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Mechanisms of conflict and aggression in the dementia context

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Abstract

It is proposed that conflict is an almost inevitable outcome, when, as in dementia communication, the delicate relationship between linguistic processing and pragmatics is upset. This relationship has been little researched, even though much is known about the two components in isolation. Making particular use of key observations and claims from the papers in this special issue, a macro-conceptualisation of the dynamics of conflict and aggression in the dementia context is developed. It is proposed that the cognitive and linguistic processing problems experienced by a person with dementia (PWD) can undermine her capacity to manage her spoken output in the way necessary to match the situational pragmatics, resulting in failure to achieve her interactional goals. The mismatch will create internal dissonance that may be expressed as aggression. Importantly, caregivers will also experience dissonance when their communicative agenda is not fulfilled. This may happen when their expectations of the situational pragmatics (e.g. old versus new information) are contradicted by the behaviour of the PWD. Here too, the dissonance may result in aggression or conflict. Modelling the mechanisms of 'Communicative Impact' (CI) offers a way to capture the relationship between processing and pragmatics and to examine how speakers attempt to resolve the dissonance. The CI model gives insights into how the risk of conflict in interaction between people with dementia and their caregivers might be minimised.

Keywords: conflict; dissonance; communicative impact; processing

Bio

Alison Wray is a research professor in language and communication at Cardiff University, UK. She has published widely on formulaic language, including monographs in 2002 and 2008. Since around 2007 she has been exploring patterns of language in dementia. Her recent research has also questioned the reliability of simple models of grammaticality, and the discreteness of the 'word' as a phenomenon.

1 Introduction

This final paper of the special issue[1] aims to take a step back and look at the larger picture. What, in the dementia context, is the causal chain that binds conflict, expectations within interaction, reactions, and ensuing further conflict? Key claims and observations from the other papers will be drawn upon to consider the various facets of conflict in dementia communication, and how they relate to each other. The account will culminate in a conceptualisation of 'Communicative Impact', a model of how speakers attempt to meet their needs through interaction with others.

In building this model, conflict will be understood as both the outcome of problems and the cause of them (Hamilton 2012). For many, conflict is the visible clash between people (e.g. Rahim 2002), but I shall develop the case for characterising conflict as, fundamentally, something less visible: the unresolved non-alignment of communicative purpose and/or achievement; and only consequently the outward expression of physical, linguistic or emotional force against someone else. This broader and more nuanced view will make it possible to locate conflict within the wider picture of issues arising in communication breakdown, including those that are not always directly observable, such as frustration,

internal and external dissonance, and hostility guilt, as well as the range of successful and unsuccessful strategies that people with dementia (PWDs) and caregivers adopt to fix conflict when it occurs. In exploring these issues, the term 'caregiver' will be used to refer to both professionals and family members. Even though they bring different experiences, skills and expectations into the relationship, the underlying mechanisms by which they use them in interaction are the same.

Resolving dissonances within our own complex agendas, or between ours and those of other people, is a constant task in interaction, and something we—including PWDs—know how to do, to a greater or lesser extent. However, effecting resolutions draws on cognitive, social and emotional resources, and if they are compromised in some way, problems are likely to arise. If the preferred or customary approach to resolution is not possible, an alternative must be found, or we will be left with unfinished business that in turn may lead to heightened emotional responses. While dementia is one catalyst for compromised resources, the stress of caring for someone with dementia is another. Thus, conflict may originate in the thoughts, feelings, actions or language of either party.

The model seeks to interpret at least some of the observations made in this special issue within a single explanatory framework. It will also be possible to offer some suggestions for what sorts of support caregivers might give to PWDs and, importantly, what sort of support they themselves need on account of the challenges they face in interaction.

2 Defining conflict in the dementia context

2.1 Is dementia conflict special?

Mikesell (this issue) points out that in fronto-temporal dementia (FTD) brain damage upsets the personality and the capacity to interact appropriately. There is "loss of social awareness, disinhibition, irritability, apathy, withdrawal, mental rigidity, stereotyped behavior" plus "loss of insight or the diminished capacity to accurately reflect on one's own behavioral changes as well as a lack of concern about them." It follows, as Mikesell points out, that "conflict behavior is ... conceptualized as incompatible with cooperative behaviour, as opposites." In other forms of dementia, too, brain pathology may account directly for changes in social behaviour. In addition, loss of memory, and other cognitive deficits will cause disorientation, distress and anxiety that could have detrimental effects on communication (Guendouzi, Meaux, and Müller, this issue).

Nevertheless, it could be a mistake to shift the entire burden of explanation onto the direct effects of neural pathology. To do so would be to create too firm a divide between the states of with-dementia and without-dementia, as if the disease suddenly and completely transforms a person into a new entity with behavioural agendas, strategies and responses unprecedented in the unimpaired population and their own previous life experience. Miesen (1999) is one who challenges that way of seeing dementia:

> persons with dementia are like normal persons in all aspects of their living. They are persons like you and I. They behave like all persons do in strange situations, and in unsafe conditions …When, try as they will, they cannot find safety and attachment in their environment, they become difficult and demand our attention (Miesen 1999, 100-1).

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In dementia, changed communicative parameters caused by reduced cognitive capacity, memory loss, stress or distress may trigger extreme reactions. In Miesen's view, this is the normal response, which means that unimpaired individuals, such as caregivers, if put into similarly stressful conditions—such as anxiety or lack of sleep—would respond similarly.[2] In other words, the communicative experience of the caregiver can, in important ways, mimic that of the PWD—what should work no longer does, with consequential emotional responses.

It might seem, in that case, that basic empathy on the part of caregivers would be enough to let them accept a PWD's linguistic output, whether it be repetitive, confused or aggressive, as forgivable. For example, Stone et al. (2010, cited by Davis et al, this issue) found that nurses did not construe verbal aggression from a PWD as an attack, which meant it did not contribute to an escalation in conflict. Yet this capacity is not always accessible to caregivers, who seem instead to construe 'normal' without any account of the abnormal pressures that fuel extreme responses. Wray (2013, 2014) points out that this engenders a paradox, whereby they must choose between expecting the PWD to interact like anyone else, and relabelling them as operating outside the bounds of normal human communication, which puts them beyond empathy.

What is needed is a way of understanding why caregivers struggle to develop and sustain a clear sense of what is happening in their interaction with a PWD. The account below points to the processes underlying communication. These are so integrated that it is difficult simply to change one parameter and find an appropriate response.

2.2 Which behaviours count as 'conflict'?

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[2] Clegg (2010), in his *Fun and Games* section, provides transcripts of unkind responses by professional caregivers to PWDs in a residential facility, including anger, scorn, turning music up loud and unnecessary teasing.

Conflict is most visible when it is manifested as a "disagreement of ideas or principles", when "interlocutors' goals and expectations are not matched" (Guendouzi et al., this issue), when a speaker displays "violence, aggression or hostility" (Davis et al., this issue), and when it "justifies intervention" because it "cause[s] stress to caregivers [or] disturb[s] other residents" (Wyles, this issue). But conflict is not synonymous with aggressive or disruptive behaviour, and the same emotional responses to a situation can just as easily turn inwards as outwards. Guendouzi et al. distinguish external conflict between individuals from what goes on "within the individual ... when struggling to understand the gist of a conversation, the interactional context, or indeed the identity of the interlocutor."

It could indeed be more productive to consider the *primary* nature of conflict as internal, with disagreement, verbal aggression and so on actually only some common consequences of that. Even though 'conflict' entails dissonance between two physical or cognitive positions, we do not necessarily have to construe that dissonance as primarily seated in the space between people. And, in taking that view, it becomes possible to identify options for resolving conflict, which are not available if conflict is located only in the external social space. Conflict as dissonance thus gives us a way to understand other behaviours exhibited by PWDs and by caregivers, including internal anxieties and a range of responses to external clashes, including depression, passive aggression, hostility guilt, stress, excessive self-sacrifice, and so on.

By conceptualising conflict as a continuum from internal unease to external aggression, we can ask useful questions that tease apart the many different expressions and responses to conflict, without oversimplifying their relationship. For example, if a misunderstanding arises

and is resolved, has there been conflict or has conflict been avoided? It makes sense to view misunderstandings as manifestations of interpersonal dissonance. As such, they are a type of conflict that has the potential, not always realised, to lead to another type of conflict. In effect, one looks deeper than the external manifestations of conflict, such as aggression, to consider not just the immediate motivation but the chain of causal links, many of them also types of conflict. Because they lie on a continuum, it will be relevant to examine the ways in which misunderstandings are resolved, for indications about how social problems featuring more explicit conflict might be addressed constructively.

As the precursor for considering why communication in dementia so easily develops into conflict (section 4), section 3 lays out a model of the more general relationship between language processing and interaction, and how changes to their operation can generate conflict.

3. Patterns of effective interaction and the impact of compromised processing

When we communicate, two types of cognitive activity intersect: (1) determining what to say and how, and (2) marshalling the appropriate linguistic resources for saying it. For researchers, the former is characterised in terms of pragmatics, semantics and socio-interactional theory, drawing on such commentators as Bakhtin (1986), Blommaert (2005), Bourdieu, (1991), Brown and Levinson (1987), Goffman (1981), Grice (1975), and others. The latter focusses on lexical knowledge and access, grammar, phraseology including formulaic language, and production mechanisms, drawing on research of three main kinds: patterns of language in its own right, experimental studies, and studies of language disorder.

Just what happens at the intersection of the two activities to enable effective communication[3] is only tangentially addressed in either mainstream approach. Of course, pragmatics and the social awareness of register do figure in accounts of what language is like and what we need to process, but questions rarely asked include:

- How does a person's communicative agenda influence how s/he processes language?
- What is the impact on the operational parameters of interaction, of experiencing a blockage in processing?

Conceptualising the relationship between interaction and processing in a manner that can help answer such questions requires us to establish what the core impetus is. The view taken here, hardly controversial, is that the driver of language behaviour is its communicative impact on others or on oneself. That is, in most if not all cases, we use language to effect change in our world. Of course, we can talk to ourselves too, and the purpose there would be that externalising ideas phonologically helps us to work with them. Mostly, though, we talk to others. Again, that may be in part to change something in ourselves—speech as action—as when we speak in order to have spoken. But predominantly, when we speak to others, we do so in order to engage their agency in some way that supplements our own. Our goal is to make a change in our world that we cannot achieve ourselves (Wray 2002a).

The main types of change we attempt involve: (a) getting someone to undertake an action on our behalf (e.g. move something, tell us something) so that our world is materially or mentally modified; (b) getting them to think something or feel something, with likely onward

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[3] 'Effective communication' means communication that fully or at least satisfactorily achieves its (many) goals, including the safe delivery of sought-for information, a desired physical or emotional response, the protection of face, and so on.

impact in their behaviour. Between them, (a) and (b) also support the management of positive and negative face (Brown and Levinson 1987). Because our needs are many and subtle, the types of change we seek can also be so. For example, we can be altruistic—effecting a change that benefits someone else *rather* than ourselves. Yet at another level, altruism gives us rewards, in modifying our world towards one in which we perceive ourselves as kind, and as likely to receive the approbation of others. As Darwin (1871, 157) observed, "a … powerful stimulus to the development of the social virtues [is] the praise and the blame of our fellow-man".

It follows from this conceptual position that processing is the servant of interaction.[4] However, it will become clear below that processing problems can also wash back, impacting on the parameters of our interactional motivations. This is crucial for understanding how conflict in dementia interaction is handled by PWDs and by caregivers.

3.1 The route from 'what I want' to 'what I get' in interaction

- Insert Figure 1 here -

The fundamental core of interaction, in this Communicative Impact model, is that individuals enter into communication with a set of agendas—things that they want to achieve—and they measure their communicative success in terms of meeting those agendas more or less successfully and fully: communicative impact. Achieving high communicative impact depends on what happens in the 'Communicative Demand Management System' (Figure 1).

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[4] The Chomskian view over the years has been that our linguistic system is independent of what we do with it. That is, language is a product of the mind and may not have evolved for the purposes of communication—it just turns out to be quite useful for it. However, even if this is so in evolutionary terms, children certainly acquire language in a step-wise parallel development of structure, processing and social interaction, so that communication is an embedded function of the linguistic system.

This system, described in more detail below, identifies the optimal strategy for encoding output.

Let us begin with a classic scenario from pragmatic theory. Imagine someone is feeling cold and she wants the door shut. For some reason, she is not in a position to close it herself. She needs to communicate her wish to another person whom she judges capable of closing it. This communication can take various possible forms, but we will focus here on uses of language. The manner in which she encodes her message will depend on how she gauges the many general and local contextual factors pertinent to the situation. In short, she needs to figure out what formulation will maximise the chances of getting the outcomes she wants. One outcome is the door being shut, but there are others—such as not being considered rude, not getting into a prolonged conversation, negotiation or argument, and so on. The experience she has built up through her life contributes to her capacity to pitch her message in the optimal way.

However, communication does not always go smoothly, and sometimes communicative impact is not as high as intended. It might be because the speaker is not all that adept at understanding and managing the subtle pragmatics of contexts (see section 3.4). Or, even if she is, sometimes she will have too little knowledge of some contextual parameters (e.g. she is in an unfamiliar setting, or is under-informed about her interlocutor), and she may make some inappropriate judgements about what is the appropriate register, level of jocularity, explicitness, etc. In such circumstances, conflict may arise for her and perhaps between her and her interlocutor. It might not be explicit: shouting, complaining, physical force. It might be internal frustration, disappointment, confusion. All these responses reflect dissonance: a conflict between the world she wanted and the world she got.

Another thing that could create conflict for her is inherent incompatibility between different things she wants. For example, if she feels that the person who left the door open has not taken her into consideration enough, one of the parameters in her choice of words might be the desire to put herself more firmly in his mind—by raising her voice, or being less than polite. But this may clash with her other objectives. The interlocutor might take exception to her rudeness and refuse to close the door, or might do so with a slam, conveying that he does not think well of her. In such cases, communicative impact is not as high as it could be— some objectives have been achieved, but at the expense of others. Inner dissonance is, here, inevitable, and it primes the atmosphere for further instances of conflict.

3.2 Managing communicative demand

- Insert Figure 2 here –

Figure 2 reveals how the Communicative Demand Management System operates. The agendas that the System receives are encapsulated in ideas (in the general semantic sense of conceptualisations, rather than the narrower sense of propositions). The ideas are filtered through an evaluation of the contextual parameters. That is, the first thing that a speaker does is deploy situational knowledge, pragmatics and the accumulated knowledge of the effects that different formulations of language can have to calculate what it will take, in the present circumstances, to get the desired outcome. It is at this stage that decisions about language code, register, directness, and so on are made. The output from the context module is input for the resources module. Here the lexicon and grammar are accessed to assemble the required components for output. They are fed into the processing module for the generation of the output.

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3.3 How interaction can go wrong, and how it can be fixed

- *Insert Figure 3 here -*

There are various stages at which the flow from the initial agenda as input to communicative impact as output can be disrupted by 'external' circumstances—that is, when the system does not work optimally. In Figure 3, the Communicative Demand Management System is challenged by three different problems (rounded rectangles), with various possible solutions also shown (ovals). Beginning in the lower left (Problem 1), a speaker can experience difficulties with processing on account of a condition like dementia or because of excessive cognitive demands resulting from multitasking, tiredness, stress or unfamiliarity with the language being used. The speaker knows what she wants to say (ideas), how to encode it effectively in order to achieve the desired goal (context), and she has accessed the relevant words and rules (resources). But the interference to processing means it is not possible to complete the production fluently and coherently.

Typically, the solution will be to draw down additional resources. They might be filler expressions that allow the speaker to hold the floor while completing the formulation; alternative formulations that require different, or less processing, such as prefabricated (formulaic) expressions; or repetitions of previously spoken output, available as a resource temporarily on account of recency, or permanently as 'lexical teddy bears' (Hasselgren 1994).

Moving to the centre right of Figure 3, a speaker can have problems with resources (Problem 2). This might happen if there are lexical accessing difficulties, or, with a language learner, a basic absence of lexical or grammatical knowledge. Where resources are inadequate, there are three possible solutions. The most demanding is to engage in additional processing, such as circumlocution, which is likely to entail a rather novel output sequence. A language learner might use this solution if lexical gaps are, overall, rare and her facility with the language is good—much as a native speaker will use circumlocution to resolve a tip-of-the-tongue difficulty.

For less proficient learners, or for people with dementia, circumlocution may create more problems than it solves, since it makes new demands on an already pressured resources module, and there may be disruptions to processing as well. Less demanding is to look for an alternative within the resource system—a synonym or alternative grammatical formulation that can be fed through to processing instead. However, the selection made may not be optimal in terms of pragmatics, as determined by the context module—if it were, it might well have been selected in the first place. Thus, a person who cannot find the word they want might access another, but one that is, say, too erudite or too coarse to be ideal for that hearer in that situation. Doing so may create a dissonance for the hearer in terms of register or politeness. Meanwhile, if the speaker falls back on material already used, the repetition will be stylistically marked or may breach the maxims of conversation (Grice 1975).

The third option is to recalibrate the context. Here, the speaker revisits the parameters she set for the output. For example, a second language (L2) speaker in an L2 context will set the contextual parameters for using the L2—it is the most appropriate thing to do. However, this forces her into relying on her limited L2 knowledge. If she is unable to find the resources she

needs, she can revisit the context, evaluating the likelihood that she can achieve her goal using her first language (L1). This is the sort of thing that English-speaking holiday makers with a smattering of the local language often do—they begin in the L2, and when they encounter an impasse in relation to achieving their goal, they take a punt on having better luck with their L1. Context is everything here. In contrast to an English speaker overseas, a native speaker of Hungarian in an English-speaking country would be less likely to assume that using his L1 would improve his communicative impact.

Finally, the speaker might have inadequate contextual information (Problem 3). This problem can occur for any of us, when in a culturally or socially unfamiliar environment—we know what we want to say, but we don't know how to formulate it appropriately. For a person with dementia, the problem can arise because they are not sure where they are or, perhaps, whom they are talking to Guendouzi (2013). Camilla Lindholm (personal communication) reports that bilinguals with dementia can fail to select the most appropriate language for their interlocutor, when they no longer remember where the person fits within their world.

One solution to having inadequate contextual information is to look for resources that can ride the ambiguity. For example, formulaic expressions (e.g. *how's the family; how's work?*) can tide a speaker through an awkward moment when they cannot remember enough detail to be more specific. Cherie Blair, wife of the former Prime Minster of Great Britain, tells the following anecdote in her autobiography: The state banquet was quite fun: I sat next to a nice old man I thought I half recognised. "How's your wife?" I asked him, knowing that old people like to be kept 'in the swing of things'. "Still Queen," he said.[5]

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[5] http://www.independent.co.uk/news/uk/politics/mrs-blairs-diary-a-family-living-in-quite-a-nice-area-but-with-rather-noisy-neighbours-403198.html

If the problem cannot be solved in one of the ways described above, there is a final option. It is to revisit the entire motivation for generating the utterance. The speaker, unable to get what she wants, changes her mind about wanting it. It is a way to resolve the dissonance of low communicative impact. This sort of recalibration has been described in Turkish immigrants in Germany. Rehbein (1987) found that, rather than increasing their resources (i.e. learning more German) so as to better meet their agendas, they redefined their needs down, to match the German they had. Many a holiday-maker will have done something similar, muttering 'it doesn't matter' when a transaction fails due to their lack of expressive or comprehension capacity. Maureen, in Davis et al.'s study (this issue), has discovered that although her output 'this is not your room' does have immediate communicative impact, it is not sufficient to get her what she really wants—no intrusion into her room by other inmates in the first place. She is not contextually well-positioned, as another resident, to find an appropriate way to use her lexical and grammatical resources to effect the change she desires. Thus, she says, "you just have to sort of grit your teeth and bear it because you really have lost all privacy." That is, she has recalibrated what she 'wants' to match what she can have.

3.4 Inherent constraints on the system

High communicative impact is the goal, but it is not always achieved, even by unimpaired native speakers. In addition to specific things going wrong, there are various reasons why individuals may find their capacity limited. Firstly, some people are more sensitive than others to the subtleties of situations, and are more adept at modifying their language in response to details of the context—and, in particular, the hearer's own agendas. The skill of working out how a message is best delivered to have the desired effect probably maps onto empathy and theory of mind to some extent. However, these capacities are typically

associated with sensitivity and kindness, which are not the only possible characteristics of those commanding high communicative impact. Since the speaker's drive is to get what she wants by engaging the agency of the hearer, the skill of accurate contextual appraisal will also benefit people who are deliberately or unintentionally manipulative, including very charismatic and persuasive personalities with self-serving goals.

Some speakers go beyond accurately predicting what the hearer will respond positively to, and frame their own wants to match what they believe the hearer wants. This kind of accommodation is described in the popular psychology literature as 'people-pleasing' and countered with assertiveness training (e.g. Biali 2013). Remedial action is needed because of the risk that inner dissonances will be created for the speaker between what she believes she wants and what she actually really wants and needs. Although focussing on pleasing others will certainly maximise the likelihood of fulfilling her want to be liked and appreciated, it may obscure her ability to understand why she feels dissatisfied with the other outcomes of her interactions. All the same, there is a potentially positive side to wants-alignment (see section 5.3).

Another way in which the system may not work optimally is when the speaker tends to exclude some socially-valued element of communication from consideration. For example, if the speaker does not care what hearers think of her, because she lacks awareness of, or interest in, others' points of view, it will free her up to express messages in a broader range of ways. She may be regularly puzzled by why she has not achieved the level of communicative impact she expected, as hearers, offended or confused by the formulation, decline to respond as she desired.

Such blindness can also be social in origin. Contexts are not neutral, but socially constructed, and it is possible for different people in a situation to frame it quite differently (Tracy 1997; Ritchie and Cameron 2014). As a result, they will differently assess what is most appropriate for navigating it and their choices may clash with the expectations of their interlocutors. Ritchie and Cameron (2014) examine the metaphors used at a meeting between a local community and police representatives after the police shooting of a young woman, to find out why conflict arose. They show that even though the parties intended to work together constructively, each failed fully to recognise how their audience understood the situation, and framed the context in a way that was unintentionally provocative.

Finally, culturally-determined interactional patterns may result in differences within subpopulations. Guendouzi et al. (this issue) review research into the different interactional patterns of males and females. They note that women's talk is collaborative and playful, and features more small-talk, politeness markers, back-channelling and mirroring than men's talk which, in its turn is characteristically "(a) more competitive, (b) more structured in terms of turn-taking, and (c) more likely to consist of information giving topics."

Males and females are socially conditioned to prioritise different in social scripts, pursuing different affective needs in their interaction, and thus encoding their output differently. Although such differences cannot be construed as limitations, where certain levelling conditions prevail, such as in dementia, one style may pay greater dividends in the short term, even it if exacts its toll later. According to Guendouzi et al., women disguise the severity of their dementia for longer—the formulaic nature of small-talk makes it relatively undemanding to achieve (Wray 2002, 2008, 2011). Maureen Littlejohn in Davis et al.'s studies (e.g. 2013, this issue) is particularly adept at "control[ling] the airspace" (Davis et al.

2013, 92) by using other-directed questions and set piece narrations to sustain a sense of normality.[6]

In terms of the Communicative Demand Management System, the female style, as outlined by Guendouzi et al., provides more resources for patching up problems with lexical retrieval, slowed processing, or missing contextual information. Implicit in their account is that men, more geared towards factual expression, will experience more directly and visibly the impact of compromised resources and processing. Lacking some of the potential resource solutions, such as formulaic language, they may have to resort sooner to other options, including recalibrating what they want. Thus, the model predicts that men will fall sooner into silence, and feel more acutely a sense of powerlessness, frustration and isolation, with, in many cases, ensuing aggression.

The model enables us to raise two additional observations. The first relates to the adoption of social scripts that can create a reliable conduit through the Communicative Demand Management System. For example, most people have a script for stopping a stranger in the street to ask for information. That script helps us encode appropriately for the context of speaking to an unknown person who must retain the option of declining to help. It may include nuanced expression to convey the speaker as non-confrontational but needy and grateful. Scripts are associated with our agendas—our wants. It follows that when a person's circumstances change, they may find themselves in new situations and with new agendas, for which their existing social scripts are inadequate. As a result, they may have to rifle through parts of the communicational toolbox that they rarely use and do not have reliable models for.

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[6] Compare also Sylvia, a person with cerebral palsy who used software to pre-construct, store and retrieve what she anticipated needing for her turns in conversation. Although she could not control what her interlocutors said, she exercised high levels of control of the discourse by formulating her turns in a manner that successfully avoided situations where she would have to break the flow of conversation by typing in new material in real time (see Wray 2002b, 2008; Wray and Fitzpatrick 2010).

For example, a person who has never before experienced the indignity of being washed in intimate places by a stranger who is also a member of the opposite sex, may struggle to find ways to express messages relevant to that activity, and find themselves drawing on, say, swearwords in the absence of other options. Caregivers will struggle to interpret such output as other than offensive, unless they have a high capacity for empathy, able to project into their context module a broader set of factors. Algase et al. (1996) propose, indeed, that much of the behaviour interpreted by caregivers as aggressive or disruptive is an attempt on the part of the PWD to express their needs (something arguably true of aggressive behaviour more generally).

For the researcher, understanding the nature and causes of conflict in interaction will require that broader view. One must model the agendas of all participants, and relate them to estimates of how each person's context module will interpret the situation. For example, in Mikesell's (this issue) case 2 (Robert and Juliet) we need to consider not only what Robert wants, and what Juliet wants, but also what the counter clerk wants and how each party construes the likely wants of the others. Interaction concerns the external juxtaposition of different agendas, which are then socially and linguistically negotiated. Participants are inevitably constrained by seeing only their own point of view, and possibly assuming that there is less difference than there actually is between their and others' context module parameters. Researchers have the scope to draw attention to the potential impact of hidden differences.

Secondly, despite how it is visually depicted in Figures 1 to 3 in this paper, the relationship between agendas and scripts will not be unidirectional. Mirroring earlier comments about the

influence of contextual constraints on the reconstrual of what one wants, even though the speaker's wants will typically trigger the script, the reverse may also occur: scripts influence what the speaker (believes she) wants. Speakers may manoeuvre themselves psychologically into positions where they can legitimate a script, or avoid having to use one. For example, someone who uses humour as a way of pitching interaction at a comfortable level of (lack of) intimacy, may suppress or reinterpret the desire for a serious conversation so as to latch into the more familiar patterns of interaction. Those patterns will deliver some outcomes associated with high communicative impact, but the abandonment of the underlying need may result in a sense that, somehow, the interaction was not as effective as it should have been. In line with Guendouzi et al.'s account of gender differences, someone who typically adopts small talk might get to the end of a long conversation that feels satisfactory, only to realise that she never got answers to some questions, because in that script there was no opportunity to ask them. Hence, Guendouzi et al.'s apposite question: "Are the forms of talk that women used actually indicative of volitional compensatory strategies? Or are they simply the result of socially conditioned habitual behaviors?"

4. Making sense of patterns of conflict in the context of dementia

Drawing on the account in section 3, we can now explore the observations made in the papers in this issue. It is not the intention to 'wrap everything up' in a perfect explanation, but rather to examine types of conflict through the lens of this account, to see what light can be shed on overall patterns, and what solutions there might be to the problems that can arise for PWDs and caregivers. In addition to the more general discussions in section 2 of what conflict is and what causes it, we can now consider how the introduction of pressure points within the Communicative Demand Management System is likely to increase the risk of conflict in the

dementia context. We will also glimpse some of the complexity that arises from the interface between interlocutors as they switch between speaker and hearer roles.

4.1 Conflict as a product of the damaged system

Each part of the system in Figure 3 can generate the conditions for conflict. At the macro-level, internal conflicts may arise from the speaker's inability to meet her agendas satisfactorily. External conflicts, that is, visible clashes between interlocutors, may arise from frustration, on the part of either party, when the PWD or carer makes their best stab at getting a message across but it does not achieve high communicative impact.

The ***context*** module is vulnerable in at least three ways. Firstly, the norm in interaction is for contextual information to be continually updated. Speakers will naturally assume that, as they hand the floor to another, their contributions thus far will be taken into account. However, a PWD may be unable to update the contextual information arising from the preceding interaction, because she forgets what, and that, she has been told. In her contextual evaluations during later output planning, she will not be able to take into account either the information itself or the fact that asking for that information (again) is a marked action from the point of view of her interlocutor, and needs special presentation (e.g. "You probably told me before, but…"). The hearer's reaction to output that does not take into account the recent additions to context may be frustration or hurt. A caregiver or family member may feel overlooked and undervalued if she finds that her attempts to explain something or answer a question have been, as it seems, ignored (Wray 2013, 2014).

Secondly, neither a PWD nor a caregiver will be able to gauge the context accurately if they are unsure of what is going on. Confusions about core points of reference in a situation can easily arise, because when something is amiss it will not always be clear which link in the otherwise unimpaired chain has been broken. For example, Hadas (2011) responded anxiously to George's taking an alternative route home because she did not know if it indicated confusion on his part or not.[7] Similarly, if either party in an interaction has not understood the output of the other, or believes that they have missed its deeper significance, it will be disconcerting for them. They may have to guess what is appropriate to say next, and may guess wrong, setting in motion further dissonances. They may choose to avoid that risk and simply change the topic, as the researcher does in the conversations discussed by Müller and Guendouzi (2005).

Thirdly, for families, the longstanding parameters of relationships that have shaped the context are shifting. There can be general resistance to the change. For example, Lockhart (2009, 70) resisted admitting that her mother had a problem: "I was too comfortable with my established view of her as the capable one, the doer; that was the familiar picture, the accepted reality." It will not always be clear any more how it is appropriate to react towards a parent who now needs—at times but not constantly—aspects of parental care (Miesen 1999). The same applies to non-family caregivers. As Davis et al. note (this issue), a PWD's communication problems may "cause[ ] caregivers to see the PWD's identity as fractured, to malignantly position the PWD in terms of their abilities … and to regard their speech as having little or no consequence." Moreover, they have to determine whether and how to adjust the wider parameters of their judgements, such as whether a PWD is morally accountable for inconsiderate or abusive behaviours (Mikesell, this issue).

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[7] I am grateful to Marie Savundranayagam, Ellen Ryan and Kelsey Moore-Nielsen for pointing me to the memoires by Hadas and Lockhart.

Difficulties with the *resources* and *processing* modules may arise from the level of cognitive damage in a PWD. Difficulties may also stem from the temporary impact of local conditions in the care context (Gauthier et al. 2010). Wyles (this issue), for example, refers to 'sundowning', a reduction in attentional capacities in the late afternoon and early evening. Another trigger may be stress, in the PWD or caregiver, arising from the situation or from other factors, e.g. in PWDs, hearing and vision impairments, or pain (Wyles, this issue); in caregivers, worries at home, problems using a second language.

When there are difficulties with resource retrieval or processing, typically, lexical resources in the form of fillers, proforms, formulaic expressions and repetitions will be used to sustain the turn (Wray 2002a). Since their usefulness derives from the fact that they make low cognitive demands and are generic, they cannot convey much explicit information. Joan, a singing teacher with symptoms indicative of Alzheimer's Disease (Wray 2010), produced output like "It makes it go on like that all the time" and "It's that kind of feeling, you know, of doing it". Hearers may be frustrated by the low communicative impact that a speaker can achieve in relation to the message content, even if high communicative impact is achieved in terms of overall communicative behaviour, manner, and so on. Joan, for example, was often not successful in conveying a clear informational message, but was unfailingly pleasant, engaged and professional.

Insofar as the hearer is expected to engage in some behaviour in response to the speaker (that is, recognises that he has a role in enabling communicative impact to be achieved) it will be disconcerting not to know what to do. In the case of Joan's singing students, her instructions were intended to result in changes in performance, but this was difficult for the student to

achieve when the content was underspecified, as in the following examples, all from Wray (2010):

Example (1)

Joan: Sometimes you're a bit dithery.

Beryl: Do you mean I'm behind the beat?

Joan: Oh yes I know.

Example (2)

Joan: Words not in all that.

Alex: Not enough words?

Joan: That's right.

Example (3)

Joan: Do that thing.

Muriel: Do what thing? ((laughs))

Joan: ((Joan demonstrates by singing)) You've got to do that, darling.

Muriel: Here? Shall I hold it more?

Joan: That's right, you've got to do it more. And Trä::::nen ((sung)) and put the 'n' on the end.

4.2 Subtle manifestations of conflict

The complex responsibilities of a caregiver will often make it difficult for her to externalise internal dissonances directly. While she might, at a given moment, want to express her

frustration, release some emotion by raising her voice—see Davis et al.'s (this issue) quote from Small and Montoro—or grab back some emotional support from the PWD, she will have other agendas as well, related to her awareness that it is unfair to blame the PWD for being ill. In such situations, we will observe the interplay of two important factors. One is inherent complexity—the difficulty of juggling different agendas in an ever-changing context. The other is human frailty in relation to getting it right every time—even if there were an ideal way to handle the complexity, caregivers would struggle not to succumb to strong emotions at least some of the time. Thus, some aggression, both on the part of the PWD and the caregiver, may be an understandable, though not inevitable, consequence of their respective internal conflicts. This is important to recognise, because it offers the possibility for helping both parties manage interaction better (see section 5).

For the reasons just given, when a caregiver does respond emotionally to the stresses of the situation, it will not always manifest as overt aggression, such as shouting, physical attack or unkind words. It can be much more subtle. There may be more of an attack on the self—feelings of hostility, frustration, disappointment that they strain to suppress, or behaviours that they need to adopt but feel bad about. Lockhart (2009, 146) describes being "catty, sharp and cold". Wyles (this issue) notes how "family members find it stressful to visit a loved one who has V[ocally] D[isruptive] B[ehavior] and as a result may visit less frequently." Distancing can also result in 'othering' the PWD as incompetent. Davis et al. (this issue) note:

> we have observed (though seldom been allowed to record) staff presenting negative
> comments that could be overheard by the target, asking 'unpalatable' questions and

performing various kinds of condescension which are, in our experience, largely

nonverbal, such as eye rolls and head turns.

Another aspect of othering is when "the PWD is silenced by being ghosted, talked over, talked across or talked for", a practice that Davis et al. "find … an act of linguistic violence on the part of the caregiver" because "Residents ... retain their ability to notice, evaluate and respond to staff impoliteness when they experience it, even if their responses are limited to …howls." Davis et al. include teasing as a form of verbal aggression, even though they also recognise that it can be a marker of respect for the interlocutor as an equal partner—that is, a reinforcement of the sense of underlying normality in the situation (see Wray, submitted a, for a discussion of the relationship between humorous and non-humorous interpretations of the normal/abnormal interface). Indeed, that very ambiguity makes it a powerful vehicle for the expression of passive aggression.

5 Approaches to conflict resolution in the dementia context

That externalised conflict, expressed as aggression or disruptive behaviour, is a problem in dementia care is clear, and there have been many attempts to address how it should be handled (e.g. Algase et al. 1996; Gauthier et al. 2010; Hamilton 2012). Some of the main ideas will be mentioned here, in the context of an attempt to frame the identification of solutions within the predictions and explanations of the model developed above.

Typical entry points in the research literature relate to caregivers having an inappropriate attitude and/or response to the situation, lacking awareness of what is going on for the PWD. For instance, Davis et al. (this issue) cite work by Persson and Wästerfors (2009) in which

staff rationalised ignoring residents by casting them as "attention seekers" or "impossible to satisfy." Yet caregivers are doing a difficult job and trying to do it well. Explanations for why they sometimes respond in this way are key to identifying alternatives that they could try.

5.1 Explanations for uncaring care

Caring for a person with dementia brings with it a complex set of demands—logistical, physical and emotional. Neither professional nor family caregivers necessarily get any training or support in recognising the less obvious ones. Whether simply raising awareness is enough, however, is questionable. We can know we are in a box and still not see how to get out of it. Caregivers and PWDs alike can be cast into roles that are difficult to escape, even if they can be seen. Just as Tracy (1997, 316) notes for police-public interactions on the telephone, so also in the dementia care context "many … routine interactional difficulties … can be traced to a set of differing expectations that the parties bring to the interaction".

One of the most pervasive conduits may be the 'patient' script, which affects people well beyond the context of dementia care. Both the PWD and the caregiver may slip easily into social roles in which the former is deprived of agency and treated as an object of care (Davis et al., this issue; Sabat 2001). For the caregiver, the script is supported by the pressures of expediency, with instrumental targets that leave little time for attending to the person. For the PWD, helplessness is an understandable response to the experience of the condition, even before a caregiver imposes 'help'. Getting what she wants entails the PWD *knowing* what she wants and how it might be got. This in turn requires an awareness of the context. The PWD needs to know why she is where she is, why someone is doing for her, with her or to her what they are, and what reasonable options she has. With poor short term memory and, perhaps,

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the confusing spectacle of hallucinations to deal with, keeping straight an assessment of what is going on will be a constant challenge that soaks up precious cognitive resources (Guendouzi 2013). It will become easy to comply with the script—that is, reassessing the context and her wants to match the patterns of interaction (Figure 3). A further challenge for both parties may be the absence of adequate social scripts for handling externalised conflict. In many societies, no one quite knows what to do with aggression, and constructive responses to it are rarely practised. As a result, aggression and disruption must be conceptualised as 'abnormal', with knock-on effects for sustaining 'normality'.

As already noted there is an actual, or at least apparent, paradox, whereby the more you treat a person as normal, the more upset you will be at their outrageous behaviour. If you distance yourself and treat them as not normal then they are no longer morally accountable (Mikesell, this issue) and that creates relief. On the other hand, by not treating them as normal, you are depriving them, and yourself, of the last vestiges of 'normality', whereas the PWD's objective, for as long as possible, is to hold onto whatever of normal life is left. This double bind easily drives caregivers into stress (Wray 2013, 2014). Stress is the kindling for the fire of conflict because it is itself born of internal dissonance. In my previous work (Wray 2014), I have suggested that some people do find a way out, through advanced empathy skills. However, the model used in this paper offers a new way of understanding the opportunities for change.

5.2 Existing solutions to the challenges of conflict in dementia care

It must be remembered that externalised conflict occurs in the space between individuals, but that internalised conflict can be hidden and suppressed, or may manifest in indirect ways,

including distancing and hostility guilt. If, as suggested, conflict is dissonance—a clash between what one expected and what one got—conflict is not necessarily bad (Davis et al., this issue). It is startling. It can be the source of humour (Wray, submitted, a), and it is what spurs us into learning and changing, because it makes us reassess the things we thought we knew and wanted (Figure 3). It can, therefore, be used creatively to effect positive changes in behaviour.

The first requirement is to be realistic about one's expectations (Miesen 1999, 133). The second is to understand the likely biological, environmental and psychosocial triggers of unease and dissonance (Gauthier et al. 2010). The third, and the one we will focus on here, is learning to see the person and not the persona (Davis et al., this issue). That is, to resist the negative effects of adopting social scripts—though, as we shall see later, there are positive benefits to scripts, too. At the heart of 'seeing the person' is navigating the paradox mentioned above: if the PWD's behaviour is interpreted as normal, then it is hurtful and offensive; yet if it is treated as abnormal, the normal guidelines for humane care are at risk (Mikesell, this issue; Wray 2013, 2014).

Hamilton's (2012, 9) account of the positive and negative impact of aggressive behaviour mirrors the paradox. On the one hand, "verbal aggressiveness increases aggressive behaviour with aggressive behavior producing an antipathy that decreases collaborative behavior". On the other, "verbal aggressiveness increases social distancing, with social distancing increasing collaboration" (ibid; compare also Jones, 2012).

The avoidance of aggression acts as a "relational waypoint if people try to navigate a path from a "place" from which they want to escape (an aggressive setting) to a "locale" that is

more comfortable (a collaborative setting)" (Hamilton 2012, 10). To effect such control of one's behaviour, however, must entail some measure of reflection, and this also requires distance. According to Miesen (1999, 131),

> Keeping the necessary distance means that you can draw a line between your own emotions and those of the other person. Without it, it becomes difficult to evaluate situations and to work out the best way to help. Without the necessary distance, caring can become 'over-involvement', 'meddling' and can even result in feelings of 'total helplessness.'"

Distancing is achieved by understanding where one is and where else one could be. It, therefore, entails recognising when one is a player in a social script, and having the capacity to escape from it or else change or rewrite it. At a practical level, changing the context in which the interaction takes place can alter the options regarding which scripts are appropriate. Joan the singing teacher (Wray 2010, 2014) benefited from the dominance of a social script that placed her in the position of valued expert. The impetus of this well-rehearsed role, and the compliance of the students in adhering to their learner script, gave her the momentum to sustain authority and dignity even in the face cognitive difficulties and a measure of eccentric behaviour. Jansson and Plejert (2014) show how a caregiver has options in how to deal with resistance on the part of a PWD to the fulfilling of a necessary care task (taking a shower). Sabat (2001) also notes how PWDs can be given roles that break through the bounds of customary expectations.

Wyles (this issue) points out the opportunities for removing unintended catalysts of aggressive behaviour in PWDs, including excessive noise and stimulation, and the absence of

basic necessities such as pain relief, hearing aids and glasses. The context can be additionally enhanced through the introduction of pleasant smells, music, clear routines, and the assignment of a single main caregiver to each person.

5.3 Solutions in the light of the Communicative Impact model

A model of interaction can shed light on why some practices are more effective than others, and thereby encourage greater attention to creating opportunities for certain dynamics to operate more commonly and freely.[8] The subsections below each articulate a potential recommendation for maximising the opportunities for satisfactory communicative experiences between a PWD and an unimpaired interlocutor.

5.3.1 Ground interpretations in 'normality'

The Communicative Impact model does not have a special 'dementia' setting. Rather, it is based on the premise that behaviours observed in PWDs are triggered in the same way as in unimpaired individuals. This does not mean that dementia symptoms will remain fully within that frame, only that one should check there first. Thus, it will be beneficial to ask whether a PWD is silent because silence is a logical response to the context, given the pressures on resources and processing. But a PWD may also be silent because she cannot generate speech.[9] It would be foolish to deny the profound impact of dementia, and to pretend that there is some magic bullet that can restore interaction to what it used to be. But treating PWDs as capable, and expecting where possible to interpret their interactional behaviour as a

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[8] Aspects of the larger model, not explored in this article, include the ways in which formulaic language, deployed to manage misalignments in perceptions of shared knowledge (a common problem in dementia interaction) can inadvertently create 'unaccustomed pragmatic spaces' (Wray, submitted, b); and how the tensions arising from such misalignments resemble those leading to humour but are more difficult to diffuse (Wray, submitted, a).

[9] The boundary between the two may, however, continue to be a surprise, as Naomi Feil's interaction with the 'silent' Gladys Wilson shows, https://www.youtube.com/watch?v=CrZXz10FcVM

reasonable response to the context they are in, will maximise the chances of not losing communicative capacity precipitately.

The model offers insights into how the paradox of empathy versus distance can be resolved. The paradox arises from a too narrow conception of what 'normal' is. PWDs react to their moment by moment challenges in the same way as their caregivers do. The more pressure on one or more of the modules, the more squeezed the communicative system is. If one solution (e.g. find an alternative word) does not work, another must be found (e.g. rephrase). If that does not work, another (e.g. try a different contextual option), until the speaker's very identification of her wants is compromised, as a way of keeping the system intact (Figure 3). Extreme solutions such as aggression, but also silence and the suppression of feelings of frustration and guilt, can be recognised as logical, and thus 'normal' responses to increasingly abnormal pressures.

It follows that a caregiver needs to do more than just ask 'how might this person be feeling, if she is responding like this?' Already, this approach will enable the caregiver to come alongside and work with the feelings, as Wyles (this issue) notes:

> Simple activities such as sitting with the resident with V[ocally D[isruptive B[ehavior], taking them for a walk, stroking their hand or hair can calm the resident and thereby reduce the potentially conflictual or aggressive behaviour.

The additional element is to recognise the full power of the potential similarity between the PWD and themselves, by asking the question 'What would it take for me to behave like that?'

Within the clutches of the paradox, the caregiver is stymied by the observation that "a normal person wouldn't behave like that or, if they did, they would be being offensive". The paradox is broken open by acknowledging a continuum of inducement to act on earlier and earlier parts of the Communicative Impact sequence, with ever-greater risk of dissonance between what the speaker wanted and what they got. Thus, Lockhart (2009, 213) speaks of "actively practi[sing] empathy": "I reminded myself that it was hard for her, asking for help like this, after so many years of being the one in charge". She might have added, "I'd probably do the same if I were in her shoes".

5.3.2 Recognise that both parties have needs and wants

Caregivers need to recognise how their own wants will probably conflict with those of the PWD, because they have different agendas and goals, and may be adhering to different scripts. The Communicative Impact model demonstrates how modifying what one wants releases the potential to take a different route through the system. Changing what one wants so that it aligns with what someone else wants was depicted earlier as a negative tendency associated with underassertiveness. But in the context of care, the aim is supposed to be that the PWD's needs and wants are attended to. It is, therefore, not necessarily a bad thing to reflect on what the underlying drivers of the PWD's behaviour might be, and to attempt to meet those needs. Recalibrating one's own wants is a way of avoiding dissonance. But that is only possible, if the caregiver can stand back and create a context for herself in which any conflicting wants of her own are legitimately set aside for later. This is, it seems to me, what Miesen (1999, 131) means by the "necessary distance [whereby] … you can draw a line between your own emotions and those of the other person".

The caregiver does, in a sense, become someone else, but it is no more than the adoption of roles that we all engage with all the time. When a traffic policeman directs cars round an obstacle, he adopts a command of the situation that he would not adopt in a meeting with his superiors. A nurse learns to put on a role with the uniform, and professional caregivers may, or may not, be adept at doing the same. As Lockhart's (2009) observation, mentioned earlier, shows, for a family member, is it the subtle recalibration of roles over time that can make healthy distancing difficult to achieve.

Aligning one's wants with those of the PWD opens up the opportunity for new scripts. These scripts are necessary, because they reduce the pressure on the cognitive system. With experience, caregivers develop them.

5.3.3 Empowering the PWD

However, the PWD is not without agency either. There are ways in which it might be beneficial to assist PWDs in learning how to become more flexible in their response to communicative challenges, by exploring different solutions to the problems in the system. Maureen (Davis et al., this issue) learned a number of strategies that could head off dissonance between what her hearer might reasonably expect from her and what she could deliver. For example, the phrase "as I said before" not only gave her extra time to plan (Davis et al. 2013, 102) but also defused the dissonance that would arise if she repeated herself without acknowledging that she was doing so (see also Jones 2012: 83ff) .

A PWD could be assisted in learning new scripts, ones appropriate to the changing circumstances. Reflecting Guendouzi et al.'s observations (this issue), men with dementia

might be helped to learn simple small-talk expressions that would both fill gaps in the conversation and refocus its purpose: that is, give them a new 'want' which is relatively easy to fulfil—sustaining conversation for its own sake. Indeed, perhaps a dementia diagnosis need not be the trigger for such learning—it might be added to the growing list of ways in which we can all future-proof ourselves against the impact of dementia.

6. Conclusion

The subtle and multileveled interplay between interaction and linguistic processing becomes evident when it goes wrong. The Communicative Impact model conceptualises the interface in a manner that offers purchase on the causes and possible solutions to both externalised and internalised manifestations of conflict. It accommodates the observation that conflict is not necessarily negative—for dissonance is the catalyst for humour and learning as well as discontent. Yet the model helps us understand why a shortfall between what the speaker wanted to achieve and did achieve might lead to various behaviours that are simultaneously highly characteristic of dementia yet also recognisable as responses to the same type of cognitive pressure in unimpaired individuals.

Thus, the model offers a rationale for the oft-made proposal that the key to helping PWDs is to empathise with them. At the same time, it illuminates a navigational path that escapes the paradox in which (a) treating the PWD as capable of normal interaction only fuels the caregiver's sense of hurt and frustration at what is not happening and *should* (Mikesell, this issue); while (b) treating them as exempt from the customary pragmatic rules of interaction

places them in a conceptual space in which humane response is not obligatory (Wray 2013, 2014).

The solutions offered here are in keeping with current best practice but potentially extend it in a manner that should protect the mental health of caregivers—an issue of considerable concern at present (Wray 2011, 2012). But it would be a mistake to think that it constitutes a simple way forward. Encased in the suggested action is attention to every aspect of how a PWD and her interlocutors engage, from wants and expectations, through what is delivered to—importantly—how what is delivered is interpreted in relation to the original agendas. Agendas of wants are almost always complex and may be contradictory. Nor do we necessarily have the skills to carve a path through the system to maximise the communicative impact of what we say, even when there are no added impediments. Meanwhile, caregivers must take up some of the burden that PWDs cannot, by anticipating their needs in a comprehensive and humane manner. At the practical level, caregivers need to understand, and be empowered to act on, likely contextual and environmental lacunae like inadequate pain relief, and the absence of hearing aids and glasses. Here, as in all aspects of their interaction, the mantra of those with the responsibility of care, whether professional or family, needs to be 'what would it take for me to respond like that?', for this maximises the likelihood of identifying the deepest unmet wants of people with dementia.

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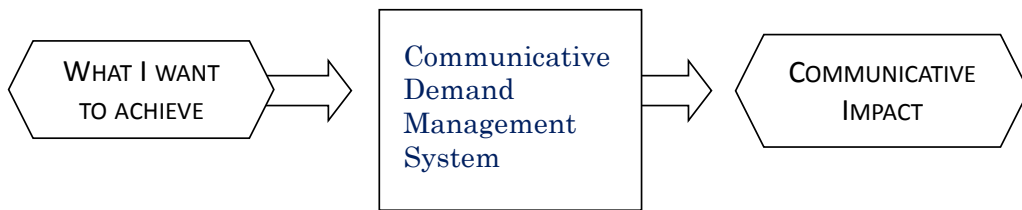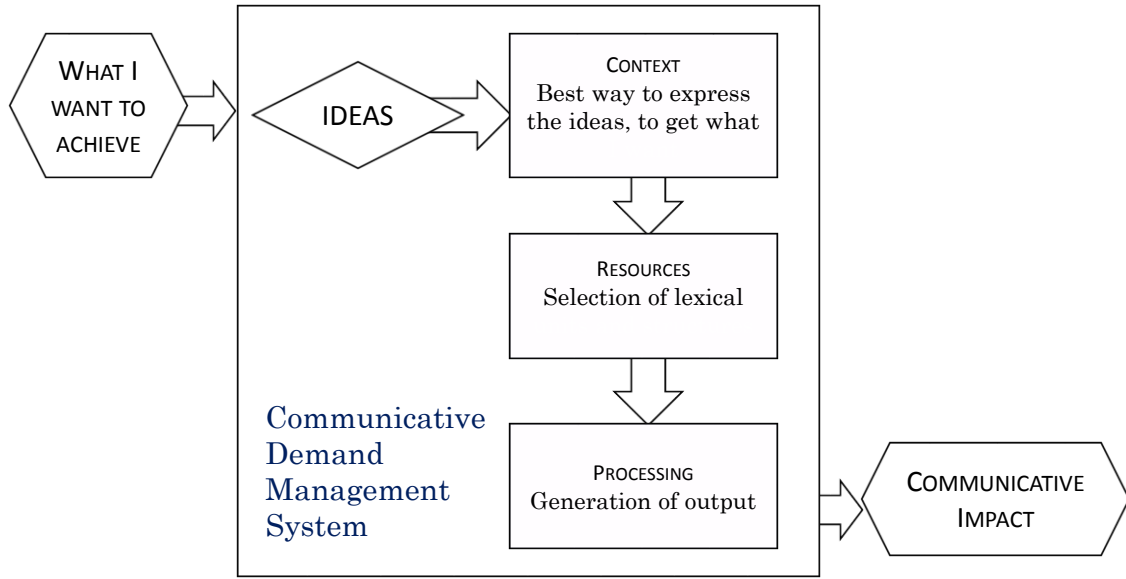
Figures

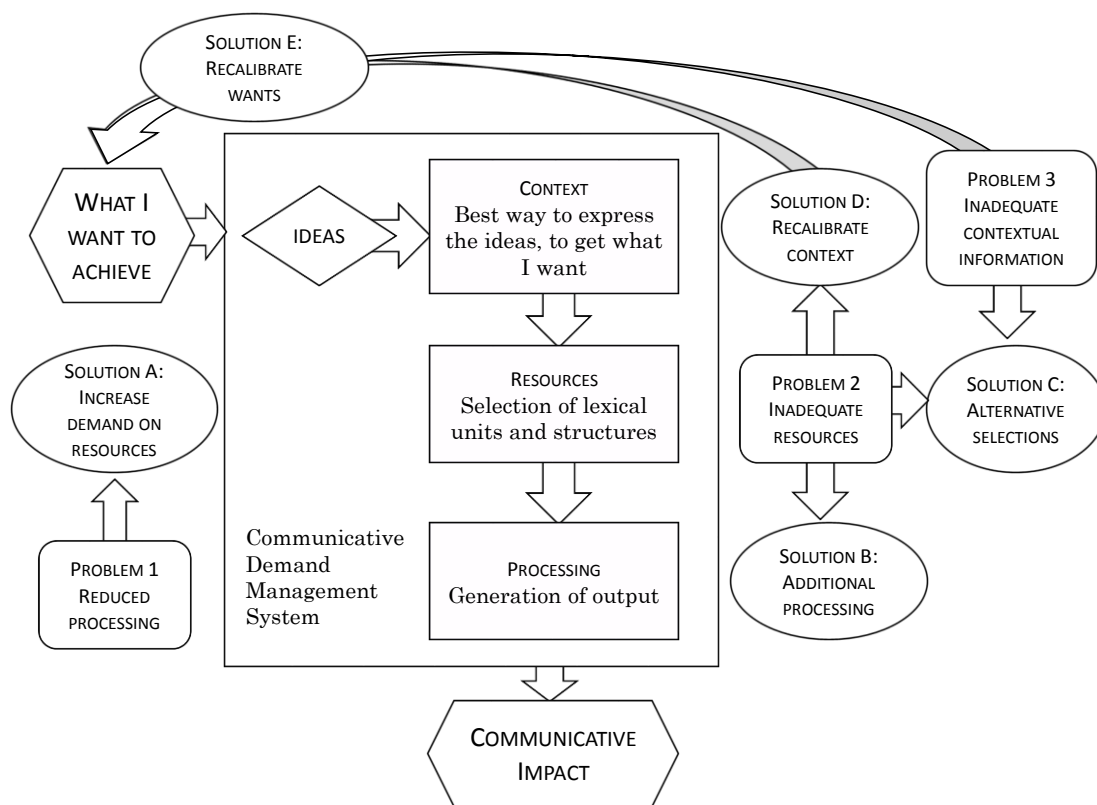**Figure 1: The outer skin of interaction**

Figure 2: Inside the Communicative Demand Management System

Figure 3: Managing disruption