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Resident Reactions to Person-Centered Communication by Long-Term Care Staff

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Abstract

Long-term care staff caregivers who are person centered incorporate the life history, preferences, and feelings of residents with dementia during care interactions. Communication is essential for person-centered care. However, little is known about residents' verbal reactions when staff use person-centered communication. Accordingly, this study investigated the impact of person-centered communication and missed opportunities for such communication by staff on resident reactions. Conversations (N = 46) between staff–resident dyads were audio-recorded during routine care tasks over 12 weeks. Staff utterances were coded for person-centered communication and missed opportunities. Resident utterances were coded for positive reactions, such as cooperation, and negative reactions, such as distress. Linear regression analyses revealed that the more staff used person-centered communication, the more likely that residents reacted positively. Additionally, the more missed opportunities in a conversation, the more likely that the residents reacted negatively. Conversation illustrations elaborate on the quantitative findings and implications for staff training are discussed.

Keywords

person-centered care, communication, long-term care, caregiving

Introduction

Person-centered care is a type of individualized care that has gained attention in long-term care. It includes acknowledging the individual as a person, incorporating life history into care, engaging in shared decision making, and focusing on the individual's remaining abilities.^{1,2} Person-centered care improves the quality of the interaction between the care provider and the individual, thereby fostering positive relationships.^{1,3} This is especially important for individuals living with dementia. Dementia is a disease often examined through a perspective of loss, as the focus is on the loss of memory and the individual's diminishing cognitive ability. As a result, the individual at risk is no longer being viewed as a person.⁴⁻⁶ Person-centered care seeks to remedy this, as the individual is seen as a whole person with his or her own feelings, experiences, values, and preferences, which are considered throughout the provision of care. This consideration reaffirms the individual with dementia as his or her own person.^{1,4,5}

Communication plays an essential role in the provision of person-centered care and the maintenance of personhood.^{3,7} It is a vital component of care as individuals with dementia have difficulty understanding and responding to caregiver requests and expressing their needs clearly.^{8,9} This often leads to the perception that conversations with individuals with dementia lack reciprocity and have little effect on the individual.³ However, individuals with dementia retain the need for and ability to have

meaningful interactions.¹⁰ Therefore, effective communication between long-term care staff and residents with dementia is needed to ensure staff understand and meet the care and social needs of these residents. This is important as unmet resident needs due to ineffective communication can lead to negative resident behaviors, making care provision difficult.^{2,10,11} This is supported by Williams et al¹¹ who found that elderspeak, a form of patronizing communication, was associated with problem behaviors such as vocal outbursts and aggression. Resistiveness to care was also more likely when elderspeak was used compared to normal communication.¹¹ Thus, communication barriers can have a negative impact on the quality of life of those living with dementia, the quality of care received and given, and the staff–resident relationships.¹² Accordingly, measures must be taken to ensure long-term care staff have the skills to communicate effectively with residents with dementia.

Modifying verbal behavior can facilitate conversation in older adults with dementia and also reduce negative outcomes,^{8,13} as

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better communication between staff and residents results in decreased agitation, aggression, and discomfort in residents.¹¹ Findings from a randomized control trial by Sloane and colleagues¹⁴ aimed at enhancing the use of person-centered communication by staff during showering and bathing tasks in a nursing home illustrate that when staff participate in engaging conversation with residents, residents exhibit calm behavior, such as decreased agitation, discomfort, and anxiety. Residents with dementia were also more alert and showed greater well-being when treated autonomously. Moreover, the use of person-centered communication resulted in greater resident cooperation, with staff reporting greater ease when bathing residents, a task that normally causes many residents to become agitated and aggressive.¹⁵ Similarly, Bourgeois and colleagues⁸ reported that providing nurses' aides with communication skills training led to decreases in problem behaviors, such as repetitive questioning and physical aggression. Other findings from the study included increases in resident well-being and improvements in communication from the residents. Communication interventions also resulted in staff reporting increased feelings of confidence while providing care.¹⁵ Therefore, improving communication between staff and residents with dementia can enhance the quality of the care relationship.

Enhancing the quality of the care relationship is essential in promoting and maintaining the well-being of individuals living with dementia. Long-term care staff and the communication they use play an important role as those with dementia look to caregivers for cues on how to react and view themselves. Thus, it is imperative that staff communicate in a way that promotes personhood, respect, and well-being.³ One way to do this is by incorporating person-centered communication strategies into care, which direct attention toward the person and what they are capable of, as opposed to focusing on the disease and the care tasks required.⁵ Previous research has focused on four of Kitwood's indicators of person-centered care that are communication focused^{3,5,16}: recognition, negotiation, facilitation, and validation. The following are definitions of person-centered indicators from Kitwood.⁴ Recognition refers to greeting and addressing an individual by their name and includes nonverbal behavior, such as using direct eye contact. Negotiation involves asking the individual about their needs and preferences. Facilitation focuses on enabling the individual with dementia to do what he or she would be unable to do by assisting them with the missing parts of the intended action. Validation entails acknowledging the individual's feelings and accepting that their reality is sometimes different from cognitively intact individuals.

The use of person-centered communication strategies by social partners can lead to greater contributions by individuals with dementia, including those in the advanced stages of the disease.^{5,17} Indeed, Kitwood⁴ outlined creation and giving as indicators of personhood by the individual with dementia. Creation involves adding something unique to the conversation, whereas giving involves offering help or expressing affection. These indicators signal to caregivers that the individual with dementia is capable of interacting with others and the indicators

can manifest themselves in several ways. Individualizing interactions by providing residents with dementia with the opportunity to participate in care activities and expressing an interest in the residents themselves, for example, resulted in residents cooperating with morning care tasks.¹⁸ Creation can occur when a resident discloses personal information. According to Edvardsson and colleagues,¹ a key aspect of person-centered care involves incorporating life history into care. When staff facilitate conversation, residents may reveal information about themselves, their life experiences, and preferences. This provides staff with the opportunity to use such information to tailor care to meet individualized needs and enhance the care relationship.² Going along with staff conversation is also a sign of creation. As mentioned above, reciprocity occurs when social partners engage and facilitate conversation with those with dementia, thereby enabling the individual with dementia to make a meaningful contribution to the conversation.^{5,8} One way in which this occurs is through asking for clarification during a conversation. By asking for clarification, the individual with dementia is signaling to their conversation partner that a misunderstanding in communication has occurred and that they are attempting to aid their partner in repairing this misunderstanding to further facilitate communication.^{19,20} Thus, it is important to note the ways in which individuals with dementia are able to give back to their social partners.

While a substantial amount of literature exists on enhancing staff communication, only a few studies mentioned earlier have focused on how residents react to improved communication by staff. When resident reactions are mentioned in the staff communication literature, the focus has been primarily on decreasing negative outcomes such as resistiveness to care and aggression. Less is known about the types of positive verbal reactions that can be elicited in residents with dementia through the use of person-centered communication by staff. Therefore, the aim of this study was to examine resident reactions in response to conversations involving person-centered communication and missed opportunities for such communication by staff during routine care tasks. The following hypotheses were tested:

Hypothesis A: An increased number of person-centered utterances by staff will be linked with an increased number of positive resident utterances.

Hypothesis B: An increased number of missed opportunities for person-centered communication will be positively related to negative resident utterances.

Methods

Participants and Procedure

Participants included 13 staff caregivers and 13 residents with dementia in a long-term care home located in a large metropolitan city in the United States. The dyads were audio-recorded during routine care tasks (eg, helping with dressing), 8 during the morning shift and the remaining 5 dyads were recorded during the night shift. Conversations were recorded at 4 occasions over a 12-week period (13 dyads at time 1, 10 dyads at time 2,

12 dyads at time 3, and 11 dyads at time 4). No time restrictions were set for the dyadic interactions. There were 46 conversations. One of the residents passed away after the first week of data collection and the other missing dyads were due to resident and/or staff illness. The length of the recordings for each dyadic interaction was 16 minutes and 47 seconds on average and ranged from 2 to 45 minutes. Sixty-five percent of recordings were with residents in late stage Alzheimer's disease (AD). Their Mini-Mental State Examination (MMSE)²¹ scores ranged from 0 to 11 of 30, with a median of 3. The remaining 35% of the recordings were with residents with middle clinical stage AD, who had MMSE scores ranging from 12 to 18, with a median of 16. All staff participants were female except for 1. Similarly, all resident participants were female with the exception of 2. All participants (or their legal guardians) provided written consent. The study was approved by the requisite human research ethics board.

Data Analyses

Conversations among the 13 dyads were transcribed orthographically and segmented into utterances. An utterance was defined as a "complete thought, usually expressed in a connected grouping of words, which is separated from other utterances on the basis of content, intonation contour, and/or pausing."^{22(p124)} A coding system of 4 communication-focused personhood indicators was developed. These 4 indicators were chosen from Kitwood's provisional list of 10 indicators of effective interactions called positive person work.⁴ Kitwood's list of personhood indicators emerged from Dementia Care Mapping, which is an observational method that codes the quality of dementia care in terms of well- and ill-being.²³ Of the 10 indicators, 4 indicators that were most relevant to language-based conversational interaction were chosen for analyses: recognition, negotiation, facilitation, and validation. This study employed the same operational definitions that Savundranayagam³ used for the 4 categories of person-centered communication.

Operational definitions for resident utterances were developed using the existing literature on positive and negative responses to care by persons with dementia. Five definitions were created for positive resident reactions: cooperation, self-disclosure, going along with conversation, asking for clarification, and politeness. (See Appendix) Articles on facilitating communication with individuals with dementia and articles on person-centered communication and communication interventions for staff were used to develop definitions for positive resident reactions.^{1,2,8,18,19,24,25} The research on facilitating communication by Gentry and Fisher¹³ and Ryan and colleagues⁵ include information on ways to elicit reciprocity in conversations with individuals with dementia. Much of the literature used on person-centered communication includes the impact communication interventions have on staff and their interactions with residents. Cooperation involves participating in care activities and complying and agreeing with staff instructions or requests.¹⁸ Self-disclosure refers to a resident telling

a staff member biographical information such as information about his or her family and present and past experiences as well as sharing feelings and preferences.^{1,2} Going along with conversation refers to a resident contributing to and going along with staff during a conversation.⁸ Asking for clarification occurs when a resident uses an expression such as "What?" to initiate clarification in order to address a misunderstanding in communication.^{9,19} Politeness occurs when a resident greets staff, expresses gratitude or praise, and encourages staff.^{24,25} Two definitions were created for negative resident reactions: resistiveness to care and distress. The literature on elderspeak²⁶ was used to derive definitions for negative reactions as this research discusses how patronizing speech can result in negative behavior from residents with dementia, such as agitation and aggression. This literature also references and defines resistiveness to care.^{27,28} Resistiveness to care is defined as resisting care from staff members or not cooperating with staff member requests or demands. This includes saying no, screaming/yelling, crying, and threatening.^{2,26,27} Distress refers to expressions of pain, discomfort, or anxiety.²⁹ The difference between resistiveness to care and distress is that the latter is an expression of pain or discomfort, whereas resistiveness to care involves opposing the care being provided.

To establish the reliability of these operational definitions for staff and resident utterances, two trained researchers independently coded 20% of the transcripts. Two transcripts from the first 3 time recording sessions and 3 transcripts from the final recording session were selected to reflect the average number of staff utterances for all transcripts. There was an average of 126 staff utterances per transcript for all 46 transcripts. For the 9 transcripts used in the agreement analysis, there was an average of 130 staff utterances per transcript. The following calculation was used to perform the agreement analysis: total number of agreements divided by the total number of agreements and disagreements. The occurrence agreement was 91% for recognition, 92% for negotiation, 84% for facilitation, 85% for validation, 82% for the missed opportunities, and 82% for resident utterances.

Analysis using G*Power 3.01³⁰ was conducted to determine the number of participants needed to achieve sufficient power with a large effect size. Results from the power analysis with 2 predictors indicated that a sample size of 40 was needed to achieve a power of .90. Analyses using linear regression were conducted to investigate the relationship between the use of person-centered utterances, missed opportunities for person-centered communication, and positive and negative resident utterances. The predictor variables were the total number of person-centered utterances and the total number of missed opportunities per transcript. The outcome variables were positive and negative resident utterances. The variable for positive resident utterances was calculated by taking the sum of the following codes per transcripts: cooperation, self-disclosure, going along with conversation, asking for clarification, and politeness. The variable for negative resident utterances was calculated by taking the sum of the codes for resistiveness to care and distress.

Table 1. Means and Intercorrelations of Study Variables.

Variable	1.	2.	3.	4.
Person-centered utterances	1.00			
Missed opportunity utterances	.52 ^a	1.00		
Positive resident utterances	.61 ^a	.36 ^b	1.00	
Negative resident utterances	.11	.41 ^a	.03	1.00
Mean	49.48	13.35	31.61	1.83
Median	42.50	12.00	13.50	1.00
SD	41.07	6.77	41.16	3.37

Note: N = 46.

^a $P < .01$.

^b $P < .05$.

Table 2. Regression Analysis Predicting Positive and Negative Resident Reactions.

Predictor variable	Positive Resident Reactions ^a			Negative Resident Reactions ^b		
	B	SE B	β	B	SE B	β
Person centered	0.59	0.14	0.59*	-0.01	0.01	-0.15
Missed opportunities	0.29	0.86	0.05	0.24	0.08	0.49*

^aFor the regression predicting positive resident reactions, $R^2 = .38$.

^bFor the regression predicting negative resident reactions, $R^2 = .18$.

* $p < .01$.

Conversation illustrations are included to augment the quantitative findings.

Results

Table 1 includes the means and correlations among the key variables. Given the high standard deviations, all variables were positively skewed except for missed opportunities for person-centered communication. This was due to the staff-resident conversations with the maximum number of utterances for the positively skewed variables (ie, person-centered staff utterances and positive and negative resident utterances). The data were analyzed twice, with and without the conversations with the outliers. No differences were found and therefore, the data presented include all 46 conversations. Table 2 outlines the results for two sets of regression analyses on the role of person-centered communication and missed opportunities for such communication on positive and negative resident reactions. In support of hypothesis A, person-centered communication was a significant predictor of positive resident reactions, $F_{2,45} = 13.07$, $P < .001$. The more that staff used person-centered communication, the more likely that resident reacted using positive statements. In support of hypothesis B, missed opportunities for person-centered communication was a significant predictor of negative resident reactions, $F_{2,45} = 4.81$, $P < .05$. The more missed opportunities present during a conversation, the more likely that resident reacted using negative utterances. The excerpts in this section depict instances where person-centered communication was followed by positive resident reactions and

where missed opportunities were followed by negative resident reactions.

Cooperation

Cooperation indicates the resident feels comfortable with the staff member and is therefore willing to do what is asked of them. One of the ways in which staff can encourage resident cooperation is by negotiating with residents and consulting with them about their preferences and needs. In the example below, the staff member asks the resident if her item of clothing can be put in the wash and explains this needs to be done because the item is wet. The resident is made aware of the staff member's intended action and is asked about how she wishes to proceed. This indicates to the resident that the staff member values her preferences and wants to incorporate those preferences into the care task, resulting in resident cooperation.

Staff: Put it in the wash? [Negotiation]
 Staff: It's wet
 Resident: Yeah [Cooperation]
 Resident: You can [Cooperation]

Self-Disclosure

Self-disclosure of information about life history, personal experiences, and preferences from residents helps to foster a more personal relationship between staff and the residents they care for. Residents sharing personal information enable the staff to gain a better understanding of who the resident is as a person and their experiences. This can be achieved by asking the resident about their thoughts and experiences. As seen below, the staff member personalizes the conversation by asking about the resident's attitude toward golfing. This signals to the resident that the staff member is interested in knowing more about them, causing the resident to reveal information about how they used to golf as much as they could despite not being the best golfer. This provides the staff member with better insight into the resident's personality, helping to establish familiarity and comfort in the care relationship.

Staff: So you kept on having a positive attitude, right? [Facilitation]
 Resident: Yeah whenever I could get out I went out there and golfed anyway [Self-disclosure]
 Staff: [Laughs]
 Resident: Cause I didn't think I was a perfect golfer either [Self-disclosure]

Going Along With Conversation

Residents contribute to and go along with conversation when staff welcome and facilitate communication between themselves and the residents. The following example demonstrates this. The staff member encourages conversation by asking the resident for more information about the statement the resident previously uttered. This causes the resident to sustain the interaction by providing the staff member with more information on

the topic they introduced. The resident's contribution is reaffirmed when the staff member expresses they gained new knowledge from their conversation. This signals to the resident that they have made a meaningful contribution to the interaction.

- Resident: I hope they found that devil that slashed his six little kids though
- Staff: When did that happen? [Facilitation]
- Resident: Ya I thought I taped it yesterday [Going Along]
- Resident: In Florida [Going Along]
- Staff: Wow I didn't hear about that Katharine [Facilitation]

Asking for Clarification

When residents ask for clarification, they are initiating communication repair to understand staff better. This is observed in the example below when the resident asks "what?" following the staff member's question. This reveals the resident is unsure of who Diane is and requires more information, which causes the staff member to clarify and state that they are referring to the resident's daughter. This leads the resident to ask for further clarification, concerning information about her daughter, helping to facilitate further conversation with staff.

- Staff: So was Diane here today? [Recognition]
- Resident: What? [Asking for clarification]
- Staff: Diane your daughter [Recognition]
- Resident: What about her? [Asking for clarification]

Politeness

Residents express politeness by greeting staff, expressing gratitude or praise, and encouraging staff. Expressions of politeness demonstrate that the residents value and appreciate the staff and their care. Politeness, therefore, is the way in which residents validate the staff for their efforts. In the excerpt below, the staff member puts the resident at ease by acknowledging their fear of wandering and reassures the resident by stating that they would never let them become lost. The resident reacts with praise and acknowledges they are aware the staff member would not let them become lost, affirming the staff member's ability to provide good care.

- Staff: Oh I would never let you be lost [Validation]
- Resident: No you wouldn't [Polite]

Resistiveness to Care

Resistiveness to care signals that care is being delivered in a way that does not meet resident needs or does not take into consideration resident preferences and comfort. This is illustrated in the example listed below. The staff member is very directive, as he or she tells, instead of asks, the resident what to do. This causes the resident to refuse to comply with the staff member's instructions. Had the staff member used person-centered communication and negotiated with the resident by asking if they could roll toward them, giving the resident choice in directing the task, resistiveness to care could have been avoided.

- Staff: Roll toward me
- Missed: Can you roll toward me on the count of 3?
- Opportunity: [Negotiation]
- Resident: No! no! no! no! [Resistiveness to care]

Distress

Distress occurs when a resident experiences pain, discomfort, or anxiety. It requires immediate attention to maintain and improve resident well-being. The example below demonstrates what occurs when staff do not address distress. The resident continually states they are in need of help and yet staff do not step in to determine what is wrong. This prolongs the experience of distress for the resident. To avoid this negative reaction, a staff member could have asked the resident what was wrong as soon as the distress was recognized in order to quickly determine the source of the problem and alleviate it.

- Resident: Help me [Distress]
- Missed: What do you need help with?
- Opportunity: [Facilitation]
- Resident: Help [Distress]
- Resident: Help me [Distress]

Discussion

The current study's findings highlight the impact of staff communication on residents. Residents responded positively to the use of person-centered communication by staff. Relationships are at the heart of person-centered care.^{10,31} The finding that person-centered communication was linked with positive resident reactions provides evidence that such communication can enhance the staff-resident relationship.³² Specifically, person-centered communication resulted in residents cooperating, revealing personal information about themselves, contributing to conversations, asking for clarification, and being polite. These responses demonstrate that residents are capable of contributing to conversations and ultimately, capable of maintaining their relationships with staff. Moreover, the findings demonstrate that person-centered communication begets further person-centered communication when residents are presented with opportunities to disclose personal preferences.

Residents are more likely to be regarded positively by staff when they demonstrate prosocial behaviors such as cooperation. McGilton and colleagues³² discussed that the contributions from residents helped staff feel closer to the resident and helped staff realize the impact of their work on residents. One such way this impact can be realized is through residents expressing politeness to staff. In the example involving resident politeness, the resident praised the staff member by validating the staff member's statement that she would never let the resident get lost. Praise from the resident, therefore, acknowledges and affirms the staff member's ability to provide quality care. As well, the excerpt on self-disclosure discussed earlier demonstrates how contributions from residents can enhance the care

relationship, creating a feeling of closeness between staff and residents. In this excerpt, the staff member asked a resident about her attitude toward golfing. The staff member's expressed interest in the resident led to the resident disclosing her thoughts, providing the staff member with further insight into a personal experience of the resident. This personal sharing by the resident, prompted by the staff member, enhances the care relationship as the staff member had a better understanding of the resident as a whole and the resident felt valued and encouraged to make meaningful contributions to conversations. These positive improvements to the work experience are supported by other researchers who discuss that relationships that are reciprocal with improved communication, such as validating feelings and recognizing their individuality, were the quality of care that residents wanted.³³ These communicative relationships between staff and residents allowed for more cooperation, more confidence for staff in their ability to provide care, and more positive work environments.^{2,8}

Conversely, missed opportunities for person-centered communication threaten the staff-resident relationship by increasing the likelihood of negative resident reactions, such as resistiveness to care and distress.^{10,11,26,34} Negative resident reactions can add stress to the staff member's workload.²⁸ In addition, negative reactions can provide negative feedback to staff about their capabilities. This can be inferred from the resistiveness to care excerpt described previously. The staff member's lack of person-centered communication and use of directive language resulted in the resident not complying with her instructions. The staff may interpret this as a sign of an inability to provide good care. Consequently, staff may feel less confident in their work roles, have more negative perceptions about their work,³² and experience lower levels of staff burnout and higher turnover.^{28,34}

Analyzing the residents' reactions to different communication approaches by staff provides insight on how to train staff to be person-centered during routine care. Specifically, the findings demonstrate the need for self-monitoring by staff in order to distinguish between a person-centered interaction and a missed opportunity. Staff caregivers need to know the strategies that constitute person-centered communication. Furthermore, they need to know how to monitor resident reactions or take cues from residents in order to sustain a person-centered interaction.³ For example, it is important to be validating when residents disclose personally relevant details. When residents ask for clarification, it is imperative that staff take the

time to respond and facilitate residents' requests. These reactions by staff are more likely to yield more positive reactions by residents. Thus, a person-centered communication training intervention for staff that enhances the relationship between the staff and the resident, improves the well-being of the resident, reduces negative behaviors, and allows the staff to provide care with more confidence and ease, is one that will respect the resident's personhood.

Although the findings support the use of person-centered communication by staff, this study had the following limitations. Person-centered communication encompasses verbal and nonverbal communication. However, the use of audio recordings in the present study was limited to verbal communication and precluded the examination of nonverbal communication, such as the use of gestures or facial expressions. In further research, inconspicuous video cameras could be placed in the room and could be analyzed for a better assessment of communication. This study was also limited by a small sample. In terms of future research, it is important to invest in increasing the sample size so that different types of positive and negative utterances can be tracked to person-centered utterances versus missed opportunities. With a larger sample, we would be able to examine the relationships between the four person-centered indicators and the five categories of resident responses. In particular, are certain person-centered indicators more likely to elicit specific resident responses? For example, are instances of facilitation more likely linked with cooperative responses by residents? Similarly, are instances of missed opportunities more likely to be linked with resistiveness to care versus distress? This level of detail can be used to inform the development of staff training on person-centered communication.

The small body of literature on person-centered communication has focused primarily on improving staff communication and examined the impact of enhanced communication on negative resident reactions, such as resistiveness to care.^{8,13,26} The current study contributes to this important area of research by demonstrating the impact of person-centered communication on positive resident reactions. This study offers tangible examples of person-centered communication. More importantly, the positive resident reactions provide evidence to staff that person-centered communication is indeed helpful, while the negative resident reactions show that the lack of person-centered communication results in distressing care encounters.

Appendix A

Operational Definitions of Positive Resident Utterances

Positive resident utterances	Example
(1) Cooperation ¹⁸ : resident participates in care activities and <i>complies and agrees</i> with staff member requests or instructions.	Staff: Okay I'm gonna take your shirt off. Resident: Yes you can.
(2) Self-disclosure ^{1,2} : involves two situations: (a) Resident tells a staff member biographical information. This includes information about their family, present, and past experiences. (b) Self-disclosure also involves residents sharing their feelings and preferences. Preferences can be within the context of care tasks and are usually observed when the staff does not pursue the topic further.	a. Residents share biographical information "I used to be a seamstress." b. Residents share feelings and preferences Staff: you wanna put your teeth in? Resident: no. Staff: okay
(3) Going along with conversation ⁸ : the resident contributes to the conversation and goes along with staff during the conversation.	Staff: I hope they have something good for you today. Resident: I hope so too. You always have something good.
(4) Asking for clarification ^{19,20} : resident uses expressions such as "what?" or "huh" to initiate clarification in order to address a misunderstanding in communication.	Staff: How many pillows do you want two or one? Resident: What?
(5) Politeness ^{24,25} : greeting the staff, expressing gratitude or praise, and encouraging the staff.	"That's good, thank-you."
Negative resident utterances	
(1) Resistiveness to care ^{2,26,27} : resisting care from staff members or not cooperating with staff member requests or demands. This includes saying no, screaming/yelling, crying, and threatening.	Staff: Don't throw them on the floor. Resident: No.
(2) Distress ²⁹ : expressions of pain, discomfort or anxiety.	"Ow, ow, ow!"

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