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TAD (Thoughts About Dementia) Newsletter

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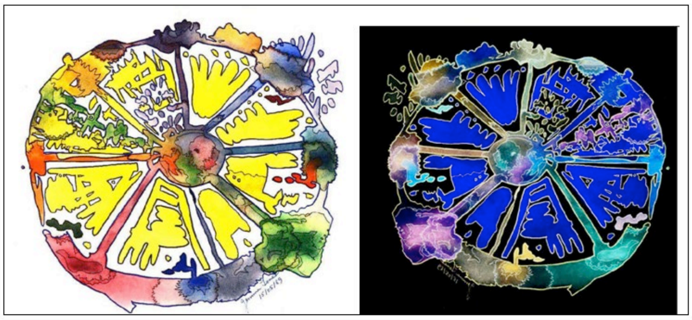

TAD 68 20 April., 2020

The ‘Ten-plus communication options model’ – Option 1: Gather more information, ask ‘good’ questions

Related ideas for observations, reflection, and research

- Did you ever think of how many types of ‘question words’ there are, and what their uses are?
- How would you define a ‘good’ question, versus an ‘unhelpful’ question, to ask a person who has dementia – especially if they are frightened and upset?
- When the police arrive at the scene of some event that needs investigating, what questions do they ask, and what questions do they *not* ask? (Interestingly, there are some parallels that can be drawn with situations that can occur in dementia care settings.)
- Have you ever thought of yourself as a sort of *‘psychological detective’* – when you have to try to find out the answers to important questions, but the person you’re asking cannot tell you ‘the facts’ accurately anymore?
- Have you ever noticed that some people tell sincere and convincing stories even though the facts are virtually all incorrect? How do you explain that?

Dear Reader,

TAD 67 was an overview of the ‘**Ten-plus communication options model’**. This TAD expands on the ‘Option 1’, by providing details and examples**.** If you forgot the options described the last TAD newsletter, see Box 1 for a summary. (The other options will be covered in future TADs.)

Option 1 is – ‘gathering information, asking good questions’ about what the person is speaking or thinking about at the moment. In essence, this means finding about the person’s ‘story’, about how they see things – from their perspective (whether it is right or wrong, or, whether you agree with it or not) [1].

You do not need to agree or disagree with the person to encourage them to speak and tell you their story. However, there are some helpful things to consider about the nature of questions and answers, which may make it easier for you.

Box 1 Summary listing of the **'Ten-plus communication options model** (Jones, 1985)

G	**1** Gather more information; ask 'good' questions; find out the person's story
O	**2** Orient the person to what's happening, tell/ explain 'the facts'
R	**3** Reminisce; through prompts, questions, triggers
D	**4** Distract, directly and indirectly
A	**5** Agree; play along with
L	**6** Lie – told to make a person feel better, but a lie none the less
S	**7** Social response; superficial, safe topics
	[visual space break- to go with the mnemonic]
V	**8** Validate (acknowledge) the person's feelings
I	**9** Idle**,** stall for 'thinking' time; remain quiet; repeat last thing person said
C	**10** Combinations of the above options - used consecutively
H	**Plus Humour, ….. and other options**
	Note that '**becoming defensive'** and '**trying to show the person you are right and they are mistaken'** are NOT options in this model.
	With more detailed knowledge about these options (in this and future TADs), and relating them to the Behavioural Stage a person is in, you'll notice that some communication options will make better starting choices than others, in particular situations.

What's a 'good question' versus an unhelpful or ineffective one?
For the purpose of these TADS, a 'good question' is usually anything except the 'Why' question, in other words, any question that keeps a person speaking to you comfortably, without becoming upset (or more upset). An unhelpful question will diminish or stop a person's responses, or upset them.

What's the value in letting a person speak, (even if you can't understand them fully), or in keeping a person speaking?
It can make them feel:
- noticed
- included
- listened to
- understood (accurately)
- identified with.

There's more! When a person with dementia speaks to someone who is genuinely interested in them, who wants to find out about their story, it can also:
- encourage their existing communication abilities so they don't become 'dormant' from lack of use
- if they're upset - decrease their adrenalin levels so they can calm down (providing the speaker doesn't get the person riled - by dismissing, correcting, arguing or contradicting them.) In fact, Feil taught ([6] refs), (and repeatedly demonstrated), that by asking five good questions, she could calm down even the most angry and aggressive residents.

Box 2 shows ideas for practicing 'asking questions' with a friend or colleague.

Box 2
Tip: Learning to ask good questions and to focus on a person's story without getting distracted or upset by 'incorrect facts' can take some practice

If this idea of gathering information by asking questions is new to you, you may want to practicing a bit with a colleague or friend before trying it out on a person you're caring for. (Usually it's not difficult to ask one or two questions in a row, but when you're trying to show that you're maintaining your interest, and finding out about the 'whole story', more questions are needed. It takes practice to develop proficiency in asking questions.)

Start simply by role-playing a situation that you have encountered before.
Try asking the first five questions in Table 2. (You choose the order of the questions – depending on the situation and circumstances.) Remember - it usually takes about five good questions for a person to become calm if they are upset.

Notice that your eye contact and body posture needs to reflect your interest.
Make sure you're in front of the person, within their visual field, and that your eyes are at the same height as theirs. It's recommended to stay about a meter/yard away), just out of 'swinging distance', unless the person invites you to move closer, or moves closer themselves. Then try ask about questions in a row, as appropriate.

For example: You might imagine the situation of a resident who says that "someone upstairs left the tap on and water has leaked through the ceiling into the room". You know that there hasn't been a leak, and the resident has 'had an accident' and is trying to cover it up.

First, validate their feelings and acknowledge their distress: "You look/sound /seem very upset.

Then ask questions, depending on the situation and the responses, like:
1 What happened? (There's a leak in the ceiling and water has come down in my room.)
2 Where did it happen? (Here, in the bedroom and bathroom; everything's wet, and my clothes.)
3 When did you notice? (This morning when I woke to use the toilet.)
4 Who was involved? (The man upstairs doesn't like me.)
5 How did it happen? He left his tap running

When you're comfortable doing that – you can use the other questions, like:

6 Has this ever happened before?
7 Have you told anyone about this? (your family, staff, residents, the manager?)
8 Has anyone helped you yet?
9 Is anything else happening that is upsetting you?

Only when the person is calmed down, you can try to solve the problem for them.

10 May I help you get washed and dressed? Then I'll sort this out, immediately.

Notice that no '*Why* question' has been asked. The reasons for this are explained, below.

Backtracking - Ever thought about how many 'question words' there are?

There are not very many. **Box 3** lists sixteen 'question words' (though I probably missed a few). Of these, the first five questions are the ones used most by the police to find out what happened, on arriving at a scene they have to investigate. (Notice that the question '**Why**' is not among them. It has been placed at the very end of this list; it gets special attention. It is the question best to avoid (in most circumstances) asking directly of people with dementia, especially people in Behavioural Stage One. More on that later.)

Box 3 List of question words (or interrogative words)

The first five essential questions to be familiar with, are the ones police use first when arriving on the scene, to get key information
(They don't ask 'Why' because they want to get the 'facts – not the theories of the bystanders. Others will figure out 'why something happened' when they have the facts.)

1 **What** - for any sort of information (... is your name?, …happened here?, …did you see?)
2 **Who**/ whose/ whom – for person or subject
3 **Where** - for location
4 **When** - for time or occasion
5a **How** - the manner, way (…did… it happen?)
5b **How** - quantity and quality descriptors (…many/few, much/little did it hurt?)
(old/young, far/close, often/rarely, long/short, hot/cold, heavy/light…?)

Some more question words
6 **Which** (…one, way, manner… ?)_
7 **Is**/ are/were/ (… you able to walk there…?)
8 **Have**/has/had (…you noticed it before?)
9 **Do**/ did/ don't (…you smell that…?)
10 **Shall**/ should/ shouldn't (…you look anywhere else…?)
11 **Can**/ could/ couldn't (… it be that…?)
12 **Will**/ won't (…that be upsetting…?) [Can be combined with 'if', as below.]
13 **May**/ might (…it be worth asking…?)
14 **Perhaps** (… you could ask…?)

Finally - the questions that directly relate to **logical thinking ability** (the ability required to determine 'cause and effect' accurately, are:

15 **Why** (…do you think that …? … (why don't you first try…?))
16 **If** (…**I** go get help, **will** you stay here…?)
'if (this happens)/ then (this will likely happen) connections', chance, and probability)
(… he put poison in the food, everyone would be ill, not just you, **don't** you think?)

[**Note**: 'Why' is sometimes camouflaged as "**What makes you think that**?". Avoid this also since it requires a person to give an account of their thinking and reasoning. If someone has dementia, asking a question that could highlight their 'weaknesses' or difficulties can put them on the spot, make them feel bad, and even make them *invent* an answer to save face.]

The paradox about asking '*Why* questions' – don't ask directly; find out indirectly
Although '*Why* questions' are not recommended, the paradox is that so often, 'Why' is precisely what carers and caregivers want to know the answer to. So - why recommend *not* asking 'Why'? If it is asked directly, there's little chance of getting a useful answer since it requires logical thinking ability, which is what is becoming weak in people with dementia (see **Appendix 1** for a detailed explanation of this.) So - how do you find out the answer to 'Why', without asking 'Why'? Ask the person enough 'good questions' so that *you* can figure out 'why', instead of hoping that the person with dementia can tell you directly and accurately.

Imagine being a 'psychological detective'. *You want to try to figure out, (if you can), what the person thinks is happening, since that will influence, if not determine their behaviour and give you ideas about how to help them*. **You want to know, in as much detail as possible, what a person thinks is happening - regardless of whether 'the facts' are correct or not** [3]**.** You do not have to agree or disagree with them… you are just gathering information. (If you discover that the person makes mistakes with names, time and dates, or places, or is afraid of someone - you have learnt something relevant to their future care needs.) See **Box 4,** and a linked example in **Appendix 2**.

Box 4 Example 1

A lady in Behavioural Stage 1 says that people are coming into her room and stealing her books when she's not looking.
You know she has likely misplaced them herself; she has misplaced other items the past months. (You want to know 'why she thinks people are stealing her books, but you know you cannot ask that questions directly to so you have the chance to think about how best calm her down and make her feel safe.)

Your reply?
Disagreeing, arguing, correcting (i.e. telling her it isn't true, that she misplaced them herself), isn't going to calm her down, or improve her frame of mind. Resist doing this.

Though we haven't covered **"Option 8 - Validating feelings"** in detail yet, - it is so useful I hope you'll be convinced to use it as often as possible. It shows the person that you've noticed them and it helps to build trust. Given those advantages, **it makes sense, even before asking about the person's story, to start with something like:**
"I can see you're very upset. I know how important your books are to you."
(The person will likely reply with something like: "Yes, I'm very upset.")

Then, continue with '*good* questions' – about what *she thinks* happened, such as:
. What happened?
. When did you notice they were missing?
. How many books?
. Which ones were the most important to you?
. How do you think it happened?
. What have you done?
. Where have you looked?

Get the story first. Only when the person is calmed down…. is the time to try to offer to help solve their problem, or distract them. If you try to solve a person's problem without listening to their story, you'll have done the 'right thing, but at the wrong time'; too soon.
Despite your good intentions, rushing in to solve the problem can make the person **feel like** you're not interested in them – just in solving the situation quickly, and leaving them alone again – their story unheard, their emotions unexpressed. (This a common communication error in the field of dementia-care.) The person will respond better when they are calmed down. They will be more distractible after they feel listened to, and if they trust the person they are speaking to (i.e. you).

So then, you might ask:
. What can I do to help you?
. Is there any chance they're still here somewhere?
. May I help you look for them?
. May I ask some other people to look out for your books too?
. May I get some books from the library for you, until we find them?

Asking 'pairs of opposite questions' helps discover the *shape* of a person's story

In its own way, every story has its own sort of size and shape. It can be helpful to think of a story as having dimensions - like an object has length, width, and depth. Asking 'pairs of questions' - as extremes, or opposites - can also help to define and get at the shape of a person's story. **Box 5a** gives examples of this.

Box 5a Continuing being a psychological detective - ask paired questions of the lady who thinks people are stealing her books

You could continue by asking 'paired questions', of this lady:
Q Is this the first time you've been missing things here? [**A** No, I don't think so…]
Q Has it happened before? [**A** Lots of things are going missing; but only the good stuff.'

Q When does this happen? [**A** In the night.]
Q When doesn't it happen? [**A** It never happens if someone is with me; they'd notice.]

Q Have you spoken to anyone about this (situation)? [**A** I don't remember.]
Use a prompt: Q Have you told staff here? [**A** No, they're always too busy to listen.]
Q Who haven't you told? [**A** I haven't told my family, and not the 'head one here'.]
(She means 'the care-home manager' but is using a simpler, 'substitute noun' instead.)

Q Who do you trust? [**A** I like the nice young lady with the red shoes.]
(Notice the typical Stage 2-type response. She's missing the exact facts and nouns, such as the person's name and job title, and replaces these with salient emotional and sensory details, and noun substitutions.)
Q Who don't you trust? [**A** I don't trust the 'head-boss' here; she tells stories about me.]

Q Is this the worst thing upsetting you right now? [**A** That's the worst right now.]
Q Are other things happening that upset you? [**A** Yes… I think the 'boss-one here' has told my family stories that I'm bad - and that they're not to come and visit me. They promised they'd come often and they never do. She must have said something to make them stay away. It means I have to be very careful who I speak to in case it gets back to her, and she makes things even worse for me.]

When this lady has told her story and is calm, is a good time to offer to help her
For example:
. What can I do to help you?
. Is there any chance they're still here somewhere?
. May I help you look for them?
. May I ask some other people to look out for your books too?
. May I get some books from the library for you, until we find them?

Possible concluding notes from the 'psychological detective' on this case:
Without clear facts, little information is certain - except for this lady's feelings*. There is evidence that she feels lonely, frightened, mistrustful of most others, and therefore doesn't know who to speak to safely. However, she has trusted **me** enough to reply to my questions without hesitation. If someone from staff needs to have an important conversation with this lady, the caregiver with the 'red shoes' is the one she seems to like and trust, and also me, – but definitely *not* the manager (the 'boss-one'). Such situations will likely recur while this lady is in Stage 1. It would benefit this lady if all staff learn to ask good questions of her whenever she becomes distressed.

What have you learned about the *shape* of her story?
No wonder she is mistrustful and blaming when her books are missing. (Notice how easy it would be to think she was 'deluded'?)

Can you imagine how this example would have ended differently if you had started out by:
. Asking "why" - "Why do you think people are stealing your books?"
. Disagreeing with her - "Everyone has their own books; they don't need yours."
. Argue (well-meaningly) with her – You probably just don't remember where you put them
. Placating her - " We wouldn't let that happen in here; we'd know if there was a thief around."
. Patronizing her - "We'll soon find them – there's nothing to worry about."

** Although there are various ways of interpreting this lady's responses this is the limit here.*

A slow transition: communicating 'facts' changes to relating 'emotional memories'

From the time a person is in Behavioural Stage 1 (making intermittent memory, attention and logical thinking errors), and onwards - they will have increasing difficulty relating 'the facts' about a situation or story, fully and accurately. They will struggle with factual details (like the date, time, names of places, people), and substitute them with more generic descriptions and the ‘emotional flavour/s’ of an event. (E.g. ‘it was *the way it is’*; ‘there were *people* there’; ‘they were doing *what they always do*‘).

When a person is in Behavioural Stage 2, (permanently disoriented in time / place), the facts are *rarely* correct, though the feelings (or details about the emotional flavour of what they are relating) are accurate. Carers and caregivers often think of communication as being wholly or essentially ‘right or wrong’, or ‘correct or incorrect’. They benefit from being taught to accept the **paradox** – that it is possible for people with dementia to communicate **totally incorrect facts whilst relating totally correct feelings or emotional memories**.

Ultimately, with respect to asking questions, it doesn’t matter which stage a person is in, as long as you try to match/mirror their speech, attention span, and have ideas for how to encourage speech and keep them speaking.

Box 5b: Example 2
A lady in Behavioural Stage 2 asks you about her mother, who is long deceased

This lady is looking lost, walking down the corridor, and asks you:
“Have you seen mother?
Do you know where she is? I’ve been looking everywhere.”

Your reply:
. (Start by answering her question) I haven’t seen her.
. (Validate her feelings) You sound worried about your mother.

Ask good questions, such as:
- How long have you been looking?
- What are you most worried about?
- Were you missing her?
- What would you like to say to her, right now?
- Would you like me to help you write it down?
- What was your mother like? Can you tell me about her? (Even though you ask in past tense, notice that people in Stage 2, invariably reply/speak in ‘present tense’.)

When the lady is calmed down, you can suggest various things:
- that you look at some photos of her mother
- that you have some refreshments in the lounge and talk about her

Notice that at no point do you have to argue with or correct the facts by saying things like:
‘Don’t you remember – your mother is dead’
‘She’s fine. I just saw her. You don’t need to look for her.’
‘I’ll help look and let you know if I find her.’
(Orienting and lying are options that will be discussed in future TAD newsletters.)

Does gathering information by ‘asking questions’ also work when speaking with people in Behavioural Stage 3?

In short, ‘yes’. It also works for communicating with people in Behavioural Stage 3. People in Stage 3 speak in what is often referred to as ‘word salad’, or ‘word doodle’. (This describes a series of disjointed phrases or words that don’t have linked nouns and verbs, as sentences do. Sometimes speech is exclusively in the form of expletives or swear-words.) Regardless, the person will still be communicating emotion, and trying to tell you about a particular memory. They know what they are trying to say, but (usually) do not know you cannot understand them; they will continue to speak if responded to.

Try to **match the person's style of speech and length of phrases.** Pick up on key words and intonation they are using, and reflect the emotion present back to them, **in the form of questions**. See **Box 6** for an example of this.

Box 6 Example 3:
A gentleman in Stage 3, is speaking in 'word salad'; you cannot understand him

He says:
" She gave me the ***photo****, but I don't know the furter, …how* ***high****, high, high, …and the spatter didn't go…. so…the* ***bugge****r, bugger, bugger. But "*

Your reply would be?
. To do nothing? - because you can't understand literally?
(The result would likely be that this person's 'attempt at conversation' might then stop, or continue in the form of speaking repetitively for the purpose of self-stimulation.)

. Repeat the dominant nouns, words or phrases the person is saying,
in the form of questions.
– such as:
She gave you the **photo**?
She gave you the *photo*?
It's **high**, high, high? How high?
It sounds like it didn't go so well?
'Bugger, bugger'? It sounds like you were angry, 'bugger angry'?

What about people in Behavioural Stage 4?
People in Stage 4 only speak with single words or sounds, so communication with them is usually in the form of short phrases, spoken in nurturing voice tones. Usually questions are interspersed with bits of comfort and information. (E.g. "I'm here to help you. Are you feeling OK? I've brought you some dinner for you to try. You look uncomfortable. Would you like to sit up higher? I'm staying with you.")

The next TAD newsletter will describe Option 2, 'Orienting the person to what's happening, explaining the facts, giving information'.

In the meanwhile, I hope you see the value of adding 'Communication Option 1' to your metaphorical 'caregiving tool-bag'. And that includes, that you will notice, and perhaps even bite you tongue, the next time you notice yourself directly asking someone '*Why*'. E.g. *Why* do you think people are stealing from you?, '*Why* do you think people are poisoning you?', '*Why* do you think your family are in cahoots with the manager here, against you?' I hope that you now feel a bit like a 'psychological detective' – more confident in asking people enough 'good questions' to find out about their current story.

Best regards,

Gemma Jones

P.S. Some puzzled course participants asked me about why was I promoting 'asking questions' since they had previously been taught a care method that said the opposite, *namely – 'Don't ask people with dementia any questions; agree with whatever they say'.*

Ultimately, the purpose of both systems is the same - to try to prevent a person with dementia from becoming upset or 'losing face' or 'feel cornered'. However, the 'Ten-Plus Communication Model' is more versatile than the other method since it defines what a 'good question' is, what the purposes for asking questions are, and makes recommendations about applying the information about the story to caregiving - in a bespoke, stage-specific way.

Appendix 1

More about why '*Why* questions' are special

Of all the questions, only '*Why* questions' are not recommended for use with people with dementia, especially people who are in Behavioural Stage1 (still often aware of their mistakes; denying or defensive about them), because it usually exposes their difficulties, which can make them feel upset, angry and mistrustful of you. Since keeping people with dementia feeling *emotionally safe* is a goal for *good care*, it's best to avoid asking 'Why?'.

There are several other contributing issues related to 'Why?'

A. **Being asked 'why' can feel like being interrogated, reprimanded or patronized**

Being asked 'why questions' can make you feel uncomfortable. This is true of adults as well as children, because it can bring back emotional associations of being powerless and fearful. Do you remember ever feeling threatened when asked why by a parent or teacher questions like:

. Why didn't you tell me you had homework to do this weekend?
. Why didn't you bring home your gym clothes for washing?
. Why haven't you given me your report card yet?
. Why can't you remember your times-tables today, when you knew them last week?
. Why do you expect me to have these forms filled in now when you only gave them to me five minutes ago?

B. '***Why* questions' are more complex than other questions** (such as who, what, where, when, how?)., which generally only require a single 'fact'. To answer '*why* questions' requires having memory of the thing or event in question, and, it means an understanding of '**cause and** (possible/ probable/ definite) **effect**'. In other words, it requires having functioning 'logical thinking ability', and this is precisely what is becoming difficult for people with dementia, (from Stage 1, onwards).

So – when a person with dementia is asked 'Why…do you think such and such happened….?', if they have difficulty remembering, or working out 'cause and effect', they genuinely won't know how to answer your '*why* question'. Worse yet…. read on.

C. **'Why questions' can force people to confabulate or lie to 'save face'**
To 'save face' and not appear to be inept or ignorant, a person may invent something in the spur of the moment, just to give you an answer. Putting a person in the position to want to 'save face' with us is the opposite of helping them to 'feel safe' with us, and be able to tell their story without fear of judgment (or correction, recrimination or reprisal).

Appendix 2

Example: 'things going missing' versus 'feeling like things are missing'

Sometimes the things people say are 'missing' are not literally gone (stolen, or misplaced), but only 'symbolically gone' while people feel unsafe.

That means that, **it can feel to someone 'as if/ like'** their meaningful **things have gone missing, or, are lost at times**. If they say this, they may be expressing their feelings versus 'the facts'. You can easily check this out with the person by saying, "You feel like (or '*as* if') your important things are missing, especially when you're alone?"

Example: In 1981, I worked with a lady in a long-stay hospital who was distraught because –

as she said - someone had stolen her best ‘Sunday dress’. I asked what it looked like, eager to go off in search of it. While she was describing the dress to me, I could see that one fitting her very description was hanging in her wardrobe. I was so happy I’d found ‘a solution to her problem’ and said enthusiastically, “It’s not missing! Look it’s right here. You don’t have to worry.” I took out the dress on the hanger to show her.

To my surprise, she did not seem relieved or pleased. She replied, *“Well someone must have known that you were coming in here and put it back. But as soon as you’re gone, it’ll be gone again too.”* I didn’t know what to make of that reply at the time, though have heard many similar things expressed since then.

The symbolic Translation for this lady’s words would be: “I only feel safe when someone is with me; when I’m alone strange things are happening, which include that I can’t keep track of my things.”]
However, then, I thought this lady was ‘a bit crazy’ and didn’t know what else to say to her, and so - I left her alone in the bedroom. I didn’t understand, then, that I missed the chance to find out what she thought had happened, and what else she thought was going on, as well as the chance to try to get her leave the bedroom to engage in some activities or conversation with others, so as not feel alone with thoughts of her losses.

I was young, without any formal dementia education, and could only think ‘literally and factually’. It took a while before I learned that it was also possible to listen emotionally and symbolically. It was Naomi Feil who taught me this [2].

References

1 Jones, GMM (2021) TAD newsletter 67; 17 Mar. The ‘Ten-plus communication options model’ for dementia-care. Sent out by TheWideSpectrum.co.uk website.

2 . Feil, N (1982 – 1995) Course notes for various Validation Therapy courses I took with Naomi Feil, in Vancouver, Canada. (Also demonstrations in care homes.)
. Personal meetings with Naomi Feil to complete the accreditation as a Validation Therapist.
. Personal communications with Naomi Feil since then, in the UK and the Netherlands.

3 **Historical note - Re: not asking questions of people who tell incorrect facts.**
We (care-giving staff, in the 1970’s and 1980’s) used to be told, not to *encourage* people who were ‘talking nonsense’, and not to ask them any questions. The explanation: ‘**Don’t collude with delusion’ because it will make them worse (i.e. more deluded and confused)**. Note that the assumption back then, taken from psychiatry, was, that ‘people with dementia who are talking nonsense are deluded’ (and sometimes even ‘psychotic’.) While this notion (of not colluding with delusion) may have good grounds in psychiatric practise, it is not helpful to the dementia-care field.

It is not possible to tell if a person is ‘deluded’ or not unless they have related their story. (We were never allowed to ask them to do, and assumed they were ‘deluded’, along the lines of ‘a bit crazy’). With our current understanding, we say that people with dementia, are more likely to be making ‘thinking and communication errors’. This comes from being ‘unable to relate facts accurately’ (resulting from their difficulties with memory, attention and logical thinking), rather than from being ‘deluded’. Medically speaking, a deluded person is defined as someone who is *unwilling* to accept the facts - even when presented with the (indisputable) evidence. In the case of people with dementia, given the types of brain damage involved, people are unable *to understand or retain*, i.e. the information and evidence, and do their best to ‘problem-solve’ events, regardless. This is like ‘not understanding’ or ‘making a best guess’ at what’s happening, but not, deliberately refusing to accept what is obvious and logical to others.

Other related references

- Jones GMM (2009) The ‘Ten Plus Communication Options Model’ (pg 208), in Chapter 14, ‘Communication options’, of the Course Notes Book for the course “Communication and caregiving in dementia: A positive vision”, (pp 205 – 222) by GMM Jones. The Wide Spectrum Pubs., Sunninghill, Berks, SL5 7BH.
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* TAD (Thoughts About Dementia) Newsletters, The first fifty. Vol. 1; GMM Jones, 2012. The Wide Spectrum Pubs., Sunninghill, SL5 7BH.

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