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RENEGOTIATING RELATIONSHIPS: THEORISING SHARED EXPERIENCES OF DEMENTIA WITHIN THE DYADIC CAREER

James Rupert Fletcher

Institute of Gerontology
Department of Global Health & Social Medicine
King's College London, United Kingdom

4th floor, East Wing, Strand, London, WC2R 2LS

Email: james.fletcher@kcl.ac.uk

ABSTRACT

The dyad is increasingly recognised as a key site of experiences of dementia, yet theoretical accounts of the dyad remain poor. 21st century political developments regarding dementia have changed the ways in which the dyad is perceived, from the carer as victim to the person with dementia as victim. Across both approaches, a problematic dichotomy of two individuals remains. The concept of 'joint career', developed from Goffman's 'moral career', offers an alternative approach to shared dyadic experiences of dementia. Using data from interviews with people affected by dementia regarding their experiences of dementia, this paper presents an account of the dyadic career, a patterned trajectory of shared experience. The introduction of dementia into pre-existing dyads entails the renegotiation of longstanding roles. As role transformation progresses, increasing difficulties lead to the creation of symbolic boundaries denoting the limits of the care-giver role. When those boundaries are encountered, they are often transgressed, and the dyadic career hardens as it continues, becoming work-like and less affective. This hardening of relationships is grounded in nihilism, apprehension and objectification.

KEYWORDS

dyad; couple; spouse; dementia; care; career; relationship; Goffman

INTRODUCTION

During a recent interview (Elder 2017), prominent dementia advocate Jayne Roberts noted the importance of maintaining a spousal relationship in response to the tendency for diagnosis to redefine partnerships:

You go into the consultation as husband and wife and you come out as "patient and carer". We've wrestled that back and we are a husband and wife team again.

In this paper, I consider the power of dementia to change people's roles in relationships, from loving partners to care-provider and care-recipient. I contend that the sustained dichotomies of historic exclusion and contemporary person-centredness position individuals in a way that is removed from dyads' shared experiences of dementia. Rather than a specific individual, dyadic relationships are presented as a principle site of dementia, with each party being integral to the other's experiences. I draw on Goffman's 'moral career' to develop a theoretical account of dementia as a dyadic experience. This experience encompasses various role, self and relationship transformations, within an overarching patterned trajectory.

Care dyads are typically formed of cohabiting spouses or a parent and child, both of which are considered in this paper, though other configurations do exist (Wimo et al., 2013: 390-391). Such dyads often consider the experience of dementia to be shared (Wadham et al., 2016: 467), informing a growing scholarly appreciation of dementia as affecting dyads and relationships rather than individuals (Wadham et al., 2016: 463). However, dyadic experiences of dementia remain poorly understood (Braun et al., 2009: 426), with research having generated vague and inconsistent results (Braun et al., 2009: 434). A major shortcoming of previous studies has been the inclusion of only one perspective within the dyad (Wadham et al., 2016: 463). This study addresses this issue through the inclusion of both perspectives. There is also a notable scarcity of theoretical accounts of dementia as a dyadic experience (Braun et al., 2009: 433). Research has found that dyads commonly experience poor health outcomes, social isolation and financial problems (Lewis et al., 2014: 7-8). As such, novel accounts of dyadic experiences of dementia are necessary as a basis for informing improved dyadic dementia care approaches and outcomes (Wadham et al., 2016: 463). This paper seeks to present such an account.

POSITIONING DYADS

Understandings of dyadic experiences of dementia must be situated within the context of evolving assumptions regarding dyads. Within broader 21st century transitions in institutional and public perceptions of dementia, care and research, conceptualisations of dementia care dyads have transformed across recent decades. People with dementia have historically been excluded from meaningful participation in care and research due to assumptions regarding their incapacity due to cognitive impairment (Brod et al., 1999: 26; McKeown et al., 2010: 1936). In their place, carers were commonly viewed as proxies for people with dementia (Dewing, 2002: 158). Carers were considered the victims of dementia (Andrews, 2017: 248-249; Woods, Keady and Seddon, 2008: 12-13; Zarit, Orr and Zarit, 1985: 1), unlike people with dementia who were deemed comparably fortunate because of their presumed unawareness of any hardships they faced (Burke et al., 1998: 317; Kelly, 2008: 539).

These attitudes partially remain. However, they have largely been replaced by new perceptions stemming from the 21st century proliferation of person-centred ideology (Brooker, 2003: 215; Clarke and Keady, 2002: 30) as a result of Tom Kitwood's (1997) reimagining of Carl Roger's (1961) psychological work. This ideology champions the experiences and perspectives of people with dementia, advocating for their greater respect and inclusion in research and care (Mitchell and Agnelli, 2015: 46). Person-centredness is not without critique (see Dewing, 2008; Higgs and Gilleard, 2016a; Nolan et al., 2002), yet it has dominated conceptualisations of dementia across the early 21st century (Brooker, 2003: 215; Clarke and Keady, 2002: 30; Mitchell and Agnelli, 2015: 46).

During this time, person-centredness has evolved. Kitwood's (1997: 8) original prescription was rooted in social interaction, as "a standing or status bestowed upon one human being by

others in the context of a relationship”. Such an approach privileges relationships (Woods, Keady and Seddon, 2008: 13). One may therefore argue that critiques of person-centredness that focus on its individualism are likely grounded in poor understandings of its original manifestations (Dewing, 2008: 11). That said, such criticism is more apt when applied to contemporary iterations of person-centredness, revolving around rhetoric of dedication to the individual with dementia. Current person-centredness often promotes individualism, independence and autonomy (Nolan et al., 2004: 46). For example, the *National Service Framework for Older People* (Department of Health & Social Care, 2001) explicitly focuses on “respecting the individual” within a person-centred approach (Brooker, 2003: 217).

This individualism partially explains the contemporary reconceptualisation of dyads within person-centredness. Whereas the ‘carer as victim’ concept positioned people with dementia as causes of burden (Andrews, 2017: 248-249; Beard, Knauss and Moyer, 2009: 227), person-centredness has cast people with dementia as victims of carers’ “malignant social psychology” (Flicker, 1999: 880; Higgs and Gilleard, 2016a: 778-779). Victim and perpetrator have swapped roles. Throughout the transition, a dichotomy of good and bad has been maintained (McParland, Kelly and Innes, 2017: 259). The political dichotomy of exclusion and person-centredness present two problems. It reifies people’s complex experiences into narrow good or bad categories; and in venerating one party, it ascribes negativity to the other, cleaving dyads into two individuals (McParland, Kelly and Innes, 2017: 264-265). We lack the means to satisfactorily account for dementia as a shared entity.

THE JOINT CAREER

An effective approach to understanding dyadic experiences must represent the significance of the dyad within dementia, alongside its processual nature – being characterised by transformation. A systematic review of qualitative research regarding dementia dyads reported that all studies described important role changes, such as self-definition as a ‘carer’ and referring to ‘I’ instead of ‘we’ (Wadham et al., 2016: 468-469). Dementia tends to alter dyadic relationships because people’s corresponding roles are transformed (Ablitt, Jones and Muers, 2009: 498; Quinn, Clare and Woods, 2009: 143). A useful account of dyadic experiences of dementia must therefore recognise that roles change gradually.

To this end, I consider the concept of the joint career to offer a valuable means of understanding dyadic experiences. The concept stems from Goffman’s (1961) popularisation of the ‘moral career’. A career is “any social strand of any person’s course through life”; a person’s trajectory through time and the various roles that they perform (Goffman 1961: 119). The ‘moral’ caveat denotes corresponding alterations in the person’s self that stem from the transitions of the career (Goffman, 1961: 119). Through this process, old selves are replaced by new selves, and so on (Goffman, 1961: 155). Sociologically, the replicability of the moral career in the lives of different people in similar situations is intriguing. It indicates “the power of social forces” as diverse individuals, events and experiences come to appear somewhat uniform over time (Goffman, 1961: 121). This uniformity is often interpreted as evidence of determinism, yet it is actually the process of interpretative interpersonal interaction that guides moral careers, rather than some inherent characteristic of the person or the situation (Fletcher 2018: 182).

The ‘joint career’ is a combination of moral careers, incorporating two people. Within the joint career, roles transform over time within trajectories that are inter-related, each role and each change corresponding with the other party’s roles and changes. Joint careers are symbiotic because one person’s role uniquely answers another’s. Drawing on the work of Karp (2001), Beard and colleagues (2012: 3) have suggested that dyadic experiences of dementia might be

accounted for as joint careers. The introduction of dementia into the dyad fuels the transformation of roles, selves and relationships (Beard et al., 2012: 3). However, this approach remains greatly underdeveloped, with only scant reference made to its possibilities. In this paper, I build upon Goffman's use of career to account for dyadic experiences of dementia in terms of patterned trajectories containing role, self and relationship transitions. This 'dyadic career' respects the two imperatives of interdependency and transformation.

METHODOLOGY

The data used in this paper is taken from in-depth interviews with people affected by dementia living in the East Midlands, United Kingdom, during research exploring experiences of dementia within informal care. Seven people with dementia were recruited through emailing local churches and community organisations. These people then identified their carers for recruitment into the study. Of the participating people with dementia, three had Alzheimer's disease, two had vascular dementia, one had mixed Alzheimer's disease and vascular dementia, and one had fronto-temporal dementia. Dementias ranged from early to moderate stages and time since diagnosis ranged from six months to ten years. Six were male and all were white British. Of the 27 carers recruited, six were spouses, nine were children, six were grandchildren, five were care professionals and one was a vicar. Six dyads were comprised of a husband with dementia and a cohabiting wife, and one dyad was a mother with dementia and a cohabiting daughter.

Data was collected via semi-structured in-depth interviews conducted individually with each participant. Interviews focused on participants' experiences of dementia, particularly regarding relationship changes over time, beginning before diagnosis and progressing to the present. Interviews were typically conducted in participant's homes, ranging in length from 40 to 105 minutes. Audio recordings of these interviews were transcribed, and the transcripts were analysed using thematic analysis and NVivo analysis software. Minute coding, applying descriptive words to small sections of transcripts, was conducted twice and generated 135 codes. Categorical coding, collating codes into broad categories, resulted in seven categories. Thematic coding, amalgamating categories within explanatory themes, resulted in four themes, one of which was the 'dyadic career' and is reported here.

This study was intended to be inclusive. People with dementia were involved as both participants and study designers via sample selection. The nature of the close relationships between participants meant that intra-network confidentiality could not be ensured. Participants were made aware of this and were instead offered extra-network confidentiality. To this end, all names used in this paper are pseudonyms. The study fell within the remit of the Mental Capacity Act 2005 and relevant research provisions were followed to enable the lawful participation of people without the legal capacity to consent to participation. Procedural ethical approval was granted by the Social Care Research Ethics Committee and the Health Research Authority (project reference: 16/IEC08/0007).

ROLE RENEGOTIATION

Many participating people with dementia found progressive reliance on their loved one to be especially challenging. People had commonly taken self-worth from historic independence and providing support to others. The gradual reversal of this support was troubling for participants. Such role reversal undermined longstanding mechanisms of self-worth within relationships. Several participants expressed sadness and anger toward their self-perceived transformation, becoming "useless" and then a "burden". While one might imagine that a lifetime of supporting

a partner might justify the reciprocation of support in later life, historic support-giving instead exacerbated people's resentment of their emerging dependencies. Janice, whose husband Paul had fronto-temporal dementia, recognised this resentment:

I know it gets him down sometimes and then he gets really ratty, but I'm not surprised. I mean, for somebody as independent as him having to rely so heavily on me, particularly when we've both been independent. I mean, we've had no option. His job, he was away all week so you sort of did your own thing. And now he's got to rely on me for a lot of things and I'm sure he doesn't like it.

The renegotiation of roles, particularly transitions from care provider to care receiver, was a substantial concern within most participating dyads. Several carers attested the importance of not carrying out too many activities for the person with dementia as a means of sustaining traditional roles within dyads. There were evident tensions in this approach. It was commonly beneficial in terms of role maintenance and wellbeing to allow people to continue performing certain traditional tasks such as cooking or cleaning, yet efficiency was conceded as carers were often better able to fulfil tasks expediently. Such scenarios were negotiated variably, ranging from near complete continuation at the expense of efficiency, through to near complete transformation at the expense of role maintenance.

Role transformation is often especially challenging within dementia because it is generally experienced in later life. Its age-associated nature means that pre-existing roles tend to have been established for long periods of time. When dementia enters dyads, roles may have substantial histories. The timeworn delegation of tasks can produce co-dependent roles, with actors being mutually reliant on one another. For example, Mary and Melvin had been cohabiting for 64 years when Melvin's dementia led to Mary taking on new roles:

Interviewer: Have you always been the main organiser?

Mary: No, no I haven't. No, he's [Melvin] usually done it all. That's one of the big changes for me because he's always done everything. He's looked after the finances. He's done any repairs that needed doing. Organised holidays, got the caravan organised and got the bookings for that done. No, he's always done everything. And now he does nothing. . . You see again, I'm not very good on paying bills. The dial-a-ride one, "Oh I'll do that in a day or two", and I'll forget it. And I've got a carer bill now and I'm waiting for Tony [son-in-law] to come and check that for me next week. So I'm not very good really.

Over 64 years, it is unsurprising that a dyad's roles become relationally routinised. Mary and Melvin's lives were intertwined to a position of substantial interdependence. Following decades of reliance on Melvin's financial management, dementia suddenly led to Mary having to adopt his previous role. This role was alien to Mary. Historic reliance on Melvin had left her unprepared. As a result, both Melvin and Mary were distressed by the requisite role renegotiation. Melvin resented his loss; Mary feared her acquisition.

Gender is an influential factor in these role transformations. All participating spouse carers were female, having husbands who had historically enacted gendered roles, Melvin's financial management being an example. Their husband's cognitive decline impelled many of these women to enact new roles, such as finance, transport and household maintenance. Traditional gender divisions had often left them ill-equipped for these roles. For many women there was often a partial, albeit unwelcome, process of empowerment as they gained new skills and power

over decision-making. However, this was not applicable to all. Mary acknowledged finding it difficult to satisfy escalating responsibilities that transgressed traditional gender roles.

Husbands likewise articulated varied responses to forced role renegotiations. At one end of the spectrum, Paul expressed great resentment at his loss of independence and responsibility. At the other end, Henry, diagnosed with Alzheimer's disease, came to accept his increasing dependency as an inevitability of the life course. All participants with dementia were able to reassert their pre-dementia roles to at least some extent. During my interviews with Paul and Janice, they were suffering with a flu-like illness which affected Janice particularly badly. Much of Paul's attention during our interview was directed toward his care of Janice during this illness, especially in the context of her pre-existing mobility issues:

Interviewer: Does the condition make it more difficult travelling?

Paul: No, well, yes and no. She can't be buggering about at the airports, standing in a queue, threading her way around the barriers. So I have to book her mobility, a chair, someone to take her straight through. So we have to only have front seats, which cost extra. And when we get a hotel or anything we've got to be able to have a walk-in shower.

What is telling in this extract is that "the condition" referred to was Paul's dementia, but he interpreted it as denoting Janice. His care-provision toward her and associated role was a source of substantial self-worth. This personally valuable role contrasted his notable difficulties with accepting his mounting dependency on Janice. Their roles were intertwined. Janice's role as care-recipient facilitated Paul's role as care-giver, enabling him to construct desired meanings. This exemplifies the importance of the dyad as a site of role renegotiation, with the ability to enhance or impede wellbeing.

BOUNDARIES

No matter the skill with which roles were renegotiated, conflicts arose within every participating dyad. No experience was entirely harmonious. The progression of cognitive decline corresponded with growing care requirements, which were largely addressed within dyads due to a lack of external input from other actors. The overall effect was that more and more effort was dedicated to addressing dementia. Beth, whose husband Bill had vascular dementia, recognised the gradual extension of her role as carer:

My life is changing slowly, and lately more rapidly, in that, for instance, I'm on the committee at [the University of the Third Age] and I do quite a lot of stuff for them. I'm communications officer, was communications officer, and I produce the newsletter. So that took a fair amount of time in a month. But I found that I just couldn't cope with that and the increasing workload, duties, whatever, with Bill. So I've had to give that up. And it's a shame really because it's an outlet for me. But my world is shrinking as well, I think. That was the justification for buying the tele. My world is shrinking, I'm having a decent tele (laughs).

Dementia gradually crept into dyadic relationships. The increased proportion of shared experience that was dedicated to care eventually led carers to consider the limits of their caregiving. Several participants contemplated the extent of their caring, particularly regarding the appropriate time to institutionalise their dyadic partner. For Mary, the issue was simple. She would not consider institutional care for Melvin because she deemed it to breach their

marital commitments. However, for many, institutional care was a challenging issue of setting boundaries. Participants created symbolic indicators that would arise in the future and denote that an appropriate juncture had been reached for the relinquishing of caring responsibilities. Each indicator marked out a future boundary, after which institutionalisation would be warranted.

Three boundaries – time, symptoms and decline – were described, often in combination. Lauren, whose cohabiting mother April had Alzheimer’s disease, employed all three boundaries to denote the rightful transition to institutional care. She said that she would care for April for two years, until April wandered during the night, and until April no longer gained perceptual wellbeing from living at home, whichever came first. In combination, these boundaries marked out a detailed set of criteria for relinquishing the carer role. However, Lauren’s case is an especially strong example of the tendency for boundaries to be disregarded. By the time of our interview, two of these boundaries had been transgressed. Lauren claimed that April no longer benefited from living at home and another family member informed me that April had started to wander during the night. However, April remained at home and Lauren maintained her dyadic carer role. With the crossing of these boundaries, Lauren had begun to explore institutional options, yet she had subsequently moved away from the idea amidst feelings of guilt and uncertainty.

This example is informative because, despite the strength of her appeals to the importance of boundaries, Lauren disregarded those boundaries when they were experienced. In the same way, all participants struggled with boundaries to varying degrees. Toileting was the most commonplace boundary. Many carers identified the point at which the person with dementia was no longer able to use the toilet alone as being a critical indicator of the need for institutional care. However, it was uncertain whether such boundaries would be respected when reached. Such issues are not unique to the participants in this study. During the 2017 British Society of Gerontology annual conference, broadcaster Beti George recounted establishing her own toileting boundary when caring for her husband, yet having continued past this boundary when the time arrived. It appears that the setting of boundaries is more readily achieved than the respecting of those boundaries.

It also appeared that participants were aware of the likely difficulties of respecting their own boundaries in the future. To this end, participants told cautionary tales to bolster their boundaries. Such justifications seemed to serve the dual purposes of justifying institutionalisation to external audiences who may judge such action harshly, whilst simultaneously offering a self-justification to minimise internal uncertainties. Beth recalled the following tale:

There was a chap whose wife had dementia and it’d gone so far that she couldn’t do anything. She couldn’t speak, she couldn’t hear, she couldn’t see much, she couldn’t do anything for herself, she was in a wheelchair. And he used to take her all over the place, you know, all these carer’s meetings and memory café and all that. And my feeling was that he did everything for her, looked after her for ten years, fair play to him, but I felt that in a way she was almost a badge of honour. He was parading her around and, “Look how good I am. Look what I do.” And really, in truth, that woman should have been in a nursing home in a safe, comfortable environment, not being trailed around in a wheelchair. He went to a bloody open day at a fire station one day with her. Well, what’s the point of that? It was for him. It was good for him. But I just felt that there comes a point where you

have to say, “Enough’s enough, I’ve done all I can.” And I feel that I will do that because I’m not a martyr, and I am still young enough to have a life.

Beth’s cautionary tale was not unusual. It supported her boundaries in various ways. The major theme is that to not set boundaries is wrong, either morally or logically. Those who do not establish boundaries are presented as either detrimental to their loved one with dementia, or at least to be providing them no tangible benefit. There is also an insinuation that there is an appropriate degree of self-sacrifice with the carer role, after which one should rightfully relinquish the role. Tied up with this is the prescription that it is somehow wasteful to dedicate too much of a person’s life to the carer role. As participants recounted such tales, I never perceived the teller to have absolute conviction in their accounts, and felt that many would struggle when boundaries were reached.

No participating person with dementia welcomed the idea of future institutional care. Some begrudgingly accepted it as preferential to burdening their relative; some disregarded the possibility; and some dreaded the prospect. Typically, people with dementia did not denote specific boundaries in the manner that participating carers did. However, Bill and Brian were exceptions to this rule. While desiring to remain in their homes, they established a boundary of causing their wives distress as indicating the appropriate time for transitioning into institutional care.

HARDENING RELATIONSHIPS

The eventual outcome of mounting role renegotiation and eventual boundary transgression was commonly a degradation in the quality of dyadic relationships – the dyad hardened. Over time, the aesthetic of interpersonal interactions gradually moved away from close personal relationships and become more reminiscent of formal service delivery. Relationships became increasingly formulaic and based around task fulfilment rather than emotion. I first became aware of this tendency due to a trend in responses to the question of coping with dementia. Dyadic carers were notably similar in their appeals to the ultimate necessity of coping. For them, not coping was not an option. The following responses to the question of how one copes with dementia are each taken from separate interviews:

Lauren: I don’t know, just because you need to I guess. What else, you know, you just have to carry on.

Janice: Well I’ve had no option have I?

Mary: I just do my best to look after him and realise that things won’t get any easier, and I shall just have to cope as best I can.

Mavis: There’s no escape from it, you’ve got to see it through.

Beth: I have no choice. I have to cope. And if I don’t cope I’ll go under. And if I go under, he goes under. So, you know, I have to cope.

Such high concordance between responses to questions was rare during interviewing, and the sentiment was thus striking. For most dyadic carers, necessity became the primary rationale for sustaining the dyad. This nihilism was somewhat attributable to their experiences of isolation, with most receiving scant support. Participating dyads were typically characterised by relatively little external input from informal or formal actors in relation to the dyadic effort. Others were involved, but most caring was contained within the dyad. In such an environment, a certain nihilism is unsurprising.

Besides the creeping nihilism of necessity, dyads were further hardened due to the carer's constant readiness to act. Participants spoke of a perpetual tense alertness to the person with dementia's potential needs. This engendered strained relations as carers were unable to relax in the company of the person with dementia. Janice expressed feeling this way in relation to Paul's possible behaviours:

You can't relax. You're always on, you're always on high awareness. You can't relax while you're out because you've got to keep an eye on what they're up to. It's not so bad when you're in. But exhausting.

There is a tension between a state of constant apprehension and readiness to act, and the interpersonal relations of a typical loving relationship. In response to this apprehension, participants actively limited their interactions in public to limit the potential for distressing situations to occur. The self-policing of interactions further detracted from the quality of the dyadic relationship, and appeared to intensify the dyadic experience of dementia.

The nihilism of necessity and constant apprehension combined to drive the hardening of the dyad. Beyond this, the practical everyday activities of dementia care were partially at odds with the interactions of normal loving relationships. Inevitably as dementia progresses, a series of associated care tasks must be fulfilled. For example, tasks such as feeding are not typically enacted within spouse relationships. While the task is necessary, it may have the unintended side-effect of repositioning the interaction as work-like rather than loving. Even the intentional continuation of traditional roles or interpersonal interactions can be viewed in terms of a therapeutic effort rather than as a natural characteristic of the dyad. Deliberate interactions risk appropriating an aesthetic of forcedness or falsity, further promoting dyadic hardening. A common example of deliberative interaction within participant accounts concerned repetitive questioning. Many participants attested the importance of patiently re-answering repeated questions when asked by a person with dementia. This explicit effort made interaction therapeutic, but simultaneously somewhat artificial. The outcome is the pervasive hardening of previously affective dyadic relationships, as interaction is increasingly a response to dementia.

The risk here is that objectification replaces partnership. One participating dyadic carer recognised that the conducting of care-related tasks sometimes made it difficult to think of their spouse as a person rather than a check-list. This participant regretted the effect on their relationship. Similarly, one participant with dementia noted that his spouse was sometimes "cold" when fulfilling the daily tasks of care. The extremity of this spectrum of hardening is the positioning of the other as completely changed. Two participants expressed their sadness at no longer recognising the people they had married. These revelations give voice to the most tragic implications of dyadic hardening.

CONCLUSION

Research has so far failed to adequately account for dyadic experiences of dementia (Braun et al., 2009: 426). This paper is an effort to partially address this deficit. A major shortcoming of previous studies has been the inclusion of only one perspective within the dyad (Wadham et al., 2016: 463). Holistic theory cannot be generated based on restricted data. How is one to understand the dyad based on the perspectives of one party? This study has sought to rectify this limitation through the inclusion of both carers and people with dementia in constructing a combined account of dyadic experiences of dementia. However, this study is limited in that people living in the community were sought. It is therefore problematic that boundary

transgression was an important finding given that boundary-respecters (those who had turned to institutional care) were actively selected out of the study. Results must therefore be interpreted as applicable to certain experiences rather than to all experiences.

This paper presents an account of dyadic experiences in terms of the joint career, positing a distinctly patterned trajectory of inter-related role transformation. As dementia progresses and role renegotiation within the dyad becomes increasingly pronounced, difficulties impel the creation of symbolic boundaries denoting the future limits of the care-giver role. However, when the time arrives, boundaries are often disregarded and the dyadic experience continues. As the career progresses, the dyadic relationship hardens. Long-term affective relationships are reinterpreted in relation to the tasks of care, in the context of low external assistance, promoting the objectification of provider and recipient. This patterned trajectory is the dyadic career, tied up with associated role, self and relationship transformations.

The version of the joint career presented in this paper is notably darker than the aforementioned account of Beard and colleagues (2012). Whereas they stressed closeness (Beard et al., 2012: 4), my own research suggests the commonplace hardening of the dyad and an associated distancing amidst objectification. This is not unacknowledged by others (see Beard et al., 2012: 8), but has certainly been downplayed. As with all experiences of dementia, it should be recognised that different dyadic careers are likely characterised by varying degrees of closeness and hardening. The interpretations presented in this paper speak solely to the few participants in this specific study. Considering the diverse findings of research into dyadic experiences of dementia (Braun et al., 2009: 434), I do not claim to offer a universal nor a comprehensive account. These findings should encourage approaches to the dyad that account for the shared nature of experience and challenge dichotomies. Ultimately, improved understandings of dyadic experiences may highlight problematic phenomena that are amenable to interventions.

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The author declares no conflicting interests.

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