1 Interaction Research and Dementia

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1.1 Introduction

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of brain functioning (NHS, 2020). Dementia is currently the seventh leading cause of death and one of the major causes of disability and dependency among older people globally. According to the Office for National Statistics (ONS) in the UK, "'dementia and Alzheimer's disease' were the leading cause of death in 2022. Collectively they accounted for 65,967 deaths (11.4% of the total), up from 61,250 (10.4%) in 2021" (Alzheimer's Research UK, 2023). It is estimated that approximately 55 million people live with dementia worldwide, with almost 10 million people developing dementia each year (WHO, 2023). The most frequent cause of dementia, present in over half of the cases, is Alzheimer's disease (AD). Other types include frontotemporal dementia, vascular dementia, and dementia with Lewy Bodies (Alzheimer's Society, 2023).

It is suggested that approximately three quarters of people with dementia have not received a formal diagnosis, and therefore do not have access to treatment, care, and organized support, which places a greater burden on family care. There is an increasing need for timely diagnosis and early intervention in order to reduce this "treatment gap" and raise public awareness of dementia-related disorders. The social ramifications of dementia are highly significant, with the symptoms of dementia being perceived differently in different parts of the world, and indeed within different cultural, social, and religious groups (Alzheimer Europe, 2018). Better public awareness and understanding could reduce the stigma associated with dementia for the people living with the condition, their family, and other caregivers (ADI, 2019).

The changes to memory, cognitive abilities, social conduct, and personality detected in people with dementia are generally assessed using clinical criteria (i.e., tests of cognitive and executive function) that are performed in institutional settings. However, there is an emerging field of research examining how these cognitive and social changes are interactively realized and negotiated in the many relevant social contexts in which people with dementia

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regularly take part. These include exploring the interactions of people being assessed for dementia (Elsey et al., 2015; Jones et al., 2016, 2020; Majlesi & Plejert, 2018) and being diagnosed with dementia (Dooley et al., 2018), as well as people with dementia and their families engaging in everyday interactions (Jones, 2015; Kindell et al., 2013; Mikesell, 2009; Nilsson, 2022) and within social care contexts (Lindholm, 2015; Österholm & Samuelsson, 2015; Webb et al., 2020). These studies have begun to explore how social relations are affected, and potentially put at risk, as they are negotiated *in situ* in the everyday social contexts in which people with dementia co-construct their lives with others.

This volume aims to bring together new advances in the field, creating a collection of papers that examine how people with dementia interact with others in a variety of social contexts ranging from clinical to everyday settings. It will focus on four highly relevant themes in dementia research: *Dementia and Diagnostics*, *Dementia and Conversational Strategies*, *Dementia and Epistemics*, and *Communicative Challenges in Everyday Social Life*. It aims to shed more light on how persons with dementia accomplish relevant goals in interaction, and also how changes in an individual's discursive abilities may impact on how conversationalists negotiate a world in common and continue to build their social relationships. All contributions for this edited volume draw on the methods of Conversation Analysis (CA), an approach to social interaction that provides a detailed view of the moment-by-moment accomplishment of social life (Heritage, 1984; Levinson, 2006; Sacks, 1995; Schegloff, 2006; Sidnell, 2012; Sidnell & Stivers, 2013). All transcriptions presented in the chapters draw from the transcription notation originally developed by Gail Jefferson and certain chapters also include notations for non-verbal conduct taken from Mondada (2018) (set out at the beginning of this book). By exploring interactional practices through the lens of CA, this volume seeks to explore interactions involving people with dementia in a variety of contexts, pointing to both the interactional difficulties that often arise and also the creativity and collaboration within these interactional encounters.

1.2 Conversational Strategies: Abilities vs. Deficits

Traditional analyses of language and dementia derive from cognitive and experimental sciences and have been based on speech samples elicited in clinical settings by psycholinguists, neurolinguists, and speech pathologists using questionnaires (Neumann et al., 1999), test batteries (Appell et al., 1982; Bayles, 2003; Blair et al., 2007), or proxy reports from relatives and carers (Logsdon et al., 2002; Sweeting & Gillhooly, 1997). These experimental studies largely focused on word-finding difficulties (anomia) symptomatic of the communicative decline predominantly associated with AD. Other

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dementias were largely absent from this early research. Language or communicative difficulties were attributed to the "patient'," situated inside the individual psyche and conceived as a product of internal mental mechanisms. Thus, much of the earlier research in the field adopted a *deficit*-focused approach underpinned by the biomedical model of dementia (Hydén et al., 2014).

Early attempts to move away from the experimental paradigm and establish a "personal research approach" came from Kitwood's psychosocial theories of dementia (1988, 1990, 1997). He argued that his approach goes "far beyond the measurement of indices or the codification of behaviors" found in the objective, depersonalized approach of experimental science (1988:176). Kitwood (1997) points out that "in society there has been a tendency to perceive people with dementia, because of their memory and communication problems, as less than human, and their experiences, views and rights to choose have not been recognized. Such views are embedded within the established and authoritative biomedical model of dementia, where psychosocial aspects of care have been marginalized" (in Aggarwal et al., 2003:187). It has been suggested that despite cognitive impairment, "personhood" survives, and may be dependent both on our attitudes towards people with dementia and our treatment of them as people (Crisp, 1999). This shift in perspective gave rise to more person-centered approaches to dementia research, reflecting the increasing need to maintain a connection to the contexts in which people are valued, and in which one's experiences are shared. Researchers began to realize the need to "preserve the wealth of living reality" (Sabat, 1991a: 16). During the late twentieth century researchers challenged the somewhat linear assumption of traditional experimental perspectives that communicative disorder merely results from cognitive impairment. It is instead necessary to observe and closely describe patterns that emerge from naturally occurring interactions that allow us to formulate an understanding of the underlying mechanism contributing to dysfunction.

Conversational interaction involving persons with dementia has been analyzed from a variety of theoretical and methodological perspectives, including discourse analysis (Sabat & Harré, 1992; Temple et al., 1999), systematic functional linguistics (Müller & Wilson, 2008), and narrative analysis (Hydén & Örulv, 2009; Örulv & Hydén, 2006). This shift also saw a rise in studies using CA to explore communication involving people living with dementia (Guendouzi & Müller, 2006; Hamilton, 1994; Mikesell, 2009, 2010; Perkins et al., 1998). Ripich et al. (1991) noted that much of the early literature failed to report on the discourse of the *other* participants who accompany people living with dementia. They suggest that "knowledge of partner's discourse features is crucial since communication is reciprocal with each participant shaping the interaction" (332). Rather than studying single utterances and isolated language products, CA researchers focus on "uncovering the *socially*

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organized features of talk in context, with a major focus on action sequences" (Heritage & Atkinson 1984:5). CA research involving people with dementia began to investigate the central features of talk such as repair (Watson et al., 1999), questions (Hamilton, 1994; Jones, 2006; Mikesell, 2009), and misunderstandings of sequential aims in conversation (Mikesell, 2009). Research in the field acknowledged the need for longitudinal analysis exploring communication and cognition over time (Bayles, 1984; Hamilton, 1994; Jones, 2012; Mikesell, 2010; Nilsson, 2018), and valued the exploration of single case studies (Hamilton, 1994, 2008; Jones, 2012, 2015; Müller & Guendouzi, 2005; Müller & Wilson, 2008), adopting an individualistic approach in order to provide a heightened understanding of interactional influence on language as it relates to dementia.

Jones (2015:556) acknowledged that "along with this focus on interaction, there was increasingly a shift in perspective, away from communicative disorder as solely situated in the limitations of a person's cognitive impairments, towards a wider focus on communication as a joint, collaborative achievement. It is important to view any impairment in communicative functioning or interaction as contextually situated and collaboratively produced." Studies found that, in the presence of cognitive deficit, people with dementia are competent, skillful, and co-operative conversationalists (Hamilton, 1994; Müller & Wilson, 2008; Sabat, 1991b). Hamilton's (1994) longitudinal sociolinguistic study, spanning over four years, detailed her conversations with a single person with AD (Elsie). Hamilton noted that even in Elsie's final stage of interactional ability, in which she had a limited communicative repertoire, she was still able to achieve a range of interactional functions including requesting clarification, turn-taking, and orienting to personal topics. Furthermore, through their conversation analytic investigation of the functional aspects of laughter during conversations with an individual with dementia, Wilson et al. (2007:1002) detailed the conversational strategies employed by people with dementia during interaction. Despite the progressive nature of the disease, they discovered that individuals retain the social proficiency that permits them to contribute to conversation as a social action in meaningful and contextually appropriate ways, being competent conversational partners. Research moved from focusing on language deficits, that is word and sentence level analysis, to studying communication and communicative competency more widely. There was a greater concern in the emerging conversation analytic research to address the notion of interactional and pragmatic *ability* as an emergent phenomenon in the field of dementia research.

In the early part of the twenty-first century, further theoretical and policy developments saw another shift in understanding dementia as a disability. Dementia is recognized as a disability both under UK domestic law (Equality Act 2010) and international convention (UN Convention on the

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Rights of Persons with Disabilities 2007). In 2010 (reviewed in 2017) the Dementia Action Alliance created the National Dementia Declaration, a set of seven expectations or statements of what life should be like for people with dementia. These were co-created by people with dementia and were used to inform the UK Prime Minister's Challenge on Dementia (DoH, 2012). Importantly, related to research, people identified "We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part" (Alzheimer's Society, 2023). Increasingly, a right-based approach to understanding dementia as a disability has been adopted, in which the voices of people with dementia are included in policy development, as well as health and social care service design and research. The social model of disability, which views people as being disabled primarily by barriers in society, not by their impairment or difference, started to influence dementia research, and indeed CA affords a promising tool for understanding social interaction and the mechanisms people use to conduct social life.

There has been a long tradition in the field of CA to "brand" the communication of those with conditions such as autism, aphasia, and more recently dementia as "atypical" (see Wilkinson, 2019). Although many of these studies have identified competency in the communicative practices of those with these conditions, atypicality based on diagnostic categories reinforces a medical model, perpetuating the "us" and "them" dichotomy – people are "atypical" by virtue of their condition. There is evidence to suggest that the interaction of some people with dementia and their interlocutors, within certain contexts, is "atypical." For example, Jones et al. (2016) and Elsey et al. (2015) formed interactional profiles which differentiate between those with dementia and those without. When people in the memory clinic without dementia could routinely answer questions about their memory problems, independently and in great detail, people with dementia often could not. In circumstances where people who had a dementia diagnosis could not answer questions about their age, for example, and had to seek help from their companion to answer, this clearly is atypical – demonstrating both a cognitive incapacity and interactional deficit. However, branding a whole population of individuals under the banner of "atypicality" no longer fits with the social model of disability. After all, there are situations in which "neurotypical" individuals breach the norms of social interaction to achieve certain interactional goals.

Within this volume, researchers have started to challenge the binary notions of normal versus abnormal, typical versus atypical, competency versus incompetency, deficit versus ability. Mikesell (Chapter 5 this volume) demonstrates how a person with dementia can use compensatory strategies within interaction that simultaneously illuminate both trouble and a demonstration of resourcefulness in navigating such troubles. Mikesell argues that such practices point to

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both deficit *and* skill and suggest that a dichotomous framework – identifying a practice or behavior as *either* a deficit *or* skill – is unlikely to accurately capture the social engagement of those diagnosed with neurological disorders. Jones (Chapter 12 this volume) also suggests that "While conversation analytic research has played an important role in changing perceptions about the *abilities* of people with dementia (and the collaborative nature of interaction), perhaps these binary concepts (competence *versus* incompetence) are not useful in defining our analysis of complex cognitive issues and interactional events, and possibly do not reflect the complexities of these social encounters." Dooley and Webb (2024) have encouraged CA researchers to ensure research in the field is inclusive, diverse, and equal, and challenge the common assumptions of condition-specific atypicality.

1.3 Epistemics and Deontics

The terms *epistemics* and *deontics*, as used in this volume, are concepts that are grounded in CA work (for a brief overview see Stevanovic & Svennevig, 2015). In broad terms, epistemics refers to knowledge and how various dimensions of knowing are important for understanding how people interact with each other. Deontics, on the other hand, refers generally to persons' authority or capacity to control courses of actions, such as getting others to do things or directing interactional agendas.

Epistemics in conversation goes back at least to Sacks' writings in the 1960s (1995) on *entitlements* of experience. He noted, for example, that people who have experienced something first-hand generally have greater rights to talk about (and also be affected by) these events than people with only second-hand knowledge of what took place. Later on, Labov and Fanshel (1977) discussed what they termed A-events vs. B-events, in which speakers uttering an A-event action (e.g., statement) have greater knowledge than their interlocutors, and lesser knowledge if uttering a B-event action (e.g., information or confirmation-seeking question). Pomerantz (1980) then introduced the notion of Type 1 vs. Type 2 knowables. Whereas the former knowable involves what a speaker is obligated to know (e.g., aspects of one's own biography, what one did the previous day or earlier in the day), the latter involves knowledge that is occasioned (e.g., knowledge of others, events experienced second-hand).

More recently, epistemics has been conceptualized within an elaborate framework involving three interconnected levels or dimensions: epistemic domains, epistemic status, and epistemic stance (Heritage, 2012a, 2012b). Epistemic domain (also termed *territories of knowledge*, Heritage, 2012b) refers to types of knowledge to which a person has special/expert access or rights. This may include biographical knowledge (i.e., Type 1 knowables)

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or field-specific knowledge such as a medical doctor's expert knowledge of "medicine," acquired through training and experience. Thus, epistemic domains tend to be populated by certain people, and in social interactions, differences in knowledge status amongst people may and do become apparent. For example, in a medical consultation doctors will have greater medical knowledge than patients. The degree of knowledge between persons is by no means absolute, however, but instead involves a gradient (Heritage, 2012a). Although some patients may have virtually no knowledge of an ailment, other patients may be in possession of detailed information (they have read about the ailment, have a relative who is a doctor, may themselves be a doctor, etc.) or they may be seen as having expert knowledge of their own experiences – compare Mishler's (1984) distinction between "medicine" and "lifeworld." Differences in epistemic status concerning a subject may, therefore, be very pronounced or even negligible. Finally, epistemic domains and epistemic status are not seen as fixed constructs, but are rather achieved and negotiated through interaction. What this means is that being an expert in an area is not taken as given. Rather, expert knowledge must be displayed and also ratified by the other conversational participants. For this reason, what is said and how it is said will work to position someone as knowing (or not knowing). Using language in certain ways thus works to build what is commonly called an epistemic stance, as someone who has greater or lesser knowledge on a given matter. A stance is very much an in-the-moment display of one's degree of access and rights to knowledge, in which [K^+] denotes greater and [K^-] lesser rights and access to knowledge. Numerous epistemic stance resources – for example, declarative syntax to inform (A-event) vs. declarative syntax to seek confirmation (B-event) – are perpetually deployed in conversation to negotiate epistemic status (Heritage, 2012a). Stance may also be put into the service of accomplishing transformations. Recipients of talk need not accept how others have positioned them with respect to knowledge; that is, interpretations may be challenged, and new facts may be brought to light.

Deontics is generally interpreted in terms of deontic status and stance, which parallels the organizational structure found in epistemic work (Stevanovic & Peräkylä, 2014; Stevanovic & Svennevig, 2015). Deontic status concerns a person's capacity to influence actions and agendas, whereas deontic stance involves a speaker's in-the-moment accomplishment of "control" (getting others to do things) or lack thereof. As with epistemics, deontic status is not fixed but negotiable, and stance resources will play an important role in either having a speaker accept the status quo or challenge it.

These concepts are of fundamental importance in dementia research for a number of reasons. The noted "cognitive decline" in persons with dementia may influence what people are able to recall or what knowledge they are able

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to display in conversation. In epistemic terms, the territory of knowledge of a person with dementia will likely diminish over time, and so that person's epistemic authority may no longer be taken for granted (see, for example, Landmark, 2021; Schrauf, 2020). As far as conversations go, this may influence what may be considered a B-event utterance. For example, can it be expected that persons with dementia will be able to take up a [K^+] position when asked what they did yesterday or this morning? Or similarly, do persons with dementia become somehow restricted in their ability to initiate A-event utterances, in which they make authoritative, epistemic displays of important events in their lives? As already stated, the focus of this volume is not solely on identifying knowledge deficits. Rather, attention is given to both limitations *and* capabilities, and – even more importantly – how knowledge issues arising within the interactions are addressed and managed: the chapters in Part 3 of this volume specifically address these points. Further, epistemic limitations do not translate into persons necessarily displaying a position of "not knowing." What many of the chapters in this volume show is that persons with dementia may also develop strategies to somehow compensate for their diminished territories of knowledge. This attests to the creativity and resourcefulness of persons with dementia in their efforts to adjust to and make up for their changing circumstances.

Dementia has also been noted to affect the deontic aspect of social interaction. As has been noted especially for frontotemporal dementia (behavioral variant), people tend not to initiate conversational sequences, thus severely limiting their ability to set or control topical agendas, placing their interlocutors in the position of having to do so in order to keep the conversation going (Muntigl & Hödl Chapter 9 this volume; Smith, 2010). Another consequence of not initiating sequences is that people then tend to be placed in "recipient" roles, that is in a deontically weaker position. Thus, rather than getting others to do things, they must constantly react to (comply with) others' requests, directives, proposals, and so on.

An examination of the epistemic and deontic challenges associated with social interactions in which persons with dementia are conversational participants sheds considerable light on the changing relationships between them and others. Losing authority and autonomy to know and act in social situations can diminish perceptions that one is a competent social actor. This can further lead to a negative self-image, threatening the *face* of the person with dementia (Goffman, 1967). Various chapters in the volume also deal with face and facework in relation to dementia. These potentially negative consequences make it especially important to examine where diminished authority/autonomy surfaces within conversational sequences, with an eye towards understanding how these threats to face may be managed in an emotionally supportive and empathic way.

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1.4 Applications: Applied Conversation Analysis

There is an emerging field of conversation analytic research which aims to effect change and which uses CA findings to inform interventions to enhance the quality of life and care of people with dementia. Whereas it is of great importance to use CA to capture experiences and thoroughly document how dementia has an impact on the everyday life of those concerned, it is equally important to use such findings as evidence that can contribute to the development of best practices in care, and inform education, guidelines, and policies. When CA is used for such purposes, it is labelled *applied CA* (see Antaki, 2011 for an overview). Applied CA is commonly associated with discourse that in one way or the other takes place in institutional settings, for example interactions in health care (e.g., dementia assessment and diagnosis, psychotherapy, suicide helpline calls), business talk, or in the classroom.

For applied CA to be effective, it should ideally be conducted in close collaboration with those directly concerned: people with dementia, partners and relatives, care-providing staff, and clinicians, to mention a few. A commonly recognized challenge is that CA methods (and the benefits of using such methods) may be difficult to understand and might seem inaccessible for some stakeholders. This can be due to a range of issues (see O´Reilley & Lester, 2019). One potential issue is that anecdotal evidence may lead to practitioner perceptions that CA is too technical and time-consuming, or that the method does not provide results that are based on quantitative measurements, which may not be well-generalizable. Another issue may be that the professionals, whose interactions are to be investigated by means of CA, are concerned that they are to be evaluated, and errors and faults will be detected and criticized. It is important to point out that this is by no means the aim of applied CA, in which the focus ordinarily is to scrutinize, as objectively as possible, how interaction in a specific setting and activity is organized and how it unfolds, with the purpose of identifying structures that can be utilized for developing best practices. To build trust is key in this context, and several visits to a setting might be needed before informants are comfortable with video recordings being made of their practices and activities (Tsekleves & Keady, 2021). Providing feedback to those who engage in the project is also a very important part of the applied approach (see Lindholm & Tykkyläinen, Chapter 14 this volume; Plejert, Chapter 4 this volume).

Even though some methodological and practical challenges are highlighted above, researchers conducting applied CA are mainly experiencing recognition and appreciation, and find themselves working fruitfully together with other professions on a mutually identified problem area or a common goal of bringing about positive change and development. Several examples are found in the present volume that connect to the approach denoted "interventionist"

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CA (e.g., Lindholm & Tykkyläinen, Chapter 14 this volume; Plejert, Chapter 4 this volume; see also Antaki, 2011; Stokoe, 2011). In this approach, CA results shed light on the organization of interaction in a specific setting – for example, dementia diagnosis, interaction in residential care, the use of communication aids, and so on – and analysis is conducted with the underlying idea or goal that some kind of intervention is to be developed to promote aspects such as patient safety and the well-being of everyone involved. Such interventions include educational healthcare interventions (see, for example Pilnick et al., 2018) and Artificial Intelligence (AI) digital doctors. Underpinned by CA findings, these can be used to assess a person for dementia, with the aim of accelerating dementia diagnostic pathways (Mirheidari et al., 2019). Other applied CA research that is emerging is the exploration of how people with dementia use assistive technologies and smart home devices to conduct daily activities at home (see Samuelsson & Ekström, Chapter 13 this volume). CA has the potential to help inform the development of such devices to ensure they are user-friendly for people with disabilities like dementia (Albert, 2021; Ingebrand, 2023).

Applied CA is about collaboration between researchers and various participants, who may gain from the specific advantages of the method's rigorous aim not to make claims beyond what can be based on evidence from the material or data at hand. Even if applied CA is viewed as a discipline in its own right, it is becoming increasingly common that it is used in multidisciplinary projects. This used to be problematic, from a more orthodox CA-stance (see Antaki, 2011; Plejert, Chapter 4 this volume), as scholars were concerned that combining CA with other methods (for example, an observer's view on context or participants' retrospective accounts of an event) would dissolve the method's original, emic ambition. However, use of applied CA allows collection of evidence to support interventions that become ecologically valid in a way that is not possible through experimental trials. Through this qualitative method, the reflexive relationship between micro and macro is illuminated (Boden & Zimmerman, 1991; Heritage & Clayman, 2011). Within the area of dementia research, applied CA thus offers the unique opportunity to provide information about details of the organization of interaction that are not so easily detectable, or even possible to obtain, by other methods.

1.5 Outline of This Book

Each Part of this volume addresses one aspect of human interaction and dementia. Part 2: Dementia and Diagnostics examines how CA can shed light on diagnostic activities involving people with dementia. Negotiating the diagnostic pathway and receiving a dementia diagnosis is arguably one of the most significant points in a person's journey through dementia. There is growing

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importance being placed on achieving timely diagnosis, and improving the rate and quality of diagnosis for those with dementia. Furthermore, interaction analysts are beginning to demonstrate how communication can play a vital role in the success and quality of diagnostic encounters. Chapter 2 (Jones et al.) examines some of the practical challenges associated with administering standardized tests (i.e., Addenbrooke's Cognitive Examination/ACE-III) to people with dementia. Drawing from the CA concept of *recipient design*, which basically means that an utterance's design features will be tailored to its addressee, they argue that physicians generally have "good interactional reasons" for deviating from the requirement of offering standardized questions as they are formulated in ACE-III. Their chapter highlights the contingent nature of testing situations and that physicians sometimes may need to make adjustments to question formats in order to properly accommodate the needs and abilities of people with dementia. Chapter 3 (Dooley and McCabe) also explores an aspect of clinical assessment by examining conversations that involve diagnostic feedback. In particular, they focus on episodes of *misalignment*, in which doctors and patients explore divergent conversational agendas: for example, when doctors attempt to provide specific feedback concerning the dementia diagnosis and patients instead pursue a different, contrasting agenda. Their work not only delves into some of the, often face-saving, strategies from doctors, but also suggests ways of improving the "diagnosis experience" for the people taking part in the feedback conversation. Finally, Chapter 4 (Plejert) takes an *applied*, *conversation analytic* view of the testing situation (Antaki, 2011). By examining an episode from a video-recorded, interpreter-mediated dementia assessment, she is able to pinpoint moments of interactional trouble that arise from the interpretation process and how such trouble is oriented to or "missed" due to the complexities of three-way communication in which one of the participants does not (fully) understand what is being said. The chapter then also discusses how this applied study may offer various types of "interventions" that can benefit professionals, stakeholders, and, importantly, persons with dementia.

Part 3: Dementia and Conversational Strategies explores unique interactional practices or patterns involving people with dementia that are commonly found in a variety of conversational contexts. People with dementia, their family members, and caregivers are found to develop interactional strategies that are highly functional and may sometimes serve to compensate for other resources that have been lost. Chapter 5 (Mikesell) examines the interactions over time of Robert, a person with the behavioral variant of frontotemporal dementia (bvFTD). This longitudinal study focuses on the evolving discursive functions of a single interactional practice – the use of the phrase "now what" – that is strategically and innovatively used to recruit assistance from interlocutors. However, his later uses of "now what" are notably less

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effective and interlocutors often do not respond. One of the chapter's unique contributions is that it blurs the distinction between deficits (the challenges individuals face) and skillfulness (the creative navigation of challenging environments) by showing how "now what" may work as a compensatory strategy that orients to both the troubles Robert faces while simultaneously demonstrating his resourcefulness in navigating the trouble. Chapter 6 (Foster) is a study of a man (Dan) with vascular dementia who sometimes sings in everyday interactions with his family, and focuses on what Dan accomplishes by singing in those interactions. His singing is responsive to prior talk, gets a range of interactional tasks done (such as complimenting, complaining, requesting, and doing humor), and makes relevant a co-participant response. Thus, the analysis of this discursive practice provides insight into communication by people with dementia and how they use these practices to accomplish everyday social goals. Chapter 7 (Kindell et al.) examines the repeated use of tag questions by spouses/carers when talking to a person with semantic dementia. They analyze the form and uses of tag questions in these interactions and explore how they can constitute a fruitful conversational device for those talking to a person with dementia. They explore the implications of these findings in terms of how use of tag questions can be seen as an example of how those habitually interacting with people with dementia may adapt their style of talking, and how it may facilitate the participation of the person with dementia in conversation. This practice has the added benefit of minimizing the disruption to the conversation brought about by the cognitive and linguistic impairments associated with dementia. Finally, Chapter 8 (Landmark and Svennevig) highlights a person with dementia's creativity in influencing courses of action despite his limited conversational resources. They found that the person in question, Koki, was able to take topical initiative in two ways: first, by expressing his unique understanding of a given situation, and second, by making decisions about how to pursue practical problems. This study places the spotlight on Koki's resourcefulness in the face of real-word interactional challenges.

Part 4: Dementia and Epistemics includes a series of chapters on the topic of knowledge or knowledge states (epistemics) in interaction, regarding how people with dementia and their families demonstrate or negotiate what they know. People with dementia are often unable to demonstrate epistemic authority due to problems with memory, comprehension, and understanding, and so it is extremely important to investigate how dementia impacts epistemic abilities during social interaction. Chapter 9 (Muntigl and Hödl) focuses on the practical epistemic organization of a common household activity in which people with FTD regularly take part: viewing family photos. In this context, the activity of viewing photos involved family members and caregivers directing the person with FTD to identify people in photographs. Epistemic stances taken up by the participants were found to index the person with FTD's

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"reduced" epistemic domain with respect to her ability in recognizing family members in photos. For example, interrogative action formats were used when answering, which suggests "guessing," and family members would often provide hints, encouragement, and positive assessments (after correct guesses). However, people with FTD often assume a position of epistemic authority when asserting who is *not* on the picture. Finally, it seems easier for persons with FTD to recognize co-present persons. This suggests that recognition may be facilitated by additional features such as voice and the cotemporal setting. Chapter 10 (Ekström et al.) focuses on how the management of telling about troubles relates to living with dementia. In the chosen excerpts for this study, the spouse without dementia is the speaker of a story in which the person with dementia is the main character. This is a challenging situation wherein the speaker balances getting the story about their partner's disease across while not imposing on their partner's rights to knowledge and experience. The analysis shows that the spouse without dementia, when disclosing sensitive matters regarding the spouse with dementia, orients to differences in epistemic status between the speakers, and also commonly makes use of multimodal resources such as touch and gaze, as well as laughter, potentially in relation to the management of face and distress in situations of memory loss. Finally, Chapter 11 (Lindley) reveals some highly sophisticated practices of demonstrating epistemic authority by a person with AD. The analysis of interactive episodes demonstrates how a person with AD uses conversational practices to help position herself as an expert in her own autobiographical events and also to be able to offer advice on a variety of subjects.

Part 5: Communicative Challenges in Everyday Social Life sets out how certain troubles may arise during interactions involving people with dementia and how these troubles are managed throughout the ensuing interaction. Chapter 12 (Jones) explores the intersection between cognition and interaction by longitudinally analyzing the cognitive abilities of a person with dementia (May) (and the change in those abilities over time), examining how memory loss is reflected in verbal conduct during everyday family communication. Chapter 13 (Samuelsson and Ekström) contributes to the understanding of the possibilities and pitfalls of using personalized communication applications installed on tablet computers to support communication by people with dementia and their conversational partners. By examining video-recorded conversations between people with dementia and their carers, using digital communication for the purpose of asking questions or managing the content of the application (e.g., deciding which photo to view), they identified a range of practices that may have either greater or lesser benefits for supporting conversation. The aim of this chapter is to further the understanding of carer strategies to promote participation and involvement for persons living with dementia. Chapter 14 (Lindholm and Tykkyläinen) examines an intervention designed

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for professional caregivers to enhance the quality of mealtime interactions between people with dementia and their communication partners. Through detailed analyses of the verbal and embodied practices during mealtimes, it is demonstrated how the staff members' view of mealtimes change during the intervention. The chapter ends with a discussion of what can be achieved by an interaction-oriented approach to accomplishing routine caregiving tasks, focusing on both the well-being of the residents and dementia care employees' satisfaction. Finally, Chapter 15 (Webb) investigates how different quiz formats facilitate or impede participation and social interaction in group quizzes. People with dementia frequently attend groups that provide opportunities for engaging in activities, often facilitated through organized games such as quizzes. Webb found that social quizzes impose an interactional framework composed of a three-part sequence (question – answer – evaluation), marking this activity as institutional. This chapter outlines not only how quizzes may be enacted in various ways, but also demonstrates how these different forms of enactment may have interactional (and social) consequences for all participants. Special attention is given to how face threats may be realized and oriented to in these contexts.

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