

Scaffolding and working together: a qualitative exploration of strategies for everyday life with dementia

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Keypoints:	<ul style="list-style-type: none"> • People with dementia and their informal carers develop strategies to manage everyday life with dementia, • These strategies can be usefully described as scaffolds as families draw on a range of supports to manage everyday life, • Scaffolds to support people with dementia may be at risk of collapse due to the changing nature of dementia, • As dementia progresses life gets more difficult and scaffolds built by families need additional support from formal services, • Professionals should work collaboratively and recognise and enhance rather than replace existing scaffolds

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Manuscripts

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8 **Scaffolding and working together: a qualitative exploration of strategies**
9 **for everyday life with dementia**
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14
15 **Abstract**
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17 **Background:** Living with dementia has been described as a process of continual change and
18 adjustment, with people with dementia and their families adopting informal strategies to
19 help manage everyday life. As dementia progresses, families increasingly rely on help from
20 the wider community and formal support.
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27 **Methods:** This paper reports on a secondary analysis of qualitative data from focus groups
28 and individual interviews with people with dementia and their carers in the North of
29 England. In total 65 people with dementia and 82 family carers took part in the research: 26
30 in interviews and 121 in focus groups. Focus group and interview audio recordings were
31 transcribed verbatim. A qualitative, inductive, thematic approach was taken for data
32 analysis.
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42 **Findings:** The paper applies the metaphor of scaffolding to deepen understanding of the
43 strategies used by families. Processes of scaffolding were evident across the data where
44 families, communities, professionals and services worked together to support everyday life
45 for people with dementia. Within this broad theme of scaffolding were three sub-themes
46 characterising the experiences of families living with dementia: doing things together;
47 evolving strategies; and fragility and fear of the future.
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3 **Conclusions:** Families with dementia are resourceful but do need increasing support
4
5 (scaffolding) to continue to live as well as possible as dementia progresses. More
6
7 integrated, proactive work is required from services that, recognises existing scaffolds, and
8
9 provides appropriate support before informal strategies become unsustainable; thus
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11 enabling people with dementia to live well for longer.
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15 **Key words:** dementia, scaffolding, community, informal care, care services
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27 **Key points:**
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- People with dementia and their informal carers develop strategies to manage everyday life with dementia.
 - These strategies can be usefully described as scaffolds as families draw on a range of supports to manage everyday life.
 - As dementia progresses, life gets more difficult and scaffolds built by families need additional support from formal services.
 - Scaffolds to support people with dementia may be at risk of collapse due to the changing nature of dementia.
 - Professionals should work collaboratively with those providing informal support, and recognise and enhance rather than replace existing scaffolds.

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For Review Only

Introduction

Living with dementia is a process of continual change and adjustment. How an individual manages life with dementia will be affected by their biography and social location [1] and their coping and adaptive strategies [2,3]. People with dementia adopt active strategies to help maximise functioning [4] and maintain wellbeing [5]. For carers, adapting to life with dementia similarly involves active strategies to adjust to the caregiving role [6].

The complexities of the caring relationship, such as perceived mutuality [7] and wider relationships in the family [8], also impact on daily life with dementia. It has been shown that people with dementia and their families work together to develop strategies for dealing with the practical and social consequences of cognitive impairment [9]. People with dementia and their partners are also found to collaborate to make sense of dementia and to adapt at a practical level [10].

Managing transitions is a particularly prominent aspect of living with dementia, for instance dealing with the grief associated with admitting a partner into long-term care [11]. With the ongoing experience of transition associated with dementia, couples develop strategies and approaches for managing and living with changes throughout this journey [12].

Friendships and the wider community are significant for living with dementia. Friendships are important for maintaining social connectedness [13], wellbeing [14] and quality of life [15]. Social networks are particularly important for people with dementia where family is geographically diverse [16], however social isolation can occur due to alterations in relationships and interactions following a diagnosis of dementia [17].

People with restricted social networks are more likely to report high unmet needs [15] and therefore may need to rely upon formal services to live well with dementia. For carers, the

1
2
3 progression of dementia is often associated with increased responsibility and the need for
4
5 outside support [18]. Consequently, families may need to rely increasingly on formal
6
7 support to manage life with dementia as their condition progresses and their social
8
9 connections diminish.

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12 This paper draws on the metaphor of 'scaffolding' to illustrate the interplay between
13
14 individualised informal and formal supports in the lives of people affected by dementia.

15
16 Scaffolding has its roots in educational psychology [19] and has been used in the dementia
17
18 field to describe different ways that people with dementia may be supported without
19
20 overcompensating for difficulties. For example, scaffolding has been used to conceptualise
21
22 how people work together to achieve successful communication or interaction [20,21,22],
23
24 or to understand couples' experience of adjusting to life with dementia from a relational
25
26 perspective [23,24]. Merrick et al. identify 'flexible scaffolding' where 'care partners
27
28 adapted the level and nature of support they provided, to reflect the fluctuating abilities
29
30 and deteriorating function of the person' [24, p.43] and Schrauf and Iris identify 'domestic
31
32 scaffolding' where family caregivers work adaptively to take over tasks such as
33
34 shopping, driving or paying bills [25, p. 759]. We extend these uses of the scaffolding
35
36 metaphor to 1) illustrate the sometimes precarious relationship between— informal and
37
38 formal supports and 2) argue for the importance of working collaboratively to introduce
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40 timely, individualised formal support to extend existing scaffolds used by families and
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42 communities.
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53 **Methods**

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55 This paper presents the secondary analysis of a qualitative data set from a user engagement
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57 project funded by Cumbria County Council and NHS Cumbria (UK) to inform their regional
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dementia strategy [26]. The qualitative component of this project involved 19 interviews and 21 focus groups with 65 people with dementia and 82 carers in 2012 and 2013. Within the paper we use 'carer' to refer to people who identified themselves as the main carers for a person with dementia, and 'families' where interviewees referred to a wider family structure. Semi-structured questions focused on experiences of services and broader questions about how people lived well in their communities. The original analysis focused on the evaluation objectives: to understand the impact of services and highlight best practice and gaps in provision. The richness of data gathered in the project prompted the secondary data analysis described below.

Participants

In 2012, interviews were conducted with people with dementia (n=5) and carers (n=12) and ten focus groups with people with dementia (n=25) and carers (n=34). In 2013, interviews were conducted with carers (n=8) and one person with dementia and eight focus groups with people with dementia (n=34) and carers (n=28). A purposive sampling approach was taken to ensure a mix of genders and ages; participants were recruited from different geographical areas, with different levels of need, and with a variety of family and support structures. This approach provided a diverse range of experiences of dementia and services.

Interview participants were recruited through gatekeepers within local third sector organisations. People with dementia were offered the opportunity to be interviewed alone or with a supporter. All but one chose to include a supporter. Interviews were conducted at a place chosen by the person with dementia. Table 1. provides more information and participant codes for the interview participants.

Insert Table 1. [h](#)Here.

Existing groups provided by adult social care and third sector services were recruited for focus groups. Key gatekeepers within organisations facilitated access. Groups included peer support groups; Dementia Cafes; day care services; and singing groups. These comprised carers only, people with dementia only and mixed groups. Focus groups took place within the normal timings and locations of the groups or immediately afterwards to minimise travel. Table 2. provides more information and participant codes for the focus group participants.

Insert [Table 2.](#) here.

Ethical considerations

Informed consent was obtained from all participants. The process of consent followed Dewing's [27] ongoing consent process. This process began with familiar professionals in gatekeeping organisations establishing initial interest amongst potential participants. With permission for access, researchers arranged to meet for an interview or focus group several days later. All participants were given an information sheet and researchers ensured this had been understood by each individual before asking them to sign a consent form. All interviewers were experienced in communicating with people with dementia and carers through active listening that was sensitive and respectful to both the person and their views. Time was taken to put people at ease at the start of interviews and focus groups, and to round off the interaction and check for any adverse impact at the end. Interviewers ensured they communicated at a pace sensitive to individual abilities, monitoring both non-verbal and verbal cues that might indicate a person was uncomfortable. If any signs of discomfort or distress were evident, interviewers stopped recording and checked the person wanted to continue; no participants chose to stop participation. For participants with

1
2
3 dementia, researchers used orientating statements to remind the person they were
4
5 conducting an interview or focus group. If there was any concern about capacity during the
6
7 process, researchers stopped to check the person understood they were taking part in
8
9 research before continuing. Participants' anonymity and confidentiality were guaranteed by
10
11 utilising a cypher and removing names from the transcripts before analysis commenced.
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14
15 The study received ethical approval from the [Ethics Committee blinded for peer review]. In
16
17 addition, the project was approved by the research governance bodies within Cumbria
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19 County Council, Cumbria Partnership NHS Foundation Trust and NHS Cumbria Primary Care
20
21 Trust.
22
23

24 25 26 27 28 **Primary data collection and analysis** 29

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31 Focus groups and interviews have been used successfully with people with dementia and
32
33 their carers in previous research [28]. Interviews and focus groups were semi-structured
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35 discussions informed by a topic guide [26]. Fieldwork was conducted by a team of six
36
37 researchers, with interviews conducted by one member of the research team while two
38
39 members facilitated each focus group. Researchers brought fruit and biscuits to meetings
40
41 as a way of thanking participants and facilitating rapport [29]. Focus group and interview
42
43 audio recordings were transcribed verbatim. The primary data analysis focused on
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45 understanding the impact of services, providing examples of best practice and highlighting
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47 any gaps in provision. Findings are reported elsewhere [26].
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Secondary data analysis

A secondary analysis of the qualitative data was conducted by the same three researchers who conducted the primary analysis [30]. This analysis took a more intensive focus on people's experiences of managing everyday life. While open questions in the original topic guide had explored people's experiences of living well, the data generated from these questions had not been analysed in depth for the purposes of the evaluation. A new set of questions guided the secondary analysis to explore how people combined informal supports with formal services to live well in their communities:

- What strategies are used by people with dementia and family carers as they manage everyday life?
- How do wider communities and informal support contribute to these strategies?
- How do services and formal support contribute to these strategies?

An inductive interpretative approach was taken using thematic analysis to understand how participants represented their experiences of informal and formal supports. Thematic analysis involved looking across the data set for repeated patterns of meaning associated with this topic and coding these using NVivo8 software. Following the process set out by Braun and Clarke [2006, 31], the researchers independently read the transcripts and generated initial codes and, once all the transcripts were examined, worked together to sort the codes into themes and sub-themes to generate a thematic map of the analysis. Themes were defined and refined following discussion between researchers about any discrepancies in coding. The main themes from this process were defined as: people with dementia using informal support by 'doing things together' with their partnerscarers, families and broader communities; evolving strategies that incorporate formal services as challenges increase;

1
2
3 concerns about the fragility of support and fear of the future as dementia progresses or
4
5 crises occur. Once themes had been defined and refined, the literature was reviewed to
6
7 relate the identified themes to theoretical constructs and frameworks in the existing
8
9 literature.

10 11 12 13 Methodological limitations

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16 We recognise this is an exploratory study that draws on data from a specific region of the
17
18 UK limiting its generalisability. More in-depth data from individual participants would have
19
20 enabled differences to be highlighted between, for example, people with different types
21
22 and levels of dementia.
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25 26 27 Findings

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30 Our analysis depicted families, communities, professionals and services working hard to
31
32 build and structure support for living with dementia. Common experiences were evident of
33
34 families drawing on changing levels and types of support to manage everyday life as needs
35
36 changed. The manner in which strategies developed can be conceptualised as scaffolding
37
38 processes that ~~were~~ built upon immediate and wider family support, then support from
39
40 communities and later from formal services. Within this overarching framework of
41
42 scaffolding three sub-themes emerged: doing things together; evolving strategies; and
43
44 fragility and fear of the future.
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50 *Doing things together: ~~partners~~carers, families and communities:*

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52 For dyads of the person with dementia and their ~~main~~-carer, there was a strong sense of
53
54 being in this together; people worked together to find solutions for the challenges daily life
55
56 brought. One carer described having treatment for cancer while caring for her mother.
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3 Since her mother could not be left alone due to her dementia, she took her mother with her
4
5 to the hospital.
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8 *Follow up appointments and things like that, we just kind of went together... 12 of*
9
10 *the 15 days she would be with us. (FG06.C4.F)*
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13
14 For another couple of working age, the carer structured each day to fit the needs of her
15
16 husband.
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19 *But he's got to do that routine and then he'll go down for the paper in the morning*
20
21 *when I'm at work. Then I'll phone and say, I'll be round in about ten minutes.., put*
22
23 *the soup on...Then I go back to work and then D, will go for his walk, and I know the*
24
25 *routine of his walk as well, just in case if anything did happen. Then, when I'm home*
26
27 *at four, he sort of has a cup of tea and all that ready for me coming in. (FG14.C.F3)*
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31 For those living as a couple, getting on with things meant adjusting to the diagnosis
32
33 together, something that other people outside their relationship could not always help with.
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37 *It's only we can do it ourselves really nobody else can really help; it just comes to you,*
38
39 *this is how it is going to be and to adjust to that. (FG02.C1.F)*
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42 Dyads were also supported by wider family and community. People with dementia stressed
43
44 the importance of family visiting and helping with housework and carers emphasised the
45
46 value of family support for offering respite.
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48

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50 *My daughter said I'll have mum on Sundays so you can go off into the hills ... I found*
51
52 *that brilliant because it just gave me time to just completely immerse myself in*
53
54 *something that I wanted to do and not even have to think about anything, and that*
55
56 *really did work for me. (I02.C.M)*
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3 However there were risks and limits associated with family and informal support, often
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5 linked to stigma and misunderstanding of dementia. One carer described how his children
6
7 could not cope with their mother's dementia.⁴³
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10 *And they all walk right by ... because N can't accept what's wrong with his mum.*

11
12 (FG06.C1.M)

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16 Not all social connections were maintained following a diagnosis of dementia due to
17
18 increasing cognitive deterioration and stigma.
19

20
21 *If people would just ignore the fact that there's supposed to be something wrong*
22
23 *with me, and talk to me properly...you feel you're not wanted anymore.* (I06.D.M)
24
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26
27 Maintaining wider social connections beyond family contributed to living well with
28
29 dementia. This carer described a strong network of friends and neighbours whom he saw
30
31 regularly and whom he could call on for help.
32

33
34 *They just live in town so when we're in town we pop in to see B and W and B and W*
35
36 *pop up to see us. C next door - we've got fantastic neighbours. If I want help - I just*
37
38 *phone up* (I20.C.M)
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41

42 Carers discussed the particular benefits of living in a close-knit community.

43
44
45 *My wife used to walk off like that but she always went to the village shop and then*
46
47 *they kept her there and then they gave me a ring and said can you pick her up.*

48
49 (FG1.C2.M)
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53 A commonality was that adapting to life with dementia involved utilising existing, -or
54
55 developing new, scaffolds of support from families, friends and communities.
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Evolving strategies

Amongst the participants there were many who were coping with dementia at a point where they needed more support than they could access within their family and informal social networks. The initial scaffolding provided by families and communities often became insufficient as time passed and our findings revealed that managing together without formal services became more challenging.

But it becomes a way of life and you just get used to it and it just becomes normal in a way, and then normal becomes harder and harder and harder. (I02.C.M)

Findings indicate that both people with dementia and carers needed someone with expertise about dementia to talk to; people with dementia wanted someone to ask questions of and to provide company; carers wanted information and someone they could unburden with when stressed. For some it was important that this person was not a family member or friend.

We've got family, but sometimes you want to talk to somebody that doesn't know him as he was, if you understand what I mean. (FG16.C1.F)

Regular day care, home care or help at home were reported as important as individuals' support needs increased.

You're meeting different people and you're listening to different conversations as well ... whereas at home you're just on your own all the time. (FG11.D4.F)

These services could support couples to remain living together at home and alleviate loneliness for people with dementia.

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2
3 *We have someone every morning for half an hour to get J showered and dressed. He*
4
5 *can do most of it himself, but he needs supervision. That half hour is...that is £7 well*
6
7 *worth spent every day ...so I've not got that stress first thing in the morning.*

8
9
10 (FG18.C2.F).

11
12
13 For many ~~families~~ there was a need to utilise a range of services and activities, patching
14
15 together different types of support to find a manageable solution.
16

17
18 *B can go to the day centre on a Tuesday from half past nine to half past two. He*
19
20 *quite enjoys it. Then we come here [peer support group] on a Wednesday afternoon.*

21
22 *Then the fourth Thursday in the month...Young at Heart. (FG18.C4.F).*
23

24
25
26 People with dementia recognised change and tended to discuss practical changes such as
27
28 the loss of their driving license.
29

30
31 *And slowly we go down; we have trouble now because I was told I had to stop*
32
33 *driving, and [spouse] doesn't drive ... we've lost that. (FG5.D2.M)*
34

35
36
37 These examples illustrate participants' increasing need for emotional and practical support
38
39 beyond that provided by family and informal community. This involved developing
40
41 progressively more complex scaffolds using more formal services. The strength or fragility of
42
43 the scaffold was contingent on the availability of services and co-ordination between service
44
45 providers.
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47

48 49 *Fragility – fear for the future*

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52 While many ~~people~~ participants felt they managed fairly well, their accounts demonstrated
53
54 the relentless nature of caring and the losses experienced as dementia progressed. As the
55
56 needs of the person with dementia changed, for many ~~people~~ carers current strategies were
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3 likely to become unsustainable. For a man of working age whose wife had dementia, his
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5 only option was to take her with him while he worked as a driver; a strategy that was
6
7 unlikely to be sustainable and potentially risky.
8
9

10
11 *I'm a lorry driver, I just go out and do cash in hand work when I can, take G with us,*
12
13 *she sits in the wagon with us. (FG15.C1.M)*
14
15

16 Strategies could also add to carers' exhaustion. Having worked all day, some carers went
17
18 walking with their spouses to meet their need for exercise, and were consequently
19
20 exhausted.
21
22

23
24 *I'm home at four I find then he's wanting to do something and I'm usually*
25
26 *shattered by this time... I think, I just want to sit here for 20 minutes, just close my*
27
28 *eyes, 20 minutes, that's all you want, and he's getting frustrated, so then you're*
29
30 *going out walking, so he's on the go the whole time. (FG14.C3.F)*
31
32
33

34 The future was a time of uncertainty and change ~~for families living with dementia~~. This is
35
36 illustrated in the concern expressed by a carer about the possibility of becoming ill herself.
37
38

39
40 *So it's things like that [becoming ill], you don't know what's going to happen to*
41
42 *yourself but you've no idea what to do if you've got an emergency like that... If*
43
44 *you're ill yourself there's nobody really. (FG.06.C2.F)*
45
46

47 Fear of advanced dementia was an issue for some, with death considered a release before
48
49 the person's condition deteriorated significantly.
50
51

52
53 *It may be a bad thing to say but I'm hoping before she starts really seriously*
54
55 *deteriorating she'll pass on. (I20.C.M)*
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3 Other carers worried about potential financial difficulties in the future, which was
4
5 associated with giving up work to care for a relative with dementia.
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7

8
9 *I still feel very worried about the future because I don't know how I am going to*
10
11 *continue paying the bills if I don't work. So that'll be the next stage of our life, what*
12
13 *am I supposed to do about that? ... just have to see how it goes. (I13.C.F)*
14
15

16 Uncertainty was an overarching theme in the accounts of many carers in this study,
17
18 reflecting the need to take one day at a time given the precariousness of their situation.
19

20
21 *She's not deteriorating as fast as I thought she would, but I can tell the slight*
22
23 *difference in the day by day ... That's why I say I just do it for today and tomorrow - I*
24
25 *look at tomorrow when I get out of bed. (I20.C.M)*
26
27
28

29 This section illustrates that scaffolds that worked at one point in the journey may not be
30
31 sufficient as time progresses. Scaffolds were fragile and at risk of failing as needs changed.
32
33 Access to support from outside the family and from formal services become more important
34
35 to bolster existing scaffolds and enable families-people to continue to live well with
36
37 dementia.
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43 **Discussion – building and maintaining scaffolds**

44
45 The concept of scaffolding is a useful metaphor for describing how carers and people with
46
47 dementia build supports for living with dementia. At first these scaffolds are built with
48
49 family, friends and the community, however, as dementia progresses, more complex
50
51 scaffolds are needed and are likely to involve more formal services. This finding builds on
52
53 current literature that shows the collaborative and adaptive ways that dyads work together
54
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56
57 [20,24] by demonstrating how strategies evolve to support families-people with dementia,
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1
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3 starting within caring dyads and evolving to include the wider community and formal
4
5 services.
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7
8 The findings suggest that building and maintaining scaffolds could be hard work and it was
9
10 difficult to plan ahead, resulting in scaffolds that were at risk of collapse as people's needs
11
12 increased. Carers often felt that there were no solutions to their predicament, suggesting a
13
14 lack of available information or support to help them cope and plan for challenges,
15
16 reflecting previous research that has established the need for greater support and practical
17
18 management strategies after diagnosis [3].
19
20
21
22

23 The data revealed a wide range of experiences amongst individuals, couples and families
24
25 living with dementia, however, commonalities were found in the strategies undertaken and
26
27 the necessity to build increasingly complex scaffolds to continue to support everyday life
28
29 with dementia. Families shared a sense of fear for the future and the need to draw on
30
31 different sources of support as they faced increasing challenges; living with dementia was
32
33 hard work.
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41 Families ~~and couples~~ were found to be resourceful and creative: they made the best of the
42
43 situations they found themselves in and worked hard to pull together different supports to
44
45 enable them to live as well as they could with dementia. Adopting active strategies has
46
47 been shown to maximise functioning and maintain wellbeing [4,5]. The people with
48
49 dementia within this research did not cope alone and there is a strength in using the family
50
51 as a system to better understand how people integrate practical strategies and support
52
53 networks to manage life with dementia. For the ~~couples and~~ families here, mutuality and
54
55
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60 togetherness were crucial. The families worked together to develop and sustain practical,

1
2
3 emotional and relational strategies for everyday life with dementia. Shared resources and
4
5 mutuality are processes identified in other studies [7,9]. Rural communities were ~~perceived~~
6
7 ~~to be~~ particularly valued in providing extended support networks, reflecting previous work
8
9 on living with dementia in rural areas [30]. Families worked with what resources they had
10
11 and added support where necessary, providing the person with dementia with the initial
12
13 scaffolding needed to live well with dementia. Merrick et al. [23] discuss how carers provide
14
15 flexible scaffolding to adapt to the fluctuating needs of the person with dementia, here we
16
17 see how families and communities adapt and develop scaffolding as dementia progresses.
18
19 However, informal strategies can become more fragile as challenges increase ~~with the~~
20
21 ~~progression of dementia~~, with families requiring more formal services to manage in the
22
23 present and ~~help cope~~ as they look to the future.

24
25
26
27
28
29 The findings here demonstrate the increasingly complex scaffolds involving family, friends,
30
31 community, and formal support and services that are built as the needs of the person with
32
33 dementia increase over time. Much research highlights the importance of friendships and
34
35 social networks for people with dementia [13,14,16] ~~and and~~ there is a need to recognise
36
37 that networks often diminish as dementia progresses. ~~Loneliness follows the loss of informal~~
38
39 ~~support as dementia progresses suggesting the need for formal support to fill in those gaps.~~
40
41
42
43 ~~The findings here demonstrate the increasingly complex scaffolds involving family, friends,~~
44
45 ~~community, and formal support and services that are built as the needs of the person with~~
46
47 ~~dementia increase over time.~~ However, we suggest that more proactive and collaborative
48
49 approaches may prevent or slow the breakdown of social networks and enable stronger
50
51 scaffolds to be sustained for people with dementia with less need for formal services. ~~We~~
52
53 ~~suggest that the scaffolds that work best are those that integrate existing informal support~~
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3 with more formal services through collaborative working. Professionals
4 Practitioners need to
5 to identify existing scaffolds and ways they can be supported and strengthened rather than
6 replaced. Co-production (33) and asset-based (34) methods are promising approaches that
7 could be adopted to guide this work, by drawing on the mutual resources of formal service
8 providers, communities, families and individuals -and informal care networks- to deliver
9 better outcomes for people living with dementia. In this way, formal services can build on
10 assets and capacities in families and communities by adopting asset-based development
11 models for integrating services with existing scaffolds. can achieve this by finding ways to
12 support strategies that use existing social networks and by introducing individualised, timely
13 formal services before informal scaffolds collapse.
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30 Conclusion

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33 We have shown that people with dementia and their family carers adopt active strategies to
34 manage daily life with dementia and that managing dementia starts as a collaborative
35 exercise involving the carer and the person with dementia. Families living with dementia
36 may also rely on wider social networks and, as the condition progresses, require input from
37 formal services. This paper demonstrates the hard work undertaken by families to build and
38 maintain scaffolds that become more complex as dementia progresses. The scaffolding
39 metaphor is useful for illustrating how families, communities and formal services can be
40 integrated to support people living with dementia. Our data suggest that the ad hoc
41 addition of services in response to changing needs or circumstances may compound rather
42 than alleviate challenges associated with living with dementia. More proactive,
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3 individualised and integrated support is required to support and build on existing scaffolds
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5 before informal strategies within families become unsustainable.
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10 11 12 **Acknowledgements** 13

14
15 We would like to thank all the people with dementia and their family carers who gave up
16
17 their time to talk to us. Thanks also go to the health and social care staff in Cumbria who
18
19 supported our work there and members of the wider research team: Ozzy Dincarslan,
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21 Corinne Greasley-Adams and Mike Wilson
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Table 1. Interview participants

Participants	Participant codes
2012	
Man with dementia, his wife and daughter	I01.D.M, I01.C.F1, I01.C.F2
Carer	I02.C.M
Carer	I03.C.F
Carer	I04.C.M
Carer	I05.C.F
Couple with dementia	I06.D.F, I06.D.M
Man with dementia and his wife	I07.D.M, I07.C.F
Carer	I08.C.F
Woman with dementia and daughter	I09.D.F, I09.C.F
Daughter of person with dementia	I10.C.F
Daughter of person with dementia	I11.C.F
Partner of person with dementia	I12.C.F
2013	
Carer	I13.C.F
Carer	I14.C.F
Carer	I15.C.F
Carer	I16.C.F
Carer	I17.C.M
Carer	I18.C.F
Carer	I19.C.F
Carer	I20.C.M
Woman with dementia	I21.D.F

Table 2. Focus group details

Description of group	Participants	Codes
2012		
Peer support group	9 carers	FG01.C1/9.M/F
Memory Lane Café	2 people with dementia, 1 carer	FG02.D1/2.M/F; FG02.C.F
Singing for the brain	1 person with dementia, 6 carers	FG03.C.1/6.M/F; FG03.D.M
Dementia Centre	5 people with dementia	FG04.D1/5.M/F
Singing for the brain	5 people with dementia, 5 carers	FG05.C.1/5.M/F; FG05.D1/5.M/F
Cross Keys Centre	4 carers	FG06.C1/4.M/F
Carers' support group	3 people with dementia, 8 carers	FG07.C1/8.M/F; FG07.D1/3.M/F
Dementia Club	3 people with dementia, 1 support worker	FG08.D1/3.M/F
Day Centre	3 people with dementia	FG09.D1/3.M/F
Day Centre	3 people with dementia	FG10.D1/3.M/F

2013		
Day centre	5 people with dementia	FG11.D1/5.M/F
Sheltered housing complex	5 people with dementia, 4 carers	FG12.D1/5.M/F; FG12.C1/4.M/F
Singing for the brain	4 people with dementia, 5 carers	FG13.D1/4.M/F; FG13.C1/5.M/F
Peer support group	1 person with dementia, 4 carers	FG14.D1.M; FG14.C1/4.M/F
Memory services support group	2 people with dementia, 4 carers	FG15.D1/2.M/F; FG15.C1/4.M/F
Memory café	6 people with dementia, 5 carers	FG16.D1/6.M/F; FG16.C1/5.M/F
Sheltered housing complex	6 people with dementia, 2 carers	FG17.D1/6.M/F; FG17.C1/2.M/F
Singing for the brain	5 people with dementia, 4 carers	FG18.D1/5.M/F; FG18.C1/4.M/F

Title

Scaffolding and working together: a qualitative exploration of strategies for everyday life with dementia

Abstract

Background: Living with dementia has been described as a process of continual change and adjustment, with people with dementia and their families adopting informal strategies to help manage everyday life. As dementia progresses, families increasingly rely on help from the wider community and formal support.

Methods: This paper reports on a secondary analysis of qualitative data from focus groups and individual interviews with people with dementia and their carers in the North of England. In total 65 people with dementia and 82 carers took part in the research: 26 in interviews and 121 in focus groups. Focus group and interview audio recordings were transcribed verbatim. A qualitative, inductive, thematic approach was taken for data analysis.

Findings: The paper applies the metaphor of scaffolding to deepen understanding of the strategies used by families. Processes of scaffolding were evident across the data where families, communities, professionals and services worked together to support everyday life for people with dementia. Within this broad theme of scaffolding were three sub-themes characterising the experiences of families living with dementia: doing things together; evolving strategies; and fragility and fear of the future.

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3 **Conclusions:** Families with dementia are resourceful but do need increasing support
4
5 (scaffolding) to continue to live as well as possible as dementia progresses. More
6
7 integrated, proactive work is required from services that recognises existing scaffolds and
8
9 provides appropriate support before informal strategies become unsustainable; thus
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11 enabling people with dementia to live well for longer.
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15 **Key words:** dementia, scaffolding, community, informal care, care services
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27 **Key points:**
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- People with dementia and their informal carers develop strategies to manage everyday life with dementia
 - These strategies can be usefully described as scaffolds as families draw on a range of supports to manage everyday life
 - As dementia progresses life gets more difficult and scaffolds built by families need additional support from formal services
 - Scaffolds to support people with dementia may be at risk of collapse due to the changing nature of dementia
 - Professionals should work collaboratively and recognise and enhance rather than replace existing scaffolds.

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For Review Only

Introduction

Living with dementia is a process of continual change and adjustment. How an individual manages life with dementia will be affected by their biography and social location [1] and their coping and adaptive strategies [2,3]. People with dementia adopt active strategies to help maximise functioning [4] and maintain wellbeing [5]. For carers, adapting to life with dementia similarly involves active strategies to adjust to the caregiving role [6].

The complexities of the caring relationship, such as perceived mutuality [7] and wider relationships in the family [8], also impact on daily life with dementia. It has been shown that people with dementia and their families work together to develop strategies for dealing with the practical and social consequences of cognitive impairment [9]. People with dementia and their partners are also found to collaborate to make sense of dementia and to adapt at a practical level [10].

Managing transitions is a particularly prominent aspect of living with dementia, for instance dealing with the grief associated with admitting a partner into long-term care [11]. With the ongoing experience of transition associated with dementia, couples develop strategies and approaches for managing and living with changes throughout this journey [12].

Friendships and the wider community are significant for living with dementia. Friendships are important for maintaining social connectedness [13], wellbeing [14] and quality of life [15]. Social networks are particularly important for people with dementia where family is geographically diverse [16], however social isolation can occur due to alterations in relationships and interactions following a diagnosis of dementia [17].

People with restricted social networks are more likely to report high unmet needs [15] and therefore may need to rely upon formal services to live well with dementia. For carers, the

1
2
3 progression of dementia is often associated with increased responsibility and the need for
4
5 outside support [18]. Consequently, families may need to rely increasingly on formal
6
7 support to manage life with dementia as their condition progresses and their social
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9 connections diminish.

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12 This paper draws on the metaphor of 'scaffolding' to illustrate the interplay between
13
14 individualised informal and formal supports in the lives of people affected by dementia.

15
16 Scaffolding has its roots in educational psychology [19] and has been used in the dementia
17
18 field to describe different ways that people with dementia may be supported without
19
20 overcompensating for difficulties. For example, scaffolding has been used to conceptualise
21
22 how people work together to achieve successful communication or interaction [20,21,22],
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24 or to understand couples' experience of adjusting to life with dementia from a relational
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26 perspective [23,24]. Merrick et al. identify 'flexible scaffolding' where 'care partners
27
28 adapted the level and nature of support they provided, to reflect the fluctuating abilities
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30 and deteriorating function of the person' [24, p.43] and Schrauf and Iris identify 'domestic
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32 scaffolding' where carers work adaptively to take over tasks such as shopping, driving or
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34 paying bills [25, p. 759]. We extend these uses of the scaffolding metaphor to 1) illustrate
35
36 the sometimes precarious relationship between informal and formal supports and 2) argue
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38 for the importance of working collaboratively to introduce timely, individualised formal
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40 support to extend existing scaffolds used by families and communities.
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50 **Methods**

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53 This paper presents the secondary analysis of a qualitative data set from a user engagement
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55 project funded by Cumbria County Council and NHS Cumbria (UK) to inform their regional
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57 dementia strategy [26]. The qualitative component of this project involved 19 interviews
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1
2
3 and 21 focus groups with 65 people with dementia and 82 carers in 2012 and 2013. Within
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5 the paper we use 'carer' to refer to people who identified themselves as the main carers for
6
7 a person with dementia, and 'families' where interviewees referred to a wider family
8
9 structure. Semi-structured questions focused on experiences of services and broader
10
11 questions about how people lived well in their communities. The original analysis focused
12
13 on the evaluation objectives: to understand the impact of services and highlight best
14
15 practice and gaps in provision. The richness of data gathered in the project prompted the
16
17 secondary data analysis described below.
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22 **Participants**

23
24 In 2012, interviews were conducted with people with dementia (n=5) and carers (n=12) and
25
26 ten focus groups with people with dementia (n=25) and carers (n=34). In 2013, interviews
27
28 were conducted with carers (n=8) and one person with dementia and eight focus groups
29
30 with people with dementia (n=34) and carers (n=28). A purposive sampling approach was
31
32 taken to ensure a mix of genders and ages; participants were recruited from different
33
34 geographical areas, with different levels of need, and with a variety of family and support
35
36 structures. This approach provided a diverse range of experiences of dementia and services.
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41
42 Interview participants were recruited through gatekeepers within local third sector
43
44 organisations. People with dementia were offered the opportunity to be interviewed alone
45
46 or with a supporter. All but one chose to include a supporter. Interviews were conducted
47
48 at a place chosen by the person with dementia. Table 1. provides more information and
49
50 participant codes for the interview participants.
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55 Insert Table 1. here.
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3 Existing groups provided by adult social care and third sector services were recruited for
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5 focus groups. Key gatekeepers within organisations facilitated access. Groups included
6
7 peer support groups; Dementia Cafes; day care services and singing groups. These
8
9 comprised carers only, people with dementia only and mixed groups. Focus groups took
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11 place within the normal timings and locations of the groups or immediately afterwards to
12
13 minimise travel. Table 2. provides more information and participant codes for the focus
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15 group participants.
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23 **Ethical considerations**

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25 Informed consent was obtained from all participants. The process of consent followed
26
27 Dewing's [27] ongoing consent process. This process began with familiar professionals in
28
29 gatekeeping organisations establishing initial interest amongst potential participants. With
30
31 permission for access, researchers arranged to meet for an interview or focus group several
32
33 days later. All participants were given an information sheet and researchers ensured this
34
35 had been understood by each individual before asking them to sign a consent form. All
36
37 interviewers were experienced in communicating with people with dementia and carers
38
39 through active listening that was sensitive and respectful to both the person and their
40
41 views. Time was taken to put people at ease at the start of interviews and focus groups,
42
43 and to round off the interaction and check for any adverse impact at the end. Interviewers
44
45 ensured they communicated at a pace sensitive to individual abilities, monitoring both non-
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47 verbal and verbal cues that might indicate a person was uncomfortable. If any signs of
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49 discomfort or distress were evident, interviewers stopped recording and checked the person
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51 wanted to continue; no participants chose to stop participation. For participants with
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1
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3 dementia, researchers used orientating statements to remind the person they were
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5 conducting an interview or focus group. If there was any concern about capacity during the
6
7 process, researchers stopped to check the person understood they were taking part in
8
9 research before continuing. Participants' anonymity and confidentiality were guaranteed by
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11 utilising a cypher and removing names from the transcripts before analysis commenced.
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15 The study received ethical approval from the [Ethics Committee blinded for peer review]. In
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17 addition, the project was approved by the research governance bodies within Cumbria
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19 County Council, Cumbria Partnership NHS Foundation Trust and NHS Cumbria Primary Care
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21 Trust.
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24 25 26 27 28 **Primary data collection and analysis** 29

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31 Focus groups and interviews have been used successfully with people with dementia and
32
33 their carers in previous research [28]. Interviews and focus groups were semi-structured
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35 discussions informed by a topic guide [26]. Fieldwork was conducted by a team of six
36
37 researchers, with interviews conducted by one member of the research team while two
38
39 members facilitated each focus group. Researchers brought fruit and biscuits to meetings
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41 as a way of thanking participants and facilitating rapport [29]. Focus group and interview
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43 audio recordings were transcribed verbatim. The primary data analysis focused on
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45 understanding the impact of services, providing examples of best practice and highlighting
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47 any gaps in provision. Findings are reported elsewhere [26].
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Secondary data analysis

A secondary analysis of the qualitative data was conducted by the same three researchers who conducted the primary analysis [30]. This analysis took a more intensive focus on people's experiences of managing everyday life. While open questions in the original topic guide had explored people's experiences of living well, the data generated from these questions had not been analysed in depth for the purposes of the evaluation. A new set of questions guided the secondary analysis to explore how people combined informal supports with formal services to live well in their communities:

- What strategies are used by people with dementia and carers as they manage everyday life?
- How do wider communities and informal support contribute to these strategies?
- How do services and formal support contribute to these strategies?

An inductive interpretative approach was taken using thematic analysis to understand how participants represented their experiences of informal and formal supports. Thematic analysis involved looking across the data set for repeated patterns of meaning associated with this topic and coding these using NVivo8 software. Following the process set out by Braun and Clarke [31], the researchers independently read the transcripts and generated initial codes and, once all the transcripts were examined, worked together to sort the codes into themes and sub-themes to generate a thematic map of the analysis. Themes were defined and refined following discussion between researchers about any discrepancies in coding. The main themes from this process were defined as: people with dementia using informal support by 'doing things together' with their carers, families and broader communities; evolving strategies that incorporate formal services as challenges increase;

1
2
3 concerns about the fragility of support and fear of the future as dementia progresses or
4
5 crises occur. Once themes had been defined and refined, the literature was reviewed to
6
7 relate the identified themes to theoretical constructs and frameworks in the existing
8
9 literature.
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11 12 13 **Methodological limitations**

14 We recognise this is an exploratory study that draws on data from a specific region of the
15
16 UK limiting its generalisability. More in-depth data from individual participants would have
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18 enabled differences to be highlighted between, for example, people with different types
19
20 and levels of dementia.
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24 25 26 **Findings**

27
28 Our analysis depicted families, communities, professionals and services working hard to
29
30 build and structure support for living with dementia. Common experiences were evident of
31
32 families drawing on changing levels and types of support to manage everyday life as needs
33
34 changed. The manner in which strategies developed can be conceptualised as scaffolding
35
36 processes that built upon immediate and wider family support, then support from
37
38 communities and later from formal services. Within this overarching framework of
39
40 scaffolding three sub-themes emerged: doing things together; evolving strategies; and
41
42 fragility and fear of the future.
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46 47 *Doing things together: carers, families and communities:*

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49 For dyads of the person with dementia and their carer, there was a strong sense of being in
50
51 this together; people worked together to find solutions for the challenges daily life brought.
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53 One carer described having treatment for cancer while caring for her mother. Since her
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3 mother could not be left alone due to her dementia, she took her mother with her to the
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5 hospital.
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8 *Follow up appointments and things like that, we just kind of went together... 12 of*
9
10 *the 15 days she would be with us. (FG06.C4.F)*
11

12
13 For another couple of working age, the carer structured each day to fit the needs of her
14
15 husband.
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18 *But he's got to do that routine and then he'll go down for the paper in the morning*
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20 *when I'm at work. Then I'll phone and say, I'll be round in about ten minutes.., put*
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22 *the soup on...Then I go back to work and then D, will go for his walk, and I know the*
23
24 *routine of his walk as well, just in case if anything did happen. Then, when I'm home*
25
26 *at four, he sort of has a cup of tea and all that ready for me coming in. (FG14.C.F3)*
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31 For those living as a couple, getting on with things meant adjusting to the diagnosis
32
33 together, something that other people outside their relationship could not always help with.
34

35
36 *It's only we can do it ourselves really nobody else can really help; it just comes to you,*
37
38 *this is how it is going to be and to adjust to that. (FG02.C1.F)*
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42 Dyads were also supported by wider family and community. People with dementia stressed
43
44 the importance of family visiting and helping with housework and carers emphasised the
45
46 value of family support for offering respite.
47

48
49 *My daughter said I'll have mum on Sundays so you can go off into the hills ... I found*
50
51 *that brilliant because it just gave me time to just completely immerse myself in*
52
53 *something that I wanted to do and not even have to think about anything, and that*
54
55 *really did work for me. (I02.C.M)*
56
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1
2
3 However there were risks and limits associated with family and informal support, often
4
5 linked to stigma and misunderstanding of dementia. One carer described how his children
6
7 could not cope with their mother's dementia.
8
9

10
11 *And they all walk right by ... because N can't accept what's wrong with his mum.*

12
13 (FG06.C1.M)
14
15

16 Not all social connections were maintained following a diagnosis of dementia due to
17
18 increasing cognitive deterioration and stigma.
19
20

21
22 *If people would just ignore the fact that there's supposed to be something wrong*

23
24 *with me, and talk to me properly...you feel you're not wanted anymore. (I06.D.M)*
25
26

27 Maintaining wider social connections beyond family contributed to living well with
28
29 dementia. This carer described a strong network of friends and neighbours whom he saw
30
31 regularly and whom he could call on for help.
32
33

34
35 *They just live in town so when we're in town we pop in to see B and W and B and W*

36
37 *pop up to see us. C next door - we've got fantastic neighbours. If I want help - I just*

38
39 *phone up (I20.C.M)*
40
41

42 Carers discussed the particular benefits of living in a close-knit community.
43
44

45
46 *My wife used to walk off like that but she always went to the village shop and then*

47
48 *they kept her there and then they gave me a ring and said can you pick her up.*

49
50 (FG1.C2.M)
51
52

53 A commonality was that adapting to life with dementia involved utilising existing, or
54
55 developing new, scaffolds of support from families, friends and communities.
56
57
58
59
60

Evolving strategies

Amongst the participants there were many who were coping with dementia at a point where they needed more support than they could access within their family and social networks. The initial scaffolding provided by families and communities often became insufficient as time passed and our findings revealed that managing together without formal services became more challenging.

But it becomes a way of life and you just get used to it and it just becomes normal in a way, and then normal becomes harder and harder and harder. (I02.C.M)

Findings indicate that both people with dementia and carers needed someone with expertise about dementia to talk to; people with dementia wanted someone to ask questions of and to provide company; carers wanted information and someone they could unburden with when stressed. For some it was important that this person was not a family member or friend.

We've got family, but sometimes you want to talk to somebody that doesn't know him as he was, if you understand what I mean. (FG16.C1.F)

Regular day care, home care or help at home were reported as important as individuals' support needs increased.

You're meeting different people and you're listening to different conversations as well ... whereas at home you're just on your own all the time. (FG11.D4.F)

These services could support couples to remain living together at home and alleviate loneliness for people with dementia.

1
2
3 *We have someone every morning for half an hour to get J showered and dressed. He*
4 *can do most of it himself, but he needs supervision. That half hour is...that is £7 well*
5 *worth spent every day ...so I've not got that stress first thing in the morning.*
6
7
8

9
10 (FG18.C2.F).
11

12
13 For many there was a need to utilise a range of services and activities, patching together
14
15 different types of support to find a manageable solution.
16

17
18 *B can go to the day centre on a Tuesday from half past nine to half past two. He*
19 *quite enjoys it. Then we come here [peer support group] on a Wednesday afternoon.*
20
21

22 *Then the fourth Thursday in the month...Young at Heart. (FG18.C4.F).*
23
24

25
26 People with dementia recognised change and tended to discuss practical changes such as
27
28 the loss of their driving license.
29

30
31 *And slowly we go down; we have trouble now because I was told I had to stop*
32 *driving, and [spouse] doesn't drive ... we've lost that. (FG5.D2.M)*
33
34

35
36 These examples illustrate participants' increasing need for emotional and practical support
37
38 beyond that provided by family and informal community. This involved developing
39
40 progressively more complex scaffolds using more formal services. The strength or fragility of
41
42 the scaffold was contingent on the availability of services and co-ordination between service
43
44 providers.
45
46
47

48 *Fragility – fear for the future*

49
50 While many participants felt they managed fairly well, their accounts demonstrated the
51
52 relentless nature of caring and the losses experienced as dementia progressed. As the needs
53
54 of the person with dementia changed, for many carers current strategies were likely to
55
56
57
58
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60

1
2
3 become unsustainable. For a man of working age whose wife had dementia, his only option
4
5 was to take her with him while he worked as a driver; a strategy that was unlikely to be
6
7 sustainable and potentially risky.
8
9

10
11 *I'm a lorry driver, I just go out and do cash in hand work when I can, take G with us,*
12
13 *she sits in the wagon with us. (FG15.C1.M)*
14
15

16 Strategies could also add to carers' exhaustion. Having worked all day, some carers went
17
18 walking with their spouses to meet their need for exercise, and were consequently
19
20 exhausted.
21
22

23
24 *I'm home at four I find then he's wanting to do something and I'm usually*
25
26 *shattered by this time... I think, I just want to sit here for 20 minutes, just close my*
27
28 *eyes, 20 minutes, that's all you want, and he's getting frustrated, so then you're*
29
30 *going out walking, so he's on the go the whole time. (FG14.C3.F)*
31
32

33
34 The future was a time of uncertainty and change. This is illustrated in the concern
35
36 expressed by a carer about the possibility of becoming ill herself.
37
38

39
40 *So it's things like that [becoming ill], you don't know what's going to happen to*
41
42 *yourself but you've no idea what to do if you've got an emergency like that... If*
43
44 *you're ill yourself there's nobody really. (FG.06.C2.F)*
45
46

47 Fear of advanced dementia was an issue for some, with death considered a release before
48
49 the person's condition deteriorated significantly.
50
51

52
53 *It may be a bad thing to say but I'm hoping before she starts really seriously*
54
55 *deteriorating she'll pass on. (I20.C.M)*
56
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1
2
3 Other carers worried about potential financial difficulties in the future, which was
4
5 associated with giving up work to care for a relative with dementia.
6
7

8 *I still feel very worried about the future because I don't know how I am going to*
9 *continue paying the bills if I don't work. So that'll be the next stage of our life, what*
10 *am I supposed to do about that? ... just have to see how it goes. (I13.C.F)*
11
12
13
14
15

16 Uncertainty was an overarching theme in the accounts of many carers in this study,
17
18 reflecting the need to take one day at a time given the precariousness of their situation.
19
20

21 *She's not deteriorating as fast as I thought she would, but I can tell the slight*
22 *difference in the day by day ... That's why I say I just do it for today and tomorrow - I*
23 *look at tomorrow when I get out of bed. (I20.C.M)*
24
25
26
27
28

29 This section illustrates that scaffolds that worked at one point in the journey may not be
30
31 sufficient as time progresses. Scaffolds were fragile and at risk of failing as needs changed.
32
33 Access to support from outside the family and from formal services become more important
34
35 to bolster existing scaffolds and enable people to continue to live well with dementia.
36
37
38

39 **Discussion – building and maintaining scaffolds**

40
41
42

43 The concept of scaffolding is a useful metaphor for describing how carers and people with
44
45 dementia build supports for living with dementia. At first these scaffolds are built with
46
47 family, friends and the community, however, as dementia progresses, more complex
48
49 scaffolds are needed and are likely to involve more formal services. This finding builds on
50
51 current literature that shows the collaborative and adaptive ways that dyads work together
52
53 [20,24] by demonstrating how strategies evolve to support people with dementia, starting
54
55 within caring dyads and evolving to include the wider community and formal services.
56
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1
2
3 The findings suggest that building and maintaining scaffolds could be hard work and it was
4
5 difficult to plan ahead, resulting in scaffolds that were at risk of collapse as people's needs
6
7 increased. Carers often felt that there were no solutions to their predicament, suggesting a
8
9 lack of available information or support to help them cope and plan for challenges,
10
11 reflecting previous research that has established the need for greater support and practical
12
13 management strategies after diagnosis [3].
14
15

16
17
18 The data revealed a wide range of experiences amongst individuals, couples and families
19
20 living with dementia, however, commonalities were found in the strategies undertaken and
21
22 the necessity to build increasingly complex scaffolds to continue to support everyday life
23
24 with dementia. Families shared a sense of fear for the future and the need to draw on
25
26 different sources of support as they faced increasing challenges; living with dementia was
27
28 hard work.
29
30

31
32 Families were found to be resourceful and creative: they made the best of the situations
33
34 they found themselves in and worked hard to pull together different supports to enable
35
36 them to live as well as they could with dementia. Adopting active strategies has been
37
38 shown to maximise functioning and maintain wellbeing [4,5]. The people with dementia
39
40 within this research did not cope alone and there is a strength in using the family as a
41
42 system to better understand how people integrate practical strategies and support
43
44 networks to manage life with dementia. For the families here, mutuality and togetherness
45
46 were crucial. The families worked together to develop and sustain practical, emotional and
47
48 relational strategies for everyday life with dementia. Shared resources and mutuality are
49
50 processes identified in other studies [7,9]. Rural communities were particularly valued in
51
52 providing extended support networks, reflecting previous work on living with dementia in
53
54
55
56
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1
2
3 rural areas [30]. Families worked with what resources they had and added support where
4
5 necessary, providing the person with dementia with the initial scaffolding needed to live
6
7 well with dementia. Merrick et al. [23] discuss how carers provide flexible scaffolding to
8
9 adapt to the fluctuating needs of the person with dementia, here we see how families and
10
11 communities adapt and develop scaffolds as dementia progresses. However, informal
12
13 strategies can become more fragile as challenges increase, with families requiring more
14
15 formal services to manage in the present and as they look to the future.
16
17

18
19
20 The findings here demonstrate the increasingly complex scaffolds involving family, friends,
21
22 community, and formal support and services that are built as the needs of the person with
23
24 dementia increase over time. Much research highlights the importance of friendships and
25
26 social networks for people with dementia [13,14,16] and there is a need to recognise that
27
28 networks often diminish as dementia progresses. However, we suggest that more
29
30 proactive and collaborative approaches may prevent or slow the breakdown of social
31
32 networks and enable stronger scaffolds to be sustained for people with dementia with less
33
34 need for formal services. Practitioners need to identify existing scaffolds and ways they can
35
36 be supported and strengthened rather than replaced. Co-production (33) and asset-based
37
38 (34) methods are promising approaches that could be adopted to guide this work, drawing
39
40 on the mutual resources of formal service providers, communities, families and individuals
41
42 to deliver better outcomes for people living with dementia.
43
44
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52 **Conclusion**

53
54 We have shown that people with dementia and their carers adopt active strategies to
55
56 manage daily life with dementia and that managing dementia starts as a collaborative
57
58

1
2
3 exercise involving the carer and the person with dementia. Families living with dementia
4
5 may also rely on wider social networks and, as the condition progresses, require input from
6
7 formal services. This paper demonstrates the hard work undertaken by families to build and
8
9 maintain scaffolds that become more complex as dementia progresses. The scaffolding
10
11 metaphor is useful for illustrating how families, communities and formal services can be
12
13 integrated to support people living with dementia. Our data suggest that the ad hoc
14
15 addition of services in response to changing needs or circumstances may compound rather
16
17 than alleviate challenges associated with living with dementia. More proactive,
18
19 individualised and integrated support is required to support and build on existing scaffolds
20
21 before informal strategies within families become unsustainable.
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35
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Table 1. Interview participants

Participants	Participant codes
2012	
Man with dementia, his wife and daughter	I01.D.M, I01.C.F1, I01.C.F2
Carer	I02.C.M
Carer	I03.C.F
Carer	I04.C.M
Carer	I05.C.F
Couple with dementia	I06.D.F, I06.D.M
Man with dementia and his wife	I07.D.M, I07.C.F
Carer	I08.C.F
Woman with dementia and daughter	I09.D.F, I09.C.F
Daughter of person with dementia	I10.C.F
Daughter of person with dementia	I11.C.F
Partner of person with dementia	I12.C.F
2013	
Carer	I13.C.F
Carer	I14.C.F
Carer	I15.C.F
Carer	I16.C.F
Carer	I17.C.M
Carer	I18.C.F
Carer	I19.C.F
Carer	I20.C.M
Woman with dementia	I21.D.F

Table 2. Focus group details

Description of group	Participants	Codes
2012		
Peer support group	9 carers	FG01.C1/9.M/F
Memory Lane Café	2 people with dementia, 1 carer	FG02.D1/2.M/F; FG02.C.F
Singing for the brain	1 person with dementia, 6 carers	FG03.C.1/6.M/F; FG03.D.M
Dementia Centre	5 people with dementia	FG04.D1/5.M/F
Singing for the brain	5 people with dementia, 5 carers	FG05.C.1/5.M/F; FG05.D1/5.M/F
Cross Keys Centre	4 carers	FG06.C1/4.M/F
Carers' support group	3 people with dementia, 8 carers	FG07.C1/8.M/F; FG07.D1/3.M/F
Dementia Club	3 people with dementia, 1 support worker	FG08.D1/3.M/F
Day Centre	3 people with dementia	FG09.D1/3.M/F
Day Centre	3 people with dementia	FG10.D1/3.M/F

2013		
Day centre	5 people with dementia	FG11.D1/5.M/F
Sheltered housing complex	5 people with dementia, 4 carers	FG12.D1/5.M/F; FG12.C1/4.M/F
Singing for the brain	4 people with dementia, 5 carers	FG13.D1/4.M/F; FG13.C1/5.M/F
Peer support group	1 person with dementia, 4 carers	FG14.D1.M; FG14.C1/4.M/F
Memory services support group	2 people with dementia, 4 carers	FG15.D1/2.M/F; FG15.C1/4.M/F
Memory café	6 people with dementia, 5 carers	FG16.D1/6.M/F; FG16.C1/5.M/F
Sheltered housing complex	6 people with dementia, 2 carers	FG17.D1/6.M/F; FG17.C1/2.M/F
Singing for the brain	5 people with dementia, 4 carers	FG18.D1/5.M/F; FG18.C1/4.M/F