarised in O'Brien et al. (2018) identified a number of ways in which communication may be different involving PLWD within the acute hospital setting. Using this data, Pilnick et al. (2021) notes, PLWD may display dementia related difficulties such as word finding difficulties and word selection errors. Within the data set studied, they also highlighted examples involving a lack of internal coherency in sentences and narratives, and instances where the topic of talk was unclear. In addition, many PLWD are likely to have co-existing conditions such as stroke, which may introduce factors such as quieter vocal volume and a reduction in articulatory accuracy. All of this contributed to talk that was classified as hard to interpret by Pilnick et al.

Additionally, during the VOICE research Allwood et al. (2017) looked at how healthcare professionals close conversations with PLWD. They found that sometimes what is considered 'best' practice in other settings may actually confuse PLWD, despite the moves feeling intuitive to healthcare staff who are competent interactants. For example, open ended questions (e.g., 'is there anything else?') may be recommended as part of closing sequences for good person-centred care. However, these kinds of broad questions do not tend to contain cues to help PLWD orient to an appropriate answer. This may then cause the PLWD to be unclear on what kind of answer they should provide, and to be distressed by their inability to answer the question. Moreover, O'Brien et al. (2020) examined requests and refusals in this population. Refusals from PLWD were made bluntly and without accounts which is unusual in interaction in general, and even more so in healthcare contexts. This atypical (and prevalent) style of refusal was noted to demonstrate the difficulties healthcare staff face when delivering care. In addition, O'Brien et al. found that higher entitlement requests and those with lower contingencies were more likely to result in agreement. Overall, the VOICE research led to the development of a highly rated communication skills training course for healthcare professional caring for PLWD (see Harwood et al. 2018), which serves to further demonstrate the practical use of CA research in health and care settings.

A different example of CA providing a more nuanced view of interaction would be well-meaning staff influencing the choices their clients made by questioning choices they made. For instance, Finlay et al., (2008) note that empowering people with learning disabilities to make choices is not straightforward. They noticed that in one of the residential homes they studied, in an effort to find out people's food preferences, the staff would rephrase questions multiple times. Although this aimed to give the individual with learning disabilities the best chance of choosing the flavour they wanted (such as with packets of crisps), in some situations, residents changed their answer many times. It is possible that they perhaps took the additional questions to mean that the answer they had originally given was incorrect or unsatisfactory.

Pilnick et al., (2010) examined this issue in detail, and noted that "*an attempt to be empowering can actually and paradoxically end in an undermining of choice and control*." (433). In a situation where an individual's choice was deemed to be inappropriate or unfeasible (for example a wish to work for the police), they demonstrate how a teacher and a young person's parent do a lot of interactional work to reject the proposal in a very mitigated way. This is done with a high degree of delicacy and the individual does not pick up on these unclear rejections, but time runs out in the meeting before the matter is resolved. The career related choice for the individual is subsequently made later without his presence. This therefore demonstrates how sometimes, attempting to privilege choice can result in a difficult situation when an unfeasible choice is made, which actually then results in less choice and control for the individual in question.

Kristiansen et al. used CA to examine how staff in institutional (care) settings used manipulation to accomplish care actions. In this context, manipulation was defined as the methods used to influence an individual's (in this case, the PWLD) behaviour without their awareness. They examined it in terms of how it could be used by care staff to accomplish care actions (such as getting an individual to move to a safe place, or take medication). In the example described by Kristiansen et al. (2019), a staff member (Susan's) interaction is designed to get a woman living with dementia (Gyda) to sit down in a chair. This is done in such a way that by the end of the interaction, Gyda has been seated in the chair, and responds as if this was her wish all along. Kristiansen et al. (2019) describe the interaction as a whole – Susan arranges the chair ready for Gyda, and then goes and gets her and takes her to the chair. Gyda had been walking around (potentially with the intention of going somewhere to talk to the researcher, who was also present). However, Gyda's walking is treated as task relevant by Susan, even if her words are not necessarily taken as relevant. Susan uses talk such as "*you like to sit here you know*." (2019: 10), which frames Gyda's sitting in the chair as something previously established, and so it appears that they are working together to accomplish Gyda's goal of sitting (when actually this is Susan's plan).

To some extent treating the PLWD's actions as task relevant is similar to how healthcare staff discussed by Pilnick et al. (2021) treated talk as task relevant. In that situation, the example given depicts a health professional encouraging a patient to stand up. However, a key difference to the work of Pilnick et al, is that in the case of Kristiansen et al. (2019) it is not immediately clear why Gyda has to sit down in the chair. It is possible that doing so will keep her safe because Susan is also cleaning the floor, but this is not specifically addressed, and it is not clear whether there is an urgent need to stop Gyda walking around. In the case of Pilnick et al, (2021), the patient needs to stand up to avoid pressure sores, so standing is an unavoidable or necessary action to prevent future pain and suffering for the patient. Furthermore, in the case of Pilnick et al., the reason for standing up is given (to avoid pressure) and the patient is not treated as though it was her own idea.

Kristiansen et al., (2019) suggest that this type of interaction is a potential avenue for the provision of person-centred care, as it allows care staff to be responsive to the individual needs of PLWD. It should be noted that the authors do point out that in an ideal situation, care staff would have time to establish what PLWD actually do need. However, often their time and priorities must be split between this and fulfilling other tasks (in the example, Susan is also trying to clean a floor). In this limited circumstance, this method of manipulation is put forward as an option for fulfilling care goals. Ethically, it could be questioned here whether this is the case, or whether this type of interaction is more about staff managing PLWD or imposing their expectations on PLWD. The word ‘manipulation’ is also potentially problematic here as the notion of influencing PLWD without their awareness does not appear to be person-centred (despite the authors claims), since one of the core philosophies of that is to include the PLWD as a part of the team, and treat them as an individual (Kitwood, 1997).

Although the above research (Finlay et al., 2008; Pilnick et al., 2010; Kristiansen et al., 2019) has painted quite a bleak picture on the concept of enabling choice for people with learning disability and PLWD, it should be noted that this is not always the case. Other research had demonstrated ways in which PLWD can be enabled to make their own choices. For example, Leyland et al. (2023) used CA to examine choice sequences in creative workshops involving PLWD, artists and carers. They found that the support of carers was vital in these interactions, and carers shifted roles where required during the interaction. For instance, in what initially looked like a dyadic framework between an artist and a PLWD would become a triadic interaction when a carer shifted from an overhearer to an instructor or facilitator to aid the PLWD making the choice offered by the artist. Where necessary work is done to simplify or shorten the requested action, to aid the understanding of PLWD. The role of the artist could also shift from instructor to facilitator where necessary. Consequently, the choice sequences were collaborative interactions that allowed PLWD to choose things relating to the art activities for themselves, which in turn allowed the PLWD some personal autonomy. This level of autonomy was noted to be important in the creative activities studied, and was argued to promote wellbeing.

Some research has suggested that the comparison of atypical speech in different populations can yield diagnostic information. A good example this was conducted by Blackburn et al., (2016). They claim that CA is sensitive enough to distinguish between neurodegenerative memory disorders and functional memory disorder (FMD). They found that individuals with neurodegenerative disorders were much more likely to experience issues such as an inability to answer compound questions fully and an inability to give detailed examples of memory failures. They also found shorter turn lengths and reduced complexity of replies. It was suggested that this kind of information could be highly useful for improving screening for neurodegenerative disorders in future primary or secondary care settings. The authors themselves state that this is one of the first pieces of research to include FMD when evaluating screening procedures for neurodegenerative disorders. Despite the potential utility of these findings, the results should be considered with caution. Although Blackburn et al., used an initial sample of 111 patients to develop their profiles of interactional features, they only tested the predictive power of the profiles with an additional 10 individuals. This may therefore limit the generalisability of claims made. Nevertheless, separate research by Jones et al., (2016) studied the same topic using 25 neurologist- patient consultations at a memory clinic and produced very similar results, which does lend some reliability to the emerging data in this area. Furthermore, a longitudinal CA study by Cornaggia et al., (2018) demonstrated it was possible to use conversational data to distinguish between cognitive impairment and functional cognitive impairment (depression) with reasonable reliability, further supporting the idea of CA as a possible tool for diagnosis. This is potentially very useful, as often formal diagnosis and communication around the diagnosis of dementia and similar conditions is difficult and complex (Dooley et al., 2020; Peel, 2015; Plejert et al., 2015).

Alexander et al., (2019) further investigated differences between FMD and neurodegenerative dementia using CA. An additional difference they explored between the two groups was how individuals shared concern about their memory loss. Individuals with FMD were more likely to describe what could be considered more everyday examples of memory lapses in a way that worked to represent them as abnormal or irregular. It was suggested that this information could be helpful for alleviating patients concerns around developing dementia, as the fact that they could recall and describe difficulties in such detail actually evidenced good cognitive functioning. As noted by Blackburn et al., (2016) above, those with more severe neurodegenerative dementia were unable to give detailed examples of memory issues.

3.5 Research Involving Methodological Implications

Chatwin and Capstick (2019) add yet another layer of complexity to the world of CA and dementia care. They observe that often people have difficulty when recording in a dementia care environment, due to excess levels of noise and activity. This can then make data analysis difficult, and data is often discarded or viewed as contaminated by unwanted background noises. Chatwin and Capstick argue however, that actually there may be layers of meaning existing within this noise. They present a situation in which a man living with dementia ('Don,') is producing a narrative to a researcher, whilst a group of care staff have a seemingly separate conversation nearby. The conversations of the two groups are transcribed separately, and then overlaying each other in a temporally relevant manner. This demonstrates some quite striking resonances between the two sets of interactions, which it is argued is unlikely to be purely coincidental. For example, at various points Don and the care staff are both talking about thematically similar things (such job offers, soldiers and marriage) at the same time. Although this phenomenon is only demonstrated with one individual (Don) in this specific set of circumstances, it does suggest that further investigation is warranted into how the wider environment influences interactions on an individual level since these interactions rarely exist in complete isolation. Furthermore, these findings potentially suggest that data which first appears intrusive, may actually be beneficial for analysis if the interaction in question is influenced or affected by the intrusions.

An additional point of consideration for research in this area, is that dementia is not a single condition, but an umbrella term. Rousseaux et al. (2010) compared conversation in different types of dementia (Alzheimer's, frontotemporal dementia and dementia with Lewy bodies) with individuals who were all classed as mild-moderately severe (as measured by the Mini Mental State Examination (MMSE) ≥ 14/30 which is a cognitive test). A key finding was that those with different types of dementia experienced very different patterns of difficulties. For example, those with Alzheimer's participated comparatively well in interactions, mainly showing a reduction in greetings. They also had some issues with verbal communication, particularly in relation to word finding difficulties. Those with frontotemporal dementia were found to be much more severely impaired with regards to participation in communication. Individuals with Lewy body dementia demonstrated less severe communication difficulties than the other two groups, but they did show some speech reduction and word finding difficulties. These findings led to the conclusion that care and rehabilitation should be adapted to the specific conditions of individuals. Whilst this supports the wider agenda of this thesis in demonstrating the importance of considering individual context, it does to an extent indicate that caution should be used when making generalisations about the talk of PLWD.

Another facet to consider in relation to dementia and communication, is individuals who speak more than one language. Research suggests that PLWD such as those with Alzheimer's disease may use the wrong language (for the individual they are conversing with) or may use a confusing mix of different languages during interactions (Liu et al., 2016; Friedland and Miller, 1999; DeSanti et al., 1989). It is possible that this behaviour may cause confusion or trouble in interactions involving multilingual PLWD, although this is not necessarily always the case. Svennevig et al., (2019) investigated language mixing (referred to as ‘code switching’) in the contexts of picture naming tests and spontaneous conversation. In contrast to the findings above, their data suggested that in the majority of cases, changing language was treated as appropriate by participants in the interactions, despite the setting predominantly being monolingual (Norwegian). The PLWD tended to switch to a language that would be recognised by the interlocuter. In addition, it was also noted that in some situations, language mixing was beneficial for PLWD. It could be used to compensate in situations where they experienced word finding difficulties in the first language.

One possible issue with many of the studies discussed in this chapter is the fact that often, they only focus on a single person, or a very small number of individuals. This may be a particular issue in more quantitative studies such as Ripich et al., (1991). However, in studies that use a conversation analysis methodology are perhaps less problematic in this sense. As noted, PLWD are very varied in terms of the symptoms and experiences they have. Therefore, the ability to study individual cases in such a level of fine detail is useful for adding to our broader understanding of how dementia might impact on interactions with others. Nonetheless, there should be caution in assuming that the findings from studies with small samples and very specific contexts can be generally applied. More detailed discussion of the strengths and weaknesses of the CA method can be found in chapter 4.

3.6 Conclusions

To summarise, this chapter has considered some aspects of communication that may be preserved or lost in atypical populations and PLWD specifically. It then moved on to consider interactional trouble that may occur, including some situations in which repair was used in ways that may be different to other populations. It also considered some specific examples of this type of research in different settings, and some research that specifically considered methodological issues in this area. Recurring themes included face (Goffman, 1955), the preserved conversational abilities of PLWD particularly in relation to structural properties of talk, and related to this, the person-centred care approach (Kitwood, 1997).

To conclude, it appears that overall, many features of conversation are preserved in PLWD, particularly the more routine or ingrained structural functions (such as turn-taking). However, it is also clear that PLWD can experience severe difficulties when it comes to communication, particularly in relation to factors such as memory and context dependent interaction which may require specific types of responses. This is exacerbated in individuals with moderate to severe dementia. In many cases, it was noted that the behaviour of interactional partners is highly important, as this can strongly influence whether PLWD can take the conversational floor and contribute to an interaction. This type of research is important, as the evidence indicates that interactions can have a profound influence on PLWD in terms of health, wellbeing, and how individuals feel about their self and personhood. This overview of the literature has also begun to demonstrate the potential for CA research to inform conversation partner training and the development of interventions which can improve care delivery.

Chapter 4: Project Methodology and Methods

The following chapter will discuss the underpinning philosophy of the research, the methodology chosen for the research, and the methods including participant recruitment and data collection and data management. It will then cover how the data were transcribed and analysed.

4.1 Underpinning Philosophy

Chalmers (1999) notes that traditionally, 'science' was often seen as something fact centred, based on things that can be observed directly through the senses, rather than those which are interpreted or opinion-based. Benton and Craib (2017) expand upon this concept by noting that within sociology specifically, the term Positivism was coined by Auguste Comte, a 19th century French philosopher. Benton and Craib (2017) explain that Positivism accepts this empirical view of science, but goes further to specify that science is the highest form of knowledge, the empirical scientific method can be used to study the social sciences, and the knowledge this produces can be used to alter behaviour within society. This positivistic view typically results in methods of social research which involve quantitative measurement and statistical methods of analysis. Although this type of methodology has useful application in many areas, such as those that require the establishment of cause and effect, and situations in which information needs to be established about a large population (Verhoef and Casebeer, 1997) it also has limitations. For example, often, particularly within social science, something that can be observed could be interpreted in multiple ways. Benton and Craib (2017) give the simple example of an optical illusion which could be seen as either a rabbit or a duck.

Both interpretations can exist from the same evidence and neither is disproven by the other. This poses issues if one considers that this observation should directly access the truth of reality. In social science, situations are often arguably much more complex than an optical illusion and have many more possible variables than simply ‘rabbit’ or ‘duck,’ suggesting that some kind of more advanced interpretation may be required.

An alternative to the positivistic view of science is social constructionism. This developed from ideas around phenomenology that were around in the 1960’s and 1970s. Phenomenological investigation aims to ignore the established ideas that we have about a particular concept, and describe how we come to know it. This is known as reduction, and is concerned with how meaning is given to the world (Benton and Craib, 2017). Benton and Craib discuss how this philosophy was brought into the realm of social science by Alfred Schutz who introduced the idea of typification. This begins with the most basic perceptions, followed by the identification of similar elements. Benton and Craib give the example of looking around and seeing objects that share the same colour, shape, texture or movement. Eventually these things can be synthesised and typified into different things (e.g. trees, grass, sky etc.). If the process is continued further, typifications of typifications can be built up. For instance, in the example above, identifying different types of grass or clouds that mean a particular weather pattern.

Schutz further developed these ideas by considering how they could be applied to the social sciences (Schutz, 1972; Karsten, 1970), examining how people are classified into particular typifications, of which certain types of actions can be expected (Benton and Craib, 2017). This begins broadly with different types of human beings, and becomes more specific as we build groups of typifications for certain people such as family or friends. In this context, social scientists can produce ideal rational types of social action, which Schutz referred to as '*second-order typifications*,' (Benton and Craib, 2017: 85). Schutz asserted that people can be seen as 'rational puppets,' in that if the person (or puppet) is put in a certain situation and their goals are known, their actions can be predicted if they act rationally. (Benton and Craib, 2017).

Later, many of these ideas were developed further into the concept of social constructionism. Notions relating to this were around much earlier, such as Mead's concept of 'Symbolic Interactionism," discussed in his posthumously published (1934) book Mind, Self and Society. This assumes that the sense of mind and self is constructed during social interaction. The term social constructionism was first used by Berger and Luckman (1967) and eventually came to refer to how in the course of interactions and actions, the meaning of objects within the world is negotiated or *constructed* (Benton and Craib, 2017). Social constructionism therefore views scientific knowledge as something that is created, rather than discovered (Andrews, 2012).

Schutz's work was also a starting point for the development of ethnomethodology by Garfinkel (Benton and Craib, 2017). Ethnomethodology was a departure from structural functionalist sociology, a popular sociological framework at the time, associated with Parsons (1937;1951), which held the idea that pre-existing social 'facts' (such as shared values and norms) exist within the social realm, and create order in society (Whittle and Mueller, 2019).

Whittle and Mueller (2019) define ethnomethodology as "*the study of the practical methods through which members of a particular social group accomplish social organization*," (2019: 20). Ethnomethodology therefore studies the societal rules which provide the impression of social structures and relationships (Garfinkel, 1967). In his words, Garfinkel writes that ethnomethodology refers to "t*he investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organized artful practices of everyday life*." (1967:11). As Whittle and Mueller (2019) put it, ethnomethodology "*pulls the rug from under the feet of functionalism,*" (2019: 24) because it does not assume that facts about society are pre-existing, and instead questions how each situation leads to the production of these social facts. Ethnomethodology therefore aligns well with social constructionist concepts.

As ten Have (1990) observes, one general methodological issue with ethnomethodology is that common sense is invisible, it is taken for granted unless there is some sort of trouble to bring attention to it. In this case, common sense is understood to be the connection of observed elements with elements of pre-existing knowledge to determine what may "*be reasonably assumed to exist*." (ten Have, 1990: 28). There is the dual issue that the unexamined use of common sense needs to be minimised, but its examinability needs to be maximised. Ten Have suggests various solutions to this. The first was very prominent in Garfinkel's (1967) work, in which he undertook 'breaching' experiments. These involved generating some kind of trouble by breaching expectations of norms, such as not following the rules of a game, or behaving like a guest whilst at one's own home. These kinds of actions quickly made co-participants angry and resulted in sense-making activities from those involved (which could be studied). The fact that participants became so emotional suggests the importance of these underlying social norms to individuals, and how much they are relied upon to get things done in many settings. These types of breaching experiments are still used to investigate social phenomena today (e.g. Stanley et al., 2020).

Another strategy suggested by ten Have (1990) to address the invisibility of common sense is a fieldwork approach, in which the researcher observes activities within their natural setting and also discusses the activities with experienced practitioners in order to identify what competency is needed for routine execution of the activities. This practice can include video recording for later observations. A final solution to this issue, ten Have suggests is conversation analysis.

4.2 Conversation Analysis

Conversation analysis was first developed by Harvey Sacks and later added to by Emanuel Schegloff and Gail Jefferson, in response to a dissatisfaction with the methodologies that were available at the time to study social behaviour (Stivers and Sidnell, 2012). It was inspired by much of Garfinkel's ethnomethodological work, particularly that which focused on shared methods of reason and action. It also has roots in Goffman's (1983) concept of an interaction order, and his idea that this interaction order is the basis of both social interaction and social institutions (Stivers and Sidnell, 2012). Goffman's (1983) essay (originally written as a presidential address for the American Sociological Association) presents an attempt to set up the world of face-to-face interaction as a field in its own right that requires independent study and analysis. He makes a case for interaction being something that is orderly and therefore predictable, as it involves shared cognitive presuppositions.

Sacks (1995) details how he first began to notice that conversation is something which is actually methodical in nature, and so can be formally described and analysed (See 1995: 3-11 for some basic conversational rules). He goes on to outline how the orderly nature of conversation allows us to generalise findings, and how normal, everyday talk can be extremely valuable in terms of providing a wider understanding of how humans do things. Sacks notes that recording and analysing real events provides unique insight that other methods cannot capture. He uses the example of hypothetical situations. If one was to use a hypothetical example of conversation for research, it would be constrained by what the researcher believes could reasonably occur, rather than what actually occurs (1995: 419) Sacks points out that by recording actual situations, you may come across phenomena that you would not have put into a hypothetical situation, as you may not have previously noticed or imagined their existence. Notably, this is a departure from the work of Goffman, who often used made up examples (Helm, 1982).

Ten Have (2007) further illustrates the value of studying talk, noting how CA can operate closer to phenomena than most other methodological approaches, as its focus is on actual interaction as opposed to summarised representations of reality (as one might get from a survey or interview, for example). CA assumes that talk-in-interaction is vital to all social life, as it is involved in everything from everyday concerns to societal institutions. As ten Have puts it, *"It does not take much effort of observation and reflection to conclude that talking together is basic to the social life of humans. When we grow up we 'become human' in and through talk and much of our social life is in fact enacted as and in talk."* (2007:10).

With this power to examine social behaviour in all situations, conversation analysis gradually became what Kuhn (1962) might call a paradigm. The method provides a unique way of looking at data, which as Stivers and Sidnell (2012: 2) point out, is distinctive from other methods in five ways:

1. In terms of theoretical assumptions, the method assumes that social interaction is something that is orderly (to minute detail) in all cases where individuals are competent at social interaction.
2. The analysis itself aims to describe overall structure of interactions.
3. As the goal of analysis is structural, the data are also unique as it must record naturally occurring interactions.
4. The way the data is prepared for analysis is distinctive, given that it must be transcribed to allow detailed analysis of patterns and structure.
5. The analysis itself is also unique, as it works with raw data and relies on case-by-case basis to identify patterns and deviant cases, allowing for generalisation without congealing everything into a single aggregate.

Despite its roots in ethnomethodology, there is some debate regarding whether conversation analysis aligns more with a positivist or a social constructionist approach (Svennevig and Skovholt, 2005). At face value, it may appear that the method is more positivist, as it aims to get close to (ten Have, 2007) and record actual reality (in the form of video or audio recordings of conversations) and accurately transcribe "what happened." (Sacks, 1984). However, it could be argued that on balance, conversation analysis actually fits better with social constructionism. Although the method sets out to look at data in an unmotivated way and locate formal patterns (Sacks, 1984), it is likely there will always be an element of interpretation. As Svennevig and Skovholt, (2005) point out, the very process of observing patterns would require some form of abstraction within the analyst's mind.

Perhaps more significantly, regarding CA, Svennevig and Skovholt, (2005) state that it is "*a version of social constructionism in that it stresses the local and situated character of social reality*." (2005: 8). As ten Have (1997) puts it, "*CA puts 'data' rather than 'theory' in first position*." (1997:1). CA therefore analyses data as it is, as opposed to as a testimony or indicator of another existing reality. Ten Have (1990) notes, at any moment in time, how an interaction will develop in the future is open and has not yet been produced by the individuals within the interaction. Therefore, when an utterance is produced, what it means or does is not fixed. Its value will be negotiated by the future utterances that follow it.

Heritage (1997: 223-224) notes three preliminary rules for how individuals are theorised to orient to interaction in CA:

1. When talk is constructed, participants usually address themselves to the preceding talk. Talk is therefore shaped by context.
2. When doing an action, participants usually project that the next action(s) should be done by another participant, thus creating (or renewing) the context of the next persons talk.

3. Participants show an understanding of prior actions that have occurred by producing their subsequent actions, so mutual understanding is developed through the intersubjective sequential architecture.

Heritage and Atkinson (1984) make a similar observation, noting that the fact that "*speakers understand an utterance by reference to its turn-within-sequence character provides a central resource for both the participants and the overhearing analyst to make sense of the talk*." (Heritage and Atkinson, 1984:7). Following this statement, they demonstrate with examples of an individual receiving information about a furniture delivery from two different sources, how similar utterances may be treated differently. In the given example, the individual interprets one utterance as an occasion to comment on the speed of the furniture delivery, and the second as a suggestion that the other individual wants her to come and see/admire the furniture. Regardless of how a recipient chooses to interpret any given turn of talk, Heritage and Atkinson's (1984) key point was that whatever conclusion someone comes to about an utterance, it will be displayed in the next turn they produce. This evidence can then be analysed by both the speakers and overhearers such as researchers to determine how each individual's turn has been treated and so understood. This is also known as the next turn proof procedure (Sacks, 1974).

In terms of turn formatting or structure, a key underlying assumption of CA is that, during 'ordinary' speaking, turns at talk are constructed during the course of the speaking using recognisable units. These units are known as TCUs (turn constructional units). When a speaker is in the process of producing a TCU, they are typically treated as owning the turn. When a unit finishes (also known as a transition relevance place/ TRP), another speaker could take a turn (unless something is done to prevent this) (Sacks, 1974, ten Have, 2007). These units or turns are built up into sequences during conversation. One of the most basic examples of this is adjacency pairs. Adjacency pairs are two relatively ordered, adjacently placed turns (turns following each other) that are pair-type related (e.g. a greeting in response to a greeting, or a denial in response to an accusation). These two turns are known as a first pair part and a second pair part (Schegloff and Sacks, 1973:295-6).

These properties of talk , and the way in which local interactional context is crucial for turn production, demonstrates that there is not just a pre-existing world waiting to be discovered (as positivism (Benton and Craib, 2017) would assume), but that aspects of the world are talked into being (or constructed) all of the time through interaction. This includes institutions such as the acute hospital.

Conversation analysis has become a well-established method for examining interactions between healthcare professionals and patients (Barnes, 2019). Drew, Chatwin et al., (2001) provide a good outline of this use. As chapter 3 demonstrates, CA is also a good way to examine potentially atypical interactions, as rather than focusing on deficit and interactional impairment, often the focus is more on competence and what works, and how it is made to work. This may be particularly significant for PLWD, since as Webb (2017) points out, examining talk can have profound real-world implications, and conversation is a shared experience. PLWD may have unique experiences which may help or impede interactions with others.

It could be argued that CA may encounter some difficulties when used for analysis on data involving PLWD. One example may be when using the next turn proof procedure (Sacks, 1974), as PWLD may not always produce a clear response to a conversational partner's prior turn (e.g. Williams, 2006) or may take longer to do so (e.g. Perkins et al., 1998). As a result, conversations may not always follow the clear turn formatting rules established for 'ordinary' speaking. This is acknowledged as a potential limitation in this thesis, and will be revisited in the later analysis chapters.

Nonetheless, it should be noted that a lack of response is not always problematic in CA. When conversational sequences occur, it is possible to establish whether it is relevant for something to come next. Hofstetter (2020) states "*Sequences provide for what is relevant to come next, and thus the lack of that relevant something is an absence.*" (2020:124). An absence of response is still therefore something that can be considered analytically. Schegloff (2007) calls this a "*noticeable absence*" (2007:20). In these types of situations, an absence may be made more noticeable if it is a silence/lack of response and it is treated as accountable by the first speaker pursuing a response from the other person (Hofstetter, 2020). In addition, in some circumstances, there may be other non-language based elements that become relevant for analysis in interaction. For instance, it has been shown that people use clicks (a non-lexical noise made in the vocal tract) to convey a multitude of meanings when they may not produce a spoken response (see Ogden, 2020, 2013).

Furthermore, Chapter 3 has demonstrated the wide application of CA to study communication involving PLWD. For instance, it has been shown that CA is sensitive enough to identify deficits and preserved abilities (e.g., Perkins et al., 1998), distinguish between different conditions (e.g., Blackburn et al., 2016), pinpoint sources of interactional trouble (e.g. Chatwin, 2014 and Kitzinger and Jones, 2007), and find mechanisms PLWD may use to compensate for difficulties (e.g. Wilson et al., 2007). It was also demonstrated that conversation could be analysed even in a situation in which the PLWD typically did not produce any verbal responses to turns (e.g. Schneider et al., 2019) and in situations where turn taking was typically followed but responses from PLWD were hard to interpret (Pilnick et al., 2021).

Friedland and Miller (1999) raise a number of methodological benefits of CA and claim that CA is an ideal method to study communication with PLWD, because prior research had mostly used arbitrary categories to classify behaviour. They note that PLWD are very heterogeneous. CA is sensitive and detailed enough that it can be used to conduct an in-depth investigation into each individual case and how each person uses language.

A key difference between CA and alternative methods of data collection and analysis was set out by Jones (2015). It was pointed out that if, for instance, one was to collect a profile of test scores, it would likely be possible to investigate how a disease such as Alzheimer's affects various functions. However, it would probably not allow inferences about PLWD's actual communicative and conversational abilities overall. CA on the other hand can be used to look at how dementia may affect people as they live in the real world. Dahlbäck et al., (2019) expands upon this argument further, by comparing how a memory task might function in an experimental, as opposed to a 'real life,' environment. They point out that in everyday interaction, a memory task is unlikely to be done without some reason or relevant purpose (other than just remembering something). A good example that they give is recalling a list of names in a laboratory, compared to planning party invitations at home. The absence or presence of relevance may influence how the task is performed.

In addition, the fact that CA often focuses with great detail on individual cases does not mean that findings are impossible to generalise. Sacks et al., (1974) provides a useful discussion in relation to how CA can be simultaneously context free and context sensitive. These two concepts can be mutually exclusive, because it is argued that CA can produce some rules of interaction which are likely to be universal (such as the turn taking systematics set out by Sacks et al.). However, these context-free (or generalisable) structures will be manifested differently by individual circumstances, hence also making them context sensitive. For instance, turns in interactions are often given meaning and influenced by turns that were produced previously (Sidnell, 2012; Heritage and Atkinson, 1984; Heritage 1997). This is not to say that using single cases as evidence is entirely unproblematic, as it could always be argued that more data are required to prove a rule. Nonetheless, CA is potentially unique in the sense that assumptions can be checked in terms of participants reactions (Sidnell, 2012). That is, something could be considered a compliment or an insult, because it has been treated as such by the other party in the conversation. Therefore, it is possible to look at relatively small fragments of data, and make some inferences around what is occurring, based on the actions and reactions of the interactants. However, it should be noted that participants may not always observably demonstrate how they are feeling, which is a limitation of this method.

Taking into account the ability of conversation analysis to go beyond individual psychological dispositions by intensively scrutinising and comparing multiple episodes to allow patterns and their consequences to be identified, it is argued that this is the best method to use for this thesis. During the literature review, it was identified that a significant proportion of the pre-existing literature in the area used hypothetical or historical accounts of behaviour. In addition, of the research that did look more directly at interactions, it was common to look at the responses or interpretations of carers only, rather than PLWD themselves. Therefore, in order to fully investigate whether elderspeak is always inappropriate, and answer the research questions in this thesis, conversation analysis will be a suitable tool for examining real interactions in the level of detail that is required.

4.3 Methods

4.3.1 Research Aims

The research questions for this project were as follows:

1) In what contexts is elderspeak used in the care of people living with dementia (PLWD), and by whom?

2) How is elderspeak received and responded to by PLWD?

3) What is the impact of local interactional context on receipt or rejection of elderspeak by PLWD? Does activity type affect receipt?

4.3.2 The data

This PhD was funded by a collaborative ESRC studentship funded by the MGS DTP in collaboration with Nottingham University Hospitals Trust. As such, the broad remit of this project (to investigate the use of elderspeak) was already delineated. I was given access to a pre-existing data set from the VOICE research project (discussed below), which held permission for future analysis. In addition, I was able to join the research team for VOICE2 (discussed in section 4.5 below), allowing me to take part in data collection and access the full data set from that project.

4.4 The VOICE Project

On (22/11/21), Ethical approval was gained from the University of Nottingham School of Sociology and Social Policy REC (see Appendix 1) for initial analysis on a pre-existing corpus from VOICE, a (2018) NIHR funded study (HS&DR 13/114/93) in which the PhD supervisors were involved (with Harwood being chief investigator, and Pilnick and Goldberg being co-investigators). This data set also held prior ethical approval from the Bradford and Leeds NHS REC (REF 15/YH/0184, 5th June 2015) for future data analysis. This data were recorded on two healthcare of the older persons (HCOP) wards in a large UK teaching hospital. It contains video recordings of routine interactions between a variety of healthcare professionals (such as doctors, nurses, speech and language therapists, occupational therapists and physiotherapists) and patients living with dementia. This included a range of activities such as assisting with eating and drinking, conducting medical examinations and tests, changing wound dressings and giving medication. All interactions were initiated by the healthcare professional. Intimate care was not recorded in this study to preserve privacy and dignity of patients.

Inclusion criteria were as follows:

- HCP Participants
    - A registered healthcare professional (doctor, nurse or therapist) working on healthcare of the older person wards at the study location.
- Other HCP and Student Participants
    - A HCP or student present and video recorded during an interaction between a patient and HCP participant.
- Patients:
    - Male or female, aged 65 years or above.
    - Admitted to a healthcare of the older person ward at the study location.
    - A diagnosis of dementia recorded in medical notes.
    - Ward staff report at least some difficulties communicating with staff.
- Relative and Friends
    - Present and video recorded during an interaction between a patient participant and a HCP participant.

Exclusion criteria were as follows:

- HCP participants
    - None
- Patient participants

    - Not a fluent English speaker.
    - Unable to give informed consent and unable to obtain consultee agreement
    - A diagnosis of Parkinson's disease.
    - Assessed by the clinical team as likely to die within seven days.
- Relatives or Friends
    - Unable to give informed consent.

From the VOICE study, I had access to 32 recordings of interactions, involving 25 HCPs and 21 patients (some HCPs and patients appeared in more than one video). This comprised approximately 5 hours of data.

4.5 The VOICE2 Project

Further ethical approval was later gained for additional data collection under the NIHR funded VOICE2 research project (NIHR134221) from the Wales 7 NHS REC (22/WA/0023 14/02/22) Appendix 3) and the University of Nottingham School of Sociology and Social Policy REC (18/03/22, Appendix 2). After obtaining a letter of access from the hospital trust, I joined the VOICE2 team to recruit participants and collect data at one of two hospital sites. In this role, I recruited 8 HCPs and 4 patients, as well as jointly helping with many others. I was responsible for 18 of the recordings and aided with multiple others. Of the individuals who did not take part in the research, I was involved in screening 144 patients (out of a total of 251) for suitability according to the inclusion criteria and approached 4 HCPS who declined to take part (out of a total of 34).

Inclusion criteria for VOICE2 were as follows:

- HCPs:

    - Registered healthcare practitioner or assistant to registered healthcare practitioners employed to work on a healthcare of the older person ward.
- Student HCP:
    - Student healthcare practitioners who are present during the interaction.
- Patients:
    - A patient on a healthcare of the older person ward of any age (although to be admitted to the ward patients would typically be over 65, usually much older).
    - Had a diagnosis of dementia recorded in medical notes.
    - Reported by staff to be prone to distress (for example, repetitive calling out, physical aggression, verbal aggression, swearing, resistance to care, exit seeking, agitation).
- Family member/friend participant:
    - Present with the patient at the time of the video recording.

Exclusion criteria for VOICE2 were as follows:

- Healthcare practitioner and student participants
    - Unwilling to give informed consent.
- Patient participants:
    - Unwilling to give informed consent or unable to gain consultee agreement.
    - Confirmed by clinical team to be at end of life (death expected within one week).

    - Did not have an appropriate personal or nominated consultee.
- Family member/friend participant:
    - Unwilling to give informed consent.

These data were recorded across two acute UK hospitals, also in healthcare of the older person wards. Similarly to VOICE, routine interactions between healthcare staff and patients were recorded. In this case, intimate care was recorded but as audio only to preserve privacy and dignity of patients.

4.5.1 Study Setting

Ten healthcare of the older persons wards were chosen for this research in two general UK hospitals. These wards were selected because they contain the highest proportion of PLWD, and the staff typically have a level of experience and expertise that gives a likelihood of good practice being demonstrated.

4.5.2 HCP recruitment

Members of the VOICE2 research team presented the research study at meetings with senior hospital staff members (such as ward managers and consultants) before beginning recruitment on the wards, in order to familiarise staff with the research and gain permission to be present on the wards. Additionally, typically a member of the research team introduced themselves and the team to a member/members of the senior ward clinical team on entering a new ward, in order to maintain good relations and make sure they were aware that the research team were present on the ward. The VOICE2 team also placed posters around the wards in question (with the permission of staff) which contained photographs of the research team and the purpose of the study, in order to aid familiarisation with the research.

HCP's were recruited from the ward in which they were working. Members of staff were approached in between duties and given the chance to read the participant information sheet and ask any questions about the research. They were informed that participation was entirely voluntary, and they could withdraw at any time, but information that had already collected may not be possible to erase and may have already been analysed.

Since the video data could not be completely anonymised, a two-stage consent process was used for all participants. The initial consent form covered taking part in the research and gave permission for the recordings to be analysed by the research team. This was completed after participants had received the initial study information (see Appendix 4 for example study information and Appendix 5 for example stage 1 consent form.) and had been given time to consider and ask questions if desired. Then, later once filming had been done, participants were given the opportunity to view the recording if they wished and were asked to sign a second level consent. This was optional, and covered five additional uses of the video material:

- Video/audio could be played to other researchers outside the research team.
- Video/audio could be played at presentations about the research.
- Video/audio could be used in communication skills training materials.
- Video/audio could be included on online platforms.
- Video/audio could be used for future research.

Participants could agree or disagree to any of the five points. See Appendix 6 for example stage 2 consent form.

4.5.3 Patient recruitment

Patients were identified by talking to staff members on the ward. All patients recruited had dementia. Under the Mental Capacity Act (MCA 2005,) dementia is considered a condition under which individuals may not have the ability to give informed consent. Therefore, the capacity of each individual had to be considered and assessed during recruitment.

When a patient who met the inclusion criteria was identified, a staff member working with them was asked to discuss the study with them, and if they were interested in taking part, introduce them to the researcher. The researcher would then discuss with them the purpose of the study and what would happen to them. All of the patients experienced some level of communication difficulty relating to their dementia (and likely other illness), so additional effort was employed to ensure that the patient understood the study to the best of their ability. Communication was done in as clear a manner as possible, with the aid of a simplified patient information sheet if necessary (see Appendix 7). The camera used for filming was also shown as a prop to the patient to make the intent clearer. A similar approach was used by Dewing (2004) who also used a camera, and is discussed in Dewing (2007). Irrespective of capacity to give informed consent, if the patient appeared to not want to be filmed or to take part in the study, (for example if they expressed displeasure at the sight of the camera), they were not recruited for the study. This was to avoid causing any additional distress, and because it would be unethical to film someone who clearly did not wish to be filmed. Additionally, CA methodology looks at interactions as much as possible as they naturally occur, and participants uncomfortable with filming would not be ideal.

After going through the participant information and talking about the study with the researchers, patients were questioned about their understanding of the information they had just been given, in order to enable an assessment of their mental capacity to consent to the research and a capacity assessment form was filled out, documenting the outcome in writing.

This approach is in line with the Mental Capacity Act (MCA, 2005) which states that a person must be considered to have capacity to make a decision, unless it is established that they lack the capacity, and the person should not be treated as unable to make the decision unless all steps that could practically be taken to help them decide have been unsuccessful. Section 3 of the MCA states that the individual is unable to make an informed decision if they are unable:

- *(a)to understand the information relevant to the decision,*
- *(b)to retain that information,*
- *(c)to use or weigh that information as part of the process of making the decision, or*
- *(d)to communicate his decision (whether by talking, using sign language or any other means).*

  MCA (2005:S3)

In all but one case, the patients were unable to give informed consent to participate in the study, as they did not meet at least one of the above criteria when the capacity assessment was undertaken. In these cases, consultee agreement was sought according to the procedures set out in section 32 of the MCA. This involved identifying a family member or friend of the patient who was willing to act as a 'personal consultee'. Under the MCA 2005, HCPs can also act as nominated consultees (under section 32, subsection 3) if they are involved with the research but have some knowledge of the patient. However we did not use nominated consultees in this study as this option was not thought appropriate by the patient and public involvement and engagement (PPIE) group consulted on this matter, as the nominated consultee would be unlikely to know the patient's views on being video recorded. The MCA takes the position that, in general, involvement in medical research is beneficial and constitutes a right rather than a threat. The procedures in the MCA therefore serve to enable and encourage participation for those lacking mental capacity to consent.

Once a consultee was identified, they were given an information sheet and the opportunity to discuss and ask any questions to the researcher. They were asked if they could advise on whether they believed that the patient would want to participate, or if there were any reasons they knew of that the patient would not want to be involved in the research. They were advised that participation was voluntary and they would be able to withdraw the patient from the study at any time and this would not affect the patient's medical care. If they wished, consultees could go away with the information sheet and take time to consider. If the consultee was happy with the information provided and agreed that the patient would want to be included in the research, they were asked to sign a declaration form.

As with other participants, the two-stage consent process was also used with patients and consultees. After filming took place, patients and/or consultees were given the opportunity to view the recording if they wished and were then asked to sign the second stage consent (or declaration in the case of consultees) with the same options described in section 4.5.2.

In addition, irrespective of whether the patient had capacity to consent or not, process consent was used throughout the data collection to ensure participants with dementia were not obviously objecting to being video recorded. Dewing (2008 and 2007) provides a detailed outline of the approach when PLWD are involved in research, but in short, once access to participants is gained, process consent involves continually revisiting whether the individual is still not objecting to participate in the research, taking into account their ability to communicate and adapting communication accordingly. This method is considered to be more inclusive for PLWD within research, as it allows them to have an ongoing voice in their participation, rather than relying solely on an advocate to agree or disagree for them (Dewing, 2008;2007). Within the present research, this method was implemented by reminding participants again before any recording took place that the recording could be stopped at any time and they were asked again if they were happy to be recorded at that time. It was established that if at any time the presence of the camera or the researcher appeared to cause additional distress to the patient or the HCP felt that recording should be stopped, recording would be immediately stopped.

4.5.4 Sample Size

A total of 26 patients living with dementia and 96 HCPs were recruited during this research. Of these, 22 patients and 54 HCPs were actually recorded (with 53 total recordings of interactions, totalling approximately 9 hours and 46 minutes of data). More HCPs were recruited due to the fact that there were often multiple HCPs working with patients at any one time. Additionally, often, there was a period of waiting, once some HCP's had been recruited in an area until an eligible patient could also be recruited. Once a patient was recruited, waiting was also required until HCPs who had also consented to the study happened to be working with that specific patient. It was therefore useful to have multiple recruited HCPs within an area, to improve the chances of being able to film any interactions that occurred with a patient. This was beneficial in terms improving the likelihood of recording a variety of different tasks and situations, allowing a wider scope of analysis.

Overall, 34 HCPs declined to take part, and although reasons for choosing not to participate were not specifically sought, some individuals did provide reasons. Most commonly, individuals stated that they were uncomfortable with the idea of being filmed, or (in the case of consultees) their relative/friend being filmed. Occasionally, HCPs also gave reasons such as being too tired/busy, or that they were leaving/transferring to a different hospital/department imminently. Some individuals took away the information to think about, and declined to return the consent form.

Additionally, in the case of patients, 251 additional patients were screened for inclusion in the study but were not recruited. Often it was time consuming to confirm that a patient met all of the inclusion criteria for the research. This involved consulting HCPs to determine whether the patient had a formal dementia diagnosis within their medical notes, and whether the patient had experienced any episodes of distress whilst in hospital (in order to fulfil the objectives of the VOICE2 study). Patients were typically unable to provide this type of information for themselves, and often multiple HCPs were talked to, as with shift changes and different roles, some had more knowledge of patients than others. In many cases, it was determined that a potential patient did not have a formal diagnosis of dementia.

Once a potential patient participant had been identified, there was the additional barrier to recruitment of contacting a consultee. Of the eligible patients whose consultee could be contacted, 16 said they did not wish for their relative/friend to take part in the research. Some patients did not have anyone who could act within this role, so they could not be included within the research. For others, it was not possible to contact their consultee or meet them on the ward. In these cases, often the patient was discharged or transferred elsewhere before it was possible to establish whether they could be included in the research. This is not unexpected, as in a similar population (hospitalised adults over 70 with mental health problems including cognitive impairment) Goldberg et al., (2012) found that 9% of people had no carer identified, and 17% were discharged before an identified carer could be contacted for consultee agreement.

4.5.5 Data collection

Data was collected between March 2022 and September 2022. Before any recording began, information and training was received from the experienced research fellows in the VOICE2 team, who demonstrated how to correctly position and operate the cameras and other equipment so that the recordings would be suitable for analysis. They also ensured familiarity with all of the processes involved, such as naming conventions and secure data storage.

Before travelling to a relevant hospital ward, all equipment was checked to ensure that the correct items were included, each item had a battery charged and inserted and everything was organised. A wheelable bag was packed with:

- The camera.
- A small tripod.
- The microphones.
- The sound recorder.
- A folder for the researcher to use, containing blank copies of each participant information sheet and consent form, and space to make notes.

Before entering the wards, in accordance with hospital staff policy, each researcher made sure that hair was tied back, any wristwatches etc were removed and clothes were short-sleeved or could be rolled up above the elbow. A lanyard was worn with the university colours and identification card. Due to the Covid-19 situation, appropriate personal protective equipment (PPE) was worn when entering the hospital/ward area. This was usually a face mask, but depending on the specific ward requirements could also include a plastic apron and gloves. Hands were sanitised regularly and washed in between interacting with patients.

Prior to each recording, if a recruited HCP informed us that they would be working with a patient participating in the study, where possible a small microphone was attached to the HCP. This microphone was wirelessly linked to the video camera. A sound recorder was also placed unobtrusively near to the scene, as a backup in case the camera audio failed, and also to allow the best chance of capturing clear enough audio for the use of CA in the busy ward environment with often multiple people talking. In some situations, (for instance if the participants were moving around) the sound recorder was carried by a member of the research team. The camera itself was either placed nearby on a small tripod (often on a windowsill if close, or a bedside table), or in cases where participants were moving around it was also carried as unobtrusively as possible. The zoom function was used in many cases, to allow the researchers to be further out of the way and allow more natural interaction, even though evidence suggests that healthcare consultations are unlikely to be impacted by recording (Parry et al., 2016). In cases of intimate care, sound only was recorded, or the camera would have the lens covered if for instance this occurred part way through an interaction in order to preserve the dignity of patients.

Interactions were recorded for as long as they naturally went on, so some had a relatively short duration (e.g. a HCP checking on a patient who just needed to locate his glasses took approximately 4 minutes) and some had a much longer duration (e.g. a patient who was concerned he would need to be prime minister was recorded for approximately 1 hour and 8 minutes spending time with HCAs on the ward). Occasionally, recording was paused and resumed during an interaction, for instance in cases where a patient was taken to the toilet, the process of taking the patient to the toilet was recorded, then there was a pause whilst they were in the toilet, and then the process of staff taking them back to their bedside was recorded.

4.5.6 Data Storage, Security and Confidentiality

During the consent process, participants were informed how their data would be used, stored and retained. In accordance with the study's data management plan and in accordance with GDPR, participant consent forms and related information were stored securely in a locked cabinet in a secure locked university office room.

Digital data were stored in a secure Microsoft Office365 Teams site. Microsoft Teams is a service which is ISO 27001 information security compliant (Microsoft, 2023). This means that sharing of data amongst the research team was secure and controlled. Teams encrypts data both in transit and at rest. The service provides continual failover support, and is approved against the University of Nottingham's Secure Data Handling Policy. On the Teams system, two separate 'Teams' were created with different folders, so that personally identifiable participant information (names etc.) could be stored separately from recorded data and anonymised transcripts. A Microsoft Excel spreadsheet stored within Teams was used to record recruited participants, participant contact etc. A second Microsoft Excel spreadsheet was used to record the metadata for each recording (e.g. the video file name, the length of the recording, participants involved (using anonymous ID codes), researcher comments/notes about the situation etc.).

After each recording was made, the data were uploaded as soon as possible to the secure Microsoft Teams site. This was usually done the same day (typically immediately after recording), although provision was made for the recording equipment to be stored securely (in a locked filing cabinet in a secure university room) if any technical reason meant data could not be immediately uploaded. Once files were uploaded, backups were copied to an additional folder within the Teams site. The uploads were double checked to make sure there was no error or loss of data, and the memory cards of the recording equipment were wiped.

Participants were given anonymous alphanumerical codes and each video was labelled according to the following convention:

VOICE2_participant number_HCP number_camera used_date

An example video label may therefore appear like this:

VOICE2_PN01_HN01_PAN_010123

Each video file was recorded and saved in MP4 format. Sound recordings were saved in WAV format. These formats are usable by most software.

4.5.7 Data Processing

Although often in research data are completely anonymised, it was not possible to completely anonymise the video in this case, because removing features such as participants' faces would impede analysis and would be likely to remove evidence that supports analytic claims in academic data sessions or presentations. Therefore, even with identifying features such as names removed, the possibility that a participant may be recognised by someone they know could not be ruled out. Participants were advised during the information and consent process that it is possible that they may be identified from the recordings. The use of the second level consent process (described in sections 4.5.2 and 4.5.3) ensured that participants/consultees had full control over how their recording would be used, and that they were comfortable with this. In order for the recording to be shared more widely (i.e. outside of the research team), all participants within the video (patient, all HCPs etc.) would need to have agreed to this.

If a participant used the name of a person or place when speaking on a recording, this was changed to a pseudonym when transcribing, and later if the video was shown to anyone outside of the research team (with appropriate permissions), then the name would be edited out by silencing that section of the audio using a programme such as DaVinci resolve. In addition, on the video recording, any identifying information (such as a written name) would be blurred/pixelated out before the video was viewed by anyone outside of the research team. If anyone else was incidentally caught in the background of the video (given that the ward is a busy environment), then their face would be blurred out/pixelated in the video.

When a pseudonym was given, this was done in a way that aimed to preserve the syllable length, stress pattern and gender of the original name so as to minimise the effect on analysis (See Liddicoat, 2021: 26-27; Saunders et al., 2015). Names of places such as towns or institutions were also changed where necessary.

4.6 Analysis

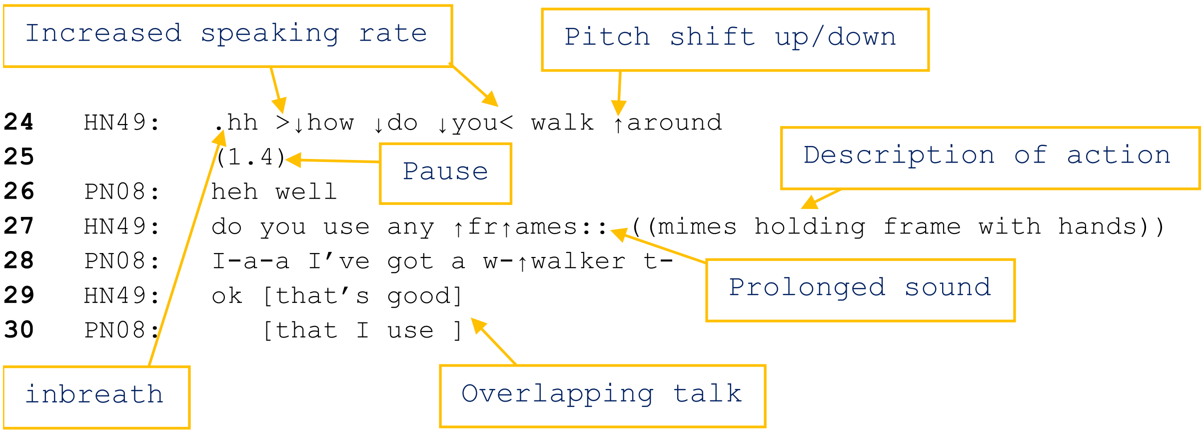
4.6.1 Transcription

Data were initially transcribed verbatim and then where sections of the interaction were identified as relevant to emerging analytic phenomena and the building of collections of these phenomena, these were refined according to

Jefferson’s (2004) CA conventions. This is the standard transcription system used within CA (ten Have, 2007; Hepburn and Bolden, 2012).

Some researchers choose to use the Mondada transcription system (see Mondada, 2018) which includes more multimodal features of interaction. This was not chosen for this analysis for a number of reasons. This method takes significantly more time both to learn and to use, which would have reduced the time available for wider analysis and other activities. In addition, this style can arguably be more difficult to understand for non-specialist audiences, which would have made it more difficult to share the findings with other members of the research team, stakeholders, communication skills learners, and other academic audiences.

The Jefferson (2004) style covers all of the spoken words, and includes some multimodal features of talk, such as silences, changes in pitch and overlapping talk. Since these data were predominantly video based, where relevant some non-verbal features such as gaze or gestures were also annotated. The following is a short example. In this case, HN49 (a male doctor) is talking to a female patient (PN08) about her mobility.



```
24   HN49:   .hh >↓how ↓do ↓you< walk ↑around
25            (1.4)
26   PN08:   heh well
27   HN49:   do you use any ↑fr↑ames:: ((mimes holding frame with hands))
28   PN08:   I-a-a I’ve got a w-↑walker t-
29   HN49:   ok [that’s good]
30   PN08:       [that I use ]
```

Figure 4.1: Example CA transcription

The labels cover some of the features typically transcribed in the Jeffersonian system. A key element is that typical punctuation is not used, as these symbols carry other meaning in these transcripts. For example, if a full stop was used at the end of a turn, it would indicate a final falling intonation, rather than the end of a sentence (Jefferson, 2004).

Transcriptions were used as an aide alongside analysis, with the video and audio recordings being the primary source. Recordings were viewed repeatedly, and the transcripts were gradually built up in detail. The accuracy of the transcription was verified through data sessions with the project supervisors and (where permitted) other researchers, as is common within CA methodology (Sidnell, 2012). Data sessions allow further refinement and development of shared understanding (ten Have, 2007).

4.6.2 Collection Building and Extract Selection

Sidnell (2012) sets out three stages of CA analysis: observation of the data, identification of interesting phenomena and collection of examples. When examples have been collected, practices can be described through analysis of singular examples and comparison across multiple cases.

I had initially begun the observation phase by examining the existing VOICE data, using Microsoft Word and Excel to document instances of elderspeak occurring. Using this system, I began to record the presence of elderspeak features in each VOICE video I had available according to definitions outlined by Ryan et al., (1995) and Shaw and Gordon (2021) (see table 4.1 below). Rather than specifically focusing on motivations behind talk, which is not accessible in CA (Hutchby and Wooffitt, 1998), I aimed to identify directly observable features of talk (e.g. a minimising word, a term of endearment or a tag question for instance). This was a starting point for analysis, since from a CA perspective, items cannot be categorised as elderspeak outside of their interactional context.

Broad Category	Specific
Vocabulary	Childish Terms
	Simple Vocabulary
	Short Words
	Minimising
Grammar	Simple Sentences
	Short Utterances
	Sentence Fragments
	Repetitions
	Long Pauses/Extra Fillers
	Tag Questions
	Directives/Imperatives
	Collectives
	Reflexives
Forms of Address	Diminutives (including T.o.E)
	First Names
	3rd Person References
Topic Management	Exaggerated Politeness
	Exaggerated Praise
	Interruptions

	Limited Topic Selection/Reinforcement
	Ignoring/Dismissive
Voice	Raised Pitch
	Excessive Pitch Range/Singsong Intonation
	Excessively Soft Voice
	Overly Loud Voice
	Excessively Slowed Speech Rate
	Over Exaggerated Pronunciation
	Overly Exaggerated Stress
Gaze	Low Eye Contact
	Staring
	Eye Rolling
	Winking
Proximity	Standing Too Close
	Standing Over
	Standing Too Far Off
Facial Expression	Frowning
	Exaggerated Smile
	Raised Eyebrows
Gestures	Laughing At
	Shaking Head
	Shrugging
	Hands On Hips
	Crossed Arms

	Abrupt Movements
Touch	Patting

Table 4.1: elements of elderspeak

The data collected under VOICE2 were combined with the preexisting data obtained from VOICE to create a collection approximately 14 hours and 46 minutes of video data.

Although the underlying principle of CA is unmotivated looking (Sacks 1984, ten Have, 2007) this is often challenging in contemporary research in which there are usually pre-existing proposals or goals to meet for funding requirements etc. (O'Reilly et al., 2020; Bryman, 2007). In the present case, my ESRC studentship agreement set my project title and aims. However, since these questions were open in that I did not aim to support one side of an argument, (e.g. that elderspeak is inherently negative, for instance), I was able to examine the data in an unmotivated way as possible. Initially, I searched for examples of elderspeak. When realising that the large size of the data set meant that more advanced organisation was required, I used NVivo software to document instances of elderspeak.

It became apparent that some features of elderspeak were noted more often than others in the data set as a whole. Although in CA, only one example may be needed to prove a concept (Schegloff, 1987), it is common practice to build up collections of examples to demonstrate a point (Sidnell and Stivers, 2012).

To refine my analysis, I chose to focus on terms of endearment (ToE) as these were a common feature within the data, and appeared to occur in many different situations. This was despite the fact that they are often considered unprofessional and are recommended against in healthcare training (Laskowski-Jones, 2015). Consistent with CA's 'bottom-up' approach (Seedhouse, 2005), I first noted instances of them occurring. I then moved onto Sidnell's (2012) later stages of identification of phenomena, and grouped similar cases together. These groups were examined in further detail, which involved repeated watching/listening to the recordings and close examination and comparison of the transcripts. Gradually, phenomena of interest were identified when it became clear that actions were being performed by the systematic use and placement of terms of endearment within talk. Further instances of these actions were accumulated, resulting in collections of examples. These actions will be demonstrated later in chapter 5.

This analysis process was repeated focusing on use of praise within the data, and then use of prosody, which are the basis for analysis chapters 6 and 7. These specific aspects of elderspeak were chosen as a focus because a) they appeared regularly within the data, b) appeared to occur across many contexts and c) when brought together, terms of endearment, praise and prosody covered many of the broad categories of elderspeak which were proposed in previous literature.

4.7 Discussion

This chapter has covered the underpinning philosophy of the research, the methodology chosen for the research, and the methods including participant recruitment, data collection and data management. It has also described how the data were transcribed, analysed and treated. The following section will consider some general limitations of these methods and then contain some reflections on this chapter and the thesis process as a whole. This is structured according to the different types of reflexivity discussed by Olmos-Vega et al., (2023) and Walsh, (2003) in order to ensure that a broad range of issues are considered and covered.

4.7.1 General Limitations

Practically, the environment itself meant that the recording process did have some limitations. Capturing the sound of all participants clearly was challenging, mostly due to the high level of background noise, and multiple people moving around and talking. At times this was additionally complicated due to the presence of face masks (due to Covid-19) making it unclear who was talking. This was unavoidable, since the purpose of this research is to examine how interactions naturally occur in the real-world environment. In addition, many of the patients had some level of communication difficulty as a feature of their dementia, so at times produced talk that was very quiet or hard to interpret (Pilnick et al. 2021). Overall, this made transcription of some of the data difficult (but not impossible). Repeated listening with the aid of good quality headphones, and discussion with other members of the research team meant that the transcriptions were as accurate as possible.

Another limitation is that being one individual with only PhD resources meant that the decision had to be made to focus specifically on only some but not all possible features of elderspeak. This limits claims about elderspeak as a general phenomena, although it was possible to examine the features included in a great amount of detail, and these provide good examples of different aspects of elderspeak. This style of analysis is arguably more useful in terms of practical application of findings, as it has the potential to identify unique actions of each feature, which would not be possible if elderspeak were considered as a single phenomenon.

A further area of consideration is the sampling method. It is possible that some bias was introduced by the methods of selection. HCPs in particular were recruited when the opportunity arose on the wards. It could therefore be that some individuals were more likely to be recruited than others, for instance those who were more willing to talk to the researchers, or those who were more likely to work with a certain type of patient (some patients need one-to-one support, for example). Nonetheless, the fact that many different HCPs (at all levels of experience from student to experienced workers) were recruited suggests that a good and representative sample was taken. Furthermore, CA looks in fine detail at individual interactions, and examines how the interaction is built up moment by moment. In this way, it is arguably less important what background the participants have, as what they make relevant in their talk is the thing that is examined.

4.7.2 Reflexivity

Reflexivity refers to the ongoing and often collaborative practices through which researchers self-consciously critique, appraise and evaluate how their research process is influenced by their own subjectivity and context (Olmos-Vega et al., 2023: 242). Different types of reflexivity include personal, interpersonal, methodological and contextual. Reflexivity is something that is often overlooked during the research process, but it can be a way to embrace a researcher’s inherent subjectivity and improve the rigour of qualitative research (Olmos-Vega et al., 2023). Quantitative research aims to reveal truths while minimising bias as much as possible, through design and adherence to processes (Young and Ryan, 2020). Qualitative research may actually *require* some level of subjectivity, as this can shape enquiry and help to untangle the 'messiness' of real world data that involves the experiences and social practices of participants (Olmos-Vega et al., 2023). Schutz (1966) similarly argues that one's experience of the world is not private, but shared (see Vargas, 2020). In other words, it could be argued that to interpret human actions in interaction, one needs to use one's own human experience to interpret, at least to some extent. Underlying knowledge of social norms and actions can be used to aid analysis and identify when instances occur that might be outside of the norm. A classic example of this would be in Garfinkel's (1967) breaching experiments discussed above, in which one would need to first know what is normal (for the society being studied) before one could begin to explain why a behaviour deviated from this, and what consequences this had. Nonetheless, although some subjectivity is an asset to research, Olmos-Vega et al., (2023) do note that the researcher must exercise caution when exercising reflexivity, so as to not become too self-indulgent or narcissistic and lose sight of the participants themselves or enter into a "*never ending hall of mirrors,*" (2023: 248) in which the researcher reflects back and forth forever and the clear message of the research is lost. Arguably, there is less danger of this issue in CA because of its aim to get at participants' orientations as they are demonstrated in the data.

4.7.3 Personal Reflexivity

Personal reflexivity involves reflection on expectations, assumptions and conscious/unconscious reactions to participants and data (Olmos-Vega et al., 2023; Walsh, 2003). When I initially came to this project, my previous research experience had centred around Forensic Psychology, an entirely different context to healthcare. I only had my (admittedly quite negative) personal experiences of witnessing relatives and friends living with dementia in hospital (most notably, my Grandmother) to base my preconceptions on. This was something that I chose to consciously set aside, particularly when first viewing the data. This involved acknowledging that the recorded data involved individuals I did not know. The recordings were made at hospital sites that were (at the time) unfamiliar to me, and none of the participants had any relation to myself or my relatives. This thought process made it easier initially to undertake the 'unmotivated looking' favoured by CA, and focus on seeing actions that took place in interactions without undue consideration of underlying motivations or other processes inaccessible to CA. This process was also aided by the extensive preparation and background research that came before any viewing of data or research participants. My literature review demonstrated an underlying assumption within elderspeak research (with elderspeak often automatically positioned as a negative), and the associated limitations that come with this. This demonstrated a need to examine what was actually happening in real life interactions involving elderspeak without a presumption of how people living with dementia might respond. To begin by searching for a particular response type (i.e. a negative one only) would have risked neglecting the lived experiences of PLWD in hospital, and so would have risked falling into the trap of narcissism discussed by Olmos-Vega et al., (2023).

It is acknowledged that some of the features of elderspeak originally described are subjective and are therefore open to interpretation that could be influenced by the researcher's underlying views. A good example of this would be "childish terms," (identified by both Ryan et al., 1995 and Shaw and Gordon, 2021). In cases such as this, possible instances were documented and then discussed with the project supervisors to confirm if others shared a similar opinion, or an argument could be made for their inclusion.

It should also be noted that this process of identifying and setting aside personal bias was an ongoing one. As new observations arose, it was necessary to revisit this process. One example of this was my analysis of terms of endearment. Personally, I do not regularly use this type of talk, and often don't appreciate it if it is used towards me (for example, when being called 'Petal' by a car mechanic). Nonetheless, my experience is not the same as someone living with dementia in hospital, who may be feeling any number of emotions, accompanied by pain or confusion. Although I can use my experience as a person living in the UK who has been in receipt of NHS healthcare services as a basis to understand the recorded interactions, I cannot impose my feelings onto them as they would not be relevant. The process of CA itself helped with this, as once a phenomenon of interest (such as a ToE) had been identified, the reaction of the receiver is evidenced in the recording and can be objectively studied and compared to others. This is an advantage of the CA approach in this context.

4.7.4 Interpersonal Reflexivity

Interpersonal reflexivity refers to how research may be influenced by relationships involved. To consider interpersonal reflexivity, the power dynamics between the researcher and participants must be considered (Olmos-Vega et al., 2023; Walsh, 2003).

In the case of patients (and consultees), before consent (or agreement) was given, they were provided with the written reassurance that their medical care would not be affected by their decision to participate or not. Aside from living with dementia, patients were also suffering from various illnesses and injuries (which brought them into the acute hospital setting), increasing their vulnerability. Therefore, there was a potential to feel threatened by an unknown researcher, particularly as members of the public often lack familiarity with research processes (Holroyd-Leduc et al. 2016). Nonetheless, in my experience this did not appear to be the case. Often, during recruitment I had what I considered to be positive conversations with potential participants/consultees. Both groups included individuals who showed willingness to ask questions about the research or my role and individuals appeared able to decline the research if they thought it was unsuitable for their relative. In the case of patients, if they showed any distress or discomfort in relation to the research or camera once research was ongoing, they were not pursued further.

In the case of HCP's, as with consultees, I experienced many positive conversations in which HCPs asked questions about the research and, they also demonstrated that they were able to decline to participate if they wished. In terms of willingness to participate, it may have been beneficial for them to know that senior members of their ward staff team were supportive of the research as in some circumstances staff members were witnessed discussing the research and recommending others as future participants. Information about the study was also posted around the wards with the permission of senior staff. This could have helped to reduce concerns around being involved in something potentially outside of their normal duties. On the other hand, to cover the possibility that HCPs may have felt pressured to participate because senior staff may have been involved, they were reassured clearly on the information sheet that declining to participate would not affect their professional position or career prospects and all participation was anonymous within the limits already discussed in section 4.5.7.

4.7.5 Methodological Reflexivity

Methodological reflexivity involves the critical consideration of how methodological decisions have impacted the research (Olmos-Vega et al., 2023) and whether the methodological approach has been made explicit as this is often neglected in published research (Walsh, 2003). This chapter addresses the methodological approach to the research. There has been ongoing consideration of how underlying philosophical concepts apply to this research. The choice to use CA has been key to how this project has developed. CA has some potential limitations, such as being unable to access the internal state of participants in the way that an interview or questionnaire might try to accomplish. Nonetheless, as demonstrated by previous research, it addresses a unique gap in existing knowledge, in that it can access real-life actions and reactions connected with elderspeak as they actually occur. Hypothetical scenarios may introduce bias and are unlikely to be directly applicable to the real world (Sacks, 1995: 419) and asking people living with dementia in hospital to recall and evaluate real world situations that have actually happened would be difficult if not impossible due to the nature of their condition.

4.7.8 Contextual reflexivity

Contextual reflexivity involves locating the research within its historical or cultural context and considers how it influences the social field in which it exists (Olmos-Vega et al., 2023; Walsh, 2003). It is likely that the specific context of this study – the acute hospital environment – will have impacted upon the interactions that took place. This is a social institution (as defined by Miller (2019), and staff members have institutional roles that must be fulfilled. HCPs must balance being caring (Campbell et al. 2000) with being efficient and doing essential healthcare tasks. Furthermore, relationships and pre-existing knowledge between individuals will be different from other situations, such as PLWD being cared for by family members or long-term carers. This could have various effects, one example may be that with HCPs, there may not be the same level of face threat (Goffman 1955) present as for a family member or friend when a PLWD confabulates (makes statements whilst unaware that they are false) (e.g. Lindholm, 2015). Although not a limitation, it does mean that caution should be taken when applying findings to contexts different from the present one.

4.8 Conclusion

This chapter has outlined the philosophical background for this research, demonstrated how this relates to the specific method of CA and has then discussed how CA was used specifically for this project. Finally, the reflexive position of the researcher was considered, and some limitations of these methods were acknowledged. The following chapter will present the first section of data analysis and will examine how terms of endearment have been used in this data.

Chapter 5: Terms of Endearment Used With People Living With Dementia In The Acute Hospital Environment.

Please note, a version of the following analysis has been published in the journal Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine (Bridgstock et al., 2024).

5.1 Introduction

The way in which individuals address others within conversation can have a significant impact on an interaction. A term of address could be used to demonstrate where each participant stands in terms of differing status, or to demonstrate solidarity between the two people. (Wood and Ryan, 1991). If there are differing perceptions of which term of address should be used, a term could be viewed as inappropriate by a recipient. This may be the case is in exchanges where the participants are of contrasting ages. Wood and Ryan (1991) note that older individuals may be more likely to view indicators of status positively, meaning that they are likely to prefer forms of address such as title-last name (e.g., Mr/Mrs Smith). Conversely, there has been a historical shift towards emphasising solidarity, so younger speakers tend to prefer more informal exchanges (such as use of first names). In environments such as a hospital ward with older patients and younger staff, there is therefore potential to view more informal forms of address as "*overly familiar and insufficiently attentive to status*." (Wood and Ryan 176: 1991). Bowie (1996) similarly claims that selecting a term of address in nursing can be challenging, due to a tension between respecting status and demonstrating solidarity. This challenge arises because using something that the recipient feels is inappropriate may lead to offence.

Bury (1997) expands upon this more generally, noting that the concept of 'patienthood' has changed over time, which has influenced the traditional doctor-patient relationship. Illness patterns have changed, with more people living with chronic conditions, medical information has become more accessible to the public, and healthcare in general has become more subject to evaluation and accountability. Bury argues that this has resulted in health professionals now carrying less of an authority role, as evidenced by patients displaying less deference towards them. This ultimately results in a change from medical care being conceptualised not as something which is done to a patient, but a shared activity which is collaboratively achieved.

Recent research has continued to examine this evolving medical relationship. For instance, Armstrong (2014) discusses how the concepts of patient autonomy and agency appeared, developed and became salient over the latter half of the 20th century. Landmark et al., (2015) examined how treatment decisions are negotiated between patients and physicians. Using CA, they showed that both parties orient to patient involvement, although in their data the physician often attempted to lead patients towards choices that correspond with their own view. Their analysis involved considering the epistemic stance (Heritage 2012) of both patients who have primary rights to their own thoughts and feelings (termed 'epistemics of experience,' (Landmark et al., 2015: 59)) and HCPs who have medical expertise ('epistemics of expertise'' (2015: 59)). Stevenson et al., (2021) further examined this issue in relation to the role of internet information in these encounters. They found that patients often researched symptoms online before consultations, and this served to provide an account for their visit and gave them a basis on which they could critically question the doctor's treatment decisions if recommendations were not in line with expectations. However, this was done carefully, with patients being sensitive about when they disclosed information to avoid direct challenge to the doctor's expertise.

This collaborative version of care may be viewed as more patient-centred by some, because the patient is more involved in discussions and choices about their own wellbeing. (Lee and Lin, 2010). However, although the concept of patient-centred care is highly ubiquitous, as Pilnick (2022) suggests, the argument for its use in practice is largely grounded in moral principles (e.g. Ekman, 2022; O'Rourke et al., 2019; Duggan et al., 2006) rather than empirical evidence and many have different notions regarding what it involves (Fix et al., 2018). Therefore, patient-centred care may look different depending on context. Additionally, research fails to demonstrate a clear link between the implementation of patient-centred interventions and improved health outcomes (Pilnick, 2022).

This issue of patient agency and decision making may be additionally complicated for care of PLWD, as although measures can be taken to enable the individual to participate and make choices (e.g. Brooker, 2007; Kitwood, 1997), this can prove challenging (e.g. Dening et al., 2017). Health professionals may therefore be placed in difficult positions when a patient lacks capacity to make decisions about treatment and medical care must be administered in a person's best interest (e.g. Hinsliff-Smith et al., 2017) and potentially against their wishes (e.g. Moermans et al., 2022; Mengelers et al., 2019). Furthermore., as noted by Antaki and Webb (2019) when examining interactions involving individuals with cognitive impairments and support workers, activities and choices often become shared tasks and so by virtue of an individual receiving support or care they must relinquish a degree of agency and control.

With regards to how patients are addressed, one widely contested area is the use of terms of endearment (ToE). These are routinely recommended against in training for nursing home staff (e.g. Williams et al., 2017) and healthcare professionals (HCPs) such as nurses (Laskowski-Jones, 2015). Furthermore, the National Service Framework for Older People (UK Government Department of Health, 2001) instructs that staff should use an older person's preferred form of address and relate to them as a competent adult. The NICE guidelines give similar instructions. (NICE, 2012) However, as this chapter will show, ToE are commonly used in practice by a range of experienced and skilled HCPs. This implies that these terms fulfil some kind of function, which will be examined below.

It is difficult to provide a definitive definition of the phrase "terms of endearment." When it is mentioned in academic literature, researchers often simply state the phrase and provide some examples such as "*honey*," or "*sweetheart*," (Brown and Draper, 2003: 16) or "*Honey*," "*Sweetie," "Grandma," "Babe"* and *"Sunshine*." (Willams et al., 2017:9). Khalil and Larina suggest "*Terms of endearment can be regarded as expressions that convey intimacy; they are usually used to address those who are close to the speaker*." (2022:29). This focus on who is being addressed appears to be important, particularly if the receiver is an older individual. Shaw and Gordon (2021) categorise ToE under diminutives as a form of elderspeak and specify that in this circumstance their use is "*inappropriate of the interlocutor relationship*," (2021:6). Likewise, when explaining elderspeak, Williams et al., (2003:246) note "*Diminutives include inappropriately intimate and childish nominal references such as honey and good girl*." A clear limitation with these definitions is the conflation of different types of ToE. It could be argued for instance that "Grandma," implies a relationship that is more familiar (and potentially familial) than something like "Honey," or "Sweetie." Furthermore, some of these terms are gendered, and some are not, which may also influence receipt.

This categorisation of ToE as a form of inappropriate or infantilising communication appears to be commonly accepted (see Willams, et al., 2017a,2017b; Schnabel et al., 2021; Shaw et al., 2022). In some cases, inappropriateness is considered self-explanatory, but other authors have attempted to explain why they are unacceptable in a healthcare context. Schnabel et al. (2021) claim that they may be considered inappropriate because their use might imply a more intimate relationship than actually exists between HCP and patient (such as that of child and parent), or it may reinforce the differential power dynamic between the patient and HCP that comes with the institutional setting. This is an interesting suggestion with respect to the work of Wood and Ryan (1991) and Bury (1997), since this provides a counter to the idea that there is an ongoing reduction in differential power dynamics between patients and HCPs as time goes on.

When ToE are studied in a more general non-healthcare context, attitudes appear to be different. For instance, Febrianti and Auwal (2021) looked at Indonesian young people's use of ToE towards each other in digital communication. In this circumstance, terms were reported more often with familiar people. However, certain terms were used as they were in fashion /on trend, and to demonstrate closeness, or build closeness with others. Khalil and Larina (2022) also looked at the use of ToE, in America-English and Syrian-Arabic. In both languages, endearments were used to show informality, closeness, and emotive-politeness. In addition, in Syrian-Arabic, the terms could be used to express respect and deference. Svennevig and Johansen (2012) examined closing sequences of chat interactions in Norwegian young people. They noted many declarations of affection, including ToE in closings, often after other goodbye tokens had already been said. Rendle-Short (2009) investigated the term "mate," in Australia and found that it is largely interpreted as positive/friendly, and occurs within many contexts such as openings, closings, assessments, agreements and the mitigation of requests and disagreements. Notably, use of mate was sequentially dependant, and this could influence its interpretation as positive or negative.

Literature considered in the previous paragraph suggests that perceptions of ToE may be both culturally and contextually dependant. Therefore, actual interaction must be studied within its real-world context to see when ToE are used, and how they are received by specific populations. As, when examining actual empirics, the evidence for blanket attribution of terms as inappropriate appears to be less clear cut.

Brown and Draper (2003) conducted a review based on speech accommodation theory (Ryan et al., 1994), which focused on patronising language towards older adults. From this they claimed that older adults typically dislike ToE, giving them negative evaluations such as irritating or patronising. However, most evidence given involved studies that provided participants with hypothetical conversation examples to be rated. This neglects to consider the impact of context and situation in an ongoing interaction. It may be that a patient in an acute hospital environment who is experiencing pain, (or in the case of PLWD also confusion/disorientation) could feel differently when addressed with ToE, compared to how they would rate them hypothetically. Furthermore, Brown and Draper (2003) claim that when over-accommodative speech (including ToE) is used in a care environment such as a nursing home/hospital, it is due to ageist attitudes, and functions as a way of controlling patients by staff adopting a parent like role. However, although they have some evidence in their review of wider patterns of power differentials and controlling nursing care, this claim involving ToE appears to be mostly based on a single article (Kenwright, 1998) although this does align with the assumptions discussed above.

On the other hand, if care is viewed as a collaborative activity (as with Bury, 1997) then this notion of control discussed by Brown and Draper (2003) could instead be considered cooperation. Evidence for how PLWD may respond to ToE as potentially controlling or collaborative is limited, although one piece of observational research by Carpiac-Claver and Levy-Storms (2007) found that endearments used by staff in USA nursing homes were used particularly with task-oriented directions and some residents responded positively when staff used ToE.

In other situations than healthcare, asking someone to do something could be viewed as a co-operative rather than controlling endeavour. For instance, requesting a favour from a friend (e.g. Harissi, 2005), or requesting assistance from a work colleague (e.g. Risberg and Lymer, 2020). Much of the research into requests appears to incorporate Brown and Levinson's (1987) politeness theory, which sets out how actions (including requests) may threaten the face needs (as originally defined by Goffman 1955) of participants in an interaction. Brown and Levinson also argue that within a given interaction, participants usually cooperate to mutually maintain face, which can include mitigating various speech acts which may threaten face. For instance, producing requests with low entitlement so that they are easier to decline.

Harris (2006) uses politeness theory as a starting point to examine requests within institutional settings that involve power imbalances (a magistrate's court, doctors' surgeries, and a police station reception) and notes how institutional members (including doctors) used strategies (such as mitigation) to offer clients a means of redress during face threatening acts, even in situations involving a large power imbalance. Moreover, McCarthy and O'Keeffe (2003) produced a paper on casual and radio conversation 'vocatives' which they define as being closely related to terms of address. They mention that this includes endearments, although the examples given of analysis focus on first names and familial terms (e.g. mum). Significantly, they reveal several functions of these vocatives, including to mitigate in contexts where there is a potential threat to face, such as when an utterance is challenging another, is potentially sensitive/offensive, or if imperatives or requests are used to direct or coerce a recipient, restricting actions or behaviour.

The concept of mitigation in conversation is longstanding. Fraser (1989: 341) wrote: "*Mitigation is defined not as a particular type of speech act but the modification of a speech act: the reduction of certain unwelcome effects which a speech act has on the hearer*." Caffi (1999) claims that mitigation is a synonym for attenuation, and results from "*a weakening of one of the interactional parameters."* (1999:882). Writing more recently, Estellés and Albelda (2022) note that mitigation can be done through many mechanisms. For example, modifiers, quantifiers, modal verbs, adverbs or prosodic devices (e.g. lowering the voice). However, and significantly, they state that mitigation does not depend on any specific mechanism. Instead, it is dependent on interactional context, and is done in a way that appears intentional and strategic to (1) reduce an aspect of communication in some way, or (2) achieve an interactional goal, or (3) protect the image/face of participants.

In the data set, 27 out of 81 video/audio recorded interactions included the use of ToE from the health care professional involved. Terms used included "darling", "sweetheart", "my lovely," and "my dear" After close examination of the data using conversation analysis, ToE were found across many phases of the interaction. Analysis will focus on what functions they may be performing across these contexts.

5.2 Data Analysis

5.2.1 Responsive Terms of Endearment

There is existing evidence to suggest that mirroring or reflecting the type of language used by patients can be a useful method for HCPs in a variety of contexts. For instance, Silverman and Perakyla (1990) demonstrate how it can be helpful for managing delicate topics of conversation in a HIV counselling context where professionals mirror terms used by clients for body parts or sexual practices. In palliative care, Jenkins et al., (2021) found that repeating patients' answers with a mirrored rhythm can provide them an opportunity to elaborate on pain descriptions. Davidsen' and Fogtmann Fosgerau's (2015) study on the treatment of depression found that when used by GP's, mirroring could convey conversational smoothness, along with displaying empathy, rapport, and attunement to the mental state of patients.

It therefore follows that if HCPs reflecting similar language to patient's is viewed as a positive in the more general sense, it may be natural to also mirror back ToE when these are used by the patient. With the background literature in mind, it is not surprising that this is a phenomenon that was found to occur within the present data. The following extract demonstrates this phenomenon.

In the below extract, a male doctor has been examining a male patient who is lying in bed. The patient has just mentioned that he drinks a lot of water, and the doctor has praised him and offered him some more. The patient has agreed, and the doctor is now arranging to raise the bed up to make drinking the water possible.

```
Extract 1 (VOICE2_PN20_HN51_PAN_250822)
86            (6.0)((HN51 getting controls to sit bed up))
87   HN51:   so I’m just going to sit you up y-okay
88   PN20:   okay duck
89   HN51:   a:ll right m↑ate
90           (3.0) ((sitting bed up))
*lines omitted* ((HCP adjusts bed further and gives the
patient a cup of water, which he drinks.))
115  HN51:   you need to drink as much as you can all right?
116  PN20:   okay duck
117  HN51:   good man
118          (6.0) ((HN51 filling cup))
```

This extract includes two examples of responsive ToE. The patient first uses an endearment (‘duck’, line 88) and this is followed by the doctor responding with the term ‘mate’ on line 89. A little later within the same interaction, the doctor is restating the importance of drinking water, and the patient provides an agreement (“okay duck”). The doctor then says, “good man.” In each case the doctor responds immediately and directly to the use of the ToE by providing his own ToE towards the patient.

ToEs used in this way were not treated as inappropriate by either party within this interaction. Other contexts in which ToE were used will now be considered.

5.2.2 Terms of Endearment as an Orientation Device (Opening/Closing)

ToE were found within opening and closing sequences of interactions. This is not unexpected as other research has identified endearments and other familiar address terms in other types of interaction in these positions (e.g. McCarthy and O’Keeffe, 2003; Rendle-Short, 2009; Svennevig and Johansen, 2012; discussed above). Additionally, more classical CA research has located general address terms within opening sequences (Schegloff, 1968) and closing sequences (including many endearments such as ‘dear’) (Jefferson, 1973).

5.2.2.1 During Opening Talk

In the following extract, the HCP arrives, draws the curtain around the bed area and greets the patient who is sitting in a chair at the side of her bed. He crouches down in front of her to talk.

```
Extract 2 (VOICE2_PN08_HN49_PAN_190522)
1   HN49:   °alright° ↓hello ↑darling
2           (1.2)
3   HN49:   hi ↓anna I’m ethan: I’m the doctor for toda:y hh
4   PN08:   You’re (.) Ethan are you,
5   HN49:   ↑Yes: Ethan. Hi how are ↓you ↑darling,
6           (1.0)
7   PN08:   Pardon
8   HN49:   HOW ARE YOU TODAY,
9   PN08:   Not bad.
```

The first greeting he uses involves the ToE (‘darling’, line 1). This does not receive a response immediately, as may be expected in a typical opening (e.g. Schegloff, 1968). Consequently, there is a noticeable absence of a response (Schegloff, 2007) and a 1.2 second pause indicating potential trouble (Pomerantz, 1984), and the HCP then takes another turn where he greets her again using her first name (given as Anna here) and introduces himself as the doctor. This leads to the patient producing a response picking up on his name, and the HCP then replies with confirmation followed by a ‘how are you?’ (e.g. Schegloff, 1986) containing the endearment ‘darling’ again. As with the first use of darling, this is again followed by a pause suggesting some further interactional trouble, which the patient confirms when she initiates the repair “pardon,” on line 7. The HCP then repeats his question louder, and this then receives an answer from the patient.

The pause after each use of “darling,” is notable. This patient did have some difficulty with hearing, which is demonstrated when she is able to reply appropriately when the HCP speaks louder. Nonetheless, this does not necessarily mean that the slight trouble in this interaction is only due to hearing loss. It is possible that the use of darling is somewhat unexpected here, since (as discussed above) endearments often signal some sort of good relationship/high solidarity, and yet in this case, the HCP also introduces himself by name and profession, demonstrating unfamiliarity. This is further evidenced by the patient’s own turn (“oh you’re Ethan are you.”), showing she does not know who he is. This may explain the trouble, as in this context a greeting such as “darling,” which implies familiarity may be treated as problematic when no familiarity exists.

In the following extract, the situation is very similar to that above. A female patient is sitting in a bedside chair, and a male doctor arrives and greets her prior to doing a medical examination.

```
Extract 3 (140_211)

1   HCP:   missis ↑bro::wn?
2   PAT:   [[looks up at HCP]]
3   HCP:   ↑hello my ↑dea::r,
4   PAT:   ↑o:h (?)
5   HCP:   °↓yea::h° [you ↑ha]ven’t ↑seen me for a ↑whi::le
6          have you:
7   PAT:             [↑e:::r,]
8   PAT:   no::
```

Unlike the previous example, the doctor first greets the patient formally as “Mrs. Brown,” and when the patient directs her attention to him by looking up, he then expands his greeting using a ToE (“my dear,” line 3). This receives an acknowledgement, and the HCP states that the patient hasn’t seen him for a while, incorporating a tag question (have you). The patient then gives the preferred response (no) on line 7.

The fact that the HCP suggests a prior relationship with the patient is significant, as it may demonstrate some solidarity, providing more basis for his use of “my dear.” This may speak to the lack of trouble within this opening sequence. It is of note that a lack of trouble occurred in other examples in this data set, in which HCP’s used endearments as a part of openings and were more familiar with the patient. Alternatively, it is possible that the patient’s reaction is related to the sequential positioning of the endearment here, as it is used after a more formal address term, whereas above the endearment is within the first line of the greeting.

5.2.2.2 During Closing Talk.

A number of interactions contained ToE within the closing sequences. The following two extracts contain examples. In extract 4, a female mental health nurse is sitting opposite a female patient. They have just discussed the patient’s situation, and this concludes with the HCP suggesting she could get the patient a cup of tea.

Extract 4: (103_214)

226 HCP1: it ↑does (.) °it does° (0.4) .hh shall ↑I: see where
227 that cup of tea is then, (0.6) we'll get you a cup of
228 tea:: °yeah° (0.8) >and some< biscuits
229 PAT: yea::h
230 HCP1: okey dokey (0.6) I'll go and get you some ↑huh ↑huh
231 (0.4) I'll joi:n you
232 PAT: are you (.)
233 HCP1: yeah
234 PAT: alright then [my duck]
235 HCP1: [alright darling] (0.4) it's ↑lovely to
236 speak to you (0.8) I'll see you shortly,(0.4) huh huh
237 huh
238 PAT: you::: bugger oo:
239 HCP1: huh huh huh

In extract 4 above, there are cues to suggest the interaction is closing. The HCP gathers her papers and suggests she will source a cup of tea for the patient (which been mentioned earlier). Within this setting, as Allwood et al., (2017) note, the suggestion of tea is often used to signal that the business part of an encounter has concluded. This is relevant because as Allwood et al. identify, there is a common theme of interactional trouble during conversation closures in this setting. Despite this, in this example, the HCP and the patient do not appear to experience difficulty when ending the interaction. There is evidence to suggest that they both orient to the closing, with them both using the word "alright" (lines 234 and 235). This word is an established method of shutting down a topic (Schegloff and Sacks, 1973). It should also be noted however that some of the ease of this closing may be due to the fact that it is only a temporary closing – it has been established that the HCP will be returning with a cup of tea.

Another notable feature of extract 4 is that the HCP is not the only one who uses ToE. The patient uses one first (“alright then my duck”), and the HCP begins her turn (overlapping “duck”) with “alright darling,” on line 235. Duck has long been considered a ToE within the English language (Landmann, 2021) particularly the East Midlands (Bowie, 1996) where these data were collected. The mutual use of the “alright,” pre-closing suggests the HCP is aligning with the patient, therefore it is possible that her use of “darling” is a continuation of that alignment as the ToE is only used after the patient’s use of “duck”. This fits with the analysis on reciprocal ToE. The following extract contains an example of another successful closing.

In the following example, the HCP (a male doctor) has just completed a medical examination of the female patient who is sitting in a bedside chair. The opening of this interaction was shown in Extract 3.

Extract 5 (140_211)

```
368   HCP:   okay (0.4) we’ll ↑see what we can do about that
369          [↓my ↓dear o↑k]a:y? (0.6) o↑kay? (0.4) ↑b[ye for] ↑no:w=
370   PAT:   [a:::::::::::h]                          [↑a:::h]
371   HCP:   =see you later
372   PAT:   yeah
373   HCP:   o↑↑kay? (0.6) take care my ↑dear
374   PAT:   alright bye::
375   HCP:   ↑bye::,
```

The ToE “my dear,” is used twice within the closing. The first instance on line 369 occurs shortly after the HCP has been discussing the subject of going home with the patient and she mentions seeing her niece. The HCP’s talk on line 369 has a high degree of pitch variation as he questions the patient, and says goodbye. Alongside ToE, this is also an established feature of elderspeak. This initial closing statement ('bye for now') comes quite abruptly, and does not receive a clearly aligning response from the patient. It is possible that the HCP chose to move to closing at this stage, as he has provided a couple of transition relevance places in which the patient could have potentially taken a turn (after each okay on line 369), and she has not given (or was not able to give) a clear response. However, it is also possible that the patient didn't hear/process the HCP's words, as she does overlap his first "my dear" and "bye" with vocalisations (used throughout the interaction). Therefore, the HCP's following on "see you later," on line 371, may be when the patient begins to orient to the closing. The patient does look up at the HCP at this stage and she does acknowledge this turn ("yeah"). After the HCP says, "take care my dear," on line 373 she responds with an appropriate "bye," which is reciprocated by the HCP.

These apparently successful closings demonstrated here are notable because, Allwood et al., (2017) identified a common theme of troubled closings within this environment, showing that closing moves that appear intuitive to HCPs could cause confusion and difficulties with PLWD. Trouble tended to arise when interactions included open ended pre-closings, mixed-messages, non-specifics, and indeterminate terms (such as terms which need context to make sense). The interactions that contain ToE within the closings do contain some of these features (e.g. non-specific phrases such as 'see you later' shown in extract 5). Nonetheless, the fact that all the features that are known to potentially cause trouble during closings are not present raises a pertinent question here. Is there something about ToE used in this position by HCPs that enables PLWD to pick up on closings when they may not necessarily pick up on other closing cues?

It is possible that ToE provide something to orient to as a closing. This would align with some of the findings discussed above, which located address terms and terms of endearment (e.g. McCarthy and O'Keeffe, 2003; Rendle-Short, 2009; Svennevig and Johansen, 2012; Jefferson, 1973) within the closings of conversations in other social contexts. Although the present context is institutional, as demonstrated by these data, ToE are prevalent within this environment. It is therefore not altogether unexpected that they are found in closings. Furthermore, the fact that they are found in other closing contexts perhaps increases the likelihood that PLWD may have experienced them in this way in the past, and so may recognise the signal that the business of the interaction is ending, even if the context is different or unclear to them as a result of their dementia.

5.2.3 Terms of Endearment Used as a Mitigation Device

This chapter will now consider situations in which ToE have been identified as a mitigation device. McCarthy and O'Keeffe (2003) observed that vocatives could occur as a mitigator during contexts in which there is a potential threat to face. Likewise, Rendle-Short (2009) noted that the term 'mate' (the object of their study) could be used as a mitigator in situations such as making requests or giving instructions. Some of the ToE within these data appear to fit within these remits, as they occurred during the context of requests for patients to repeat their turns, and during healthcare activities in which the HCP was giving a health or medical instruction or producing other talk relating to task completion. Both of these contexts are situations in which face could potentially be threatened.

5.2.3.1 When Asking a Patient to Repeat

Multiple examples of HCP's using a ToE when they asked the patient to repeat a turn they had either misheard or misunderstood were identified, and two examples from the data are shown below. This phenomenon has been found in other circumstances. Baumgarten (2021) identified situations in which individuals used the endearment "love" (the focus of their research) during clarification requests. However, within their data they found that these requests only occurred within non-institutional settings. They also noted that they were usually a result of mishearing; lack of knowledge or inattentiveness in parent-child or older adult-younger adult groups (the opposite to the present sample). Although their focus was comparatively narrow (the term 'love,' only), this raises questions around why ToE were found within the present data set, which was gathered in a highly institutionalised healthcare environment. One possibility is that it is the individuals within the local interaction that inspire the use of ToE, rather than the wider hospital context. Evidence suggests that elderspeak (including ToE) may be triggered when people notice old-age cues, (Catona, 2010; Ryan et al., 1995; Hummert and Shaner, 1994), particularly those relating to cognitive impairment (Cavallaro et al., 2016; Kemper et al., 1998). It is possible that difficult to interpret talk from the patients is being treated this way, i.e. signalling a vulnerability on the part of the patient. This aligns with Baumgarten's (2021) findings of love-framed clarification requests being used in parent-child interactions and older adult-younger adult groups. Although the present data has the reverse age gradient (typically younger HCP's talking to older patients), elderspeak type talk has been previously characterised as how one might speak to a young child. (e.g. Cavallaro et al., 2016).

In Extract 6 below, the male HCP (a doctor) is checking the female patient's breathing and has a stethoscope in his ears. He takes it out and asks the patient to repeat ("say again darling," line 162).

Extract 6 (140_211)

159 HCP: yeah? (.) take a ↑deep ↑breath in, (1.6) tha::t's
160 ↑good (.) o↑ka::y
161 PAT: ↑how ↑d'you ↑do (.) ↑this? (0.8) you do it (?)
162 HCP: say a↑gai:n dar↑li:ng,
163 PAT: (how d'you do checking myself)
164 HCP: just check the ↑che::st, (0.4) is not in↑fected
165 or anythi:ng.
166 PAT: ↑a:::h

The patients talk on line 161 is hard-to-interpret (Pilnick et al., 2021), and the HCP asks her to repeat with the "say again darling," on line 162. The patient again responds with something difficult to interpret, but the HCP then chooses to respond to the word "checking", framing a response that explains his actions and echoes the patient's word. This response from the HCP is noteworthy because Pilnick et al., (2021) demonstrated how picking up on an aspect of a hard-to-interpret utterance and repeating it can be a way of maintaining the face (Goffman, 1955) of the patient.

In the following speech and language assessment, a female HCP (a speech and language therapist) is attempting to give to the (male) patient some water as part of a swallowing assessment. The patient has been declining to eat or drink and appears quite sleepy. He is in bed with the HCP standing at the side.

Extract 7 (122_220)

HCP: are you ↑↑staying with me::
PAT: (?) my a::rm (?)
HCP: what my lovely, (1.2) say that agai:n
PAT: (?) (↑arm) here
HCP: what’s that thing the:::re (0.4) ↑that’s my
↑ba::dge, (0.6) it tells you::: (.) who I am
PAT: ↑te::lls?

The HCP asks “are you staying with me”, (referencing his apparent sleepiness). The patient then says something hard-to-interpret (Pilnick et al, 2021), and the HCP uses the ToE “lovely” when she asks the patient to repeat. When his response is again difficult to understand, as above in extract 6, the HCP attempts a response that appears based on what she has interpreted from the patient’s turn.

Past research has demonstrated that the management of repair involving PLWD is difficult (e.g. Perkins et al., 1998; Schrauf, 2020), particularly within this context (the acute hospital) (Pilnick et al., 2021). Within these situations, in line with previous mitigation literature (e.g. Estellés and Albelda, 2022), the ToE works towards reducing the impact of the HCP’s statement. This consequently mitigates the fact that the HCP has not understood the patient’s talk, which could be face threatening (Goffman 1955) for the patient. This is supported by the fact that in both above examples, following the repeat request the HCP then attempts to answer, rather than making further clarification requests which could more clearly locate the problem with the patient’s turns, so drawing further attention to the difficulty. This mitigating ToE therefore aligns with the research on other mitigation (e.g. Brown and Levinson, 1987; Harris, 2006; McCarthy and O'Keeffe, 2003). It also makes sense in relation to Pilnick et al., (2021), who identified that pursuing repair in this context can lead to trouble and potential face threat towards PLWD.

5.2.3.2 Instructions During Healthcare Tasks

ToE used during healthcare-based instructions, requests and general task-based talk were common in these data. Health or medical instructions will be examined initially, followed by other task-based talk.

This extract is from the same interaction as extract 7 above. The HCP has already attempted to offer the water multiple times in order to try to assess his swallowing, but the patient has refused. At this point, the HCP is returning to offering the water after trying other foods

Extract 8 (122_220)

HCP: ↑alright my lovely (0.4) shall we try that ↑wa:ter again,
PAT: I think you're done well he:re (0.4) (it's already gone away)

The HCP uses the endearment "my lovely" as a part of her proposal to try the water again. It is of note here that the HCP uses the collective "we," as part of her request. The "we," in this case denotes a collaborative action. The glass needs to be held by the HCP to assist the patient. Bowie (1996) notes that HCPs (in that case, nurses) may choose higher solidarity forms of address when they wish to impart commonality of purpose and a sense of closeness with patients. The use of collectives such as 'we," and the use of ToE were both suggested to do this. Hence, it is possible that the request here is designed to encourage cooperation between the patient and the HCP. Nonetheless, Bowie notes that in both cases, some patients, particularly those who were older may find this type of talk an infringement of propriety or potentially patronising if more formal communication is expected. This is akin to the findings of Wood and Ryan (1991) and Brown and Draper (2003).

With this in mind, a question about control could be raised. Brown and Draper (2003) claim that ToE are used due to an underlying ageist attitude and aim to exert control over older people. It is true that many of the tasks shown in this section were considered medically necessary and so required a certain amount of collaboration between HCPs and patients for their safe completion. However, as with many cases within these data, it appears that this ToE may function to create a favourable environment for cooperation, rather than being an agent of direct control as Brown and Draper (2003) suggest. It may be impossible to avoid giving a patient an instruction in a healthcare setting where necessary care must be delivered. This environment for cooperation occurs when the ToE is used to soften the instruction, particularly in situations where the patient may be uncomfortable or potentially unwilling to carry out the action.

Giving instructions has implications for interactional asymmetry. As Antaki and Webb (2019) demonstrated, it is unavoidable that being cared for results in some relinquishment of control and agency on the part of the care recipient (i.e., the patient). The carer (in this case HCPs) likely has more knowledge of the healthcare activity that must be completed and the rationale behind it. If the patient is unsure or unwilling to do the activity however, then instructing them to do it may be face threatening because their presumed agency to negotiate the medical care they receive is compromised (Armstrong, 2014; Landmark et al., 2015). Including mitigating features of talk in this situation will serve to reduce this threat to agency and face, softening instructions that could otherwise sound potentially harsh or inappropriate. Another example of this follows below.

Extract 9 (VOICE2_PN03_HN18_CAM_210422)

In this situation, the male patient (PN03) is lying in bed. There is a nurse (HN20) on his left and a healthcare assistant (HN18) on his right (both female). Their goal is to move the patient and then help him into a sitting position so he can then be assisted with his dinner.

```
Extract 9 (PN03_HN18_CAM_210422)
21   HN20:   Right ↓k:↑e:n, we just have to use the sl↓iding
22           sheet ↓just to slide you up the ↓be:d (0.4) is
23           ↑that ↓all: right?
24   PN03:   #okay#
25   HN20:   ↓yeah?
26   HN18:   You're going to roll to↓wards ↓m↑e: all ri:ght
27   PN03:   yeah okay
28           (1.6)
29   HN18:   just cross your ↓ank↑le¿
30           (1.6)
31   HN20:   yeah ↑bend this ↓knee my love,
32           (1.5)
33   HN18:   ↑and come to↓wa:rds ↑me
34           (0.6)
35   HN20:   roll on ↑your ↓side ken t[hat's it.]
36   PN03:                            [be carefu]l
37   HN20:   >its ↑ok↓ay< ↑you're not gonna ↓fa:[ll]
```

In the extract above, both HCP's work together to turn the patient onto his side safely. HN20 uses the word "just," minimising the suggested task, and both seek confirmation from the patient before beginning ("all right?"), which the patient responds to with agreements (lines 24 and 27). HN18 also uses the minimiser "just" when asking the patient to cross his ankle, softening her instruction (similar to high entitlement mitigated requests found in O'Brien et al., 2020). HN20's turn at line 31 continues her ongoing sequence of instructions, and uses the "my love" endearment at the end, likely also having a mitigating effect.

These mitigators are notable here, because as the instructions are given, the HCPs do the task with the patient contemporaneously. His own movements are therefore not really in his control; his body is being moved by the HCPs to complete the task. Having one's body moved in this way by others could be very threatening to agency. However, the talk is framed as if the patient is working with them to complete the task. For instance, when HN20 says "bend this knee my love," she is at least partially bending it for him, but by framing it as a mitigated instruction, it may feel as if the patient has more choice in the action. This constructs it as a collaborative activity, and situates the patient in a position of co-operation, supporting the sense of agency.

Extract 10 below is similar to extract 9 above as it involves two female HCPs working together to move a patient around on a bed. However, this case provides an example of care where the patient is actively resisting. For context, the HCP's involved here reported afterwards that the patient's distress began when they had to turn her onto her 'bad,' (more painful) side. Most of this interaction was recorded as audio only due to personal care. However, prior to this, the HCPs discuss how the patient is a 'fighter' suggesting difficulty is anticipated. The patient's turns reinforce this, as she accuses the HCP's of hurting her and uses multiple swear words. When the extract starts, HN63 is telling the patient her daughter is visiting whilst she attempts to move or change her.

```
Extract 10 (PN13_HN63_CAN_120722)
91     HN63:   ↓l↑i↓ly?
92             (0.6)
93     HN63:   your ↑daugh↓ter ↑is he:↓re you know ↑↑sa↓nd↑ra
94             is he::↑re (1.7) ↓sandra ↑is ↓he:re (1.0) your
95             daugh↑ter
96             (4.6)
97     HN63:   >↓don’t< ↑push ↓me: (1.5) £↑don’t£ push me
98             ↓love↑ly,
99             (11.2)
               *lines omitted 100-118*
119    HN63:   ↓↓l:i↑l↓y ↑that’s ↓not ↑very nice¿
120    HN64:   hhhm (0.2) we need to roll her again
121    HN63:   °okay this side I think ↓towards you and then
122            I’ll pull this in°
123    HN64:   heh
124    HN63:   ↓come ↑on lovely¿
125            (14.6) ((HN64 talks to someone off camera))
126    PN13:   >you’re< fucking hu:rting ↑me: ↓you ↑bas↓tard
127            (6.3)
128    HN63:   ↑l↓i↑ly °yes towards me a little bit°
129            (3.5) °that’s it°(2.3) ↑we’re ↑done it ↑no:w
130            (2.4) ↓o↑ka:y,
```

After telling the patient that her daughter is there, there is a pause before HN63 says don’t push me, evidently responding to a physical action from the patient. The phrase is then repeated in a softer voice with the endearment (lovely) added. There is a second ToE on line 124 (“lovely,”).

It is notable that this is a difficult situation for both the HCP’s and the patient. After the activity has begun, the patient demonstrates mid-task that she has become distressed with physical resistance and verbal aggression. Despite this, the HCP's have begun the process of changing her, and arguably could not stop mid-task as this would leave the patient still uncomfortable and exposed, threatening her safety and dignity. They therefore must somehow complete the task, and account for the fact that the patient is in continued distress and is resisting.

The incorporation of these ToE may work to soften and reduce the severity of HN63's instruction to not push or work to deescalate since in most contexts, physical violence such as pushing could be seen as unsettling or threatening (E.g. Zuzelo et al., 2012) and a more confrontational response might be anticipated. Additionally, the HCPs may also be working to soften the fact that they are continuing an activity the patient is not comfortable with. By doing so, the ToE imply a caring relationship or solidarity (Bowie, 1996) towards the patient on the part of the HCP's, in order to try to mitigate some of the situational discomfort and account for their actions. Evidence for this can be seen in their characterisation of the patient's turns as inappropriate. For instance, HN63 says "that's not very nice," (line 119) in response to the patient swearing just prior. In addition, their continued lack of a reciprocal negative response is also notable, demonstrating, in terms of the next turn proof procedure (Sacks, 1974) that the patient's behaviour is not treated as something that requires or should occasion this reciprocation. Nonetheless, within this context, the patient's distress does not appear to be obviously reduced. It is unknown whether this is due to a feature of the interaction, or whether in this case, she was simply in too much pain or distress. However, it is significant that the distress also does not escalate further, and the task is completed successfully, with the patient ending up in bed in clean clothes and bedding.

5.2.3.3 Responses to Patient Unease During Healthcare Tasks

The following section will cover situations where the HCP was trying to achieve a particular medical task or goal but was not giving an explicit instruction or request to the patient. In the extract below, a female patient was sitting in a chair at the side of her bed and is having a blood sugar test carried out by a female nurse.

Extract 11 (136_207)

```
25   HCP:                       [↑yea::h?] (0.8) let’s have a
26          look the:n, (3.0) >bit of a< ↑shar- (.) ↑sharp
27          little ↑prick on your finger thou::gh, (8.6) get
28          some ↑blood ↑ou:t of ↓you ↓cecilia (0.6) you’re
29          ↑storing it a:ll
30   PAT:   (°°I never) (?)°°
31   HCP:   ↑I won’t be a second dar↑lin’
32          (1.4)
33   PAT:   °°that’s enough°°
```

Similarly, to Extract 3 above, the HCP uses a different form of address first, in this case the patient's first name (given as Cecilia here). This occurs when the HCP is narrating her actions, whilst she tries to get the required amount of blood from the patient’s finger. The ToE (darling, line 31) occurs just after the patient produces some unclear talk and is looking around touching the nearby curtain as if beginning an action. It is therefore likely that the HCP’s turn is responsive to the patient’s apparent initiation and is working to delay the patient from this whilst she completes the blood collecting task. At the same time, the HCP is also indicating that the task will quickly be completed. The patient responds to this by returning to attending to the task, and after another short pause observes "that's enough," when some blood has been collected.

Along with the rest of the language in this extract, the ToE works to foster an environment of co-operation between the patient and HCP. As with extract 9 above the language is minimising, for instance when the HCP says, "bit of a sharp little prick," (line 26-27). Additionally, the phrase "I won't be a second," emphasizes that the task is small or brief. It therefore orients to the fact that something painful is occurring which the patient wishes to stop but is unable to. The endearment "darling," works to mitigate the fact that the patient's initiation attempt is overridden by the HCP. The issue of patient agency again becomes relevant here. The HCP's use of "I," (line 31) establishes that the activity is something she herself is doing (as opposed to a joint action with the patient). This carries the implication that the activity of the HCP is of more importance in that moment than whatever the patient wished to say. Although logistically, this is reasonable (the blood collecting could not easily be paused mid-task), the result in that instant is a lack of agency for the patient. The mitigating ToE may therefore serve as a means of recognition and redress (Harris, 2006) in this context.

Moreover, although the patient's potential initiation has been overridden by the HCP's statement (which includes the ToE "darling") , the HCPs statement can be considered politely delivered (Brown and Levinson, 1987), in the sense that the need to wait whilst the task is completed is attended to, whilst the imposition on the patient is minimised.

This skill of resolving conflicting needs or actions and maintaining a positive co-operative interaction is hugely important within this environment, in which the specific communication and cognitive difficulties of PLWD has already been discussed and demonstrated (see chapter 3). Further examples of this particular kind of reassurance were seen in cases where the HCP appeared to be trying to mitigate a patient's distress around a certain issue. For example, in the following extract, a male patient is convinced that he is going to have to take over the job of Prime Minister (of the UK) and is quite distressed by this idea as he states he is unable to meet the demands of the role. The HCP (a female HCA) working with him has been trying to convince him that he won't have to do the job.

```
Extract 12 (PN15_HN67_PAN_250722)
73   HN67:   ↑no well don't >well you< don't have to: (.) you
74           don't have to do ↓it
75           (1.2)
76   PN15:   you're ↓conning me in↑to joining,
77   HN67:   ↑no ↑I'm not ↓sweetheart
78   PN15:   well I can't help ↑it
```

In this case, the ToE ("sweetheart," line 77) occurs as part of the HCP's disagreement with the notion that she's trying to get the patient to join the government. Her objection to his assumption is softened by her use of "sweetheart," mitigating any conflict that could arise because of her disagreement. Again, the HCP's turn in this case deals directly with the patient's concern. Following this, the idea that the HCP is 'conning him' is not pursued by the patient, and instead he continues to share his worries regarding what would happen if he declined to take the job.

A similar sort of need for reassurance occurs in the following interaction. In this case the continence pad of a male patient has just been changed by a female nurse (HN05) and a female HCA (not shown here).

Extract 13 (PN17_HN05_OLY_260722)
PN17: (~I've- what have done wrong~)
HN05: nothing darling ↑you've done nothing ↓wrong (0.3)
o↑kay

The patient raises concerns that he has done something wrong in a shaky voice (i.e. he has soiled himself). The HCP reassures him that he is clean now (not shown here) and he hasn't done anything wrong. This recording is audio only at the time of this extract. The ToE again occurs when the HCP produces a disagreement with an assumption or statement made by the patient. Similarly to extract 7 above, the HCP's words contradict the patient's utterance but this contradiction is softened by the use of the ToE ("darling," in this case). The HCP's statement is reassuring even though it is in opposition to what the patient has said because it implies that since the patient has done nothing wrong, there is no problem with the situation.

Therefore overall, when used in response to patient unease, ToEs are a way of potentially avoiding (extract 11) or managing (extracts 12 and 13) conflict. In the case of extract 11, the ToE attends to the fact that the patient's cues or wishes are overridden by the HCP. Extracts 12 and 13 demonstrate how ToEs soften apparently contradictory statements. In both situations, the patient's concern is directly addressed by the HCP's response. Nonetheless, it should be noted that the ideal of answering a patient's concern directly may often be challenging to meet in the acute hospital context.

5.2.3.4 When ToE are Rejected

The following section provides two examples in which ToE used by HCPs are treated as problematic by patients. In the following instance, a female patient (PN05) is having a cannula inserted. This has been deemed medically necessary by the HCPs involved. At this moment in the interaction, the patient is sitting in an armchair at the end of a ward bay. Prior to the interaction, there was discussion amongst the HCPs about trying to take her back to her bed area for the treatment, but it was decided that this would likely cause more distress. During this extract, two mental health nurses (HN12 (male, left) and HN24 (female, right)) are talking to the patient whilst restraining her by each holding one of her hands. A doctor (not in transcript) inserts the cannula. The patient has issued numerous protests.

```
Extract 14 (PN05_HN12_PAN_110522)
90   PN05:   no [ (.)  no ]
91   HN12:      [↑just ve:]ry very ↓briefly
92   PN05:   n[o   ]
93   HN24:    [it’s] only ↓a little n↑eedle [sweet]heart
94   PN05:                                  [ no  ]
```

Notably, (as with many other PLWD in this data) this individual did not have the mental capacity to decide on the medical treatment she needed. Consequently, the hospital staff had a deprivation of liberty safeguard (DoLS) authorisation in place (MCA, 2005 as amended by MHA 2007) in order for them to give her this treatment in her best interests.

```
          *lines omitted*
290   PN05:    >I want it< ↑off [(.) off]
291   HN12:                     °[ne:arly]there°
292   PN05:   off
293   HN24:   ↑in a m↓inute sweet↑heart
294           (0.8)
295   PN05:   never ↓mind about ↑sweet↓heart >come on< off (.)
296           off (.) off (.) [off ]
297   HN12:                   [near]ly [there]
```

Again, as with examples above (e.g. extracts 9 and 11) both of the HCPs are using minimising language, implying the short time frame and small nature of the task they are trying to complete. (e.g., “only a little needle sweetheart”). Nonetheless, the patient issues multiple protests (and continues to do so repeatedly throughout the interaction).

Once the cannula has been inserted, the patient repeatedly states that she wants it removed (e.g. “I want it off, off,” line 290). In response, the HCPs continue to take turns designed to delay compliance with the request to take the cannula out or let her go (e.g. “in a minute sweetheart”). They also continue to emphasise the minimal, soon to be completed nature of the task (e.g. “nearly there.”). However, unlike other instances where this indication of brief temporal delay results in cooperation or lack of objection from a patient, the patient does object in this case. Notably, she identifies the ToE “sweetheart,” as specifically inappropriate (“never mind about sweetheart,” line 295). Her dismissal of the word “sweetheart,” followed by “come on off, off…” suggests that the ToE has been treated as irrelevant to her objective (to get them to take the cannula off) and she has rejected the attempts from the HCPs to delay her from the pursual of her objective.

The fact that the ToE used by a HCP is explicitly treated as inappropriate by the patient in this instance but not others, should be considered. It is feasible that this rejection was specifically due to the nature of the task itself, or the individuals who were involved. On the other hand, arguably the task discussed here is a particularly invasive and may be less familiar or routine than other things that form a more regular part of hospital care. The patient's objections are also repeatedly expressed strongly and clearly. Therefore, the fact that the task continues in the face of these protests (albeit in her medical best interest) means that there is an obvious and very strong threat to the patient's sense of agency. Nevertheless, as in Extracts 10 and 11 above, this is an activity which cannot be stopped easily once it has begun.

In situations where a patient has the capacity to decide on their medical treatment, treatment would not be administered by HCPs against the will of the patient. To do so would be considered an assault on the patient. The exceptions to this are individuals who lack the mental capacity to decide for themselves (MCA, 2005) and children who are under the authority of their parents. As previous literature has established during chapter 2, talking to older adults in a way that positions them as a child (i.e., elderspeak) does have possible negative connotations such as diminishing self-esteem, belittling or othering (Ryan et al.,1995) and threat to their sense of personhood (Williams et al., 2017).

Unlike the HCPs in extracts 12 and 13, both of HN24's turns involving ToE "it's only a little needle sweetheart" and, "in a minute sweetheart," do not attend to the patient's immediate concerns (that she does not want the cannula, and she wants it off). This (in conjunction with the continued actions of the HCPs) demonstrate to the patient that the HCP's are not meeting her wishes. The patient's reaction to the word 'sweetheart' is therefore likely related to this clear rejection of her assumed agency as an adult to refuse medical treatment. In this case, the mitigators present (including the ToE) were not received as sufficient to account for the HCP's actions or for the actions to be oriented to as acceptable. In short, this example demonstrates that ToEs will not always achieve their intended aim.

The following extract involves another example where a patient is objecting to a medical treatment and a ToE is used in the HCPs talk. In this case the HCP (a female nurse) is attempting to persuade a female patient to have an injection to avoid blood clots. Unlike extract 9 above the treatment has not yet been started. The HCP's turn is objected to by the patient and it is treated as unsatisfactory or potentially inappropriate. However, in this instance, the ToE itself is not explicitly problematised.

```
Extract 15 (PL01_HL04_PAN_180822)
11   PL01:   I refused ↑it and that was [it  ]
12   HL04:                              [yeah] >that's the<
13           reason why: we're (.) en↑couraging you to have it
14           because ↓you've missed some of the d↑ays (0.5)
15           ((clears throat))
16   PL01:   I feel ↓like a pin cushion
17   HL04:   ↑↑hmm?
18   PL01:   I feel like a pin cushion
19   HL04:   pin ↑cush↓ion ↑n↓o::?
20   PL01:   ↑y↓e:s?
21   HL04:   it's just a l↑it↓tle amount ↓love
22   Pl01:   ↑it ↑hu̲rts
23           (0.4)
24   Hl04:   ye:ah ↓it ↑i[s:. ]
25   PL01:               [↑you] have ↓it,
```

In this extract, the patient (PL01) does have more initial agency, since this is a discussion about a potential treatment before the actual treatment itself takes place. The patient demonstrates her sense of agency by outlining some of the reasons she has to refuse the injection, namely she has already refused it successfully previously, and (when countered), she feels like a "pin cushion." (i.e. she has already had many injections). The HCP replies to the patient's disagreement with a mitigating response which downgrades the procedure ("just a little amount,") and involves a ToE ("love," line 21). The patient produces a strong objection to this turn with "it hurts" in a slightly raised voice. A 0.4 second pause follows this, demonstrating potential trouble for the HCP's response (Hepburn and Bolden, 2012) and when HL04 then tries to respond the patient adds the further "you have it," implying she has not taken HL04's mitigations as adequate.

As with extract 14 above, the rejection of the HCP's attempts at mitigation may well be grounded in the patient's view that her objections have not been addressed adequately and so from her perspective, her presumed agency as an adult who can make medical decisions is not being respected. Adults with capacity to make their own medical decisions would be free to reject care that was deemed unnecessary or unwanted. The two examples presented at the end of this chapter demonstrate that ToE will not always work to mitigate what are deemed to be inadequate accounts for the delivery of care where patient requests are overridden.

5.3 Discussion

This chapter has examined some examples of ToE which are used within the acute hospital context in interactions between PLWD and HCPs. In terms of the contexts in which ToE are used in (research question 1) ToE were used frequently in this environment. The data contained a mix of different health professionals. Doctors appeared to use ToE slightly less often than others, with HCAs and nurses using more. This may reflect the familiarity aspect of ToE (Khalil and Larina, 2022), since doctors would typically see patients less frequently or potentially as a one-off visit (depending on staff rotations), whereas many of the nurses and HCAs would interact with the patient multiple times over the day(s). Additionally, these members of staff were likely to have more varied interactions with the patient, including medical observations, assessments, assisting with personal care or eating/drinking and general chat (examples from the data included talk about gardening, family members and personal items such as teddy bears). Doctors on the other hand were typically videoed during ward work in which they were present to assess/examine the patient.

ToE may fulfil multiple functions within communication. Firstly, they may be used reciprocally between PLWD and HCPs, potentially aiding therapeutic relationships by demonstrating alignment between HCP's and patients. Secondly, they may serve as an orientation device in both openings and closings of conversations. In openings, this may lead to trouble if there is a lack of initial familiarity between the interactants, or possibly if the term of endearment is used prior to other turns which do the initial work to establish a level of familiarity. In closings, however, endearments may provide a familiar signpost that an interaction is closing for potentially disorientated patients or patients who have less ability to pick up on more subtle closing cues.

Thirdly, and perhaps most significantly, ToE were found in many contexts serving a mitigating function. This included during situations in which conversational repair was needed, for example with hard to interpret talk on the part of PLWD. It also included contexts in which HCPs were attempting to complete a healthcare task with PLWD, and there was some threat to the agency of the PLWD such as when patients were instructed to do something, or were having something uncomfortable done to them. It appears that the success of mitigation is sensitive to the specific interactional circumstances in individual actions, and potentially the responsiveness of the HCP to the patient's voiced concerns.

As an additional theoretical interpretation, it is also possible that ToE might serve to support comfort (in Kitwood's 1997 terms), by implying informality, intimacy, parental concern and potentially also reducing anxiety and defusing sense of threat. Arguably, someone intending to harm you would be unlikely to use ToE, so even in cases of disorientation where perception of harm is a misinterpretation (e.g. a patient not realising they are in hospital believing their house is full of strangers), the ToE could provide a cue that the HCPs do not intend harm. This is an avenue of potential future investigation, although some limited evidence for this interpretation can be found in Proctors (1996) study of comfort talk, examining how nurses talk to patients in pain in trauma centres.

In terms of how ToE are responded to (research question 2), if mitigation is successful, then it is a potential aid towards fostering an environment of cooperation between PLWD and HCP's. Although it is impossible for ToE to completely remove the issue of denial of individual agency, they (along with other mitigations) can acknowledge and respond to this and consequently reduce the level of threat to face (Goffman, 1955). This finding is highly relevant with regards to previous literature which frames ToE as patronising, inappropriate (Willams, et al., 2017a,2017b; Schnabel et al., 2021; Shaw et al., 2022) and controlling (Brown and Draper, 2003). The analysis in this chapter has demonstrated that if used successfully, patients can be supported by ToE as they acknowledge the sensitivity of situations in which expressed wishes have to be overridden, or an objected to course of action is continued. Nonetheless, patients may not always accept this mitigation, so ToEs are not a 'magic bullet' that can be used with impunity to avoid treatment refusals and/or distress in PLWD.

The underlying assumption of a lot of the previous research (much of which has focused on doctors e.g. Bury, 1997; Landmark et al., 2015) on decision making regarding delivery of care is that patients have a (potentially educated) awareness of the situation they are in, and a sufficient knowledge of whatever condition is troubling them complete enough to allow debate with HCPs over things such as treatment decisions (e.g. Stevenson et al., 2021). However, this is likely not entirely the case (to varying degrees) for the PLWD included in the present research, who often displayed a lack of awareness to situational factors such as the fact that they were in hospital and were there to receive medical treatment. This resulted in various challenges such as patients threatening to phone the police or becoming otherwise distressed when they were unable to leave the secure ward, or not recognising medical issues (such as a patient claiming there was nothing wrong with her plaster casted arm, when a HCP requested to check on it). Therefore, in some situations, straightforward negotiation between HCP's and patients regarding the medical treatment needed may be challenging, and as demonstrated treatment may need to go ahead in the patient's best interest where patients lack capacity. These kinds of more unusual situations may be extremely difficult to mitigate successfully. If the treatment decision is in conflict with the expressed wants of a patient, a HCP may be unable to directly respond to a patient's request to stop or avoid it. For example, if the request is for the immediate cessation of treatment, when the HCP is in the middle of a vital task that cannot be paused and left for later, there is little option but to continue the activity. The best that a HCP can do in this situation is to mitigate continuation.

Another consideration is the cultural implications of this data. The majority of patients included from both VOICE and VOICE2 were white British. The HCP's involved in VOICE were also majority white, although some had English as a second language. VOICE2 was more diverse, as although there were many HCPs who self-reported as white-British, following deliberate efforts to recruit more participants reporting their ethnicity as Black, Asian or mixed heritage. The diversity of the HCP sample was approximately in line with the Gov.UK (2020) figures obtained from NHS digital on the diversity of the NHS workforce. There is some indication that the use of ToE may be culturally specific, with different cultures having different perceptions of the level of respect that ToE imply. It is therefore interesting that ToE appeared to be used by staff of multiple nationalities, rather than being used exclusively by any one group. The lack of diversity within the patient group is a potential limitation, although while it perhaps does allow for more cross comparison between patients, it may reduce the ability to extrapolate the data more widely.

The question of whether this analysis might apply more widely is relevant. Since CA methodology was used, there is a limit on inferences that can be made around the underlying causes and motivations behind the use of ToE. However, since they have been shown to serve important functions in this context, it is possible that findings may also apply in other analogous situations in which these functions could be required. For example, perhaps in other care environments involving PLWD, such as care homes, ToE may also serve as an orientation cue to openings and closings, or there may be situations in which agency becomes a delicate issue oriented to in talk. These findings may also be potentially relevant in other healthcare settings more widely. For instance, in situations where patients are placed in a vulnerable position through pain or illness, and so require something done to them that is potentially outside of their control and mitigation is relevant (for example talking to gravely injured patients in trauma centres (Proctor et al., 1996).

Nonetheless, the background literature demonstrates strong evidence of negative experiences of PLWD in hospital (e.g. Røsvik and Rokstad, 2020; Featherstone and Northcott 2020; Dewing and Dijk, 2016; Sampson et al., 2009), and additional tools to aid communication are likely be useful for HCPs working with PLWD in difficult healthcare contexts. This includes helping PLWD to orient to when conversations are beginning and ending, providing cues that the HCP in question is caring (as with reciprocal ToE), that it is acknowledged that the activity in question is not pleasant from the patient's perspective and mitigating threats to agency and face.

To conclude, the administration of healthcare to PLWD in the acute hospital environment can be challenging for staff, and a range of approaches are likely to be needed to respond to individual contextual circumstances. It is also important that any prohibition or discouragement of interactional practices, such as the idea that ToEs are always inappropriate, should be supported by empirical evidence. The interactional evidence presented here does not support a blanket ban on ToE, since they serve a number of important purposes in the context examined here, including orientation. mitigation, and the preservation of face.

Chapter 6: The Use of Praise Towards People Living With Dementia in the Acute Hospital Environment

6.1 Introduction

This chapter will examine the use of praise towards people living with dementia in the acute hospital environment. Pomerantz (1978) defines praise broadly by placing it in the category of supportive actions alongside compliments, which can have the status of assessments. These compliments/praises are typically structured so that the next action in the conversation would be acceptance/rejection or agreement/disagreement, with a preference for acceptance and agreement (but also avoidance of self-praise). Jansson (2016) provides the following more specific definition when examining praise in residential care settings: "*a compliment or praise is here seen as an assessment in that the speaker is positively evaluating a state of affairs: an action, appearance, ability, or form of behaviour of the co-participant.*" (2016: 68). Hudak et al., (2010) discuss 'therapeutic compliments' (previously studied by Wall et al., 1989) which are defined as "*praise or affirmation that therapists give to clients"* and they state these *"can enhance manoeuvrability, empower clients and promote change in client behaviour*." (2010: 778). The online Oxford English Dictionary simply defines praise (as a verb) as "*To express warm approbation of; to proclaim or commend the excellence or merits of; to speak highly of; to laud*." (2006).

For the purposes of this thesis, praise is therefore understood as a positive evaluation, a commendation or supportive action used by HCPs in talk towards patients. These are often produced as assessments at the end of sequences in these data. However, they are also found mid-sequence where they positively receipt a component of an action, but also project the need for continuation. (but may not necessarily take this form). These are distinguishable from situations in which praise like words are performing a different action in talk. For example, in chapter 5, words that could be considered a praise in other situations are used as a term of endearment, but these are not also a praise in that circumstance. E.g. "*come on lovely*" (chapter 5, extract 10). In this example, "lovely," is used as a form of address towards the patient, rather than an evaluation of the state of affairs.

In the context of care for older people, particularly those with dementia, there are conflicting ideas around the use of praise. In their tips for carers, the Alzheimer's Society (AS) (2022 https://www.alzheimers.org.uk/get-support/help-dementia-care/understanding-supporting-person-dementia-psychological-emotional-impact) suggest that a person with dementia should be offered plenty of praise and encouragement, so that a focus on the positive can be maintained, and successes can be celebrated. These tips are found in an advice page on how to deal with psychological and emotional impacts of dementia. The Alzheimer's Society approach reflects pervasive person-centred care ideology, which asserts that existing abilities of the individual should be supported and accommodated, rather than focusing on areas of deficit (Kitwood, 1997, Brooker, 2007).

On the other hand, some research categorises excessive praise as a form of elderspeak (Shaw and Gordon, 2021) which is often claimed to be infantilising (Williams et al., 2017) and patronising (Ryan et al., 1995). It should be noted however that within the literature, ‘excessive’ praise often appears to be treated as self-explanatory, without a clear explanation as to what counts or does not count as excessive. The analysis in this chapter has therefore focused on all types of praise identified within the data set, with respect to the definitions mentioned above. This is in line with the wider objective of this thesis: to identify whether elderspeak should always be considered inappropriate. The use of CA methodology allows detailed examination of individual situations to look at in-the-moment reactions to different forms of praise.

There is some existing sociolinguistic and CA work within this area. For instance, Backhaus (2009) used Brown and Levinson’s (1987) politeness framework to conduct a cross-cultural comparison of politeness in institutional ‘elderly care’, (by comparing his Japanese data to pre-existing literature from other countries). In relation to praise, he identified situations in which it was used as an attempted relief from institutional impositions on residents (such as when potentially face-threatening directives were used to get a resident to do a task). Some praise however was claimed to demonstrate unequal power relations between residents and staff, if it was used quite suddenly (without prior context), and in a way that was “too exaggerated.” (2009: 67). These latter types of praise did not receive a response from the residents involved. This was noted as significant, because as Pomerantz (1978) demonstrated, compliments typically warrant a response in conversation. It was suggested that this lack of response indicated discontent on the part of the residents, and led Backhaus to claim that praise is potentially not a successful politeness strategy within this context.

Nonetheless, it is unclear exactly what Backhaus (2009) categories as ‘excessive’ with regards to praise. In an example of prior research given (an extract from Sachweh (2003: 150) recorded from a German nursing home), and in the example of praise in his own data, Backhaus notes the use of intensifying adverbs (e.g. translated as ‘*really’* and ‘*very*’ (2009: 59)) involved in praises, and claims that these result in a condescending tone. He also notes in his own data unusually informal language (for the Japanese institutional context), so it is possible that this collection of features together was considered ‘excessive,’ although this is not explicitly stated. Moreover, the overall conclusion of the paper later lists praise as a positive politeness strategy which is used “*more or less successfully*,” (2009: 69) to overcome threats to face in the everyday life of institutions. This therefore suggests that the picture with regards to how praise is used may be complex.

Jansson (2016) conducted an arguably more in-depth analysis specific to praise in Swedish nursing homes. All residents included in this study had a dementia diagnosis. Thirty high-grade assessment sequences were identified and examined using CA. She found that praise (from care workers) was used ‘online’ (simultaneously with manual activities) and after a resident complied with directive(s). The overall function of praise in these contexts appeared to be a device to compel action or encourage residents to complete tasks, although notably (other than undertaking the requested action), residents rarely produced any direct response to the praise. Despite this, Jansson argued that caregivers used praise in an attempt to connect with residents, as it was also found that praise use intensified after mutual gaze was established between participants, or any minimal response was received. Furthermore, praise was also found in a small number of disagreement sequences. Although most praise was directed towards residents, one case of collaborative praise was discussed, in which a resident says how strong a carer is, who is helping her get up from a bed. The carer then minimises her influence, and instead praises the resident's own strength. Jansson concludes overall that although the data contain some positive moments of contact, the escalated use of praise may be a threat to the epistemic primacy of residents (who should have the epistemic right to determine whether personal care tasks are completed satisfactorily) (Heritage and Raymond, 2005; Heritage, 2012). Therefore, a more sensitive use of praise could improve the person-centredness of care, and *"in order to maintain the older person's dignity, the caregiver must treat the older person as a competent individual, and leave it to the resident to determine, at least to a certain degree, how tasks should be performed*." (Jansson, 2016: 83).

Whilst the preservation of dignity is an important factor in caregiving, it is questionable whether the data here lead comprehensively to this conclusion because Jansson's (2016) data contains only a small number of disagreements with praise. Aside from this, many of the interactions reproduced arguably appear quite positive, as residents did complete the necessary activities which in many cases, they would have been unable to do successfully without the level of assistance they were given. Additionally, it appears that in at least some cases, it is the cooperation of residents that is praised, rather than the end point of tasks. This could be considered to make care more person-centred (Kitwood, 1997, Brooker, 2007), because it attributes some agency to the residents for co-operating in situations where actual agency is limited, because the task is being completed under the direction of the carer.

In support of this argument, and as previously noted, Antaki and Webb (2019) observe that when studying interactions between support workers and individuals with cognitive impairment, the act of receiving support necessitates that some level of agency and control is given up by the person being cared for, as the activity becomes a shared task which is navigated interactionally. Moreover, epistemically (Heritage and Raymond, 2005; Heritage, 2012), Antaki and Webb claim the person giving support may hold more knowledge of how to accomplish the specific given task (or hold more understanding of the necessity of the task) and will therefore work to preserve the long-term institutional agenda of acting in the best interest of the individual receiving support, rather than fulfil in-the-moment objectives (which may be against the best interest). It could therefore be argued that praise directed at a PLWD's action, co-operation or even lack of resistance in carrying out a necessary task may be one way of attempting to mitigate the fact that (some) agency has been lost.

Lindström and Heinemann (2009) explored the concept of epistemics specifically in relation to praise, when examining low and high-grade assessments used in Danish and Swedish domiciliary care. Low-grade assessments were words such as "good, better," whilst higher grade ones were e.g., "very good, great, brilliant." In contrast to Jansson (2016) above, in Lindström and Heinemann's (2009) data, task completion was commonly a negotiated matter, in which the home helpers conceded to the resident's greater epistemic right to judge whether personal tasks had been completed adequately (they know if they feel physically comfortable on a chair for instance). On one occasion when a carer claimed the epistemic right to determine whether a task was complete (declaring the pillow she had adjusted as ‘better’), this assessment was rejected by the resident. Also, and in contrast to the research described above (e.g., Backhaus, 2009; Jansson, 2016), assessments were used by both helpers and residents in this setting. Notably, when assessments were used (by either/both party) regarding a task done by a helper, they were typically low grade. Lindström and Heinemann (2009: 322) suggest that since the task was an expected part of the person’s job, it was only necessary for it to be judged to be done adequately or “*good enough.”* High grade assessments were more unusual within these data, and when they were found, they were evaluative of a resident’s performance. This led Lindström and Heinemann to claim that in these situations, the helpers were promoting the recipient’s independence by treating the completion of challenging (for the resident) tasks as an accomplishment.

Wider research on praise from other contexts may also be applicable to the present research. Antaki et al., (2000) examined two sets of interviews assessing quality of life conducted by psychologists. One set involved individuals with learning disability, and one involved those with cancer. Most cases of praise were identified within the learning disability group. This may be noteworthy with relation to elderspeak, since research shows that this type of talk more generally can be inspired by perceived cognitive impairment or disability (Hummert and Shaner, 1994; Cavallaro et al., 2016; Schnabel et al., 2020). Notably, in Antaki et al., high-grade assessments (such as ‘brilliant’) were linked to progression through a series of questions and were used more in interviews involving those with learning disability. A typical sequence was: *“[answer receipt] + [“ok” or “right” etc] + [high-grade assessment] + [next item]”* (2000:239). During the series of questions, the high-grade assessments were not used as a news receipt for the question answer, because the informational content of the prior turn appeared to be irrelevant (i.e. it did not matter if the answer was incorrect). Instead, it appeared that these assessments were used as a signal that a section of questioning had been completed successfully.

Antaki et al. (2000), argue that this use of assessments demonstrates a certain level of entitlement on the part of the individual doing the questioning. The use of the assessment suggests they hold the authority to judge whether the answer given is sufficient and so the section is finished, and it is appropriate to move on to the next. Although this is a different context to the present data, these findings are still relevant. The current hospital context is also an institutional one, and (as will be demonstrated later) healthcare professionals are also likely to hold some level of entitlement when completing Q & A assessments with patients. This may be partly due to their level of medical expertise. HCPs such as physicians, for example, are often treated as a source of authoritative information (Stivers et al., 2018) or expertise (Landmark et al., 2015; Stevenson et al., 2021) in relation to medical issues. Additionally, simply being in the position of questioner is likely to afford someone higher entitlement in many situations, since they will be in a position to judge whether they have received a sufficient answer to the question they have asked.

Subsequent research by Antaki (2002) found that high-grade assessments were not just used to close sections in institutional question sequences but were also found in mundane non-institutional telephone closings. These closings were mostly successful, indicating that high-grade assessments may work to signal the end of interactions. This was further supported by the examination of some interrupted closings, as in these cases, the assessments were demonstrated to mark the resumption of the closing sequence. As with Antaki et al., (2000) , this use of high-grade assessments was argued to be a display of control, as the individual using them held some entitlement to initiate a close to the conversation. Nonetheless, although this suggests that praise research may be relevant to wider non-institutional contexts, these specific findings may have limited applicability to the current data, as prior research has demonstrated that individuals with dementia in the acute hospital environment can experience difficulty with closings, and may fail to notice more subtle cues that the conversation is ending (Allwood et al., 2017).

Overall, it appears that a common theme of praise research is the relationship with epistemic rights and the balance of authority and entitlement in interactions. In some contexts, it may be that praise could imply an imbalance of power (e.g. Backhaus, 2009) that may threaten the rights of individuals to assess their own experience or choose the activities they undertake. Nonetheless, it is possible that in some interactions (particularly institutional ones with a specific agenda), drawing on an interactional resource that clearly marks topic transitions and enables topic shifts to take place smoothly is likely to be beneficial (e.g. Antaki et al., 2000). Furthermore, in other contexts it appears that praise could be a potential aid for promoting agency and independence in patients (Lindström and Heinemann, 2009) or potentially facilitating difficult tasks that need to be accomplished in the patient's best interest (Jansson, 2016).

6.2 Analysis

The following analysis will first present instances of praise occurring within question-and-answer sequences. Subsequent to this, praise will be examined in relation to physical task completion, reported events, ongoing collaborative events, and events in which something is done *to* someone.

6.2.1 Praise following a Question-and-Answer Sequence.

Praise words were frequently found within question-and-answer sequences. These were often high-grade (Lindström and Heinemann, 2009) (e.g. “brilliant”, “excellent”). For the purposes of this analysis, these types of words are considered praises in that they are providing a positive expression, assessment, or commendation.

The following is an example taken from an interaction between a male patient and a male physiotherapist (a female physiotherapist is also present but does not speak here). They have recently completed a walking exercise and the patient has now returned to sitting in his chair:

Extract 1 (VOICE 107_216)

```
196   HCP:   okay (0.4) do you know what year it is
197   PAT:   ↑↑yea::r?
198   HCP:   yeah what’s the year
199   PAT:   °o::::h° (two/a) thousand and £↑six£ hu:::h
200   HCP:   two ↑thousand ↑a:[nd? ]
201   PAT:                    [no ] no no I’m jokin:
202   HCP:   go on have a go[::]
203   PAT:                  [u:]:m,(0.8).tch (1.0)(ninety)
204          e:r two thousand and [fiftee:n     ]
205                               [((HCP2 nods))]
206   HCP:   ((nods)) >lovely an< do you know what ↑month
207          ↑it ↑is
208   PAT:   ↑what ↑mo:nth?
209   HCP:   yeah
210   PAT:   °↑october°
211   HCP:   brilliant and what’s your date of ↑↑birth?
212   PAT:   °nine two thirty [↑(one)°]
```

In the extract above, the HCP has asked the patient what year it is, and then his date of birth (as part of a wider assessment list of questions). Each time he gets an answer, he responds with a praise word (“lovely” on line 206 and “brilliant” on line 211). In each case, this is followed by a new question. The praise words in this case therefore appear to mark the transition between questions. i.e., the patient’s action of answering is assessed as satisfactory by the HCP, and the HCP then initiates the next topic. It should be noted that it is the action of answering, rather than the answer content that is being praised, as the content does not appear to matter. In the extract above (and in other examples in the data set), praise is given even though the answer is not factually correct, reflecting the work of Antaki et al., (2000).

The following extract contains another similar example. In this case, a male mental health nurse is conducting an assessment with a male patient sitting in a chair. He has been working through a written list of questions with the patient.

Extract 2 (VOICE 114_213)

```
121   HCP:   so what colours can you think of
122   PAT:   ↑gree:n
123   HCP:   o↑kay, (2.8) any ↑othe:rs,
124          (8.6)
125   PAT:   ↑navy blue
126   HCP:   ↓blue: (.) that's lovely thank ↑you ↑very
127          ↑mu::ch, (7.6) ↑can ↑you ↑remember ↑the
128          ↑fi:ve wo:rds (0.4) that I asked you to
129          ↑think ↑of, (4.0) the five words I ↑asked
130          you to remember earlier ↑o:n (.) can you
131          remember any of those?
132          (3.8)
133   PAT:   ↑no
```

In this example, the HCP asks the patient to think of some colours. The patient replies by naming green, and the HCP encourages him to think of some more. After a long pause of 8.6 seconds, the patient responds with navy blue. The HCP repeats the word blue, confirming receipt of the patient's answer, and then praises this as "lovely," (line 126). In a slight variation to the first exchange, he adds in an additional appreciation (thank you very much), before moving onto the next question item. Again, in this case, the praise appears to be produced because the patient has made an attempt to answer, rather than because the answer is fully 'correct,' or comprehensive (for example a longer list of colours could have been provided).

In the following case, a female occupational therapist is discussing the layout of a patient's home with her, for the purposes of assessing her possible discharge from hospital.

Extract 3 (VOICE 102_209)

404 HCP: you've got to go: that way have you, (0.4) out of
405 your bedroom a::nd (.) and le:ft (0.4) and then
406 [to your toilet]
407 PAT: [(?)]
408 HCP: ↑yeah? (0.6) ↑↑fabu↑↑lou:s, (0.6) do you ever get
409 up at ↑ni:ght to go to the loo
410 (1.6)
411 PAT: someti::mes

In this example, the patient's answer on line 407 is difficult to hear on the recording, but the HCP treats it as an affirmative, as she repeats "yeah," and then after a short pause produces the assessment "fabulous," which closes the sequence. She then moves on to her next question. In this situation, no further elaboration was needed from the patient, as the HCP is simply asking the patient to confirm information she has previously been given by her. Therefore a standalone 'yes' is sufficient and it is not necessary (as in the examples above) to pursue a more detailed or expansive answer.

The overall pattern of these Q&A sequences is comparable to that identified in Antaki et al., (*"[answer receipt] + ["ok" or "right" etc] + [high-grade assessment] + [next item]"* (2000:239)) and although the context is different, it is likely that the praise here holds similar functions. In each case, it appears that the HCP uses the praise to mark the successful completion of a Q&A sequence from their perspective, allowing them to move onto the next item. In doing this, the HCP asserts their epistemic right as the professional and the questioner to judge whether the question has been answered sufficiently.

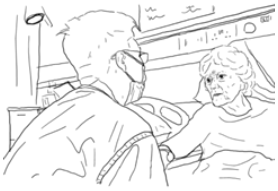
Aside from clearly marking the end of individual Q&A sequences, it is argued that this usage of praise may be beneficial for PLWD, and also aid interactional progressivity more subtly. As demonstrated by the examples presented above (and others in the wider data set), patients with dementia often have difficulty with answering questions (e.g Blackburn et al., 2016) particularly those that target elements of memory (Schrauf, 2020) or abstract thought (Collins et al., 2023; Rapp and Wild, 2011), and also may have wider challenges with talk (e.g. Pilnick et al., 2021; Perkins et al., 1998; Ripich et al., 1991). These individuals may therefore be reluctant or unsure about answering these questions from HCPs, leading to difficulties in carrying out assessments. It has also been shown that this patient group are prone to refusing requests from HCPs and care more generally (O'Brien et al., 2020). Although in the cases presented here, the praise from HCPs appears to be praising the action of answering the question, rather than the content of the answer, this may not be obvious to patients. Praise may therefore function to support patients to keep attempting to answer subsequent questions, so ultimately it aids progressivity of the interaction. Some evidence for this can be seen in the turns following each of the praise usages above. In each case, the patient answers the next question, even if, as in extract 2, (line 133), the answer is potentially face threatening (Goffman 1955) as he is unable to remember the words. In addition to supporting patients, this aid to interactional progressivity is also arguably beneficial to HCP's doing assessments, as they would receive more information from an incorrect answer than if the patient did not answer at all.

Although all the above examples appear to demonstrate that praise can be a useful tool in Q&A sequences between HCPs and patients with dementia, it should be noted that trouble can potentially occur when it is used in this sequential position. One example of this is identified below.

The following extract involves a male doctor (HN49) examining a patient (PN08) sitting in her bedside chair. He has been asking about her usual walking habits when she is at home. His question beginning on line 41 refers to how the patient moves when using a walking frame.

```
Extract 4 (VOICE2_PN08_HN49)

41   HN49:   I ↑mean are-are are you wiggling or are you
42           steady, ((hand gestures to demonstrate))
43           (1.2)
44   PN08:   we↓ll ↑I I think I do all right
45   HN49:   okay that's cool
46   PN08:   [is it]
47   HN49:   [↑very] well g-↓well done ↑girl (0.6) ↓so:
48           first of all any p:↓ain?
```



This extract is unusual in comparison to many of the examples in this collection, because the patient questions the HCP's initial praise (line 46). Typically, the interactional norm in this situation appears to be a lack of response by the party receiving the praise and an immediate transition to the next question item by the questioner (as in Antaki et al., 2000).

Jansson (2016) demonstrated a case in which a care home resident disagreed with a caregiver's praise. In this situation, the resident had defecated in her incontinence pants, which the caregiver praises as 'great,' (2016: 78). The resident disagrees, and the caregiver produces a counter argument. Jansson suggests that the disagreement in that case was due to the resident not considering the action as praiseworthy (a view which would be common in many contexts), so she responds in a way that demonstrates her dissatisfaction with the caregiver using the praise inappropriately. Although this is a different specific context to the current data, it may be applicable in terms of explaining the above extract. In the case above, PN08 has just produced an assessment of her own performance ('all right," line 44), which HN49 then assesses as 'cool.' (line 45). It is possible that the word "cool," was received and treated as too much of an upgrade on "all right." The activity being praised is perhaps less problematic than in the case of Jansson (2016) above, but it could still be considered unusual to praise the way someone walks with a walking frame too highly.

Additionally in this extract, there is the fact that this question is about something that the patient does at home, outside of the institutional remit of the doctor. Individuals usually treat themselves (and are treated) as having a primary right to know about their own experiences and lives (Heritage and Raymond, 2005). The patient therefore holds a strong epistemic right to knowledge about this activity, and to assess it. To an extent, then, her question ("is it?") may also be rejecting the HCP's right to assess her performance. Alternatively, it is also possible that the specific word choice of "cool," which is not a term of assessment generally used in this context (in the data available), is in itself treated as problematic here. Notably, following (and overlapping) the patient's question, HN49 does not attempt to pursue any further answer to his original question. He instead chooses to upgrade his praise further, and amends what he was starting to say to "well done girl," bringing in a term of endearment to the praise. This term of endearment may be significant, since elsewhere in this data set, these have been demonstrated to serve various mitigating functions in conversation. In this case, there is then the typical pause, before a move onto the next topic without further interactional trouble.

6.2.2 Praise Used to Congratulate Task Completion.

The following examples are similar to those considered above in that a HCP provides a positive assessment of some aspect of a patient's performance. However, unlike above, these statements appear to cover a prior activity undertaken by the patient, rather than a simple question-answer. This category therefore involves praise for completion of a physical task which has recently been conducted, rather than praise for an interactional action (as above).

In the following extract, the female patient (PAT) has just undertaken a walking exercise with a male physiotherapist (HCP). The HCP helps her to sit back down in her bedside chair, and then he offers praise on her performance.

Extract 5 (VOICE 124_211)

```
165   HCP:   slowly do::wn,
166   PAT:   ↑o:::::h hhh
167   HCP:   o::kay
168   PAT:   oh go:::d.
169   HCP:   ↑well done,
170   PAT:   oh huh
171   HCP:   are you [al↑ri̲ght?]
172   PAT:           [(?)      ] (0.6) °o:::h° (0.4) °↑o::h°
173   HCP:   you managed that we::ll
174   PAT:   ↑mm:::: not bad,
175   HCP:   yeah?
```

When the patient finally sits down, she says "oh good," drawing out the "o" sound so it appears she is relieved to sit down and implying that she has found the task physically challenging. The HCP then first offers the praise “well done,” on line 169. The patient does produce a response on line 170, although it is slightly ambiguous as to whether she is commenting on the ‘well done’, or whether she is making a pain sound (which continues on line 172). This leads to an expansion sequence, in which the HCP asks if she is alright. The patient then produces an unclear response but does move her head up, and the physiotherapist appears to treat that as an indication that she is alright because he returns to assessing her performance with another praise (line 173), which the patient responds more directly to.

This interaction is structured similarly to many described by Pomerantz (1978). Pomerantz notes that, in everyday talk, when a person receives a supportive action such as a compliment or praise, there is a preference for agreement and acceptance. When praises do not receive the preferred agreement response, the individual doing the praising often reasserts the praise. Despite the fact that this is an institutional environment, the HCP orients to these conversational norms, as evidenced by his pursual of the praise when an initial clear agreement or acceptance is not forthcoming on line 173. Notably, Pomerantz also observed that there is a second interactional preference at work here: to avoid self-praise. This can lead to conflict, because the two preferences are potentially at odds. If someone was to agree with praise too strongly, they would in effect be praising themselves (which may be viewed as impolite). One solution Pomerantz describes is for a praise-recipient to offer a second assessment, which agrees with but downgrades the initial assertion. This is what the patient does here on line 174, downgrading ‘well’ to ‘mm:::: not bad’.

The concept of epistemics (Heritage 2012) is also relevant here. As Pomerantz (1984) notes, when a person gives an assessment, they are claiming knowledge of the thing they are assessing. Likewise, Heritage and Raymond (2005) note how assessment sequences commonly involve an assumption of access to a referent state of affairs. As praise is a form of positive assessment (Jansson 2016), it follows that when praise it used by HCPs, they are claiming knowledge of the activity or action they are evaluating. In the case above, it would make sense for the HCP to be in a position to evaluate the patient’s performance of the task, because he is working in the institution as a qualified physiotherapist, and the task (walking with the frame) was one he had initiated as part of his professional role. He would therefore hold a relatively high epistemic status and so have authority to judge the patient’s performance (Heritage, 2012). Hence, his confidently delivered statement in first assessment position (Heritage and Raymond, 2005) “you did that well.” On the other hand, the patient is the one who has just physically completed the activity. She therefore also has theoretical rights to knowledge about it (Heritage, 2012; Pomerantz, 1980; Kamio, 1997), and so also holds a relatively high epistemic status (Heritage, 2012). This is demonstrated when she asserts her right to downgrade the HCP’s comment, categorising her performance as “not bad,” and the HCP provides an agreement (‘yeah’). Nonetheless, it should be noted that although the conversational norms for agreement and avoidance of self-praise, and the epistemic positions of each interactant appear in this case to both be relevant, it is difficult to unpick which might be having more influence in this case.

The following extract demonstrates a similar phenomenon, but with two shorter duration tasks. An occupational therapist asks a patient to get on and then off a bed, which the patient does quite quickly.

Extract 6 (VOICE 102_209)

441 PAT: ↑ha ↑ha ↑ha ↑ha
442 HCP: .hhh can you square yourself up a bit marg↑ery?
443 (4.0) °fa:b° (3.4) brilli↑a::nt,
444 PAT: ↑am ↑I ↑all ↑↑ri::[ght]
445 HCP: [I'v]e never seen anyone get on
446 a ↑bed so quick
447 PAT: ↑ha:: ↑ha ↑ha ↑ha
448 HCP: .hhh £and can you get yourself off again Margery
449 as we:ll£
450 PAT: one two three
451 (7.0)
452 HCP: brilliant (0.6) have a sit back in he:re
453 PAT: hhhh .hhh hhhhh .hh hhhhhh .hh hhhh .hhh hhhh .hh
454 hhhhh hhhhhh [kuh kuh hhhhh]
455 HCP: [just get your] breath ba::ck

In this case, the HCP treats getting on the bed and getting off the bed as two separate tasks, as each one is assessed separately with high grade praises when complete (“fab,” “brilliant,” and then “brilliant,” again). After the patient has initially sat on the bed, she receives the first praise from the HCP, and she then seeks approval (line 444) to confirm that she has done the action correctly, which recognises the HCP’s more knowledgeable position as a qualified occupational therapist. This turn is perhaps slightly unusual, however, as although it does do downgrading to avoid self-praise, it does not conform to the preference for mitigated agreement described by Pomerantz (1978). This may be why the HCP responds with an upgrade on line 445/446 (similarly to extract 5 where the HCP also did not receive an immediate agreement).

Although talk in the examples presented in this section match patterns found in everyday talk (Pomerantz, 1978) and some of these physical tasks (such as getting on/off a bed) could be considered mundane, both parties arguably orient to the institutional situation (i.e. that some sort of professional assessment is being undertaken) to some extent. This can be seen in the fact that HCPs assert their right to praise these mundane acts, and patients accept (e.g. extract 5) or ask for further feedback (e.g. extract 6) which they might not do if the action was considered unpraiseworthy or outside the HCP's remit (e.g. extract 4). As Pilnick (2022) notes, the authority of a HCP is a "*relational, collaborative achievement between professional and patient,"* (2022: 86). This type of interactional negotiation has been observed in other healthcare contexts. For instance, Landmark et al's., (2015) examination of treatment negotiations between patients who have primary rights to their own thoughts and feelings (termed '*epistemics of experience*') and HCPs who have clinical expertise ('*epistemics of expertise'* (Heritage, 2013:392)). In Landmark et al's case, they argued that the epistemic stance (Heritage 2012) of both parties was relevant during debates around treatment decisions, although HCPs did attempt to lead patients towards the choice that corresponded with their own viewpoint with various strategies, including using both their epistemic and deontic rights as a medical expert.

The present data are also relatable to the work of Lindström and Heinemann (2009) since they considered the balance of epistemic rights between residents and staff in at-home care tasks. However, in that context, it was often a resident who held the greater right to assess whether a task was completed successfully due to the personal nature of the tasks (things such as hair care, pillow placement etc). This is not always the case within the acute hospital setting, in which participants are patients (not residents in their own home) and healthcare professionals. As demonstrated by the cases above, tasks often involve an element of clinical expertise on the part of the HCP, giving them significant rights to assess task performance of patients. However, experiences of patients are still relevant. They are the person who has physically completed the activity, and also many of these activities will have been completed by them previously in a mundane context when they are not being assessed (e.g. getting on/off a bed). Therefore, although the balance of epistemic rights may be slightly different in the current environment, there is still some interactional negotiation of authority (as in Landmark et al., 2015) and similarly to Lindström and Heinemann's data, knowledge that both parties hold is relevant. Still, it is notable that achievements of patients in this context appear to be treated as an accomplishment worthy of strong praise, which is potentially supportive of agency and independence.

6.2.2.1 Generalised Praise

The following examples still involve praise directed at accomplishments of patients but involve HCP's assessing more general activities that they were not necessarily present for. In the following case, a male doctor is examining a male patient who is lying in bed. They have just discussed a scan that the patient needs to have on his hip, as he has a possible infection.

Extract 7 (VOICE2_PN20_HN51)

76 PN20: I drink i drink a re:al lot of water
77 (1.0)
78 HN51: [yeah g-]
79 PN20: [and milk]
80 HN51: good man good man
81 PN20: I am a bit
82 HN51: you want you want some more water
83 PN20: yeah

In the example above, the patient introduces the topic of drinking water, claiming that he drinks a lot. The doctor (HN51) then praises him for this behaviour with the repeated use of “good man.” This situation is slightly different to examples in the section above as the patient has introduced the topic, and he is speaking about an action he does more generally (i.e. likely at home and not under the doctor’s direct supervision). He therefore holds strong epistemic rights to knowledge about this activity. However, in this case, even though the doctor has not directly observed the action, in this context the drinking of water is generally hearable as a good thing (Sacks 1992) and epistemically (Heritage 2012; Landmark et al., 2015) he also still holds a right to assess the validity of the action as a medical professional (Stivers et al., 2018). These two concepts allow the praise to be given unproblematically, which the patient accepts with a mitigated agreement (line 80) (Pomerantz, 1978). Similarly, to extracts five and six above, this praise is again likely supportive of the patient’s sense of agency, perhaps actually more so because the patient is being praised for a general health promoting behaviour that they claim to undertake of their own volition (rather than a task instigated by a HCP).

Nevertheless, this type of praise is not always trouble free. The following extract involves a female doctor talking to a female patient who is also sitting in a bedside chair. The HCP has examined the patient and the conversation has involved some general talk about the patient's wellbeing. Prior to this, the HCP has just checked the patient's breathing, and the patient has said she doesn't want to be hurt and that she typically stays in her house (it is unclear what led her to this turn).

Extract 8 (VOICE 109_207)

```
197   HCP:   say it a↑gain
198   PAT:   I stop in the hou:se all the time [I'm (?)]
199   HCP:                                     [is i::t]
200          (0.4) yea::h (0.6) your ↑walking's doing
201          pretty good at the mom↑e::nt,
202   PAT:   is ↑i::t?
203   HCP:   ↑mm
204   PAT:   ↑↑what we doing?
205   HCP:   ↑yeah (0.4) you've been walking up and
206          do::wn, (0.6) >which is< ↑very goo::d,
207   PAT:   ↑whe::re?
208   HCP:   ↑you ↑ha::ve, (0.6) up ↑he::re,
209          (3.2)
```

In this case, the HCP offers an assessment of the patient's walking (pretty good), which the patient reacts to with what appears to be surprise, as her turn on line 202 has an increase in pitch, and a questioning intonation. The HCP produces a confirmation, and the patient then further reveals her confusion by asking “what we doing?” This leads the HCP to say the patient has been walking up and down in the hospital, which she then upgrades her praise of to “very good.” The patient however still reacts with confusion, and the HCP attempts to locate the praise with the patient’s action again (line 208). This is still not taken up by the patient however, leading to a pause of 3.2 seconds which is relatively long in conversational terms and indicates significant potential trouble within the interaction (Pomerantz, 1984).

The patient’s lack of agreement or acceptance is significant here. As noted above, this is not the preferred response when a praise is received (Pomerantz, 1978), and the HCP orients to this when she reasserts the praise with the upgrade. Nonetheless, in this situation, the patient has not introduced the topic or recently participated in the task with the HCP, so the exact nature of the walking is perhaps unclear or abstract to her, given that it is a general activity, not a specific one. This issue of non-specificity is likely to be particularly salient for PLWD, as they may already be confused or disorientated particularly within this setting as evidence suggests they often find the hospital environment challenging (e.g. Røsvik and Rokstad, 2020; Featherstone and Northcott 2020; Dewing and Dijk, 2016; Sampson et al., 2009). There is therefore likely a large difference in the relative knowledge positions of the patient and the HCP in this situation, with the HCP holding considerably more knowledge of what is being praised (Heritage 2012). The topic of walking is potentially even more confusing considering the patient was just previously speaking about not leaving her house, and it is unclear whether this new topic is related (although her talk is quiet, and the HCP may or may not have fully understood).

Typically, as considered above, in order to affiliate with an assessment, one needs access to the state of affairs under assessment (Pomerantz, 1984; Heritage and Raymond 2005). In the prior example (extract 7) the patient had introduced the topic himself. So, although the activity (drinking water) was a generalised state of affairs (similar to walking), in that case he had access to the thing being praised, avoiding confusion. Therefore, if initiated by HCPs, generalised praise may be particularly problematic within this setting, due to confusion over the referent.

6.2.2.2 'Online' Praise

In the examples presented thus far, the praise that has been analysed has occurred after a topic or a task has been completed. However, it should be noted that praise was also found to occur during ongoing activities 'online,' (Heritage and Stivers, 1999) as patients completed actions. The use of praise in this interactional context will be examined below.

In the following example, a female nurse has helped a female patient stand up from her bedside chair, and they have agreed to go together to the toilet (the HCP is supporting the patient to help her walk). Prior to this, the patient initially appeared reluctant to get up from her chair and produced an overt refusal (discussed in O'Brien et al., 2020: 4) when the nurse asked her. However, following this, she was persuaded to get up, and they then proceed to the toilet.

Extract 9 (VOICE 133_206)

```
104   HCP:   yea:h we can do:: that that’s fine, (0.6) so: (.)
105          let’s ↑walk ↑to↑gether, (3.0) [tha:t’s i::t]
106   PAT:                                 [(?)         ] (?)
107   HCP:   that’s i:t one ↑foot in ↑front of the ↑other
108          tha:t’s fine wonderful (0.4) [another] ↑step
109   PAT:                                [(?)    ]
110   PAT:   ↑’ow about ↑me? (1.8) (alee) (0.6) (yeah) (4.6) I
111          (‘ain’t got a bag)
112   HCP:   well we’ve ↑got your ↑bag here
113   PAT:   yea::h that
114   HCP:   so:: you don’t ↑need to worry about your [bag]
115   PAT:                                            [my:]
116          ↑(?)
117   HCP:   are you on about your ↑husba::nd,
118          (0.6)
119   PAT:   °(oh no I::)°
120          (2.0)
121   HCP:   o::h that’s that (.) ↑o::h ↑wonder↑ful
122          ↑wonder↑ful (.) ↑keep co↑ming,
```

During this extract, the nurse provides the patient with positive feedback as they slowly walk together. The patient takes turns at appropriate locations; however, many of them are hard to interpret (Pilnick et al., 2021). It is possible that some of her words could be treated as objections or cause to stop, such as line 111 when the patient has paused her walking and mentions she doesn’t have a bag (in other social situations a potential issue when going to the toilet). The nurse however simply chooses to reassure the patient about her bag, and then after the patient resumes walking, she then continues to praise the ongoing movement (lines 121-122). Extract 10 below demonstrates a similar situation.

The extract below shows an interaction between a male physiotherapist and a female patient. Another part of this interaction is shown above in relation to praising task completion (extract 5). In the extract below, the physiotherapist helps the patient to stand up with the assistance of a frame, and she then begins walking along the ward with his help.

Extract 10 (VOICE 124_211)

```
55   HCP:   ↑are ↑you ↑ready?
56   PAT:   ↑u:::h
57   HCP:   ↑shall ↑we ↑go ↑on ↑three?
58   PAT:   ↑u:::::h,
59   HCP:   ↑o::ne, (0.4) ↑two::, (0.4) ↑↑three (0.6) up ↑you
60          ↑come (0.6) lovely::
61   PAT:   u::::h, (0.6) ↑a::::h [ha::]
62   HCP:                         [well] done.
63   PAT:   °°u::h°°
64   HCP:   ni:ce and tall. (0.6) very ↑↑goo::d,
65          (0.4)
66   PAT:   °u::::::[:::h]°
67   HCP:           [just] clear this
68   PAT:   °°↑a::::h ha ha ha ha°° (0.6) °°u:::::h huh huh huh
69          huh°°
70   HCP:   [that's ↑it]
71   PAT:   [(?)       ]
72          (3.0)
73   HCP:   w[ell do:ne,]
```

In the example above, the physiotherapist uses a number of praise terms throughout (and these continue in a similar fashion for the rest of the patient's walking activity). Similarly to extract 9 above, he treats the patient's physical actions as if they are task relevant, even though some of her spoken turns are difficult to interpret. A key example of this can be seen on line 57, when the physiotherapist suggests the patient stand on a count of three. The patient makes an utterance which is not clearly an agreement or disagreement (she makes similar utterances throughout, which appear related to back pain that is discussed later in their interaction). However, she does appear to physically be attempting to stand (her hands push up on the arms of the chair and she leans forwards) and this is treated as an agreement by the physiotherapist, as his next turn is to count as he helps the patient stand. This standing is then assessed as "lovely." His following "well done"s and "very good" occur when the patient appears to be attempting to move forward with the walker. These sequences indicate that he is continuing to treat the patient's actions as praiseworthy; a physical action from the patient is followed by a praise being given.

Praise in these types of situations aligns well with the findings of Lindström and Heinemann (2009) who found when praise was used towards PLWD in situations that were physically challenging for them to achieve, it was used in a way that treated their actions as an accomplishment worthy of celebration, arguably supporting their sense of independence and agency. This also appears to be the case in the current data. The regular use of high-grade assessments provides positive feedback during challenging activities such as those demonstrated above. In both cases, patients appear to be facing physical difficulty (both patients required significant help with walking). Both also experienced potential confusion or disorientation regarding the task itself or the environment (both paused regularly and produced hard to interpret turns of talk). Therefore, praise seems to be used to support progressivity of the activity at hand.

6.2.2.3 Attributing Agency to a Patient for HCP's Actions

The subsequent analysis will demonstrate that praise is not just used when patients are undertaking activities with a HCP's aid. The following extracts are similar to extracts 9 and 10 above in that the praise occurs during ongoing healthcare tasks. However, a key difference is that these tasks are done *to* someone, rather than *with* someone, in the sense that active participation from the patient is not required.

In the following extract, a female nurse has been checking on a female patient's broken arm. The patient is sitting in a bedside chair. She appears to be quite disoriented, as she does not recognise that her arm is broken when the HCP asks to check it. Most of her talk relates to her mother and father, but is hard to interpret (Pilnick et al., 2021). At this point, the HCP has checked her arm, and is putting the patient's cardigan back on whilst the patient talks.

Extract 11 (VOICE 117_227)

```
101   HCP:   [do ] you fancy going for a ↑walk ma[ry]
102   PAT:                                       [↑N]O::: ↑NO:
103          huh huh [huh huh] huh
104   HCP:           [no::::,]
105   PAT:   no I'm going 'o:me (0.4) to my mum >huh huh huh<
106   HCP:   the::re you are (.) well do:ne (0.4) [↑hows]
107   PAT:                                        [she's]
108          ↑only just around the corner
109   HCP:   ↑yea[::::h?]
110   PAT:       [you ha]ve to (0.4) ↑take her every day co:s
111          ↑she:'s (0.4) not very well (0.4) she's my ↑mum,
112          (0.4) huh
113   HCP:   'o[w's that for you]
114   PAT:     [I:'ve got my ↑mu]mmy, (.) huh huh huh huh huh
115   HCP:   is that better is that cosy
```

When the action of putting the cardigan on is almost complete, the HCP says “well done,” (line 106), even though the patient has not actively participated in the task; rather she has not resisted it. The patient does not appear to react to the praise, as she overlaps the HCP’s turn on line 107 to continue her talk about her mother. The HCP produces a response to this on line 109 and then continues her objective of establishing if the cardigan is correctly positioned (line 113 – 115). The patient never produces a direct response to this question.

Situations such as the example above do pose challenges in relation to the next turn proof procedure (Sacks, 1974), because, since the patient does not appear to react directly to the HCP’s utterance, it is difficult to argue that she treats or receives it as a praise. Nonetheless, in this situation we do have the HCP’s turns in lines 113 and 115. These indicate that from the HCP’s perspective, something has been accomplished which should result in a more positive state for the patient (being ‘better’ or ‘cosy’), and the patient’s actions (or lack of them) have allowed this to happen.

One way of interpreting the praise in this type of situation is an attempt on the part of the HCP to attribute some agency to the patient for her cooperation (or lack of resistance). Another example of this is demonstrated below.

The following interaction involved two female healthcare professionals (a nurse and a rehabilitation support worker) working together to provide personal care and change the clothes of a female patient. At this stage of the interaction, they have explained that they need to roll the patient over so that they can remove a wet bed sheet. The patient has expressed some distress just prior to this and there was some talk about where she hurt initiated by the

HCPs.

Extract 12 (VOICE2_PN11_HN59)

```
86   HN59:   that’s it (0.2) [over to ↑me ]
87   HN60:                   [over you ↓go]
88   HN59:   that’s it (0.9) ↓well ↑done, (0.7) that’s it
89           °you° ↑see? (0.9) nothing to ↓worry ↑about ye:ah?
90   PN11:   not yet not yet
91   HN59:   n(h)o: £↑not at ↓a(h)ll£ (0.6) .h ↑not at ↓all
92   PN11:   (°all done/xx xx°)
93   HN59:   yea:h?
94   HN60:   we’ll all be ↓done so:on
```

This interaction was recorded with audio only (to preserve the dignity of the patient during personal care), but the praise in this case appears to occur after the patient is rolled over. Note that the overall activity is not complete at this stage, as the bed still needs to be remade, and the patient is rolled over the opposite way shortly after this extract. (It is possible the patient demonstrates awareness of possible further discomfort with her “not yet” if this is seen as a reply to the assertion that there is “nothing to worry about.”). It therefore appears that the ‘well done’ is intended to praise the patient for enduring something she has expressed discomfort with and also for co-operating with this part of the activity despite her discomfort, as she does not protest at this stage or express distress as she has previously in the interaction (not shown).

This praise may also work as part of the reassurance that there is “nothing to worry about,” from this activity, since the HCPs heavily minimise the significance of their actions through their use of language (e.g., “that’s it”, “all be done soon” etc). Overall, this talk positions the act of moving the patient around on the bed as a minimal imposition. At the same time the praise “well done,” acknowledges that she has potentially done work to endure the unpleasant activity without resistance, attributing some agency to her in a situation where her agency is otherwise very limited.

In the following situation, the patient’s potential agency is limited even further. In the extract below, a female patient (PN05) is having a cannula inserted to allow an iron infusion. She is being restrained by two mental health nurses (a male (HN12) and female (HN24) holding each arm) whilst a male doctor (HN16) inserts the needle. The patient is sitting in a chair at the end of a bay. A separate part of this interaction is discussed in chapter 5 in relation to terms of endearment.

Extract 13 (VOICE2_PN05_HN12)

```
160   HN24:   right ↑little ↓scratch
161   PN05:   [n:o ]
162   HN12:   [(xx)] (scratchy now)
163   PN05:   NO (1.4) NO
164   HN16:   (that’s good)
165          (0.6)
166   PN05:   N↑O:
167   HN24:   ↑that’s ↓it
168   HN12:   well done=
169   HN24:   that’s it-
170   HN12:   well done
171           (2.6)
172   PN05:   $no
173   HN12:   well done
174   PN05:   I don’t want to it do↓ing
175   HN24:   I ↑↑know you d-don’t but (.) we want to get you
176           better
```

177 PN05: I don't want [(xx xx xx)
178 HN16: [all done=]
179 HN12: =well done (.) well done
180 (1.4)
181 HN12: just keep that hand still just for a few more
182 moments
183 PN05: no (1.1) no
184 (1.5)((HN16 gets a plaster to put on top of
185 cannula))
186 PN05: no
187 HN12: well done
188 PN05: NO
189 HN12: the sooner we can get this done the sooner we
190 can get you out of here

Throughout this extract, aspects of the wider medical task are continually being done to the patient (e.g., inserting the needle, adding a plaster). In this case, the patient clearly attempts to assert her sense of agency by making overt objections throughout the interaction (e.g. lines 161, 163, 166, 172, etc.) On line 174 she specifically formulates that she doesn't want it (the cannula) doing. Despite her objections, the male mental health nurse (HN12) continues to praise her with repeated use of the phrase "well done." (lines 168, 170, 173, 179, 187).

It should be noted that this is a particularly difficult situation to manage. As in other parts of this data set, this is a situation that the medical team consider necessary to complete in the patient's best interest, but the patient lacks the capacity to decide on her medical treatment and may not recognise or agree with the necessity of the task. Nonetheless, interactionally, some kind of accounting is warranted on the part of the HCP's. They continue doing the activity to the patient that she is objecting to, and without an account the patient may be placed in a position of objectification, which could be highly face threatening (Goffman 1955). Recognising the patient's endurance through praise does attribute some agency for the endurance despite the fact that she has little choice but to endure. It also opens a potential avenue for face saving (Goffman. 1955) through the attribution of agency and mitigation of the imposition.

Although it is impossible to determine whether the patient is responding directly to the HCP's talk, or their continued actions, it does appear that in this instance the praise does not create a space in this case for the activity to be completed unproblematically. This sets this case apart from others such as extracts 9-12 above, in which the HCP's are able to continue the activities with the cooperation (or at least lack of disagreement) of the patient. This has implications in terms of the person-centred care philosophy (Kitwood, 1997; Brooker 2007) which perpetuates the idea that PLWD should be supported to make their own choices, and that they have a psychological need to have a sense of agency and be meaningfully involved in activities. In many cases, praise does function to create a sense of agency where the scope of actual agency is severely limited.

Extract 13 is also a situation that challenges the definition of praise given above by Jansson: "praise is here seen as an assessment in that the speaker is positively evaluating a state of affairs: an action, appearance, ability, or form of behaviour of the co-participant" (2016: 68). In this case, the patient is resisting care verbally, and is being physically restrained, so it is unlikely that it is her actions or behaviour that are being treated as praiseworthy. The use of the "well done"s are still however a positive evaluation of the state of affairs, which aligns with Pomerantz's (1978) more broad definition which simply locates praise within the sphere of 'supportive actions.' This broader definition is therefore more applicable in healthcare scenarios in which something is considered necessary for a patient, but the patient objects to the task.

6.3 Discussion

This chapter has examined a number of examples of praise used by HCPs towards patients living with dementia in the acute hospital environment. With regards to research question 1 (in what contexts is elderspeak used in the care of PLWD), overall, it appears that praise is often used in contexts where there is some sort of imposition on the patient, such as when they are being questioned, when they have been asked to complete some kind of healthcare task or when a healthcare task is being or has been done to them. Generally, it appears that praise is used to fulfil a number of functions, and this has been considered in relation to question-and-answer sequences, congratulating on task completion, and during ongoing activities (including those done *with* patients, and those done *to* patients). Common themes throughout include praise as a supportive action aiding orientation to tasks and activities, and the preservation of agency and face. It could be argued that these two themes may on the face of things conflict with each other, however below it will become clear that this is not the case.

With regards to praise as a supportive action, the question arises; is there a controlling or manipulative aspect to praise? This is a challenging question to answer, as whether or not praise is involved, receiving support involves giving up some aspect of agency and control regardless (Antaki and Webb, 2019). Nonetheless, within these data, praise does appear to be used as a device to encourage action in some cases (e.g. extracts 9 and 10). This finding aligns well with the work of Jansson (2016) who suggested that increased use of praise could be used to compel action in nursing home residents. However, the overall premise of these interactions is often more interpretable as cooperation rather than control, as actions of patients are treated as relevant and important to a task a HCP has initiated. The positive feedback and the implied inclusion of the patient in the tasks being completed may help to provide reassurance and encourage teamwork between patients and HCPs, if the praise provides a cue that the action is being done correctly, and the patient orients to the task as collaboratively completed.

Furthermore, Jansson (2016) claims that this encouraging to act may threaten epistemic primacy of the residents who held certain rights to assess personal care task completion. However, this issue may be more nuanced within the present context, due to the hospital environment and professional role of the HCPs involved. In many cases, it appears that HCPs held a potentially equal (e.g. extracts 5 and 7) or higher (e.g. extracts 1-3) position with respect to patients' epistemic right to assess whether the task/action has been done sufficiently. In these situations, trouble did not arise, and interactions proceeded relatively smoothly, further suggesting benefits for the use of praise in completing tasks. For instance, praise may be particularly beneficial during questioning that patients may find challenging, or during physical tasks that they find difficult. This finding is especially valuable in an environment where patients are likely to refuse requests and resist care (O'Brien et al., 2020), particularly in situations in which care must be completed in the best interests of patients who do not have the capacity (as defined by the mental capacity act (MCA), 2005), to make treatment decisions themselves.

In these situations, as Lindström and Heinemann (2009) found, praise may not only provide interactional structure and cues for collaboration, but also promote the independence of patients. It does this by treating their actions as accomplishments worthy of congratulation during tasks they undertake themselves, and also by attributing them with an active role during situations in which something healthcare-related is done *to* them. Hence, using praise as a supportive action may be protective of agency and face. This use of praise can potentially make the hospital care of people with dementia more person-centred, since it upholds the ideas posited by Kitwood (1997) and Brooker (2007) that PLWD should be supported to achieve what they are able to within their existing abilities. These findings contribute to answering research question 2, which explores how PLWD receive and respond to elderspeak.

Nonetheless, (with consideration to research question 3), sensitivity to the local interactional context is likely important, as it does appear that in some situations, praise is not able to create a space for the activity to be completed unproblematically. This may be due to the patient simply being too distressed to respond to any positive effect of the praise. Alternatively, it may be that some tasks create too much of a burden on the patient to be overcome with praise, or that praise is not a sufficient counter when a patient is actively rejecting treatment. One limitation of this methodology is that it is impossible to know the internal state of patients, so we cannot know the reasons why praise does not appear to fulfil the same functions for certain patients. However, from the available data, it does appear that many people with dementia retain the interactional competence to assess whether praise is appropriate within the local context and respond accordingly (whether it be to downgrade and agree, or to raise it as a point of issue).

One salient question is how these findings relate to the debate around elderspeak and the use of praise. ‘Excessive’ praise is often categorised as a feature of elderspeak (Shaw and Gordon, 2021; Ryan et al., 1995), however it is subjective as to what constitutes excessive, and there has not been clarity or consistency in how this term has been defined across previous studies. The present data contains many instances of praise that could be considered high-grade (Lindström and Heinemann, 2009), such as “brilliant,” and “wonderful,” and many of these praises are for very little or sometimes no action, so it is argued that this analysis is relevant to the debate. Overall, however, it appears that praise within this environment is not usually objected to, and patients typically respond appropriately following established conversational conventions for compliments (Pomerantz, 1978) or Q&A sequences (Antaki et al., 2000). Although there were a small number of interactions where trouble occurred, this was explainable with consideration to contextual factors, such as praise using unusual or uncommon terms for the context, or a lack of a shared referent for the praise. Furthermore, on the whole it seems that praise in this environment is not in and of itself controlling, and patients demonstrate their ability to reject praise they disagree with. Overall, therefore, it appears that within these data it is not the ‘excessiveness’ of the praise but the context in which it is used that determines whether it is treated as appropriate or not.

These findings are particularly relevant for the hospital environment, but may also apply to other areas such as care homes, in which individuals work with people living with dementia to help them to accomplish tasks. However, some features of this environment may be less applicable to other situations. For example, hospital ward staff are subject to pressures around productivity, ‘flow’ (rapid throughput of patients) and efficiency (NHS Improvement, 2018) and often have tasks such as medical assessments that must be carried out in a timely manner. This may be additionally complicated by wider institutional problems such as staff shortages (Waitzman, 2022). Other contexts involving care of PLWD may not necessarily involve such an element of assessment, urgency, or (for some medical tasks) level of invasiveness, and in other contexts an activity may be more easily postponed to another time.

In addition, the present data were collected on UK hospital wards only, and although there was a good level of diversity amongst HCPs recruited, nearly all patients were recorded as White (British). Findings may therefore have limited applicability in other national contexts, as perceptions around praise and related factors (politeness for instance; Backhaus, 2009) may vary. Nevertheless, these findings are still of importance. Given that research has repeatedly highlighted severely negative outcomes from hospitalisation of PLWD, including increased likelihood of falls, disorientation, distress, functional decline, malnutrition and death (e.g. Røsvik and Rokstad, 2020; Featherstone and Northcott 2020; Dewing and Dijk, 2016; Sampson et al., 2009), anything that may improve the hospital experience of PLWD is worth consideration.

One potential limitation of this analysis is that some forms of praise which are common in ordinary interaction were not present in the data set. This might be due to the nature of the data collection itself. For instance, as these data were videoed when a HCP was planning to attempt a task with a patient (VOICE) or when a patient was likely to be in distress (VOICE2) more casual and non-task related forms of praise could have been omitted, such as praise of appearance (e.g. "your hair looks very nice today"). These types of praise have been observed by the research team to occur on the wards but did not happen to be recorded. Therefore, future investigations could further explore the more casual talk that occurs between patients and HCPs on hospital wards, during periods when there is not necessarily a task on the immediate agenda.

Chapter 7: Use of Prosody Involving PLWD in the Acute Hospital Environment

7.1 Introduction

Kemper and Harden (1999) state that elderspeak has historically been assumed to be an accommodation made for perceived communication needs of older individuals, and that this is judged to be disrespectful or patronising, due to the assumption of cognitive impairment. Nonetheless, as the literature review in this thesis documents, there is little evidence of 1) whether or not elderspeak provides any useful accommodation for those with actual communication needs (much of the literature is based on perceptions of hypothetical examples or laboratory studies (see Ryan et al. 1995; Shaw and Gordon, 2021) and 2) how individuals with cognitive impairment (specifically in this case, dementia) respond in real world contexts to this type of talk. Previous chapters have demonstrated that two aspects of elderspeak (terms of endearment and praise) can in some contexts have benefits for HCP's working with PLWD in the acute hospital environment. This chapter will continue this investigation in relation to prosody.

Elderspeak has been considered a special speech register, which includes exaggerated prosody (along with simplified syntax, restricted vocabulary and slower speech rate) (Kemper and Harden, 1999). Pitch that is either raised or excessively modulated (sometimes referred to as sing song intonation) is a commonly referred to feature of elderspeak (Shaw and Gordon, 2021). These features are often grouped with other voice elements of elderspeak (Ryan et al.1995) such as overly loud volume, excessively slowed speech rate and exaggerated pronunciation (Ryan et al., 1995; Shaw and Gordon,2021). Notably, Nencheva et al., (2021) provide a similar definition for child-directed speech prosody; *"higher fundamental frequency, increased pitch variability, exaggerated and repetitive intonation contours, slower rate of speech, and distinct spectral timbre."* (2021:2). This is demonstrative of the idea that elderspeak is typically considered to be a similar style of talk to how one would speak to a young child (Shaw and Gordon, 2021). Collectively, many of the features that Nencheva et al identify can be grouped together under the title of prosody (See Wang, 2014). Prosody is defined by Peppé (2009) as "*the characteristics of speech deriving from variations in the duration, amplitude and fundamental frequency of speech-sounds, which provide the acoustic realisations of certain communicative functions... It thus serves to modify the meaning and impact of what is said."* (2009:2)

This focus on the modification of meaning and impact of talk is notable, as Liu et al., (2022) argue, perceived pitch (operationalised as fundamental frequency) is potentially the first, and most salient auditory component that we experience from birth. Research shows that infants begin to use varied prosody very early in language development (Liu et al., 2022; Wermke et al., 2021; Snow and Balog, 2002). Additionally, raised pitch and exaggerated intonation (known as 'motherese' or baby talk rather than elderspeak when used towards children), has been demonstrated to attract and hold the attention of infants (Fernald, 1985) and prosodic information may help infants to learn new words (Estes and Bowen, 2013). All of this taken together appears to suggest that prosody is an important and likely innate aspect of spoken language.

In a wider context, prosody has many functions in adult talk. For example, there is some evidence to suggest that using prosody differently can portray different emotions (Banse and Scherer, 1996; Bänziger and Scherer, 2005; Wilson and Wharton, 2006; Zupan et al., 2009). McHenry et al. (2012) audio recorded interactions between HCPs and patients with cancer. The patients were either receiving bad news or neutral news from the HCPs. It was found that in the bad news condition, HCPs typically reduced both their pitch and speaking rate (in comparison to the neutral condition). These recordings were then edited, so that the words were unintelligible, but the intonation was unchanged. Twenty-seven graduate students then rated the recordings on how caring, sympathetic and competent they considered them to sound. Sections of the same visit could be labelled differently (e.g. the beginning may be neutral, and later may be bad news). Despite the unintelligible speech, the graduate students were able to perceive a difference between the two conditions and rated lower pitch and slower speech as more caring and sympathetic. This suggests that prosody contains some distinguishable meaning, even without the informational content of the associated words. Nonetheless, as Ogden (2006) demonstrates, features of prosody (such as pitch span and range, loudness and voice quality) do not always mean the same thing, as they are tied to sequential placement within talk.

Some research indicates that prosody could be used to negotiate interactants' positions within conversation. For example, Reed (2020) conducted a CA based study examining everyday conversations of university students. She found that participants chose to use sound (prosodic) mirroring within conversation (rather than it always being automatic), and this mirroring was used to support interactional progressivity. Additionally, the speakers in the conversation could affiliate, deaffiliate or be affiliation-neutral when mirroring. The key component was both of the speakers being committed jointly to an interactional cause. Zellers and Ogden (2014) used a mixed methods study (CA and statistical analysis) to examine contrasts in spontaneous conversations (from the TalkBank database, MacWhinney, 2007). Zellers and Ogden found that in interactional situations where something problematic was occurring (e.g. when one individual changed the topic away from an unpleasant one), the contrasting turns prosodically matched prior turns. It was suggested that this was done to orient to the potential for it to be problematic, and to make the new different turn match the prior turns as closely as possible (even though the topic was different). This prosodic matching was therefore said to prioritise conversational progressivity. In some situations, where contrasting turns were not matched to the previous talk, the prosody was either upgraded (e.g. louder, higher pitched) or downgraded (quieter, lower pitched). The downgraded prosody turns were suggested to acknowledge the different topic/situation, but the upgraded turns were found to only occur in situations where the contrasting turn was not likely to be problematic (i.e. cause disruption to the interaction).

Returning to the concept of prosody helping to clarify meaning within talk, Cohen and Faulkner (1986) conducted an experimental study to examine the impact of stress and intonation on understanding and recall of talk in older people. They sought to answer the question of whether elderspeak (defined in this case as enhanced intonation and stress patterns) should be considered as a reflection of patronising attitudes, or whether it should instead be viewed as a functional adaptation which aims to facilitate communication in accordance with the capacity of the listener. In this instance, ‘stress’ was defined as words with increased pitch, amplitude and duration, and increased duration of subsequent pauses. After having younger and older adults listen to text which was read out with either focal stress (stress on key words), non-focal stress or no stress, listeners were questioned about what they had heard and scored on accuracy. It was found that for the older listeners, both comprehension and recall were better for the experimental condition with stress on key words, and less accurate for the other conditions. This led them to conclude that stress is not only an acoustic enhancement (i.e. it allows easier hearing of words more easily), it also improves the linguistic and perceptual processing of the talk, because the effect was only found when key words were stressed, and not random words. Notably, this effect was only found for older and not younger listeners.

Kemper and Harden (1999) also examined many of these features within their investigation of elderspeak. As with Cohen and Faulkner (1986), they also used an experimental design, and compared groups of older and younger adults receiving and reproducing map directions. A version of the map directions was given with exaggerated prosody, in which the speaker stressed key words, paused before and after each key word, spoke slower and with exaggerated enunciation. This prosodic exaggeration was noted to be similar to elderspeak previously identified by Kemper et al., (1995) and Kemper et al, (1996). Kemper and Harden (1999) examined how different elements of this talk affected comprehension and evaluations of elderspeak. Overall, they concluded that for older adults, prosodic features (short sentences, slower speaking rate and high pitch) were not beneficial to task performance, may actually impair it, and could potentially lead to negative assessments of both the listeners and speakers' communicative competence. In contrast, other elements of elderspeak, such as a reduced number of clauses per utterance (a measure of grammatical complexity) did aid processing of map directions, but only when combined with neutral prosody. These results are markedly different to Cohen and Faulker (1986) above, in that the features of prosody which may stress key features/words were not deemed to be helpful. Nonetheless, a key part of this research was participants' perceptions of their own and the speaker's competence. Whilst a useful record of how participants experienced the task, these perceptions may not apply to this type of talk used within other contexts. Notably, as with Cohen and Faulkner (1986) above, these effects were not found for younger adults, potentially further suggesting an influence of local interactional context.

Samuelsson et al., (2013) recorded naturally occurring conversations within Swedish geriatric institutions between five (female) staff members and four older people (three females, one male). Some conversations involved multiple people. Talk directed towards the older people, and talk directed towards other staff members was compared. Samuelsson et al. analysed elderspeak more broadly but noted that prosodic features were most prominent within their data. Overall, it was found that the staff used a higher pitch (fundamental frequency) when talking to the older residents, in comparison to their same-aged colleagues. In addition, most individuals used a slower speech rate, but fewer pauses when talking to the older residents. Pitch range was much more variable, as three staff members used more pitch variation towards the older residents (although only 1 interaction had a significant level of difference), and two used significantly less pitch variation towards the older residents. In terms of results interpretation, Samuelsson et al., noted that although they found that higher pitched talk was used towards older residents, there were no communication breakdowns within their sample. This was described as unexpected, as with the prior findings of Kemper and Harden (1999) in mind, and the fact that older adults are more likely to experience hearing loss of higher frequencies they had anticipated that higher pitch may hamper interactions. Samuelsson et al. suggest that the lack of trouble may be due to the fact that the high pitch was intermittent, rather than continuous throughout talk. If this was the case, it would fit well with the notion of prosodic features making talk easier to hear and process demonstrated by Cohen and Faulkner (1986) above. These findings suggest that there is some level of importance to how and where talk is prosodically stressed within interactions.

With regards to PLWD specifically, not much research describes the use of exaggerated prosody towards this group. Cunningham and Williams (2007) conducted a case study on one individual with dementia (a 78-year-old woman). Four interactions with nursing staff were videoed (total ten minutes of recording). Recordings were then coded for elderspeak, resistiveness to care and emotional tone. It was found that increased use of elderspeak was associated with more resistance to care. Nonetheless, although prosodic features of elderspeak were included within the elderspeak scoring (slower speaking rate, high pitch and sing song voice), all aspects of elderspeak were conflated for the analysis, limiting inferences about prosody specifically. Furthermore, the premise of this research is built on the assumption that resistiveness to care is a direct result of the elderspeak being used. It is possible that elderspeak may have been inspired by the situation itself – i.e. it could have been used more because a staff member perceived difficulty was already occurring, or expected it to occur. Additionally, there are countless other variables that could have contributed, such as the fact that the PLWD had fallen and broken her leg in the week preceding the study, and had consequently been transferred to the nursing unit where she was recorded. This unfamiliar environment and her unknown level of pain could have contributed to her resistiveness to care, limiting the generalisability of these claims.

Small et al., (2009) examined whether specific aspects of prosody (pitch and loudness) were associated with conversations that were successful or unsuccessful with spouses with Alzheimer's disease, in their home environments (twelve caregivers, and twelve PLWD). Conversations were considered unsuccessful if a breakdown in communication occurred (e.g. if a misunderstanding or clarification request was present). Overall, there was no clear difference found between the pitch and loudness used by caregivers and the success of the conversation. However, on closer examination, one subgroup of (eight) caregivers had increased pitch associated with unsuccessful conversations, whereas in another subgroup (of four carers) reduced pitch was associated with unsuccessful conversations. Similar results were found for loudness, although with subgroups of six and six caregivers respectively. As a possible explanation for these results, Small et al., suggest that in some cases, caregivers may have favoured non-prominent talk (i.e. the reduced pitch and loudness). These were cases that typically didn't favour their partner such as a disagreement (i.e. there was a threat to face, (Goffman, 1955)). They argue that this is supported by Yaeger-Dror's social agreement principle which claims that to focus on disagreement would be face threatening and so dispreferred in conversation (see Yaeger-Dror, 1997). On the other hand, Small et al., suggest that in other cases where talk was more prominent, caregivers may have focused more on the informational content that they were trying to get across. Therefore, according to the Cognitive Prominence Principle (Kaufmann, 2002) they would be more inclined to use prosodic emphasis to convey negative items despite the items being negative. Additionally Small et al., note that the above principles may have more utility in explaining the results in comparison to previous elderspeak research. This is because the findings for increased prosodic prominence would align with patronising perceptions of elderspeak, the findings on decreased prosody would not fit.

A great deal of prior research into prosody and related areas has used laboratory settings (e.g. Kemper and Harden, 1999; Cohen and Faulkner, 1986) and/or actors attempting to replicate real life interaction (e.g. Banse and Scherer, 1996; Bänziger and Scherer, 2005). Whilst potentially useful for initially exploring the topic, these methods have limited applicability to real world situations. As Ogden (2006) notes: "*all talk occurs within a context. Context is embedded within talk, and talk also creates context.*" (2006: 1754). This point highlights the importance of examining how talk develops within actual interaction. It is not enough to know that features of talk exist, the sequential context in which they occur must be taken into account. Wilkinson (1999) further illustrates this point when discussing individuals with communication impairments. He shows how people can function better in real-life conversations than in tests, as sequentiality provides a resource through which individuals are able to contribute meaningfully to conversations, and help themselves be understood. Therefore, hypothetical examples devoid of the rich context of real-world interactions are unlikely to have real applicability to this area.

Ogden (2006) used CA to examine talk (in that case assessment sequences) alongside some phonetic analysis. This chapter will also use CA (in keeping with the rest of this thesis). However, unlike in Ogden's work, numerical analysis of features such as pitch in a program such as Praat was not undertaken. In the present data, participants are often moving around, were variable distances from microphones, talk was often overlapping and there is an exceptional amount of background noise (a feature of the ward environment). As Walker (2012) notes, these types of features would be problematic for computer based acoustic analysis. Walker further notes that much useful research has been carried out on relationships between the organisation of talk and phonetic design without including a measure of acoustics. Indeed, it is argued that within the present data, the relevance is not the overall pitch (or loudness) of the participants voices, it is the in-interaction reactions to prosody that are important. This chapter will now present some ways in which prosody is used within the data to achieve particular actions.

7.2 Analysis

7.2.1 Greetings/To Gain Attention

Prior research has demonstrated that background noise can influence interactions with PLWD. (Chatwin and Capstick, 2019). The hospital ward environment is often extremely busy, with lots of noise both from medical machines, people and also many different health professionals working with different patients, resulting in lots of greetings and requests. This situation can be very disorientating for people living with dementia (for a description of the noisy ward environment, see Goldberg et al., 2014: 1335) and the question of who talk is being addressed to can be ambiguous. This difficulty may also be increased for people with hearing loss, which is common within this population (Roth et al. 2011; Smith et al. 2020).

High pitch and other stress are often located within greetings in these data. Below are some typical examples. In the following extract, a female patient is sitting in her bedside chair with a table in front of her. She is drinking what appears to be a cup of tea. A female nurse arrives with the patient's medication.

```
Extract 1 (137_215)

HCP:   ↑↑hello ↑↑(there)
PAT:   hel[lo]
HCP:      [↑h]ello:::, (1.4) hilary::, (.) I ↑brought your
       medica↑tio::n
PAT:   hm mm:: ((nods))
HCP:   ↑yeah? (0.4) I brought two tab↑le:ts, (0.4) would
       you like to ↑take (them from me)
```

The HCP initially produces a "hello there" with substantial pitch rise. The patient returns the greeting, and after another "hello," (with a drawn out 'o' sound and pauses between the hello, the patient's name and the next phrase), the HCP introduces the reason for her visit (i.e. the medication). There is increased pitch, and stress on the words "brought" and "medication". During this extract, the patient looks up slightly when she returns the initial hello, but then looks down at her drink again. This may be why the HCP does the second greeting (line 3) followed by a pause and then produces the patient's name, as this is a clear summons, re-capturing her attention. This is evidenced by the patient looking up again at this point, making eye contact with the nurse and responding with an affirmative sound and a nod after the nurse says the word "medication."

Following this, the HCP hands over the medication and the patient takes it without issue. It therefore seems that in this case, the prosody is used to announce the HCP's presence and emphasise the greeting (likely helping to gain the patients attention), and then to stress the reason for the HCPs presence by emphasising the keywords of her statement and request. All of this is done quite efficiently, in that the interaction is trouble free, and the PLWD is informed immediately that a) she is the target of the HCPs speech, and b) the HCP is there to give her her medication. This is significant in this environment, since disorientation is common and often there are multiple people moving around and talking at any one time. It also aligns well with the findings of Cohen and Faulkner (1986), since they found that prosodic stress (defined as words with increased pitch, amplitude and duration, and increased duration of subsequent pauses) on key words aided comprehension and recall in older listeners.

A similar pattern occurs in the following extract. In this case, a female nurse has just arrived to talk to a female patient who is sitting in her bedside chair. The nurse is attempting to persuade the patient to stand up, in order to relieve pressure and avoid the risk of pressure sores.

Extract 2 (133_206)

```
HP:   ↑hello ↑mau↑↑ree::n,
PT:   °hello°
HP:   ↑how are ↑you:?
PT:   not too: bad,
HP:   not too bad, (0.6) good good (0.4) I ↑was ↑just
      ↑wondering if I could help you with (0.4) relieving
      some ↑↑pressure on ye:r ↑botto:m
      (1.0)
PT:   °°no::°° hhh
```

As with extract 1 above, the HCP's greeting contains pitch increases which are designed to gain the patients attention. In this case, after the initial 'hello' and the patient's name (with substantial pitch increases), the patient responds with an immediate (if quiet) greeting in return, demonstrating that she is orienting to the interaction. The HCP's greeting makes it very clear that the patient is the addressee, since the patient's name is given with a lot of prosodic stress (pitch increases and drawn-out sounds). This is accompanied by the HCP leaning down to eye level with the patient, and looking directly at her. Following the initial greeting, the HCP initiates a "how are you," (found in other types of conversational opening, e.g. Schegloff, 1968; Sacks, 1975), and the patient responds appropriately. Once the greeting sequence is concluded, the HCP leaves a small pause (0.4 seconds), and then makes a proposal to assist the patient with relieving some pressure (i.e. helping her stand up, though the action associated with the request is not made clear at this point). Also as above, there are additional pitch increases and emphasis on key words of her message. In this case, the patient at first refuses, although the task is later accomplished.

The following extract involves the same female nurse as above, but with a male patient. At the start of the recording, he is laying on top of his bed fully clothed. He is looking upwards prior to the nurse's approach. She arrives with the blood pressure monitor and leans in slightly when she talks.

Extract 3 (133_201)

HCP: ↑hello ↑the:re ↑↑terry::,
PAT: how are you
HCP: ↑are ↑you ↑all ri:ght I'm all ↑↑ri:ght (0.4) ↑can
↑I ↑check ↑your ↑↑blood pressure ↑plea::se,
PAT: yeah

The HCP greets him as she arrives, and the patient looks towards her and makes eye contact. He demonstrates an awareness of her greeting with his "how are you," (Schegloff, 1968; Sacks, 1975). Overall, similarly to extracts 1 and 2 above, the nurse's greeting has efficiently announced her presence, gained the patients attention and made it clear why she is there (to check his blood pressure in this case).

Although many greetings in these data contain features of prosodic stress (particularly high pitch), it does not always immediately work to gain the patients attention. In the following example, a female nurse has arrived to give a male patient his medication. He is in bed, and appears to be very tired. He keeps his eyes shut for most of their interaction.

Extract 4 (104_204)

```
1   HCP:   ↑morning ↑↑ke::n, (1.4) [[hand rubbing PAT's
2          shoulder]] ↑↑ke::n,
3   PAT:   what
4   HCP:   ↑↑morni::ng,
5   PAT:   morn↑ing [[keeps eyes shut]]
6   HCP:   morn↑↑i:ng, (0.6) I've ↑just ↑got ↑your ↑medications
7          for ↑you: (1.8) can you open ↑your ↑↑eyes fo:r ↑↑me::
8          (1.0) ↑ke:n, (2.0) am I okay ↑to ↑give you your
9          medici::nes,
10         (2.4)
11         he's got his mou:th ope:n so I'll, (.) >have a° try::,
12         (0.8) there you go ke::n (2.0) there you go:
13         (10.0)[[puts spoon in mouth, PAT takes without opening
14         eyes]]
```

In this case, the HCP repeats her "morning" greeting three times (each with pitch increases). These are designed to gain the patients attention, as evidenced by her repeated greeting and the delay in stating the reason for her presence until she has received a response from the patient.

Taking the next turn proof procedure (Sacks, 1974) into consideration here, the patient's lack of response is notable in that it is a noticeable absence (Schegloff, 2007). In this situation, a reciprocal greeting or similar response to the HCP's initial greeting would have been a relevant next turn. So, when the patient does not respond, the HCPs repeat of his name treats this lack of response as accountable, and when the patient then comes in with "what" (line 3), both indicating he has not heard or understood the HCPs prior turn and potentially accounting for his lack of prior response, she gives the greeting again (line 4).

At this point when the patient does return the HCP's greeting with his own (line 5), but he keeps his eyes shut. This apparent lack of full engagement is oriented to by the HCP who produces an additional “morning” in line 6 which again has pitch rises and a drawn out ’i’ sound. The fact that she uses this additional greeting before stating the reason for her visit further indicates that she is attempting to gain the patient’s full attention. There are of course practical as well as interactional reasons for this pursuit: it would be dangerous to attempt to give oral medication to someone not fully awake and alert who might therefore have trouble swallowing them.

After the greeting is completed, her explanation for why she is there contains multiple pitch increases, and emphasis on key words (e.g. “↑medi<u>ca</u>tions”). This is also delivered at a relatively slow pace, due to the regular pauses, and drawn-out words. When there is again no response from the patient after her initial statement about medications (line 6-7) she asks him to open his eyes, and tries another summons (his name, line 8), before mentioning the medication again (this time phrased as “medicines”). Following this, the HCP does give the patient his medication. Although he takes it with minimal interaction on his part, he does not protest.

Most of the greetings with these prosodic features are relatively ‘trouble free’ in that the patient typically returns the greeting in some way, and both parties appear to share or develop a mutual understanding of the situation. Below is a different example, in which a patient specifically takes issue with a greeting. During this extract, the female HCP (a doctor/consultant) arrives to see a female patient sitting in her bedside chair with a table in front of her.

Extract 5 (143_227)

1 HCP: he↑llo:: ↑mary:: (0.6) good ↑morning,
2 PAT: ↑what you saying ↑like ↑↑tha:t for me:
3 HCP: good ↑mor↑↑ning
4 PAT: that's not a good one for me: is i:t?
5 HCP: ↑isn't i::t,
6 PAT: (cup ↑blighters/cut m'lighters u:p)

As the HCP gives the first greeting (line 1) she is in the process of crouching down in front of the patient, resting her arms on the table. She is smiling and makes eye contact with the patient (who was initially looking away). After the first "morning," (line 1) the patient does not smile in return but does lean towards the HCP as if engaging in the conversation.

The initial greeting on the first line is quite drawn out, with the 'hello,' and the patient's name elongated, a pause and then emphasis on the initial part of "morning." The entire sentence is delivered in quite a high-pitched voice, with extra pitch rises during the hello, patient name and 'morning,' and ending in a slight rise in intonation. Notably, the patient questions the greeting. It is difficult to tell exactly what she means (and of course we cannot know her internal state), but she does do a big pitch increase on the word "that," (Line 2) so it is possible that she is reacting to the high pitch of the HCP's initial greeting, (although later it seems she may be problematising the "good," part of the statement). This patient's talk was hard to interpret (Pilnick et al., 2021), on many occasions, and the HCP appears to have picked up on the initial part of the patient's turn ('what you saying?'), because she repeats her greeting again, with further pitch increases and emphasis on "morning." It is also likely that the

HCP may be repeating her greeting again, as she hasn't received a greeting in response, which would be the norm in conversation (Sacks, 1975; Schegloff, 1968).

Following the HCP's repeated 'good morning', the patient still does not return the greeting, and instead chooses to problematise the HCP's use of good at this point. This is also irregular in terms of typical conversation, as in most cases in response to a 'how are you,' individuals choose some form of 'not bad,' response (particularly when responding to a relative stranger). (Sacks, 1975). So, arguably the expected response to 'good morning' would be to treat it as a courtesy rather than an enquiry. This more standard responses can be viewed above from the patient in extract 2. It is unusual to share ones problems immediately at this stage in an interaction (some specific circumstances excluded, such as calling an emergency line (e.g. Cromdal et al. 2012). In addition, commonly within this data, 'good morning,' is usually treated as a greeting, rather than a literal descriptor.

The following extract is different again, as trouble is already occurring, and a HCP comes in with a new greeting later in the interaction. This is unusual, as greetings typically occur at the beginning of interactions (Sacks, 1975). The situation involves a patient (PN07) sitting in her bedside chair. Her son (FN01) is present, along with two female HCA's (NH39 and HN40). The HCAs have been trying to persuade the patient to get up and go to the toilet with them. It is HN39's first day working with PN07, but HN40 has worked with her for a few days (approximately three shifts). PN07 has two teddy bears for which she displays strong affection. Prior to this extract, HN39 has just tried to take one of the teddies, leading to PN07 shouting “Get off,” in a loud voice.

Extract 6 (PN07_HN39_PAN_120522)

31 PN07: [GET ↑O:FF:] ((looks up at HN39))
32 (0.8)
33 HN39: ((places hand on PN07’s arm)) [we just] need to walk
34 you to the
35 FN01: [↓mu::m?]
36 HN39: toi↓let [that’s] all we’re going do
37 PN07: ((shakes head))[no]((shakes arm off)) N↑O
38 (1.8)
39 PN07: I don’t want anybody ↓n↑ow in my house
40 (0.3)
41 FN01: you’re ↓just going to go for a ↑wee [mum]
42 HN39: [you’re] in
43 hospital at the minute
44 (1.2)
45 PN07: ((looks at FN01 then as speaking turns to HN39)) **no** (.)
46 **no** (.) **no.**
47 (1.2)
48 HN40: ↓Da↑:w:n? ((leans towards PN07))(0.5) ↑he↓llo it’s
49 ↑An↓na
50 (0.9)
51 HN40: ↑h↓e↑llo¿
52 (0.3)
53 HN40: ↑can we have that little wal↓k we were talking about t
54 the ↓toi↑let,
55 PN07: ((closes eyes/possibly nods?))(1.3)
56 HN40: ↑you ↑take ↑my h↓and,
57 ((PN07 takes HN40’s hand))(1.3)

During this extract, the patient is resisting all requests or proposals (mainly from HN39 and FN01) up until approximately line 48 on the transcript. At this point, HN40 (who had been standing back slightly) steps in and leans right down appearing to make eye contact with the patient. Despite the fact that the interaction is already in progress, she then initiates a new greeting with a lot more pitch variation than had been used so far within the interaction. Her language is also delivered more slowly because it is broken down into shorter sections with multiple pauses. Notably, it is at this stage that the patient stops resisting. She takes HN40’s hand and subsequently HN40 is able to take the bear from PN07 and both HCAs help her to stand up and walk to the toilet (HN40 bringing the bear with them).

It is difficult to ascertain to what extent the patients change of behaviour in this instance is directly related to the difference in prosody used by HN40. It is possible that other factors are also at play, such as HN40’s minimising of the task (e.g. “little walk,” line 53), or the higher level of familiarity HN40 has with the patient (both real and implied by her language, such as line 53). Nonetheless, since components of actions do not exist in isolation it is likely that at least some of the patient’s reaction is related to the exaggerated prosody used by HN40. The initial use of the patient's name and the hello (line 48) appear to capture the patient's attention, when she had previously appeared to be very disengaged with her hands wrapped around herself (and a teddy), and her face looking down away from everyone. On receipt of the new greeting, she looks up and meets HN40’s gaze, demonstrating her attention had been captured. Up until this point, the patient had appeared relatively disoriented (demonstrated by her mention of being in her house). HN40 then clearly suggests the walk to the toilet (with a lot of pitch variation on ‘toilet’), in a way which minimises the actual action (e.g. ‘little walk). This sentence likely cuts through the ambiguity of the interaction and makes it clear what the HCPs are trying to achieve by clarifying the action associated with their request (i.e. walking to the toilet). This conclusion is supported by the fact that the patient then stops resisting, takes HN40's hand and allows them to assist her in standing up. Previous research has demonstrated HCP's wording of requests is important in this environment (O'Brien et al., 2020). This analysis contributes to this area of research.

As demonstrated by the extracts above, talk and body language that draws attention to a greeting or key message may be extremely valuable for PLWD, particularly with consideration of the busy and noisy ward environment. Consequently, this analysis begins to demonstrate how prosodic features of talk that would acontextually be categorised as features of elderspeak serve a particular purpose. This does not only apply to greetings, but also a broad range of other situations in which it is important for patients to be able to engage with HCPs' talk. Some of these will be addressed below.

7.2.2 Emphasis (Outside of Greetings)

The analysis in this section involves exaggerated prosody on key words during various HCP-Patient interactions. The following extract is a male doctor talking to a male patient who is lying in bed. The doctor is asking questions relating to a possible urine infection.

Extract 7 (132_201)

43 HCP: this week (0.4) how ↑about ↑going ↑to ↑the ↑toilet?
44 (0.4) >are you having< any ↑burning or sting↑ing at a:ll?
45 PAT: °no:°
46 HCP: are you going more ↑often ↑than ↑normal ↑do ↑you ↑think?
47 PAT: ↑I ↑just tried to go bu::t (0.4) I °(?)° (0.4) I'm not
48 °going (?)°
49 HCP: ↑not ↑goi:ng (0.8) do you feel like you ↑need to go:

As above, pitch increases can be seen on the key words of the doctor's questions. In this case, the patient provides answers to the questioning. The patient's reply on line 47 does have some raised pitch at the start of his turn. It may be that he is also using prosody for emphasis, in this case to demonstrate the recentness or relevance of his symptoms. Some of the patient's talk is hard to interpret but the HCP gives a reply on line 49 based on what he has understood from the patients turn. This is a method previously identified in Pilnick et al (2021) and discussed in chapter 5 in relation to ToE. Notably, in this case, his reply has pitch rises on what is arguably the key elements of his turn; the patient's message that his is 'not going' to the toilet, and his follow up question of whether the patient feels like he 'needs' to go.

In the extract below, a female speech and language therapist is offering a drink to a female patient (in order to assess her swallowing). The patient is lying in bed. They have been talking for a little while, and have already tried some water, which resulted in the patient coughing.

Extract 8 (111_212)

```
107   HCP:   it's just some a↑pple ↑jui:::ce, (0.6) >and there's<
108          a little bit of powder in i:t, (0.4) just to make
109          th- (.) the (0.4) liquid a bit slowe:r (0.4) and
110          give you longer to react to it (0.8) do you like
111          apple ↑jui::ce?
112   PAT:   (°mm: no- ne↑va-°)
113   HCP:   £not rea↑lly::£ (0.4) would you have [a litt-]
114   PAT:                                        [ne↑ver ] ↑had
115          it [°before°]
```

The HCP raises her pitch on 'apple juice' and draws out the word juice on two occasions. She also pauses regularly throughout, so her language is delivered relatively slowly. She stresses that she has put some powder in the juice, which will make the liquid slower to swallow and give the patient longer to react. It is arguably important at this stage that the patient is clear what she is being given, as the patient had previously coughed when trying water without thickener. The HCP's explanation is therefore potentially reassuring (in that it will be easier for the patient to swallow this second drink). Following this, the patient agrees to try the apple juice, and then later some other things (e.g. yogurt). Notably, the HCP interprets the patient's quiet response on line 112 as a dislike, rather than (as it turns out) a lack of familiarity with the juice. This is potentially because the patient's response is difficult to hear and her prior question had been whether the patient likes apple juice, so the initial "no" (line) may have been treated as a refusal.

The following extract is also a female speech and language therapist (a different one from above), in this case working with a male patient who is lying in bed. In this situation, the patient had previously produced a lot of hard to interpret talk and had refused food and drink repeatedly by this stage. Other parts of this interaction are described in chapter 5 in relation to ToE. This extract is towards the end of the interaction, in which the HCP has repeatedly been trying to assess the patient drinking water, which he has not done.

Extract 9 (122_220)

```
315   PAT:   [°(?)° (.) (?)                              ]
316          [((Pt watches the HCP putting the side of the bed
317          back up))]
318   HCP:   ↑did you ↑want the ↑water? (0.6) what about in this
319          glass (0.6) ca:rl, (0.6) do you want the ↑water
320          (1.6) can you see the wa:ter  (0.6) do you want the
321          ↑wa:↑↑ter?
322   PAT:   (I already) (?) (.) (water)
```

The HCP uses pitch increases regularly on the word “water.” Notably, if examining the extract as a whole, the key message would still make sense if you only heard the higher pitched words and stressed words. Including the questioning intonation used on two of the ‘water’s, this makes it quite clear that she is asking if the patient wants water. In this case, the patient continues to refuse the water, demonstrating that even if prosody makes the message clearer and/or more persuasive, patients may still choose to refuse requests if they wish. This is also demonstrated in extract 2 above, in which the female patient at first declines to stand up.

It should be noted also that although partially hard to interpret, the patient’s refusal here on line 322 does demonstrate that he has understood the request as it does address the offer of water. Even if a patient chooses to refuse a request, the fact that the request has been made understandable to them is arguably a success. Making requests clearer or more understandable gives patients a better chance of being able to make an informed choice in their care, supporting the principles of the MCA (2005) and person-centred care (Kitwood, 1997; Brooker 2007).

In the following extract, a female mental health nurse is walking around the ward with a male patient. She has brought the patient’s dinner with her and is attempting to get him to eat something whilst walking with the patient. At this stage, the patient has eaten some of the main course already. Some of the patient’s talk is hard to interpret.

Extract 10 (103_225)

```
199   HCP:   ↑david? (0.6) would you like some more of the
200          bea::ns (1.4) ↑there you ↑are,
201   PAT:   (turnip/turn up)
202   HCP:   ↑do ↑you ↑want ↑to ↑↑try ↑some ↑mo::re?
203   PAT:   I just ↑'ave e::r, I just had (.) plenty again like
204          you (were)
205   HCP:   ↑what (0.4) what about ↑apple crumble and [custa:rd]
206   PAT:                                             [yea:::h ]
207          yeah that's it duck (.) ↑yea:h,
```

As with extracts 1-6 above, the HCP uses the patient's name with raised pitch as a summons to gain his attention (the patient is continually walking and looking around at his surroundings, and does not appear to attend to his uneaten food). She then is able to give him some beans to eat, and suggests he try some more with pitch increases on each word and an elongated o sound on 'more.' (line 202). The patient declines, suggesting he has had plenty, demonstrating that he has heard and understood her question. The HCP then switches to suggesting dessert, with a pitch increase on the word "apple," emphasis on the word "crumble," and a drawn out 'a,' sound in custard. The perhaps helps to clarify that she is offering something different to the existing meal and is responsive to the fact that he has said he has had plenty of the first course. The patient produces an agreement following this, and the patient subsequently ends up eating some dessert. This could be seen as a particularly positive result, as PLWD are known to have difficulties with eating and appetite, particularly whilst in hospital (Anantapong et al. 2023; Williams and Weatherhead, 2013).

Although the hospital ward environment always has some level of noise, the following extract is a good demonstration of communication occurring between a HCP and a patient alongside a particularly high level of background noise which the participants orient to (this includes a nearby patient who is shouting in distress). The HCP (a male mental health nurse) is conducting a memory assessment with the (male) patient, who is sitting in a bedside chair with a table in front of him.

```
Extract 11 (114_213)

289   HCP:   I’m ↑going to ↑read out a list of wo::rds now (0.8)
290          what I’d like you to do is say them back to ↑me so
291          that I know you’ve ↑hea:rd me oka:y (0.8) °okay° so
292          the ↑first ↑word is, (0.8)  [[distressed shouting
293          from another patient]] trai:n
294   PAT:   is? [[leans forwards]]
295   HCP:   we’ll try that again in a minute, [[gesturing pen
296          towards curtain in direction of distressed
297          shouting]] (1.6) so the ↑first ↑wo:rd is (.) trai::n
298          (2.0) [[slight nod from PAT]]
299   HCP:   °okay° (0.6) the second ↑one ↑i:s (0.4) egg, (1.8)
300          the next one is (0.4) ↑ha:t (1.2) the next on i:s
301          (0.6) chai:r, (0.6) and the ↑final one (.) is blue
302          (1.4) so can you say those ↑back to me (0.6) which
303          ones
304          (2.8)
305   PAT:   yea:::h ↑no:: (0.4) I ↑can’t ↑think
306   HCP:   okay so w- we’ll try again (0.6) >so it’s< ↑trai:n,
307   PAT:   trai:n,
308   HCP:   egg,
309   PAT:   ↑e:gg
310   HCP:   ↑hat
311   PAT:   ha::t
312   HCP:   chai:r,
313   PAT:   chai:r
314   HCP:   and blue
315   PAT:   blue
```

The HCP does a lot of work within this extract to ensure that the patient has heard the words that he is asked to memorise. Initially on line 290 he asks the patient to repeat the words back to him. His turn is interrupted by the other patient and he pauses for a moment before saying the word train. The patient then demonstrates that he is struggling to hear, by leaning towards the HCP and repeating the word "is," with a questioning intonation. The HCP acknowledges the difficulty hearing with the background noise, and then repeats the word train again, and following an acknowledgement from the patient, he gives the full list of words for the patient to remember. When the patient is unable to repeat any back to him, they then go through the list again, one at a time.

In terms of prosody, the HCP's talk is delivered relatively slowly, with lots of pauses throughout and some drawn out words. There are also pitch increases or intonation shifts and some emphasis on many of the key words in the HCP's talk, such as "heard," and the words to remember such as "egg." In fact, the only word to remember without a change in pitch is "blue" (although the first use on line 301 does have still have some emphasis and has a pause just before and after). "Train" (line 293) doesn't have an initial pitch change, (but is drawn out), but then gets one later after the patient has difficulty hearing (line 306). The fact that the HCP's talk follows this prosodic pattern in a situation in which talk is demonstratively difficult to hear is further evidence for HCPs using prosody systematically for emphasis to make their talk easier for patients to hear and comprehend.

Although so far in this analysis, prosody has been demonstrated to improve comprehension and understanding, it should be noted that this is not always the case. In the following situation, a female doctor has been assessing a female patient, who was sitting in her bedside chair. The curtain is drawn around and the patient appears to be confused regarding where she is. The doctor has asked her a number of questions around her mental and physical health and has completed a physical examination of the patient. During this interaction, there have already been some breakdowns of understanding between the patient and HCP. One of these is demonstrated in extract 8 in chapter 6 of this thesis in relation to praise. The present extract is towards the end of the interaction.

Extract 12 (109_207)

```
217   PAT:   is ↑this my 'ou::se?
218   HCP:   this isn't your ↑hou::se,
219   PAT:   well there you go::
220   HCP:   but you're very ↑welcome to have a walk around all
221          the sa:::me (3.6) shall we >↑go<?
222   PAT:   I don't know what to do
223   HCP:   I'll tell you >what I'm gonna do< I'll open the
224          curtains so th't you can see what's ↑happeni::ng
225          (0.4) .hh and we can go and sit at the table (0.6)
226          is ↑that all ri:ght?
227          (10.4)
228   HCP:   °there we go° (0.4) ↑can ↑you ↑have ↑a ↑seat ↑↑he:re?
229          (0.6) there's a bit more going ↑o::n
230          (2.0)
231   PAT:   there's another (?) man walking towards me
232   HCP:   that's okay he's been looking after ↑you::, (0.6)
233          (he's) been looking ↑after you
234   PAT:   he's got me (?)
235   HCP:   that's ↑↑only cos he's looking ↑after [you:]
236   PAT:                                         [no::] no duck
```

In this situation, the HCP does use a lot of pitch increases, emphasis on words and drawn out words. However, in this case, the patient does not appear to gain much beneficial understanding of the situation. She does go with the doctor to sit at a table in the middle of the ward, which is suggested with a lot of pitch rises on line 228. However, towards the end of the interaction, another HCP approaches, most likely to assist with the patient. The doctor repeats that the man is “looking after,” the patient but there are pitch increases on the “you,” and “after.” These are arguably not necessarily key words in the doctor's message. Furthermore, “after,” and “you,” could be misconstrued in a more threatening way, which is potentially why the patient replies with “he’s got me.” (line 234).

Although it is impossible to know the internal thoughts of the patient, this extract helps to demonstrate that the placement of pitch and other emphasis matters, and although exaggerated prosody is likely useful in many contexts in which clarity is needed, if the stress is placed on the wrong words, further disorientation may instead follow.

So far, this chapter has covered examples of prosody used to gain attention, and add additional emphasis to talk. The following section will cover some instances in which prosody is used to add an additional layer of meaning to a turn.

7.2.3 Adding Meaning

Aside from capturing attention or emphasising key words, prosody can bring meaning to conversation in many other ways. As Ogden (2006) noted, for any sentence, there is an *"infinite number of ways in which it can be phonetically realised*." (2006: 1772). I.e. it is not the words themselves that necessarily matter, often it is how they are delivered. For instance, prosody could be used to demonstrate alignment with another person. In the following situation, a female doctor arrives to greet a female patient.

Extract 13 (131_224)

1 HCP: good afternoo↑::n,
2 PAT: good afternoo↑::n
3 HCP: my name's michelle I'm one of the docto:rs
4 PAT: yes mi[chelle]

The HCP in this case initiates the greeting with a "good afternoon," with a pitch increase and elongated 'o' sound and a slight rise at the end of the word. The patient echoes the "good afternoon" with almost the same intonation. This mirroring demonstrates an alignment between the two parties. Reed et al., (2020) used CA to demonstrate how prosodic or sound mirroring in conversations is a way for conversation participants to display joint orientation to an interactional project, and support progression of the interaction. In the case of the extract above, both the HCP and the patient are orienting to the greeting sequence and progressing the interaction forward.

Equally, prosody could also demonstrate misalignment or disagreement. In the following situation, a female nurse (HL04) has been trying to convince a female patient (PL01) to have an injection to prevent blood clots. The patient has been objecting to the treatment. This interaction is also discussed in chapter 5 in relation to terms of endearment.

```
Extract 14 (PL01_HL04_PAN_180822)
17    PL01:   I feel like a pin cushion
18    HL04:   pin ↑cush↓ion ↑n↓o::?
19    PL01:   ↑y↓e:s?
20    HL04:   it’s just a l↑it↓tle amount ↓love
21    Pl01:   ↑it ↑hurts
22            (0.4)
23    Hl04:   ye:ah ↓it ↑i[s:. ]
```

In this case, the patient states that the injections are making her feel like a pin cushion. The HCP repeats the words “pin cushion” back to her with a disagreement (‘No’) drawn out with a pitch increase then decrease then a sharp rise at the end. Notably, the patient then disagrees on line 19 with her ‘yes’ using almost the exact same prosody as the HCP’s ‘no,’ (line 18). Unlike extract 13 above, where both participants use the same phrasing, in this case the use of the similar prosody on the opposing word (no – yes) underlines the disagreement between the two. Reed et al., (2020) in her analysis of mirroring included some examples of disagreements. In those cases, although there was disaffiliation between the stances that interactants took, conversational alignment (as defined by Stivers et al., 2011) was still achieved in the sense the trajectory of the conversation progressed (as opposed to being interrupted or abandoned, for example). This is also the case in extract 14 above, in the sense that the HCP and the patient continue their conversational projects (the HCP to persuade and the patient to disagree). Intersubjectivity is therefore achieved between the two parties in the sense that they both understand the topic of conversation, they just have differing viewpoints on it.

Following the mirrored turns, the HCP attempts another argument for having the injection (line 20), minimising the suggested imposition by claiming that it is just a little amount (with a mitigating ToE, discussed in chapter 5). This statement is in opposition to the patient's statement that she feels like a pin cushion, as this implies many injections (i.e. a large amount). The HCP's statement on line 20 has some pitch variation on the word "little," emphasising the minimisation, and further falling pitch on the word "love." In contrast the patient's next statement online 21 has rises in pitch, and emphasis on the 'u' sound in the word "hurts." Zellers and Ogden (2014) noted that contrasting turns often had matched prosody when interactional progressivity was prioritised, but they only found upgraded prosody on contrasting turns when the contrasting turns were not problematic. In this case, the patient's pitch increases could be considered an upgrade, but her assertion that "it hurts," (line 21) is clearly problematic both in a moral sense, as not only is the claim that something is painful difficult to argue against but also interactionally. The 0.4 second pause following this statement, demonstrates potential trouble with a reply. When she does reply, it is an agreement with the patient's point. One possible explanation for the patient's upgraded prosody on her disagreement is that the patient would not necessarily have reason to progress the interaction, since the HCPs agenda was to convince her to have the unwanted injection.

In the following situation, a female nurse had come to talk to a female patient who was in bed. The patient had very limited mobility, and shortly after this interaction she was recorded again when two HCPs attempted to help her out of bed with the aid of a rotunda. The patient was unable to get out of bed at that time, although it was discussed elsewhere in that interaction that she had been able to accomplish this at an earlier time that day. At this time, the nurse (HN59) is asking the patient why she is moving her legs around in the bed.

```
Extract 15 (PN11_HN59_PAN_220622_REC1)
21   HN59:   ↑what are you ↓wiggling ↓for,
22   PN11:   ↑toh get ↓off
23   HN59:   wh-why where are we ↑going?
24           (1.1)
25   PN11:   well I:’m getting ↑out I don’t know what y↓ou’↑re
26           doing
27   HN59:   ↑eh↓huh (0.9) wel- (0.3) wer- (.) if you’re going
28           out where you gonna ↓go: (.) where are we gonna
29           ↓go
30   PN11:   I don’t know just riding up the road °somewhere°
31           ((wiggles legs))
32   HN59:   ↑↑ri↓ding ↑up (0.6) on a ↑↑Bike? (0.4) or on a
33           ↓ca:r- [ >in a< car  ]
34   PN11:          [(we’ll go in)] that (0.4) car
```

The HCP asks her initial question with some pitch variation, increasing on the ‘what,’ decreasing on the ‘wiggling,’ and ‘for,’ before a slight increase again at the end of the turn, giving it a questioning sound. The patient immediately answers this question without any obvious trouble (line 22). This answer is perhaps slightly unexpected due to the patient’s lack of physical mobility, but the HCP treats this as a valid answer by asking a follow up question about where they are going, with a pitch increase and continuing rising intonation at the end of the word, making it clear that it is a question.

In this case, there is a pause of 1.1 seconds before the patient answers, indicating that she may have some trouble with responding to the HCP’s question. When she answers, she makes the trouble clear – she has taken issue with the collective “we,” used by the HCP, which she demonstrates by specifying that she will be the one getting out. This is a legitimate trouble to raise, since the patient is the only one in the bed, and she is treating getting out as an action that she would be doing alone. From the HCP’s perspective, she is potentially treating it as a shared activity due to her knowledge that the patient will need assistance to get out of bed.

The HCP demonstrates her awareness of the trouble that has occurred with a laugh and a couple of false starts before she asks another question about where the patient wants to go. The patient answers this with another unexpected answer (riding up the road). The HCP's response to this demonstrates her surprise as it contains large pitch changes and emphasis on what are arguably the most surprising words (riding and bike) and a pitch decrease and elongated 'a' sound on the perhaps slightly more feasible suggestion of a car. The patient answers this quickly, overlapping the HCPs self-correction with her answer that they will go in the car.

The prosody used within this extract does a number of things in terms of adding meaning to the utterances. As in many cases above, it includes some emphasis on key words, potentially aiding the clarity of the communication. In addition to this however, it also makes it clear that some turns are questions, some perhaps more overtly than others. The turn with the most questioning intonation was the one followed by trouble (line 23) although based on the patient's reaction, it seems likely that the trouble was occasioned by the wording of the question (specifically the word 'we'), rather the way in which it was delivered. The HCP's later prosody becomes further exaggerated (line 32), likely demonstrating her difficulty with the patient's utterances. It also shows that the patient has said something unexpected, but the patient does not observably object to this. This extract serves to demonstrate the complexity of this data, as it shows that (as if often the case), many things are going on a once during interaction.

7.3 Discussion

To summarise, this chapter has described the use of prosody within these data. In terms of research question one of this thesis (in what contexts is elderspeak used) prosody has been shown to serve a key role in greetings and gaining attention. It is also used to emphasise key words and messages from HCPs, and provide additional meaning to utterances for both HCPs and patients such as demonstrating alignment or disagreement, making a turn a question or showing surprise at an answer.

Regarding research question two (how is elderspeak received and responded to?), these functions of prosody are arguably beneficial in the hospital ward environment, a context which can be disorientating for PLWD in particular. It seems that using prosody to capture attention is likely to be useful in terms of engaging PLWD in the conversation and avoiding confusion regarding who HCPs are addressing. Using prosody to emphasise key words can also help to avoid confusion and likely distress, since it aids communication and therefore understanding of what is occurring at the time. PLWD within the current data have frequently demonstrated a lack of orientation to their environment and situation, so anything that aids with this is likely to be valuable. In addition, in terms of practicality, any aids to clarifying utterances from HCPs are likely to be beneficial in terms of completing tasks such as assessments efficiently and effectively in the busy and noisy environment. Nonetheless, as with other areas of analysis within this thesis, the use of specific aspects of prosody such as raised pitch or emphasis prosody are not a magic bullet that ensures all interactions are without trouble. It must be used sensitively, or it has the potential to cause further confusion (as in extract 12) or to disrupt interactional progressivity (extract 14).

In terms of whether activity type might affect receipt (research question 3), it is difficult on the basis of the evidence here to say for certain. Elderspeak-like prosody was found across all situations with all kinds of professionals (supporting Shaw et al's 2022 claim that approximately 97% of nurse-patient interactions involved elderspeak). It is likely something about the ward environment (or patient communication limitations) in particular that inspires this type of talk, as for example greeting someone alone in a quiet room extra loudly, with high pitch or otherwise emphasised prosody is likely to be less appropriate. This is supported by the clear demonstration in this analysis that prosodic emphasis appears in some cases to be prompted by background noise and demonstrations that patients are struggling to hear (e.g. extract 11). Therefore, in terms of HCP's choosing to use exaggerated prosody, an evaluation of the local interactional context is advisable. If for instance, a patient is noticeably having trouble hearing the HCPs talk, or is obviously disorientated (extract 12) or disengaged with the conversation (extract 6) then choosing to emphasise key words such as the reason for the HCP's presence (e.g. bringing medication), or the task they are trying to accomplish with the patient (e.g. drinking water) may be one useful option in the array of conversational tools at their disposal.

As discussed in the introduction to this chapter, Kemper and Harden, (1999) refer to elderspeak as a "*special speech register*," (1999: 656). It therefore could be considered whether certain prosodic features in these data are indexical of a specific elderspeak register of talk. There are, for example, features of talk that could be considered exaggerated, or may not appear so frequently in other contexts, such as the multiple rises in pitch that occur consecutively in many of these extracts. These features clearly fall within what has previously been described as the elderspeak 'umbrella' (in which exaggerated intonation and high-pitched talk both appear) (Shaw and Gordon, 2021)). They therefore could be presented as a register for how elderspeak type talk may appear in CA transcription. However, as Schegloff (1997: 505-506) states *"... practices, deployed always in some position, can accomplish different actions; and actions can be accomplished through a variety of situated practices*." Likewise, Walker (2014: 24) notes when discussing phonetic design, "*it is basically incorrect to say that rising pitch means anything. Rising pitch is only rising pitch. It becomes involved in meaning when it occurs at a particular place…"*. Finally, Ogden asserts "*The communicative function of many phonetic parameters, perhaps most notably intonation, has remained elusive."* (2006: 1752).

Therefore, although it is possible to identify specific interactional functions occurring within these data, and therefore make claims about what elderspeak style talk is doing in this circumstance, it is impossible to say that *all* talk designed in this way is elderspeak. The focus of the present analysis has been to identify actions that are being performed and consider whether these are context specific.

It is possible that talk characterised by multiple pitch rises and stresses (as in these data) may occur elsewhere for other reasons, for example gaining attention from people who do not have dementia, or expressing excitement.

Additionally, even if this style of talk is considered representative of elderspeak in this situation, it may not apply to other environments in which there is less background noise and/or distractions, given that this analysis has identified that a key function of this talk is to emphasise meaning or key messages. This is an area of potential future investigation, where fruitful comparisons could be made with interactions with PLWD in other settings.

It is also possible that the pitch rises in this talk could carry additional meaning other than has been covered here. For instance, as mentioned above McHenry et al., (2012) found that people were able to differentiate between bad and neutral news purely from the prosody used in the messages. In that case, the bad news condition typically had lower pitch and slower speech, which was interpreted as a more caring and sympathetic tone. Its therefore possible that the reverse is true – for example higher prosody may indicate good news, or at least an absence of bad. If this was the case, it would align well with the findings of this analysis, particularly with regards to the greetings used here. Sounding friendly or well-meaning on arrival to do a task with a patient may aid the progressivity of the interaction regardless of whether the specific message is understood immediately. Nonetheless, it is outside the scope of this analysis to measure the internal state of patients. Hence, we cannot know for certain from this data whether a patient has classified the HCP's prosody or tone as conveying good or bad news or sounding caring (or any other emotion related state) if they do not react explicitly to it during the interaction. This is one limitation of CA methodology, and is why this analysis has focused on actions that can be demonstrated from the recorded talk.

An issue worth further exploration, is whether these findings might apply to patients who struggle to hear or comprehend for other reasons (e.g. hearing loss, disability etc), as these groups will also likely struggle with a busy and noisy ward environment. Many of the patients within the current analysis did demonstrate difficulties with hearing, although these were not formally recorded which is a limitation. It is therefore unknown to exactly what extent the PLWD in this data experienced conversational trouble due to hearing loss separately to conversational trouble that arose relating to difficulties associated with dementia. Nonetheless, as research shows that hearing loss is extremely common in this setting (Roth et al. 2011; Smith et al. 2020)) it is likely that HCPs in this setting regularly need to communicate with individuals with both (and other) conditions. As conversational trouble is common in this population, the fact that these findings indicate that prosodic emphasis can improve communication in this group is arguably valuable, regardless of the underlying cause of the difficulty.

To conclude, this chapter has explored HCPs use of prosody towards PLWD in the acute hospital. Prosody has been used systematically to draw attention to HCPs and their intentions, convey key messages in talk, and add additional layers of meaning to turns. The following chapter will provide some discussion on the findings of the thesis as a whole.

Chapter 8: Thesis Discussion

8.1 Introduction

Overall, this thesis has utilised conversation analysis to empirically investigate the use of elderspeak in hospital dementia care. Elderspeak is defined by Shaw and Gordon as: "*a simplified speech register used with older adults which sounds like baby talk. It is characterized by a variety of linguistic adjustments in rhythm, sound, sentence structure, and meaning, such as a high-pitched and over nurturing voice, use of inappropriate terms of endearment (e.g., sweetie), and collective pronoun substitution (e.g., we instead of you).*" (2021: 2). The following questions have been answered: 1) In what contexts is elderspeak used in the care of people living with dementia (PLWD), and by whom? 2) How is elderspeak received and responded to by PLWD? 3) What is the impact of local interactional context on receipt or rejection of elderspeak by PLWD? Does activity type affect receipt?

The three analysis chapters have revealed that the picture with regards to elderspeak is more complex than previous literature would suggest. Each of the three elements of elderspeak examined in detail showed multiple possible interactional functions which could aid patient care, but the analysis also demonstrated some situations in which negative consequences can occur. This suggests the benefits of elderspeak style talk are context dependent and it should not be used in every situation. This chapter will consider these findings in relation to the thesis as a whole, in relation both to the prior literature, and the analysis conducted during this project. It will also consider how this thesis has made a unique contribution to knowledge, strengths and limitations and future directions for research.

8.2 In what Contexts is Elderspeak Used in the Care of People Living With Dementia (PLWD), and by Whom?

The literature review in chapter 2 concluded that elderspeak in general is used widely in the care of PLWD, particularly during assistance with activities of daily living. This was based on evidence predominantly collected from long-term care facilities, but also included some research conducted within experimental settings, home environments, and three papers on hospital settings (Schnabel et al., 2020a; Schnabel et al., 2020b; Shaw et al., 2022). From the literature review, I also concluded that the use of elderspeak is prompted by features of the individual it is directed towards, rather than the setting, given that it occurs across local contexts. These features may be those related to cognitive impairment and/or more general old-age cues (e.g. Cavallaro et al. 2016; Kemper et al. 1998; Schnabel et al. 2020; Hummert and Shaner, 1994).

The analysis presented in this thesis has supported these conclusions. PLWD were recorded interacting with different kinds of HCP, including doctors, nurses, healthcare assistants (HCAs) and occupational therapists, speech and language therapists and physiotherapists. Multiple different activity types were recorded including medical and therapy assessments, healthcare tasks and personal care activities (such as supporting patients to eat or drink, shaving patients and helping them to change their clothes). The fact that elderspeak was found across all of these activities and was used by all types of staff demonstrates that elderspeak is commonly used within the present context (the acute hospital).

When features of elderspeak were analysed in detail, more specific aspects of context were identified. Terms of endearment (ToE) were found to be used in conversation openings and closings, and also systematically to mitigate potentially face threatening contexts such as when a patient is asked to repeat something that is hard to interpret, when they are asked to do a necessary but unwanted task or when they are expressing unease or discomfort (such as during personal care by HCPs). Praise was used in contexts where there is some sort of imposition on the patient, including: during question-and-answer sequences; when a task was completed by a PLWD; and during ongoing activities which had the potential to cause discomfort (including those done with patients, and those done to patients). In these situations, it served to aid orientation and also served agency and face preserving functions. Finally, prosody (variable pitch, amplitude, word duration and other emphasis) was used to gain attention of patients and to emphasise key words in HCPs' messages, aiding patient understanding. It was also used by both HCPs and patients to add additional meaning to utterances, such as to demonstrate or emphasise a disagreement and to demonstrate surprise or questioning.

8.3 How is Elderspeak Received and Responded to by PLWD?

The literature review in chapter 2 concluded that PLWD have the potential to receive and respond to elderspeak in varied ways. Reactions ranged from very positive to very negative, depending on individual situation, context and how the PLWD positioned themselves within the conversation.

A common finding identified in previous research was that elderspeak was linked to resistance to care (RTC) in PLWD (e.g., Backhouse et al., 2020; Christenson et al., 2011; Cunningham and Williams, 2007; Herman and Wiliams, 2009; Williams et al, 2017). Much of this evidence came from observations in care home environments. There is also evidence to suggest that elderspeak led to PLWD being placed in a passive role, resulting in issues such as lower self-esteem, increased-dependence, feelings of incompetence, frustration, agitation or depression and potential aggression (e.g., Bugental and Hehman, 2007; McLaughlin, 2020; Salari, 2005). Some research also suggested that in some cases elderspeak may hamper or impede communication with PLWD (Williams, 2016; Small et al., 2009).

Within the present data, there were cases where aspects of elderspeak were objected to, some more specifically than others. For instance, in relation to terms of endearment, one patient clearly took issue with the use of the word "sweetheart," (shown in chapter 5, extract 14). Likewise, a patient's use of prosody (discussed in chapter 7, extract 14) demonstrated her rejection of a HCP's statement. In other cases, elderspeak use occurred alongside or prior to disorientation or other confusion such as agitation, such as when a patient was praised for walking around (chapter 6, extract 8). These examples demonstrate that in some cases, elderspeak is related to conversational trouble or breakdown of shared understanding if not used sensitively. Although it is impossible to comment on how participants were feeling internally, negative feelings were physically and verbally demonstrated by PLWD, particularly in the VOICE2 data, since this was specifically aimed at recording PLWD who were prone to distress. This distress took various forms, including shouting/crying out and verbal and physical resistance to care.

In most cases, distress was present prior to or separately from elderspeak occurring. Therefore, it is unclear to exactly what extent (if any) elderspeak contributed to distress level. This was particularly the case where the patient was undergoing an unpleasant but necessary task (such as personal care, or having a cannula inserted) as this often appeared to be at least a significant source of their distress, rather than the specific talk used. In these cases, it is likely that elderspeak from HCPs was a reaction to the patient's negative emotion or other distress, rather than the origin. This assumption is supported by the prior literature that suggests that elderspeak is triggered by cues that signal some kind of vulnerability (e.g. Cavallaro et al. 2016; Kemper et al. 1998; Schnabel et al. 2020; Hummert and Shaner, 1994). It is also supported by the fact that in most cases, elderspeak was not obviously rejected in these data and this analysis has identified numerous useful functions of elderspeak (summarised in section 8.2 above). If a healthcare situation is more challenging because a patient is in distress or is resisting care for other reasons, it follows that HCPs would use whatever communicative tools they have at their disposal in an attempt to aid the situation. In some cases, these tools may be aspects of elderspeak.

Aside from being used in more challenging situations, elderspeak was also used in more positive interactions. For instance, when a task had been completed successfully, PLWD were not only praised in a congratulatory way but also themselves acknowledged or produced agreements with the praise.

Additionally, ToE or prosodic features were used reciprocatively, demonstrating an acceptance of this communication style from some PLWD. The idea that elderspeak elicits positive reactions is supported by a small amount of prior literature (Sachweh, 1998; Jansson; 2016; Marsden and Holmes, 2014). Marsen and Holmes (2014) in particular noted that endearments and other features of elderspeak may be related to the building of good, warm relationships between caregivers and care home residents, and Sachweh (1998) noted that elderspeak was mostly accepted or even liked by nursing home residents, which would be in line with the present findings.

To summarise, with regards to how elderspeak is received and responded to, in most cases in this setting PLWD do not object to this type of talk, and use some aspects of it reciprocally. In many cases, elderspeak improves the reactions of PLWD to distressing, difficult or unpleasant situations through various means. These include: mitigating potentially unwanted but necessary actions of HCPs; providing encouragement (praise) during confusing or difficult tasks; protecting face and sense of agency; and avoiding misunderstandings through gaining attention and emphasising key messages. Occasionally, elderspeak is objected to or leads to conversational trouble.

8.4 What is the Impact of Local Interactional Context on Receipt or Rejection of Elderspeak by PLWD? Does Activity Type (e.g., Medical History Taking vs Assisting Someone With Eating) Affect Receipt?

Evidence gathered in the literature review in chapter 2 was limited in relation to answering this question. There was some suggestion that the PLWD's reaction is related to the level of familiarity they share with the carer, or the level of institutionalisation of the situation they are in (e.g. a long-term care home vs a day centre). There was also some evidence to suggest that elderspeak is directed more towards females (Cavallaro et al., 2016; Sachweh 1998), but in the papers that noted this (particularly Sachweh 1998) the majority of PLWD included were female which limits the sex comparisons that can be drawn.

Within the present data, elderspeak style talk was used towards both males and females (and used by males and females). It was used across different time periods (VOICE and VOICE2), hospital wards, and the two different hospital sites. One interpretation of this, is that elderspeak used in the ways identified in this thesis is not just a localised cultural concept, but is likely a wider interactional one.

With regards to activity type, a wide variety of different activities were recorded in the current data. These included medical consultations, healthcare assessments (physical and verbal), healthcare tasks (such as injections and wound cleaning/care), and assisting with food and drink and personal care of patients. Elderspeak occurred across all of these, and no obvious pattern was observed in relation to specific activity type. More salient factors were the underlying distress level of the patient, and the extent to which they refused, objected to or expressed displeasure with the activity at hand. It is likely that the more invasive or unwelcome PLWD considered a procedure, the more they were likely to object and take issue with any language the HCPs used. Examples of this include the female patient being changed in chapter 5 extract 10, the patient attempting to refuse an injection in chapter 5 extract 15 and the female patient having a cannula inserted in chapter 6 extract 13. All of these patients used language such as “get off,” or made statements that they did not want the care/treatment, demonstrating that they were treating the actions of the HCPs as inappropriate or unwanted. In these cases, even if elderspeak is being used with the aim of improving the situation, it is not enough to account for the imposition on patients’ sense of agency. Nonetheless, it is difficult to ascertain for certain whether these kinds of situations make the patient more likely to reject elderspeak talk specifically, or if in these contexts they would object to all interactions from HCPs more widely.

8.5 Unique Contribution to Knowledge

This section will outline how this thesis makes a new and important contribution to knowledge, first in the specific area of hospital dementia care, and then more widely. Up until this point, very little research had examined elderspeak in real life interaction and even less had looked at its use specifically in a hospital environment. Schnabel et al., (2020a) examined the emotional tone used by nurses towards older adults with and without cognitive impairment in general and geriatric German hospital settings. They used mixed methods involving audio recordings of interactions and interviews. The interviews were used to gather background and demographic information about the patients and nurses. The emotional tone used by nurses in the recordings was rated by 12 naïve individuals with a mean age of approximately 33 years. The rating was said to indicate that the tone was either person-centred or controlling. Person centred rating items included: nurturing, affirming, respectful, supportive, polite, caring and warm. Controlling items were: patronizing, bossy, dominating and controlling. Raters could choose options from 1 (not at all) to 5 (very) (pg.

374). Overall, nurses were found to use more person-centred tones in both hospital settings but were more controlling towards patients with cognitive impairment in the geriatric hospital, although this difference was not significant when functional status was controlled for. These findings were explained in terms of negative old-age stereotypes inspiring more controlling language in patients who were identified as "*vulnerable older patients with a lower functional status.*" (2020a: 379).

Schnabel et al., (2020a)'s research bears some similarity to the present research. As well as being based in a hospital context, it looks at interactions between HCP's (nurses) and patients. The communication they examined was not exclusively elderspeak, but they did identify what they considered controlling or patronising communication as sitting within the elderspeak remit. They also referred to elderspeak in relation to the underlying old age stereotypes motivating the controlling talk. The present research does not support these definitions/classifications, since features of elderspeak have been shown to serve functions which could be considered person centred (Kitwood 1997, Brooker 2007) such as respecting patient autonomy and saving face. The notion of control has also been discussed, particularly in chapter 6, in which it was determined that whilst some talk may involve an element of control, overall interactions seemed to be based more on co-operation between HCPs and patients to complete necessary care. Therefore, the notion that talk can be either elderspeak and controlling or person centred is not supported here.

Furthermore, the notion that elderspeak style talk is only inspired by old age stereotypes is disputable. The present research only included older patients (over 65) with a diagnosis of dementia, so comparisons to talk directed at different patient groups is impossible. These results confirm that elderspeak is used towards this particular participant group. Nonetheless, the fact that all elements of elderspeak analysed were demonstrated to serve particular conversational functions shows that elderspeak is also used for reasons other than because an individual is perceived as stereotypically ‘old’ or ‘vulnerable’. An explanation for these findings may be Shaw and Gordon’s (2021) noticing that it is ambiguous as to whether overaccommodating speech (elderspeak) is viewed as helpful and caring, or patronising (and controlling). This judgement could potentially depend on the situation and context of the individual judging. HCPs for instance, might view an action as caring or helping to get an important healthcare objective accomplished, whereas a patient may not be aware of the need for the objective and an observer may find it difficult to separate their own judgement from that which a PLWD would make, and so would find the talk inappropriate. In the case of Schnabel et al., (2020a), the people rating the speech were all relatively young and were not in the position of patient themselves. The present research examined the interaction as it actually unfolded, in much greater detail, and has analytically described the actions and reactions of both patients and HCPs by examining how they each treat the talk, rather than attributing subjective values to an interaction from an outside source without specific interaction-based evidence. Therefore, the fact that additional functions of and responses to the talk have been uncovered is not surprising and sheds new light on the area.

Schnabel et al., (2020b) used a very similar setting and methods to Schnabel et al., (2020a), however in the later study rather than observers rating the interaction, talk was transcribed and then coded for specific features of elderspeak. These were separated into likely harmful features (tag questions, diminutives and collective pronouns) and 'hybrid' features (sentence fragments (length of utterance), complex grammatical units, type-token ratio (number of different word forms related to the total number of words) and speech rate) (2020b: 5). These features were examined statistically for relationships with proximal contextual variables (e.g. patients' cognitive group and functional status) and distal contextual variables (e.g. acute hospital setting, psychogeriatric knowledge, and evaluative age stereotypes). They concluded that elderspeak was likely inspired by lower functional status of patients. It was suggested that more research is needed to separate which elements of elderspeak are beneficial or harmful, but the appropriateness of elderspeak depends on many factors. These included level of familiarity, degree of simplification and the specific combination of linguistic features used. For instance, if a patient had a good/close relationship with a HCP, then they may wish to be addressed with a more familiar term and this may be considered more person centred in that case.

This conclusion fits better with the findings of the current study, in that it acknowledges the complex picture behind elderspeak as a whole, and considers that different features and different contextual factors may produce varying results (which may be positive or negative). However, analysis of the present data has shown that reactions to elderspeak are about the specific circumstances of the interaction itself, rather than the type of elderspeak used. It is therefore unlikely that certain features of elderspeak can be classified exclusively as harmful, whilst others are not. Rather, each feature may be responded to in a positive, neutral or negative way according to context.

Shaw et al. (2022) also conducted research focused on communication from nurses, this time in the USA and focused specifically on PLWD. The nurse talk study used an observational design to describe attributes of elderspeak used in that setting, and determine characteristics associated with the use of elderspeak communication by nursing staff (pg. 1). Audio recordings were coded for elderspeak to determine frequency and characteristics. It was found that more than a quarter of all speech from nurses towards PLWD could be classed as elderspeak, and most (97%) of care interactions included elderspeak, most commonly minimising words and mitigations, childish terms, collectives, laughing at, diminutives (including ToE) and praise. Additionally, they found that elderspeak was used more by older nurses, but equally for all ages of nursing assistants, and more when interacting with patients with delirium and those who were hospitalised longer. The gender of nursing staff, their confidence level and knowledge of dementia, comorbidities and the type of dementia experienced by patients were not associated with frequency of elderspeak. This recent research is likely the closest in existence to the current project, in terms of subject area and context. It holds value in demonstrating the extremely high presence of elderspeak on acute hospital wards with PLWD, which in turn shows the importance and wide relevance of the research conducted for this thesis. In addition, the findings are notable in relation to the argument of whether elderspeak is inspired by old age cues and stereotypes. The finding that it was more prevalent with increased delirium and longer hospital stay would support this concept, but the finding that patient comorbidity was not related does not. It is possible that there is more nuance to this situation than it appears, and, in support of the claims in the paragraph above, other contextual and interactional factors play a bigger part in the use of elderspeak than originally considered.

The present research did not focus in detail on numerical frequences of elderspeak within these data, as once it was established that elderspeak was routinely present within these interactions, as expected with reference to the prior literature, the main focus was on answering the questions listed at the outset of this chapter. The main contribution of this thesis therefore, is that it uniquely identifies new circumstances in which elderspeak is used in the care of PLWD, the functions that it serves in these contexts, and the ways in which PLWD respond, in actual interactions within the acute hospital. These findings can be used to underpin future healthcare research, policy, practice and training as they provide empirical evidence of useful functions of elderspeak style talk which (if used sensitively) can have demonstratable benefits on interactions. They also identify areas in which there is potential for patient misunderstanding, dissatisfaction or distress, allowing for future investigation and caution. Overall, this will contribute to a better patient experience in future, along with more effective healthcare for PLWD.

The contribution of this thesis also extends more widely. The knowledge gained here will contribute to the existing literature on communication with PLWD, and on key issues for the study of social interaction. The PLWD within these data have exhibited interactional competence on many levels when responding to elderspeak style talk. For instance, in chapter 6, extract 5, a female patient demonstrated her ability to respond to praise with a typical downgraded agreement (Pomerantz (1978), and in chapter 7, extract 15, a patient identifies the inappropriate use of a collective (we) that she objects to. On multiple occasions, patients in the data have demonstrated an ability to align conversationally with HCPs, responding in kind to ToE, and matching HCP prosody to give turns additional meaning. Furthermore, this research has demonstrated that shared understanding and intersubjectivity can be achieved in interactions with PLWD, despite many of them displaying complex communication difficulties. This is evidenced by the many examples of healthcare tasks being successfully completed with patients and HCPs working collaboratively together. This is of note in relation to the field of epistemics (Heritage, 2012) and may contribute towards the understanding of how asymmetrical knowledge can be managed in interactions (See Stivers et al., 2011), since in many cases, HCPs within these data displayed a different knowledge of the situation to patients. This applies both to successful situations (in which healthcare goals were achieved) and/or patients cooperated with HCPs and situations where misunderstanding or trouble occurs. Consider for instance the patient who was unaware of her broken arm (chapter 6 extract 11), or the two different patients mentioned in chapter 5, who did not agree that they needed medical treatment (a cannula, and an injection to treat/prevent a blood clot, respectively). Cases such as this contribute towards the understanding of situations in which there is a breakdown of shared understanding. They also serve to demonstrate how incredibly skilled the interactional work that HCPs do is in this context (Pilnick et al., 2021).

This work has drawn on older sociological roots to enrich the meaning of this data, indicating its contribution to the development of sociology as a discipline. The work of Goffman has been influential, both in relation to his consideration of institutional environments (1961) and their difference to other contexts, and his work on face (1955) and interactional order (1983). The use of conversation analysis as a method has allowed an unpacking of some of the interactional specifics of person-centred care as conceptualised by Kitwood (1997) and developed by Brooker (2007), and the ways in which they are operationalised in this data.

8.6 Strengths

One key strength of this research is its use of video data collected directly from hospital wards. The literature review identified the lack of research that examines real life interaction in this setting (as opposed to hypothetical examples). However, the rarity of the use of video itself should be acknowledged. The three prior research studies discussed above which examined elderspeak in a hospital setting with PLWD and/or cognitive impairment all used audio data only. The use of video is widespread in CA research, but due to the challenges of recording in a hospital environment, in healthcare contexts the focus has been on primary care or hospital outpatient clinics (not the acute hospital ward) (See Barnes and Woods, 2024; Barnes 2019; Stevenson et al. 2021; Toerien, 2021). This method was utilised for the VOICE research project (O'Brien et al., 2018) and has now been successfully used again for VOICE2, providing a rich collection of data that was used for this analysis. Video data has a number of benefits for CA, including the greater level of detail it provides, and the ability to examine embodied actions of participants. The fact that the interactional setting can be viewed and reviewed can lend more information about the setting and context than may otherwise be known.

Another strength of this research is the diversity of HCPs recruited. These included many professions, such as doctors, nurses, HCAs, occupational therapists, physiotherapists, speech and language therapists and others. The three existing studies identified that focused on hospital environments and PLWD/cognitive impairment recruited nurses only (Shaw et al., 2022; Schnabel et al., 2020a and Schnabel et al., 2020b), so the inclusion of multiple types of HCP is novel for the study of elderspeak and dementia care. This has numerous advantages, notably that PLWD will experience many of these different HCPs whilst staying in hospital, so to only examine nurses would exclude a huge proportion of interactions, and so neglect a substantial part of their healthcare experience. The inclusion of multiple professionals has also allowed a greater range of activities and situations to be captured, which will have improved the generalisability and the scope of the analysis.

Thirdly, the rigor of the methods used in this thesis is a strength. As mentioned in chapter 4, CA typically involves data sessions, in which data is shared with other researchers who provide critical thoughts and feedback on analysis which helps to develop shared understanding (for full description of the data session process, see ten Have, 2007:138-139). This improves the quality of data analysis, as by sharing analysis with a group, personal biases can be questioned and removed, and the data can be inspected more deeply. Furthermore, VOICE and VOICE2 received regular feedback from a patient and public involvement

(PPI) group. Research has demonstrated multiple benefits from PPI involvement in research, including the identification of issues the researchers may not have been aware of, and making the findings of the research more applicable and understandable to the public it involves (Arumugam et al., 2023).

8.7 Limitations and Future Directions

Shaw and Gordon (2021) noted that there is no clear cut off point in the spectrum of elderspeak style speech accommodation between what can be regarded as helpful, and what is considered patronising. A well-established limitation of CA is that it does not have the capacity to examine the internal state of participants. although arguably any method can never directly access the reality of someone's mind. Even in the case of questionnaires and interviews which ask about experiences, they can only access a snapshot representation of that state, which may be subject to desirability bias and other recall errors (e.g. Latkin et al, 2017; Schmier and Halpern, 2004). As already established elsewhere (see chapter 4), these methods would be particularly implausible for PLWD who, as the present data has shown, are likely to have some degree of disorientation and may lack access to memory of the events in question. Although CA cannot access internal states, it can still examine how each turn of an interaction is treated by its participants and how this in turn influences the interaction as a whole (Heritage, 1984: 300-314). Since conversation is talked into being (Heritage and Atkinson, 1984) and this moment to moment construction can be objectively examined to identify the consequences of a given action, CA is the best method that could have been chosen for this specific research project, despite its limitations. Arguably, it is the actual (in the moment) outcomes of interactions that are important, rather than what individuals believe they might do under hypothetical conditions or what they (perhaps inaccurately) recall from past situations. This is particularly true in the current environment in which the outcome of interactions can in turn have a significant impact on patient experience and health outcomes. Therefore, the power of this analysis is that rather than focusing on whether or not elderspeak is considered a priori patronising or helpful, it has demonstrated whether elderspeak was treated as being patronising by PLWD (which it was not in most cases). It also showed how certain features served a demonstratively functional purpose in interactions (examples being ToE used to mitigate, praise used to encourage, or prosody used to draw attention to key words, for instance).

Another limitation is that an in-depth examination of every single potential feature of elderspeak has been outside of the scope of this PhD. This is something that could continue to be explored in future research. The analysis covered a broad scope of different elderspeak categories as described in the literature (Shaw and Gordon, 2021; Ryan et al.,1995), such as forms of address (ToE), topic management (praise) and vocabulary, grammar and voice (prosody). Additionally, other features were also considered when they became relevant to the analysis of the main features of focus, since typically in naturally occurring interaction things do not happen in isolation. For instance, in the case of ToE, when being used to mitigate they were often used in conjunction with a lot of other minimising language, or in situations when a HCP was trying to gain the attention of a patient and using prosody for emphasis, body positioning, movements and eye contact were also considered. It therefore stands that claims about elderspeak as a phenomenon can be confidently made from this analysis. Nonetheless, there is scope to further examine features that have not been studied in detail here. One good example would be the use of collectives (such as “we,”) in this data. Whilst this has been touched on at some points there is evidence that this is a common feature of elderspeak (Shaw and Gordon, 2021; Ryan et al., 1995) in general, and it is therefore possible that there may be additional functions not yet identified. In addition, this thesis has not focused on embodied action in a great deal of detail, although the data set is now being examined for use of touch elsewhere.

In the VOICE1 data, all patients involved were identified as White-British. In addition, while the information available from the VOICE2 data set does demonstrate a level of diversity in the HCPs involved, all patients were also identified as White-British and spoke English as their primary language aside from one patient who identified as Polish and did not speak English as their primary language. Whilst this is a limitation in terms of fully representing the diversity of PLWD across the UK population, it is a reasonable representation of PLWD in this acute hospital setting. Due to the unintentional lack of diversity in the VOICE 1 study, during participant recruitment for VOICE 2, significant efforts were made to improve the diversity of the patient sample. This included the employment of a Matron for Community Engagement, Innovation and Inclusion on the VOICE2 team as a co-applicant, with a specific role in inclusive recruitment. However, despite specific efforts to recruit a more diverse group of PLWD, it was not ultimately possible. This was because of a lack of presence on the wards at the time of recruitment.

This lack of diversity is not unusual in terms of PLWD admitted to the acute wards studied for this project, despite the fact that the two hospital sites were based in cities with populations of considerable ethnic diversity. This may be due to a number of factors including the recognised inequality of diagnosis for people from ethnic minority groups (Arblaster, 2021; Mukadam et al. 2013) and the potential additional challenges PLWD from ethnic minority groups face when accessing healthcare services (Alzheimer Europe, 2018). The sample of PLWD who were recruited are therefore representative of the population of PLWD with a formal diagnosis who are present in the acute hospital.

As mentioned above, a diverse group of HCPs were recruited to the study; this diversity is roughly in line with the nationwide diversity statistics on staff published by NHS digital (Gov.UK, 2020). Taken together, the sample of participants suggests that the overall analysis is representative of and applicable to current acute hospital situations. Future research could focus on other care environments which are likely to have a different level of diversity, such as care homes or in-home care. However, it is important to recognise that interactions taking place in those settings may be very different, given the likelihood of longer-term relationships by carers and the fact that such environments may be primarily centred around meeting social as well as medical need.

8.8 Conclusion

To conclude, this thesis has shown that in the care of PLWD in the acute hospital environment, elderspeak is not always inappropriate. In fact, in many cases it serves useful functions, aiding with healthcare delivery and improving the experience of PLWD whilst in hospital. Nonetheless, since there is also a potential for this talk to cause interactional trouble or confusion, elderspeak should be used in this environment with caution and sensitivity to specific circumstance. Furthermore, this thesis has demonstrated the value of using CA to examine actual interactions in this context.

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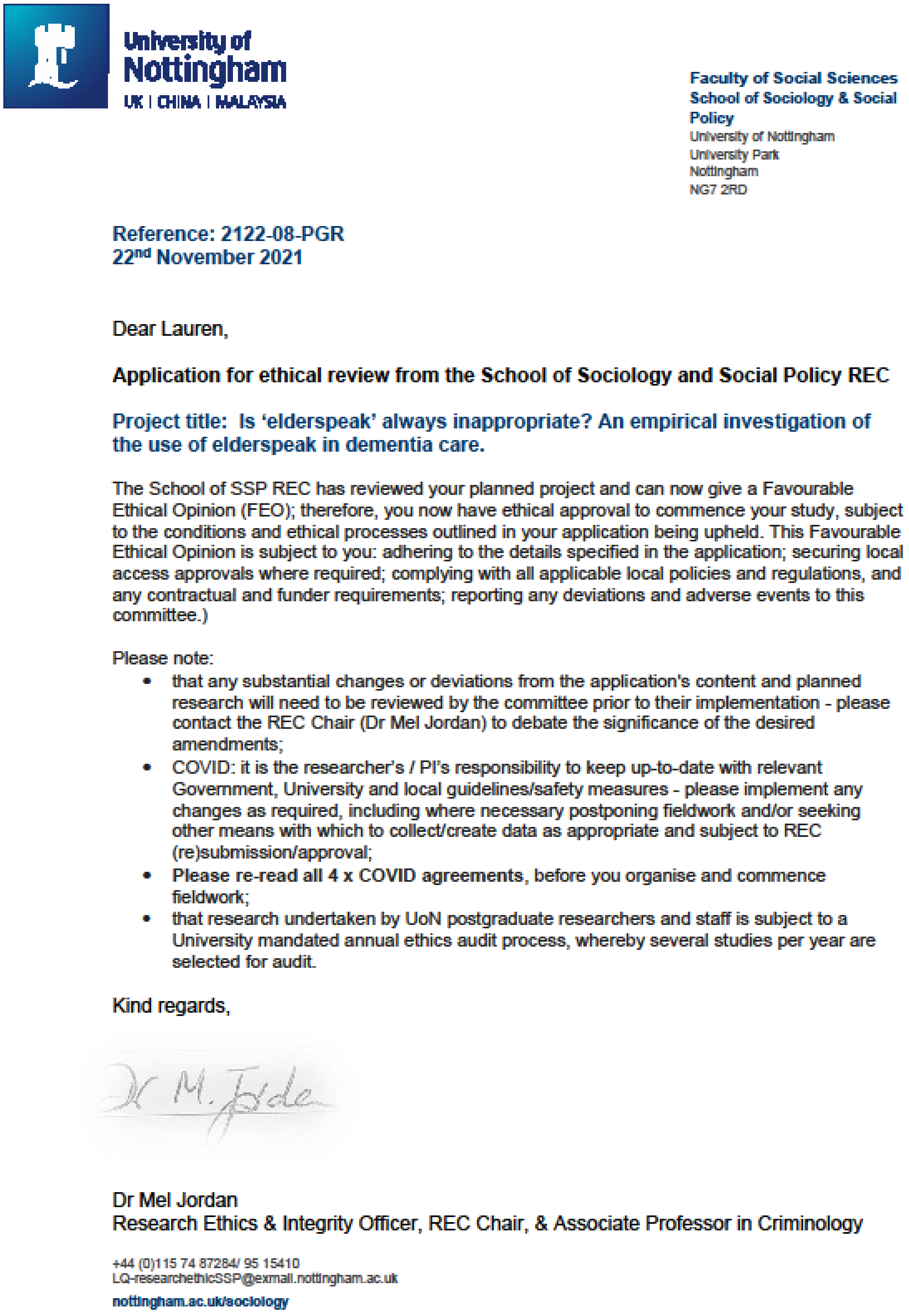
Appendix 1 University Ethics Acceptance Letter Stage 1



University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Social Sciences
School of Sociology & Social Policy
University of Nottingham
University Park
Nottingham
NG7 2RD

Reference: 2122-08-PGR
22nd November 2021

Dear Lauren,

Application for ethical review from the School of Sociology and Social Policy REC

Project title: Is 'elderspeak' always inappropriate? An empirical investigation of the use of elderspeak in dementia care.

The School of SSP REC has reviewed your planned project and can now give a Favourable Ethical Opinion (FEO); therefore, you now have ethical approval to commence your study, subject to the conditions and ethical processes outlined in your application being upheld. This Favourable Ethical Opinion is subject to you: adhering to the details specified in the application; securing local access approvals where required; complying with all applicable local policies and regulations, and any contractual and funder requirements; reporting any deviations and adverse events to this committee.)

Please note:

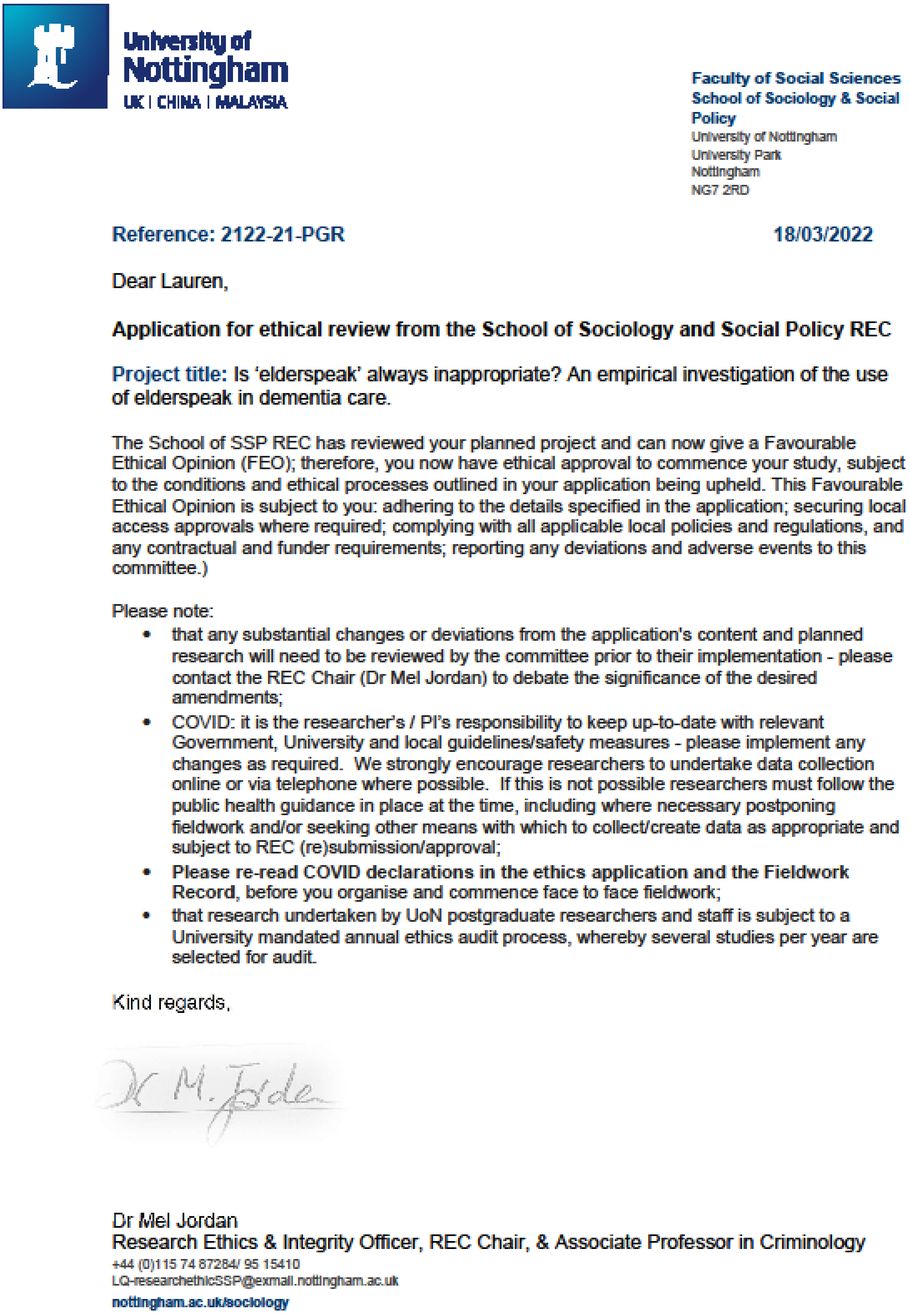
- that any substantial changes or deviations from the application's content and planned research will need to be reviewed by the committee prior to their implementation - please contact the REC Chair (Dr Mel Jordan) to debate the significance of the desired amendments;
- COVID: it is the researcher's / PI's responsibility to keep up-to-date with relevant Government, University and local guidelines/safety measures - please implement any changes as required, including where necessary postponing fieldwork and/or seeking other means with which to collect/create data as appropriate and subject to REC (re)submission/approval;
- Please re-read all 4 x COVID agreements, before you organise and commence fieldwork;
- that research undertaken by UoN postgraduate researchers and staff is subject to a University mandated annual ethics audit process, whereby several studies per year are selected for audit.

Kind regards,

Dr Mel Jordan
Research Ethics & Integrity Officer, REC Chair, & Associate Professor in Criminology

+44 (0)115 74 87284/ 95 15410
LQ-researchethicSSP@exmail.nottingham.ac.uk
nottingham.ac.uk/sociology

Appendix 2: University Ethics Acceptance Letter Stage 2



University of
Nottingham
UK | CHINA | MALAYSIA

Faculty of Social Sciences
School of Sociology & Social Policy
University of Nottingham
University Park
Nottingham
NG7 2RD

Reference: 2122-21-PGR **18/03/2022**

Dear Lauren,

Application for ethical review from the School of Sociology and Social Policy REC

Project title: Is 'elderspeak' always inappropriate? An empirical investigation of the use of elderspeak in dementia care.

The School of SSP REC has reviewed your planned project and can now give a Favourable Ethical Opinion (FEO); therefore, you now have ethical approval to commence your study, subject to the conditions and ethical processes outlined in your application being upheld. This Favourable Ethical Opinion is subject to you: adhering to the details specified in the application; securing local access approvals where required; complying with all applicable local policies and regulations, and any contractual and funder requirements; reporting any deviations and adverse events to this committee.)

Please note:

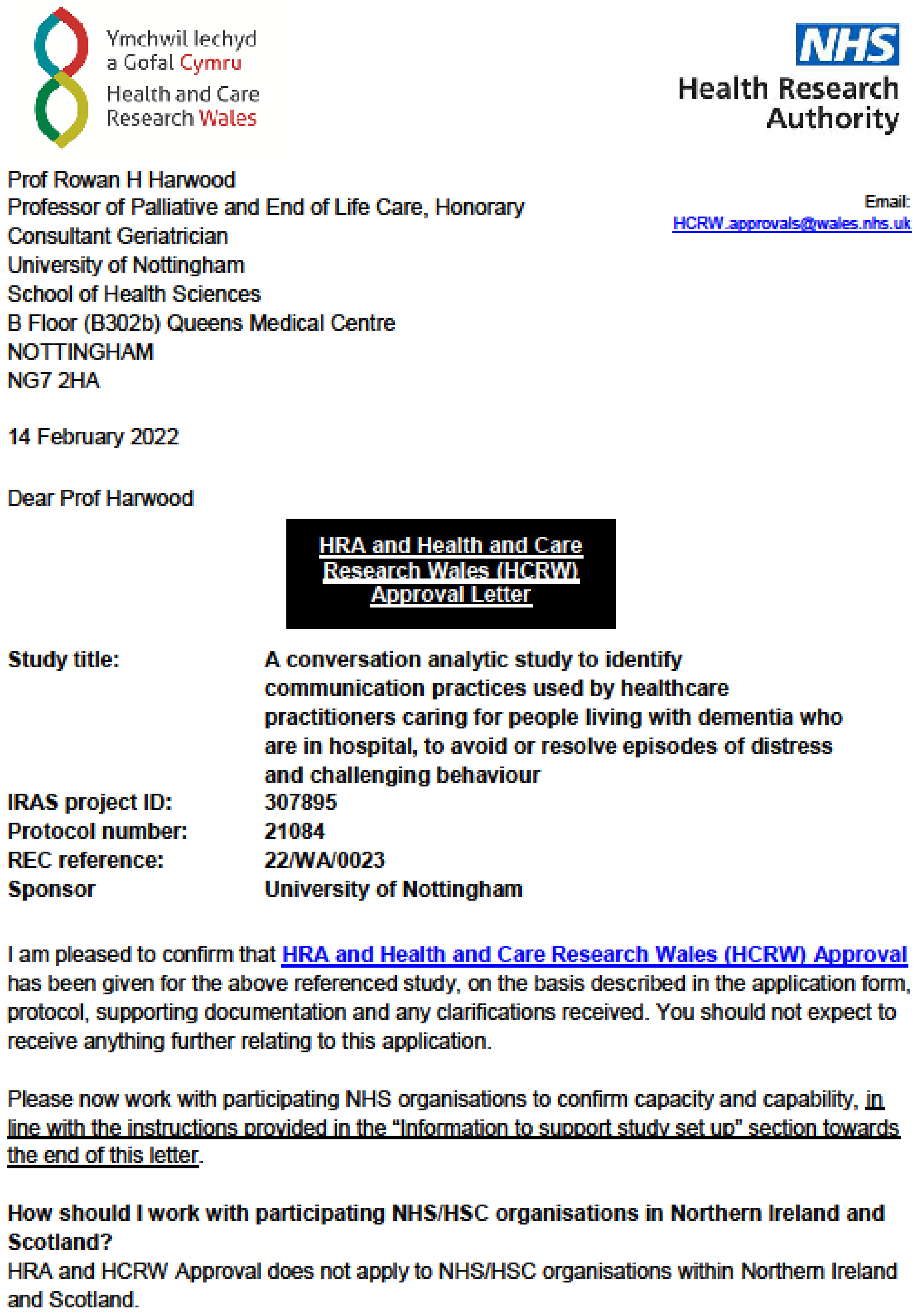
- that any substantial changes or deviations from the application's content and planned research will need to be reviewed by the committee prior to their implementation - please contact the REC Chair (Dr Mel Jordan) to debate the significance of the desired amendments;
- COVID: it is the researcher's / PI's responsibility to keep up-to-date with relevant Government, University and local guidelines/safety measures - please implement any changes as required. We strongly encourage researchers to undertake data collection online or via telephone where possible. If this is not possible researchers must follow the public health guidance in place at the time, including where necessary postponing fieldwork and/or seeking other means with which to collect/create data as appropriate and subject to REC (re)submission/approval;
- **Please re-read COVID declarations in the ethics application and the Fieldwork Record**, before you organise and commence face to face fieldwork;
- that research undertaken by UoN postgraduate researchers and staff is subject to a University mandated annual ethics audit process, whereby several studies per year are selected for audit.

Kind regards,

Dr M. Jordan

Dr Mel Jordan
Research Ethics & Integrity Officer, REC Chair, & Associate Professor in Criminology
+44 (0)115 74 87284/ 95 15410
LQ-researchethicSSP@exmail.nottingham.ac.uk
nottingham.ac.uk/sociology

Appendix 3: NHS REC Letter (VOICE2)



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email:
HCRW.approvals@wales.nhs.uk

Prof Rowan H Harwood
Professor of Palliative and End of Life Care, Honorary
Consultant Geriatrician
University of Nottingham
School of Health Sciences
B Floor (B302b) Queens Medical Centre
NOTTINGHAM
NG7 2HA

14 February 2022

Dear Prof Harwood

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A conversation analytic study to identify communication practices used by healthcare practitioners caring for people living with dementia who are in hospital, to avoid or resolve episodes of distress and challenging behaviour**
IRAS project ID:	**307895**
Protocol number:	**21084**
REC reference:	**22/WA/0023**
Sponsor	**University of Nottingham**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

Appendix 4: Example Study Information Sheet

Local

Letterhead added

Healthcare Practitioner Participant Information Sheet

Final version 1.1 Date 8th February 2022

IRAS Project ID: 307895

Title of Study: An observational study of communication skills to manage distress

Name of Chief Investigator: Professor Rowan Harwood

Local Researcher(s) [to be added by local sites]

1. Invitation to take part

We would like to invite you to take part in a research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through this information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

2. What is the purpose of the study?

Staff working in hospital have said they don’t know how best to talk to patients with memory problems who may get upset or distressed. There is little advice on how to do this.

In this study, we will video or audio record care being given to patients on hospital wards. We will use these recordings to find out which ways of communicating work best to prevent or reduce distress. This will be used to develop a communication skills training course for healthcare staff.

3. Why have I been invited?

You are being invited to take part because you are a healthcare practitioner who regularly works with patient with dementia who have been prone to getting upset or distressed in hospital. We may ask you specifically because you are currently working with a patient who has consented (or has consultee agreement) to be in the study. We are inviting up to 50 participants like you to take part.

4. Do I have to take part?

It is up to you to decide whether or not to take part.

If you do decide to take part, you will be given this information sheet to keep and you will be asked to sign a consent form.

If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.The consent form asks about **two things**:

1) If you agree to take part in the study by being video and audio recorded and the recording being viewed and analysed by our research team.

2) If you are happy for us to show the video and audio recordings to other people – for example as part of staff training. We will ask you about this after we have made the recording. You can watch/listen to your video and audio recording before you decide. You can take part in the video and audio recording but then choose not to let us show it to others.

5. **What will happen to me if I take part?**
    - A member of the research team will organise with you and the patient a good time to video and/or audio record you delivering care to the patient.
    - We will record what would have been happening anyway as part of your patient care on the ward. The only difference will be the recording.
    - The recording equipment will be set up beforehand. The researcher will avoid being close to you during recording, where this is possible. The researcher may need to move the camera if someone moves out of view.
    - If we record some intimate patient care (such as washing and dressing), we will only record sound.
    - The researcher will check that you are comfortable with being recorded before we start recording. At any stage, you can stop the recording. So can the patient or researcher. Recordings will vary in length, depending on how long the interaction naturally lasts. We expect on average they will be around 10 minutes, but they could be up to 60 minutes.
    - After the recording has been made, the researcher will ask to meet you at another time for 15 minutes to one hour. This could take place on the hospital ward or at the University. This visit is optional.
    - The researcher can show you the video or audio recording at this meeting.
    - At this meeting, the researcher will ask you whether we can use the recordings for educational purposes, such as for our training course, at scientific meetings or for future research projects. You will have a chance to ask any questions. If you

let us use the recording in training courses, at scientific meetings or for future research projects, the researcher will ask you to sign a further consent form to make this clear.

- No one outside of the research team will watch or use the recording unless you say we can. If you do not want us to show the video and audio recording in our training course, at scientific meetings or for future research projects, we will only use it for this research.
- You will be involved in this research for up to six months. This will give us time to organise one or more times to record you, and to play you any recordings afterwards. You may stop bring involved at any time without giving a reason.

6. Expenses and payments

Participants will not be paid to participate in this study.

7. Who will see and hear the recordings and why?

The research team will need to see and hear the recordings in order to do the research. Research authorities may need to check the recordings to see that the study is being carried out properly. Approved transcribers may view or listen to the recordings in order to write down the words used. Everyone will have a duty of confidentiality to you as a research participant.

We would also like to play clips of some of the recordings to other people, but will only do this with your specific permission. We hope this will allow us to improve patient care, through training hospital staff about what works best in these situations and sharing these findings widely with other researchers, clinicians and patient groups.

If you agree to us showing video or audio clips to other people, names of people and places will be removed, but faces will be seen.

We would like to use video and audio clips, and photos taken from the videos, for the following purposes, if everyone in the recording has agreed to it:

> **A. In closed meetings** with other communication researchers, to help strengthen our understanding.
>
> **B. In presentations** about our research to scientists, healthcare staff, students or patient and public involvement groups.
>
> **C. In the training materials** that we produce. These will be accessible to registered trainees on our courses.
>
> **D. In on-line educational resources** which are publicly available, for example through online platforms such as YouTube. This could include recordings of academic presentations or training which included the video clips. Video and audio clips would only be made publicly available as part of educational materials.
>
> **E. For future research** aiming to better understand other areas of communication needed for good care.

8. Will I get a chance to see and hear the recording?

You will be offered an opportunity to see the recording before you decide on further sharing of the recording. If you wish to, you may also see your recording at any time from the time you give your agreement up until the end of the study (Dec 31st 2024). To request this, you should contact Dr O’Brien or Professor Goldberg, whose details are at the end of this sheet. You will not be permitted to keep a copy because it will involve not just you, but also the patient and potentially other healthcare staff, healthcare students or relatives.

9. What are the possible disadvantages and risks of taking part?

It is possible that the recording process will affect how you and the patient communicate. We will do all we can to make sure recording does not disrupt your interaction with the patient. If you feel that the recording is causing problems, please ask us to stop recording. The patient will do the same.

If you agree to our using your recording in training and scientific meetings, it is possible that someone you know will be there, and that they will recognise you. We will make it clear that if someone recognises you, they must not use your name, or discuss your personal details, during the meeting or afterwards.

10. What are the possible benefits of taking part?

We cannot promise the study will help you directly. We hope that the information we get from this study will help staff to care better for patients in the future, by improving how they communicate when patients are upset or distressed.

11. What happens when the research study stops?

The information from the video and audio recordings will be analysed in detail by the research team. The findings will be used to develop a training course for healthcare practitioners working in hospitals. The training course will be tried in different hospitals to see if it improves patient care.

We will also write up the results of the study in healthcare journals and share the results with other healthcare practitioners, researchers and public representatives.

We will provide a summary of our findings to all participants at the end of the study.

12. What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers’ contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting: one of the Research Ethics Officers from the School of Health Sciences, University of Nottingham:

- Kristian Pollock (kristian.pollock@nottingham.ac.uk)
- Nicola Wright (nicola.wright@nottingham.ac.uk)'.

In the event that something does go wrong and you are harmed during the research, and this is due to someone's negligence, then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

13. Will my taking part in this project be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use the information collected from you for our research.

This information (such as your name, contact details and the recordings) will be kept strictly confidential, stored in a secure and locked office and on a password protected database at the University of Nottingham.

Under UK Data Protection laws,

- the University of Nottingham is the Data Controller (legally responsible for the data security)
- and the Chief Investigator of this study (Professor Rowan Harwood) is the Data Custodian (manages access to the data).

This means the University of Nottingham and Professor Harwood are responsible for looking after your information and using it properly.

Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

The data collected for the study (the recordings and other study data) will only be looked at by the following authorised people:

- the research team, who are organising the research
- the research authorities who check that the study is being carried out correctly
- the approved transcribers for the University who write down the words being said.

All these people will have a duty of confidentiality to you as a research participant and will do their best to meet this duty.

Any written information about you which leaves the hospital or university will have your name and address removed and a code will be used so that you cannot be recognised from it.

When your recording is transcribed, the original recording (which may contain your name being spoken) will be made temporarily accessible to University approved transcribers. All names will be removed in the written transcriptions so that you cannot be identified. These anonymised transcriptions may be used in training materials or published for scientific purposes and stored in data archives for future researchers interested in this area.

The recordings we collect will never leave the site and be shown outside the research team without your explicit permission. We will ask your permission to show the recordings at scientific meetings and to use them in our in training resources, which will mean showing them to other researchers, healthcare staff and students or patient representatives and the public.

Your contact information will be kept securely by the University of Nottingham for 12 months after the end of the study, so that we are able to contact you about the findings of the study. This information will be kept separately from the research data collected. Only those who need to, will have access to it.

The research data we have collected, including the recordings, will be kept securely for at least 7 years after we have completed all work on the study. During this time, all precautions will be taken by all those involved to maintain your confidentiality. Any training resources which include recordings, will be stored on a password protected website or equivalent. Only members of the research team given permission by Professor Harwood (Chief Investigator and Data Custodian) will have access to your personal data.

After this time, your research data (including the recordings) will be disposed of securely, unless you have given us permission to use the recordings in training courses, scientific meetings or further research.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised, so that you could not be identified- such as sharing the transcripts. However if we need to share identifiable information (such as sharing your recordings) we will only do this if we have your consent for this. We will always ensure your data is secure.

We do not expect to share our data in countries whose data protection laws differ to those of the UK.

Should we observe or be told anything during the study that puts you, or anyone else, at any risk of harm, we may feel it necessary to report this to the appropriate persons.

14. What will happen if I don’t want to carry on with the study?

Your participation in the study is voluntary and you are free to withdraw at any time, without giving any reason. Your legal rights would not be affected if you withdrew. We would stop collecting any further recordings.

If we have already collected a recording from you, then we are not allowed to delete it completely. Research authorities ask us to keep all research data for a minimum of 7 years. The research team may already have viewed your recording and started to transcribe or analyse it. However if you request it, we will not view your recording for any further analysis in the study.

15. What will happen to the results of the research study?

We hope the results from this study will be available during 2022. The results will be used to design training to improve communication skills amongst hospital staff. We will know the impact of the training across several hospitals by the end of 2024.

The results will be discussed at research meetings and written about in research journals. The results will also be written up as part of an educational qualification of a PhD.

Anonymised direct quotes from the observations and transcripts may be used in the study reports, or in training or educational materials or in presentations. You will never be identified by name in any written publication or in any presentation or training. We will change your name in all written transcripts.

If you have agreed to us playing recordings in presentations or training, then we will edit your name in the recordings so that it cannot be heard.

If you have agreed to us showing your video recordings or photos from the recordings, in presentations, training or publications, then your face may be visible and recognisable.

16. Who is organising and funding the research?

The research is being organised by the University of Nottingham (the ‘Sponsor’) working in close partnership with [state NHS Trusts here].

This research is funded by the National Institute of Health Research. This is the part of the NHS responsible for funding clinical research.

17. Who has reviewed the project?

All research in healthcare is looked at by an independent group of people called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the Wales Research Ethics Committee 7 Carmarthen.

18. Further information and contact details

If you have any additional questions, please contact one of the research team at the University of Nottingham.

- **Senior Clinical Research Fellow** Dr Rebecca O’Brien on xxxxxxxxxxxxxxxx or on email: rebecca.obrien@nottingham.ac.uk
- **Project Manager** Prof Sarah Goldberg on 0115 8230543 or on email: sarah.goldberg@nottingham.ac.uk
- **Chief Investigator** Prof Rowan Harwood on 0115 8230873 or on email: rowan.harwood@nottingham.ac.uk

Appendix 5: Example Stage 1 Consent Form

HEALTHCARE PRACTIONER CONSENT FORM

(Final Version 1.1: 8th February 2022)

Title of Study: An observational study of communication skills to manage distress

IRAS Project ID: 307895

Name of Researcher: [to be added at local site]

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.1 dated 8th February 2022 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the observations of my interactions with patients will be video, or audio recorded and that anonymous direct quotes from these observations may be used in the study reports or in training or educational materials or in presentations. ☐

5. I agree to take part in the above study. ☐

____________________________ __________________

____

Name of Participant Date Signature

Name of Person taking consent Date Signature

2copies: 1 for participant, 1 for the project notes

Appendix 6: Example Stage 2 Consent Form

Other Healthcare Practitioner and Student Consent Form Part Two– After each recording

(Version 1.1 Draft 1st November 2021)

An observational study of communication skills to manage distress

REC ref:

Name of Researcher:	
Name of HCP/student:	
Date of recording	
Recording anonymised label	

I am aware that standard procedures will be followed to protect confidentially. Person and place names will be removed from video and audio clips. Video and audio clips (and photos taken from the videos) will only be shown in presentations, training materials or online or in future research studies where I specifically agree to these uses.

***Where I have initialled, I agree to the following use(s) of the recording*.**		Please initial if you agree
A	**Video and audio clips may be played to other researchers** I agree that video and audio clips from this recording may be used in closed sessions with other communication researchers, to help strengthen the research results.	
B	**Video and audio clips may be played at presentations about the research** I agree video and audio clips from this recording may be used in talks about this research for professional audiences of researchers, health and social care staff and trainees or to patient and public involvement groups.	
C	**Video and audio clips may be used in communication skills training materials** I agree that video and audio clips from this recording may be used in communication skills training materials for courses with appropriate registration. I understand that names will not be	

		Please initial if you agree
	revealed during training sessions but faces may be seen in video clips.	
D	**Video and audio clips may be included on online platforms** I agree that video and audio clips from this recording may be made publicly available through online platforms (such as YouTube) for example included within recorded academic presentations and training. I understand that video and audio clips will only be made publicly available when they are included in educational material.	
E	**Video and audio clips may be used for future research** I agree to use of the video and audio recording for future research aiming to better understand other areas of communication needed for good care.	

Signature of participant

Name of participant

Date

Signature of person taking consent

Name of person taking consent

Date

2 copies: 1 for participant, 1 for the project files

Appendix 7: Patient Simplified Information Sheet

Summary Patient Information Sheet

Final Version 1.1 Date 8th February 2022

IRAS Project ID: 307895

Title of Study: An observational study of communication skills to manage distress
Name of Chief Investigator: Professor Rowan Harwood
Local Researchers: [to be added for each site]

We invite you to take part in a research study.
We know that people with memory problems in hospital sometimes get distressed.
We want to study how hospital staff communicate in these situations.
This will help us understand what staff do well to prevent or reduce distress.
We will use this information to develop a training course for hospital staff.
If you take part:

- We will video or audio record examples of everyday care taking place on the hospital ward.
- You can stop the recording at any stage.
- We will tell your medical team that you are taking part.
- We will show you your video recordings.
- We will ask your permission to use your recordings in staff training, research meetings and future research

You do not have to take part, if you do not want to.
Please ask if you want more time to make up your mind, or if you need to know more. You can stop taking part at any time, just by telling us.

There should be no risks from the study. Your hospital treatment will stay the same. In the study we are only recording and watching what happens during your usual hospital care. The independent Wales Research Ethics Committee 7 Carmarthen has looked at the study and is happy to let us do it.
Please let us know if you are worried about this study. Ask your researcher, or contact Rowan Harwood on 0115 823 0873 or rowan.harwood@nottingham.ac.uk

Any information we collect will be kept strictly private. We will use the information from this study to develop training courses for hospital staff. We will tell other hospitals what we find at healthcare meetings and write articles in healthcare journals. But we never mention any names. We will only show other people your video if you give us special permission. We will not show other people your video if you do not want to.