The discourse of self in dementia

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ABSTRACT

The preservation of self-identity in dementia is dependent upon internal (cognitive) and external (social) conditions. This study investigates the integrity of self (internal) and personae (external) in dementia as indexed by the verbal and nonverbal behaviours of dementia residents and their caregivers in a special care unit. Videotaped observations of spontaneous nursing staff-resident interactions were collected over a three-day period. The recordings were transcribed and subjected to detailed discourse analysis. Our analyses focused on several indexicals of self and personae including personal pronouns, proper nouns, interpersonal conflicts, and discursive positioning. The findings revealed that both self and personae are susceptible to decline in dementia. However, the results also provide evidence that even in severe dementia self and personae can be indexed in a variety of ways. We discuss the important role that caregivers can have in reinforcing self and personae in dementia.

KEY WORDS – Self, dementia, discourse.

Introduction

Dementia is a progressive neuro-degenerative brain disorder that implicates many cognitive domains while sparing the person's physical health. The most prominent symptom early in dementia is memory loss, but accompanying this deficit are noticeable declines in language, reasoning, judgement, and orientation. Dementia sufferers' memory loss affects their ability to remember new information and integrate recent and current events with information in long-term memory. This memory limitation, when combined with other cognitive deficits (language, reasoning, orientation), affects the individual's ability to function in social interactions. People with dementia may not be able to remember what is being asked of them; they may not be able to clearly express their desires or needs; and they may appear confused, disoriented, or irrational when they misunderstand or are misunderstood.

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The dementia sufferer's declining ability to communicate with others about the present and its relationship to the past has led some authors and practitioners to hypothesise an 'internal' loss of self in dementia. For example, Cohen and Eisdorfer, commenting on their many years of working with people with Alzheimer's disease and their families, suggest that 'the victim of Alzheimer's disease must eventually come to terms with…the complete loss of self' (1986: 22). Post, speaking on the appropriateness of life-prolonging care for dementia sufferers, refers to dementia as an 'agonizing deterioration of the self [in which] the very substratum of the self with respect to identity and coherence is on the path toward radical disintegration' (1992: 42). Kitwood and Bredin (1992: 285) describe it as an apparent, though not inevitable, 'drifting towards the threshold of unbeing'. Others have suggested that 'the demented patient has no insight into his or her own state of helplessness…he forgets who he is himself' (Souren and Franssen 1994: 20). In these authors' view, the dementia patient 'slowly but inevitably regresses to the functional level of an ailing, helpless newborn baby' (1994: 14). Similar sentiment was expressed by a nursing home staff person who commented, 'they don't know who you are or what you are doing so what difference does it make anyway?' (Richter *et al.* 1993: 24).

Recent research on the narrative or discursive properties of communication with dementia sufferers has identified several 'external' influences on the preservation of self or personhood in dementia (Golander and Raz 1996; Kitwood and Bredin 1992; Mills and Coleman 1994; Nussbaum 1991; Ramanathan-Abbott 1994; Sabat and Harré 1992). This research looks beyond the internal (*i.e.* neuropathological and neuropsychological) declines and addresses the equally important role of external, or social psychological, factors in maintaining personhood (Kitwood 1990). That is, the manner in which others interact with the dementia sufferer can have a significant impact on the individual's own sense of well-being. In this respect, self-identity is considered to be constituted by and through social interaction (Coupland *et al.* 1993; Hadden and Lester 1978; Mead 1934; Shotter 1993).

Ramanathan-Abbott examined parallels between the dementia patient's 'weakening sense of self and a non-facilitative social context' (1994: 33). She reports on conversations from a dementia sufferer-caregiver dyad in which the caregiver impeded and controlled the attempts of the person with dementia to narrate personal events. In so doing, the caregiver denied the dementia sufferer's own presentation of self in their interactions.

The nursing home context has also been frequently cited for its non-facilitative social environment (Carstensen 1986; Carstensen and Fremouw 1988; Foner 1994; Pillemer and Hudson 1993). Rates of social interaction are low in nursing homes, and interventions to increase these rates may not be accompanied by an increase in the quality of interactions (Carstensen and Erickson 1986). Nussbaum (1991: 159), in a study that elicited staff and resident interaction goals, attributes the deficient social interaction in nursing homes to the differing interactional preferences of the staff and the residents. The latter reported relational closeness with the staff as being very important (*e.g.* 'I wish they [staff] were less concerned about my health and we could talk about real things'). The staff, on the other hand, reported being much more task oriented (*e.g.* 'Mrs. X wants to talk about her children so I pretend to be interested to get her to the dining room'). Thus, the residents' desire to engage in personally ('self') fulfilling interactions is often ignored or discouraged by the task-oriented staff.

In response to this impoverished social environment, Kitwood (1990) has proposed that caregivers can and should modify their interactional styles in order to maintain and replenish personhood in dementia. He suggests that caregivers respect and provide opportunity for the individual's self-expression while at the same time accommodating to the individual's greater dependency on others. Similarly, Mills and Coleman (1994) and Golander and Raz (1996) recommend that caregivers recreate the fragmented personality of the dementia sufferer through elicitation and/or validation of personally significant autobiographical memories. This interdependence between appropriate interpersonal accommodations and personal well-being in ageing and dementia, although widely recognised in the research community (*e.g.* Ryan *et al.* 1986; Ryan *et al.* 1995), continues to be an often neglected dimension of dementia care.

Judging from the preceding studies, it appears that the postulated decline in the self of people with dementia may be due to both internal (cognitive) and external (social) factors. One recent study, however, argues that the internally defined self in dementia remains intact, whereas the externally defined self (or 'persona') is susceptible to decline (Sabat and Harré 1992).

Sabat and Harré draw upon constructionist theory in describing and delineating the sense of 'self' versus 'selves' or 'personae' (hereafter, self and personae). Self is viewed as one's 'personal identity, which is experienced as the continuity of one's point of view in the world of objects in space and time' (1992: 445). Personae are one's publically

presented selves in social interactions. Whereas the existence of personae hinges on social cooperation, the self 'does not require the cooperation of any other person in order to exist' (1992: 446). In the constructionist account, the existence of self can be confirmed in discourse through an individual's use of first person singular pronouns (I, me, myself, my, mine). If an individual with dementia can be shown to use first-person pronouns coherently in his or her discourse, he/she has displayed an intact self (1992: 447). Personae, on the other hand, are identified by co-constructed roles that individuals take on in various social contexts (*e.g.* as professor, student, parent, child, doctor, patient). Personae are mutually constructed in that each party 'positions' his/her persona in relation to the other's (Davies and Harré 1990). If person A's presentation or positioning of a certain persona is misinterpreted or not acknowledged by person B, it can be said that one of A's personae is being denied by person B.

Sabat and Harré (1992) report on several conversational interactions between four dementia sufferers and their caregivers or a social worker. The authors present selected excerpts from these interactions in which the dementia sufferers clearly demonstrate the coherent use of first person pronouns. They also present accounts of how the dementia sufferer's presentation of personae (*e.g.* as an academic or as a helper and nurturer) was ignored and denied by certain conversational partners. These partners viewed the person's 'dysfunctional' behaviours as indicating helplessness and confusion rather than seeing them as presentational cues to the person's preferred persona. For example, one dementia sufferer, who had been an academic, did not participate in the programmed activities at an adult day care centre. His non-social behaviour could be dismissed simply as symptoms of the disease. However, other partners, who took time to find out about his past, elicited a presentation of this individual's persona as an intellectual. From this perspective, he chose not to participate in the centre's activities because he considered them a waste of time and energy. By acknowledging and affirming these cues, these other partners helped co-construct the dementia sufferer's preferred persona.

The authors conclude from their findings first, that the self of personal identity remains intact in dementia well beyond the loss of many cognitive functions, and secondly, that the loss of personae in dementia can be prevented if the caregiver and others do not position the dementia sufferer as helpless and confused.

In the present study, we set out to expand the findings of Sabat and Harré using additional sources of internal and external evidence for the integrity of self and personae in dementia. Although we agree in large

part with these authors' interpretation of their data, we think a more comprehensive evaluation of the linguistic and non-linguistic behaviours of the dementia sufferer and the caregivers is warranted. In particular, we would argue that the exclusive use of first person singular indexicals (pronouns) is neither a necessary nor sufficient condition in determining the integrity of self. We believe it is not a necessary condition because other forms of language and nonverbal behaviour can also index 'selfhood'. Thus, even if dementia sufferers were to show an absence of or a decline in their use of first person singular pronouns, the presentation of their self could be accomplished in other ways (described below). The exclusive use of first person singular pronouns is also not a sufficient condition because of dementia sufferers' word-finding difficulty. Difficulty in accessing lexical items is an early and pervasive symptom of dementia, especially for more uncommon words (Kirshner *et al.* 1984; Shuttleworth and Huber 1988). The use of first person pronouns may, therefore, reflect their common occurrence in English (Kucera and Francis 1967) rather than a preservation of the self. Sabat and Harré allude to this possibility but suppose that such an explanation 'would soon be dispelled by study of the discourse as a whole' (1992: 447). These authors do not, however, go on to investigate this alternative explanation in their study. In our study, we address the possibility that dementia sufferers' use of first person pronouns is due to their anomia – or in Sabat and Harré's words, 'a mere verbal habit' (1992: 447) – by examining their use of first person pronouns vis-à-vis their use of words from other lexical classes.

We also examine the integrity of external personae in dementia. In addition to identifying the more global discursive properties of personae, we identify particular linguistic features that convey the dementia sufferers' understanding of personae. Specifically, we will demonstrate that dementia sufferers' use of certain pronominal forms reflects an intact ability to position multiple personae.

Finally, Sabat and Harré claim that the use of statistical procedures is not appropriate for the analysis of discursive events (1992: 448). Although this may be true for the type of analysis done in their study, it is not the case for other studies using a more multivariate descriptive approach to discursive material. In fact, the kind of material used in much of discourse and conversational analysis is quite amenable to statistical analysis. The advantage of employing quantitative analysis in combination with qualitative analysis is that one can ascertain whether there are quantitative patterns in the discourse that support the qualitative analysis. The advent of computer software for

qualitative data analysis has brought with it greater capabilities of combining qualitative and quantitative approaches to one's data (for a review, see Weitzman and Miles 1995). The present study, utilising this software, will demonstrate the complementary use of both approaches.

Method

Setting

We chose to examine the integrity of dementia sufferers' self-identity in a nursing home context. Residents and nursing home staff were observed in a special care unit (SCU) for dementia (28 beds) attached to an intermediate care facility (139 beds) in British Columbia, Canada. It is in this context that one is likely to see the greatest challenges to the internal (cognitive) and external (social) factors supporting one's self-identity. Thus, if one finds the dementia sufferers' self or personae to be preserved under such conditions, a strong argument could be made for the preservation of self-identity into the end stages of dementia.

Participants

Seventeen residents (fourteen female and three male) and 25 staff (23 female and two male) were involved in the study. Fifteen residents had been diagnosed with dementia, primarily of the Alzheimer's type, and two with clinical depression with dementia-like behavioural problems such as confusion and memory loss. Data from the latter were included in the analyses since these two residents were often in the activity lounge interacting with other residents and the staff. Excluding interactions involving them would have resulted in a considerable loss of data from the other residents and staff. Support for including them was obtained from analyses showing a similar pattern of results (use of pronouns, involvement in conflict) with these two removed. The ages of the residents ranged from 69 to 95 years. Most residents were at the severe stage of dementia as indicated on the LTC-1, the standard assessment form used by the Continuing Care Division of the British Columbia Ministry of Health. The LTC-1 includes a rating of an individual's judgement, perception, affect, communication, and level of performance in activities of daily living and instrumental activities of daily living. The LTC-1 is a reliable instrument for determining the level of continuing care required (Stark *et al.* 1982).

The staff included three Registered Nurses, eighteen full- or part-time Care Aides and four support staff (*e.g.* activity coordinator, maintenance). The staff did not rotate between the SCU and the intermediate care facility. The staff in the unit received no formal dementia care training on the job.

Procedure

As part of a larger study (Gutman and Clarke Scott 1997), videotaped observations were collected in one of two activity lounges in the dementia unit. Informed consent for participating in the study was obtained from the staff and the residents' family members. A Panasonic WV-BL90A video camera was strategically positioned in the corner of the ceiling in the lounge. This position afforded the widest possible view of activity in the lounge while being as unobtrusive as possible. The microphone on the camera provided high clarity recording of interactions throughout the lounge. The recording mechanism on the camera was controlled by a WatchMate® (Instantel® Inc.) monitor and a passive infra red motion sensor. The residents wore wrist bands that activated the recording mechanism via the WatchMate® monitor when they entered the activity lounge. The wrist bands were comfortable and lightweight, and each resident's consent was obtained prior to putting the wrist band in place. When there was no WatchMate® signal and the motion sensor had not detected movement for 30 seconds, the recording function on the VCR was stopped. The recordings were made using a Panasonic AG-1300 Video Cassette Recorder.

The residents and nursing home staff were recorded over three successive days. One advantage of recording interactions over an extended period was that it provided a continuous account of an individual's positioning of self and personae (Hadden and Lester 1978). As one might expect, interactions between residents and staff occurred primarily during the day. The total duration of recorded activity was just over six hours.

Data coding and analysis

The complete videotape recordings were transcribed onto a word processor. The transcription format followed that of Gumperz and Berenz (1993). This system permitted considerable export compatibility with the qualitative software programme employed in coding the

transcripts. The transcribing was carried out by one of the authors and was verified by a second author.

Once transcribed, the videotaped interactions were exported to Atlas-ti for Windows, a qualitative data coding and analysis programme (Muhr 1996). This programme was used to code and analyse the data for various discourse markers of the residents' self and personae. These markers included: (1) first person pronouns (I, me, my, mine, myself, we, us, our, ours, ourselves), (2) second and third person pronouns (you, your, yours, yourself, yourselves; he, him, his, himself, she, her, hers, herself, they, them, their, theirs, themselves), (3) other lexical classes (nouns, verbs, adjectives and adverbs), (4) proper nouns (*e.g.* Mary), (5) conflict in interactions (see below), and (6) the positioning of personae (see below).

1. *First person pronouns.* We followed the constructionist account of interpreting the use of first person singular pronouns (I, me, my, mine, myself) as an expression of one's personal identity. However, we extended Sabat and Harré's exclusive use of the first person singular and included first person plural forms (we, us, our, ours, ourselves). The use of a first person plural by definition includes oneself with at least one other person (Quirk *et al.* 1985: 340).[1] As such it can index one's selfhood as well as a particular instance of a personae, namely, the shared world of the speaker and another person. Thus, the use of first person plural pronouns by staff or residents can reflect their 'self' and their 'shared selves'.

2. *Second and third person pronouns.* The identification of second and third person pronouns served to indicate the degree to which the residents acknowledged and made sense of the other personae in their environment. For example, the residents' use of 'you' or 'he' would indicate that they have positioned others as having an existence and role in the residents' social world.

3. *Other lexical classes.* It was hypothesised that use of first person forms by the residents may relate to a decline in the availability or accessibility of other lexical items. As Sabat and Harré mention, the dementia sufferer may use first person pronouns out of 'mere verbal habit' (1992: 447) or, as we suggested earlier, because of word-finding problems. To address this possibility, we examined the residents' use of words from other lexical classes to see if there was a restricted range of vocabulary overall.

We first examined the residents' and staff's use of first person

pronouns relative to other pronominal forms (second and third person). If the residents, but not staff, were to show greater use of first than second or third pronouns, this would suggest that the residents are more reliant on first person pronouns.

We then calculated a Type-Token Ratio (TTR; Templin 1957) to determine the lexical variability shown in the residents' and staff's use of four categories of content words (nouns, verbs, adjectives, and adverbs). The TTR quantifies the variability of lexical items in a sample by dividing the total number of different words used by the total number of words in the sample. If residents show a reduction in their repertoire of lexical items from these other lexical classes, this would support the interpretation of their preferential use of first person pronouns as a 'verbal habit'.

4. *Proper nouns*. Addressing another person by his or her name (*e.g.* Bill, Mrs. Robertson) acknowledges and affirms that person as a unique human being with a particular identity. In this regard, proper nouns are different from second and third person pronouns which can be used generically to refer to any other person(s). The staff's use of a resident's name can thus index and reinforce the resident's perception of self.[2]

5. *Conflict in interactions*. Sabat and Harré mention one of their dementia sufferers (I.K.) who was very limited in verbal expression but who nevertheless indexed self through nonverbal gestures. For example, she indicated preference for a particular chair by tapping on the chair and pointing to herself.

In the present study, another nonverbal expression of self was demonstrated in conflicts involving residents and staff. Conflicts were defined and marked by disagreements in the goals and behaviours of interacting parties (Putnam and Wilson 1982) or by dispreferred responses by one or more of the parties (Levinson 1983). Conflict often takes place when a person asserts his or her desire and will in opposition to the desire and will of another person (Kitwood and Bredin 1992: 281). For example, a common conflict in the nursing home setting occurs when the staff attempt to make a resident sit down but the resident refuses. We interpreted the resident's refusal (or other disagreeable behaviour) as an expression of self in that the resident recognises and resists the violation of his or her own desires and goals. An awareness of one's own desires in relation to the desires of others is a clear indication of a perceived self.

6. *Positioning of personae*. The existence and expression of personae

depends on the cooperation of others (Sabat and Harré 1992). In the present study, we initially set out to examine the discursive interactions of residents and staff in terms of co-constructed personae. However, as Davies and Harré note, positioning can 'involve shifts in power, access, or blocking of access, to certain features of claimed or desired identity' (1990: 49). In our data, it quickly became apparent that most interactions were initiated and controlled by the staff, and their positioning of residents was more often than not as dependants. In only one interaction did staff position a resident as having a unique biographical identity other than as a resident in the SCU. The following is an excerpt from this unusual conversation:

Example 1

S1:   ((mopping floor in lounge))
        = you're a real carpenter/ =
R1:   = (   ) =
S1:   hey Bill what's the best thing you ever built//
R1:   huh?
S1:   ((continues mopping but walks toward centre and faces R1))
        what's the best thing you ever built//
R1:   I?
S1:   the best thing//
        you ever made/
R1:   buildings//
S1:   you made buildings/
R1:   really?

In contrast to S1's positioning of R1 as a carpenter, other residents were not positioned as having a social or autobiographical identity and were not given opportunity to position their personae in a personally meaningful way. For this reason, our analysis focused on the staff's circumscribed positioning of the residents' personae as either dependent or independent (Baltes *et al.* 1994). Staff were considered to be engaged in dependent positioning when treating residents as incapable of self-care or as being unable to respond appropriately. Independent positioning, conversely, involved encouragement of residents' self-care and provided opportunities for residents to respond in interactions. The residents' responses to staff positioning were categorised as cooperative (accepts the staff's positioning), neutral (ignores or does not react to the staff's positioning), or uncooperative (verbally or nonverbally resists the staff's positioning). A predominance of cooperative or neutral responses to dependent positioning by the staff would suggest that the residents have acquiesced to being in a dependent role. A predominance of uncooperative responses to dependent positioning would convey the

residents' desire to position a different (perhaps non-dependent) persona. Cooperative or neutral responses to independent positioning by the staff would indicate that residents support being treated as an independent persona. Uncooperative responses to independent positioning might suggest that residents prefer being treated as a persona that needs assistance. Such responses, however, may also indicate resistance to what the staff want the resident to do.

Results

First person pronouns

Descriptive statistical analyses were carried out to determine the residents' usage of first person singular and plural pronouns. Less than half (8 out of 17) of residents employed first person singular pronouns. Only one resident used first person plural pronouns. Of those residents who used first person singular pronouns, the average number of first person forms used as a proportion of their total utterances was 0.28 (range 0.14 to 0.45). In other words, these residents employed first person pronouns, on average, in just over one quarter of their utterances. The following is an example of first person pronoun usage by one resident:

Example 2

R2: where did **my** dinner go/
S2: OK Virginia/
    ((takes cup from her tray and lifts toward her mouth))
R2: **mine**//
S2: all right/
    ((pulls tray away from R2))
R2: ((appears to be trying to take off her bib))
    I can't (   )//
S2: let me help you//
    ((wipes and moves tray))
    let me = help you// =
R2: **I** do it (   ) =
S2: ((moves tray against wall; R2 still fiddling with bib))
    let me help you/
    let me help you/
    ((takes bib, puts it on cart and heads toward exit))
R2: {[loud] oh no::: to wear it//}
    {[shouting] (have it)   }
    (muttering loudly)

TABLE 1. *Resident and staff use of lexical items*

	Pronouns[1]			Proper nouns[1]	TTR[2]
	1st person	2nd person	3rd person		
Residents	0.28	0.16	0.05	0.02	0.39
Staff	0.13	0.24	0.10	0.21	0.49

[1] Proportion of total utterances in which form was used.
[2] Lower ratio indicates more restricted range of vocabulary.

Second and third person pronouns

Seven of the 17 residents used second person pronouns. For these seven residents, the average use of second person pronouns as a proportion of their total utterances was 0.16 (range 0.05 to 0.30). Five residents used third person pronouns. All five were also second person pronoun users. The residents' mean proportional use of third person pronouns was 0.05 (range 0.01 to 0.09). Because third person forms were used so infrequently by the residents, they were not included in further comparisons. An example of second person pronoun usage by a resident follows:

Example 3
S3: ((walking into lounge with other resident by the hand))
R3: ((enters lounge))
S3: hi Sally//
R3: **you** look lovely today/
     ((stoops over to look at S3's uniform))
     Carolyn,
     that's **your** name (   )//
S3: thank you//
     just gonna get Francis her drink here//
R3: oh yah//

Other lexical classes

The residents' more frequent use of first (0.28) than second (0.16) person pronouns prompted a comparison with the staff's use of these forms. The results for the staff show a pattern that is the reverse of that observed for the residents. Namely, the staff made greater use of second person (0.24) than first person singular (0.13) pronouns. The differences across groups suggested that the residents may be over-relying on the first person forms. To investigate this possibility, we

calculated each group's Type-Token Ratio (TTR) for items from other lexical categories.

The residents' mean TTR for nouns, verbs, adjectives, and adverbs was 0.33. This mean is substantially lower than that reported for oral interviews from normal older persons and mild dementia sufferers: 0.46 (Lyons *et al.* 1994). The residents' mean TTR for nouns and adjectives (0.39) is also much lower than the mean TTR for the same forms for the staff in the present study (0.49).[3] It appears, then, that the residents' overall range of vocabulary is restricted and that their over-reliance on first person pronouns may be attributable to general vocabulary limitations (see Table 1 for group comparisons).

Proper nouns

Twenty (out of 25) staff employed proper nouns (*i.e.* residents' names). The staff's use of proper nouns as a mean proportion of their total utterances (0.21) was similar to their mean proportional use of second person pronouns (0.24). Thus, it was not the case that staff avoided using residents' names in favour of the generic second person pronouns (*e.g.* you). The following example illustrates the staff's use of residents' names:

> *Example 4*
> S4: OK, let's go **Virginia**//
> ((guides resident by hands toward exit of lounge))
> S3: (for a stroll   )?
> I'll just move this out of the way//
> **Gladys**,
> sit down on that chair//
> OK?
> there you go,
> ((moves a resident's wheelchair out of her way))
> watch your toes **Mildred**?
> **Gladys**?
> S5: ((stands facing a resident))
> hi (**Betty**)?
> **Betty** wants a bite//
> S3: a bite//
> is that what she said?
> S5: (bite   )
> S3: ((wheels resident into restroom))

Conflict in interactions

Percentage agreement in the identification of conflicts was 0.98 between two coders. Fourteen (out of 17) residents were involved in conflicts primarily with the staff and with other residents. These 14 residents participated in a total of 111 conflicts over the three day period, averaging eight conflicts per resident. For purposes of the present study, the analysis of conflicts focused on the six residents who rarely verbalised and who did not index self through the use of first person pronouns. If the integrity of self were determined solely on the basis of employing first person pronouns, these residents would have been classified as having an impoverished self. The importance of looking at nonverbal behaviours in conflicts as indexicals of self was readily apparent in our data. For example, one resident (R4), who had only one intelligible verbalisation (out of six), was involved in seventeen conflicts. The examples below illustrate this resident's recurrent defence of her self when she felt her rights were being infringed upon.

Example 5

S6: = let's go/ =
      ((reaches down to take R4's hand))
R4: ((holding onto chair))
S6: let's go/
      Francis/
      come on?
      ((tries prying R4's other hand off of chair))
R4: ((does not let go of chair))
S6: ((keeps pulling R4's arm and finally releases it from chair))
R4: ((grabs chair again))
S6: Francis/
S7: ((enters lounge, restroom, then assists S6 by taking R4's other hand))
      (Francis)/
      (problems)
R4: ((is escorted out of lounge by S7 and S6))

In this example, R4 refuses to let go of the chair in response to S6's attempt to get her to leave. It is not until another staff person (S7) assists S6 that they are successful in overcoming R4's desire to stay put. In the example below, R4 refuses to comply with the staff's wish for her to sit down. However, on this occasion R4 is successful in maintaining her desired stance.

Example 6

S3: ((returns to lounge pulling R4 by arms))

> here you are Francis//
> come on sit down//
> ((guides R4 to chair in lounge))

R4: ((mumbling, doesn't sit down))

S3: sit//

R4: ((continues standing))

S3: ((leaves R4 standing, goes to restroom))

R4: ((walks toward restroom))

Both of these examples clearly indicate that the resident, despite being unable to articulate her desires in words, is cognisant of her own desires and rights. We would argue that R4's nonverbal resistance to what the staff want her to do reveals an intact self as much as would the use of words such as first pronouns. Nevertheless, it is possible that, similar to first person pronoun use, the residents' refusals could be the mark of an (unconscious) habit. If this were the case, refusal should appear indiscriminately across contexts. For example, residents should be equally likely to exhibit refusal in response to different kinds of staff positioning. In fact, our data in the next section show that the occurrence of refusals (or uncooperative behaviour) is dependent upon the manner of staff positioning (see Table 2). Therefore, residents do not seem to be using refusal simply because it is an over-learned automatic behaviour. Rather, refusal serves an intentional purpose in response to particular staff behaviours.

The other five residents who did not use first person pronouns demonstrated the integrity of self in similar conflicts. We provide one further representative example below from a resident who had only five intelligible verbalisations but was involved in fifteen conflicts.

Example 7

S8: ((feeding R5))
> Betty/
> open it//
> open the mouth//

R5: ((resisting))

S8: open the mouth/
> OK/
> open the mouth/
> OK/
> open the mouth/
> open the mouth/

R5: ((still resisting, tilting her head back away from food))

S8: Betty/
> oh good/

((starts to retract hand))
((food falls?))
ohhh/
((walks away))

Positioning of personae

The coding of staff positioning and resident responses was carried out by two coders. Percent agreement between coders was 0.98 for positioning (dependent, independent) and 0.97 for residents' responses (cooperative, neutral, uncooperative). There were a total of 88 interactions in which staff positioning could be identified. Staff engaged in dependent positioning in 86 per cent of the interactions and independent positioning in 14 per cent. Dependent positioning elicited more uncooperative (43 per cent) than cooperative (32 per cent) or neutral (25 per cent) responses by the residents. Example 8 below illustrates one of the dependent-uncooperative interactions. In this interaction, the staff positions R2 as requiring assistance in drinking. R2 responds uncooperatively to the staff's attempt to get her to drink.

Example 8
S2: Virginia,
     apple juice/
     ((lifts glass up to R2's mouth))
R2: {[irritated tone] don't **stand on my (gaz   )}
     ((strikes at S2))
S2: ((moves away from R2))

In contrast to the dependent-uncooperative pattern, independent positioning was most often followed by cooperative (75 per cent) rather than neutral (25 per cent) or uncooperative (0 per cent) responses. The following example illustrates the predominant independent-cooperative pattern:

Example 9
R3: ((enters lounge, sits down))
S8: ((in other corner of lounge attending residents))
     hi Sally//
R3: hi dear//
S8: how are you//
R3: oh very good dear/
     I had a good dinner,
     so I feel pretty good now yah//
S8: you had good dinner?
     Sally?

R3: yah/
      very good dinner//
S8: that's good//

In this interaction, the staff encourages R3 to express herself as an independent person ('how are you?' 'you had a good dinner?'). R3's cooperative acceptance of this positioning is evidenced by her elaborated responses to the staff's questions.

Given that independent positioning usually produced cooperative responses, one might have expected dependent positioning to elicit a greater number of uncooperative responses. In fact, residents responded in a cooperative and neutral manner in over half of the dependent positioning interactions. In an attempt to explain this unexpected pattern, we re-examined the dependent positioning for characteristics that might lead to different types of responses. Our analyses revealed that the staff conveyed dependency in either a personalised or depersonalised manner. In the personalised approach, the staff employed one or more of the following features: addressing the resident by name, encouraging responses, asking for agreement on action taken, or explaining the action being performed. In the following example, the staff personalises her response to a resident who appeared to be confused about where she lived:

Example 10
R6: (   )
R7: (   ) stay?
S9: ((nods head at R7, looks at R6))
      but you live here Emma ((R6))/
R7: eh?
S9: she lives here//
      yah/
R7: yah,
S9: yah//
      everything's OK Emma//
      there's always nurses around//
      yah//
      go for a walk outside with Helen ((R7))//
      ((R7 and R6 walk toward the patio door))

Conversely, in the depersonalised approach, the staff did not use the resident's name, they limited verbal interactions to yes/no responses, and they did not provide opportunities for the residents to express themselves, as in the following example:

Example 11
S8: ((tries to get R5 to drink))

T ABLE 2. *Percentage of resident response types by manner of staff dependent positioning*

	Resident response type			
Staff positioning	Cooperative (%)	Neutral (%)	Uncooperative (%)	Total (= 100%)
Personalised	40	25	35	55
Depersonalised	9	24	67	21

      here//
R5: ((refuses))
S8: ((takes cup away for a moment, then tries again))
      drink some coffee or tea?
R5: ((refuses))
S8: tea tea//
R5: ((refuses))
      (oh)
S8: ((walks away from R5))

Our analysis revealed that the residents responded more unco-operatively to dependent positioning when it was depersonalised than when it was personalised (67 per cent versus 35 per cent, respectively; see Table 2). In contrast, residents were more likely to have cooperative responses to dependent positioning when it was personalised than when it was depersonalised (40 per cent versus 9 per cent, respectively). Thus, the less-than-expected incidence of uncooperative responses to dependent positioning could be attributed to the staff's use of a personalised approach. These findings indicate that even when residents are positioned in a dependent role, personalising the interaction leads to greater compliance with that positioning.

Discussion

This study set out to investigate the preservation of self and personae in persons with dementia as indexed by features of discourse. The research findings provide new evidence that the self and personae in dementia are indexed by both verbal and nonverbal behaviours. The study found that indexicals of self and personae can be positive or negative and that some indexicals are used more frequently than others. In the remainder of the discussion, we will summarise and interpret the evidence for and against the preservation of self and personae in dementia. Finally, we

discuss the implications of the findings for caregiving and clinical practice.

Self in Dementia

To the extent that self is indexed by usage of first person pronouns, the absence of first person pronouns in the discourse of more than half of the dementia residents suggests that the self-identities of many SCU residents may be compromised. Moreover, the virtual nonexistence of first person plural forms for the residents indicates that they did not seek or have opportunity to combine their selves with the selves of others.

For the residents who did not use first person pronouns, self was, nevertheless, indexed in other ways. These residents were frequently involved in conflicts in which they defended their rights as an individual. In these conflicts, their awareness of and resistance to the violation of their desires by others was a clear expression of an intact self. However, because conflict is an undesirable event, the residents' behaviour in conflict can be viewed as a negative expression of self. The self of the residents was also acknowledged and reinforced by the staff's common use of residents' names. Addressing residents by name indexes their identity as unique human beings and thus serves as a positive marker of self. Together, these findings indicate that although some residents could not demonstrate self verbally, the integrity of self was effectively conveyed through nonverbal behaviours and forms of address.

For the residents who did use first person pronouns, the use of these forms outnumbered their use of second and third person pronouns. This pattern was the reverse of that observed for the staff. The residents' apparent dependency on first person pronouns was further supported by analyses demonstrating the residents' limited repertoire of words from other lexical classes such as nouns. These findings suggest that the residents' use of first person pronouns may be a consequence of a restricted vocabulary, and therefore should not be used as the sole index of self.

An alternate explanation for the disparate patterns of using first versus second person pronouns by the residents and staff may be related to the different roles played by each group. Staff are the primary initiators of interactions and as such may be more inclined than residents to use second person pronouns when addressing the residents. Residents, on the other hand, who are often the addressees in interactions, may have greater opportunity than the staff to respond in

the first person. This explanation, however, fails to take into account the fact that residents, as addressees, respond to an addresser and thus have ample opportunity to address the staff in the second person, as in Example 3 presented earlier. In addition, because residents and staff are often involved in conflicts, both residents and staff can assume the roles of addresser and addressee. The following excerpt illustrates such opportunities:

Example 12
R2: ((reaches out to S10 as she passes by))
S10: ((walks back into main part with tray))
R2: {[shouting] no **you're** not gonna (   )}
S10: shhhh/
R2: that's **my** friend//
      ((holds out extended arm toward S10 and a resident))
      (**my**   )
S10: ((walks toward wing, extends her hands to R2))
      it's OK Virginia::/
S6: ((walks toward wing, passes R2 but waits nearby))
S10: how's your (   ) OK?
      ((caresses R2's cheek))
R2: no **you** (   )
      ((points at S6))
      (look at her   )

A third possible interpretation of the residents' frequent use of first person pronouns is that they employed these forms as a defence against what they perceived as a decline in self. The present study confirmed much previous research in finding very little caregiver support for the residents' autobiographical selves despite the fact that many residents' autobiographical memories do not appear to be lost (*e.g.* Mills and Coleman 1994). In response to this lack of external support for their personal identity, the dementia residents may be using first person pronouns as one of the limited means by which they can maintain a sense of self or control over their personal lives (see also Kitwood and Bredin 1992: 283).

In summary, the self in dementia was manifested in several forms and appeared to be resilient in the face of declining cognitive functions. The residents' use of different indexicals of self depended in large part on their capacity to verbalise. Residents who verbalised more indexed self through first person pronouns as well as in conflict, whereas residents with limited verbalisation expressed self only in conflict. The staff reinforced the self of residents regardless of their functional status by addressing them by name.

Personae in dementia

First person plural pronouns were considered to index personae as well as the self. By definition, this plural pronoun includes oneself and at least one other individual. We interpreted this joining of multiple selves as an instance of what one might call a 'shared world' persona. As mentioned in our discussion of self above, residents employed very few first person plural forms compared to the staff. The latter finding may reflect the different interaction preferences of the residents and the staff (Nussbaum 1991). That is, because the residents, but not the staff, are relationally oriented, the residents may prefer not to engage them in joint productions as indexed by 'we'. On the other hand, over half of the staff employed first person plurals, indicating that many staff sought to acknowledge residents as part of their interactions. The staff's use of these pronouns seemed to index an instrumental desire for cooperation by the resident more than an interactional desire for personal closeness, as shown in the following example:

Example 13

S3: ((re-enters lounge with a resident by the hand))
yah, well **we** better go and try//
come on/
come in here OK?
then **we'll** go for (coffee) hmm?
((enters rest-room with resident))

The residents employed second person pronouns much more frequently than third person pronouns. Based on their appropriate use of second person pronouns, one can infer that some residents were capable of positioning the personae of others as part of their world. The relative non-occurrence of third person pronouns, on the other hand, demonstrates that these residents rarely positioned others as third party personae in an interaction. This difference between second and third person forms indicates that the residents were more likely to position the personae of others with whom they had direct dyadic involvement. The residents' memory and attention deficits may have limited the number of interlocutors they could address or reference in their discourse.

The discursive analysis of how the staff positioned the residents revealed that in only one interaction did a staff member engage in cooperative co-construction of a resident's unique persona. In all other cases, the residents were positioned in relation to their dependency on the staff. The staff positioned residents much more frequently as dependent than independent personae. This finding concurs with

previous research by Baltes and her colleagues, who describe this pattern of behaviour in terms of a dependency-support script (Baltes *et al*. 1994). The staff's contribution to this script comes in the form of anticipating real or expected weaknesses on the part of the residents. The residents support the script by using their dependency as a means of social contact and gaining attention from the staff. In the present study, however, the residents resisted being positioned as dependent and cooperated when treated as independent, thereby showing that their preferred persona is one of independence. It appears then that the staff, but not the residents, adhered to a dependency-support script. The residents' refusal to support the staff's dependent positioning may be due to the residents' desire for more than just social contact; they want meaningful social interaction (Carstensen and Erickson 1986; Nussbaum 1991). The staff's dependent positioning lacked in this respect, whereas their independent positioning offered opportunity for disclosure of personal information by the staff and residents.

Implications

The findings of this study have several implications for clinical practice and caregiving. Caregivers can reinforce the self of dementia residents by addressing them by their name. Some residents may prefer being addressed by their first name, whereas others, who do not desire solidarity with the staff, may prefer being addressed by title and last name (Wood and Ryan 1991). Caregivers should be willing to find out each resident's preferred form of address and make an effort to accommodate them.

The staff can also affirm the residents' self through the use of first person plural forms. These forms, however, should be used judiciously since they can be interpreted as patronising, especially if accompanied by paralinguistic markers of baby talk such as high pitch and exaggerated intonation (see O'Connor and Rigby 1996).

The resident's verbal and nonverbal presentation of self in conflicts should be acknowledged by caregivers so that a mutually satisfactory resolution can be achieved. Although conflicts are undesirable, respecting the 'face' of the residents when they do occur should give residents a sense of their self-importance. In so doing, it may help prevent the conflict from escalating and may lead to an earlier resolution.

Caregivers can help preserve the personae of residents by cooperating in the co-construction of the residents' preferred personae. This will require taking a personal interest in the residents' background and

acknowledging the residents' interpretation of their needs and desires for certain forms of care. Regarding the former, we observed only one instance of a staff member taking personal interest in the resident's background. Although staff cannot be expected to personalise their discourse in every interaction because of time or task constraints, we observed many opportunities where staff had ample time to address the residents on a personal level. One might argue that there is little reason for staff to talk with nonverbal residents about their (residents' or staff's) personal lives since it would be a one-way conversation. This perspective, however, fails to take into account the retained receptive abilities of many nonverbal demented residents. The fact that residents may not respond verbally does not mean that they do not understand. Moreover, as our analyses above revealed, residents may be more inclined to respond in a cooperative manner when the content of the staff's behaviour is personalised.

In the present study, the staff's care patterns reflected a predominant positioning of the residents as dependants. Such over-accommodation points to a need for staff to acknowledge the residents' own interpretation of their needs and desires for care. Previous research has found that staff can be trained to encourage independent behaviours while at the same time meeting the residents' expressed needs for care. Baltes *et al.* (1994), for example, have shown that nursing home staff can be re-oriented from employing a dependency-support script to an independence-supportive script. The latter script endorses 'providing security and support only when and where truly needed and otherwise supporting autonomy and stimulation' (1994: 186). Treating the residents in this manner will allow them to recapture a portion of the independent persona they once knew.

Conclusion

Determining the integrity of self-identity in dementia has been shown to involve much more than verifying the use of words from one type of lexical class (first person pronouns). The present study has revealed the complexity of interpreting the presence or absence of first person pronouns in resident-staff interactions. By examining a greater range of indexicals of self and personae, this study presents a more complete picture of the obstacles to and potential for preserving self-identity in dementia (for additional perspectives, see Chin 1996; Golander and Raz 1996; Kitwood and Bredin 1992; Mills and Coleman 1994; and Ronch 1996).

The findings of this study provide useful information for caregivers about the markers of residents' self and personae in staff-resident interactions. Although the content of staff-resident interactions is likely to vary according to context, *e.g.* activity lounge versus resident's room (Gibb and O'Brien 1990), opportunities for indexing self and personae should be present across contexts. Further research is needed to document and compare the frequency and types of 'self' indexicals in other domains.

NOTES

1 Although a staff statement such as 'we can sit down over here' when helping a resident sit down, does not literally include the speaker insofar as the speaker does not sit down, the use of 'we' can nevertheless reflect inclusion and/or solidarity in that the staff includes him/herself in the activity (Quirk *et al.* 1985: 350). It is admittedly very difficult to infer motives or intentions from speakers' forms of address (Wood and Ryan 1991) but, from a linguistic standpoint, the use of the first person plural form unequivocally references oneself and at least one other person.
2 While it is true that the use of residents' first names can reinforce residents' self-identity and support their desire for relational solidarity, for some residents it may indicate a lack of respect for the resident. That is, to the resident, the staff may be viewed as strangers and thus should not use familiar forms of address (Wood and Ryan 1991).
3 We restricted this comparison to these two lexical classes because the staff and residents had similar numbers of tokens for nouns and adjectives (287 against 225 and 114 against 89 respectively) but not for verbs and adverbs (731 against 416 and 241 against 145). Because TTRs decrease as the size of the sample increases, it is not appropriate to compare the TTRs for verbs and adverbs across these groups.

Acknowledgement

References

Baltes, M. M., Neumann, E.-M. and Zank, S. 1994. Maintenance and rehabilitation of independence in old age: an intervention program for staff. *Psychology and Aging*, **9**, 179–88.

Carstensen, L. L. 1986. Social support among the elderly: limitations of behavioral interventions. *The Behavior Therapist*, **6**, 111–13.

Carstensen, L. L. and Erickson, R. J. 1986. Enhancing the social environments of elderly nursing home residents: are high rates of interaction enough? *Journal of Applied Behavior Analysis*, **19**, 349–55.

Carstensen, L. L. and Fremouw, W. J. 1988. The influence of anxiety and mental status on social isolation among the elderly in nursing homes. *Behavioral Residential Treatment*, **3**, 63–80.

Chin, C. 1996. Reconstructing the self with drama and creative arts therapies. *American Journal of Alzheimer's Disease*, **11**, 1, 36–42.

Cohen, D. and Eisdorfer, C. 1986. *The Loss of Self*. W. W. Norton and Company, New York.

Coupland, N., Nussbaum, J. F. and Grossman, A. 1993. Introduction: discourse, selfhood, and the lifespan. In Coupland, N. and Nussbaum, J. F. (eds) *Discourse and Lifespan Identity*. Sage, Newbury Park, California, x–xxvii.

Davies, B. and Harré, R. 1990. Positioning: the discursive production of selves. *Journal for the Theory of Social Behaviour*, **20**, 1, 43–63.

Foner, N. 1994. Nursing home aids: saints or monsters? *The Gerontologist*, **34**, 2, 245–50.

Gibb, H. and O'Brien, B. 1990. Jokes and reassurance are not enough: ways in which nurses relate through conversation with elderly clients. *Journal of Advanced Nursing*, **15**, 1389–401.

Golander, H. and Raz, A. E. 1996. The mask of dementia: images of 'demented residents' in a nursing ward. *Ageing and Society*, **16**, 269–85.

Gumperz, J. J. and Berenz, N. 1993. Transcribing conversational exchanges. In Edwards, J. A. and Lampert, M. D. (eds) *Talking Data: Transcription and Coding in Discourse Research*. Lawerence Erlbaum Associates, Publishers, Hillsdale, New Jersey, 91–121.

Gutman, G. M. and Clarke Scott, M. A. 1997. Behavioural outcomes of environmental design interventions in an SCU in Canada. Paper presented at the 16th World Congress of Gerontology, Adelaide, Australia, August 19–24.

Hadden, S. C. and Lester, M. 1978. Talking identity: the production of 'self' in interaction. *Human Studies*, **1**, 331–56.

Kirshner, H. S., Webb, W. G. and Kelly, M. P. 1984. The naming disorder of dementia. *Neuropsychologia*, **22**, 23–30.

Kitwood, T. 1990. The dialectics of dementia: with particular reference to Alzheimer's disease. *Ageing and Society*, **10**, 177–96.

Kitwood, T. and Bredin, K. 1992. Towards a theory of dementia care: personhood and well-being. *Ageing and Society*, **12**, 269–87.

Kucera, M. and Francis, W. 1967. *Computational Analysis of Present-day American English*. Brown University Press, Providence, Rhode Island.

Levinson, S. C. 1983. *Pragmatics*. Cambridge University Press, New York.

Lyons, K., Kemper, S., LaBarge, E., Ferraro, F. R., Balota, D. and Storandt, M. 1994. Oral language and Alzheimer's disease: a reduction in syntactic complexity. *Aging and Cognition*, **1**, 4, 271–81.

Mead, G. H. 1934. *Mind, Self, and Society*. Chicago University Press, Chicago.

Mills, M. A. and Coleman, P. G. 1994. Nostalgic memories in dementia: a case study. *International Journal of Aging and Human Development*, **38**, 3, 203–19.

Muhr, T. 1996. *ATLAS/ti for Windows* [computer software]. Scientific Software Development: Berlin, Germany. (Internet site--http://www.atlasti.de)

Nussbaum, J. F. 1991. Communication, language and the institutionalised elderly. *Ageing and Society*, **11**, 149–65.

O'Connor, B. P. and Rigby, H. 1996. Perceptions of baby talk, frequency of receiving baby talk, and self-esteem among community and nursing home residents. *Psychology and Aging*, **11**, 1, 147–54.

Pillemer, K. and Hudson, B. 1993. A model abuse prevention program for nursing assistants. *The Gerontologist*, **33**, 1, 128–31.

Post, S. G. 1992. To care but never to prolong? *Caring Magazine*, June, 40–3.

Putnam, L. L. and Wilson, C. E. 1982. Communicative strategies in organizational conflicts: reliability and validity of a measurement scale. In Burgoon, M. (ed) *Communication Yearbook 6*. Transaction, New Brunswick, New Jersey, 629–52.

Quirk, R., Greenbaum, S., Leech, G. and Svartvik, J. 1985. *A Comprehensive Grammar of the English Language*. Longman, London.

Ramanathan-Abbott, V. 1994. Interactional differences in Alzheimer's discourse: an examination of AD speech across two audiences. *Language in Society*, **23**, 31–58.

Richter, J. M., Bottenberg, D. and Roberto, K. A. 1993. Communication between formal caregivers and individuals with Alzheimer's disease. *The American Journal of Alzheimer's Care and Related Disorders and Research*, Sept/Oct, 20–6.

Ronch, J. L. 1996. Mourning and grief in late life Alzheimer's dementia: revisiting the vanishing self. *American Journal of Alzheimer's Disease*, **11**, 4, 25–8.

Ryan, E. B., Giles, H., Bartolucci, G. and Henwood, K. 1986. Psycholinguistic and social psychological components of communication by and with the elderly. *Language and Communication*, **6**, 1–24.

Ryan, E. B., Meredith, S. D., MacLean, M. J. and Orange, J. B. 1995. Changing the way we talk with elders: Promoting health using the communication enhancement model. *International Journal of Aging and Human Development*, **41**, 2, 89–107.

Sabat, S. R. and Harré, R. 1992. The construction and deconstruction of self in Alzheimer's disease. *Ageing and Society*, **12**, 443–61.

Shotter, J. 1993. *Conversational Realities: Constructing Life through Language*. Sage Publications, Thousand Oaks, California.

Shuttleworth, E. C. and Huber, S. J. 1988. The naming disorder of dementia of Alzheimer type. *Brain and Language*, **34**, 222–34.

Souren, L. and Franssen, E. 1994. *Broken Connections: Alzheimer's Disease, Part I, Origin and Course – The world of the patient*. Swets and Zeitlinger, Amsterdam.

Stark, A. J., Gutman, G. M. and Brothers, K. 1982. Reliability of level of care decisions in a long-term care program. *Journal of Community Health*, **8**, 2, 102–9.

Templin, M. C. 1957. *Certain Language Skills in Children: Their Development and Interrelationships*. University of Minnesota Press, Minneapolis, Minnesota.

Weitzman, E. A. and Miles, M. B. 1995. *Computer Programs for Qualitative Data Analysis*. Sage Publications, Thousand Oaks, California.

Wood, L. A. and Ryan, E. B. 1991. Talk to elders: social structure, attitudes and forms of address. *Ageing and Society*, **11**, 167–87.

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