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Identity cues and dementia in nursing home intervention

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Abstract

This study examines the identity cues that family caregivers and healthcare personnel use with seniors living with dementia and living in nursing homes. The identity cues represent biographical knowledge used to stimulate the dementia sufferer, trigger signals and incite interaction. Our grounded approach hinges on three objectives: to identify and categorize identity cues; to document their uses; and to gain a better understanding of their effectiveness. We interviewed nine family caregivers and 12 healthcare workers. Qualitative data indicates that the participants use identity cues that evoke seniors' sociological, relational and individual characteristics. These identity cues play a central role in communication and constitute important information that the family caregivers can share with healthcare personnel. They sustain memory, facilitate care and reinforce seniors' self-value. These results help to define identity, foster a greater role for family caregivers, and constitute a sound basis for the implementation of personalized interventions.

Keywords

Dementia; family caregiver; healthcare personnel; identity cues; nursing home

1. Introduction

This article stems from both original research and previous work on the support provided by family and healthcare professionals in the help and care given to seniors living in nursing homes and suffering from cognitive deficiencies linked with dementia. It is inspired by the 'person-centered care' approach used in long-term care. As outlined by Brooker [1], as well as Wellin and Jaffe [2], the person-centered care approach, based on Tom Kitwood's work [3–5], promotes four basic principles set out in the 'VIPS' model: (V) *value* people living with dementia and their caregivers, (I) treat these people as *individuals,* (P) tackle the

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situation from the *perspective* of those living with dementia, and (S) provide a *social environment* that fosters their well-being. Although many nursing homes adopt this approach with a particular emphasis on communication, expression of choice, active listening, and maintaining residents' identity, only a few present a clear practical frameworks and guidelines to attain these objectives [6], as suggested by the Bradford Dementia Group [7–9]. Moreover, the scientific literature of recent years offers little insight into the real contribution of family caregivers and healthcare personnel in helping seniors living in nursing homes to maintain their identity and exercise their social roles, and a number of commentators point out the need for further research in this area [10–12]. Authors stress the importance of gaining a better understanding of the strategies used by the stakeholders, including family caregivers and healthcare personnel [13–15], to help seniors as much as possible to remember and use their skills, to help them live by their values and life experiences on a daily basis in institutional settings [7,16–18].

This study focuses on psychosocial interventions, in which maintaining identity is considered one of the determinants in the participatory activity of residents in nursing homes [2,19]. Specifically, this study examines the use of identity cues to reinforce the self-value and personhood of residents and to bolster their biographical memory. In the context of our research, the identity cues represent biographical knowledge (seniors' feeding preferences, meaningful objects, hobbies, childhood and adult life memories, and others significant roles and events) used by family and healthcare personnel to stimulate, trigger signals and incite seniors to interact with their immediate surroundings [20]. These identity cues seek to activate the dementia sufferer's memory. Our grounded approach is underpinned by three objectives: 1) identify and categorize the identity cues used by healthcare personnel and family caregivers, 2) document how they are used, and 3) gain a better understanding of their usefulness in interactions with seniors living with dementia in residential settings.

2. Scientific literature review

An overview of the scientific literature shows that numerous works tackle the notion of identity, but as Kaufmann [21] points out: "although a number of authors refer to this concept, few have had the courage to define it." Despite the lack of consensus on a definition, three key elements emerge. First, a majority of the authors agree that identity is constructed through exchanges or interactions between individuals and their environment [22]. The second element is that identity is made up of both the social identity and the personal identity. Social identity takes shape under the influence of social structures: culture, race, religion, and gender [23,24] as they provide a shared sameness among the members of a group. Personal identity, however, relates to concepts such as the self and self-image. This identity is based on how individuals view themselves, on their perception of how others regard them, and a sense of otherness that separates an individual from the others. Personal identity and social identity are intertwined in the individual; they coexist and influence each other [23]. The third element is identity viewed as a multidimensional concept. It encompasses a number of dimensions of the individual, such as their character traits, tastes, habits, socio-demographic characteristics and social roles. Identity evolves over time, through personal experiences, and in social roles, thus adding to the definition of the self. It is more accurate, then, to talk of an individual's multiple identities. The definition of identity

that we used in our study is: “all of the physical, psychological, moral, legal, social, and cultural characteristics based on which individuals can define, introduce, know and present themselves or by which others can define, situate, or recognize them” (translated from Tap, 2005 [25, p. 68]). The identity cues are then expressions of the multiple dimensions and facets of an individual identity evoked interacting with him.

To begin examining the question of identity in people with dementia, it is important to mention a clear conviction expressed by many authors who state that identities persist beyond dementia [2,26–29], along the works of Tom Kitwood in UK [3–5,30] and Steven R. Sabat in the USA [31,32]. This assertion is supported by a growing number of empirical proofs [18,33–35]. It clearly acknowledges the personhood status of those living with dementia and announces a true paradigmatic shift in dementia care [28,36]. Individuals with dementia can no longer be viewed solely as sick, or deficient and lessened by cognitive losses, but rather be regarded as full-fledged persons with full rights and needs who can assume their own identities according to their own ways of communicating and interacting with others. As of the idea of a “malignant social psychology” pointed out by Kitwood [3] or the similar notion of a “malignant positioning” [37,38], they show that other people’s views and reactions have a considerable effect on the self-perception of persons with dementia [39]. It is important to stress that identity or, more accurately, identities evolve throughout the course of a person’s life, through social interaction, including the individual’s shifting roles, as well as in environments and contexts, including the institutional settings such as examined in our study.

3. Method

This exploratory study is based on the constructivist research paradigm, which argues that human generate knowledge and meaning from their experience. This paradigm assumes that there are multiple realities; that the knowledge is established through the meaning attached to the phenomena studied and that the researchers interact with the subjects of study to obtain data [40]. This study is used a qualitative method characterized by the processing of data that is difficult to quantify, by the use of a flexible and inductive method of analysis, and by the systematization of the daily life experience [41]. This fosters a grounded approach to identity and psychosocial interventions among persons with dementia:

3.1. Description of the research environment

The research was conducted at a nursing home in a semi-urban community located in the Greater Quebec City area of the province of Quebec, Canada. A proportion of the institution’s healthcare personnel are often neighbors, friends, acquaintances, or members of the extended family of one or more of the seniors living in the residence. Our study was concerned exclusively with the institution’s special care unit, which houses 17 of this nursing home’s 80 residents. The special care unit personnel applies an approach partly based on a person-centered care approach. This unit includes seniors suffering from Alzheimer disease and other types of dementia. Some residents exhibit several behavior disorders or other challenging behaviors. However, none of them are subject to any restrictions on their movement within the special care unit. However, they must be free to

move about to remain in this unit. To help healthcare personnel become better acquainted with new residents, the family members and caregivers complete a brief biographical information form for the new resident, which includes identity-related information such as the person's tastes, habits, significant past experiences, hobbies and any significant members of the person's social network. Thus, healthcare personnel can refer to the resident's file to consult his or her biographical information.

3.2. Sampling

The findings of this study are based on an intentional sample [42] of family caregivers and members of healthcare personnel. To select the sample, the institution's administration mailed a study information brochure (research objectives, details on the participation request, rules of ethics and a registration form) to all family caregivers associated with the 17 seniors living in the unit. A poster, with the same information, was displayed on a bulletin board at the unit. On family members' visits, the healthcare personnel could invite them to take part in the study. In order to be selected as participants, the family caregivers had to visit the senior on a regular basis (every week or every other week). More than one family caregiver could be selected per resident. On family members' visits, the healthcare personnel could invite them to take part in the study. The family caregivers who agreed to participate in the study could submit their registration forms by mail, by telephone, or by dropping them in a box set up at the unit. For the personnel, the administration placed the same informational brochure in the mailboxes of all healthcare personnel, indicating that participation was limited to those who currently worked or had worked on a regular basis with persons with dementia. Information sessions were held during regular staff meetings to field any questions. Registration forms were collected according to the procedure described above. This study and procedure were authorized by the Université Laval Ethics Committee (CERUL 2006032).

3.3. Data collection method

Data was collected between September 2006 and January 2007 during semi-directive interviews that lasted an average of 90 minutes. The interviews were conducted by an experienced research professional in participants' homes or onsite, as per the participants' preferences. The interviews were recorded directly onto a computer. The verbatim record was produced using InqScribe software (v. 2.0.5). At the end of the interview, a brief questionnaire was used to gather information on socio-demographic characteristics of the family caregivers or healthcare personnel as Well as their socio-professional characteristics. The interview included questions related to our research objectives, as in these examples: How would you describe your relationship/role/contacts with the seniors in the unit (healthcare personnel) or your relative (family caregiver)? On a visit, or in your work, how do you initiate contact with the person with dementia/how do you do that? To what end(s) and how do you get and use the knowledge you have of the senior?

3.4. Data analysis method

The verbatim record was analyzed using Atlas-ti, a qualitative analysis software (version 5.2), based on the manifest content of the interviews [42,43]. The first step in the interview analysis enabled us to make a list of the identity cues mentioned by the healthcare personnel

and family caregivers. A more refined analysis yielded new information, such as how the cues are used, as well as insights into their usefulness according to family caregivers and healthcare personnel.

A number of measures were taken to ensure the trust-worthiness of the data [44]. First, a sufficient number of interviews were performed to achieve data saturation. To round out the information collected from the interviews and to enrich the research material using a triangulation method [45], the research professional conducted two days of participatory observation in the special care unit. The goal was to gain a first-hand perspective on the daily life of residents, staff and visitors, and to better understand their interactions and the factors associated with both work and visits. In order to ensure the internal validity of data, we randomly selected two interview records, one conducted with a family caregiver and another with a healthcare staff member. A senior researcher, a co-researcher and the research professional each analyzed and coded these two interviews separately, using inter-rater validation [46]. This allowed us to reduce the number of index items and to regroup certain items under a single code based on a definition agreed upon by the three researchers. The coding and analysis of all the interviews were then reviewed in light of these changes. The results of the analysis were discussed with a group of 12 interviewees (5 family caregivers and 7 members of the healthcare personnel) to ensure that our understanding of the collected statements was correct and that it accurately reflected the interviewees' reality [43].

3.5. Description of the sample

The recruitment procedure enabled us to meet nine family caregivers: two men (2 sons of residents) and seven women (1 spouse and 6 daughters of residents), each of whom was married. Their average age was 59.9, ranging from 42 to 72 years. Seven of the nine (77%) had up to 12 years of schooling. The family caregivers visited their relatives regularly, up to several times a week, and had been doing so over periods ranging from 2 to 15 years. Twelve healthcare professionals (11 women and 1 man), including 1 occupational therapist, 2 nurses, 4 nursing assistants and 5 attendants took part in the interviews. Three of them had obtained a secondary school diploma, six had a Long Vocational Diploma, two had a CÉGEP (Québec's pre-university college system) diploma college degree, and one had a university degree. Their training and experience dealing with seniors and persons with dementia was highly varied. The healthcare personnel's formal training ranged from a few hours to various types of specialization and training in gerontology and geriatrics, and their experience with this type of clientele ranged between 6 months to and 24 years.

4. Results

In the following section, we will discuss the identity cues mentioned by family caregivers and healthcare personnel, how they are used, and their usefulness in interactions with persons living with dementia. We will also identify similarities and differences apparent in the statements of family members and caregivers. The numerous identity cues were classified in three groups that reflect the diversity of the statements compiled. We did not aim, however, to present an exhaustive list of all the dimensions of identity.

4.1. Classification of identity cues

During the analysis process, we found that reported identity cues reflect different types and levels of knowledge about the elderly person. They can be classified into three main groups, referring to: (a) the sociological, (b) the relational, and (c) the individual characteristics associated with the elderly person's identity. The levels of knowledge can be placed on an axis ranging from intimate to public knowledge.

Sociological characteristics make up the first group of identity cues. Through these cues, family members and healthcare personnel evoke elements related to age, sex, nationality, marital status, origins (place of birth, home town, neighborhood), language, cultural backgrounds, religious beliefs, education, political leanings, and income levels. In addition to characteristics that points to the seniors' social identity and groups to which they belong, the participants also use references to groups with which the seniors identify, or groups that can be associated with a hobby, a recreational activity, or an occupation that the elderly persons had in the past and which still hold meaning for them. While visiting her father, a caregiving daughter talked of the hardships of the agricultural profession, which the father had worked at from a very young age: "Dad, the local farmers just finished bailing their hay. It wasn't easy because of all the rain. You remember those years back home when everything rotted in the fields."

The seniors' social networks, their roles within these networks and the nature of their relationships with their human environment, make up the second group of identity cues. Over the course of life, people experience various relationship settings: within a marriage, in cohabitation, in a household, in the family, in the neighborhood, with friends, at work, within organizations, or as citizens or community members. Participants use identity cues to refer to roles and people in relationship settings known by familiar to the person with dementia, such as: wife, mother, sister, best friend, colleague, or neighbor. The participants often link these identity cues with current events or biographical anecdotes related to the dementia sufferer's personal history and social network. These identity cues are reminders of relationships developed in various roles and settings during the senior's life. A caregiving daughter reminded her mother of the friendship she shared with a woman at their parish: "You know her, …Diana. She was active in our parish. She lived near by… a little brunette with a sweet smile… you liked her very much. She brought you fresh vegetables from her garden". These relational identity cues connect to social and personal history. They focus on the senior's social self and the meaningful roles and relationships of both their public and private life, thus challenging both their social and personal identities and memories.

The third group of identity cues includes the seniors' individual characteristics, such as tastes and character traits, that define part of their psychological profile and personality, as well as how such variables influence their interactions with others and the way people react to them. These individual characteristics include the seniors' relation with food and space, their body and emotions (e.g. touching and being touched), their self-image and personal hygiene, their need for movement, their moods and emotions and, sociability, their values and views of the world, and perceptions of time. A female caregiver recounted to members of the healthcare personnel: "My husband always had been strong-minded – he speaks loudly and can get angry from time to time, but he isn't mean at all. He's just somewhat

emotional about things." A caregiving daughter reminded her mother: "You always had a sweet tooth. Chocolate is your favorite treat." These characteristics distinguish seniors as individuals in how they express their personal needs and react to their surroundings on a day-to-day basis. This is part of their personal identity.

It is important to distinguish between two categories of individual characteristics. Even when dementia is clearly diagnosed, it is evident that elderly people suffering from it continue to exhibit some the individual characteristics they had for many years, and which may remain completely unaffected by dementia, such as a taste for sweets, or musical ability. However, other characteristics appear only with the onset of dementia. We may cite several examples, as reported by healthcare personnel: "Every morning when she wakes up, Ms. T. asks us to open the curtain, close the bathroom door, switch the lights on or off at least twice, before she agrees to get out of bed." "Ms. C. will only take her pills if you sing her Happy Birthday…" "Sometimes, when he doesn't want to get dressed, just tell him it's Sunday morning and he has to clean up to get to mass, and everything will go fine…" These characteristics become part of the seniors' identity in the unit.

Among these three groups of identity cues, certain of the seniors' characteristics are well known to family members and easily recognizable to healthcare personnel upon preliminary observation. These may include clothing and feeding preferences, for example. In interviews, these identity cues were frequently mentioned, both by family members and by healthcare personnel. Other identity cues, already known to family members, can be discovered by healthcare personnel over time and through regular interactions with the seniors, and include character traits and daily habits. Behaviors, which emerge with the onset of dementia, and which can sometimes be disruptive, as well as the approaches best suited to each individual are often discovered by trial and error, by chance, or by an intuitive hunch. These cues were frequently mentioned by healthcare personnel as they can very handy dealing with the individuals showing these behaviors or unsettling reactions. For some seniors, adequate care eventually requires more probing and the gathering of information from other sources, such as their work history, their social roles and the major events in their active life. Such characteristics were well known and often cited by the caregiving spouse, as well as the majority of the caregiving children, in our sample. Healthcare personnel discover and learn to use these identity cues after a few months of contact with the senior or could learn about them during discussions with family members. Yet some information does remain private or relatively secret, such as the more difficult episodes of one's family and love life, although these certainly can shed light on a person's behavior. According to the study participants, such information is often known only to the caregiving spouse and, on occasion, by the Caregiving children. It may be passed on to members of healthcare personnel, if the family considers that this may improve the quality of care their parent receives, or improve their interactions. These identity cues were mentioned by several of the caregiving children and the caregiving spouse in our sample, but were not present in the testimonies of healthcare personnel. In short, the identity cues cited by family caregivers and healthcare personnel may differ based on how well they know the senior and on how private or secret such information is kept by family members. A gradual biographical learning process about the seniors, through observation and conversation with them or their family members, equips healthcare personnel with the ability to use highly

personalized identity cues; yet some areas may be ignored, left unknown or withheld from them, and the same can be said for family caregivers. Some meaningful ways to deal with individual peculiar unsettling behaviors can also be shared between coworkers as part to an individualized care approach to this individual.

4.2. How identity cues are used

The identity cues take on a variety of forms (objects, symbolic expressions) and are used in a variety of places in the unit. They constitute the underlying fabric of casual daily interaction and socialization. They often carry important biographical and personal meanings that family caregivers can either share or withhold from the healthcare personnel.

The senior's room is a good setting to gather information on the elder's identity, especially for healthcare personnel. Observations about personal objects such as photos, mementos, bedspreads, a rocker chair and other pieces of furniture, the contents of drawers (candies, beauty products, clothing) can convey many facets of identity because they are associated with the tastes, habits, and memories of the senior, as well as with people who played significant roles in their life. A few questions about these objects can offer indications about the personal and social meaning imbedded within each of them. Often initially expressed as conversational questions by the healthcare staff, these identity-probing questions serve as an opening to initiate interaction. Talking about the weather, they gradually move on to discuss the small things of daily life, the day's news and weather, the seniors' likes or dislikes, the people and places on photographs, the memories tied to mementos on the senior's dresser, and so on. A member of the healthcare personnel gave the following example: "Hello Mr. T. What a nice picture on your billboard… Who is…? Looks like a nice family…", and: "… What a beautiful dress…your daughter brought it? …" Positive statements are generally a good start to encourage the person living with dementia to express themselves and enjoy the conversation. Identity cue probing is a way to get in contact with the elders, to know them better, and to personalize the relationship that gradually form with them.

A number of facets of the person's identity also emerge from the expressions used to greet people as "Hello, Mom," "Hello, Dad". The expression used immediately identifies the relationship between the people present and indicates their respective roles. It is not uncommon to hear family members say their first name and specify how there are related, their kinship with the seniors: "Hello, Mom, it's Germaine, your daughter." For spouses, the use of terms of endearment such as "my dear", "my sweet" expresses intimacy and bonds of love. For the healthcare personnel, it is common to address residents as "Mr." or "Mrs." followed by their last name. Depending on their perception about the elders' response and mental ability, members of the healthcare staff sometimes use Mrs. or Mr. with the resident's first name if the senior no longer reacts to their surname. This is viewed as a sign of respect and is in line with the residence's internal policy of avoiding over familiarity, which could be viewed as inappropriate by the senior's family or by the seniors themselves. These expressions, commonly used in society at large, acquire a distinct significance in this setting because they are meant to elicit memories and trigger signals in people living with dementia, thereby inciting them to interact.

Family caregivers use identity cues during visits when bringing news from the senior's social network, referring to family, relatives, neighborhood, friends and coworkers, as well as subjects that can interest the senior. A caregiving daughter, speaking to her mother: "Mom, do you remember Mrs. G., our neighbor on B. Street? I think you worked with her at the church? She's a great-grandmother now." Visits are also opportunities to talk about upcoming events in the senior's hometown or about family gatherings. A caregiving son informs his mother about parish activities: "There is a party at the church next week. We could drop by for a little while. A lot of people you know will be there. We could even go see your sister. She lives nearby."

The use of identity cues, related to the knowledge of a senior's habits and idiosyncrasies that have emerged after the onset of dementia, calls for discernment from well-advised people and respectful attitudes from family members or healthcare personnel. A caregiving daughter mentioned: "My mother likes and ask for candies all day long. I call her, and some of the attendees do call her, *The Candy Lady.* It's ok. I don't bother. I known they respect her and really care about her. It's just the way she is nowadays." Even in positive tones, these identity cues must be used carefully, one should care to ensure that neither the senior nor their family members are likely to be offended, or demonstrate an attitude that stigmatize those they depict or reduce them to their peculiar behaviors, but merely help to enter into contact with them and stimulate exchange.

Informal chats between family caregivers and healthcare personnel during visits allow family caregivers to share and to gather information from healthcare personnel about their relatives. When a family member lives in a residence and is affected by dementia, the family caregivers often stress the senior's past abilities, roles, and accomplishments. They bring up significant events in the family's history (the good times they had, the jokes they shared, etc.) to illustrate the achievements, character, and values that marked the senior's life. A caregiving daughter explained to healthcare personnel: "You know, my mother wasn't always like this. She was a very active woman. She was sweet, but she wouldn't let people walk all over her. Oh no, my brother-in-law found that out the hard way!…" When faced with the changes brought on by cognitive disorder and memory loss, family caregivers bring up these topics to contrast what they have lost. People guard the memory of how their loved ones once were, in comparison to the state that the effects of illness have brought upon them. As mentioned by family caregivers, these conversations - often take place when the seniors are nearby, and function, to some extent, as testimonies to their memory and self-image, as apologies for their difficult behavior and as appeals for the healthcare workers' kindness and understanding.

4.3. Usefulness of identity cues

By their very name, the purpose of identity cues is quite evident; i.e. to trigger a signal and incite the senior affected by dementia to interact with those around them. This study examined two main groups who use identity cues: family caregivers and healthcare personnel. As outlined above, the two groups have different degrees of access to information about the seniors' identity and, therefore, to the- deeper meanings of that information and the attendant identity cues. Family caregivers generally have better knowledge of these

identity references and can use them more easily often sharing a common identity with the senior. It is important to remember that along with the definition of identity given above, identity cues are also part of how people develop and acknowledge their relationships. According to the study participants, the use of cues bolsters seniors' memory, eases relations with them, facilitates care, reinforces their sense of innate personal value, and allows for increased expressions of interest and sympathy.

For persons living with dementia, identity cues serve as a reminder, a cue to their own remembrance. When a caregiving daughter says to her mother: "Hello, Mom, it's Gisele, your daughter," she is trying to make it easier for her mother to identify her and establish their respective roles. For healthcare personnel, the repeated use of the senior's last or first name helps to anchor the senior's identity and reinforces self-recognition. It reminds them of who they are, in a respectful subtle way.

Identity cues are used in almost every conversation with the seniors living in the unit. The family caregivers and healthcare personnel awaken the multiple aspects of the seniors' past and present identities in their interactions with them. The general objective of such conversations can be to socialize with the seniors, to ensure a good relation, or to mobilize or steer their attention toward positive thoughts. In the specific context of treating a person with dementia, the art of small talk, coupled with the use of identity cues, is a valuable tool to facilitate contact.

As mentioned above, family caregivers and, in particular, healthcare personnel become familiar with a certain number of characteristics that seniors develop with the onset of dementia (behaviors, reactions, or particular ways of doing things). These identity cues are used in some strategies, such as foreseeing the seniors' moods, or to bring up subjects or actions that generally prompt them to react positively. These personalized strategies, using some knowledge of personal identity cues, also make things easier for healthcare personnel when taking care of residents' personal hygiene, as well as at bath time, during meals, and when it is time for them to go to bed or wake up. This knowledge becomes part of a person' individualized care and is part of a communication strategy with that particular individual. Knowing what pleases or displeases a person, what subject will interested them, what kind of music or song will keep them in a good mood, what are their personal sensitivities, and so forth, are all part of identity cues that healthcare personnel use to divert seniors' attention, refocus it in a positive way, or head off subjects and events that cause them to worry or become anxious. A member of the healthcare personnel recounted: "When Mrs. R. is upset and sad because her daughter did not come to see her, one strategy is to bring out the underlying emotion, her affection for her daughter and lead her to a related topic by asking her about her children or grandchildren, talking about the activities she likes to do with her daughter when she comes to visit, or complimenting her on the clothing her daughter brought her." Thus, in addition to directing the seniors' attention, the identity cues are also used to express interest for their concerns, while taking into account the underlying emotions.

The use of identity cues is also intended to acknowledge the self-value of persons affected by dementia through compliments and by encouraging them to use their residual skills.

Family caregivers also help to acknowledge seniors' value through the information they share about their relatives in casual discussion with healthcare personnel. The seniors' pride, resilience, accomplishments, and the importance of the roles they used to play, are all part of the image that family caregivers nurture of their loved one, and which they wish to convey to the healthcare personnel. They often seek the sympathy of the healthcare personnel and remind them that their relative was not always the person they see today. Sometimes it is a way of accounting for the senior's behavior. Speaking with healthcare personnel, a caregiving son apologized for his mother's behavior: "It's not her fault, it's the illness. She used to be so …" Coming from a caregiver or a family member, the use of identity cues can express solidarity and family values, and play an underlying role in a grieving process.

5. Discussion and conclusion

The purpose of this study was to gain a better understanding of how family caregivers and healthcare personnel use identity cues with seniors suffering from cognitive deficiencies associated with dementia, in a nursing home setting. This qualitative study, which was conducted in a single nursing home on a small sample composed of family caregivers (mainly women: a female spouse, two sons and mostly 6 daughters), and healthcare personnel, cannot claim transferability for its results. However, it does provide observations that may serve to foster further research and practice on questions relating to identity in people affected by dementia. The results show that family caregivers and healthcare personnel use identity cues that draw on the seniors' sociological, relational and individual characteristics. Although not an exhaustive representation of the multiple dimensions of identity and the personal knowledge useful in a person-centered care approach, this classification nevertheless helps to refine the concept of identity, which remains complex, as well as vague, according to a number of authors [21]. This classification also expands on the definition of identity used by certain authors [36] who had focused on self-identity roles played by seniors living with dementia. With a grounded approach, this study has therefore helped advance knowledge about and the definition of identity in persons affected by dementia.

Regarding practice in the workplace, the diverse uses of identity cues mentioned by study participants allowed us to identify various strategies to foster cooperation and communication with a clientele exhibiting challenging behaviors. Identity cue probing is a way to get in contact with the elders, to know them better and to personalize the relationship that gradually form with them. These identity cues are used in some strategies, such as foreseeing the seniors' moods, or to bring up subjects or actions that generally prompt them to react positively. These personalized strategies, using some knowledge of personal identity cues, also make things easier when taking care of residents' personal hygiene, as well as at bath time, during meals, and when it is time for them to go to bed or wake up.

The use of identity cues such as news about seniors' parish, family, and friends, neighbor or colleagues, helps to preserve their social identity. Reinforcing the value of seniors' achievements and skills contributes to their self-esteem and self-image. The study's findings also highlight the significant role family caregivers can play when their relatives are placed in a nursing home [11,48] and the partnership sought both by family caregivers and

healthcare personnel. The complementary value of two types of expertise or know-how (i.e. the healthcare personnel's professional expertise and the biographical knowledge of family caregivers who have a greater understanding of the seniors' multi-faceted identity must be recognized and put to better use [11,12,36]. The relations between looking after and caring for their kin in long tem care raise many challenges for the family caregiver. In the process of institutionalization, from home to the nursing home and throughout the many encounters between the health system and the caring family, the caring relation goes from "doing things" to "managing things". The caregivers must adapt, gradually establish a trusting relation with trustworthy personnel, discreetly supervise and control how things are done, create new ways to manage and achieve their own goals in taking care of their relative. Whereas the common belief puts forward the relief which should be felt after the relative' institutionalization, it most often means a loss of control and a renegotiation on several dimensions in the caregivers daily life. They are confronted within the institutional settings to multiple schedules, restrictions, organizational standards and explicit or otherwise implicit internal policies. To institutionalize a close relative with dementia is also to undergo multiple lost and an equivocal grieving process and most often, culpability. The full burden of these emotions is not always taken into account by the personnel, nor do they muster the time or strategies to face it or help them throughout. These emotions can be accompanied by a feeling of helplessness and inability to share with others. On the beginning of the relative's institutionalization, the family caregivers feel the need to protect their relatives who do not express themselves clearly. They often wish to share their knowledge about the tastes and ways to manage their relative into a truly personalized care. Except from casual discussion and biographical forms completion, the effective methods to share the caregivers' know-how and the expertise of the health personnel still remain to be explored.

In addition to facilitating the care of, and contact with, seniors living with dementia, the use of identity cues makes it possible to get to know seniors, motivate them, and acknowledge them as individuals, which is consistent with the philosophy of the person-centered care approach and supports the premise of authors who maintain that identity persists beyond dementia [2]. By sharing information about seniors' identity with healthcare personnel and by talking about their relatives before the onset of illness, family caregivers are able to reclaim part of the senior's identity, a moral heritage, and begin a much-needed grieving process [12]. In conclusion, a better understanding of the use of identity cues will make it possible to develop more personalized interventions that contribute to a higher quality of life and the increased interaction of seniors living with dementia in residential settings.

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