THE **GERONTOLOGICAL**
SOCIETY OF AMERICA®

OXFORD

Supporting Persons With Dementia: Perspectives From Certified Nurse's Assistants

Malinda Dokos, MS,[1,†] Rebecka Schultz, MS,[1,†] Jacob D. Gossner, MS,[1,] and
Elizabeth B. Fauth, PhD[1,2,*,]

[1]Department of Human Development and Family Studies, Utah State University, Logan, Utah, USA.
[2]Alzheimer's Disease and Dementia Research Center, Utah State University, Logan, Utah, USA.

*Address correspondence to: Elizabeth Fauth, PhD. E-mail: beth.fauth@usu.edu.
†M. Dokos and R. Schultz contributed equally as first authors.

Decision Editor: Steven M. Albert, PhD, MS, FGSA

Abstract

Background and Objectives: Many persons with Alzheimer's disease or related dementias (ADRD) receive care from paid staff in residential communities. The most common staff in these communities are certified nursing assistants (CNAs). Although CNAs have a high number of interactions with residents, and thus the possibility of engaging in social interactions, evidence suggests that they provide limited social support to persons with ADRD. Little is known about the attitudes of CNAs toward providing social support to persons with ADRD and their perception of components of quality social interactions with these individuals.

Research Design and Methods: We conducted a thematic analysis of semistructured interviews with 11 CNAs (91% female participants, mean age 23.6) to understand their perceptions about providing social support to persons with ADRD and the components of effective social interactions.

Results: Our results show that CNAs consider providing social support to be an important part of their role as CNAs. Additionally, participants emphasized the interplay of verbal communication, nonverbal communication, and internal beliefs and attitudes toward persons with ADRD in creating effective social interactions. Participants highlighted multiple barriers to providing residents with social support, including lack of time, lack of training, and the behavioral and psychological symptoms of dementia.

Discussion and Implications: We offer implications for expanding training for CNAs working with persons with dementia and improving policy based on our results.

> **Translational Significance:** Improving the quality of life for persons with dementia in residential care communities requires opportunities for social interactions. Certified nurse's assistants (CNAs) can provide needed social support, but there are multiple barriers to doing so. Based on semistructured qualitative interviews, CNAs consider providing social support to be an important part of their role. Effective social interactions require a combination of attitudes and beliefs about persons with dementia and verbal and nonverbal skills. Lack of time for training remains significant barrier. Increasing CNAs dementia-specific training, targeting attitudes, person-centered care, and confidence, could improve interactions and residents' quality of life.

In the United States, there are an estimated 6.5 million individuals currently experiencing Alzheimer's disease or related dementia (ADRD; Alzheimer's Association, 2022). As the population ages, this number will increase, with an estimated 12.7 million individuals experiencing ADRD in 2050. Although most persons with ADRD are cared for by unpaid informal caregivers (spouses, adult children, etc.), a significant minority are cared for by paid caregivers, either at home or in residential communities (Alzheimer's Disease International, 2018). In residential care, certified nursing assistants (CNAs) are the most common direct care providers, resulting in their providing most of the care for persons with ADRD (Willemse et al., 2015).

Because CNAs have the greatest opportunity for interactions with persons with ADRD in these settings, they are situated to provide residents with crucial social support, which could enhance the residents' well-being (Leung et al., 2015). However, multiple constraints combine to deincentivize effective social interactions between CNAs and persons with ADRD. The purpose of this exploratory qualitative study is to investigate to what extent dementia-care CNA staff consider social support to be part of their professional duties, the forms of verbal and nonverbal communication that they feel are effective with residents, which attitudes and beliefs seem to encourage CNAs to provide support, and barriers to offering social support.

Background and Objectives

Persons With ADRD

Alzheimer's disease and related dementias are a family of neurocognitive conditions that impair individuals' memory, executive function, language skills, and social cognition (Alzheimer's Association, 2022). Although different forms of dementia begin in different areas of the brain and are initiated via different pathological mechanisms, as dementia progresses, it gradually leads to highly impaired functioning and necessitates caregiving, either by paid caregivers or informal family caregivers.

Dementias are currently incurable with pharmacological means; thus, intervention resources are primarily devoted to improving the quality of life of those living with ADRD (Kishita et al., 2020). Quality of life is the multidimensional perception of one's life, covering social, psychological, and physical aspects of overall well-being (Brod et al., 1999). Components of quality of life for persons with ADRD include positive mood, engagement in pleasant activities, social support, and ability to perform activities of daily living (ADLs; Afunugo & Samper-Ternent, 2019; Kishita et al., 2020). Although each of these components contributes to the quality of life, residents in nursing homes have a limited ability to perform ADLs and are less able to engage in the pleasant activities they enjoyed prior to dementia and/or moving into residential care. Therefore, social support and positive mood are paramount contributors to the quality of life in facility-dwelling persons with ADRD.

Social Support

Social support is defined as the perceived availability and reception of resources, including emotional, instrumental, informational, companionate, or esteem support, from either a formal or informal helping relationship (Gottlieb & Bergen, 2010). Social support is a key determinant of quality of life and well-being in humans throughout the life span (Hajek et al., 2017; Kolanowski et al., 2012). Recent longitudinal research using data from the Health and Retirement Study shows that social support (both the number and quality of interactions) is a significant predictor of quality of life for persons with ADRD (Afunugo & Samper-Ternent, 2019). Relatedly, person-centered care, which necessitates personal interaction, is associated with improved quality of life for persons with ADRD in long-term care communities (Chenoweth et al., 2019).

To maintain quality of life, residents require attention, belonging, and human touch. According to a study conducted by Beerens et al. (2018), persons with dementia who were actively engaged in an interaction or activity showed positive affect 96% of the time, compared with showing neutral affect 82.6% of the time when not actively engaged. A similar study by Fauth et al. (2020) found that when staff engaged residents in positive interaction, residents displayed positive affect 81% of the time, compared with 36% of the time during neutral or no interactions. Although language and communication with others are impaired as the disease progresses, there is evidence that those with late-stage dementia can perceive and benefit from the interaction, even after the loss of language ability (Clare, 2010).

Additionally, research has shown that persons with dementia who have close personal relationships with their family caregivers show slower cognitive decline and also exhibit fewer challenging behavioral symptoms (Norton et

al., 2009). Longitudinal research suggests that residents who have fewer interactions with their family members or other residents and who rarely participate in activities exhibit more Behavioral and Psychological Symptoms of Dementia (BPSD; Arai et al., 2021). Although these studies did not directly involve paid caregivers, they suggest that meaningful social support can reduce the incidence of BPSD in persons with ADRD.

CNAs as Providers of Social Support

Certified nursing assistants (CNAs) and other direct care providers in nursing homes and assisted living communities provide most of the hands-on care for residents, affording them approximately 4.1 hr/day interacting with residents (Harrington et al., 2018). Although this is a substantial amount of time, most of this care occurs in the form of brief check-ins as the CNA assists residents with ADLs, administers treatments, and performs housekeeping tasks (Machiels et al., 2017; McGilton, 2004). According to Ward et al. (2008), residents spend most of their days by themselves without social interaction. In their systematic review, Anderson et al. (2016) found that CNAs' ability to interact with residents with dementia may be predictive of resident mood, a key component of quality of life (Kishita et al., 2020). Interpersonal factors, such as empathy, focus on person-centered care, and flexibility in care tasks were associated with slowed functional declines and better intake of food among people with ADRD (Anderson, et al., 2016). Relatedly, observational research during feeding identified that behavioral symptoms (aberrant vocalizations, resisting care, etc.) were more likely to occur following task-centered interactions with staff, such as when staff was being physically or verbally controlling or ignoring during care provision, versus when staff used person-centered interactions, including affectionate touch, assessing their comfort, showing interest, and more (Gilmore-Bykovskyi et al., 2015).

Effective Social Interaction Between CNAs and Persons With ADRD

Effective social interactions with persons with ADRD involve a combination of verbal and nonverbal communication (Dijkstra et al., 2013). Nonverbal communication in care includes artifacts (the presence of physical objects), chronemics (use of time), haptics (use of touch), kinesics (movement of the body), physical appearance (e.g., clothing), proxemics (use of space and distance), vocalics (aspects of the voice, like tone), and silence (Wanko Keutchafo et al., 2020). Although both verbal and nonverbal communication is important in effective social interactions, most information people share with others is given through nonverbal communication (Kozlowska & Doboszynska, 2012). For this reason, nonverbal communication is perceived as more important to patient satisfaction than verbal communication (Dijkstra et al., 2013; Timmerman et al., 2017).

Barriers to Social Interaction

There are a number of structural and personal barriers to CNAs providing social support to persons with ADRD. At the personal level, the ability of the person with ADRD to communicate may be severely hindered by the disease. Additionally, the BPSD may make staff uncomfortable engaging the person with ADRD. As the disease progresses, communication necessarily becomes increasingly one sided, rather than reciprocal.

This can feel awkward and increase ambiguity, leading CNAs to limit initiating interactions. This can be problematic because it can lead to an increase in nonconsensual care and subsequent increases in BPSD (Morris et al., 2022).

Staffing ratios constitute one of the most significant structural barriers to CNAs offering social support (Bowlbis, 2022; Koren, 2010). Although the Center for Medicare and Medicaid Services (CMS) offers clear guidelines for the number and hours of registered nurses and licensed nurses, it requires only that a "sufficient" number of CNAs are present to meet residents' needs (Center for Medicare Advocacy, 2014). In practice, this can lead to too few CNAs providing care for too many residents, limiting CNAs' ability to build relationships or provide social support (Squires et al., 2015). Recent research suggests that very few nursing homes maintain sufficient nursing staff (Bowlbis, 2022).

Another barrier to CNAs providing social support is limited training on how to interact with persons with ADRD (Alzheimer's Association, 2014). This is unfortunate because various studies have provided evidence that dementia-specific training improves the quality of care provided by CNAs (Chenoweth et al., 2009; Gkioka et al., 2020; McGilton et al., 2003; Spector, et al., 2016). Additionally, dementia training is associated with less stress for CNAs from providing care for persons with dementia (Islam et al., 2017).

Purpose of the Present Study

Although CNAs are in a position to provide meaningful social support to persons with ADRD, there are also significant barriers to providing this support. The purpose of this study was to address the following research questions: (1) To what extent do CNA staff members consider providing social support to residents with dementia part of their professional duties? (2) What forms of verbal and nonverbal communication do CNAs consider necessary in quality interactions with residents with dementia? (3) What attitudes and beliefs do CNAs report as facilitating effective social interactions? (4) What barriers do CNAs report that may hinder their ability to provide quality social support?

Research Design and Methods

To address our research questions, we used thematic analysis (Braun & Clarke, 2006) of semistructured interviews with 11 CNAs. We note that Braun and Clarke have added more nuanced descriptions to their thematic analytic processes since this 2006 publication, culminating in a more detailed description of *reflexive* thematic analyses in their textbook (Braun & Clarke, 2021). Our data were collected prior to the COVID-19 pandemic, thus we did not yet have access to this resource. In sum, our process more closely follows the 2006 procedures, justifying why we call this "thematic analysis," and not "reflexive thematic analysis." We do include a reflexive statement, however.

Participant Recruitment

Following Institutional Review Board (IRB) approval at a large mid-western university in the United States (IRB #10027), we gathered a purposive sample of participants who met the following criteria: current CNAs, work with persons with ADRD, work during the day (as those who worked nights would not have sufficient opportunities for social interactions with residents), and fluent in English.

Participants were recruited by solicitation of local skilled nursing and assisted living communities where residents with ADRD reside. With approval from the administration, two research team members attended staff meetings and described the study opportunity to the CNAs. In addition, flyers with study information were posted in the break rooms and near time clocks. One facility that did not allow team members to attend staff meetings sent information about the study in an email to all CNA staff members. Participants were interviewed during nonwork hours in their place of preference (e.g., a university office or study room in the library).

Sample

The final sample included 11 CNAs from three care communities and one home health and hospice service. All of the communities had a memory care unit, but only some of the participants worked exclusively in the memory care unit. The other CNAs worked with residents who had ADRD in the general unit. Ten CNA participants were female participants (91%) and one participant was male (9%). Participants' average age was 23.6 years, with length of time worked as a CNA ranging from less than 1 year (five participants) to 1–3 years (five participants) and over 3 years (one participant). Ten participants were non-Hispanic White and one was Latino or Hispanic. Six participants had attended some college, four had an associate's degree, and one had a graduate degree (see Table 1 for sample demographics). To protect confidentiality, we assigned pseudonyms to all participants and use these pseudonyms when making direct quotes.

Data Collection

We conducted 30- to 45-min semistructured, in-person interviews focused on perceptions of the importance of social support, verbal and nonverbal behaviors that contribute to effective social interactions, and barriers to providing social support. To establish standardization and consistency across interviews, two team members were present for eight of the interviews. Once both interviewers were confident they could maintain that consistency in interviews alone, we utilized only

Table 1. Participant Demographics

Variable	Mean (SD)	N (%)
Age	23.6 (6.81)	
Gender		
Female		10 (90.9)
Male		1 (9.1)
Ethnicity		
White		10 (90.9)
Latino or Hispanic		1 (9.1)
Education		
Some college		6 (54.5)
Associate's degree		4 (36.4)
Graduate degree		1 (9.1)
Time as certified nursing assistant		
Less than 1 year		5 (45.5)
One to 3 years		5 (45.5)
More than 3 years		1 (9.1)

Note: SD = standard deviation.

one team member for the final three interviews. Interviews began with general questions and then included follow-up prompts based on participant responses and a review of the literature. An example interview question was, "Think about the times that you think you have had a high-quality social interaction with a resident with dementia, or you saw another CNA interacting really well with a resident with dementia. What verbal behaviors, like the ways that you or they were talking to the resident, made this most effective?" Follow-up prompts examined volume, tone, language, and other behaviors. Interviews were recorded and transcribed verbatim with the assistance of Otter.ai.

Data Analysis

Using techniques from thematic analysis (Braun & Clarke, 2006), we used in vivo and values coding to develop initial codes. In vivo codes allowed us to stay close to participants' language and ensure that all themes were based on participants' actual descriptions. Values coding allowed us to characterize descriptions of similar behaviors into different themes based on the attitude or intention with which they were done (Saldaña, 2016). For example, two participants who emphasized the importance of playing into residents' realities articulated different reasons for doing so, despite using the same phrase. Although one participant emphasized "going along" with residents to avoid causing them distress and confusion, another emphasized "going along" with residents because it was easier to get things done that way than argue with them. In this example, the intention of the phrase is essential to consider in coding.

For initial coding, two coders independently coded each transcript. As coding continued, the coders then discussed their reasoning for the codes they assigned in regular team meetings. Based on discussion and in-depth analysis, we developed themes to capture the emerging analysis. There were minor differences in opinion that were brought up in initial coding. As the research team engaged in an iterative discussion, they came to a consensus about the meaning of different quotes, with each coder having an equal say. A third coder with experience in qualitative analysis but no background in the content area then coded all transcripts. Following this coding, the codes and themes were revised to again achieve consistency across the three coders. Our results consist of the themes agreed upon by all three coders.

Reflexivity

Reflexivity is the practice of reflexively considering the influence of the researcher on the research at each stage of the analysis. To facilitate this, we reflected regularly on how previous experiences and identities influenced study conceptualization, data collection, and analysis. Three of the authors have previous experiences in residential care communities and one does not. Team meetings provided us an opportunity to reflect on how our experiences were shaping our analysis and to ensure that all conclusions were based on participant responses.

Trustworthiness

We engaged in multiple strategies to promote the trustworthiness of our analysis. First, we used a research team and regular team discussions to ensure that our emerging analysis accurately represented our participants' responses. These team meetings allowed us ample opportunity to discuss our interpretations and to back up our conclusions with multiple pieces of data. Second, our incorporation of a third coder with extensive experience in qualitative research and no prior experience in the content area allowed us to check our biases and ensure that we were conducting a rigorous qualitative analysis. Third, we engaged in regular reflexivity practices and considered how prior experiences with dementia caregiving influenced our analysis.

Results

RQ1: Importance of Social Support and CNAs' Role in Providing It

Our participants all endorsed social support as an important component of their role as CNAs. Participants explained that assisting residents with ADLs afforded them the opportunity to have regular one-on-one conversations if the residents desired to do so.

Connie (age 22, CNA for 28 months) explained:

The biggest person I think [social support] lands on is the CNA. I'm the one that's in their room 10 to 30 times a day … Their family isn't in there every day, the nurse isn't in there all the time … as a CNA, I'm the one that spends the most time with them.

Certified nursing assistants (CNAs) discussed multiple experiences when these social interactions felt meaningful and others when residents did not respond favorably, which added significant complexity to their efforts to facilitate positive social interactions.

Liz (age 22, CNA for 12 months), remarked that on the one hand, "it just feels like I'm serving all day long, which is really, really nice, even though it's really, really hard sometimes." At the same time, she explained that trying to have meaningful interactions with residents was "difficult because there's different levels [of cognitive impairment]. So some people are really, really confused, and other people are like pretty with it still." She reported that struggling to adapt her interactions to meet the needs of individuals in both groups was "hard, because you see, it's just not as rewarding because you don't know exactly what to do."

Although participants reported that CNAs bore primary responsibility for providing social support to residents, they also expressed the need for other staff and family members to contribute to meeting each residents' needs. Ann (age 18, CNA for 15 months) reported the need for a "good balance between the caregivers and the family and the nurses … because not one person should have to do it all … Each staff or the family can provide a different kind of support."

RQ2: Effective Social Interactions

Based on participant responses, we divide effective social interaction into three themes: verbal communication, nonverbal communication, and learning by personal experience.

Verbal communication

Meaningful verbal communication included the words CNAs used and the tone, volume, and speed with which they said them. Many CNAs reported that making adjustments in their word choice to match the cognitive level of the resident helped improve the quality of their interactions and lessened feelings of confusion. Violet (age 21, CNA for 12 months) stated, "You have to use simpler language. You can't use a

huge vocabulary because it might seem confusing. They'll sometimes understand that, but you just have to be very concise and you can't use big sentences." Participants also clarified that simplifying language was a sign of respect, not a way to "talk down" to residents.

Participants described an appropriate tone as being "friendly," "sweet," "comforting," and "warm." Ann (age 18, CNA for 15 months), explained that she adjusted her volume depending on residents' hearing, but always tried to use a calm tone. She stated, "When you talk to somebody with dementia, you try to use a very, like calm [tone] … [otherwise,] they will get aggravated so fast." Violet (age 21, CNA for 12 months) said, "You just have to have a very comforting tone while you're talking to them … You're being very friendly, and the friendlier you are, the more that they're willing to talk back."

Some participants reported altering their speed of communication with residents depending on the residents' needs. Rachel (age 19, CNA for 6 months), reported talking softer, slower, and calmer to a resident at bedtime. She explained,

> When I put her to bed, I make sure she goes to the bathroom, I see to all [her] needs, tell her [**spoken softly and slowly**], 'It's going to be warm in [your] room, the sun will come in tomorrow, everything will be good.' And I think that when you put them to bed in that sort of way then they're like relaxed and it's okay.

Nonverbal communication

In addition to verbal communication, participants described the importance of eye contact and touch in communicating respect and establishing trust with residents. Abby (age 22, CNA for 22 months) emphasized that eye contact was particularly important. She explained:

> Eye contact is very important to both establish trust and to demonstrate that you are truly listening to a person. I think it just shows respect and people appreciate being respected. And then people are more likely to cooperate with those with whom they have established a relationship of mutual respect.

Every participant identified appropriate physical touch as important to quality social interactions. They reported needing to gauge the individual preference of each resident and respond accordingly. Violet (age 21, CNA for 12 months) reported:

> There are residents I work with they love hugging and so when I greet them, I'll go up and give them a hug and then they just, like, light up, and they're so happy. The ones that are little more reserved, I'll just touch their arm and that just kind of gets their attention and warms them up to it [touch]. It depends on the resident.

Learning by personal experience

Whether participants reported minimal or significant amounts of dementia-specific training, they reported having to learn how to interact with residents from their own experience. This required a willingness to try different strategies and to observe the outcomes on an individual basis. Ann (age

18, CNA for 15 months) described her continual process of learning, explaining:

> You're always learning how to talk to them, keywords to say, ways to phrase things. And it's different for all of the residents. There's not like a one way that works for all … a lot of [helping residents with] Alzheimer's and dementia is just as you go, figuring out what happens and what works for that resident.

Central to the learning process was a willingness to make mistakes and to adjust over the course of repeated interactions with residents. Liz (age 22, CNA for 12 months) described, "You just kind of have to learn what different personalities like and work with it. You just have to make some mistakes sometimes because you don't know what the outcome will be … It changes for each person." Similarly, participants emphasized that they needed to be able to move forward after difficult social interactions, rather than hyper-focusing on them and allowing them to interfere with subsequent social interactions.

As participants actively engaged in the process of learning to interact effectively, they reported enjoying their interactions with residents, especially as they genuinely sought to know and understand them. Shawna (age 22, CNA for 5 months) explained: "We're supposed to interact with the residents; we're supposed to entertain them and keep them busy … That's maybe the part of my job that I like most: just learning about people, being able to interact with them."

RQ3: Attitudes and Beliefs that Facilitate Social Support

In addition to verbal and nonverbal communication, participants reported that their attitudes and beliefs about persons with dementia were key to effective interactions. Participants described valuing personhood, getting on the residents' level, and being a friend as facilitating quality interactions by changing the way they viewed residents.

Valuing personhood

Participants emphasized that the heart of effective interactions was seeing the person with dementia as a full person. One way this manifested was in encouraging as much independence as was appropriate and safe, typically by giving residents choices. Connie (age 22, CNA for 28 months) explained that a resident is more likely to refuse when they are told they "have to do something," such as take a shower. Instead, she tries to ask, "Is it alright if I help you get out of your shirt? This one is dirty and I want you to look nice." Offering residents choices gave them some freedom to exercise self-determination.

Relatedly, participants reported that it was necessary to not allow residents' memory loss or BPSD to serve as excuses for not treating them as a person. Ann (age 18, CNA for 15 months) explained that it was important to try to gain residents' trust over and over again, even when they forgot who she was. She stated:

> You're their caregiver, and so you're supposed to help them feel safe and happy. And when you succeed at that, and when they are safe and happy … they do trust you even though they can't remember your name or remember that you were there yesterday … it's very rewarding.

Getting on the person with Dementia's level

Multiple participants referenced the importance of adjusting to the cognitive capabilities and perceptions of the reality of residents. One participant explained that when she asks residents about their day, they often talk about their day at work rather than at the facility. Rather than correcting them, she asks questions about their employment and seeks to build rapport with them. Similarly, Abby (age 22, CNA for 22 months) explained that going along with the reality of the residents with dementia tended to prevent agitation and promote well-being. She stated, "You can try to correct them and be like, 'No, that's wrong. It's not 1950. Your husband is dead.'" However, she explained: "It's better to not contradict them … Instead, be like, 'Okay, yeah' and kind of try to redirect it to something else."

Being a friend

Multiple participants referenced the idea that part of their role was to be a friend to the residents and to make them feel noticed and appreciated, despite their deteriorating cognitive capabilities. Common words used to describe this were "friendly," "nice," "upbeat," and "bubbly." Participants emphasized that treating residents as friends could take many forms, including asking them questions that they could answer and taking extra time to help them feel cared for. Alex (35, CNA for 6 months) explained that he likes to "touch their arm or some kind of physical contact that lets them know that I'm there. I'm their friend. I care about them." Another participant explained that "After showers, I'll be like, 'Hey, do you want to use like the scented lotion?' Instead of just like drying them off and getting them ready to go … I think it just makes them feel more like [a] person."

RQ4: Barriers to Effective Social Interactions

Participants identified lack of time, BPSD, and lack of training as significantly impeding their ability to effectively provide social support to residents with dementia.

Lack of time

Participants reported that, although getting to know residents was one of the most rewarding parts of their work, the primary barrier to doing so was lack of time. Because of this lack of time, participants reported primarily talking with residents while assisting them with ADLs, which partially inhibited effective social interactions. Violet (female participants, aged 21), explained, "I'm still able to get to know people while I'm giving them care, I'm just not able to have as good of conversations when it's a little more distracted."

Additionally, participants reported trying to engage multiple residents at the same time in order to maximize impact of their time. However, they reported that it was difficult to engage residents with different interests, personalities, and cognitive abilities in the same interaction. Shawna (female participants, aged 22) explained: "You might be helping one person and trying to help another and they realize that they're not getting your full attention … They start to get a little bit angry when that happens."

Behavioral and psychological symptoms of dementia

Multiple participants reported that a significant barrier to providing social support was the extent to which the residents exhibited BPSD. Many participants described feeling that they simply did not know how to offer social support to residents with dementia when they were exhibiting significant BPSD. Abby (age 22, CNA for 22 months) reflected: "I've had a couple times where I have dementia patients who don't really speak that much, or just like, won't communicate with me. I didn't really know how to deal with that."

Liz (age 22, CNA for 12 months) stated:

> There are some people who react very strongly or abruptly to anything … I'll just want to come and keep them company. But because [of the BPSD], maybe they don't want me there. They don't know why I'm there. They just react negatively to that.

Although participants understood that the BPSD were markers of the disease, not signs of residents' resistance, some CNAs expressed frustration that residents were not more cooperative.

Alex explained that "Sometimes it doesn't do any good, like there's nothing you can say, to get them to cooperate." He described a repeated situation of trying to change a woman's soiled brief where she reacted defensively. He reflected:

> I've tried so many different ways of trying to put her at ease or get her to just cooperate … we try to convince her, you know, 'We're your friends, we're here to help you.' But now, it's kind of gotten to the point where we just, we just do it, because nothing we say really helps.

Lack of training

Multiple participants identified a lack of dementia-specific training as impeding their ability to provide meaningful social support to residents. One way this manifested was in being emotionally unprepared for the difficulties of trying to provide care for persons with dementia. Rachel (age 19, CNA for 6 months) stated: "I guess I didn't realize how hard it can be really. When I was training in CNA class I [thought I] understood … but I guess I didn't realize what it would be like really in person."

Certified nursing assistants (CNAs) reported that their training was primarily focused on how to complete ADL tasks, not specific to caring for persons with ADRD or how to provide them with social support. This lack of dementia-specific training resulted in CNAs attempting to learn from trial and error and direct observation, both of which required significant time and effort. Alex (age 35, CNA for 6 months), reflected on his experiences first working on the Alzheimer's wing at his facility. He explained:

> [I felt] pretty unprepared for how to deal with residents who … don't want to eat, and yet you still are required to provide those services for them. And so it, I felt really awkward … it took me a while to sort of see how the other CNAs handled things and kind of adapted to it.

Discussion and Implications

We used semistructured qualitative interviews with 11 CNAs to understand perceptions of the importance of providing social support to persons with dementia, components of effective social interactions, and barriers to providing social

support. The study demonstrates that CNAs included in this study valued providing social interactions to residents with ADRD and considered doing so a vital component of their role. Notably, CNAs in the study understood that socializing validated the personhood of the person with dementia. A second benefit of social interactions with residents was that it made it more likely that residents would cooperate with staff members during care. These findings highlight the importance of person-centered care and confirm that providing person-centered care to persons with ADRD requires social interaction (Chenoweth et al., 2019).

Effective Social Interaction

CNAs in this study reported that engaging in effective social interactions with residents required altering their verbal and nonverbal communication patterns. Although participants reported verbal communication as important, they emphasized nonverbal communication as being equally important. Other research similarly suggests that nonverbal communication is particularly important in health care settings (Dijkstra et al., 2013; Timmerman et al., 2017). In particular, therapeutic touch can be helpful for persons with dementia, although further research is needed in this area (Senderovich et al., 2022). The components of nonverbal communication that our participants referenced as important are similar to those identified in other research focused on patients in the terminal phase (Kozlowska & Doboszynska, 2012) or in hospital settings (Gkioka et al., 2020).

In addition to verbal and nonverbal communication, participants repeatedly emphasized the importance of holding to internal beliefs and attitudes about persons with ADRD such as valuing personhood, getting on the residents' level, and being a friend. These beliefs are foundational to providing person-centered care (Chenoweth et al., 2019; Koren, 2010). Person-centered care highlights the value of recognizing each person for who they are, rather than focusing on their physical or cognitive diseases. Acknowledging "personhood" leads care providers to offer individual focus to each person and to provide them with decision-making opportunities insofar as possible.

Participants emphasized that providing consistently high-quality social support required teamwork among various staff members. If all staff members who have regular contact with residents with ADRD are all contributing to the emotional and social needs of the residents, this increases the likelihood of residents having their needs met. This suggests that in addition to providing skills training, it is imperative that CNAs and other nursing home staff receive training on person-centered care to alter the culture of care. Although not directly referenced in our sample (perhaps due to a selection effect), it is likely that personal biases toward persons with dementia may inhibit some staff members from providing social support to persons with dementia. For example, if staff were to have a bias that all persons with dementia are resistant to making relationships, or incapable of understanding language, social interactions would be less utilized or of lower quality. It is also possible that care facilities may have cultures that systematically inhibit quality care for persons with dementia due to a deficit-oriented approach rather than a person-centered, strengths-based approach. Accurate information and education about the capabilities and needs of persons with dementia are important steps in helping to address these biases and promote quality care.

Improving Social Interactions

Valuing social interactions is important, as is improving and increasing them. Participants noted significant time constraints in being able to interact with residents as much as they would like. Prior research has also supported that CNAs and other staff may be focused on care tasks and miss opportunities to engage in positive interaction with residents with dementia (Fauth et al., 2020; Machiels et al., 2017; Ward et al., 2008). Although negative or controlling interactions are more clearly understood as inappropriate during care, "no interactions" may be problematic. Ignoring residents is not purely benign, in that it is both not person-centered (Gilmore-Bykovskyi et al., 2015; Lann-Wolcott et al., 2011); and it suggests that the residents may have unmet needs, including social needs (Fauth et al., 2020). In sum, increasing the number of positive social interactions is important, given their highly positive impact on residents' quality of life (Afunugo & Samper-Ternent, 2019; Beerens et al., 2018).

Barriers and Policies

Consistent with other research, participants identified multiple barriers to providing social support, including lack of time, lack of training, and the BPSD. Although staffing shortages may preclude CNAs from getting more time with residents (which would be ideal), care communities may want to include more dementia training opportunities when onboarding a new employee, and/or as regular booster training at staff meetings. Multiple participants reported that the training they received was insufficient to allow them to provide quality social support for persons with dementia and that they had to learn how to interact effectively through a process of trial and error and observing coworkers. Although some experimentation is inherent in providing person-centered care, evidence suggests that additional training could improve the quality of interactions that CNAs are able to facilitate with persons with ADRD (Chenoweth et al., 2009; Gkioka et al., 2020; McGilton et al., 2003; Spector, et al., 2016). It is worth noting that persons with dementia receiving care may be exposed to poorer care or poorer responses during the CNA's experimentation or learning process, suggesting that while experiential learning is necessary, training could potentially reduce negative consequences for care recipients. Additionally, training may improve the delivery of nonconsensual care, thus reducing BPSD (Morris et al., 2022). Training are available for free from State Health departments and/or the Alzheimer's Association and via further certifications, such as the Certified Dementia Practitioner training program through the National Council of Certified Dementia Practitioners.

Limitations

Our study design used in-depth semistructured interviews to examine CNAs attitudes and actions around providing social support for persons with dementia. At the same time, there were significant limitations, including the relatively homogenous sample of young, native-English-speaking, early-career CNAs. Future research should recruit participants from different geographic areas, age groups, and ethnic groups to examine similarities and differences. Except for one participant, the CNAs in this study had a fairly short amount of time in the role. Although CNAs in nursing homes have a well-documented high turnover rate (Gandhi et al., 2021), it is possible that responses would be different for people who are career CNAs. Additionally, participants self-selected to be

part of this study, which may be indicative of certain biases of our sample; perhaps this group has higher levels of commitment to providing social support, or to their role as a whole, than typical CNAs. Thus, results should be interpreted in light of this possible selection bias; results may not be generalizable across all CNA's.

An additional limitation of the study is that we utilized thematic analytic procedures described in 2006. Our study was planned and data were collected prior to the COVID-19 pandemic. Since our study started, Braun & Clarke (2021) have provided additional detail on *reflexive* thematic analyses. We appreciate the refinements made to the original approach, and we recommend that future explorations use the most up-to-date reflexive approach.

Conclusion and Implications

In this study, we examined CNAs reports of the importance of providing social support to persons with ADRD, components of effective social interactions, and barriers to providing social support. Insufficient training in social care, despite having been taught "about dementia," remains a problem, and although the benefits of training are documented, the presence of dementia modules is not enough. These trainings can be adapted to include even brief sections on handling social issues in dementia, and training can seek to increase positive attitudes and confidence in working with this population, in addition to dementia knowledge (Parveen et al., 2021). Our study was not just about barriers to providing social care, however. The main contribution of our study is that CNAs are willing to engage with their clients with dementia. With experience and observations of other staff, they were able to identify that residents need to be treated individually, with modifications to touch and speech for each person, and they established person-centered approaches in engaging with their residents socially. They endorse that social interactions are part of their job, thus fostering these behaviors may be facilitated, as this already falls within their existing schemas.

Funding

Conflict of Interests

None.

Acknowledgments

References

Afunugo, W. E., & Samper-Ternent, R. (2019). The effect of social support on quality of life of persons with cognitive impairment. *Innovation in Aging*, 3(Suppl_1), S906–S906. doi:10.1093/geroni/igz038.3308

Alzheimer's Association. (2014). 2014 Alzheimer's disease facts and figures. *Alzheimer's and Dementia*, 10(2), 6–11. doi:10.1016/j.jalz.2014.02.001

Alzheimer's Association. (2022). 2022 Alzheimer's disease facts and figures. *Alzheimer's and Dementia*, 18(3), 700–789. doi:10.1002/alz.12638

Alzheimer's Disease International. (2018). *Global estimates of informal care*. https://www.alz.co.uk/adi/pdf/global-estimates-of-informal-care.pdf.

Anderson, K., Bird, M., MacPherson, S., & Blair, A. (2016). How do staff influence the quality of long-term dementia care and the lives of residents? A systematic review of the evidence. *International Psychogeriatrics*, 28(8), 1263–1281. https://doii.org/10.1017/S1041610216000570. doi:10.1017/S1041610216000570

Arai, A., Khaltar, A., Ozaki, T., & Katsumata, Y. (2021). Influence of social interaction on behavioral and psychological symptoms of dementia over 1 year among long-term care facility residents. *Geriatric Nursing*, 42(2), 509–516. doi:10.1016/j.gerinurse.2020.09.008

Beerens, H. C., Zwakhalen, S. M. G., Verbeek, H., Tan, F. E. S., Jolani, S., Downs, M., de Boer, B., Ruwaard, D., & Hamers, J. P. H. (2018). The relation between mood, activity, and interaction in long-term dementia care. *Aging & Mental Health*, 22(1), 26–32. doi:10.1080/13607863.2016.1227766

Bowblis, J. R. (2022). The need for an economically feasible nursing home staffing regulation: Evaluating an acuity-based nursing staff benchmark. *Innovation in Aging*, 6(4), 1–11. doi:10.1093/geroni/igac017

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide*. Sage.

Brod, M., Stewart, A. L., Sands, L., & Walton, P. (1999). Conceptualization and measurement of quality of life in dementia: The dementia quality of life instrument (DQoL). *Gerontologist*, 39(1), 25–35. doi:10.1093/geront/39.1.25

Center for Medicare Advocacy. (2014). *Deficiencies in nursing facilities: Rarely cited, seldom sanctioned*. https://medicareadvocacy.org/staffing-deficiencies-in-nursing-facilities-rarely-cited-seldom-sanctioned/

Chenoweth, L., King, M. T., Jeon, Y.-H., Brodaty, H., Stein-Parbury, J., Norman, R., Haas, M., & Luscombe, G. (2009). Caring for aged Dementia Care Resident Study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: A cluster-randomised trial. *Lancet: Neurology*, 8(4), 317–325. doi:10.1016/S1474-4422(09)70045-6

Chenoweth, L., Stein-Parbury, J., Lapkin, S., Wang, A., Liu, Z., & Williams, A. (2019). Effects of person-centered care at the organisational-level for people with dementia: A systematic review. *PLoS One*, 14(2), e0212686. doi:10.1371/journal.pone.0212686

Clare, L. (2010). Awareness in people with severe dementia: Review and integration. *Aging & Mental Health*, 14(1), 20–32. doi:10.1080/13607860903421029

Dijkstra, H., Albada, A., Klöckner Cronauer, C., Ausems, M. G. E. M., & van Dulmen, S. (2013). Nonverbal communication and conversational contribution in breast cancer genetic counseling: Are counselors' nonverbal communication and conversational contribution associated with counselees' satisfaction, needs fulfillment and state anxiety in breast cancer genetic counseling? *Patient Education and Counseling*, 93(2), 216–223. doi:10.1016/j.pec.2013.05.014

Fauth, E. B., Meyer, K. V., & Rose, C. (2020). Co-occurrence of positive staff interactions and positive affect in memory-care residents: An observational study. *International Journal of Geriatric Psychiatry*, 35(7), 759–768. doi:10.1002/gps.5299

Gandhi, A., Yu, H., & Grabowski, D. C. (2021). High nursing staff turnover in nursing homes offers important quality information. *Health Affairs*, 40(3), 384–391. doi:10.1377/hlthaff.2020.00957

Gilmore-Bykovskyi, A. L., Roberts, T. J., Bowers, B. J., & Brown, R. L. (2015). Caregiver person-centeredness and behavioral symptoms in nursing home residents with dementia: A timed-event sequential analysis. *Gerontologist*, 55, S61–S66. doi:10.1093/geront/gnu164

Gkioka, M., Schneider, J., Kruse, A., Tsolaki, M., Moraitou, D., & Te-ichmann, B. (2020). Evaluation and effectiveness of dementia staff training programs in general hospital settings: A narrative synthesis with Holton's three-level model applied. *Journal of Alzheimer's Disease*, 78(3), 1089–1108. doi:10.3233/jad-200741

Gottlieb, B. H., & Bergen, A. E. (2010). Social support concepts and measures. *Journal of Psychosomatic Research*, 69, 511–520. doi:10.1016/j.jpsychores.2009.10.001

Hajek, A., Brettschneider, C., Mallon, T., Ernst, A., Mamone, S., Wiese, B., Weyerer, S., Werle, J., Pentzek, M., Fuchs, A., Stein, J., Luck, T., Bickel, H., Weeg, D., Wagner, M., Heser, K., Maier, W., Scherer, M., Riedel-Heller, S. G., & Konig, H. H.; AgeCoDe Study Group (2017). The impact of social engagement on health-related quality of life and depressive symptoms in old age—Evidence from a multi-center prospective cohort study in Germany. *Health and Quality of Life Outcomes*, 15(1), 140. doi:10.1186/s12955-017-0715-8

Harrington, C., Carrillo, H., Garfield, R., Musumeci, M., & Squires, E. (2018). *Nursing facilities, staffing, residents and facility deficiencies, 2009 through 2016. Kaiser Family Foundation.* https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/

Islam, M. S., Baker, C., Huxley, P., Russell, I. T., & Dennis, M. S. (2017). The nature, characteristics and associations of care home staff stress and wellbeing: a national survey. *BMC Nursing*, 16, 22. doi:10.1186/s12912-017-0216-4

Kishita, N., Backhouse, T., & Mioshi, E. (2020). Nonpharmacological interventions to improve depression, anxiety, and quality of life (QoL) in people with dementia: An overview of systematic reviews. *Journal of Geriatric Psychiatry and Neurology*, 33(1), 28–41. doi:10.1177/0891988719856690

Kolanowski, A., Bossen, A., Hill, N., Guzman-Velez, E., & Litaker, M. (2012). Factors associated with sustained attention during an activity intervention in persons with dementia. *Dementia Geriatrics Cognitive Disorders*, 33(4), 233–239. doi:10.1159/000338604

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, 29(2), 312–317. doi:10.1377/hlthaff.2009.0966

Kozlowska, L., & Doboszynska, A. (2012). Nurses' nonverbal methods of communicating with patients in the terminal phase. *International Journal of Palliative Nursing*, 18(1), 40–46. doi:10.12968/ijpn.2012.18.1.40

Lann-Wolcott, H., Medvene, L. J., & Williams, K. (2011). Measuring the person-centeredness of caregivers working with nursing home residents with dementia. *Behavior Therapy*, 42, 89–99. doi:10.1016/j.beth.2010.02.005

Leung, P., Orrell, M., & Orgeta, V. (2015). Social support group interventions in people with dementia and mild cognitive impairment: A systematic review of the literature. *International Journal of Geriatric Psychiatry*, 30(1), 1–9. doi:10.1002/gps.4166

Machiels, M., Metzelthin, S. F., Hamers, J. P. H., & Zwakhalen, S. M. G. (2017). Interventions to improve communication between people with dementia and nursing staff during daily nursing care: A systematic review. *International Journal of Nursing Studies*, 66, 37–46. doi:10.1016/j.ijnurstu.2016.11.017

McGilton, K. S. (2004). Relating well to persons with dementia: A variable influencing staffing and quality of care outcomes. *Alzheimer's Care Quarterly*, 5(63), 71–80. https://journals.lww.com/actjournalonline/Abstract/2004/01000/Relating_Well_to_Persons_With_Dementia__A_Variable.12.aspx

McGilton, K. S., Obrien-Pallas, L. L., Darlington, G., Evans, M., Wynn, F., & Pringle, D. M. (2003). Effects of a relationship-enhancing program of care on outcomes. *Journal of Nursing Scholarship*, 35(2), 151–156. doi:10.1111/j.1547-5069.2003.00151.x

Morris, P., McCloskey, R., & Bulman, D. (2022). Iatrogenesis in the context of residential dementia care: A concept analysis. *Innovation in Aging*, 6(4), 1–16. doi:10.1093/geroni/igac028

Norton, M. C., Piercy, K. W., Rabins, P. V., Green, R. C., Breitner, J. C. S., Ostbye, T., Corcoran, C., Welsh-Bohmer, K. A., Lyketsos, C. G., & Tschanz, J. T. (2009). Caregiver-recipient closeness and symptom progression in Alzheimer disease: The Cache County Dementia Progression Study. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 64(5), 560–568. doi:10.1093/geronb/gbp052

Parveen, S., Smith, S. J., Sass, C., Oyebode, J. R., Capstick, A., Dennison, A., & Surr, C. A. (2021). Impact of dementia education and training on health and social care staff knowledge, attitudes and confidence: A cross-sectional study. *BMJ Open*, 11, e039939. doi:10.1136/bmjopen-2020-039939

Saldaña, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Sage.

Senderovich, H., Gardner, S., Berall, A., Shultz, R., Grant, B., & Santaguida, V. (2022). Therapeutic touch in the management of responsive behaviors in patients with dementia. *Dementia and Geriatric Cognitive Disorders*, 51, 142–149. doi:10.1159/000523752

Spector, A., Revolta, C., & Orrell, M. (2016). The impact of staff training on staff outcomes in dementia care: A systematic review. *International Journal of Geriatric Psychiatry*, 31(11), 1172–1187. doi:10.1002/gps.4488

Squires, J. E., Hoben, M., Linklater, S., Carleton, H. L., Graham, N., & Estabrooks, C. A. (2015). Job satisfaction among care aides in residential long-term care: A systematic review of contributing factors, both individual and organizational. *Nursing Research and Practice*, 157924. doi:10.1155/2015/157924

Timmermann, C., Uhrenfeldt, L., & Birkelund, R. (2017). Ethics in the communicative encounter: Seriously ill patients' experiences of health professionals' nonverbal communication. *Scandinavian Journal of Caring Sciences*, 31(1), 63–71. doi:10.1111/scs.12316

Wanko Keutchafo, E. L., Kerr, J., & Jarvis, M. A. (2020). Evidence of nonverbal communication between nurses and older adults: A scoping review. *BMC Nursing*, 19, 53. doi:10.1186/s12912-020-00443-9

Ward, R., Vass, A. A., Aggarwal, N., Garfield, C., & Cybyk, B. (2008). A different story: Exploring patterns of communication in residential dementia care. *Aging & Society*, 28, 629–651. doi:10.1017/S0144686X07006927

Willemse, B. M., Downs, M., Arnold, L., Smit, D., de Lange, J., & Pot, M. A. (2015). Staff-residents interaction in long-term care for people with dementia: The role of meeting psychological needs in achieving residents' well-being. *Aging & Mental Health*, 19(5), 444–452. doi:10.1080/13607863.2014.944088