Multilingual Life in Dementia Care
Crossing Linguistic Boundaries and Cognitive Gap: Navigating Mutual Understanding

Maziar Yazdanpanah
The cover image was generated on July 1, 2023, using AI Bing Image Creator, based on the provided prompt: "Communication in residential care facilities involving care workers and residents with dementia from various linguistic backgrounds, where a shared verbal language is absent." Subsequently, puzzle grid was incorporated to the image.

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Abstract
This dissertation presents empirical research in the field of multilingual communication in residential homes of people living with dementia.

Prior research has emphasised the crucial function of a common language and culture between care workers and residents in such settings. It has been argued that a shared language is essential for fostering mutual understanding between care workers and residents with dementia. The absence of a common language can result in significant issues, such as creating misconceptions about the capabilities of multilingual residents, potentially preventing care workers from recognising the residents' communicative abilities. This can prevent residents with dementia from participating in social activities, leading to social isolation and negatively impact their well-being. This, in turn, increases costs for all parties involved, including residents, care workers, and residential homes.

While the significance of a shared language for mutual understanding is undeniable, it's not always feasible to match care workers and residents linguistically and culturally in a multilingual society with diverse ethnic groups. This situation prompts questions about how to achieve mutual understanding in the absence of a shared language in residential homes. This dissertation investigates how care workers and residents from various linguistic and cultural backgrounds in dementia care achieve mutual understanding during task-oriented communication, despite the absence of a shared verbal language.

Employing a micro-analytic perspective, this research delves deep into instances of multilingual communication within residential homes to uncover the function of linguistic features such as sound prolongation in task-oriented communication. Additionally, the study explores how forms of address contribute to achieving mutual understanding in dementia care when there's no shared verbal language in multilingual communication. These questions are addressed using data obtained through a combination of ethnography, video recordings, and interviews. The study involves participants, including residents from ethnic minorities displaying symptoms of dementia and care workers from diverse linguistic backgrounds.

Conversation analysis is employed for transcribing and analysing interactions among participants, while thematic analysis is applied to the interview data. The results suggest that in the absence of a common verbal language, participants recycle each other's verbal and nonverbal actions to foster understanding. This process relies heavily on the actions of care workers. The findings also underscore the importance of care workers' knowledge of residents' life histories, including their preferred forms of address, as a valuable resource for establishing rapport with residents.

In conclusion, this dissertation highlights that the effectiveness of specific linguistic resources in multilingual communication not only varies among individuals but is also contingent on the particular situations in which a resident is involved.

Keywords: Dementia, Multilingualism, Communication
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Maziar Yazdanpanah
List of papers

This dissertation consists of three publications.


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1. Introduction

This thesis deals with multilingual encounters, mutual understanding, meaning making, and dementia care in Swedish residential homes; particularly when residents and care workers do not have a shared verbal language.

Migration have contributed to linguistically and culturally diverse societies across the globe. Although this is not a new phenomenon, it may pose challenges to different societies. For example, collaboration between employees from linguistically and culturally diverse backgrounds now constitutes many multilingual workplace settings, with both clients and co-workers from majority as well as minority ethnic backgrounds. This situation has attracted researchers who are interested in issues such as mutual understanding in multilingual encounters in the workplaces (e.g., Andersson, 2009; Blackledge, Creese, & Hu., 2015; Nelson, 2010).

1.1 Mutual Understanding

Workplaces are meant to provide services or products based on coordinated actions for their clients. Coordinated actions become possible when a common understanding of the situation is achieved. This is
made possible only when there is a mutual understanding between participants with respect to each party’s individual situation. Mutual understanding can be observed in interaction when participant A makes a contribution, participant B responds, and participant A follows up with evidence that participant B’s response displayed enough understanding for the current purpose (Bavelas, Gerwing, & Healing, 2017; Clark, 1996; Linell & Lindström, 2016; Mead, 1934). In other words, the interlocutors’ relevant responses produce a weave of interactional moves which in turn provides an experience of mutual understanding for both interlocutors (Linell & Lindström, 2016). Furthermore, mutual understanding is dependent on participants’ meaning making—i.e., they must achieve agreement on the meaning of their verbal and nonverbal actions in interaction in individual situations (Linell, 2009; 2014; 2017). When making meaning in each specific situation through interaction, participants have a tendency to partially recycle one another’s actions (See Anward, 2004; 2015). This indicates that mutual understanding is achieved as a result of interaction (Linell, 2014). In addition, when participants enter interaction in each specific situation, they bring their related assumptions and expectation to the current activity, which may assist them in establishing mutual understanding (Goffman, 1974; Levinson, 1992; Linell, 2017). This is probably the basis for Rommetveit’s (1974) claim that participants seem to take mutual understanding for granted before achieving it, when they are about to interact.

In the absence of mutual understanding, interaction either does not progress or it leads to misunderstandings between interlocutors and
breakdown of communication. This may add to complications in interactions between co-workers and clients in workplaces, which swallows employee resources and increases the costs of the employer as well as clients’ levels of dissatisfaction.

One source of interactional difficulties and a source of misunderstanding is interaction in multilingual contexts. Multilingual encounters can involve two different situations: first, multilingual participants speak a second language as a shared language; second, multilingual participants lack a shared language or they have limited access to a shared language. In the context of multilingual communication, when participants with diverse linguistic backgrounds engage in second language conversation, troubles can still threaten mutual understanding and joint meaning making (e.g., Gardner & Wagner, 2005). Still, second-language conversation provides a symmetry in linguistic resources for participants and helps them in achieving mutual understanding. Whereas in multilingual interaction where participants do not have a shared language, the asymmetry of participants’ linguistic resources poses further difficulties to achieving mutual understanding. In these situations, language brokers—people who share the respective language of each participant—can contribute to establishing mutual understanding between them (Bolden, 2012; Harjupää, 2021). But language brokers are not always accessible in multilingual encounters where participants do not share a language. In these situations, if participants are co-operative, they can cross their languages step-by-step to establish mutual understanding (cf. Zeshan, 2015). In this process, participants tend to draw heavily on resources that are used by speakers of a second language in addition other speakers. For example,
being involved in word search, the speaker of a second language can clarify her/his utterance by circumlocution; i.e., describing the features of the target word instead of using the word itself; exemplification; nonverbal behaviour, such as gestures; and code-switching (e.g., Eskildsen & Wagner, 2015; Gardner & Wagner, 2004; Mazeland & Zaman-Zadeh, 2004). In regards to nonverbal resources such as gestures, gaze, posture, and handling of artefacts, it is worth noting that these resources are used by all speakers, including speakers of second language as well as speakers in multilingual encounters (Eskildsen & Wagner, 2015). As a responder, the recipient of a gesture may recycle it to display her/his understanding in multilingual conversations (cf. Eskildsen & Wagner, 2013). Furthermore, nonverbal behaviour can be the primary source of communication rather than a secondary one; participants can deploy nonverbal behaviour instead of the spoken language, rather than a supplement to it (Eskildsen & Wagner, 2015).

Another major resource available to a multilingual person is code-switching. A multilingual person can switch between several languages, when s/he faces an issue such as word finding. Resolving a word search, a multilingual person tends to refer to her/his “most available word” (Grosjean, 1982, p.151). Code-switching can function either as way to buy time, while the speaker continues his/her search, or it can be received by an interlocutor as an appeal for assistance (e.g., Plejert, 2004). In the latter case, code-switching can trigger collaboration between interlocutors and result in mutual understanding. Thus, code-switching is regarded as a natural tool in smooth progress of interaction and can lead to mutual understanding when the interaction involves multilingual interlocutors.
(e.g., Gunnarsson, 2014; Svennevig et al., 2019). The function of nonverbal practices as well as code-switching indicates that body and language are integrated; different languages and embodied resources make up the unique repertoire of a multilingual person (Mondada, 2016).

1.2 Communicative Disabilities

Another reason for potential problems with mutual understanding is when a participant has communicative disabilities, caused for instance by dementia. Dementia\(^1\) is known as a set of clinical symptoms and syndromes that can be caused by a range of diseases such as Alzheimer Disease (AD) or other injuries to the brain. The symptoms are mostly attributed to cognitive, communicative, and functional declines with implications for everyday life. Efforts in understanding the management of communication between people with dementia and their interlocutors, such as family members or care workers has inspired studies in recent decades (e.g., Backhaus, 2017; Boyle, 2014; Hamilton, 1994; Hamilton, 2003; Hamilton, 2019; Hydén & Samuelsson 2019; Jansson, 2016; Lindholm & Wray, 2011; Lindholm, 2015; Müller, 2003; Nilsson, 2018; Ramanathan, 1997; Small, 2009; Schrauf & Müller, 2014; Webb, 2017).

The first studies that shed light on the discourse of people with dementia in everyday interaction were authored in the 1990s (e.g., Hamilton, 1994; Ramanathan, 1997). These studies, however, were conducted in monolingual settings. While Ramanathan focuses on issues such as the

\(^{1}\) It should be remembered that the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), to avoid stigmatising people, has moved away from the term ‘dementia’ in favour of the term “Major Neurocognitive Disorder” (NCD).
ability of people with dementia to reflect on their life history, Hamilton’s study, based on naturally occurring conversation, concerns the abilities of people with dementia in everyday interaction (e.g., Kindell, Wilkinson, Sage & Keady, 2018; Kindell, Wilkinson & Keady, 2019). A shared finding by Hamilton and Ramanathan points to the role of the other party, whether it be an interlocutor or care worker, in enhancing the success of communication and improving quality of life for a person with dementia. Thus, if communication with a person with dementia breaks down, it is viewed as being due to a constellation of factors made up of details about conversational partners’ practices and the setting.

Later studies on interaction involving people with dementia address mutual understanding and meaning-making more specifically (Hamilton, 2019; Müller, 2003). The role of settings and interlocutors are again emphasised in successful communication leading to mutual understanding (e.g., Hamilton, 2019; Müller, 2003). For example, in a monolingual encounter involving a person with AD and hearing loss who is also affected by stroke, Müller (2003) shows through detailed analysis of transcriptions that participants achieve mutual understanding despite cognitive and communicative decline. The interlocutors manage to keep mutual understanding in a stable state by employing compensatory strategies (Müller, 2003). For example, both participants tolerate longer pauses before taking the ground as the next speaker; allowing for longer pauses buys enough time for the person with dementia as the current speaker to complete her utterance and to manage instances of the word search which is a common experience in AD (Müller, 2003). This indicates that interlocutors’ knowledge and expectation with respect to the interaction plays a key role
in employing strategies that help sustain mutual understanding (Müller, 2003). However, this should not lead us to conclude that the interlocutor’s knowledge about the person with dementia always contributes positively to mutual understanding; instead, it might shape presumptions and lead to a tendency to interrupt and correct utterances of the person with dementia, which might hinder mutual understanding (e.g., Ramanathan, 1997).

A comparison between Müller and Ramanathan draws our attention to the fact that adaptability of the interlocutors is a key factor in establishing and maintaining mutual understanding in interactions involving people with dementia. Ramanathan calls for further research shedding light on communication involving people with dementia from ethnic minority groups. This is the path followed by this dissertation.

1.3 Multilingual Interaction and Dementia

In multilingual interaction involving persons with dementia from ethnic minorities, achieving mutual understanding can become even more difficult. First, for a multilingual person, his/her later-learned language is likely not their strongest language (Plejert et al., 2017). Second, multilingual persons with dementia may experience language deficits with linguistic forms that are learned later in the sequence of language development; e.g., a second language (Cummings, 2020; Vega-Mendoza et al., 2019). Thus, a multilingual person with dementia from an ethnic minority probably has a limited access, even may lack access, to the majority language. This may have implications for mutual understanding between a
person with dementia and his/her interlocutors who speak the majority language either as a mother tongue or as a second language. In these situations, a lack of mutual understanding may lead to misunderstandings and a breakdown in communication. Consequently, in settings such as residential homes, multilingual residents with dementia may undergo social isolation and experience dissatisfaction. Social participation and social support are important factors in the well-being of all individuals, including older adults. Poor well-being among residents adds to care workers’ burdens as well as residential home costs.

The above introduction introduces a new situation for mutual understanding, where people with dementia are involved in multilingual interaction. To my knowledge, Ekman (1993) was one of the first publications with a focus on the communication aspect of residential care for people with dementia from ethnic minorities in a multilingual society. Although there are earlier studies such as Jones & Van Amelsvoort Jones’ (1986) exploration of communicative issues, such as lack of talk directed to residents with ethnic minority backgrounds, Ekman’s study is interesting for its focus on the progression of interaction involving multilingual residents with dementia. Ekman portrays this picture by observation of interaction in residential care, by interviewing care workers and relatives, and by investigating communication between monolingual and multilingual care workers and multilingual people with dementia.

Ekman’s insights are influential in finding lack of understanding between residents and care workers with different linguistic backgrounds. These finding are also reported by care workers in more studies (Söderman & Rosendahl, 2016). Ekman reports cases of misunderstanding and
a lack of understanding between monolingual care workers and multilingual residents. For example, misunderstandings can occur when monolingual care workers do not understand the residents’ utterance in their mother tongue, Finnish, whereas the residents can understand the care workers’ utterances in Swedish. This lack of understanding may lead to a false perception about the abilities of multilingual residents and eventually hinder care workers from understanding residents’ communicative abilities.

Ekman (1993), in line with Hamilton (1994), and Ramanathan (1997), underlines the role of the other party’s action in successful communication and in improving quality of life for a person with dementia (cf. Schrauf & Müller, 2014). Thus, emphasising the necessity of mutual understanding between care workers and residents, Ekman suggests that it is important in dementia care to provide a situation where residents from ethnic minorities are encouraged to use their remaining capacities (see also Schrauf & Müller, 2014). This goal can be achievable in multilingual environments by engaging care workers who share the linguistic backgrounds of the residents (Ekman, 1993). Ekman (1993) and subsequent works (e.g., Jansson, 2014; Söderman & Rosendahl, 2016) have influenced the recommendations of The Swedish National Board of Health and Welfare (Socialstyrelsen, 2017) in regards to linguistic matching between care workers and people from diverse linguistic and cultural backgrounds living with dementia. However, it might not always be possible to match residents and care workers in terms of their linguistic and cultural backgrounds (Plejert et al. 2017). Furthermore, an emphasis on linguistic matching as the only solution for enhancing the quality of life
of residents from ethnic minorities might contribute to further segregation of ethnic minorities. Therefore, identifying the communicative resources for achieving mutual understanding when residents and care workers do not have a shared linguistic and cultural background would be a helpful source of knowledge in residential care. This is the aim of this dissertation, as a part of a larger project.

1.4 Multilingual Care and Dementia

The project Multilingual Practices and Pedagogical Challenges in Older People’s Care (Grant no: 2013-2020), from which this dissertation extends, draws on meaning-making and mutual understanding to investigate care for older people in terms of the interaction between multilingual care workers and trainees and residents with symptoms of dementia in Swedish residential homes (Jansson, 2014). The project, through the observation of verbal and nonverbal communication, pays special attention to the practices deployed by residents and care workers when they compensate for lack of a common spoken language. Apart from this dissertation, the collaboration between the researchers involved in the project resulted in several publications focusing on multilingual encounters in residential homes in Sweden (e.g., Jansson, 2016; Jansson & Majlesi, 2020; Jansson, Plejert & Lindholm, 2018; Jansson & Wadensjö, 2016a; 2016b; Jansson & Wadensjö, 2017; Jansson, Wadensjö & Plejert, 2017). These publications are based on naturally occurring data, as care workers and trainees with different levels of proficiency in different languages and linguistically diverse residents with symptoms of dementia interact despite limited access to a common spoken language.
A frequent task in residential care, including in multilingual encounters, is a time when care workers are expected to offer emotional support to residents. This issue is raised by Jansson et al. (2017) in situations where care workers—despite a lack of a shared linguistic background with residents—manage their tasks in establishing emotional support and trust for older people with symptoms of dementia (see Strandroos & Antelius, 2017). One such moment is when care workers are expected to manage moments of trouble-telling, such as complaints. It seems that in these situations, care workers need to understand the source of the trouble before providing proper support. The proper emotional support is also expected to be made in a way that is understandable to residents. This is all expected to be accomplished despite a limited access to a shared language. Jansson et al. (2017) shows that sometimes a multilingual care worker, as a language broker, can contribute in establishing mutual understanding between residents and other staff members who do not share the resident’s language background. In addition, when language brokers are not available, the creativity and attentiveness of care workers can compensate for lack of a shared language when managing residents’ complaints. This is achieved without access to the content of the resident’s complaint turns. For example, the care worker, through learning about the sensitive situations that are more likely to trigger a complaint, can often predict a complaint before it happens. Furthermore, the care worker—by paying attention to nonverbal cues and prosodic features of the resident’s voice—becomes aware of an upcoming complaint, and through the creative deployment of an utterance from the resident’s mother tongue tries to turn a pressing situation into a cheerful one. In
regard to the significance of nonverbal resources, it has been established that residents with symptoms of dementia in linguistically diverse encounters most often use nonverbal behaviours in communication with care workers (Small et al., 2017).

The findings of Jansson et al. (2017) contrast the findings by Plejert, Jansson, & Yazdanpanah, (2014) indicating that a lack of mutual understanding functions as a drawback for care worker’s efforts to offer emotional support in response to a residents’ complaints. In a case study, Plejert et al. (2014) found a number of response practices that care workers deploy during morning care to manage the complaints of a resident with whom they have a limited common language. Despite care workers’ efforts, none of these response practices address the resident’s source of trouble, because care workers lack access to the content of the resident’s complaints. Among care workers’ practices, two features are prominent because they are used with higher frequency across different types of care workers’ response: vowel prolongation and using the resident’s first name.

1.5 Sound Prolongation

Vowel prolongation as an exaggerated prosodic feature most often accompanies soothing responses when care workers are attempting to address a resident’s overall sense of distress (Plejert et al., 2014). In the literature, the term ‘elderspeak’, referring to adjustments in talk directed toward older people with patronising versus nurturing implications, is used to refer to a range of exaggerated prosodic features, such as a higher
pitch, a louder voice, and exaggerated intonation patterns (i.e., the melody and rhythm) (Caporael, 1981; Österholm & Samuelsson, 2015; Shaw, Gordon, & Williams, 2021; Small, Huxtable, & Walsh, 2009). Although these prosodic attributes are the most prominent domain of elderspeak, adjustments of talk directed at older adults comprises other linguistic domains such as morphology, syntax, and semantics (Samuelsson, Adolfsson, & Persson, 2013). Previous research indicate that care workers use different attributes of elderspeak with the best of intention (Grimme, Buchanan, & Afflerbach, 2015; Lombardi et al., 2014). For example, care workers believe that they would sound friendlier to residents and that they can convey comfort when residents are addressed with features of elderspeak such as exaggerated prosody (Grimme et al., 2015). However, a large part of the literature argues that elderspeak leads to negative consequences and should be avoided altogether (Balsis & Carpenter, 2005; Kemper & Harden, 1999; Ryan, Bourhis & Knops, 1991; Williams, 2013; Williams, Herman, Gajweski, & Wilson, 2009; Williams, Perkhounkova, Herman, & Bossen, 2017). Alternatively, studies such as Small et al. (2009) address individual characteristics of elderspeak (rather than evaluating elderspeak generally) in real-time conversations and found variable communication outcomes.

In regards to increased pitch variation and loudness, different outcomes are reported for different participants; for example, while unsuccessful communication can be attributed to care workers’ reduced pitch variation and loudness in one group, care workers’ increased pitch variation and loudness may be associated with unsuccessful communication in another group (Small et al., 2009). These findings in Small et al. (2009)
point to the fact that establishing a determined pattern of deploying pitch and loudness in educating care workers on how to communicate with people with dementia is untenable. Similarly, in regards to using sound prolongation as an interactional resource in the management of complaints in linguistically diverse encounters, drawing a determined conclusion is impractical. It is therefore important to investigate sound prolongation across different contexts of naturally occurring data in residential care and compare the communicative outcomes during a variety of care activities.

1.6 Address Practices

Using first names to address older adults is reported as another feature of elderspeak (Backhaus, 2009; Fairhurst, 1978; Grainger, 1993; Marsden & Holmes, 2014; Ryan, Hummert, & Boich, 1995). For the aims of this thesis, there are two aspects of the appropriateness of using first names as forms of address for older adults: individual preferences and cultural norms. First, there can be always personal preferences in forms of address. For example, despite similar cultural backgrounds, some older adults may consider using first names as appropriate forms of address, whereas for some, being addressed by their first name is deemed disrespectful. (Allman, Ragan, Newsom, Soufos, & Nussbaum, 1999; Harwood, 2007).

Second, forms of address are culturally sensitive (Clyne, Norrby, Warren & Warren, 2009). The cultural aspect of forms of address be-
comes highly relevant for this dissertation because it investigates encounters in residential care, where residents and care workers are often from diverse linguistic and cultural backgrounds. For example, while the cultural preference in the Japanese context is to use an older adult’s surname followed by the person honorific; ‘-san’ (Backhaus, 2009), in Sweden, using first names has become a standard form of address since 1960s for all Swedish speakers regardless of age, gender, social class, or ethnicity.

An interesting point is that Sweden had a rather homogeneous population when first names became the standard forms of address in the 1960s. The population has diversified over recent decades; for instance, while by the end of 1969, there were 41,205 foreign-born people in Sweden from outside Nordic countries, this number had increased to 875,318 by the end of 2019 (Population statistics, 2021). Similarly, the number of foreign-born citizens aged 65 and older has been growing—from 6866 in 1973 to 63,130 in 2020 (ibid). This indicates that in Sweden the number of foreign-born people from outside the Nordic region with diverse languages and cultures has multiplied since the end of the 1960s. Comparing these statistics, we can comparatively expect a rise of intercultural encounters in everyday interaction and in workplaces such as Swedish residential homes. In addition, the number of older adults with migrant backgrounds who have spent a considerable amount of their lives in their countries of origin has been growing. Many of these older adults, from diverse linguistic and cultural backgrounds, move into Swedish residential homes, where using first names to address their residents is consid-
ered the standard form of address. However, residents with migrant backgrounds may have different preferences due to individual and/or cultural reasons. This issue will be returned to in section 6.6.

Understanding the function of communicative resources such as address forms and sound prolongation, especially in multilingual encounters, can have considerable implications for the quality of communication with residents who lack the language of the residential home. We know that communication is essential for social participation, and according to the guidelines of World Health Organisation (WHO) in relation to dementia, social participation and social support are essential for the well-being of all people, including multilingual people with dementia. This may be a far-reaching goal for some older adults, such as people with dementia from ethnic minorities (Gove et al., 2018). The intersection of multilingualism and dementia can add to the complexity of achieving WHO’s recommendation in regard to social participation for people living with dementia. Dementia is a neurocognitive disorder, and a person who is affected by it successively experiences various kinds of cognitive declines that may seem to impact communication and social participation; however, it does not impair all abilities and resources at once. Therefore, it is important to know about these resources, and to raise awareness about the remaining abilities and their optimisation (cf. Lindholm, 2008; Schrauf & Müller, 2014).

1.7 Aim and Research Questions

Drawing on mutual understanding as a major issue in multilingual encounters, this dissertation investigates how care workers and residents in
dementia care accomplish mutual understanding despite lacking a shared verbal language. This can be especially relevant in dementia care, where care workers are often expected to provide emotional support in response to residents’ trouble-telling such as complaints. In addition, I am going to investigate the function of communicative resources such as sound prolongation and forms of address when care workers do not have access to the content of the residents’ utterances. Considering an overall picture of all types of practices, the dissertation adopts the view that body and language are integrated, and that different languages make up the unique repertoire of a multilingual person (See Mondada, 2016). This view inspires data-driven research that resulted in three distinct studies. Thus, the central questions guiding this dissertation are:

1) How do residents and care workers from diverse linguistic and cultural backgrounds establish mutual understanding in dementia care despite lacking a common spoken language?

2) What are the different outcomes of deploying sound prolongation when care workers try to manage residents’ complaints when they do not share a common spoken language?

3) How are forms of address relevant in dementia care in multilingual encounters for residents from ethnic minority groups?
1.8 Thesis Disposition

This thesis is presented in seven chapters. After the introduction, chapter 2 provides a review of previous research about dementia. Chapter 3 deals with multilingualism. Chapter 4 describes the methods, data gathering, transcriptions, ethical considerations, and recruiting. Chapter 5 summarizes the findings and conclusions of each study. The discussion of the dissertation is presented in chapter 6. The dissertation concludes with its implications in chapter 7.
2. Dementia and Communication

2.1 Introduction

This chapter is a literature review of monolingual interaction involving people living with dementia. The focus is set on the studies based on naturally occurring talk in everyday interaction and interaction in residential homes involving people living with dementia (see Hamilton, 2019; Hydén, 2013; Lindholm, 2008; Small et al., 1998).

First, I give an overview of communicative problems such as word searches. Next, the problem of establishing common ground and the problem of executing routines are presented. Despite communicative problems, people with dementia (PWD) and their conversational partners undertake a range of strategies and practices to maintain mutual understanding. Section 2.4 addresses the management strategies undertaken by participants. Section 2.5 addresses different categories of interaction specific to residential homes. This section also turns its attention to two communication styles that are not uncommon in residential homes; resistiveness-to-care and elderspeak, undertaken respectively by residents and care workers. Concluding points will be discussed at the end of the chapter.
2.2 What is Dementia?

Dementia as an overall term refers to a particular group of symptoms, including difficulties with memory, language, problem-solving, and other thinking skills that eventually affect a person’s ability to perform basic activities of daily living (Alzheimer’s Association, 2021). The most common cause of dementia is Alzheimer’s disease (ibid).

2.3 The Main Problems in Communication Involving Persons Living with Dementia

The major problems in communication involving PWD is the problem of communicative actions, the problem of establishing common ground, and the problem of executing activities.

2.3.1 Communicative Actions

Participants in interaction undertake communicative actions interpersonally to establish mutual understanding. Communicative actions are collaborative in the sense they are dependent on each other; participants use utterances and the understandings produced so far to produce new utterances and understandings (Linell, 1998).

Regarding communicative action and dementia, despite the crucial role of remembering what has happened so far, memory deficits seem to be a common symptom of dementia. These deficits may lead to disorientation in the continuous process of updating memory systems with the passage of time and changes in location. (O’Brien & Thomas, 2017; Wentzel et al., 2001).
More advanced levels of dementia are indicative of increasing the problems of communication. As dementia progresses, the person living with dementia will face increasing communicative problems. In the early stage, semantic and pragmatic aspects of language are disrupted (Cummins, 2020). Thus, instances of word search considerably increase (Hamilton, 2019). Pauses, hesitations, and substitutions are indicators of word search. Also, a frequently demonstrated sign of word search is the use of an imprecise substitute such as thing, kind, somebody, one, and place, which are used when an individual with dementia refers respectively to inanimate objects, persons, and locations (Hamilton, 2019). It is an indisputable fact that these imprecise substitutions may lead to mismatches in meaning between a person with dementia and the interlocutor, thereby adding to misunderstanding.

In the early stages of dementia, motor speech disorders such as dysarthria and apraxia may be displayed, making utterances even more difficult to understand (Cummins, 2020). Even language comprehension in the early stage is disrupted (Cummins, 2020; Lindholm & Stevanovic, 2022). In the moderate stage, semantic associative relationships (part/whole) are also declining (Cummins, 2020). It is also reported that memory and visuospatial skills are severely impaired, and the person displays fluent aphasia (ibid). In the late stage of dementia, structural aspects of language, such as phonology and syntax are usually disrupted (Cummins, 2020). This is a stage where PWD are unable to independently carry out basic activities (Kempler & Goral, 2008).
2.3.2 Common Ground

Problems with diverging common grounds (not remembering previous events, not remembering what happened in the ongoing conversation, forgetting autobiographical facts, etc.) increase at every stage. A major challenge experienced by interlocutors of PWD is the problem of establishing common ground (Hydén et al., 2013; Lindholm & Stevanovic, 2022).

The notion of common ground is used when people are involved in joint activities (Clark, 1996). ‘Common ground’ in communication is understood as “mutual knowledge, mutual beliefs, mutual assumptions, and mutual awareness” (Svennevig, 1999, 55). This is something that participants usually take for granted due to, for example, shared language, shared cultural norms, or shared history (see Clark & Brennan, 1991; Gardner, 1998; Goodwin, 2003; Klippi, 2003; Laakso, 2014). The assumption of having common ground (albeit not necessarily in full scale) is required before participants can progress in an interaction.

Using common ground requires the ability to recall the knowledge and experiences that a person has accumulated through the years. This very ability is prone to damage in PWD in the sense that PWD may struggle to remember not only recent events such as what has happened in an ongoing interaction, but also autobiographical facts (Brown et al., 2013). In these situations, establishing common ground may seem very challenging or may even lead to communicative breakdown (Small, Geldart, & Gutman, 2000).
2.3.3 Sequential Organisation of Actions

Common ground is a key factor in performing joint activities; however, this can be challenging in communication involving PWD. In dementia care, even routine activities may become very complicated—especially for people in late-stage dementia. Although the effect of dementia on one’s capacity to perform activities overall is extensive, the impact of dementia on one’s capacity to perform smaller, more routine tasks may not be disrupted to the same extent (Ekström et al., 2017; Hydén, 2014). Recent studies have found that parsing an entire activity into subtasks and dividing these subtasks to even smaller units may facilitate PWD’s collaboration in complex activities (Ekström et al., 2017; Hydén, 2014; Ingebrand et al., 2021; Majlesi et al., 2021). For PWD, it is more practical to collaborate on a sequence of subtasks that are temporally arranged in order, rather than performing an overall activity at once (Ekström et al., 2017; Hydén, 2014). When an activity is divided into subtasks, PWD find an opportunity to focus on an individual subtask and perform one subtask at a time before proceeding to the next subtask (Ekström et al, 2017). In this process, PWD can even take the initiative in actions, which increases their self-esteem (ibid). In the end, by linking all of the accomplished smaller units and subtasks, PWD are capable of performing everyday activities. This strategy makes it possible for PWD and their care workers to display their engagement in interaction and their understanding of what is going on.
2.4 Problem Management

The review indicates that despite seemingly diverse difficulties in achieving mutual understanding, PWD and their conversational partners have different solutions at their disposal empowering them to carry out their interactional goals (see Hamilton, 2019; Kindell, Keady, Sage & Wilkinson, 2017; Lindholm, 2008). It should be noted that ‘repairs’ are understood as a group of phenomena through which ongoing conversation is suspended in order to attend to some trouble that has become apparent (Schegloff, Jefferson, & Sacks, 1977). Repairs become even more vital in communication involving PWD, when we remember that in any interaction participants use the utterances and understandings produced so far to produce new utterances and understandings (cf. Linell, 1998). PWD, because of symptoms such as loss of memory, may have difficulties in not only not remembering things like autobiographical information but also what has just been said when they are involved in a conversation. In these situations, establishing common ground is challenging, and may result in interactional and interpersonal problems which can take toll on PWD’s self-esteem. In these moments of trouble, PWD and their interlocutors may frequently employ repairs maintaining mutual understanding. It should be noted that repairs are not exclusive to communication involving PWD. As a matter of fact, repairs are basically central to the management of mutual understanding as an ongoing process and tackling probable misunderstandings (Schegloff, 1992). Repairs can be identified as two distinguishable elements; the actual repair is distinguished from the initiation of repair, which is the act of marking something as a trouble
In this section, two ways of initiating repairs by PWD or conversational partners are presented.

2.4.1 Self-Initiated Repairs

Repairs are preferably initiated by the current speaker and fall within her/his utterance (Hamilton, 2019; Samuelsson & Hydén, 2017; Scheglof et al., 1977). This preference is due to structural organisation and the fact that opportunity for self-initiation comes before opportunities for other-initiation (Scheglof et al., 1977).

In conversations and in the face of lack of access to a specific piece of autobiographical facts, PWD’s first choice of management is relying on their episodic memory to produce a proper answer (Hamilton, 2019). Drawing on interconnected memories, PWD optimise available resources to come up with an approximate answer (Hamilton, 2019). When PWD’s efforts to rely on their own memories do not succeed, they pursue innovative strategies to self-repair. These are strategies such as circumlocution, or using easily retrieved expressions such as proverbs (Wray, 2010) substitutions, and neologisms. Circumlocution is a way of talking around the word when a person struggles to find the exact word. Employing this strategy, an individual with dementia narrows down the scope of the meaning and hence makes mutual understanding achievable, despite not being able to find the exact information (Hamilton, 2019; Hydén et al., 2013). In dementia, usually, there are some well-preserved word strings such as proverbs and “formulaic language” (Lindholm & Wide, 2017; Wray, 2010; Wray, 2014), which can be used in repairs. Although they may seem meaningless superficially, these types of ready-made language,
particularly in combination with the context, can be used as a coping strategy.

PWD may also substitute the source of trouble with other words that are similar in one way or another (e.g., semantically or phonetically), to the source of trouble. In understanding these substitutions, the context and physical environment play a crucial role (cf. Majlesi et al., 2019). When none of the aforementioned strategies address the issue at hand, PWD may self-account for lack of access to the requested information.

Although self-repair is preferred, the efforts by PWD may not always succeed in resolving the source of the trouble. In such situations PWD may seek assistance from their interlocutors rather than remain imprisoned in situations that may be followed by threats to one’s self-esteem and mounting interactional pressure (Hamilton, 2019). Inclination toward asking for the other’s assistance in moments of repair echoes the description by Schrauf and Müller that “cognition is in fact something that happen between people” (2014, 22).

2.4.2 Other-Initiated Repairs

Conversational partners may initiate repairs, or ‘other-initiated repair’, when PWD display behaviours indicating they are struggling to come up with a specific utterance. These are behaviours such as recurrent pauses, hesitations, fillers, and “thinking face” (Goodwin & Goodwin, 1986). Conversational partners of PWD usually initiate repairs by two means; they may come up with a suggested word/answer or they may begin speaking for PWD, especially in multiparty conversations (Hamilton,
Encountering the indicators of trouble in PWD’s utterances, a conversational partner proposes a candidate answer (ibid). Depending on the situation, an interlocutor’s candidate answers may be suggested by drawing on culturally shared knowledge and/or one’s physical environment (ibid).

The possibility of the second type of other-initiated repair is higher in conversations of more than two participants involving PWD. When PWD display signs of encountering an interactional trouble, another participant may step up in the PWD’s turn and speak for or about PWD (Hamilton, 2019; Nilsson et al., 2018). Becoming the speaking subject of others in his/her presence, PWD undergoes a process through which s/he may shift from an active participant to a bystander (Nilsson et al., 2018). These situations are potentially face-threatening. In other-initiated repairs, face-saving has a central function. Encountered by PWD’s inability to come up with some specific personal information, the interlocutor may attempt to justify or make an excuse for PWD’s forgetting by providing an other-account. For example, the interlocutor may comment that remembering the knowledge in question would be difficult for most people (Hamilton, 2019). PWD, however, may sometimes manage to speak for her/himself, which may result in conflicting utterances with those provided by the other. These conflicting utterances may provide an opportunity for negotiation and collaborative management between participants.
2.4.3 Collaborative Management and the Physical Environment

The settings of an interaction, such as its physical surrounding, are considerable resources affecting the collaboration of an individual with dementia and her/his interlocutor in resolving communicative problems (Hamilton, 2019). Depending on an interlocutors’ ability to take advantage of their shared physical surroundings, meaning-making can be split in two categories: immediate mode and displaced mode (Hamilton, 2019). Interlocutors’ immediate physical presence, as a resource, makes it possible for them to orient themselves towards an object of joint attention in the here and now (Hamilton, 2019). For example, if an individual with dementia struggles to find the name of an object in the shared physical surroundings with her/his interlocutor, s/he can use a combination of the shared presence and nonverbal resources, such as pointing to the object. This combination leaves a rather easy task for the interlocutor in relation to achieving mutual understanding with PWD. However, sometimes the burden on the interlocutor of a person with dementia becomes heavier, because s/he needs to work harder to find the reference of the word search. These are situations that physical presence alone is not enough for meaning-making; for instance, when the source of the trouble is associated with an activity rather than an object. These situations require interlocutors to have another aspect of shared epistemic access; i.e., culturally shared scripts (Hamilton, 2019; Schank & Abelson, 1977).

In displaced mode, when the object of joint attention in the shared physical space is absent, the type of collaboration for finding the missing word is different. Here, the interlocutor takes the responsibility of provid-
ing different proposals to PWD. Relying on their ability to recognise suggested candidates, PWD can reject irrelevant proposal/s in favour of the proper candidate proposal (Hamilton, 2019). As an example, we can refer to the situations where an individual with dementia occupies the position of a more knowledgeable person because s/he draws upon her/his autobiography (Heritage, 2012).

2.4.4 Face-Saving

Stigma is an issue which, in communications involving PWD, may be brought about due to the deficits associated with the condition; thus, face-saving, or management of stigma, can be a regular conversational practice between participants. A major source of stigma in the context of dementia communication is forgetfulness (Beard & Fox, 2008; Shabahangi, Faustman, Svennevig & Dalby Landmark, 2019; Thai, & Fox, 2009). Preventing the loss of face, people with dementia and their conversational partners employ a range of accounts: normalisation, exceptionality, and justification of forgetfulness (Svennevig & Dalby Landmark, 2019). These three practices are described accordingly. When a person with dementia is expected to refer to his/her personal experiences at a particular point in a conversation but s/he does not remember it, s/he may find her/himself in a situation that needs to account for a lack of knowledge.

In those cases, normalisation, or claiming that it would not be easy for anyone to remember the information in question, is a practice for both the person with dementia and her/his interlocutor to avoid the loss of face associated with forgetfulness (ibid). The second practice for participants is to exceptionalise a case of forgetfulness, due to a temporary lack of
access to the information rather than a permanent cognitive or communicative impairment. Finally, the person with dementia and her/his interlocutor may justify not remembering the information in question by claiming that it is not relevant or important to remember the information. The above practices dissociate the social character of a person with dementia from the forgetfulness and thus saves face and prevents from being stigmatised based on forgetfulness.

2.5 Communication in Institutional Settings of Residential Homes for People with Dementia

Ward et al. (2008) and Lindholm & Wide (2019) suggest considering communication with a person with dementia to be a professional task. This suggestion is particularly relevant in the context of residential homes, where it can be seemingly challenging for both people with dementia and care workers to hold any conversation other than task-oriented interaction. Task-oriented interaction differs from non-task talk; in the former, care workers control the flow of conversation (Backhaus, 2017). This is manifested, for instance, in both the openings and the closure of interaction where substantial control is assigned to care workers (Backhaus, 2017). The above introduction brings us to divide interaction in residential homes into three major categories: absence of communication, task-oriented communication, and non-task communication.
2.5.1 Absence of Communication

A reported issue in residential homes is the fact that there is a considerable absence of talk between carer workers and residents, or between residents (Grainger, 2004). This is partly attributable to the fact that a number of residents suffer from neurological or physiological communication disorders such as dementia symptoms, dysphasia, and dysfluency, but it can be compounded by other factors, such as low staff expectations of residents’ mental capacities or their ability to communicate (Grainger, 2004; see also Gravell, 1988; Meikle & Holley, 1991). Lack of communication can also be attributed to residents’ attitudes about interaction and the fact that residents withdraw from talking; partly because they are very selective about their conversational partners, and partly because of a lack of privacy, the adoption of a patient role, and inactivity (Grainger, 2004; cf. Lubinnski, Morrison, & Rigrodsky, 1981). Carers are often overloaded with tasks due to staff shortages, which results in great amounts of stress, and often there is not time for staff to sit and just have a chat and converse with a resident (Grainger, 2004; cf. Meikle & Holley, 1991). In addition, it seems that talk with residents involves effort and does not come as easily as talk with colleagues (Grainger, 2004; see also -Caris-Verhallen, Kerkstra, & Bensing, 1997: Marr, 1996). Consequently, care workers may come up with a number of talk-evasive strategies to avoid trouble talk; “deflection” (Grainger, 2004, p.487) is one of these strategies and occurs when the troubles are not amenable to plausible solutions, and when addressing the problem threatens to interfere with the furtherance of the physical care task being conducted. This is despite the fact that interpersonal communication with care workers adds to residents’
well-being (Grau et al., 1995; Williams, 2011). There are studies reporting that even small talk with care workers has a key function for residents (Backhaus, 2018; Ōta & Miyoshi, 2005).

2.5.2 Task-Oriented Communication

The major part of interaction in residential homes consists of utterances that are centred around care tasks (Grainger, 2004; Williams, 2011). Even if tasks and talk are performed in parallel, the task is the core activity in task-oriented communication and talk is marginalised. Furthermore, it has been reported by Backhaus (2018) that in most cases of task-oriented communication, the openings and closings of conversations are initiated by care workers. In adjacency pairs, for instance, care workers usually have access to a given first turn, which contributes to the construction of their active role and residents are left with a passive role (ibid). This may indicate that residents have less power to claim control over the initiation and termination of task-oriented communication and its trajectory; in other words, it seems that during tasks, residents are, by default, supposed to respond to the care workers’ requests and not make requests themselves (Backhaus, 2017). This is also a problem of agency, in the sense that residents’ agency is diminished because of the dominant structure of the organisation of the openings and closings of task-oriented communication (see Backhaus, 2018; Svennevig & Hamilton, 2022). As a result, the asymmetric distribution of turns at talk will contribute to an embedded feeling of hopelessness. This is in line with previous research which
has argued that a reduced agency can be associated with residents’ depression and lower quality of life (Kasser & Ryan, 1999; Svennevig & Hamilton, 2022).

Contrary to the observations of Grainger (2004) and Backhaus (2017), Jansson et al., (2018) show a different case; their study, through multimodal analysis at a micro level, shows a case where a resident—despite the lack of a shared verbal language with the care worker—initiates a request and recruits the care worker to transfer an object. The case of Jansson et al. (2018) shows that even despite the lack of shared verbal language, a person with symptoms of dementia can take on agentic roles in interaction (ibid).

A review of some quantitative studies exploring the percentage of task-oriented talk in daily residential care reveals that a meaningful portion—64%–75%—of staff–resident interactions on geriatric wards occurred while staff were occupied with a physical care task (Grainger 2004; cf. Fairhurst, 1978; Seers, 1986; Wells, 1980). This claim is resonated by Evers’ (1981) argument that as a result of institutional pressure on staff to get certain tasks done, inevitably, residents are sometimes treated as work objects (see Grainger, 2004). Explaining the reasons for domination of task-oriented talk, Grainger (2004) refers to lack of adequate training and the fact that communication is not given priority in comparison to the requirement of accomplishing tasks as quickly as possible (Allen & Turner, 1991; Evers, 1981; Grainger, 2004; Spence, 1985; Seers, 1986; Wells, 1980).
Despite improvements made more than a decade ago, research shows that there are still underexplored areas in task-oriented communication (cf. White et al, 2008; Williams, 2011). This lack of change can be associated with societal ageism (Butler, 1969; Grainger, 2004; Vervaecke & Meisner, 2021). Ageism, in both its positive and negative forms, can echo problematic attitudes and presumptions in regard to the mental and physical abilities of residents, which may trigger behaviours such as residents’ resistiveness-to-care (Vervaecke & Meisner, 2021).

2.5.3 Non-Task Communication

Non-task communication focuses on issues other than performing tasks (Linell, 1998). Describing none-task communication in residential homes, Backhaus (2017) broadens the scope of the definition and maintains that even working while talking may be included in the category of non-task communication. However, talking while working is considered task-oriented communication. To put it in another way, talk is the main activity in non-task communication, while the task is marginal.

The subjects of non-task communication are examined by Backhaus (2017). Backhusa (2017) finds that the majority of non-task communication sequences cover topics related to the here and now of everyday life (ibid). An interesting observation by Backhaus (2017) is care workers’ preference for talk about topics other than their in-group subjects. This preference is displayed particularly when care workers themselves initiate non-task communication. However, when these subjects are brought up by residents, they (the subjects) remain unattended to
Both residents and care workers do not avoid talking about their personal life and background to a some limited extent (ibid).

In non-task communication, care workers are careful to reduce their asymmetrical relationships; they tend to distance themselves from their professional role, but not in a bad sense (ibid). It is a way of inducing mutual involvement in chit-chat, which is itself considered an act of care (ibid).

Backhaus’s observation indicates that in an instance of interaction, task and talk may go hand-in-hand, and, in another sequence, they alternately be the core or the marginal activity (2017). However, in competition between the two, task-oriented communication has more chance to overrule non-task-oriented communication (Backhaus, 2017; Webb, Lindholm & Williams 2020). The domination of task-oriented communication, as well as the absence of talk, may contribute to the overall scarcity of non-task communication; for instance, the total amount of non-task communication in an occasion in residential homes for people with dementia is reportedly as short as two minutes over a six-hour period (Lindholm & Wray, 2011). A contributing factor to this problem is the interactional structure of task-oriented communication, which limits acceptable task-oriented contributions and treats utterances not in line with task-oriented communication as “off topic” (Webb et al., 2020, p.510). As a result, non-task communication is vulnerable to being cancelled at any moment of interaction.
2.5.4 Resistiveness-to-Care

A major challenge that care workers encounter while they assist residents is residents’ resistiveness-to-care (RTC) (Natelson Love & Geldmacher, 2018). RTC, noncompliant behaviour, can be displayed especially during care workers’ assistance with activities such as bathing (e.g., Natelson Love & Geldmacher, 2018). RTC usually begins with subtle resistance and gradually turns into verbal aggression, even leading to physical assault; in other words, RTC follows an escalating pattern (ibid).

It is reported by Kales et al. (2015) that RTC, as a symptom of dementia, is associated with decreased autonomy in activities of daily living. One of the first studies was Ragneskog et al. (1998), who maintained that residents communicated agitatedly when they felt that they had lost control over the situation; for instance, during care workers’ care task, residents had felt that their personal space was being invaded. From a resident’s perspective, it makes sense to defend one’s personal space against a stranger.

Although aggression may co-present with RTC, the two are distinct, in that the underlying intent of a resident rejecting care is to refuse a care worker’s activity but not harm her/him (Choi et al., 2017). Resident’s RTC might begin with a complaint which, if not addressed properly, might turn into stance of anger and subsequently may escalate.

One study by Williams et al. (2009) reports that during care work for PWD, residents displayed more RTC when the care workers used elderspeak to address them. It should be noted that instances of RTC are not independent; they unfold in sequences of actions.
A noteworthy point about studies on RTC is that data are obtained from care workers’ perspectives (Choi et al., 2017; Patel & Hope, 1992). Therefore, focusing on the micro level of turn-taking in interaction, as well as ethnographic information including the perspectives of residents and care workers is required. This type of data can probably address how RTC is produced in turns of action, and whether it is a response to care workers’ elderspeak (cf. Williams et al., 2009).

2.5.5 Elderspeak

Elderspeak is defined as adjustments to talk directed toward older adults. Elderspeak is characterised by behaviours such as less complex, shorter utterances; more redundancy; and more interrogatives (Ashburn & Gordon, 1981). Other attributes include talking about residents to a third person in the resident’s presence, addressing residents by their first names, staff’s use of ‘we’ instead of ‘I’ in conducting tasks, using tag questions, and a prevalence of modal verbs (Grainger, 2004; cf. Lanceley, 1985). It is also reported that nurses’ talk to the residents may include terms of address such as Gran or Pop, and using first names that can convey affection and intimacy that, if not actually felt, and if undesired, will be perceived as disrespectful (Fairhurst, 1981).

Residents may be addressed by care workers’ superlative talk, which are defined as comments that exaggeratedly praise a resident’s performance of a fairly ordinary task, implying that staff have low expectations of the resident’s capabilities, so that anything they can do, no matter how ordinary, is considered praiseworthy (Grainger, 2004; cf. Fairhurst 1981). Superlative talk, as well as other expressions of approval, may be
accompanying embodied behaviours such as a pat on the back or on the arm (Grainger, 2004; cf. Fairhurst 1981). Some prosodic features such as higher pitch, louder voice, and exaggerated patterns of intonation are also reported as fitting the definition of elderspeak (Caporael, 1981; Österrholm & Samuelsson, 2015; Shaw et al., 2021; Small, Huxtable, & Walsh, 2009).

Elderspeak is particularly criticised for its controlling implications, such as persuasive talk (Ryan, Hummert, & Boich, 1995). Persuasive talk or compliance gaining consists of staff’s verbal attempts to get the resident to cooperate with specific activities (Ryan, Hummert, & Boich, 1995). Williams (2011) maintains that when care workers using elderspeak such as persuasive talk and diminutives (e.g., ‘honey’), directly result in residents’ RTC and eventually in residents’ learned helplessness (cf. Rodin & Langer, 1980). ‘Learned helplessness’ is a resident’s loss of control over their environment, which in turn may result in a passive resident who just undergoes the provided care without any confidence or motivation to think or act independently (ibid).

In contrast to studies that generally point to the problematic nature of elderspeak (cf. Williams, 2011; Williams et al. 2009), Small et al. (2009) conclude that every feature of elderspeak needs to be considered in the specific setting in which it is used. It is reported that the uniqueness of each situation, setting, and context are decisive; for instance, residents in residential homes and community-dwelling older adults may respond differently to specific elderspeak attributes (Shaw et al., 2021, cf. Hummert et al., 1998; O’Connor & Pierre, 2004).
As Ryan, Hummert, & Boich (1995) point out, elderspeak can be received as condescending or as nurturing by the recipient. It can be difficult for care workers to communicate the correct balance between a nurturing and a respectful attitude, because the two are, to some extent, incompatible. Care workers may opt for nurturing styles at the expense of the patients’ dignity (Grainger, 2004). This is defined as a 'communication predicament', and in elderspeak it refers to how to convey solicitude without patronising the resident (Ryan, Hummert, & Boich, 1995).

2.6 Conclusion

The chapter concludes with assembling a toolbox for the purpose of discussing the findings. We saw that awareness of communicative problems in communication involving PWD is the first step. These are problems of memory deficits and communicative actions, problem of producing utterances, and problems of language comprehension. Secondly, the notion of common ground is necessary in discussing communication involving PWD and how it is established, despite communicative problems. Third, considering problems in establishing mutual understanding, I select the concept of repair. Fourth, face-saving is a common practice in communication involving PWD, especially when they do not succeed in managing the source of trouble. Fifth, three categories of communication in residential homes are selected: absence of talk, non-task communication, and task-oriented communication. Finally, when discussing task-oriented communication, two concepts of RTC and elderspeak are needed. RTC refers to noncompliant behaviour displayed by residents during activities.
like bathing. On the other hand, elderspeak is a communication style directed towards older adults.
3. Multilingualism and Dementia

3.1 Introduction

This chapter will focus on multilingualism, political views on multilingualism, and research on multilingualism in dementia and dementia care settings. The linguistic challenges of multilingual people with dementia are addressed, and code-switching as a topic relevant to the linguistic challenges of multilingual people living with dementia is discussed. The discussion of multilingual encounters in residential care homes will cover multilingual instances of task-oriented communication and how care workers address residents’ complaints; in particular, improvised strategies such as different models of recycling, playful language, and bodily practices such as gestures. The chapter concludes by highlighting major points related to the aim of this dissertation.

3.1.1 Multilingualism and Dementia Care

Multilingualism, in this dissertation, is a concept applied to any encounter where participants use resources from more than one language to communicate with each other (see Jaffe, 2012). In Sweden, we have witnessed a large-scale increase of linguistic and cultural diversity in recent years.
This pattern is more or less present in different sections of society, not least in residential care homes for people living with dementia. The rise in linguistic diversity in residential care homes is partly due to increasing number of multilingual residents, and partly due to a high rate of staff from ethnic minorities employed in residential care homes. Although most of the care workers and many of the residents use Swedish as a second language, it is not uncommon for many residents to use languages other than Swedish. This can be due to several conditions. First, in regards to multilingual people, we know that in the process of gradual loss of language, which is a common symptom of dementia, the greatest toll is often on the later-learned language; in other words, language deficit, in multilingual individuals begins with linguistic forms that are learned later in the sequence of language development (Cummings, 2020; Vega-Mendoza et al., 2019). Second, the later-acquired language of a multilingual person is probably not the strongest one, especially if it is learned in older adulthood (Plejert et al, 2017). These are major conditions for a multilingual resident’s inclination for using her/his strongest language, which may be a language other than Swedish.

Considering multilingual residents’ linguistic inclination, Ekman (1993) argued for linguistic matching between residents and care workers. This proposal, in more recent times, is echoed in the recommendation of the Swedish National Board of Health and Welfare (Socialstyrelsen, 2017). Although these recommendations about linguistic matching can facilitate mutual understanding between residents and care workers, hav-
ing a shared language does not guarantee multilingual residents’ wellbe-
ing. In addition, due to residential care home limitations, such as the shortage of staff members who speak residents’ languages, it is not always possible to match residents and care workers linguistically (Plejert et al., 2017). Accordingly, residents and care workers with distinct linguis-
tic backgrounds may face situations where they have a limited or no common language, which may lead to communication difficulties. Alt-
ough residents and care workers lack a common verbal language, their collaboration is still essential in performing joint activities. This is an area that have motivated a number of studies on everyday multilingual inter-
action in residential care homes (e.g., Heikkila, Sarvimäki, & Ekman, 2007; Runci, Eppingstall & O’Connor, 2012; Runci, Eppingstall, B, van der Ploeg & O’Connor, 2014; Runci, Redman & O’Connor, 2005; Söder-
man, Rosendahl, & Sällström, 2018).

3.2 What is Multilingualism?

Language contact is the essence of multilingualism. People of different linguistic backgrounds may come across each other and establish contact due to different reasons such as education, politics, religion, economy, or technology (Wei, 2011). Workplaces such as residential care homes, are a substantial example where multilingual encounters occur on a daily ba-
sis. Despite linguistic diversity, participants need a shared language ena-ling them to participate in joint activities. Sharing one language in mul-
tilingual communication involving people living with dementia, is hardly ever possible.
A shared perspective among a group of studies indicates that meaning-making is not confined to the use of languages as distinct, enumerable, bounded sets of linguistic resources (Canagarajah, 2013; Creese & Blackledge, 2015; Creese & Blackledge, 2010; Madsen, 2011; Otsuji & Pennycook, 2011; Rampton, 2011). In line with the above studies, the notion of separate languages as bounded systems of specific linguistic features belonging together and excluding other linguistic features may be considered inadequate for the analysis of language in use and in action (Creese & Blackledge, 2015; Jørgensen, Karrebæk, Madsen, & Møller, 2011; Makoni & Pennycook, 2012).

However, the idea of separate languages is taken for granted; particularly in political debates. Another way to express the idea of separate languages is the concept of majority languages as opposed to minority languages (Marilyn, Blackledge, & Creese, 2012). Majority language becomes a fundamental element of nation-state politics (Marilyn et al., 2012). This perspective is derived from the notion of one nation, one language (ibid). In this atmosphere, the idea of separate languages can depict a reduction in communicative abilities by favouring monolingualism at the cost of multilingualism.

3.2.1 Political Views on Multilingualism

This subsection reviews the major points in the debate between dominant political views on multilingualism. Whatever the outcomes of these debates, they directly affect multilingual people living with dementia. If the outcome promotes multilingualism, it lends itself to mobilising all remaining linguistic elements, regardless of their metalinguistic tags.
Whereas a non-recognition approach towards multilingualism and minority languages may jeopardise the communicative abilities of multilingual people living with dementia.

Reflecting on her personal experience of being raised with two languages, the American author, Jhumpa Lahiri, emphasised the influence of power structures in society on peoples’ non-recognition attitudes, including hers, toward minority languages (Lahiri, 2019). In this regard, Baker (2011) discusses multilingualism within the framework of ideology, political systems, and power in society. Lahiri’s point of view can be explained in detail by Baker’s (2011) words. According to Baker, *calls for and against* multilingualism are based on some basic beliefs. These basic beliefs are about issues such as minority languages and cultures, immigration and immigrants, linguistic and cultural diversity, equality of opportunity and equality of outcomes, empowerment, assimilation and integration, desecration and discrimination, pluralism and multiculturalism, diversity and discord, social division and social cohesion, and equality of recognition for minority groups (Baker, 2011). On the one hand, some groups maintain that a multilingual society will facilitate national cohesion and cultural integration and empower different language communities inside a country to communicate with each other, such as the situation in Singapore (Baker, 2011). On the other hand, according to others, a bilingual society will lead to language factions, national disunity, and economic, cultural, and political disintegration (Baker, 2011). These two major groups of beliefs, within the politics of multilingualism, leads to two contradicting perspectives about language: language as a problem
and language as a right (Ruiz, 1984; cf. Baker, 2011). Moreover, Baker identifies a third perspective, which regards language as a personal and national opportunity for development—language as a resource.

3.2.1.1 Language (Minority) as a Problem

Language is considered as a problem at two levels. For those whose assumptions associate language, at the individual level, with problems, multilingualism can account for cognitive problems of operating in different languages (Adler, 1977; Baker, 2011; Pavlenko, 2006; Ricento, 2000; Ruiz, 1984; cf. Schmid, 2004). From this perspective, multilingualism can even lead to disorders in personality such as split identity, cultural dislocation, a poor self-image, low self-esteem, alienation, emotional vulnerability, normlessness (anomie), and language anxiety (shisoglossia), which can be due to fear of judgement from others or a poor self-image (Baker, 2011; Machan, 2009; Molinsky, 2007; Pappamihiel, 2002; Pavlenko, 2005). At the group level, language may result in problems of national or regional disunity and intergroup conflict (Cooke & Simpson, 2012). As a result, language diversity can be viewed as a political problem that may result in less integration, less cohesiveness, more antagonism, and more conflict in society (Baker, 2011). According to the proponents of that perspective, the prescribed solution is assimilation of language minorities into the majority language (Baker, 2011). This solution can, of course, involve ascribing low status to minority languages, and to attributing high status to majority languages. It means discouraging using language minorities in public, which is in line to Lahiri’s point of view. However, the opposing perspective argues that it is possible to
have national unity without uniformity; the examples given include Luxembourg, Singapore, Switzerland, Wales, and Ireland. This view, at least, does not discourage multilingual encounters where minority language is part of the communicative resources, in contrast to the notion of minority languages being viewed as problematic. Furthermore, the depiction of minority languages as problematic may have implications beyond linguistic concerns; it may also result in a portrayal of speakers of minority languages and their distinctive needs as a social issue (see de Bot et al.; 2020 Torres, 2006).

3.2.1.2 Language as a Right; Linguistic Rights

The second assumption is made by people who consider language a basic human right (Baker, 2011). It is argued that just as one has rights in one’s choice of religion, so there should be an individual right to choose a language (Baker, 2011). This right becomes an extremely disputable topic when there are tensions between minority languages and the majority language. Two identifiable oppositional perspectives are a rights-oriented approach and a non-recognition approach. The first approach promotes self-determination of ethnic minorities; for example, speakers of a minority language assert the right to use their language freely, including in all official settings (Baker, 2011). However, that approach is rejected by proponents of non-rights, laissez-faire approaches to minority languages, by arguing against any form of intervention for language minorities (Baker, 2011). The non-recognition approach to language rights is considered to provide the conditions for oppression, domination, and injustice (Hall, 2002; cf. Baker, 2011). The outcome of each one of the aforementioned
perspectives fundamentally affects individuals with ethnic minority backgrounds.

The root of individual language rights is in human, legal, and constitutional rights (Baker, 2011). It also draws on individual liberties and the right to freedom of individual expression (Baker, 2011). This is particularly highlighted in the studies in Linguistic Human Rights (LHR), where there are claims that especially after the Second World War, the rights formulated by the United Nations were supposed to protect individuals with minority backgrounds (Skutnabb-Kangas, 2012, see also Phillipson & Skutnabb-Kangas 1995). The goal of LHR is a dignified life where everybody can fulfil her/his basic needs (Skutnabb-Kangas, 2008; Skutnabb-Kangas & McCarty, 2008). It is also designed to protect the individual against unjust, arbitrary, or degrading treatment (Phillipson & Skutnabb-Kangas, 1995). Thus, the consumers of human rights are naturally vulnerable, dispossessed, and inarticulate minorities.

The linguistic rights of individuals from ethnic minorities are drafted in the Universal Declaration of Linguistic Rights (UDLR). The UDLR, an attempt to expand Universal Declaration of Human Rights, is a document that was prepared by many parties, including experts in linguistic rights, NGOs, and PEN centres to define equitable linguistic rights regardless of political or administrative status of the territory to which a given linguistic community belongs. There are arguments advocating for the consideration of linguistic rights as emic rights, taking into account the specific cultural, linguistic, and contextual situations rather than considering them to be universal rights. However, it seems that certain linguistic rights could be considered universal (Baker, 2011; Paulston, 1997;
According to the UDLR, among these rights are a series of inalienable personal rights such as the right to maintain and develop one’s own language and culture and the right to use one’s own *name*.

### 3.2.1.2.1 Linguistic Rights of Multilingual People Living with Dementia in Sweden

Discrimination on the grounds of linguistic background, gender, religion, and race have been prohibited through various phases of development of human rights (Phillipson & Skutnabb-Kangas, 1995). Some groups are subjected to multiple forms of discrimination, where two or more grounds are crossing. For example, multiple discrimination is possible against older people living with dementia from minority linguistic backgrounds.

In Sweden, legislation enumerates and prohibits seven grounds of discrimination including: gender, gender identification, ethnic membership, functional disabilities, sexual orientation, and age (Butler, 1969; Vervaecje & Meisner, 2021). The Swedish National Board of Health and Welfare has made a series of recommendations with respect to providing care for people living with dementia who are from linguistically and culturally diverse backgrounds (Socialstyrelsen, 2017).

Among the recommendations are providing culturally adapted food and religious rituals, as well as linguistic matching between carers and residents (Socialstyrelsen, 2017). The protection of language and identity of PWD from ethnic minorities is embedded in the recommendation for linguistic matching between residents and carers. The recommendations
of the Swedish National Board of Health and Welfare indicate that language is not only a right but also a resource that facilitates social participation.

3.2.1.3 Language as a Resource

The third perspective considers language as a resource at both the individual and national level (Baker, 2011; Ruiz, 1984). Learning a second or foreign language presents many opportunities for an individual, such as access to different communities, lifestyles, and economic perspectives. Multilingual individuals also have an advantage in preserving cognitive abilities as they age; active use of different languages counterbalances general ageing effects on cognition (Bialystok & Sullivan, 2017; de Bot et al., 2020; Rossi & Diaz, 2017). Moreover, some studies indicate that multilingualism appears to hold back the symptoms of dementia, despite the neurodegenerative process; in other words, it preserves cognitive resources for a longer period of time (Bialystok, Craik, & Freedman, 2007; Lerman & Obler, 2017; cf. Bialystok & Sullivan, 2017; Chertkow et al., 2010; de Bot et al., 2020).

From a national perspective, language is considered as a resource not only in the economy but also in education, policy, and culture. Countries constantly strive to increase their economic participation and influence on the global stage (Baker, 2011), and as a strategy to achieve this, foreign language learning is promoted at the national level. This underscores the idea that language is considered a resource, even from a national perspective. The irony, however, is that there is a contradicting pol-
icy (Baker, 2011). While the dominant line of economic policy encourages citizens to learn second/foreign languages and the media attributes many health advantages to multilingualism with respect to learning high-status languages (de Bot et al., 2020), the assimilation/integration policy pressurises the speaker of minority languages, low status languages, to forget their own languages (Baker, 2011). This attitude toward minority languages is supposedly a measurement taken to prevent societal separation. But, from the perspective of language as a resource, diversity does not necessarily mean disunity (Baker, 2011). It is rather suppression that translates into separation. These contrasting policies, among other things, lead to a ranking system; i.e. a hierarchical order in which certain languages are considered more prestigious and important than others. Majority languages are highly ranked, whereas minority languages are granted less status (Baker, 2011; Ruiz, 1984).

In conclusion, the three perspectives on language have different implications for multilingual individuals living with dementia. On the one hand, the top priority of language as a problem perspective is the assimilation of minority languages in majority language. This policy assigns a low status to minority languages, thereby discouraging the use of minority languages, especially in the public sphere. As a result, multilingual residents in residential care homes, might be deprived of the opportunity to communicate in their strongest language; often their mother tongue, (see Ardila & Ramos, 2008; de Bot., 2020) with care workers and with younger generations and relatives. This stands in contrast to Ekman’s (1993) empirical research, which demonstrates that minority languages are decisive in establishing mutual understandings between multilingual
people living with dementia and care workers. The perspective of language (minorities) as a problem can multiply the communicative barriers of individuals living with dementia. When care workers do not speak the resident’s strongest language, communication difficulties can exacerbate the symptoms of dementia, making them appear more severe than they are in actuality (Ekman, 1993). This situation eventually contributes to residents’ social isolation, which in and of itself causes a negative spiral. The lack of practice in utilising available linguistic resources leads to further decline of the cognitive abilities and linguistic skills of the residents (see de Bot et al., 2020).

On the other hand, the ‘language as a right’ perspective draws upon human rights and individual liberties, claiming freedom of expression for residents with minority languages. This orientation removes any barriers to using minority languages, regardless of political territories. This approach releases all the remaining communication resources and provides the opportunity for multilingual people living with dementia and their interlocutors to achieve their communicative goals together. Thereby, multilingual people living with dementia, including those in late stages, can experience initiative-taking and independence (Ekman, 1993). These opportunities can be the smallest verbal units; which, if not responded to may lead to neglect of their full potential (cf. Lindholm, 2016). The third perspective considers language, including minority languages, to be a resource. This perspective can encourage care workers who speak minority languages to view their linguistic skills as an asset and to use them in multilingual communication with residents (Ekman, 1993). Thus, the last
two perspectives—language as a right and language as a resource—legitimise and motivate the use of minority languages for care workers and multilingual people living with dementia. Whereas the ‘language as problem’ perspective adds to their communication difficulties.

3.3 Linguistic Challenges Facing Multilingual People Living with Dementia

Language possesses a dynamic nature; the linguistic skills of a multilingual individual can change throughout her/his lifespan (de Bot, Lowie & Verspoor, 2007). For those living with dementia, different languages may follow different decline trajectories. (Ivanova, Salmon, & Gollan, 2014). This change for older adults who speak minority languages might include a faster decline in the language they acquired later in life (Ardila & Ramos, 2008; de Bot et al., 2020). Factors such as education, country of origin, and time spent in the country of immigration can all contribute to the decline of less-dominant languages. In these languages, however, retrieving language elements that have been used more frequently, may decline last (de Bot et al., 2020; Ivanova et al., 2014). For dominant languages, whether they are one’s mother tongue or a second language, people living with dementia may experience greater loss of the most difficult words and those words used less frequently (Ardila & Ramos, 2008; de Bot., 2020; Ivanova et al., 2014). Therefore, investing in all remaining linguistic resources, irrespective of their linguistic tags, could prove to be advantageous in overcoming linguistic challenges.

As multilingual people develop symptoms of dementia, not all their linguistic skills deteriorate to the same extent (Hyltenstam & Stroud,
Deterioration of one’s second language may lead to the isolation of people living with dementia if there is no one else who can communicate with them in their first language (Ekman, Robins Wahlin, Viitanen, Norberg, & Winblad, 1994). This isolation can make the symptoms of dementia appear to be more severe than they are (Ekman et al., 1994). This situation leads to a vicious cycle, where multilingual people living with dementia experience increasing isolation. The first language in the case of a person speaking a minority language, can be the strongest one, and often is more resilient in respect to regression. However, this does not mean that other linguistic skills completely disappear (see de Bot, 2019). The remaining parts of all linguistic skills constitute a unique linguistic resource of a multilingual person living with dementia (see de Bot, 2019). Although word search is a common symptom in dementia, the patterns of language loss in multilinguals with dementia are diverse (de Bot et al., 2020; cf. Bowles, Obler, & Albert, 1987; Müller & Guendouzi, 2009). This diversity is due to different types of dementia, such as Alzheimer disease, vascular dementia, frontotemporal dementia, with unique causes, pathologies, and clinical presentations (Vega-Mendoza, 2019).

Language decline in multilingual people is not specific to people living with dementia; it can also develop in the process of healthy aging (Isurin, 2019; Schmid, 2004). Although they may look similar in a few symptoms such as word search, symptoms of language decline in dementia are not identical with language decline such as language attrition in healthy aging (see Schmid, 2004). First language attrition in multilingual
(older) adults happens in migration settings, where the spoken language in the environment takes over and the heritage language fades away due to a lack of practice (Schmid, 2004).

3.4 Code-Switching in Communication Involving People Living with Dementia

In care encounters where there are limitations in a shared spoken language, residents and care workers may deploy instances of code-switching; i.e. they may use elements from different languages. This section will highlight the tension between two perspectives with respect to code-switching and dementia: pathological perspectives vis-à-vis code-switching as multilingual resources in meaning-making.

3.4.1 Code-Switching: A Deficit

The phenomenon of shifting between different languages in studies of multilingualism is referred to as ‘code-switching’, which has inspired several studies as early as the 1980s (Friedland & Miller, 1999; Gafarranga, 2007; Goral, Norvik, & Jensen, 2019; Hyltestam, 1995; Hyltenstam & Stroud, 1989; Hyltenstam & Stroud, 1993; Svennevig, Hansen, Simonsen, & Dalby Landmark, 2019).

According to researchers in applied linguistics, a person who is multilingual possesses distinct languages, each with its own unique system (Hyltenstam, 1995; Hyltenstam & Stroud, 1993). This is in contrast to a different view of multilingualism, which claims that a multilingual person possesses an integrated linguistic system (e.g., Friedland & Miller, 1999). The theories of Hyltenstam (1995) and Hyltenstam & Stroud
basically hold that there is an organisation of inhibition and disinhibition for different language systems (cf. de Bot, Plejert, & Simonsen 2020). In the organisation of inhibition and disinhibition of language systems, the selection and activation of one language system involves the inhibition of alternative/s (Hyltenstam, 1995; Hyltenstam & Stroud, 1993). However, non-selected language may not be totally inhibited. This can justify how a bilingual person has simultaneous access to the alternative language in both production and comprehension (Paradis, 1985). Thus, any interruption to the organisation of inhibition and disinhibition of languages leads to “language mixing” (Hyltenstam, 1995, p. 306). This concept refers to a multilingual person’s inability to engage in language separation and language choice in accordance with her/his interlocutors (ibid).

In the framework of inhibition and disinhibition, it is argued that the more available linguistic item has a lower threshold of activation; in other words, the item is easily accessible (Paradis, 1985). The accessibility of a linguistic item is due to the function of frequency and recency of the item’s activation, which contribute to its availability (Hyltenstam & Stroud, 1993). Hyltenstam & Stroud (1993) hypothesised, on the one hand, that the most used and the most recent items are the most available items; in other words, the available linguistic items have high degree of automatisation (Hyltenstam & Stroud, 1993). In addition, multilingual older adults, who actively use all languages and need constantly to inhibit non-relevant language and to select the target language, keep their executive control, or the ability to inhibit non-relevant language, strong (Bialystok, Craik, Klein, & Viswanathan, 2004; Bialystok, Craik, & Luk,
On the other hand, an incompletely acquired language has lower degree of automatisation. Hence it is concluded that PWD, who have not premorbidly acquired their L2 to a sufficient level, do not have the necessary resources to inhibit their L1 and disinhibit their L2 (Hyltenstam & Stroud, 1993).

The inhibition and disinhibition theory put forward by Hyltenstam (1995) and Hyltenstam & Stroud (1993) regarding language mixing in everyday conversations of PWD has not been empirically proven (Friedland & Miller, 1999). This criticism maintains that since it is impossible to determine the underlaying mechanisms such as disinhibition and inhibition, using labels such as language choice and language separation remains a fundamentally arbitrary decision (Friedland & Miller, 1999).

3.4.2 Code-Switching: A Strategy

According to the recent neuroscientific studies of multilingualism, a multilingual person’s use of elements from different languages in her/his utterances does not mean that there are different separate languages in her/his linguistic system (de Bot, 2019). S/he may just use the most available and suitable linguistic element for a specific situation (ibid). These linguistic elements are rooted in an individual’s life history and experiences (Hopper, 1998). In fact, all the linguistic items of a multilingual person constitute her/his unique linguistic system (ibid).

Considering the fact that dementia, especially AD, has heterogeneous symptoms and different people progress at different rates and present different symptomatologies, we need an in-depth investigation into each individual instance to see how the conversation unfolds turn by turn.
(Friedland & Miller, 1999). Therefore, it is recommended we consider more structured qualitative approaches, such as conversation analysis (CA) when studying PWD’s multilingual linguistic behaviours, such as code-switching (Friedland & Miller, 1999). In addition, CA is sensitive to unique cases of every instance of conversations involving PWD; in other words, this may help us achieve a more context-relevant explanation of PWD’s communicative behaviour (ibid). Furthermore, CA’s approach to multilingual interaction seems to be in line with the neuroscientific views of multilingualism that prefers considering “situation-specific utterances” (De Bot, 2019, p. 12), rather than separate language systems. From this perspective, at a metalinguistic level, an utterance is labelled as belonging to a specific language, but that does not imply that it is tagged as such in the brain (ibid).

Svennevig et al. (2019), through a cross-disciplinary methodology, both quantitatively and qualitatively approaches combining CA and cognitive and psycholinguistic tests, by exploring code-switching practices of multilingual people with dementia (cf. Lindholm, 2017). The findings show two main communicative functions of code-switching for people with dementia both in natural conversations and in the tests (Svennevig et al., 2019).

First, in contrary to Hyltenstam (1995) and Hyltenstam & Stroud (1993), code-switching constitutes a resource for multilingual people with dementia, allowing them to compensate for word retrieval problems; in other words, code-switching is recognised in most cases as a strategic choice rather than as a deficit (Svennevig et al., 2019).
The second function of code-switching is producing metacommunicative remarks related to the process of speech production, such as expressions of frustration or self-addressed memory prompts (Svennevig et al., 2019). The metacommunicative insertions are considered to be expected accounts from the speaker when talk is challenged by pauses and hesitations; they display to the interlocutor that the speaker is engaged in the activity of word searching and is committed to pursuing the endeavor further (Svennevig et al., 2019). It is noteworthy that interlocutors treat most instances of code-switching as appropriate by claiming understanding and continuing the communicative activity at hand, rather than initiating repair or producing corrections (Svennevig et al., 2019). Thus, code-switching is considered a process of multilingual meaning-making.

A substantial proof against the claim that code-switching is ‘pathological’ in nature is the situational awareness of PWD; multilingual people with dementia usually switch to a language known to their interlocutor. Lindholm (2017) shows cases of language choice in interaction between multilingual professional care workers and two groups of multilingual residents. The language choice is dependent on specific situations; i.e., the period each group of Finnish-Swedish PWD have spent in Finnish residential care homes. The analysis indicates that long-term residents mostly spoke Swedish, which was the language of the residential care home (Lindholm, 2017). On the other hand, short-term residents spoke Finnish more frequently than long-term residents (Lindholm, 2017). The observation of Lindholm (2017) highlights residents’ capacity for situational awareness. In the case of short-term residents, Lindholm (2017) argues that Swedish-speaking Finns living in bilingual municipalities are
accustomed to navigating a landscape where Finnish is the majority language and Swedish is a minority language. Therefore, Swedish-speaking Finns by default use Finnish when entering situations not previously known for providing services in Swedish (Lindholm, 2017). Thus, when short-term residents enter the nursing home for periods not exceeding a few days, they address other residents and care workers in Finnish (Lindholm, 2017).

Situational awareness in regard to PWD’s code-switching is also reported by Müller (2017). She reports on cases where a resident states her awareness of switching between Irish and English purposefully to manage interactions; for example, bilingual interaction is held in group events and her individual interactions with Irish speakers are in Irish (Müller, 2017). Müller (2017) devises the concept of bilingual “fluidity” (p.90) to describe the phenomenon where a multilingual individual consistently switches languages based on situational context and environments.

3.5 Multilingual Interaction in Residential Care

This section focuses on the topic of multilingual interaction in Swedish residential care homes, which has attracted substantial attention from researchers in recent years. The section especially investigates the growing body of research on everyday communication between residents and care workers who must navigate the constraints of shared verbal language in residential care homes (e.g., Kong, Deatrick & Evans, 2010). A major line of the research are the strategies developed by both parties in managing everyday activities. These strategies encompass
both verbal and nonverbal practices, such as recycling, brokering, and playful language. Two primary points are explored: the role of shared language and nonverbal resources in task-oriented communication; particularly in managing residents’ complaints and requests and the importance of cultural sensitivity among care workers. The section concludes with a summary of key points to the dissertation.

3.5.1 The Role of Shared Spoken Language

The study conducted by Ekman et al. (1994) reveals the relationships between the cognitive, linguistic, and neuropsychological abilities of bilingual residents with dementia and the presence or absence of care workers who share the residents’ language (Ekman et al., 1994). Ekman et al. specifically examined bilingual Finnish–Swedish-speaking individuals living with dementia born in Finland who migrated to Sweden. While most of the residents who had learned Swedish in adulthood had difficulties communicating with Swedish speaking care workers, they could effectively communicate with Finnish-speaking staff (Ekman et al., 1994). Additionally, the presence of Finnish-speaking care workers sharing the language of the residents with dementia contributed to residents’ enhanced language abilities (Ekman et al., 1994). Whereas a lack of a shared spoken language with a large number of care workers who did not speak Finnish was an involving factor in the isolation of the residents (Ekman et al., 1994). The challenges in communication—mostly a lack of common language—can of course hamper mutual understanding, even leading to misunderstandings about residents (Ekman, 1994; Plejert et al., 2014). One such misunderstanding is that residents’ linguistic abilities
are underestimated due to the absence of care workers who speak and understand the residents’ language; residents’ symptoms of language decline might appear more severe than they actually are. This misconception about the linguistic decline of bilingual residents can result in care workers concluding that communicating with bilingual residents is to no avail, leading to further isolation of the residents and atrophy of their linguistic abilities due to a lack of practice. In conducting daily tasks such as assisting in personal hygiene, the underestimation of residents’ linguistic abilities may lead to one-way communication, jeopardising the residents’ sense of comfort, autonomy, and dignity (Ekman et al., 1994). In one-way communication, the care worker often gives commands, directives, and interrupts the resident, which may result in negative feelings and the resident’s negative stances such as an oppositional stance and stance of anger (see Jansson & Wadensjö, 2016a; Pejert et al., 2014). Such situations eventually add to the workload and the stress of the care workers, who may find themselves trapped in the dilemma of fulfilling institutional duties and managing residents’ non-compliant behaviours (Plejert et al., 2014; Plejert & Jansson, 2021).

Trying to manage the communicative challenge, the care worker may seek help from other colleagues or the residents’ relatives (Jansson, 2014; Jansson & Wadensjö, 2016a; Rosendahl, Söderman, & Mazaheri, 2016). Thus, a dyadic interaction between a care worker and a resident becomes a triadic interaction involving another care worker who has a shared language with the resident. The care worker, who has a shared language with the resident, contributes to the interaction via brokering between her/his colleague and the resident (Jansson, 2014; Jansson &
The term ‘broker’ in studies of multilingualism, is used to refer to the individuals who bridge the linguistic gap between people speaking minority languages and people speaking the majority language (Bolden, 2012; Jansson & Wadensjö, 2016a).

When family members are available in residential care homes, their role can be identified as a link to the healthy life story of the family member with dementia and an expert and an interpreter for nursing staff (Rosendahl et al., 2016; Small et al., 2015). Family member’s roles as brokers can be unique in the sense that meaning-making with people living with dementia is highly dependent on shared forms of life; many utterances, which cannot be grasped by others, are meaningful to people who are close to people living with dementia (cf. Hughes, 2013; Morris et al., 2018). However, Small et al. (2015) caution that involving family members in the task of brokering can present challenges. Conflicts may occur between family members and care workers, as the former’s role shifts from visitor to broker, and each party has her/his own interests to consider (Small et al., 2015). Additionally, even when interpreting a non-family resident, a relative’s involvement may seem problematic due to confidentiality issues (Small et al., 2015).

Lack of a shared spoken language between care workers and residents, in combination with the absence of a broker who can bridge the language gap between the two parties may lead to complicated situations. Nevertheless, it is important to note that mutual understanding can extend beyond a shared spoken language (see Strandroos & Anteljus, 2017).
3.5.2 Nonverbal Resources

There are several studies of communication in dementia care showing the integration of verbal and nonverbal resources such as gazes and gestures in the sense that they mutually support each other (Ekman 1993; Ekman et al., 1994; Ekström et al., 2017; Jansson, 2014; Small et al., 1998; Small et al., 2015; Small et al., 2017; Majlesi, Ekström, & Hydén, 2019; Majlesi, Ekström, & Hydén, 2021; Nilsson, Ekström, & Majlesi, 2018; Jansson, Plejert & Lindholm, 2019).

Small et al., (2015) is one of a few studies that probe the function of nonverbal resources in multilingual encounters in long-term residential homes. Small et al. (2015) discovered that both residents and care workers effectively use nonverbal resources in variety of situations. For example, when resisting a care worker’s activity, the residents’ nonverbal resources are shaking or moving their head, grimacing, or refusing to make eye contact. Additionally, when displaying compliance, residents looked at care workers when addressed by them, smiled, nodded their heads, and pointed to object of interest to care workers (Small et al., 2015). On behalf of care workers, they tried attracting residents’ attention through touching and pointing, and avoiding eye contact to dodge direct communication with residents. As care workers conveyed affection, they smiled and touched residents, and held eye contact with residents, especially when facilitating task accomplishment. An important point is that these resources are hardly used in isolation; rather, they are used in combination, such as in sequences of touch, facial expressions, body posture, and dietic and iconic gestures (Small et al., 2015). These practices are observed
even in communication involving people living with advanced dementia (Ekman, 1993; Small et al., 2015). With respect to turn-taking in non-verbal communication, especially in task-oriented communication, care workers usually initiate with both verbal and nonverbal actions and residents’ responses are often nonverbal (Small et al., 2017). Nonverbal resources seem to be a key factor in mutual understanding where a shared spoken language is missing (cf. Hydén, 2013). In these situations, the chance of establishing mutual understanding by relying on nonverbal resources increases with higher degree of care worker’s familiarity with the resident (Ekman et al., 1994). Similarly, care workers’ responsiveness and positive attitudes towards the resident increases the chance of using nonverbal resources to establish mutual understanding (Ekman et al., 1994). This points to the fact that functional communication—especially in multilingual settings—requires care worker’s knowledge of resident’s background information and life history (cf. Brown et al., 2013; Caddell & Clare, 2010; Gross et al., 2004; Kindell et al., 2018; Kindell et al., 2019; Small et al., 2015). This information, as a common ground for residents and care workers, facilitates mutual understanding in delivering person-centred care despite the lack of a common spoken language (cf. Kitwood, 1997; Penrod et al., 2007).

Jansson (2014) investigates nonverbal interaction in multilingual settings when care workers are dealing with complaints. She provides a few examples where care workers use nonverbal resources, such as using fingers for numerals, to indicate medication timing to a resident with de-
mentia with whom she had limited common language. These bodily resources helped establish mutual understanding between the care worker and the resident.

The resident also skilfully uses nonverbal resources, deictic gestures, and gaze direction to point to a specific object in the environment, indicating the source of her concern. The gesture and the direction are taken up by the care worker when she responds with a deictic gesture synchronised with a single linguistic element from the resident’s mother tongue. This short response correctly addresses the resident’s concern and mitigates her anxiety (Jansson, 2014)

3.5.2.1 Managing Everyday Activities

Plejert et al. (2014), in a case study, shows that a lack of a shared language affects mutual understanding negatively; even leading to misunderstandings. In delicate cases such as keeping personal hygiene which involves care worker’s treatment of resident’s body, misunderstandings can lead to escalation (Plejert et al., 2014). The escalating pattern usually begins with subtle resistance and gradually turns into verbal aggression, even leading to physical assault (e.g., Natelson Love & Geldmacher, 2018). These situations are associated with negative outcomes for both the resident and the care worker.

Undergoing a process where not only her/his wishes and preferences are not taken into account but also another’s plans and actions are imposed on her/him, the residents experience a loss of control and decreased autonomy in her/his most personal issues, such as in maintaining
personal hygiene (Plejert et al., 2014; Ragneskog et al. 1998). A resident’s loss of control over their environment can lead to damaged self-confidence and a lack of motivation to think and act independently (Heikkila et al., 2007; Rodin & Langer, 1980).

On the part of care workers, they may undergo increasing workloads, stress, and anxiety because they face tasks that seem unsolvable. This situation, consequently, can lead to care workers’ burnout and health problems (Jansson, 2014; Juthberg et al., 2008; Robinson et al., 2012; Small et al., 2000). These negative effects—on both residents and care workers—probably adds to the costs of residential care homes.

Addressing the aforementioned challenges, recent studies show that care workers and residents have resources at their disposal that can be used both in parallel and in the absence of a common spoken language (Jansson, 2014; Jansson, 2016; Jansson et al., 2017; Small et al., 2017; Strandroos & Antelius, 2017). These studies’ foci are mostly on activities that can be placed in the category of task-oriented communication. Two common issues in task-oriented communication include managing residents’ complaints as well as addressing residents’ requests (Jansson, 2014; Jansson, 2016; Jansson & Wadensjö, 2016a; Jansson et al., 2017; Jansson et al., 2019).

3.5.2.1.1 Managing Complaints

Jansson (2014), in a case study, shows how multilingual care workers, in an encounter with the resident with whom they do not have a shared language, creatively use their multilingual and nonverbal skills to cope with complex situations. Jansson’s (2014) case study focuses on multiparty
interactions, where one care worker has a common language with the resident, but the other care workers do not. Still, the care workers’ tasks involve establishing rapport, coping with trouble talks, and affiliating with the resident (Jansson, 2014).

While the care worker with a common language engages in both task-oriented communication (namely complaints), as well as non-task oriented communication such as talking about memories and trauma, the care workers without a common language engage mostly in task-oriented communication (Jansson, 2014; Jansson & Wadensjö, 2017). The latter’s management of the resident’s complaint is facilitated by the former, as a language/cultural broker (Jansson, 2014).

It should be noted that in residential care homes there are many other instances of communication that are dyadic; i.e., the language broker is not involved (ibid). Despite the limited extent of a common language in the dyadic interaction, care workers and residents employ a few strategies to achieve mutual understanding. For example, if there is a common element in their respective languages, care workers and residents draw upon the shared element. They also synchronise the shared element with bodily practices (Jansson, 2014). When there is not a shared linguistic element, they try to make one. This is accomplished mostly by recycling an element from the prior participant’s utterances (cf. Kurtić & Gorisch, 2018; Tannen, 1989; Zellers & Schweitzer, 2017). This linguistic recycling can be accompanied by recycling of bodily practices (Jansson, 2014). The concept of recycling has captured the attention of both linguists and conversation analysts. In 1987, Goodwin and Goodwin incorporated the term format tying into their analytical framework. This
concept illustrates the recurrence of elements from prior utterances, whether partially or exactly, in various interactional practices among the participants. Additionally, Anward (2004) introduced the concept of recycling with a différence to illustrate how participants employ patterns of recycling by utilizing the same turn format to contribute to an activity. In doing so, Anward demonstrated how participants effectively facilitate mutual understanding and advance in their interactions. (Anward, 2004; Goodwin & Goodwin, 1987; Zellers & Schweitzer, 2017). As mutual understanding cannot be achieved, the care worker employs other strategies to promote the progressivity of communication. S/he may use creative strategies, such as playful language and frame shifting, or shift from the current topic to the next topic without addressing the actual content of the utterance (Jansson, 2014; cf. Goffman, 1974). Although fame shifting contributes to the flow of communication, it can be risky when the actual content of the prior utterance is not addressed, and may thereby lead to misunderstandings.

In managing residents’ complaints, care workers who are acquainted with the resident—with her comforting situations, her habits and life history, and have knowledge of her routines—are better equipped to address the source of the problem; in other words, when the care worker and the resident have established a common ground, they are better equipped to establish a mutual understanding, a cornerstone of delivering person-centred care (cf. Jansson, 2014; Kitwood, 199). Having common ground with residents means the care worker can address the source of the trouble even though they may not have access to the actual content of the residents’ utterances (Jansson, 2014; Jansson et al., 2017; Jansson et
The care worker who has acquainted herself with the resident and has the knowledge of her routines, can also mediate between her colleagues who do not share common language with the resident (Jansson, 2014; Jansson et al., 2017; Jansson et al., 2019). This advantage is not necessarily related to a shared language, as the mediator can be a care worker who has very limited shared spoken language with the resident (Jansson, 2014; Jansson et al., 2017; Jansson et al., 2019). A care worker, as a mediator, can intervene in managing moments of conflict and resident’s distress (Jansson et al., 2017). The mediator can intervene in intense situations and turn stressful situations into cheerfulness (Jansson et al., 2017). A mediator clarifies the source of the trouble for her colleague and can thereby address the issue properly.

3.5.2.1.2 Addressing Requests

The here and now in communication—especially in task-oriented communication—is a substantial element. For instance, seeking assistance, namely by making requests, is a regular issue in residential care homes. In these instances, the resident recruits the care worker to achieve a goal (Jansson et al., 2019). Depending on the available resources, the resident and the care worker employ different strategies to fulfil the request.

Jansson et al., (2019) through multimodal analysis at the micro level, provides distinct examples of how three residents who do not share a spoken language with their care worker, are able to initiate requests and recruit the care worker to assist them with respective errands. The residents and care worker draw upon the interplay of talk, prosody, bodily
practices and manipulation of the available objects in the immediate environment (Jansson et al. 2019; Kindell, Sage, Keady & Wilkinson, 2013; cf. Plejert & Jansson, 2021). Residents are quite diverse in terms of the way they utilise communicative resources; i.e., everyone has a unique communicative repertoire (Jansson et al., 2019; cf. Jaffe, 2012). While some residents use a more balanced combination of resources, others rely heavily on bodily practices such as on different kinds of gestures. Jansson et al. (2019) show an example of mutual understanding with respect to the resident’s request. The resident and the care worker primarily rely on bodily practices and semiotic resources in the environment. The resident makes a sequence of iconic and deictic gestures to project a course of action as a request, while the care worker pays close attention to the resident’s bodily movements, recognises the request, and fulfils it accordingly. What make the request recognisable to the care worker are the resident’s gestures and the visibility of two relevant objects; namely two used napkins in resident’s hand and the trash bin. The combination of the gestures, the crumpled napkins, and the trash bin makes the projected course of action recognisable as a request to dispose of the used napkins.

The function of the semiotic resources of the physical environment are not always easily accessible; this can be due to the unavailability or invisibility of the objects in question. It is here that an extensive collaboration between the residents and the care workers unfold in pursuing the goal (Jansson et al., 2019). It is here that a person with as limited repertoire as three spoken words—*yes, no, and and*—can display collaboration in complex communicative activities, thereby establishing mutual understanding. Goodwin (1995) reports how a man with aphasia, who had just
three words at his disposal, participates in everyday interactions. This collaboration involves people in his surroundings providing candidate proposals to the person with communication difficulties and this person accepts or rejects them (Goodwin, 1995; Jansson et al., 2019). In residential care, this process involves care workers’ willingness to communicate and attentiveness to all the communicative behaviours of the residents (Jansson et al., 2019). The care workers pay attention to gestures, spoken words, and audible signs such as signs of discomfort (Jansson et al., 2019). By paying attention to bodily practices and semiotic resources, care workers can understand the requests without access to the spoken language of the resident (Jansson et al., 2019).

The cases in Jansson et al. (2019) show that shared attention is essential in participants’ endeavours to accomplishing the request. The care workers’ competences contribute to settings where residents can assume agentic roles in interaction and contribute to meaning-making (Jansson et al., 2019). Whereas a lack of attention to resident’s communicative behaviours may lead to reduced agency, which can be associated with residents’ depression and lower quality of life (Kasser & Ryan, 1999; Svennevig & Hamilton, 2022).

In conclusion, care workers, in task-oriented communication such as managing complaints and fulfilling requests, may find themselves in challenging situations; especially when there is a lack of a common language. However, they can use their creativity to recycle utterances and bodily practices to establish shared linguistic resources. The care workers, as well as residents, utilise the semiotic resources such as gestures and objects in their environment to establish mutual understanding. Care
workers also learn a few key utterances of a resident’s language to utilise them when needed (Jansson, 2014).

3.5.3  Research on Intercultural Encounters in Residential Care Homes

In regard to cultural sensitivity in multilingual encounters, research has focused on care workers awareness of residents’ culture. Boyd & Smith (2009) focuses on the cultural competence of new care workers in the U.S. to the culture of PWD from ethnicities who speak the language of the ethnic majority—i.e., English (cf. Boyd & Smith, 2009). Whereas in a multicultural and multilingual society there might be many PWD who are from ethnic minority groups rather than from the major ethnicity. In addition, we know that PWD from ethnic minorities are subject to greater loss with respect to the majority language. Some cases are reported where, due to lack of substantial cultural and communicative support, older adults from ethnic minorities may seek to migrate from their place of residency (Hojat et al., 2010). In dementia care it is similarly vital for care workers to improve their cultural competency with respect to ethnic minority PWD.

A lack of cultural awareness about residents from ethnic minorities can negatively affect residents’ well-being. These competences are not necessarily expensive; however, they may bring about considerable positive outcomes. Rosendahl, Söderman, & Mazaheri (2016) consider a number of negative outcomes due to lack of cultural awareness regarding ethnic minority residents. Comparing the everyday lives of ethnic minority and ethnic majority residents, Rosendahl et al. (2016) have found discrepancies between the everyday lives of ethnic majority PWD and PWD
from ethnic minorities. First, there is a scarcity of participation in activities on the part of ethnic minority residents; namely physical activities, such as going for walks, spending time outside, going on trips, and receiving occupational therapy. According to their relatives, ethnic minorities with dementia were made to rest during the day instead of being involved in activities (ibid). While PWD from majority languages took part in activities that did not require much physical energy or strength, such as small talks between the meals, listening to music, watching television, or browsing the magazines on their own or with nursing staff, ethnic minority PWD preferred television programmes and music that they were already familiar with (ibid). Residents from ethnic minorities preferred traditional food that they had been used to, but it was not included in daily catering of the residential care home. Ethnic minority residents did not socialise with each other either (ibid). From the perspective of the professional care workers, it could be difficult to activate people with severe dementia, and they might not want to or basically did not have the physical strength to join in various activities (ibid).

3.6 Clinical Dementia Assessment Practices and the Use of Interpreters

It is crucial for people with dementia to be diagnosed early enough so that the family members as well as care workers can adapt to the new situations. Therefore, access to validated test batteries with respect to multilingual people living with dementia is a requisite (Franzen et al., 2021; Nielsen et al., 2011; Plejert, Antelius, Yazdanpanah, & Nielsen, 2015).
The assessment of dementia includes critical aspects, such as taking histories, conducting cognitive assessments, and using diagnostic tests (DSM-5). Cognitive assessment, as the central aspect of the evaluation, is conducted via cognitive tests such as the Mini Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975), the Modified Mini-Mental State (3MS; Teng & Chui, 1987), and the Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005). A few of these tests, such as 3MS and MoCA are used widely to assess abstract thinking, delayed recall, and verbal fluency. It is reported that most of the tests are culturally biased and they are not inclusive in respect to individuals from cultural and linguistic minorities (Nielsen et al., 2011; Singh et al., 2021).

The results of these tests are reliable if the client and the healthcare professional can establish mutual understanding in the process of assessing functional losses in the social, interpersonal, and daily functioning of the client (See DSM-5).

The above procedure is usually linguistically- and culturally adapted to the ethnic majority population. Therefore, people from ethnic minorities are rarely included in the screenings, unless the assessments are rendered in the respective minority language. This rendering is performed either by interpreters in triadic communication or provided by the translations of the test batteries. The role of an interpreter is sometimes taken on by family members, who are not trained interpreters, especially when it comes to taking medical histories of the development of symptoms (See DSM-5). Even professional interpreters are likely to miss decisive details of the assessment (Plejert et al, 2015). Ekman et al. (1994)
reveal that multilingual people with symptoms of dementia were likely to be misdiagnosed in neuropsychological assessments mediated by interpreters; therefore, the study maintains that correct diagnosis needs to be administered by multilingual physicians and psychologists sharing the client’s language/s. Although there are several validated translations in many languages, they potentially hinder the reliability of the assessments, because they often do not take into account the cultural backgrounds of the clients (Nielsen et al., 2011; Plejert et al., 2015). Considering the aforementioned situations, several studies have been conducted in recent years that recommend devising culturally- and linguistically adapted test batteries (Franzen et al., 2021; Nielsen et al., 2011; Plejert et al., 2015). In addition, most recent research points to the accuracy of the cognitive screening instrument Rowland Universal Dementia Assessment Scale (RUDAS), regardless of the cultural, linguistic, and educational backgrounds of all patients with suspected dementia (Torkpoor et al., 2022). Under the recommendations of the studies, a few initiatives have been taken in the European societies; however, there is place for more collaboration in the research and development of the tests (cf. Franzen et al. 2021; Torkpoor et al., 2022).

3.7 Conclusion

The absence of a shared language between care workers and a multilingual resident not only makes mutual understanding less achievable, but it can also lead to the underestimation of the resident’s linguistic abilities, even in her/his strongest language. This, in turn, may cause care workers to believe that communicating with the resident is futile. This can lead to
a vicious cycle, where the resident becomes increasingly isolated, and due to a lack of practice, their remaining linguistic abilities may undergo faster decline.

However, despite the absence of a shared language, there are still resources available to compensate at least to some extent. One such resource is the presence of a responsive care worker who is interested in the resident and has enough knowledge about the resident’s background. If this condition is fulfilled, the care worker can utilise a variety of resources to establish mutual understanding with the resident, even without a shared spoken language.

The studies, based on detailed analyses of multilingual communication involving people living with dementia, emphasise the importance of embodied resources; i.e. the use of verbal and nonverbal resources. They show how care workers and people living with dementia use all available resources such as linguistic, bodily, and semiotic resources to establish mutual understanding in the absence of a shared spoken language. Recycling verbal and nonverbal practices is a creative way of making shared communicative resources available for use. However, this capacity can be hindered when monolingualism is promoted at the expense of multilingualism.
4. Data and Methods

4.1 Introduction

This chapter turns to material and methods, the choice of different methods and fieldwork for generating data, including observation, fieldnotes, video-recordings, and interviews. Second, the recruitment procedure is described. Next, selecting the analytical methods of analysing data—conversation analysis and thematic analysis as well as transcription methods are discussed. The chapter concludes with ethical considerations.

4.2 Methods for Generating Data

The aim of this dissertation is to investigate the functions of communicative resources and forms of address in establishing mutual understanding between care workers and multilingual residents in residential homes when there are limitations on the amount of shared spoken language available to participants. The focus is primarily on task-oriented communication in residential homes, and to achieve this, I have used several different methods for gathering data: observations, fieldnotes, video-recording, and interviews.

Data collection began with observing the participants’ communication while taking fieldnotes. During my observations, I also noticed that the
residents spent a considerable amount of time in solitude. While observations and fieldnotes were helpful in achieving an initial understanding of the communicative processes between residents and care workers, the analysis of mutual understanding required access to material that could be viewed repeatedly to capture the details of communication and participants’ situated actions. Therefore, video-recording became the preferred method, as it has proved to be a reliable method for studying mutual understanding (Hutchby & Wooffitt, 2008; Chatwin, 2014). Moreover, I needed to have access to the residents’ preferences and care workers’ insights as to their choice of forms of address. These points of view could be captured through interviewing participants (cf. Samuelsson & Hydén, 2017).

4.2.1 Ethnography: Choosing the Field, Observations, and Fieldnotes

Fieldwork involved going to two residential homes, Cedar and Oak, located in a midsize city in Sweden (the names have been changed to protect participants’ anonymity). The main selection criterion for these residential homes was that they housed residents with minority backgrounds whose languages were not always shared by care workers. In addition, care workers who spoke Swedish as a second language were included in the project. Contacts with residential homes were guaranteed prior to the start of the PhD programme and continued throughout the fieldwork period. The first residential home, Cedar, was approached by my co-supervisor and the project head. While doing fieldwork in Cedar once a month, I established contact with the second residential home, Oak.
The fieldwork in Cedar began in June 2014 and lasted until May 2016, while my fieldwork in Oak took place between August 2018 and March 2019. During my visits in Cedar, which occurred almost once a month, I gained valuable insights through observation and by taking fieldnotes. However, sometimes, it was not possible to take notes in real time. Instead, I would write down my observations immediately following the observed activity in a pocket handbook (‘jottings’) and later transferred them into a word document. Additionally, I employed a third method of writing, which was based on reviewing video-recordings from fieldwork and from what I remembered about a particular episode. These fieldnotes consisted of descriptions of settings, participants’ actions, direct quotations, and my own interpretations of the situations I observed. In total, the fieldnotes comprised almost 16 A4 pages.

This ethnographic data, including observations and fieldnotes, provided an overall understanding of communication processes in residential homes. It also provided a background understanding for more in-depth investigations of video-recordings and in preparing the interviews which will discussed in sections 4.2.2 and 4.2.3, respectively. To obtain this background information, it was essential for me to immerse myself in the environment. Beginning the fieldwork, I used to sit in an armchair in the hallway, in a sofa in the living room, or walk around the residential home. Sometimes, I had the opportunity to follow the care workers when entering residents’ apartments, but other times, I did not have permission to do this.

Depending on the time of the day, I was generously invited by the care workers and the participants to join them for meals and breaks, which
allowed me to give up the pattern of a *fly on the wall* and try and adopt the *flying fly* approach (e.g., Geertz, 1998; Iverson & Gurdun, 2018). Towards the end of the data collection period, I realised that most people in the residential home saw me as less of a stranger than they did earlier on in the fieldwork period.

While spending hours in the residents’ apartments, I observed that residents often spent most of their time alone. Communication with care workers usually occurred during mealtimes, breaks, medication administration, and hygiene activities, which led me to conclude that task-oriented communication was the dominant form of communication. These observations motivated me to conduct video-recordings.

4.2.2 Video-Recording

In exploring the participants’ experience of mutual understanding, I needed to carefully analyse their communication in detail and do so repeatedly. To achieve this, I chose to use video- and audio recordings. Recordings were made using a Handycam Canon video camera, which I often used while in motion. I rarely planted the camera in one location in order to avoid recording people without their permission. Additionally, I preferred to record only moments where participants were about to interact, resulting in several shorter clips of their communication.

The recordings consist of a total of 138 distinct audio and video clips, 124 of which were recorded by the author during different fieldwork sessions. The total length of the recordings from residential home Cedar is 670 minutes. These clips mostly contain recorded everyday in-
teractions between staff and three residents with multilingual backgrounds. The other 14 videos and audio clips were recorded by Gunilla Jansson, one of the co-supervisors for the thesis within whose project this PhD/project was conducted. She has made video/audio recordings at two separate residential homes, distinct from Cedar and Oak. These recordings were made up of interactions involving staff and two multilingual residents, each living in a separate residential home. The length of these recordings total 194 minutes.

4.2.3 Interviews: Informal and Formal

The third method used is interviews, both informal and formal. An informal interview is a conversation with a lack of a formal structure and control (Russel, 2006; Swine & Spire, 2020), while a formal interview is defined as a formal semi-structured interview (Russel, 2006).

Informal interviews were performed during conversations with care workers, residents, and relatives. The informal interviews were primarily conducted at the beginning of the fieldwork period and when a new informant was recruited. The informal interviews were also made parallel to observations, thereby adding context to the data. The informal interview conversations became a rich source of data, addressing the questions that emerged in direct observation and formal interviews. It is worth noting that the informal interviews were not recorded and were conducted in Farsi, Kurdish, and Swedish. For instance, during a meeting with a recently arrived Kurdish-speaking resident and his relative, the researcher noticed that the resident’s preferred form of address was different from his first name, which was used by the care workers. This conversation
turned into an informal interview, which, in combination with other conversations, led to the idea of dedicating a section of the research to exploring forms of address in multilingual encounters.

Formal interviews were conducted through a semi-structured or in-depth interviewing technique (Bernard, 2006). The formal interviews were a scheduled activity, and were based on an interview guide that followed a general script covering a list of topics. However, the interview guides were open-ended. Therefore, there were several instances where topics not covered in the interview guide became dominant during the interviews.

The formal interviews used in the third study consist of 31 recordings made from August 2018 to March 2019 in two residential homes. I made eight recordings with residents and 23 recordings with staff which total 715 minutes.

4.2.4 Recruitment of Participants and Informants

Studies 1–3 are indebted to the participation of 5 residents and 24 care workers. The recruiting procedure is described below.

This dissertation initially began as a part of the project, “Multilingual practices and pedagogical challenges in elderly care” supported by the Swedish Research Council (Grant no: 2013-2020). When I started out as a PhD student, the leader of the project, Gunilla Jansson, had already

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2 In-depth interview is a method that requires participant observation fieldwork before conducting interviews to gain a deeper understanding of a particular aspect of informant’s life (Bernard, 2006). Once the researcher has observed the participants, s/he may refer to them as informants during interviews (Bernard, 2006).
established some contacts with a residential home for data collection. Towards the end of the first semester in the PhD programme, in co-operation with Gunilla Jansson, also a co-supervisor of this dissertation, we arranged a meeting with the first potential participant with an ethnic minority background, resident Seyed Pasha, and we met with him and his children. Prior to this meeting, we distributed (via the residential care facility) a written presentation of the research project in both the resident’s language, Farsi, and in Swedish. In addition, during the meeting we presented the aim of the study and explained that the method of the project is video recording. In addition, information such as the commitment to respect the participant’s anonymity and his freedom to withdraw participation at any point during the research project was explained. At the end of the meeting, Seyed Pasha gave his consent by signing a consent letter. The same procedure was repeated for care workers. In this residential home, 12 care workers were recruited for participation in the study (Appendices 3, 4).

While trying to recruit new participants, I was traveling throughout the first year almost once in a month to follow and collect data from interactions between Seyed Pasha and care workers. After about a year, the second resident with migrant background, Anni, joined the project.

Twenty-two months into my fieldwork, as I continued to visit the residential facility, I met a new resident, Malaa Sherko, diagnosed with dementia. Although he was able to interact verbally in his mother tongue, it was difficult to make sure that he was able to give informed consent. Therefore, I asked his son for consent. In a few days, after consultation

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3 The names have been changed for privacy reasons.
with the rest of the family, he gave informed consent for Malaa Sherko’s participation in the project.

Sara and Amir are the other residents who gave their consent to participate in the project. They were living in residential care facility—Oak—specialised for PWD. By this time, it has been two years since I had started the fieldwork. Sara had a guardian who was in control of the affairs related to her. First, I met Sara and explained the aim and the method of the project to her, and she appeared welcoming. However, it was Sara’s guardian who signed the informed consent. The residential home arranged a meeting with Amir and his son, where I could present the project. Amir’s son signed the informed consent. In the second residential facility, 12 care workers gave their consent for participation. Appendix 5 presents a table of all recorded material.

4.3 Methods Used for Analysing Data

The type of data collected requires different analytical methods be used. For video recordings, a detailed analysis of both verbal and nonverbal interaction was necessary. Conversation Analysis (CA) is often considered the method of choice due to its ability to capture the nuances of interaction.

In the case of interviews, the topics and themes were of high importance. Therefore, a thematic analysis was recommended as an appropriate analytical method to identify themes within the data and understand the relationships between them.
4.3.1 CA and Transcriptions

Video-recordings were utilised to gain insight into how care workers and residents understand each other. To analyse these recordings, CA was the preferred analytical method. CA originated from the works of Harvey Sacks in the 1960s for a systematic analysis of the talk produced in everyday situations of talk-in-interaction (Hutchby & Wooffitt, 2008). When it comes to investigating both verbal and nonverbal interaction in residential homes, CA is recommended for a number of reasons (Chatwin, 2014).

First, CA offers a highly detailed method of transcription that allows us to capture even the smallest nuances of a verbal conversation (Jefferson, 1973). Second, in addition to talk, CA provides a detailed transcription of participants’ other channels of modality such as prosody, body posture, gestures, and gaze (Mondada, 2006, 2016, 2019). This allows for a comprehensive understanding of nonverbal communication, which is a substantial part of the collected multilingual interaction material. Most of the data consists of interaction between care workers and residents who do not have a common spoken language; hence, nonverbal resources such as gaze, prosody, gestures, and body posture are central in function. These bodily behaviours are transcribed by adopting the conventions for multimodal transcription developed by Mondada (2006).

Third, CA enables the analyst, through an emic perspective—i.e., the participants’ perspective—to observe the unfolding process of interaction and participants’ understandings of each other. Next-turn proof procedure, the most basic tool of CA, enables the analyst to understand each participants’ understanding of the prior turn (Hutchby & Wooffitt,
2008). Going through the selected sequences of highly detailed transcribed interaction, my analysis pays attention to the turn-by-turn contributions of participants. I focused on each participant’s display of understanding of another participant’s contribution in the prior turn. For example, in the conversation between participants A and B, my sequential analysis investigated B’s display of understanding of A’s contribution in the previous turn, and consequently A’s mutual understanding of B’s recent contribution.

There are a variety of software available for transcribing audio and video recordings. Depending on the data type, I utilised two different softwares. Praat version 6.0.33 was used for transcribing audio-recordings and for measuring certain acoustic features of the participants’ speech (Boersma & Weenink, 2017). When the focus was on bodily movements such as body postures, the software Elan 5 was used (ELAN, 2017). Multimodal aspects, gaze, body postures, and gestures, are transcribed in accordance with the conventions of CA (Mondada, 2006; Ochs et al.1996). The transcriptions were then translated from Swedish and Farsi into English. The analysis of the utterances was conducted taking into account both the original language and the translations. However, the prosodic analysis relies on the original language.

4.3.2 Thematic Analysis of Interviews

A thematic approach was used to analyse the formal interviews in Study 3. Initially, the semi-structured interviews were recorded and transcribed, in contrast to the transcription of the video-recorded interactions, without including any details. The next step was to carefully read through the
transcripts to identify recurrent topics. This was performed by employing both top-down and bottom-up approaches (Agar, 1983). The primarily focus was on identifying themes related to forms of address. The themes had emerged in the beginning of the fieldwork as I was conducting informal interviews. Additionally, an inductive approach was used to identify other themes that may have emerged from the data as the transcriptions were browsed through (Ryan & Bernard, 2003).

Once a theme was identified, all the relevant passages were extracted from the transcripts and categorised into respective themes (Agar, 1983). The themes were developed and re-categorised as more examples were identified. Making sure that an outsider could comprehend the themes that developed, I analysed the relevant passages in combination with one another (Agar, 1983). I continued this process until the transcripts could be understood in terms of the interrelated themes that had emerged (Agar, 1983). Thematic analysis made a comprehensive understanding of the data possible. The observations, fieldnotes, recordings, and informal interviews contributed to identifying the theme of address practices. The data highlighted the discrepancy between the care workers’ forms of address, both oral and written, and the residents’ preferred forms of address. This theme played a crucial role in shaping the interview guides used for the formal interviews.

4.4 Ethical Considerations

This dissertation has obtained ethical approval from the Regional Committee for Research Ethics (Dnr 2013/2211-31).
As the initial step in the recruitment process, potential participants and informants were given detailed information about the project—both orally and written. Next, informed consent was obtained. The information included the aims and methods of research, voluntary participation, and a commitment to anonymise the participants’ identities. It was also emphasised that the participants are free to recant their informed consent and cease their participation in the project at any point during data collection. Because many of the potential participants had linguistic backgrounds other than Swedish, the project information was presented in their respective languages. In terms of presenting the project information to the residents, the ambition was to have the presentation in the presence of their relatives. Although all participants had given informed consent, they were, additionally, asked for verbal permission prior to each recording. As participants occasionally withheld permission for recordings, asking for verbal permission before each recording proved to be in line with meeting the criterion of protecting the individual that requires avoiding psychological or physical harms and wrongs (The Swedish Research Council, 2017). The recordings were anonymised by changing all the names of the participants and their respective locations, which is in accordance with the promise made to them (see also Swarbrick et al., 2019). I also applied different methods to anonymise participants’ physical identities, where it was necessary to include pictures of moments of interaction in the texts as well as in displaying data in conferences and data sessions. The researcher is also committed that the data will not be shown to the public, rather it will be used only by other researchers involved in the project for scientific purposes. These are among the conceivable safety
measures undertaken when respecting the private lives of the participants and maintaining confidentiality.

The ambition has been also to meet the research criterion; i.e., an ethically motivated imperative to conduct research in the sense that research should lead to improvements in both existing knowledge and people’s quality of life (The Swedish Research Council, 2017).

Conducting the current study needed observation of people’s interactions. Observations were overt, in which participants are always informed that research is being conducted. This is different from covert participant observation, without informing participants of their participation, which is rare and according to the Swedish Research Council (2017), should be the exception rather than the rule.

In regard to video recordings, the ethical principles of the Swedish Research Council (2017) mandate that recording should be done in a respectful manner and individual integrity must be respected. Although the Swedish Research Council (2017) provides such directives to protect a vulnerable group such as children, it does not provide any recommendation for conducting research involving other vulnerable groups such as people with symptoms of different cognitive disabilities such as dementia who have not received a formal diagnosis. In the case of this dissertation, there are two groups of resident participants: the first group are residents with formal diagnoses of dementia, whose letters of consent were signed by their guardians. The second groups are residents without a formal diagnosis, who themselves signed the letters of consent in the presence of their relatives. Additionally, oral permission from both groups was obtained prior to recordings.
5. Summary of the Studies

This section provides an overview of the key findings and insights derived from three studies, a book chapter and two articles, which serve as the foundational sources of the dissertation.

5.1 Study 1: Accommodation Practices in Multilingual Encounters in Swedish Residential Care

The first study of the dissertation (Yazdanpanah, & Plejert, 2017) is published in the volume *Multilingual Interaction and Dementia* (Plejert, et al., 2017), and draws on CA to study how participants establish common ground when they do not have a shared spoken language. A detailed analysis of multimodal features of video-recorded interaction indicates that the first interactant shifts his body postures to signal trouble. Recycling a similar bodily movement, the second interactant displays his understanding of the trouble expressed bodily by the first interactant. The study draws on the concepts of turn-format and recycling with différence (Anward, 2015) to show the way the participants establish a ‘tradition’, despite the lack of a shared spoken language. The chapter also highlights participants’ recycling of other interactional resources, such as pitch and
intensity, through which a care worker displays her alignment and affiliation with a resident’s complaints. The chapter discusses how common ground may be established, despite the lack of a shared spoken language between participants.

5.2 Study 2: An Interactional Perspective on Sound Prolongation in Multilingual Encounters in Residential Care

The article explores how care workers use the prosodic feature of sound prolongation in managing emotionally intense situations in interactions with residents. The analyses consist of two categories. Drawing on the concept of preference, the study shows that when a preferred action is going on, the care worker’s sound prolongation to claim affiliation leads to mitigation. However, when a non-preferential action is anticipated, claiming affiliation with sound prolongation leads to an escalation in the resident’s conduct. The analyses indicate that the action and the utterance should be affiliative in establishing mitigation using sound prolongation. A combination of non-preferential actions and affiliative utterances seems to be perceived as less preferred and therefore also results in escalations in residents’ emotional stance. In the article, care workers’ use of sound prolongation is also discussed in relation to the notion “Elder-speak”, which is a controversial concept in relation to how older persons are addressed.
5.3 Study 3: What’s in a Name? Address Practices in Swedish Residential Care Facilities

The article focuses on the residents’ preferred forms of address in residential homes. It also explores the carers’ practice of addressing the residents. The material is based on direct observation, fieldnotes, video- and audio recordings, informal interviews, and semi-structured interviews. Thematic analysis was used as a method to find available themes in the material. Eight themes were found: mismatch between residents’ names and their ID, equality in address, differences in address due to context-dependency, addressing with idioms expressing taarof, access to residents’ living histories, terms of endearment, fictive use of kinship terms, and addressing residents with nicknames. The results indicate that it is important to pay attention to the details of life histories of residents, such as the way they used to be addressed before entering residential homes.
6. Discussion and Conclusions

6.1 Introduction

Considering the literature review presented in chapters two and three, I conclude this dissertation with a comprehensive discussion of the findings from three separate studies.

In Chapter one of this dissertation, the aim is declared as exploring how residents with dementia and care workers who do not share a common language manage to establish mutual understanding in multilingual encounters. This aim is based on the combination of two challenges. First, dementia is characterised by a collection of symptoms, including cognitive and communicative decline, which poses major challenges to people with dementia and their conversational partners in monolingual settings as they strive towards mutual understanding. Secondly, having a shared spoken language is conventionally considered a condition for achieving mutual understanding. However, in the absence of shared (spoken) language, this condition is hampered, and verbal communication is challenged. The combination of these two challenges, as was demonstrated by the results, certainly makes establishing mutual understanding more complicated for participants.
Addressing this aim, I used empirical data gathered from everyday interaction between residents with dementia and care workers who either did not share a spoken language or had a limited amount of a shared spoken language. Through the use of CA methodology, I examined the sequences of their interaction. The principle of next-turn proof procedure was particularly useful in investigating how residents and care workers displayed their understanding of each other’s actions.

6.2 A Brief Summary of Findings in Relation to Aims and Research Questions

After analysing the empirical data and adopting an emic perspective, I have arrived at three main conclusions.

First, while having a shared language is significant in establishing mutual understanding, care workers and residents were still able to establish at least a partial mutual understanding for performing certain activities, despite the absence of a shared language. This was made possible by utilising both verbal and nonverbal resources as well as the objects in the environment. This is supported by the results in all three studies. Studies one and two show that residents and care workers without a shared spoken language, use nonverbal resources, verbal resources, and the physical environment to establish a shared understanding of the situations in task-oriented communication. The verbal resources they employed included for instance, code-switching, recycling, frame shifting, and using limited elements from the resident’s mother tongue. Nonverbal resources were
typically body postures, gestures, and prosody. Care workers and residents also used the objects such as wheelchairs, the temperature of the shower, and clothes, which were the objects of mutual attention.

Second, establishing full mutual understanding is not always an absolute requirement in every situation. For instance, in task-oriented communication, care workers can still provide effective support to residents, even if there is only a partial understanding of the resident’s concerns. Studies one and two revealed that this can be achieved by being responsive, which can be as simple as recycling, using sound prolongation, having a positive attitude toward the resident, and having knowledge of the resident’s background and history (see study three). Therefore, in task-oriented communication, supporting residents in managing emotional situations does not necessarily depend on a full understanding of all the details in play (cf. Strandroos & Antelius, 2016).

Third, it is important for care workers to know how a resident preferred to be addressed or what s/he was accustomed to before arriving at the residential home. This knowledge can be valuable in supporting the resident’s sense of identity and in maintaining a positive mutual relationship with her/him, especially for those in advanced stages of dementia, who may experience significant memory difficulties. Study three shows that sometimes residents have strong preferences for specific forms of address, which are closely tied to their identity. However, this point was not considered a high priority in residential homes.

These three issues will be discussed further below.
6.3 Establishing Mutual Understanding

Previous research on mutual understanding in everyday interaction, involving speakers with as well as those without a communicative or cognitive impairment, relies heavily on data where participants communicate in a shared language (see Clark & Brennan, 1991; Gardner, 1998; Goodwin, 2003; Klippi, 2003; Laakso, 2014). The studies in this dissertation—studies one, two, and three—revealed that the condition of having a shared language between interactants is not always met in multilingual encounters. This is especially evident in workplaces such as residential homes, where not only a shared language is missing but communication conditions, such as dementia, may also pose challenges to mutual understanding. Despite these challenges, the results of the dissertation revealed that the care workers and the residents use various resources to accomplish joint activities.

6.4 Different Resources

The results of the dissertation point to the resources care workers and residents draw on to establish mutual understanding. These resources include a shared spoken language, nonverbal resources, and verbal resources.

6.4.1 A Shared Spoken Language

Most examples presented in this dissertation are interactions between care workers and residents who do not have a shared language. However, in study three, there is an excerpt of an interview with a care worker who
explains how she addresses a resident who shares her mother tongue. In this excerpt, the care worker holds that she chooses to use a fictive use of a kinship term to address the resident. Employing baba, papa, a fictive use of a kinship term, the care worker utilises her shared linguistic and cultural background with the resident to show linguistic courtesy towards him by reference to connotation rather than denotation of the kinship term. Hence, she applies the courteous and emotional aspects of the word ‘papa’, rather than its literal meaning.

The high level of sharing in linguistic skills enables participants to distinguish between connotation and denotation of a word. This is consistent with Ekman (1993)’s findings that emphasise the relationship between the communicative abilities of multilingual residents with dementia with the presence of care workers who speak the multilingual resident’s dominant language (cf. Ekman et al., 1994). The research conducted by Ekman et al. (1994) emphasises the significance of care workers who speak the residents’ dominant or preferred language/s in enabling them to fully utilise their linguistic skills and display linguistic nuances which might be otherwise underestimated in the absence of care workers who share their linguistic backgrounds. Sharing a language with residents can significantly enhance the success of care workers in delivering person-centred care (Heikkila et al., 2007; Kitwood, 1997; Runci et al., 2012; Söderman et al., 2018). When there is a shared language and a shared form of life, a shared culture, it can significantly reduce barriers to understanding and it makes verbal and nonverbal actions meaningful to both residents and care workers (Heikkila et al., 2007). Eventually, this can contribute to the overall wellbeing of residents to such an extent that it
may reduce the need for certain medical interventions like antidepressants medications (Heikkila et al., 2007; Runci et al., 2005). The wellbeing of residents is supported by utilising their shared language and background with care workers in participating in joint activities such as selecting music, discussing various topics, and watching TV programmes together (Heikkila et al., 2007; see also Kindell et al., 2018). These language-based services are difficult to achieve without the presence of a shared language (Müller & Guendouzi, 2009).

In contrast, when there is a lack of a shared language with care workers, residents are highly likely to experience social isolation and increase the risk of receiving inappropriate care (Heikkila et al., 2007; Runci et al., 2012; Söderman & Rosendahl, 2016). The transition from living an independent lifestyle in one’s own home to residential care settings can be a dramatic change in the life of an older adult. This transition can be even more drastic if it entails discontinuity in their form of life—i.e., in their language and culture. The importance of a common language to wellbeing is also emphasised by relatives of multilingual people with dementia living in residential facilities where residents lack access to care workers with similar linguistic backgrounds (Kong et al., 2010; Runci et al., 2014; Rosendahl et al., 2016).

Returning to the example in study three, we can see the resident also displays his understanding of the context in which the kinship term is used. According to the care worker, the fictive use of the kinship term is responded by the resident with either baba or my dear, both of which are interpreted by the care worker as the resident’s positive/endorsing stance. The proof of the resident’s positive/endorsing stance is that he
responds with recycling baba, address inversion, which is used mostly in reciprocating kinship terms such as when a mother responds to her daughter or son by addressing them as mom.

Thus, the high level of shared linguistic skills—i.e., the address system of their shared language—provides a common ground where the care worker and the resident achieve mutual understanding.

6.4.2 Using Nonverbal Resources

The findings of all three studies and previous research, including Ekman et al. (1994), Hamilton (1994), Lindholm & Wray (2011), Small et al. (2015), and Small et al. (2017) show that although many communication difficulties may emerge as dementia and a lack of a shared language co-exist, some communicative abilities, such as turn-taking, remain intact—even in advanced dementia. Through nonverbal communication, residents and care workers can utilise bodily resources such as gazes, gestures, posture, and pointing to take turns in interaction, thereby establishing a common ground as it is revealed in the results (cf. Hydén, Majlesi, & Ekström, 2022; Jansson et al., 2019; Small et al., 2015; Small et al., 2017).

The results in study one show that the care worker and the resident use the reaction to the high temperature as a ground, a substrate, upon which they collaborate to establish common ground and mutual understanding. The multimodal transcription revealed that as the resident was being assisted with showering, the high temperature of the water triggered a change in body posture, resulting in a shift in body position. Thereafter the care worker incorporates the resident’s bodily response in
his own action by recycling it with différance (Anward, 2004); i.e., he recycles a modified element of the resident’s prior turn to keep the flow of communication moving forward (see Anward, 2004). In other words, the care worker repeats an upgraded version of the resident’s body posture shifting. The care worker’s action becomes meaningful in relation to the resident’s bodily response to high temperature in the previous turn. This is proven in the following sequences, as the posture shifting in two horizontal and vertical directions becomes a framework for the communication. This bodily framework provides a common ground for the care worker and the resident to attain mutual understanding in regard to negotiating the temperature of the water until they achieve an agreement that the temperature meets the resident’s need.

The recognisability of changes in body posture and its meaningfulness to both the care worker and the resident not only establishes mutual understanding but also supports the resident’s agency, reinforcing his ability to act rather than just undergo with respect to the shower temperature (see Hydén et al., 2022; Svennevig & Hamilton, 2022). The care worker’s recycled action is designed to mirror an upgraded version of the resident’s prior action, enabling the resident to understand it. During the joint activity of assisting in the shower room, the resident with dementia, despite one side being paralyzed and the absence of a shared spoken language, effectively utilises body posture shifting to communicate with the care worker to adjust the shower temperature until it becomes acceptable. In this intercorporeal interaction, the resident’s bodily action, without the need for verbal accounts, acquires meaning when it is reciprocated by the care worker’s recycled bodily action (see Hydén et al., 2022). Hydén et
al. (2022) characterise intercorporeal interaction of people living with late-stage dementia by coordinated body movements as the main media of interaction surpassing the verbal resources. These body movements are recognisable and meaningful for both the resident and the care worker (Hydén et al., 2022). Verbal resources in intercorporeal interaction possess a marginal function, serving to create a joint space of attention (Hydén et al., 2022).

The function of nonverbal resources such as body movements and gaze direction in communication involving people living with last stage dementia have been pointed out by Hydén et al. (2022). The findings of this dissertation contribute to our knowledge of communication in dementia care, especially in the context of diverse linguistic backgrounds and the absence of a shared language. Building upon the current knowledge of turn taking and bodily actions as communication resources in dementia care, the dissertation shows the function of concerted recycling of actions in establishing mutual understanding. Even actions triggered by environmental factors, such as temperature, can serve as common ground for meaning-making in intercorporeal interactions between linguistically diverse care workers and residents living with dementia (see Hydén et al., 2022).

6.4.3 Verbal Resources

The results in all three studies point to different verbal resources employed by residents and care workers when a shared spoken language is absent. These are, respectively, code-switching, recycling, frame shifting, and care workers’ utilising of single linguistic elements from a resident’s
mother tongue such as forms of address. These strategies are utilised as means of establishing a common ground and facilitating mutual understanding in the absence of a shared spoken language.

The results in study one reveal that although the Farsi-speaking resident with dementia has a limited number of English words at his disposal, he skilfully utilises these few words when encountering a care worker who does not speak Farsi at all. The resident’s languages are more than his mother tongue. He can speak at least two dialects of Farsi. Additionally, he can speak Arabic as a second language. An important point is that the resident switches only between his mother tongue and those few words of English, rather than using Arabic or his other languages. These English words are his only shared verbal resources with the care worker. In other words, the resident strategically selects linguistic elements from the limited shared language repertoire that are appropriate to the setting and the interlocutor, as he requires care worker’s response. By highlighting the situational awareness of residents with dementia in selecting the appropriate language, Lindholm (2017) presents evidence against the claim that code-switching among individuals living with dementia indicates a pathological condition (cf. Svennevig et al., 2019). The crucial point is that the resident uses code-switching, along with a range of non-verbal resources as a strategy to use all his communicative resources to achieve understanding with the care worker. His strategy can be defined as a fluid manoeuvring of linguistic resources in the face of the communication obstacles. The concept of multilingual “fluidity” (Müller, 2017, p.90) refers to the phenomenon in which the multilingual individual regularly switches between languages in response to the situational context,
facilitating the flow of conversation and establishing mutual understanding. The resident selects the most appropriate utterance at a specific situation to navigate the communicative obstacles, which elicits the care worker’s affiliative response to the resident’s complaint. Although the care worker may not have understood the resident’s utterances completely, she realises the source of the problem, solves it, and affiliates with the resident. In this way, the lack of shared verbal language is compensated for by code-switching along with nonverbal behaviour and the physical environment (see 3.4.2). Although this code-switching does not lead to full understanding of the resident’s utterances, it can be sufficient for the care worker to provide an appropriate response to the resident’s complaint.

The projected outcomes of employing code-switching as a communication strategy may not always be fulfilled. In an example of task-oriented communication in study two, the care worker in the middle of the routine activity switches to the resident’s mother tongue to get her to comply with the task. The care worker, however, has learned only a few elements, mainly greetings, of the resident’s mother tongue. As a result, although the care worker has switched to the resident’s mother tongue, she does not understand the core of the resident’s response and therefore does not address the resident’s concerns. This lack of understanding between them leads to a situation where tension escalates. In discussing care workers’ strategies to evade troublesome conversations that could interfere with their tasks, Grainger (2004) identifies “deflection” (p.487) as one such practice (see also Plejert et al. 2014). The care workers’ continuation of the physical care without addressing the resident’s concern,
originating from a lack of understanding in their multilingual interaction, may be seen as deflection from the resident’s perspective. What seems to be the care worker’s attempt at frame shifting to mitigate the situation backfires. During the discussion, the care worker greets the resident in her mother tongue without addressing the root of the resident’s RTC. From the resident’s perspective, this frame shifting may look like as if her concerns are being deflected. To make a comparison, please see section 6.4.3.1 below, where there is another example illustrating how a care worker prioritises the resident’s concern.

6.4.3.1 Recycling

Mutual understanding is dependent on common ground, or a common history of negotiated meaning (Anward, 2015). Study one presented examples where the care worker and the resident recycled a turn format to establish common ground. Coordinating with the resident in establishing common ground, the care worker recycled the resident’s code-switching to English. Although the care worker’s recycling was limited to the extent of the resident’s repertoire of English words, she made slight changes in each turn so that she often upgraded the resident’s utterances; i.e., recycling with différance. Additionally, the care worker was paying attention not only to the resident’s utterances, but she also was responsive. Being responsive despite being engaged with errands, the care worker displayed that communication was the main activity and working was marginal. Paying attention and being responsive, even in situations where full understanding of the resident’s utterances may not be possible, the care
worker could provide appropriate responses in potential slots, transition-relevance places.

The phenomenon of participants in interaction through recycling each other’s behaviours has been reported in previous studies (Anward, 2004, 2015; Goodwin & Goodwin, 1987; Lindholm & Wray, 2011; Zellers & Schweitzer, 2017). Participants may use recycling for different communicative purposes, such as displaying disagreement or opposition (Goodwin & Goodwin, 1987), other-initiated repair (Schegloff et al., 1977), reducing misunderstandings, and smoothing out interactional difficulties to foster positive relationships between interactants (Kurtić & Gorisch, 2018; Zellers & Schweitzer, 2017).

Anward (2004) proposes a comprehensive task for recycling, suggesting that it not only contributes to coherence and progress in interaction but also functions to establish and develop common ground among participants (Anward, 2004). According to Anward, recycling serves as both a mechanism for coherence and progress and a tool for establishing mutual understanding (Anward, 2004).

Introducing a form of recycling within the context of dementia, Lindholm & Wray (2011) discussed formulaic language such as proverbs (cf. Wray, 2014; Lindholm & Wide, 2017). When individuals living with dementia are asked to retrieve specific information for completing proverbs as a tool for examining or training their memory, the activity often breaks down. However, when the focus is on interaction, people living with dementia can use formulaic language as an opportunity to participate and creatively recycle elements of the interlocutor’s previous utterance and make their own utterance contributing to the flow of communication.
Formulaic language, as an opportunity for recycling, offers an efficient and less taxing way of producing utterances while also facilitating understanding of utterances by providing less dense discourse, which can scaffold declining memory in interaction (Lindholm & Wray, 2011; cf. Hydén & Örulv, 2009; Tannen, 1989).

Recalling Anward’s idea of recycling as the backbone of creating common ground, it can be concluded that every verbal element is a valuable resource that can be used and recycled (with différence) in establishing mutual understanding in dementia care in the absence of a shared spoken language (Anward, 2004, 2015; cf. Lindholm, 2016). One such verbal item is the resident’s name, which turns out to be an important source of expressing common ground, especially in the absence of a shared language (Clyne et al., 2009). This point is discussed in more detail in Section 6.6.

6.5 Sound Prolongation in the Management of Task-Oriented Communication

The results in this dissertation show that in the absence of a shared verbal language, care workers become innovative in their responses to the residents. Study two shows that sound prolongation is used as a creative strategy in different settings with different outcomes. These settings were managing resident’s complaints and resident’s resistiveness-to-care (RTC). Sound prolongation as an exaggerated articulation of a sound can also be discussed in relation to elderspeak (see Section 6.5).
6.5.1 Complaints

When facing the resident’s complaints and agitation, the care worker had to deal with two issues: first, tackling the source of the agitation, and second, managing the resident’s agitation. Despite the lack of a shared language, the care worker was attentive to the resident’s verbal and nonverbal actions. So she discovered the source of the agitation and solved the issue.

Secondly, the care worker had to manage the resident’s agitation. The care worker addressed the resident’s concern by using sound prolongation in combination with bodily behaviours such as shaking her head to show her affiliation. In this example, the sequence of actions, including several instances of elderspeak and sound prolongation, contributed to de-escalation and even to alteration of the resident’s agitation with a humorous moment for both of them.

6.5.2 Resistiveness-to-Care (RTC)

The use of sound prolongation in another example of task-oriented communication can have unintended consequences, as illustrated by a specific example in study two involving two care workers encountering the resident’s refusal of the care provided by care workers, which is referred to as ‘RTC’. In this example, the care worker used sound prolongation as a strategy to make the resident compliant with the hygiene task. But this approach backfired and led to an escalation of the situation. This example of sound prolongation can also be discussed in terms of “deflection” (Grainger, 2004, p.487), a strategy that care workers employ when addressing the resident’s RTC threatens to interfere with the completion of
the physical care task being conducted. However, from the resident’s perspective, the care worker’s actions, including sound prolongation, diminished her agency and reinforced her position as an *undergoer* rather than an *actor* (cf. Svennevig & Hamilton, 2022).

Sound prolongation as an exaggerated pattern of articulation directed to an older adult can be identified as a feature of elderspeak. According to previous research, ‘elderspeak’ generally refers to adapted communication patterns observed when interacting with older adults (Caporael, 1981; Cohen & Faulkner, 1986; Ryan, Hummert, & Boich, 1995; Samuelsson, Adolfsson, & Persson, 2013; Shaw et al., 2021; Small, Huxtable, & Walsh, 2009; Williams, 2011). It encompasses using exaggerated styles of speech, emphasising the generational gap between the care worker and the resident, and employing patronising or infantilising language reminiscent of the way one would converse with children. If we need any touchstone in evaluating sound prolongation as an attribute of elderspeak, we need to pay attention to the perspective of its recipient. Each instance of interaction is unique, and the recipient’s perspective is crucial in determining the inappropriateness or effectiveness of elderspeak.

Study two showed that the same resident responded differently to the same care worker using sound prolongation in two different settings. This observation highlights the importance of considering the specific context in which elderspeak is used. Sound prolongation, like other feature of elderspeak, cannot be evaluated in a vacuum; the sequence of utterances and the broader context of interaction must be taken into account.
(Small et al., 2009). This approach to analysis helps us gain a detailed understanding of each feature of elderspeak and its impact on older adults in residential homes.

6.6 Forms of Address in Multilingual Encounters of Dementia Care

In the literature about multilingual interaction involving people living with dementia, it is emphasised that care worker’s familiarity with a resident’s life history plays a crucial role in establishing shared understanding between them (Brown et al., 2013; Small et al., 2015; Svennevig & Hamilton, 2022; cf. Kindell et al., 2019). The results in study three point to the function of forms of address that are associated with an individual’s life history. The results indicated a contrast between the established form of address in the majority language and the preferred forms of address of residents with minority languages. It is particularly important to be aware of the significance of forms of address in situations where residents with dementia interact with care workers who do not speak their language. In such cases, forms of address can serve as one of the available resources for verbal communication and contribute to building common ground.

6.6.1 Forms of Address in Swedish Language (Majority Language)

During the 1960s and 1970s, Sweden implemented a linguistic reform known as the du-reform, which aimed to promote egalitarian values within society (Bratt Paulston, 1976; Clyne, et al., 2009). This reform represented a significant shift towards abandoning hierarchical linguistic conventions. As a result, traditional indicators of hierarchy, such as the
use of the second person plural pronoun *ni* for a singular addressee to convey politeness or distance, as well as the use of titles, were abolished. Instead, the second person singular pronoun *du* became the preferred form of direct address, replacing the second person plural *ni*, and the use of first names was encouraged, fostering more equal relationships among individuals. Since then, the use of first names and the second person singular pronoun *du* has become the prevailing norm in Swedish (Bratt Paulston, 1976; Clyne et al., 2009).

6.6.2 Forms of Address in Minority Language

Since the 1960s, Swedish society has become increasingly multilingual, leading to the emergence of many minority languages. These languages often have distinct systems of forms of address that reflect their unique cultural backgrounds. These systems of forms of address, including pronominal and nominal modes of address, serve as a common ground for the speakers of each respective language (Clyne et al., 2009). Study 3 shows that there is a discrepancy between the preferred forms of address of the residents with minority languages and the identification information available to the staff, such as their first names. This mismatch can create challenges in establishing a common ground and building rapport between residents and staff.

According to study three, a person’s name is a significant indicator of her/his identity (Clyne et al., 2009). Despite deficits to autobiographical memory in different types of dementia, people living with dementia recollect the details of their names in both mild and moderate to severe
stages of dementia (Caddell & Clare, 2010; Gross et al., 2004). Additionally, elements of identity such as forms of address are embedded in the life histories of the residents. Using preferred forms of address are resources that create common ground, and scaffold the identity of the residents (cf. Hydén & Örulv, 2009).

Fairhurst (1981) has discussed forms of address (nicknames) as an attribute of elderspeak. Study three examined a case where the resident objected to being addressed with a hypocoristic nickname. In contrast, the same resident in study two responded positively to being addressed with sound prolongation, another feature of elderspeak, and his stance of anger de-escalated. So, the same resident responded differently to two different features of elderspeak. These findings suggest that each feature of elderspeak should be evaluated individually, as residents may respond differently to different features of it.

Finally, cultural awareness is important in choosing suitable forms of address, particularly in relation to specific addressing norms within each culture. Study three showed that although residents may have their preferred forms of address, care workers, when considering cultural aspects may in some situations come up with their own forms of address such as fictive kinship terms and nicknames. When the care worker chose forms of address with cultural sensitivity, such as fictive kinship terms, the resident endorsed them. However, when the forms of address such as hypocoristic nicknames were chosen with the best intentions, but without cultural awareness, the resident opposed them.
7. Implications

The discussion concludes with social policy and educational implications.

7.1 Social Policy

Mutual understanding and common ground are intertwined and interconnected concepts that support each other. Common ground provides a foundation for achieving mutual understanding, while mutual understanding helps build common ground. Progress in either one eventually enhances the other. Nevertheless, achieving mutual understanding requires active effort.

Shared language, culture, and traditions in monolingual settings involving participants with rather intact memories provide considerable common ground that may facilitate the achievement of mutual understanding. The Swedish National Board of Health and Welfare has recognised this and recommended linguistic matching between care workers and residents (Socialstyrelsen, 2017). However, in cases where linguistic matching is not amenable, such as when it is difficult to match linguistically or there are staff shortages and people with dementia are involved, participants must build common ground from the base up, despite the absence of a shared language. This demands even more efforts and attention. Otherwise, in the absence of common ground and mutual understanding, particularly in task-oriented communication, the well-being of
residents may be negatively impacted, care workers may face an increased workloads, and the costs of residential homes may rise. The lack of mutual understanding can jeopardise a resident’s ability to communicate their needs and preferences effectively, which can make them undergo communication rather than actively participate in it (Plejert et al., 2014; Ragneskgog et al. 1998). This can impact a resident’s well-being, cause frustration, and add to care workers’ confusion. Resident’s frustration and struggle to communicate their needs and preferences may effectively lead to their refusal of the routine tasks performed by care workers (Plejert et al., 2014; Yazdanpanah et al., 2019). Multiple care workers may be needed to make a resident comply with a single task, due to the resident’s resistiveness-to-care and lack of mutual understanding (Plejert et al., 2014; Plejert & Jansson, 2021; Yazdanpanah et al., 2019). This can result in increased time and effort expended as well as delays and an increased workload. Residential homes may face a difficult decision between increasing paid hours for care workers or compromising the quality of care. However, simply increasing paid hours for care workers may not be enough to compensate for working in stressful and unhealthy work environments, which can lead to higher turnover rates and reduced job appeal for those who are enthusiastic about working in residential homes. This in turn can result in staff shortages over the long term and higher training costs for new staff, who must compensate for the experienced care workers who leave their jobs due to increased workload, stress, and burnout. Additionally, compromising the quality of care can be costly in the long term because it can lead to an increased demand for more expen-
sive services. Providing lower quality care can result in residents’ declining health, leading to the development of psychosomatic issues that require extensive medical attention and care. This can eventually lead to higher costs for both the residential home and the affected resident, while also potentially compromising their dignity (cf. Wray, 2014).

Therefore, policies are required to pay more attention to the area of communication training and support for care workers in multilingual settings of dementia care. Additionally, the residential homes, stakeholders, and institutes working with multilingual people living with dementia should adapt their guidelines, promoting building common ground and establishment of mutual understanding between care workers and residents from diverse cultural and linguistic backgrounds.

7.2 Education

It has been found that conversation partner training, both in familial and institutional settings, produces significant gains in person-centred care for PWD. These types of intervention are reported to improve communication; even for family members who provide care for their relatives (Cummings, 2020; Kindell et al., 2017; Kindell et al., 2018; Kindell et al., 2019; Morris et al., 2018). The family members who participated in communication training, suggested a reduction in asking open-ended questions that were associated with more failed responses by people living with dementia than other question types such as yes/no and choice questions (Cummings, 2020; Ripich et al., 2000; cf. Samuelsson & Hydén, 2017). In a similar study, Boyd & Smith (2009) observed that
when developing culturally sensitive training for communicating with people living with dementia, care workers used indirect questions instead of open-ended or direct questions. This approach was found to be effective in facilitating information recognition for people living with dementia, scaffolding information retrieval (cf. Hydén & Örulv, 2009; Hydén, 2011).

Furthermore, communication training for care workers has been demonstrated to be effective in improving institutional communication between care workers and residents (Jansson & Majlesi, 2020; Levy-Storms, 2008; Shaw et al., 2021; Williams et al., 2017). After communication training of staff, residents’ agitation was decreased and nonverbal communication between residents and staff was enhanced (Boyd & Maclagan, 2017; Boyd & Smith, 2008; Burgio et al., 2002; Medvene et al., 2006; Roth et al., 2002; van Weert et al., 2005). Apart from the benefits of using indirect questions, Boyd & Smith (2008) found positive effects of active listening with ‘go-aheads’, such as minimal responses, e.g., ‘yes yes!’, ‘really!’ and ‘mmm-hmms’. Moreover, trained care workers are enabled to close topics by mutual agreement with the person living with dementia. Shaw et al. (2021) reported that staff training in communication leads to positive outcomes such as a reduction in antipsychotic medication administration (see Runci et al., 2005).

Person-centred care for residents living with dementia requires paying attention to the unique details of the identity, which are shaped by their life history. A major aspect of residents’ identity is their name and...
preferred forms of address (study two). By paying attention to these details in educational programmes, care workers can provide more individualised care to residents with minority languages living with dementia.

Additionally, addressing the residents with their preferred forms of address may indicate being with residents, and sharing their history narratives. It is a way of sharing a form of life that eventually contributes to building common ground, which facilitates mutual understanding despite an initial lack of a shared spoken language. Therefore, having familiarity with a resident’s life history is important for providing culturally sensitive care in multilingual encounters. In terms of cultural sensitivity, study three, which examines the use of forms of address in multicultural and multilingual encounters, indicates that using a title in one context may be an articulation of respect toward a person with a fragile identity. However, in another context, the use of similar titles may reflect power relationships. Therefore, these terms, despite loose similarity, are incomparable because they do not share a common standard of measurement, given the uniqueness of people’s experiences, histories, characteristics and contexts. In contrast, sometimes-similar traits are reported across different cultures; for example, in many cultures, the prevalent assumption is that older adults living with dementia experience a “second childhood” (Boyd & Smith, 2008). This assumption may lead to using elderspeak as the primary communication style when interacting with older adults living with dementia, without taking into consideration their perspective on the speech pattern being used.

To establish mutual understanding, as demonstrated in study one and earlier studies (Ekman et al., 1994), it is crucial to be responsive to
residents’ actions, which helps keep the flow of communication alive. The findings in study one indicate that an effective strategy in being responsive is through participant’s recycling with différence (Anward, 2004). This demands care workers’ attention to both verbal and nonverbal aspects of communication (study one). However, it should be noted that although this is not a guarantee for fully achieving mutual understanding, the results in study one reveal that even partial mutual understanding can help address significant issues; especially in task-oriented communication.

Conventionally, there are certain linguistic resources that are associated with elderspeak that are not recommended (cf. Shaw et al., 2021; Williams & Herman, 2011). However, prohibiting the use of certain communicative behaviours, which are labelled as elderspeak, can intensify communication difficulties in multilingual dementia care settings where participants do not share a common verbal language. Lindholm (2010) emphasises the crucial function of adapting communication to the level of an individual living with dementia. For example, a person with dementia might require additional time for cognitive processing, which fosters understanding and minimises misunderstanding in dementia care (cf. Samuelsson et al., 2013). Hence, assigning negative consequences solely to certain communicating behaviours in multilingual interaction in dementia care based on their resemblance to elderspeak can further complicate the interaction. This is because communication is already limited in such settings, and further restricting the available resources for effective communication can make it even more challenging for care workers and
residents with diverse linguistic backgrounds, to keep up the flow of communication. While studies two and three do not provide clear criteria to recommend or discourage these linguistic resources, their use should depend on different situations. For instance, sound prolongation may escalate tension in one situation, but deescalate it in another. Similarly, calling a resident *papa*, generally considered an attribute of elderspeak, may be positively received by the resident, who has his own preferred form of address based on his life history. Therefore, the most reliable criterion for determining appropriate communication style is the resident’s response and their perspective, emphasising the importance of person-centred care.

In a person-centred care setting, the emphasis is on promoting the well-being of persons living with dementia through providing supportive care, comfort, identity, dignity, and inclusion (Kitwood, 1997; Penrod et al., 2007). Care workers adapt their approach to meet the unique needs of each individual, taking into account factors such as personality traits, language abilities, cultural background, and cognitive impairment. This responsive and individualised approach is a key aspect of person-centred care.

To conclude, this thesis has demonstrated the functions of different resources for establishing mutual understanding in dementia care, even in the absence of a shared language. First, establishing mutual understanding hinges on care worker’s actions, when communicating with a multilingual individual living with dementia. Recycling (Anward, 2004) has proven to be effective in utilising verbal and nonverbal resources, when participants are striving toward mutual understanding. Moreover, having a (basic) knowledge of the residents’ life history, including their
preferred forms of address, can be a valuable resource in fostering rapport between care workers and residents. Lastly, it is important to note that the effectiveness of a particular linguistic resource not only varies from person to person, but is also contingent upon the specific situations in which a resident is involved.
References


Jansson, G., & Majlesi, A. (2020). "She didn't expect to get a slap": Modeling "proper" conduct among teachers and students in training


of the experiences of their family members and nursing staff. *BMC Geriatrics*, 16, 1–12.


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Appendix (1) Interview Guide for Care Workers

The semi-structured interviews are guided by a set of questions. Depending on the informant, the interviews may take different paths, but certain questions focusing on forms of address were pursued more strictly. Below are the translated questions. The interviews are conducted in three languages: Farsi, Sorani and Swedish.

1) Let me introduce myself.
2) I present the research, and its aims and methods.
3) Would you participate in an interview and allow me to record it?
4) Could you please introduce yourself?
5) How do you think communication works in the workplace between you and the residents?
6) When do you think communication works well?
7) How do you think communication works in situations where residents have language disabilities such as dementia or aphasia and have difficulties in communicating verbally?
8) Do you feel that you speak differently with older adults?
9) Have you had any experience of speaking more slowly, speaking more loudly, or using specific manner of speaking with residents? if so, how was it received by them?
10) What do you do when you experience that the person does not understand you?
11) When addressing a resident, how do you address her/him?
12) Do you have anything else that you are considering regarding communications?
Appendix (2) Interview Guide for Residents

The interviews with residents involve asking them a set of questions, which are conducted either in Farsi or Swedish, depending on the resident’s language preference. English translation of the questions can be found below.

1) Let me introduce myself.
2) I present the research, its aims and methods.
3) Would you participate in an interview and allow me to record it?
4) Could you please provide some background information about yourself (background information such as your name, place of birth, places of living, occupation, education and languages spoken)?
5) In the past, how were you typically addressed?
6) Who were the individuals who used to address you in that way?
7) How are you currently addressed?
8) What form of address do you prefer and how would you like to be addressed?
Appendix (3) Informed Consent of Care Workers

Multilingual practices and pedagogical challenges in care for older adults
The goal of the project:
As the population of Sweden ages, a fraction of the older adults undergoes communication difficulties, such as different forms of dementia. An increasing number of older adults do not have Swedish as their mother tongue. This is also applying to many care workers and trainees who work in residential homes. The goal of this project is to explore communication in residential homes for older adults. The study will focus particularly on how care workers use different resources in communication in residential care. We are after answers to the following questions:

1. How do participants mange language constrictions in task-oriented communication?
2. What linguistic resources are used? And by who?

Things to note:
- The study is not an inspection or evaluation of your work
- Your work will not be disturbed as a result of participation
- Your participation will be anonymous
- Participation is voluntary, and you withdraw at any time
- The employer’s treatment of you will not be affected by your decision to participate or not to participate
- The material collected will merely be used for research purposes, and the recordings will be shared to a close group of researchers.
• The publications and spreading of the results of the study will not include any information such as name of places, institutes, or cities that reveal your identity or someone else.
• You have the right to access the information collected and request corrections

Gunilla Jansson, supervisor
Department of Swedish Language and multilingualism University of Stockholm
gunilla.jansson@su.se

Maziar Yazdanpanah, PhD student
Department of culture and communication University of Linköping
Maziar.yazdanpanah@liu.se
Response form:

I have read and understood the information about the project “Multilingual Practices and pedagogical challenges”. I agree to participate.

Signature………………………………………………………………
Name……………………………………………………………………
Datum…………………………………………………………………

Researchers……………………………………………………………
Signature………………………………………………………………
Appendix (4) Informed Consent of Residents

Multilingual practices and pedagogical challenges in care for older adults

You are invited to participate in a research project. If you participate in the project, we will study the daily communication between you and care workers in care work. The aim of this study is to gain knowledge about the impact of linguistic and cultural diversity in residential homes on both residents and care workers. We are looking for an answer to this question: To what extent is the ability of a care worker to speak the language of a resident important in the care and satisfaction of the resident? To find the answer to this question, we use recording methods (audio or video). The recorded material will only be used by the researcher, and others will not have access to it. Mainly, Maziar Yazdanpanah will visit the residential home. Maziar can speak several languages. In addition to Swedish and English, he speaks Farsi and Sorani.

The knowledge gained from this project can be useful in care for older adults and can be used in personal training. Participation in the project is voluntary, and you can withdraw at any time. Your anonymity is guaranteed.

Gunilla Jansson, supervisor
Department of Swedish Language and multilingualism University of Stockholm gunilla.jansson@su.se

Maziar Yazdanpanah, PhD student
Department of culture and communication
University of Linköping
Maziar.yazdanpanah@liu.se
Response form:
I have read and understood the information about the project “Multilingual Practices and pedagogical challenges. I agree to participate.

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Appendix (5) Table of the recorded material-interactional data

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Appendix (5) Table of the recorded material-interactional data

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Total 138 clips 14.4 hours
## Appendix (6) Table of the Recorded Material-Interviews

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<td>3 Carer</td>
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<td>4 Resident</td>
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<td>5 Carer</td>
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<td>6 Carer</td>
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Appendix (6) Table of the recorded material-interviews

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Appendix (7) Glossary of Key Terms

**Code-switching** refers to participant’s shifting between two or more languages during a conversation.

**Ethnic minority** is a group of individuals who share a common language and culture and are typically regarded as a minority within a country or a political territory.

**First language** is the initial language that an individual acquires, often from their parents.

**Majority language** is the language predominantly spoken by the most significant section of the population within a specific political territory.

**Minority language** is a language spoken by a smaller number of individuals within a specific area, often associated with an ethnic minority.

**Multilingualism** is the ability to employ more than one language in interaction.

**Second language** is a language that an individual acquires after their first language.
Papers

The papers associated with this thesis have been removed for copyright reasons. For more details about these see:

https://doi.org/10.3384/9789180754040