Resilience and Dementia: Understanding the Implications of Cultural and Linguistic Differences in the Canadian Care Environment

by

Maija Jalkanen-Sargent

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Department of Communication Sciences and Disorders

University of Alberta

Abstract

Resilience has been defined as ‘doing ok’ during adversity. To date, very limited research has been conducted on resilience and dementia. My study explored the influences of cultural and linguistic differences between individuals with dementia and foreign-born care workers in order to understand how these differences influence resilience of the ‘dementia care triad’ (individuals with dementia, family members, foreign-born health care workers). Four participants were interviewed about dementia and resilience in the context of cultural and linguistic differences. Thematic analysis methods were used to identify themes and categories from the interview data. The themes identified through the study included ‘Values’, ‘Culture and language’, ‘Community of support’, ‘Maintaining dignity and autonomy’, and ‘Understanding dementia’. The themes were comprised of categories which acted as protective or vulnerability factors for the participants. The connections between the categories associated with the themes were complex. Cultural and linguistic differences were perceived to have both negative and positive influences on the resilience of the individuals with dementia, their family members, and the foreign-born health care members. Communication strategies employed by the family members and the care staff member, cultural adaptation, and sharing cultural aspects were believed by the participants to counteract some of the identified negative influences. The cultural value ‘Respect for elders’ was found to be a protective factor. The clinical recommendations for speech-language pathologists from my study include organizing supported communication strategy workshops for foreign-born care workers and family members to help improve interactions and facilitate resilience, and acknowledging, utilizing, and encouraging the sharing of cultural values and beliefs in the Canadian care environment.

Preface

The thesis is an original work by Maija Jalkanen-Sargent. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "Resilience and Dementia: Understanding the Implications of Cultural and Linguistic Differences in the Canadian Care Environment", No. 00067829, October 31st, 2016.

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Introduction

Resilience is a term which is becoming popular in both academic and non-academic literature. Generally speaking, resilience refers to a system's capacity to endure, overcome, or recover from trauma or other adverse events (Masten, 2007). Resilience can be studied at a number of levels, ranging from the molecular to the global and is researched in many disciplines, including computer sciences, biology, anthropology, and ecological sciences (Masten, 2007; Zautra, Hall, & Murray, 2010). The study of resilience has been of interest to researchers since the 1960s, with the rise of developmental psychopathology. Researchers in the 1960s and 1970s were on a mission to understand the underlying causes of mental illness to aid in both prevention and intervention. They studied children whose parents suffered from mental illnesses such as schizophrenia, and found that these children were at an elevated risk of developing mental disorders compared to children whose parents did not suffer from mental illness (Luthar, 2006; Masten & Powell, 2003; Masten, 2007). However, researchers found that despite a high risk of mental illness, some children showed surprisingly positive adaptation patterns (e.g., Garmezy, 1973; 1975, as cited in Garmezy, Masten, & Tellegren, 1984). Garmezy and his colleagues went on to isolate the factors that contributed to children's coping with significant risk (Garmezy et al., 1984). This pioneering work in developmental psychopathology gave rise to resilience research in its current form (Luthar, 2006).

Early research in resilience focused on identifying personal characteristics in children who showed positive adaptation patterns. However, as researchers continued their work in the field of resilience in the 1980s and the 1990s, it became clear that external factors, including family and wider social and societal characteristics, were also involved in resilience (Luthar, 2006). Researchers posited that resilience was not a fixed trait but rather a pattern that fluctuates over time as life circumstances change. Research in the 1990s also identified that resilience is not an all-or-nothing phenomenon, but rather a domain-specific process, meaning that an individual can adapt positively in one area but have deficits in coping in another, leading to more specified terms such as emotional resilience (Luthar, 2006). Resilience studies have also shown that these fundamental systems of functioning do not remain the same across the life-span and across different stressors and situations, and that they can be influenced by a variety of factors (Masten, 2001).

Masten (2007) has identified four waves of resilience research. The goal of the first wave was to identify and describe the correlates of resilience, the characteristics of the individual, family, and community that are connected with resilience. The second wave focused on learning more about the processes behind the correlates of resilience by studying family interactions and biological self-regulating systems, and their links to early development. The third wave of research approached the subject of resilience from a different angle. Researchers tested the ideas of resilience by conducting prevention or intervention experiments to try to boost previously identified protective processes. The fourth and current wave of research attempts to study resilience at multiple, integrating levels. For example, a researcher might be interested in the resilience processes on a cellular and on a behavioural level (Masten, 2007). Ungar and colleagues (2007) suggest that the fourth wave of research should also include resilience studies across cultures, as to date resilience has been primarily studied from a western perspective, and we do not have an adequate understanding on how resilience is perceived in non-western cultures.

Resilience research, especially among children who face a high risk for psychopathology, commonly has been conducted by using either *variable-focused* approaches or *person-focused* approaches (Masten, 2001). The variable focused-approaches use statistical analyses such as multiple regression to test for relations between measures of outcome, potential individual or environmental qualities, and risk and adversity measures (Luthar, 2006; Masten, 2001). Variable focused-approaches have been shown to be powerful tools for finding links between predictors and outcomes, and identifying processes that underlie patterns of resilience (Masten & Powell, 2003; Masten, 2001). In comparison, person-focused approaches compare people or groups of people whose profiles vary on a set of resilience criteria. For example, two groups of children who face the same significant risk, one group with adaptive outcomes and one with maladaptive outcomes, could be compared to identify naturally occurring patterns of resilience (Masten, 2001). Examples of studies that took a person-focused approach are the Kauai study by Werner and Smith (1982, 1992) and the Rochester studies by Cowen and colleagues (Cowen, Wyman, Work, & Parker, 1990). The person-focused approach has been found to be useful in resilience studies when the researcher wants to discover naturally occurring resilience factors in the lives of real people (Masten & Powell, 2003; Masten, 2001). Combining both the person-focused and the variable-focused approaches has been shown to be beneficial in resilience research (Masten & Powell, 2003; Masten, 2001).

Masten (2001) argued that resilience is “ordinary magic” (p. 227). Both person- and variable focused studies have shown that resilience is not a rare and special phenomenon, but rather is common, and emerging from powerful, yet everyday human adaptive processes. Studies have shown that individuals are capable of amazing recovery and adaptation when facing adversity and risk by using the resources and tools that are characteristic of human functioning (Masten & Powell, 2003; Masten, 2001). The realization that resilience is not rare and present only with certain people in special occasions has made an important contribution to the movement of positive psychology (Masten, 2001).

Defining Resilience

According to the widely referenced work of Ann Masten (2007), *resilience* refers to “the capacity of dynamic systems to withstand or recover from significant disturbances” (p. 923). In developmental research, resilience can be viewed as a complex process that helps an individual to ‘bounce back’ or ‘do ok’ in the face of adversity (Luthar, Cicchetti, & Becker, 2000; Masten, 2007; Masten & Powell, 2003; Windle, 2011). Resilience is commonly considered to have two necessary requirements: (1) the presence of adversity and (2) positive adaptation in relation to the adversity (Luthar, Cicchetti, & Becker, 2000). Greve and Staudinger (2006) describe resilience as a constellation of developmental stressors or risk factors on one hand, and developmental status or outcomes on the other hand, with personal (i.e., psychological, such as personality traits and self-regulatory processes) and environmental (i.e., non-psychological, such as socio-economic factors) resources in between (Figure 1). Resilience can be thought of as the interaction of the two types of resources through this constellation, or as an outcome in which the person’s functioning and/or development remains normal, or is better than expected, given the initiating adverse event or significant risk (Greve & Staudinger, 2006; Windle, 2011).

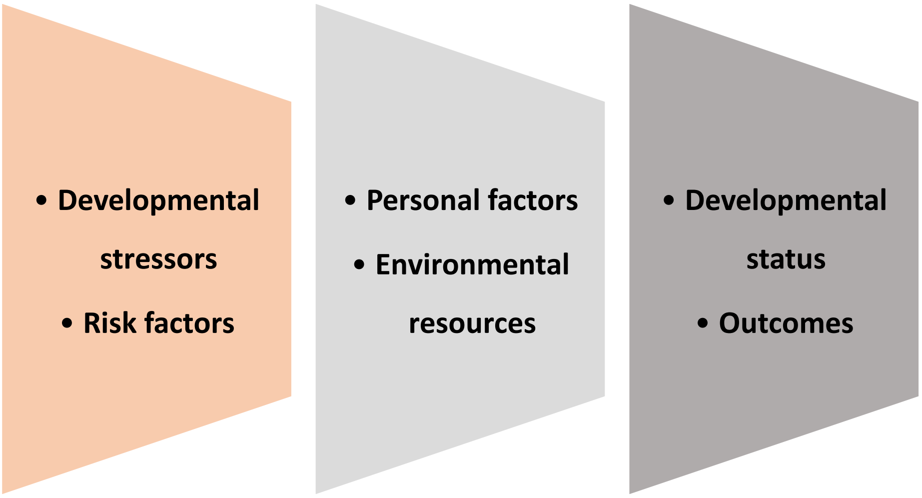

Figure 1. Illustration of the description of resilience constellation. Adapted from "Resilience in later adulthood and old age: Resources and potentials for successful aging" by W. Greve, & U. M. Staudinger, 2006, in *Developmental psychopathology volume three: Risk, disorders, and adaptation* (pp. 796-840), Hoboken, NJ: John Wiley & Sons, Inc, p. 823.

Research suggests that a person who manifests patterns of resilience in their behaviour in one circumstance, may not do so under all life circumstances (Masten & Powell, 2003; Zimmerman & Arunkumar, 1994). Ungar (2008) argues that capturing the interplay between an individual and his or her social ecology is important when defining resilience as highlighted in the following ecologically focused definition of resilience:

> In the context of exposure to significant adversity, resilience is both the capacity of individuals to *navigate* their way to psychological, social, cultural and physical resources that sustain their well-being, and their capacity individually and collectively to *negotiate* for these resources to be provided and experienced in culturally meaningful ways. (p. 425)

The concepts *competence, ego-resiliency, hope, hardiness*, *Sense of Coherence,* and *self-efficacy* (see Appendix A for definitions) are related to resilience and are common in resilience research. However, unlike resilience, these terms refer to individual traits, and should therefore not be used as synonyms with resilience. Other terms that are related but not equal to resilience are *Quality of Life, coping, and successful aging* (see Appendix A for definitions). Since resilience is not considered to be a trait or a characteristic of an individual but rather a description of a pattern, as defined by the current resilience research, calling someone *resilient* is not considered the proper way of using the terminology (Masten & Powell, 2003). Masten and Powell (2003) point out that using terms such as “features of resilience” (p. 4) or “resilient pattern” (p. 4) is more appropriate than the term resilient.

Protective Factors

Protective factors are attributes of individuals and their contexts that are associated with resilience. These factors facilitate positive adaptation despite significant risk, and enable an individual to ‘do ok’ in situational adversity. The presence of protective factors is commonly included as one of the necessary requirements for resilience (Windle, 2011). Even though protective factors moderate the effects of harmful events or environmental contexts, they do not necessarily yield resilience. In cases where adversity is significant, the presence of protective factors may not be adequate to overcome the negative effects (Masten, Best, & Garmezy, 1990). Protective factors do not eliminate the adversity or risk but they ameliorate an individual’s reaction to the risk or adversity and help the individual to deal with it in an effective manner (Werner & Smith, 2001).

Protective factors can be divided into three categories: (1) individual factors, (2) social factors, and (3) community and society factors (Figure 2) (Masten & Powell, 2003; Windle, 2011). Individual factors have also been called *assets* and factors external to the individual (i.e., social, community and society factors) have also been referred to as *resources* (Windle, 2011). Examples of individual factors include cognitive abilities, positive outlook on life, and personality characteristics. Social factors include close and supporting relationships with parents, spouse, and friends. Examples of community and society factors are accessibility to good schools, health care, and public safety (Masten & Powell, 2003). These three groups of protective factors reflect the idea that resilience is an interactive, dynamic process (Windle, 2011). The three categories also reflect the principles of Ecological Systems Theory which states that human development is influenced by factors and by the interactions of these factors, which are contained in a set of nested structures in the individual’s living environment (Bronfenbrenner, 1979).

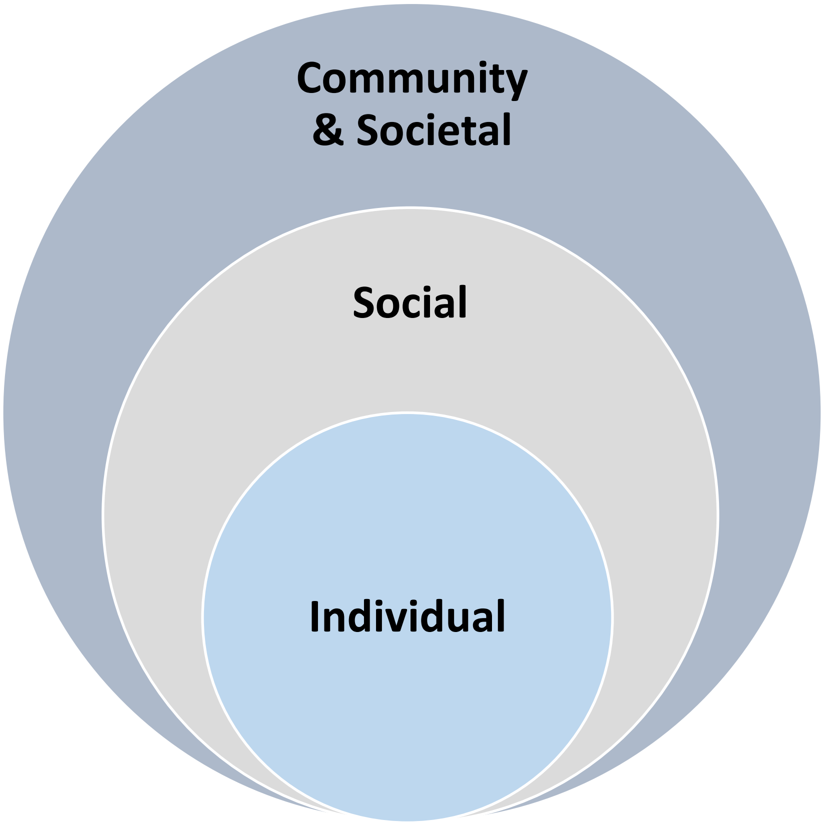

Figure 2. The nested levels of protective factors (Bronfenbrenner, 1979: Masten & Powell, 2003; Windle, 2011)

A combination of protective factors can have a *cumulative effect*, meaning that any one protective variable might have a small effect on an individual's reaction but multiple variables will have an exponentially positive influence (Rutter, 1999). Another term related to protective factors is *positive chain reaction*, which means that an individual's response to adversity or some individual quality might bring about a more positive response from other people, which then leads to the individual feeling that he or she can handle stress and challenges, fostering resilient patterns (Rutter, 1999).

Vulnerability and Risk Factors

Like protective factors, *vulnerability factors* can also be either internal or external to the individual. However, vulnerability factors increase the probability of a negative outcome (Fergus & Zimmerman, 2005). Low self-esteem is an example of an internal vulnerability factor whereas having limited positive interaction with friends and not having access to extracurricular activities are examples of external vulnerability factors (Fergus & Zimmerman, 2005). The term *vulnerability* is very closely related to *risk exposure*. Werner and Smith (2001) describe vulnerability as “an individual’s susceptibility to a disorder” (p. 3), and risk factors as “biological and psychosocial hazards that increase the likelihood of a negative developmental outcome in a group of people” (p. 3). Fergus and Zimmerman (2005) argue that the presence of a risk factor allows an individual to practice strategies and identify resources for overcoming adversity. As long as the level of the risk factor is not too high and as long as the individual can overcome the challenge, the experience can prepare him or her for future difficulties (Zimmerman & Arunkumar, 1994). However, the occurrence of risk factors can lead to *cumulative risk*, the combined effect of multiple risk factors (Masten & Reed, 2002). Other terms related to risk and vulnerability factors are the *cascade effect* and *negative chain reaction* (Masten & Powell, 2003; Rutter, 1999). These terms suggest that a risk factor early in childhood can lead to adverse reactions, which in the future leads to further problems in multiple domains of life (Rutter, 1999).

Resilience and Aging

The majority of resilience studies have focused on resilience in childhood and adolescence. In fact, studies about resilience in middle and late adulthood were rare until the late 1990s (Greve & Staudinger, 2006). Research has shown that negative life changes increase in later adulthood, and that discussions among older individuals often focus on adverse events, such as illnesses, or changes in roles and responsibilities (Allen, Haley, Harris, Fowler, & Pruthi, 2011). Yet, the majority of older individuals do not experience a decrease in Quality of Life (QoL) in later adulthood. This would suggest that there is a mechanism that protects the individual against the increasing negative influences of life changes and losses. When viewing development as a loss-gain ratio that is constantly changing, it becomes clear that resilience is not specific to only certain stages of life, but rather is in play throughout the lifespan (Greve & Staudinger, 2006). Wells (2010) found that resilience levels do not decrease with age, but remain the same or increase. Wells (2010) hypothesized that this was due to the feeling of success older adults gain from overcoming challenges. A study by Felten (2000) suggested that for the older women in her study resilience did not occur by chance or coincidence, but rather as a result of planning and using practical strategies. Allen and colleagues (2011) argued that behaviours and choices indicative of resilience are more readily seen in middle-aged and older individuals than in young individuals. The researchers hypothesized that older individuals use their many life experiences as sources of information for resilient behaviour (Allen et al., 2011).

Factors affecting resilience in older adults. Several variables affecting resilience in older adults have been identified in resilience research. Individual protective factors identified by research include self-reliance, better perceived physical and mental health status, determination, religious and spiritual values, and previous experience with hardship (Felten, 2000; Wells, 2010). Strong social networks including family support and involvement at a senior center were also found to boost the resilience of aging individuals (Felten, 2000; Wagnild & Young, 1990; Wells, 2010). Some community and society factors that were found to influence resilience included access to medical care and cultural traditions, such as healing techniques and practices (Felten, 2000).

Resilience and Culture

The decades of resilience research in the field of developmental psychology have focused on outcomes that are important in typical western mainstream culture (Ungar, 2008). To date there has not been much of an attempt to study how resilience is defined and manifested in non-western cultures, or an effort to validate the findings from cross-cultural resilience research. Ungar (2008) argues that the degree of positive outcomes, competencies, or coping mechanisms involved in resilience is influenced by an interaction between an individual and levels of social ecologies, including the individual's culture and context (Ungar, 2008). Ungar and colleagues (2007) defined *culture* as "the customs and traditions, languages and social interactions that provide identity conclusions for individuals and groups" (p. 291), and *context* as "the social, temporal and geographic locations in which culture is manifested" (p. 291). Cross-cultural resilience studies, such as the *International Resilience Project* (IRP) take a decentered research approach: instead of focusing on the individual, these studies focus on the interactions between the individual, cultural, and contextual factors, following the ecological perspective by Bronfenbrenner (1979) (Ungar, 2010b). Vulnerability and protective factors can be organized into nested levels, starting with ontogenic or individual factors, and moving on to micro-level (family and peers), meso- and exo-level (neighborhood and schools), and macro-level systems (society and culture) (Bronfenbrenner, 1979; Panter-Brick & Eggerman, 2012). The results of the IRP led the researchers to develop four 'propositions' (Resilience Research Centre, n.d., Ungar, 2008). 'Proposition one' is about the heterogeneous and homogenous aspects of resilience, meaning that resilience involves global as well as contextually and/ or culturally specific features. ‘Proposition two’ states that an individual’s culture and context determine the influence different aspects of resilience may have on the individual’s life. ‘Proposition three’ suggests that aspects of resilience do not fit neatly into the four domains (individual, relational, community and cultural), but rather relate to each other thematically. Finally, ‘proposition four’ introduces the notion of seven ‘tensions’, which were identified in every culture that was researched. Resilience is experienced as a good fit between the solutions for the challenges caused by the seven ‘tensions’ and the constraints and the norms of the community, culture, and context. The interaction of the seven ‘tensions’ which shape resilience patterns, were found to differ between cultures (Resilience Research Centre, n.d., Ungar et al., 2007; Ungar, 2010a; Ungar, 2010b).

Immigration and resilience. Immigration offers a unique opportunity to study resilience and culture. Individuals who immigrate to a new environment are faced with stressors and challenges, such as language barriers, changes to social networks, and new cultural aspects (Castro & Murray, 2010). Resilience research can aid in our understanding of how immigrants cope with these changes, and what aids individuals in the acquisition of cultural competencies (Castro & Murray, 2010). When a person migrates to a new country, and when they start having continuous contact with a new culture, they can experience *acculturative stress* (Berry, 2006; Castro & Murray, 2010). With acculturative stress, the individual will realize that he or she is experiencing challenges because of inter-cultural contact. In most cases, the stressors faced are still controllable, and many strategies can be used in an attempt to cope with these challenges. However, if an individual faces many stressors during the acculturation process, psychopathology may result (Berry, 2006).

Risk and resource factors. Research on immigration has identified factors that either impede or aid in successful immigration. Castro and Murray (2010) call these risk and resource factors, respectively, and they can be divided into individual, family, community, and societal level factors. Some of the individual factors that may aid in successful immigration include linguistic competence and education. Good language skills are associated with better adaptation, and poor language skills are often associated with social isolation, which makes it harder for immigrants to adapt to the new culture and their new environment. The most successful immigration outcomes take place when an individual brings some positive individual features with them, and when the receiving community can offer the individual some external resources, such as social support groups or language courses, that will aid in the cultural adaptation process (Castro & Murray, 2010).

Dementia

Dementia is not a specific disease but rather a set of symptoms that can be caused by a variety of diseases (Alzheimer Society Canada, 2015b). Dementia is characterized by progressive deterioration of cognitive functions, such as language, memory, visuospatial abilities, executive functioning, and judgement (World Health Organization, 2015; Mahendra & Hopper, 2013). Mood, emotional regulation, and social behaviour are also commonly affected by dementia (Alzheimer Society Canada, 2015b; World Health Organization, 2015). Most dementia sufferers are over the age of 65; however, dementia is not part of normal aging but is caused by a variety of neuropathologies (Alzheimer Society Canada, 2015b). Since dementia affects such a wide range of cognitive functions and activities of daily living, it is one of the major causes for dependency and disability among older adults (World Health Organization, 2015). Due to longer global life expectancy, there continues to be an increase in health conditions that cause dementia. According to Alzheimer Society Canada (2015a), in 2011 there were 747,000 Canadians living with dementia (14.9% of Canadians 65 years and older). The number of individuals with dementia in Canada is expected to increase to 1.4 million by 2031 (Alzheimer Society Canada, 2015a). World Health Organization (2015) reported that in 2015, there were 47.5 million people worldwide who suffer with dementia, and that the number is predicted to almost triple by 2050.

Alzheimer's disease. Alzheimer's disease (AD) is an irreversible, slowly progressive neurodegenerative disease that causes changes in a variety of cognitive functions (Bourgeois & Hickey, 2009). AD is the most common cause of dementia, accounting for about 60-70% of all cases (World Health Organization, 2015). AD is a fatal disease but the course it takes, and the types of symptoms an individual presents with during the disease trajectory vary for each person suffering from AD. As the disease progresses, it is likely to affect every aspect of the individual's life, and an individual suffering from AD will require long-term care (Alzheimer Society Canada, 2015c; Bourgeois & Hickey, 2009).

Vascular dementia. Vascular dementia is the second most common type of dementia, accounting for approximately 15-20% of dementia cases (Mahendra & Hopper, 2013). Vascular dementia is caused by ischemic changes to the brain, and the onset of vascular dementia can be abrupt. The progression of vascular dementia is step-wise, characterized by periods of stable functioning and then sudden losses of functioning due to new vascular events (Bourgeois & Hickey, 2009; Mahendra & Hopper, 2013). The cognitive impairments presented with vascular dementia are variable, depending on the affected brain area. In general, individuals suffering with vascular dementia tend to have less severe memory problems than individuals with AD, and are more likely to present with gait alterations, attention deficits, and personality changes than individuals with AD (Bourgeois & Hickey, 2009; Mahendra & Hopper, 2013).

Language characteristics of individuals with dementia. Both language comprehension and production can be affected by dementia, and the language impairment will change as the underlying disease progresses. Compared to memory, language skills remain relatively intact in the early stages of AD (Bourgeois & Hickey, 2009). Word finding problems are common but individuals with AD are still often able to describe and provide broader categorical information about words (Martin & Fedio, 1983). Understanding abstract language starts to become challenging for individuals with early stage AD; however, turn-taking, answering questions, and contributing to conversations are generally not yet affected (Hopper et al., 2001). As the disease progresses, word-finding deficits become more severe, and signs of pragmatic deficits become evident. Producing novel speech with meaningful content becomes more challenging as the disease progresses, but individuals with middle stage AD are still able to contribute to conversations. (Bourgeois & Hickey, 2009; Mahendra & Hopper, 2013). Even in the late stages of AD with very severe cognitive decline, some preserved language functions often remain (Hopper, Bayles, & Kim, 2001; Mahendra & Hopper, 2013). For example, individuals with severe AD might still be able to answer simple choice questions (Hopper et al., 2001).

Cultural views on dementia. Culture can affect the opinions an individual has about dementia, and can impede diagnosis of dementia. For example, in some cultures, dementia is considered part of normal aging, and not as a pathology that needs to be treated (Iliffe & Manthorpe, 2004). Culture of the individual suffering with dementia and his or her family can also affect other aspects of living with dementia, such as treatment decisions and caregiving roles (Mazaheri, 2013). For example, outside help might not be accepted because of cultural traditions of family responsibilities (Bourgeois & Hickey, 2009). Only limited research has been conducted on the cross-cultural aspects of dementia, especially from the point-of-view of minority ethnicities, but the current research literature suggests that an individual’s cultural views on dementia should be considered when making treatment plans and decisions (Iliffe & Manthorpe, 2004; Mazaheri, 2013). Being aware that the needs of minority caregivers and their responses to challenges with caregiving can be different from those of caregivers from the majority culture has been shown to support positive caregiving outcomes (Bourgeois & Hickey, 2009).

Resilience and Dementia

Dementia is a debilitating syndrome, which affects many aspects of life of the individual who is diagnosed with dementia as well as the lives of his or her family members (Cotrell & Schultz, 1993; Pesonen, Remes, & Isola, 2013). AD is one of the most common health conditions that leads to an individual becoming institutionalized in a nursing home or another type of long-term care facility (Cavanaugh, Blanchard-Fields, & Norris, 2008). Therefore, dementia also touches the daily lives of many healthcare workers. An individual with dementia, his or her family, and his or her care staff can be thought of as members of a triad, which I will henceforth call the ‘dementia care triad’ (Figure 3). Research on resilience and dementia will be reviewed in the next sections from the point of view of each of the triad members.

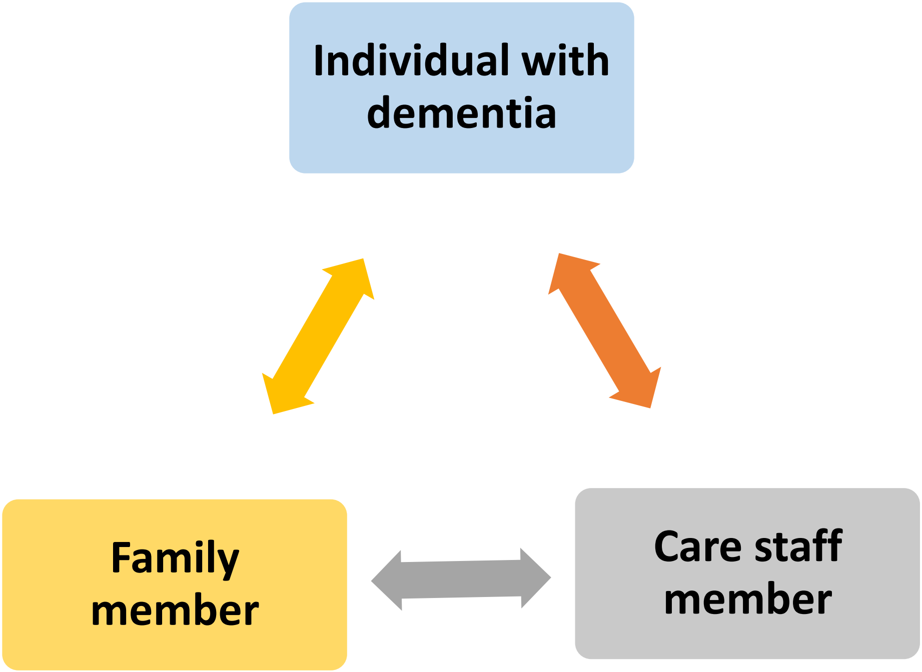

Figure 3. The members of the ‘dementia care triad’.

Individuals with dementia.

Research suggests that despite the debilitating nature of the dementia, individuals that are diagnosed with dementia can exhibit resilient patterns in their lives (Harris, 2008). Studying resilience builds on a strength-based approach in dementia research.

Rather than focusing on the impairment, researchers can focus on the positive outcomes these individuals experience, despite their daily struggles with dementia (Williamson & Paslawski, 2016). Learning more about the factors that lead to resilient behaviour or impede resilient patterns in individuals that are suffering with dementia is important in order for health care professionals to best help these individuals to ‘do ok’ (Williamson & Paslawski, 2016). Excluding individuals with dementia as agents who can provide valuable information about dementia and its course has been common in the past. Researchers assumed that because of cognitive decline and communication problems, data received from individuals with dementia might not be reliable, and therefore not useful (Cotrell & Schultz, 1993). However, there is some evidence that individuals with dementia can provide valuable information about resilience, and therefore should not be excluded from being participants in research (Harris, 2008; Williamson & Paslawski, 2016).

Many protective and vulnerability factors associated with individuals with dementia have been identified through past research. Harris (2008) identified personal assets which included effective coping strategies (such as accepting the situation and the changing self), positive attitude and self-concept, and religious beliefs. Protective factors related to social support networks included family members, who were willing to help and provide support without trying to take away the participant’s independence. Lastly, community resource assets included access to the Alzheimer’s Association and the health care system. Some of the risk or vulnerability factors found in the study included concomitant health problems, social isolation, family members’ health problems, limited economic means, living alone, and limited support from family (Harris, 2008). Earle (2015) studied factors that affected the resilience of both individuals with dementia and their caregivers. Four main factors that influenced the resilience of individuals with dementia were identified: (1) communication, (2) family and friends, (3) perspective and attitude, and (4) quality of care. These four factors were found to operate on individual, family, and community levels, and were also found to represent a continuum from a vulnerability to a protective factor (Earle, 2015).

Family members. After a dementia diagnosis, an adjustment period to various changes and losses associated with dementia takes place. For example, a family member may need to assume more responsibilities than before and take on the role of a caregiver (Bourgeois & Hickey, 2009). Caregivers of individuals with dementia are at greater risk of physical and mental health problems, and tend to report lower QoL than non-caregivers (Bourgeois & Hickey, 2009). Paying attention to the health needs, both physical and mental, of the caregiver has been found to be an important factor for establishing a positive caregiving experience (Bourgeois & Hickey, 2009). Resilience has been used to explain why some caregivers persevere with responsibilities related to caregiving with normal or enhanced functioning, and are less likely to experience the challenges of caregiving as negatively as others (Cherry et al., 2013; Gaugler, Kane, & Newcomer, 2007).

Cherry and colleagues (2013) argued that factors affecting caregiver resilience fall into three categories: (1) caregiver's psychological resources, (2) properties/aspects of the care relationship, and (3) social and cultural caregiver factors. Social and cultural factors related to resilience in dementia caregiving include ethnicity and culture, knowledge of dementia, and religion and spirituality. Cherry and colleagues (2013) report that different cultures vary in social support availability and coping styles, as well as how caregiving is appraised. Earle (2015) found five main factors in her study that affected the resilience of caregivers of individuals with dementia: (1) communication, (2) understanding dementia, (3) relationship, (4) quality of care, and (5) care of self. Because of the close relationships between the individual and his or her caregiver, factors identified to affect resilience of the caregiver also affect the factors that influence resilience of the individual with dementia and vice versa (Earle, 2015).

Care staff. Due to global population aging, dementia has a major influence on health care systems around the world (Elliott, Scott, Stirling, Martin, & Robinson, 2012). Elliott and colleagues found that retaining staff and high staff turn-over are problems in the dementia care workforce. Dementia care workers have also reported that they are not able to deliver good quality care, resulting in lack of job satisfaction (Elliott et al., 2012). Elliott and colleagues (2012) suggested that the dissatisfaction might be due to the lack of knowledge of dementia, dealing with behavioural problems related to dementia, and lack of time to perform care tasks in a satisfactory way. Elliott and colleagues (2012) concluded that increased knowledge in issues regarding dementia care could help health care workers to feel more satisfied at work, benefit their well-being, and reduce problems with turn-over, retention, and recruitment that the dementia health care field is now facing (Elliott et al., 2012).

Cultural and Linguistic Differences in the Care Environment and the Effects on Resilience

Because of the aging population, the need for an aged care workforce is an issue in Canada as well as in many other Western countries. Addressing the workforce needs has been increasingly dependent on migrant workers (Leutz, 2010; Nichols, Horner, & Fyfe, 2015). For example, in Australia in 2012, 35% of the workforce in the aged care facilities were born outside of Australia (Nichols et al., 2015). In Canada in 2014, visible minorities made up 15% and linguistic minorities (i.e., individuals who speak a language other than or in addition to English or French as their mother tongue) made up 20% of the nursing professions workforce (Premji & Etowa, 2014). Between 2007 and 2011, the proportion of internationally trained registered nurses (i.e., registered nurses that received their training outside of Canada) in Alberta increased from 4.8% to 10.5% (Canadian Institute for Health Information, 2012). It is clear that the Canadian long-term care facilities are becoming increasingly multicultural and multilingual environments. To date, very limited research on how the linguistic and cultural differences between the long-term care staff and individuals with dementia affect the resilience of all of the parties involved (individual with dementia, family member, and care staff) has been conducted.

Influence on individuals with dementia and family members. Earle (2015) studied resilience and dementia by interviewing both individuals with dementia and their family members. One of the family members in the study had identified culture and language differences between the long-term care staff and the individual with dementia as a vulnerability factor for the individual's resilience. The participant had described how culture and language barriers between the staff and the individual with dementia impedes good quality of care. The researcher hypothesized that the problems individuals with dementia have with social aspects of language might make communicating with a staff member from a different cultural and linguistic background challenging. Earle (2015) suggested that more research on the topic of cultural and linguistic differences between the individual with dementia and the care staff, and their effect on resilience of both the family member and the individual might be valuable.

A Canadian study by McGilton and Boscart (2007) interviewed long-term care residents, their family members, and care providers to find out how they conceptualized close care-provider relationships in long-term care environments. The researchers found that residents, family members, and care providers defined close-care relationships by using different terms. What is of interest here is that family members identified language barriers between the residents and staff members as a factor that prevented the formation of a close care relationship. Furthermore, the residents felt neglected if the care providers did not listen to their questions or never asked questions of the residents regarding their care. In these cases, there was no chance for a close care-provider relationship to be formed. The care providers also identified some characteristics about the residents that prevented the formation of close care relationships. These characteristics included declining cognitive status, inability to communicate, and lack of social interactional skills, all of which can be relevant to an individual with dementia. Since close care-relationships are related to higher life-satisfaction scores for long-term care residents (Huss, Buckwalter, & Stolley, 1988, as cited in McGilton & Boscart, 2007), they are also likely to be related to the residents' resilience.

In a study by Walsh and Shutes (2013), migrant care workers and older adult care recipients were interviewed about their experiences and perceptions on relational aspects of care. It should be noted that the older adult care recipients in this study were not specified as having or not having dementia. The researchers found that it was harder for the care recipients to form a close relationship with the migrant workers when their English language proficiency was lacking. Not sharing the same cultural outlook on customs, traditional food preparation, and historical background was also found to hinder the formation of a close care relationship (Walsh & Shutes, 2013). However, the care recipients also commented on the migrant care workers' strong attitudes and values towards compassionate care. The researchers concluded that there is a congruency between the migrant care workers and the care recipients with respect to what good quality care means. Reciprocity, having the potential to facilitate the wellbeing of both the care recipient and the migrant care worker, was found to be an important aspect of a good care relationship (Walsh and Shutes, 2013).

Influence on care staff. An Australian study by Nichols and colleagues (2015) researched the experiences that health care workers from culturally and linguistically diverse backgrounds have had when working with individuals with dementia in Australia. Previous research (King et al., 2013) suggested that 25% of culturally and linguistically diverse workers had identified a lack of Australian culture knowledge and deficient English language skills as weaknesses when working with the aging population. The researchers collected data from managers, health care workers, and family representatives. The care workers were asked about their familiarity and understanding of dementia before they came to Australia. Most of the care workers responded that in their countries of birth, symptoms of dementia are understood as part of the normal ageing process. Also, those health care workers that had received training in their countries of birth said that their knowledge of dementia was very limited, and that they had not had much experience in caring for someone with dementia. When asked about interactions with individuals with dementia, culturally and linguistically diverse workers shared both positive and negative experiences. The workers talked about sharing interests and beliefs with the residents, and about 50% of the workers identified them as positive experiences. However, 60% of the workers also described negative interaction experiences, such as a resident reacting negatively to the worker because of visible ethnic differences. Some workers responded that they were badly affected by racially motivated reactions, whereas other workers reported that they understood that the negative interactions with the resident with dementia were due to the illness process. The workers were also asked about the cultural differences between Australia and their country of birth. Many of the workers talked about the cultural shock they experienced when they first started working in Australia and the need to learn new customs. Similarly, one of the managers identified problems with cultural norms in communication as a barrier between the culturally and linguistically diverse workers and the residents. More positively, the researchers pointed out that many of the workers showed great respect for elders, and form close relationships with the residents they cared for (Nichols et al., 2015).

Nichols and colleagues (2015) suggested four key components that make up cohesive multicultural workforce in residential aged care: intrinsic factors (the cultural background, values, and beliefs of the staff), moderating factors (training and experience in dementia care), extrinsic factors (policies, guidelines, and the culture of the workplace), and communication processes (verbal and non-verbal communication and cultural competence). Nichols and colleagues (2015) suggested that addressing all four components is necessary in order to build a culturally competent and supported workforce. Acknowledging and prompting the sharing of cultural heritage, providing opportunities for training and mentoring programs in dementia care, and identifying gaps and barriers in workplace policies were some examples of the strategies the authors suggested when addressing problems in an increasingly multicultural aged care workforce (Nichols et al., 2015).

Research Questions

The purpose of my study was to further our understanding about resilience and dementia, specifically about the role cultural and linguistic differences play in resilience. The specific impacts of these factors on resilience were studied, as well as the interactions of language and culture with previously identified resilience factors. Two specific research questions were explored:

(1) What are the perceptions of the individual with dementia, his or her family, and the care staff on cultural differences affecting the resilience of each of the parties involved?

(2) What are the perceptions of the individual, his or her family, and the care staff on linguistic differences affecting the resilience of each of the parties involved?

Significance of the Research

Researching resilience can support steps forward in designing both assessment and intervention strategies that adhere to the principles of the *World Health Organization International Classification of Functioning, Disability, and Health* (WHO-ICF) model. The WHO-ICF states that in addition to ’health condition’ and ‘body structures and functions’, health care workers should pay close attention to other factors influencing an individual’s health and well-being, including ‘personal factors’, ‘environmental factors’, and ‘activity/participation factors’ (World Health Organization, 2002), all of which are strongly present in the resilience literature.

Since dementia affects so many areas of an individual’s functioning, making it a very debilitating condition, studying resilience in individuals affected by dementia can give us important insights into resilience patterns and processes. To effectively support each member of the ‘dementia care triad’, namely the individual with dementia, his or her family member, and his or her care staff member, more research is needed to explore factors that promote and impede the resilience of each of the members. Currently there is limited research suggesting that cultural and linguistic differences between the individual with dementia and his or her care staff member can have negative influences on the resilience on all of the ‘dementia care triad’ members (Earle, 2015; McGilton & Boscart, 2007; Nichols et al, 2015; Walsh & Shutes, 2013).

Communication appears to be the factor that is very central to the perception of resilience with all of the ‘dementia care triad’ members. Since working on communication impairments with individuals with dementia is within the scope of practice of speech language pathologists

(SLPs) (Speech-Language & Audiology Canada, 2016), research on dementia and resilience has important implications to the field of speech language pathology. Bourgeois and Hickey (2009) point out that the specialized training SLPs have about communication deficits makes them ideal professionals to be working both with service delivery to individuals with dementia, and with long-term care staff education and counselling. SLPs can also have an important role as communication facilitators during communication break-downs between staff and family members (Bourgeois & Hickey, 2009). Understanding the influences of linguistic and cultural differences in a supported living environment is important in order for health care professionals to be able to design intervention tools to boost the resilience and well-being of all of the parties involved. Considering the trend of hiring foreign-born health care workers (Leutz, 2010; Nichols et al., 2015) leading to increasingly multicultural and multilingual health care environments, research in this area is very timely. Furthermore, the findings in my study might be transferable to other situations in health care and in some related areas (e.g., in educational settings), in which individuals of differing linguistic and cultural backgrounds interact.

Position of the Researcher

My interests in studying the topic of resilience and dementia, and the effects that cultural and linguistic differences have on resilience are three-fold. First, I find the concept of resilience fascinating, and I have seen and keep seeing examples of resilience when interacting with the people around me. For example, my godfather suffered several strokes over approximately 12 years of his life. Even though his functioning got increasingly impaired after each stroke, he would continue to ‘bounce back’ and ‘do ok’. In addition to his incredibly determined personality, I believe one of his protective factors was my godmother who looked after him at home as long as she could, and then visited him nearly daily in the long-term care facility. The second reason I am interested in the topic of my study is that I was born and raised in Finland, and I moved to Canada when I was 19 years of age. I have experienced immigrating to a new country and starting work in a culture different from mine. Having these experiences to reflect upon, I feel that I may understand at least some of the struggles health care workers from other countries might experience when they move to Canada and start working. The third reason I feel drawn to this research topic is because of my current field of study, speech language pathology. In the future, I wish to help individuals with communication difficulties that prevent them from living the life they could live. It is my hope that my study can aid the field of speech language pathology to find ways to promote the resilience of individuals with dementia, and the other individuals whose lives are touched by dementia.

Methodology

I used the methodological approach of interpretive description (Thorne, 2008; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004) in my study. Interpretive description is an appropriate approach for small sample studies about a clinical phenomenon (Thorne et al., 2004). Themes and patterns are identified from data to facilitate clinical understanding by exercising critical examination of the phenomenon, without forgetting individual variations within the common patterns. Ideally, the end product of interpretive description has potential clinical applications by providing a mental heuristic that confirms expert clinicians' analytic reasoning (Thorne et al., 2004). This was a person-focused study. Currently there is very limited information about the potential protective and vulnerability factors that may affect the resilience of the 'dementia care triad' members in situations where cultural and linguistic differences are present. A person-focused approach allowed me to study actual patterns of resilience that occur naturally in individuals by identifying factors that influenced the resilience of the participants (Masten, 2001; Masten & Powell, 2003). Some aspects of variable-focused research were also applied by investigating the relationships between individual and contextual factors, and the processes underlying resilience (Masten, 2001; Masten & Powell, 2003).

Methods

Participants. The intention was to recruit two 'dementia care triads'; however, recruiting difficulties led to the recruitment of five participants, four of whom were ultimately able to complete the study. The first group consisted of a foreign-born care staff member (P01), a family member of an individual with dementia (P02), and an individual with dementia (P03). The second group consisted of the same foreign-born staff member (P01) and a family member of an individual with dementia (P04). An individual with dementia was recruited for this group but was unable to complete the study because she was unable to participate in a semi-structured interview.

Inclusion criteria. All participants had to be willing and able to (1) provide the researcher with demographic information (Appendix B), (2) participate individually in a semi-structured interview (Appendix C) in English with supported communication techniques used as necessary, and (3) be audio- and video-recorded during the interview. The individual with dementia had to reside in a supported living environment, (i.e., in long-term care facilities or assisted living environments). He or she was also required to complete standardized measures on QoL, cognition, language competency, and depression. The family member of the individual with dementia was required to complete a standardized QoL measure. The staff member had to have a cultural and linguistic background different from that of the individual with dementia and his or her family member, and to have immigrated to Canada in 2011 or later (Canadian Institute for Health Information, 2012). He or she was also required to complete a QoL standardized measure. In the event that the individual with dementia would have gotten fatigued during the interview and had to discontinue the study temporarily, it was possible to reschedule a follow-up appointment at a convenient time as close to the first appointment as possible to complete the study. Two appointments were needed to complete the study with the individual with dementia (P03) as he was fatigued during the first meeting.

Exclusion criteria. A participant who was not willing or able to (1) provide demographic information, (2) participate in a semi-structured interview individually conducted in English, (3) be audio- or video-recorded during the interview, and (4) complete the standardized measures outlined above did not qualify for the study. With the individual with dementia who participated in my study (P03), only the standardized measures on language competency and depression were completed. The measures on cognition and QoL were discontinued due to participant frustration. The coordinator of health services for the care facility in which P03 resided was also in the room during the interview and the administration of the standardized measures. Since I was still able to successfully complete the interview with P03, I decided to include P03 in the study. The individual with dementia associated with the family member in the second group (P04) was excluded from the study because she was not able to participate in a semi-structured interview.

Individuals with dementia who did not reside in a supported living environment, who did not speak English, or were not able to participate in conversations did not qualify for the study. Individuals with dementia who had concomitant health problems were not excluded from my study. Family members who did not speak English did not qualify for the study. Staff members who did not have a cultural and linguistic background different from that of the individual with dementia and his or her family member, who moved to Canada before 2011, and who were not able to participate in the semi-structured interviews in English did not qualify for the study. A foreign-born health care worker who was going to be part of triad two had to be excluded because she had come to Canada prior to 2011. As no other staff members from the facility were willing to take part in the study, the foreign-born health care worker who was part of the first group (P01) was also used as a participant in the second group, after confirming that P01 had cared for the individual with dementia associated with the second group.

Recruitment. Convenience sampling (Thorne, 2008) was used to recruit the triads of participants who met the inclusion criteria through private long-term care facilities and assisted care environments in Edmonton and Calgary. Recruitment began by following the ethics approval from the University of Alberta Human Research Ethics Board. In total, I approached 26 supportive care facilities by phone and email, explained the purpose of the study, and asked for permission to recruit participants. I attached a summary of the study purpose and methods as well as a poster for study recruitment to each email. On average, three contact attempts (emails and/or phone calls) were required until I had a chance to talk to a person who could make the decision regarding study recruitment. All of the participants for my study were recruited through a private long-term care facility in Edmonton. The coordinator of health services at the facility emailed family members of residents with dementia providing an overview of the study. The coordinator of health services also talked to the foreign-born health care-workers about the study and put up a poster about the study in the staff room. Once a triad was identified, I contacted the possible participants to confirm eligibility for the study and to arrange for the individual meetings.

Data collection. Data collected from the individuals with dementia in my study included demographic information (Appendix B), semi-structured interview responses (Appendix C), and standardized measures pertaining to participant's level of communicative competence and depression (Table 1). The measures pertaining to the participant's level of cognitive impairment and QoL were attempted but discontinued (Table 1). The data collected from the family member of the individual with dementia included demographic information (Appendix B), semi-structured interview responses (Appendix C), and a standardized measure of the participant's level of QoL (Table 1). The data collected from the long-term care staff member included demographic information (Appendix B), semi-structured interview responses (Appendix C), and a standardized measure of the participant's QoL (Table 1). In addition, information from the supported living facility about the requirements for hiring foreign-born health care workers was collected (Appendix B).

Standardized measures. Some standardized measures were used in my study for descriptive purposes. For all of the participants in my study, the World Health Organization Quality of Life –BREF (WHOQOL- BREF; World Health Organization, 2004) assessment was administered (Table 1). This assessment measure is well-established and widely used, and allowed me to examine the relationship and possible interactions between QoL and resilience. To understand the basic level of cognitive functioning of the individuals with dementia, the Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005) was used. In addition, to help determine the communication competence of the individuals with dementia, the Object Description Subtest of the Arizona Battery of Communication Disorders of Dementia (ABCD; Bayles & Tomoeda, 1991) was used. To determine the possibility of depression in the individuals with dementia, the short version of the Geriatric Depression Scale (GDS: Yesavage & Sheikh, 1986) was used. The MoCA, ABCD, and GDS results provided context to answers individuals with dementia gave to the semi-structured interview questions (Table 1).

Table 1

Data Collected from the Study Participants

Data Collected	Individual with Dementia	Family Member	Staff Member
Demographic Information	✓	✓	✓
Semi-structured Interview Responses	✓	✓	✓
WHOQOL-BREF (World Health Organization, 2004)	Not completed	✓	✓
MoCA (Nasreddine et al., 2005)	Not completed		
The Object Description Subtest of the ABCD (Bayles & Tomoeda, 1991)	✓		
GDS (Yesavage & Sheikh, 1986)	✓		

Semi-structured interviews. The questions used during the interview (Appendix C) built on previous projects examining resilience in adults with dementia (Earle, 2015; McGilton & Boscart, 2007; Nichols et al., 2015). The semi-structured interviews focused on how the participants defined resilience and factors that contributed to resilience for persons with dementia. For the family member and care staff member, resilience was also discussed for themselves in relation to the person with dementia. Specific questions about how cultural and language differences between the care staff members and the individuals with dementia affected resilience were included. The staff members were asked about the knowledge they have about dementia and how that knowledge affects their resilience. Supported communication techniques (e.g., speaking slowly and clearly and writing down key words) were used as needed during the interview to help the individuals with dementia and the staff member to understand the interviewer, to help them to express their ideas, and to verify messages (Aphasia Institute, 2015a). The semi-structured interviews were conducted first before administering the standardized measures as this order for session has been used effectively in prior investigations (Earle, 2015; Williamson & Paslawski, 2016) to establish rapport. The semi-structured interview protocol allowed me to ask the participants probing questions when I wanted them to provide me with more details or to elaborate on the answers which they had provided me (Creswell, 2009).

Consent. A consent form was reviewed and signed by each of the participants. In addition to the consent form, an assent form was also reviewed with the individual with dementia. The individual with dementia (P03) was not physically able to sign his name on the consent and assent forms. A witness was present in the room when the study was explained to the participant and the witness signed both the assent and consent forms indicating that verbal assent was received. The family member of the individual with dementia also signed the consent form on the behalf of the individual. Each participant was given a copy of the consent form for their records.

Session location. The participants of the study were given the option to participate in the research study at the long-term care facility, at his or her residence, or at the University of Alberta. Three of the participants chose to complete the study at the long-term care facility and one of the participants preferred to complete the study at her residence.

Protection of privacy. An ID number was assigned to each of the participants. A master list of the participants’ names and ID numbers was stored separately from all other study data. In all of the transcripts, pseudonyms and ID numbers were used to maintain confidentiality. The audio- and video-recordings of the interviews were accessible only to Dr. Paslawski and myself on an encrypted computer in Dr. Paslawski's laboratory at the University of Alberta. All data were stored in a locked cabinet at the University of Alberta, separate from the master lists, and will be destroyed in five years, in accordance with University of Alberta Human Research Ethics Board requirements.

Data analysis.

Transcription and transcript verification. The interviews were video- and audio recorded for verification purposes. All interviews were transcribed verbatim to allow for systematic thematic analysis (Guest, MacQueen, & Namey, 2012). Following the recommendations of Easton, McComish, and Greenberg (2000), I conducted the interviews, and transcribed the recordings of the interviews. Each transcript was spot-checked for accuracy by Dr. Paslawski a minimum of two minutes per 10 minutes of recording (Easton et al., 2000; Maclean, Meyer, & Estable, 2004). Gestures and facial expressions were included in the transcriptions in square brackets when they were found to either change or enhance the meaning of the speech of the participants.

Transcript analysis. Thematic analysis was used to analyze and interpret the interview data. Following the guidelines by Guest and colleagues (2012) and Vaismoradi, Jones, Turunen, and Snelgrove (2016), the text was read several times to identify recurring categories and themes. The text was then segmented by defining boundaries between the identified categories, which allowed me to explore the relationships and similarities between the categories and themes (Guest et al., 2012; Vaismoradi et al., 2016). We (MJS and TP) created a codebook containing the operational definitions of themes to establish reliability of the coding system. The coding process, which focused on how the themes were interconnected and represented across the participants, was used to generate a description of the data. Finally, we interpreted the meaning of the data. My personal explanation of the data as well as information from past research literature was used to interpret the meaning of the findings (Creswell, 2009; Vaismoradi et al., 2016). To enhance the integrity of analysis, we also explored competing themes and explanations. Exploring other explanations of the study findings was important to test the interpretations of the themes and patterns identified in my study (Patton, 1999).

Reliability and validity. Reliability and validity were established by following the recommendations of data triangulation by Patton (1999). Qualitative data source triangulation was established by taking into account the perspectives of all of the dementia triad participants: the individuals with dementia, the family members, and the care staff members, ensuring the validity of themes. Using different sources of data allowed me to identify similarities and differences in findings across the participants, and to discuss the possible reasons for differences and consistencies. Analyst triangulation was established by having two coders (MJS and TP) involved in identifying and ordering the themes in the interview data to prevent researcher bias (Patton, 1999). The same codebook was used by both of us, and we applied the codes to sections of the transcripts independently (Guest et al., 2012). Our coding was compared to see where in the transcript the coding matched and where it differed in order to establish intercoder agreement (ICA). ICA was conducted to achieve reliability for coding, and also to establish the variability in interpreting the meanings of the code. Double-coding was done more frequently in the earlier stages of data analysis, and tapered off as coding became more consistent. In the event in which ICA was less than 80%, changes in the codebook were made to improve the precision and consistency of the coding process and the interpretation of the codes (Guest et al., 2012).

Results

The results of my study included demographic information, information from the long-term care facility about the requirements for hiring foreign-born health care workers, standardized measures, and themes and categories identified from semi-structured interview responses.

Demographic Information

Demographic information was collected from all of the participants. The ages of the participants ranged from 55 to 82 years of age. All of the participants were married. All of the participants, except for the foreign-born health care worker were born in Canada and spoke English as their first language. All of the participants had at least two years of post-secondary education.

The demographic information collected from the foreign-born health care worker (P01, henceforth referred to as Sarah) can be seen in Table 2. Sarah, aged 55, worked as a health care aide in a private long-term care facility in Edmonton. She was born in the Philippines and at the time of the interview, she had been in Canada for about one and a half years. She had completed the health care aide program in a college in Canada. Sarah's first language was Tagalog, but she also spoke English and Thai.

Table 2

Demographic Information: Care Staff Member

Pseudonym (Participant Number)	Gender and Age	Marital Status	Education	Country of Birth and Cultural Background	Time of Migration to Canada	Languages Spoken	Past and Current Jobs
Sarah (P01)	Female, 55	Married	BSc, MA (in the Philippines) College certificate (for health care aide training, in Canada)	The Philippines	2015	Tagalog, English, Thai	Past: teacher, social development worker Current: health care aide

The demographic information collected from the two family members (P02 and P04, henceforth referred to as Mary and Joan, respectively) can be seen in Table 3. Mary was aged 82 and her husband had dementia. Joan was aged 71 and her mother had dementia. Both Mary and Joan were born in Canada and spoke English as their native language.

Table 3

Demographic Information: Family Members

Pseudonym (Participant Number)	Gender and Age	Marital Status	Education	Country of Birth	Cultural Background	Languages Spoken	Relationship to Individual with Dementia
Mary (P02)	Female, 82	Married	1 year of university, 3 years of nursing	Canada	Canadian/ Scottish/ Irish	English, some French	Wife
Joan (P04)	Female, 71	Married	2 years of college, on-going training as an artist	Canada	Canadian/ German/ Irish	English	Daughter

The demographic information collected from the individual with dementia (P03, henceforth referred to as Peter) can be seen in Table 4. Peter, aged 77, was reportedly diagnosed with vascular dementia in 2011. Peter lived in a long-term care facility in Edmonton. He was born in Canada and spoke English as his native language.

Table 4

Demographic Information: Individual with Dementia

Pseudonym (Participant Number)	Gender and Age	Marital Status	Education	Country of Birth	Cultural Background	Languages Spoken	Type of Dementia, Time of Diagnosis
Peter (P03)	Male, 77	Married	7 years of university	Canada	Canadian	English	Vascular dementia, 2011

Information from the supported living facility about the requirements for hiring foreign-born health care workers was also collected. According to the coordinator of health services at the facility through which the participants were recruited, foreign-born health care aides must have completed the health care aide program at an institution approved by Alberta Health Services. As for language competency requirements, the college that Sarah attended required students to successfully pass the English language arts academic testing when applying for the health care aide program; international documentation of English language competency was not accepted.

Standardized Measures

Family members and staff member. The World Health Organization Quality of Life – BREF (WHOQOL- BREF; World Health Organization, 2004), assessment was administered to the family members and the care staff member. The scores for the assessment can be seen in Table 5. The WHOQOL-BREF yields a scaled score in four domains: Physical Health (Domain 1), Psychological Health (Domain 2), Social Relationships (Domain 3), and Environment (Domain 4). Scores are scaled in a positive direction, with a maximum score of 100 in each domain. Higher scores on this measure indicate a higher perceived QoL.

Table 5

The WHOQOL-BREF Assessment Results

Participant	Domain One (Physical Health)	Domain Two (Psychological Health)	Domain Three (Social Relationships)	Domain Four (Environment)
Sarah (care staff member)	88	81	94	94
Mary (family member)	69	75	81	81
Joan (family member)	56	75	69	94

Note. The scores are out of 100, a higher score indicating a higher perceived QoL.

Individual with dementia. To help determine the communication competence of the individual with dementia, the Object Description Subtest of the Arizona Battery of Communication Disorders of Dementia (ABCD; Bayles & Tomoeda, 1991) was used. To determine the possibility of depression in the individuals with dementia, the short version of the Geriatric Depression Scale (GDS: Yesavage & Sheikh, 1986) was used. The results of these two standardized measures can be seen in Table 6.

Table 6.

The Results of the Standardized Measures for the Individual with Dementia

Participant	Object Description Subtest of the Arizona Battery of Communication Disorders of Dementia (ABCD)[a]	Geriatric Depression Scale (GDS)[b]
Peter (individual with dementia)	1	2

[a] The average raw score obtained by typically functioning adults on the Object Description Subtest of the ABCD is 9.2 (2.2). [b]Scores between 0-5 on the GDS are considered normal.

To understand the basic level of cognitive functioning of the individual with dementia, I attempted to administer the Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005). Peter received the score of zero (out of potential eight points) on the first three tasks. Since Peter got increasingly frustrated as the administration of the MoCA continued, the assessment was discontinued. The administration of the WHOQOL-BREF was also attempted with Peter but he declined to answer the first question of the assessment. I decided not to continue with the WHOQOL-BREF assessment to avoid further frustration.

Interview Data

Categories were identified from the semi-structured interview responses conducted with the care staff member, family members, and individual with dementia. Themes were developed from the ideas expressed in the identified categories (Vaismoradi et al., 2016). The term *category* is used to describe a collection of similar data or explicit participant accounts, whereas the term *theme* is used to describe meaningful patterns in the participants' responses at a more implicit level (Morse, 2008; Vaismoradi et al., 2016). The five themes and their associated categories for each of the participants can be seen in Table 7. It should be emphasized that the categories identified are not mutually exclusive. There are many connections and considerable overlap between the categories. Many of the categories were seen as functioning on a continuum from enhancing resilience to interfering with resilience. Categories were also found to work at different levels: individual, social (family/friends), and community/societal.

Labels for the themes and categories were purposefully chosen to reflect what were perceived as the intentions of the participants. The category labels were chosen to reflect the operational definition of each category. Operational definitions were formulated for each of the themes based on the ideas found during categorization (Vaismoradi et al., 2016). In my study, the theme 'Values' was defined as personal perspectives that the participants have identified as guiding principles. The theme 'Culture and language' was defined as meaningful cultural and linguistic aspects that have the potential to influence resilience as described by participants. The theme 'Community of support' was described as participant's social network that provides him or her support at home, at work, or out in the community. The theme 'Maintaining dignity and autonomy' included engagement and interaction that help to maintain the dignity and autonomy of individuals with dementia by taking into account their personality, interests, and level of functioning. The theme 'Understanding dementia' referred to participants' acquired knowledge about dementia.

Quotes from interviews were used to support and enhance the description of the categories and to reveal the function of the category for each participant. For ease of reading, participant quotes have been italicized and all interjections, hesitations, and repetitions have been removed, if they did not change the meaning of the utterance. In cases where gestures or vocalizations (e.g., laughing) were found to either change or enhance the meaning of the participant's speech, transcriptions of them have been included in square brackets.

Table 7

Themes and Associated Categories for Each Participant

Themes	Sarah (care staff member)	Joan (family member)	Mary (family member)	Peter (individual with dementia)
Values	Competence	Advocacy	Striving to be better Helping others Lack of self-pity	
Culture and language	Respect for elders Cultural and linguistic differences Cultural adaptation	Cultural and linguistic differences	Cultural and linguistic differences	
Community of support	Sharing experiences Partnership Gratitude from residents	Support from friends and family Faith Sharing experiences Support for staff	Social isolation Support from friends and family Societal support Relationships at care facility Faith	
Maintaining dignity and autonomy	Appropriate communication Appropriate care	Appropriate care	Appropriate communication Appropriate care	Appropriate communication
Understanding dementia	Past experiences and training On-going learning	Past experiences and training On-going learning Staff dementia training Theory into practice	Past experiences and training On-going learning	

Sarah (care staff member). The interview with Sarah revealed five main themes. The themes and the associated categories can be seen in Table 7.

Values. For Sarah, the theme 'Values' was found to be comprised of one category: 'Competence'. 'Competence' was found to determine what 'doing ok' means for Sarah, in relation to work: *MJS: So what does it mean for you to do ok? Sarah: That I can do the task, even if I have to resort to calling others. [Laughs] As long as the task is performed or done.* 'Competence' was also reflected in later interview responses when Sarah identified her time management and multitasking skills and to-do lists as tools that help her to 'do ok' both at work and at home.

Culture and language. For Sarah, the theme 'Culture and language' was found to be comprised of three categories: 'Respect for elders', 'Culture and linguistic differences', and 'Cultural adaptation'.

Sarah described 'Respect for elders' as a cultural value of the Philippines:

> *The culture of the Philippines is that… although it's a culture of everybody [laughs] I guess. There is a high respect for elders. . . . When we speak with elders, we don't raise our voice. . . . And anything mentioned by the elders, the young ones should follow. . . .*

'Respect for elders' was identified as a protective factor, helping Sarah to 'do ok' at work:

> *That culture, we can bring it here. That if the resident is agitated and he would say in high tones… words, we, the young ones, don't speak back, don't answer back. So, we just keep our lips sealed. Ok, so there will be residents who are agitated and they want this in as fast as possible. . . . so you really need to do your best to, to attend to their needs but without answering them back. That's the culture of the Philippines.*

'Respect for elders' was also found to be the underlying reason for the cultural aspects of 'Cultural and linguistic differences', which was identified as a vulnerability factor for Sarah. Sarah discussed how Filipinos express their respect for older people by kissing and through gestures: *There is a high respect for elders. So actually back home, when you meet an elderly person, you pay respect by kissing the hands. We have gestures of how we show respect to the elders.* She described how touch as a sign of respect can be perceived as a cultural difference between the Philippines and Canada and how this cultural difference can influence her work:

> *And in the Philippines, we are quite touchy. We hug the elders. We kiss the hands. We kiss the forehead as a sign of respect, even if she's not your real grandma. But here you*

> *don't really have to touch the resident because they would say that you are physically harassing them. So you, sometimes I tend to touch but… "Oh, sorry"… I stop.*

Terms of endearment that are used in the Philippines as a sign of respect for older people was also identified as a cultural difference by Sarah:

> *In the Philippines we express respect for the elders with terms like [Tagalog words]… it's not here in Canada. You just say what you want. And then in the Philippines, we have words of endearment: "mama", "grandma", but here, we don't. That's one thing in the Philippines, everybody is a grandma. Old people we call grandma, grandfather because if you don't call them that way, it's a sign of disrespect on your, on the younger side.*

Sarah described how this cultural difference between Canada and the Philippines can influence the interactions between her and the residents:

> *But here we call the residents by their first name. So at first I was so embarrassed of myself [laughs]. I feel bad because oh, I called him by the first name because. . . if a Filipino will hear you that: "Oh, you're very disrespectful". But in here, if you call the resident "grandma", they will say: "I'm not your grandmother!"*

Sarah also discussed the differences between Canada and the Philippines in how elder care is arranged:

> *It comes in a natural way that you care with the elders. It comes from your love for your elders to take care of them, so it's just kind of in-born, innate tendency to care for the elders. Whereas here, as I mentioned, it's an established system. You have the rules, you have the law, you have the facilities, you have the equipment, so you have the organizations.*

According to Sarah, older people, including individuals with dementia, have different roles in the Philippines than in Canada:

> *Because in the Philippines… not very many facilities like this, we take care of our olds at home. So even if they have dementia, we still enjoy the company of the elders. And the culture is such that we look up the elder as the one with the most wisdom in the family. So anything he says is ok. Things like that. He is not regarded as a patient or a burden. Whereas here in Canada in facilities like this, the residents are not… anyway I am HCA here. They are not consulted of the situation or in the family so they do not give advice.*

Sarah described how her accent made it harder for her to ‘do ok’ at work because the residents did not understand her: *There may be a difference in the accent. And so sometimes we can understand what the resident say but if we answer back, the resident cannot understand because of the accent.* It was also noted that Sarah was not familiar with some English phrases, for example, during the administration of the WHOQOL questionnaire, Sarah asked what ‘feeling blue’ meant.

The category ‘Cultural adaptation’ refers to Sarah’s ability to adapt to the Canadian culture: making the effort to conform to the Canadian cultural norms, even if it is difficult for her. ‘Cultural adaptation’ was identified as a protective factor. Sarah discussed how she uses this strategy out in the community: *First I observe what they’re doing and how things are done. And then, do what the Romans do when they are in Rome.* She also described how ‘Cultural adaptation’ facilitated her resilience at work:

> *But in the Philippines, if you call “Maria”, you are being disrespectful because you call her by the first name. But since we are in Canada, we have to do what the Canadians are doing. So that’s how I cope with that.*

It was also noted that Sarah had found a way to reconcile the Canadian cultural norms (e.g., not touching the care facility residents) with her own cultural norms (e.g., touching the older people as a sign of respect):

> *And I noticed it at once when I went here in Canada and I started working in a facility during my practicum. You don’t really have to hold them because they “Ah, don’t hold me!” so you have to just some kind of... light touch.*

Community of support. For Sarah, the theme ‘Community of support’ was found to be comprised of three categories: ‘Sharing experiences’, ‘Partnership’, and ‘Gratitude from residents’. It became clear through the interview responses that Sarah’s work colleagues were an important part of her ‘Community of support’, and facilitated her resilience at work and also outside of work.

‘Sharing experiences’ was found to function as a factor that facilitates Sarah’s resilience. Sarah discussed two types of sharing: sharing experiences to relieve tension (e.g., after she had a hard day at work) and sharing experiences for on-going learning at work.

Sarah shared experiences with her friends: *I call my friends and can we have some coffee and we just chat and we share experiences and laugh with ourselves. Laugh at what happened to* *us*. She also shared experiences with colleagues, finding the support helpful after a hard day at work: *. . . share it with a person who can understand what you're doing [laughs]. You share it with another health care aid. "Oh, I have done this like this, like this". . . So, you release the tension on yourself*. Experiences with care facility residents and care strategies were shared between partners in order to learn how to better care for the residents:

> *There will be a time you that share the experience [brings hands together] so you learn from each other. . . . During break times are spent sharing the experience so that when the next time that the resident is under your care you know exactly or have an idea of what went wrong what went right. . . . That techniques also, techniques of how to do the care. You can learn it from your partner.*

In addition to 'Sharing Experiences', "Partnership" was identified as a protective factor for Sarah:

> *If it is possible, you can also call your shift partner and one will distract the resident and converse with the resident while the other is changing the cloths, putting up the pull-ups or incontinent… things like that. So it's a partnership between the two health-care aides.*

On the other hand, unsuccessful partnership was described by Sarah in terms of a vulnerability factor, interfering with her ability to 'do ok' at work. Sarah discussed the partner's attitude as an important aspect in successful partnership:

> *So basically, it will boil down to the attitude of the person. So if you do not go along with the other, so it's a problem. . . . If you need help or two person should assist one resident, you cannot call her because it may be possible that she would not agree to help you. . . . And there will be partners that will check on you every time.*

Sarah identified lack of communication as the main reason for unsuccessful partnership: *And usually the problem starts when you are not talking to each other of what you plan, what you are going to do.*

Sarah described how gratitude expressed by the residents gave her life meaning. 'Gratitude from residents' was seen as a factor that increased Sarah's job satisfaction, and enhancing her resilience at work and in life in general.

> *I do my job and sometimes the resident would say before I leave: "Thank you very much for the help!" so it's a big thing for me because I know that even if you did little, it's a*

> *big thing for them because they cannot do that and so you do that for them. And so they are very grateful. So that makes life meaningful, doing little things for them.*

Maintaining dignity and autonomy. It was clear through the interview with Sarah that providing compassionate care that helped to maintain the dignity and the autonomy of the individual with dementia was important to her:

> *This dementia grandmothers and grandfathers are loved-ones of somebody else so you really have to take care of them or you don't hurt them, things like that. You don't shout at them or you really show compassion or compassionate care because they are the reasons of why I'm here. And they are loved-ones of somebody else. So you have to really respect them or take care of them. Maintain their dignity or privacy.*

It seemed that Sarah recognized the importance of maintaining autonomy for individuals with dementia, who are having to adjust to new roles in life. Her awareness of changing roles and how that can threaten a person's sense of autonomy was reflected in the story Sarah shared about her father. Sarah's father suffered a stroke, leaving him physically immobile. However, Sarah's father found a way to cope with the situation and his changing roles:

> *He was not able to walk, so, it's kind of difficult for him in physical aspect because he is used to being physically active, being a carpenter for all his life and then suddenly he's in a rocking chair all the time. . . . And then he is updated on the news. . . . So even if he's confined on the chair, he reads the newspaper every day so you ask him of the news and he could tell you all the news for the day. So he is our newscaster at home. So that's how he copes with the difficult situation.*

For Sarah, the theme 'Maintaining dignity and autonomy' consisted of two categories: 'Appropriate communication' and 'Appropriate care', both of which helped Sarah to 'do ok' at work. Sarah discussed some of the communication challenges that can make it difficult when interacting with individuals with dementia. For example, Sarah shared a story of a resident who believed that she still lived in her own house and was asking Sarah where she is going to be sleeping. Sarah summarized the difficulty she experienced when interacting with the resident: *Sometimes there are just moments that they think of the past. Our words do not meet but the idea's there.* Sarah also discussed how the residents' tendency to talk about the past can be used to facilitate positive interactions:

> *They're saying something that, that they remember during the younger days, you just try to: "Oh what happened?" They will tell you the story and it's interesting. You will admire the person because they can tell you what they did before. So my point is, they remember what they have done.*

Sarah described a number of other components of 'Appropriate communication' that help to facilitate positive interactions between her and the residents, such as giving short and clear instructions.

> *You need to give clear instruction, short, do not talk very long and the more that the dementia person will become confused. . . . You really have to communicate but shorter and clear so that dementia person will not be confused. Otherwise if she will become confused of what you are saying, the more she will be agitated for the day.*

She also identified the use of gestures as a strategy to make herself understood if the residents could not understand her because of her accent: *We just really have to explain more, or through actions of what we want them to… what we want to say.* It was noted during the interview that Sarah used many gestures and facial expressions when speaking. Many of her gestures were iconic (e.g., gesturing a telephone or pointing) which added to her verbal message and made it easier for the listener to understand her.

Sarah's discussion on how to communicate with individuals with dementia reflected the aspects of maintaining the dignity and autonomy of the individuals. For example, she emphasized the importance of patience: *They should be patient with the person with dementia because somebody with dementia may be slow. But still, they can understand what's happening.* Sarah also described respectful and loving ways of communicating with an individual with dementia: *So, they have to converse or communicate with the person. Not baby talk or do not shout! And always say loving words. Loving words… couple it with your actions, hugs or you hold the hands.*

Sarah discussed how difficult it was for her as a HCA when the residents ask after their families. She found it hard to answer their questions, but has found a way to respond that she believes helps to build hope in the residents' minds:

> *So, it's difficult for us, HCAs to tell them: "Oh, they're not coming" so we just say: "Just wait, they will come", things like that so…"Oh, when will they come?" I don't know also when will the family visit so I have to say "They will just come, just wait".*

Sarah identified giving space and time as an important strategy when caring for a resident who is agitated:

> *If I am with a resident who got dementia and she is agitated, so I take time, pause first, give her space to do what she want. And later on, she will forget what happened so you come back. So that makes it ok and she can follow short instructions.*

She found that by being patient and giving the residents' time, Sarah was able to maintain the residents' autonomy as much as possible by allowing them to complete tasks that were appropriate to their level of functioning:

> *People with dementia… My experience is that you really have to be patient. If you help them dress up or peri-care, you really have to wait because they're physically slow. But when you say: "Could you wash your face?" I'm happy that they can do what they want. "Would you like to wash your hands?" I'm happy that they can wash their hands.*

Understanding dementia. For Sarah, the theme 'Understanding dementia' was made up of two categories: 'Past experiences and training' and 'On-going learning'. The category 'Past experiences and training' was found to be a protective factor for Sarah. She described a practicum at a dementia care facility which she felt prepared her for her current job. Sarah also identified a valuable experience she took part in during her training that she described as a dementia simulation, which has facilitated her resilience at work:

> *In the simulation, you are treated like you are the person with dementia. So you feel how it is to have dementia. . . . You would really cry after that experience because you now understand better the person with dementia. There are so many things bombarding them, they hear many things that they cannot understand. . . . You put your feet in the shoes of the dementia person.*

'On-going learning' was found to help Sarah 'do ok' at work. During the interview, Sarah expressed an interest for continued learning about dementia. It was also found that Sarah desires to continue to learn and excel in her job through self-reflection: *I reflect of what happened during the day, so "I should have done this one", things like that. So the next time, at least you know what exactly have happened or what, what you should have done better.*

Joan (family member). Five themes were identified from the interview with Joan. The themes and the associated categories can be seen in Table 7. It was clear through the interview that Joan's resilience was closely linked with her mother's resilience. For example, when asked what it means to her to 'do ok', Joan started her response with the words: *Well, I mean given the disease, they can only achieve so much. . . But, I certainly would hope that the people who are caring for her. . .* This response suggested that Joan's resilience was very much interconnected with how her mother was doing, and that separating Joan's perceptions of her own resilience from her mother's was very challenging. Consequently, because of the close link between Joan's and her mother's resilience, categories that Joan described in terms of vulnerability or protective factors for her mother could be considered to be important categories for Joan as well.

Values. For Joan, the theme 'Values' consisted of one category, 'Advocacy'. It was clear through the interview that advocating for better care for her mother was very important for Joan. Joan's advocacy also went beyond her mother. The reason Joan decided to participate in the study was because she had concerns about linguistic and cultural differences between the residents in the care facility and the staff. She made it clear that she is concerned for all residents with dementia and wishes to continue advocating for them:

> *I know my mom will be looked after because if you don't do it, we will make sure something changes. But what about all those people? Those people have nobody. And I will to continue to advocate, whether my mother gets care from us or not. They also deserve someone to advocate for them. And, I'm gonna to keep doing that.*

Culture and language. For Joan, the theme 'Culture and language' contained one category: 'Cultural and linguistic differences'. She described 'Cultural and linguistic differences' in terms of a vulnerability factor for herself and for the residents in the care facility.

Joan described her views on the cultural differences between the care staff and the residents as a barrier:

> *Well, because I've had concerns about language and cultural differences between the residents and the caregivers and I just see a big disconnect. They don't have the background we have so they don't relate to the people from our culture.*

Joan gave some specific examples about cultural differences she has noticed when observing the interactions between the staff and the residents. She shared some stories involving meal times at the care facilities and situations in which the resident did not want to eat the food on her plate: *Well the staff are like: "But we told her just eat what you want". And I say: "But culturally, we don't do that. Culturally, whatever's on your plate, we're supposed to eat".* Joan also discussed the cultural difference in how to address the residents: . . . *because they always call everybody*

"Mrs." or "mommy", "mama", this is not how we address, my Mom would say [laughs]: "I'm not your mama". These cultural differences were seen as having the potential to disrupt the interaction between the care staff and the resident, and to interfere with the resilience of the individual with dementia.

Joan was also concerned about the linguistic differences between the staff and the residents. Joan raised concerns about the ability of foreign-born staff to understand English when completing the health care aide training: *There's no accountability, as to whether or not they can accomplish these skills. Whether they've even understood it, because it's a different language. They're learning a different language while they're learning all this information.* She also indicated communication break-downs when she has been interacting with the staff:

> *Some staff, you ask them a question and they're "Yeah, yeah, yeah" and then you ask them a question that you can't answer with yes: They didn't understand a word you said. So I had to start asking questions differently because, I mean even my mom can say yes to things and it's not true.*

Joan identified colloquial phrases and medical terms as examples of the type of language that can be challenging for foreign-born staff:

> *They struggle a lot… Because, as every language has its own nuances about it and words that we use that aren't definitive, colloquialisms or whatever, we say things that mean something that the words don't say. And there's no way they can know that. And we're not even aware that we're doing it because it's just part of our culture. . . . I think they have a lot of trouble with language because… If you give them a medical term they've never heard of before… I mean, what do they have to relate to.*

Joan repeatedly raised a concern for the staff's tendency to say 'yes' even when they had not understood:

> *And the response is "Yeah, ok". Because, the other response could mean, I'm not capable of doing this job, I've lost it. So I think there is fear on their part of not doing well enough to keep their job, I think that's always a concern.*

Joan identified speaking in simple terms as a strategy when interacting with foreign-born staff. She also discussed how not having the expectation that the staff will understand was crucial but also difficult for her: *So, [we] have to be very simplistic when we speak, and I think the hardest* *thing is having an expectation of them understanding you, and realizing: I can't have that expectation. It's not gonna work.*

Community of support. For Joan, the theme 'Community of support' consisted of four categories: 'Support from friends and family', 'Faith', 'Sharing experiences', and 'Support for staff'. Joan identified her family as a source of support, helping her to 'do ok' with her mother's dementia diagnosis: *I have a very supportive family. My siblings are very supportive. What helps me is I know our family will look after my mom.* On the other hand, Joan also discussed how having all of her siblings involved in the decision making regarding her mother's situation when she was first diagnosed was difficult, suggesting that at times, family involvement made it harder for Joan to 'do ok' with her mother's diagnosis:

> *So, it was difficult in the beginning, not from my perspective but to get everybody on board. I have 7 siblings. So just getting 7 people on the same page, is not always that easy. But I must say, once the full information was given to them, they were very much on board. It was very sad for them, but they were very much on board with how do we help her.*

'Faith' (in my study described as the participant's belief and relationship with a deity) was found to function as a protective factor for both Joan and her mother, from Joan's perspective. Joan described how she is able to use aspects of 'Faith' to help her mother when she is feeling anxious: *I have a very deep faith and so, my mom came from that background too so sometimes the best way to bring her peace if she's anxious about something is to just pray a prayer she knows.*

The category 'Sharing experiences' was seen as a protective factor for Joan, both in her personal life with her friends and also in the care facility, when looking after her mother. With both instances of sharing, the ultimate goal appeared to be personal growth or learning. Joan discussed how being honest about what is happening in one's life is important as other people might share the same types of experiences, making sharing with friends an opportunity for growth: *I think sharing the truth about life and then how things are, not trying to be like everything's perfect and, you know, wonderful life. I think it's important for us to share with people, things that do happen in our life because very often we find people have similar experiences and you can grow from that.*

Joan also described how she has shared tips about her mother with the care staff, to help them care for her mother. This type of sharing was seen as improving the relationship between Joan and the care staff as well as helping the care staff learn how to better care for Joan's mother, boosting Joan's resilience:

> *So we just try to share those things that we found, that are simple, that they can help them with, so because otherwise you're just like this all the time [bumps fists together], so we just decided ok, we're going to be as positive as we can. If there are issues, we'll just say: "You know, we notice this with Mom, this has helped us".*

Joan described how 'Sharing experiences' has helped to overcome some of the negative influences of cultural differences described in the previous section: *So when we would spend some time and just say: "Just call her by her name, that's the most important thing" you know, it took a while, but in some ways we took responsibility for helping them.*

Joan suggested that the care staff was not being supported enough by the facility to be able to 'do ok' at work. Lack of 'Support for staff' was seen as a possible vulnerability factor, not just for Joan but also for the care staff members and Joan's mother. Joan stressed that the staff is doing the best they can with the support they have been given, and that she believed the real problem in delivering proper care is with the executive level at the care facility:

> *But you also have to educate you staff and support them in their journey of culture, language and even information issues. That's probably the biggest thing. . . . I don't think it's the staff's fault. I really don't. Not everybody's the same but, they're trying their best.*

Maintaining dignity and autonomy. For Joan, the theme 'Maintaining dignity and autonomy' was found to consist of one category: 'Appropriate care'. Joan described 'Appropriate care' in terms of both a vulnerability factor and a protective factor. Joan contrasted 'Appropriate care' with merely completing tasks as part of a job:

> *What would have helped my mom do better I think, is having staff that weren't on a: "We have to get these things done" as opposed to: "We need to care for this person and these things need to be accomplished". And it's a huge difference. If you just have a routine, we have to brush our teeth, we have to get them dressed, all those things… And then your work is done, your goal is to tick off "I've done this".*

Joan also indicated her frustration when she could see ways the staff could provide more appropriate dementia care, for example, during meal times, and they did not. For Joan, the perception of the staff not providing appropriate care but only completing a job made it harder for her to 'do ok' with her mother's dementia diagnosis:

> *If you wanna ask me what's difficult, that's what's difficult. When I can see what needs to be done, that is just normal, like you and I, if that was my parent and they weren't eating, I wouldn't just take the food away and say "They're not hungry today", I would try and figure it out. And sometimes it, all it is, is just someone sitting with you and being positive with you instead of saying: "Eat that. That's good for you. You know what that is". And all that does is bring up all this anxiety for them, and then they won't eat at all. And then they're considered a problem. If you don't understand these parts, you cannot care for dementia people. You can't! It's just a job then.*

On the other hand, Joan also indicated that because the North American culture is very private about personal care, it is easier for her mother if a person outside the family is caring for her than if a family member was completing activities such as bathing:

> *So, from my mom's perspective, this non-person in a way, it's easier for her to accept that this is the person that's going to help her do this. If I have to help her, she feels so bad that I have to do it. . . I mean for all the time that she was cognitive: "I don't wanna be a burden, I don't want this, I don't want that". So, in some ways that's our way of preserving her dignity that she wouldn't want us to have to deal with those things.*

Understanding dementia. For Joan, the theme 'Understanding dementia' consisted of four categories: 'Past experiences and training', 'On-going learning', 'Staff dementia training', and 'Theory into practice'.

'Past experiences and training' was found to be a protective factor for Joan. Joan felt more prepared when her mother was diagnosed with AD because of the experiences with dementia and dementia training Joan had in the past. She discussed the experienced she had with her father, who was also diagnosed with AD, and how that affected her ability to cope with her mother's diagnosis: *Well first of all, my dad had dementia, Alzheimer's. . . . But there's a difference between aging and having dementia. And because of my dad, I was in tune with more of those things.* After Joan's mother was diagnosed with dementia, Joan took a course on Alzheimer's with her sister. She also reached out to a family member for information on what to look for in people who have been diagnosed with dementia. Joan felt more prepared with her mother's dementia diagnosis because of these experiences:

> *Right away, we were advised to go take this Alzheimer's course. Which was the best thing we did. . . . and I did have a. . . [family member] who knew someone who had ran a facility for elderly and dementia patients. So, we asked her if she would, she was a friend, would she just help us be aware of what to look for, so that you know there's a time when she'd still be by herself and then there's a time when we have to say "Ok, this is not good".*

Joan discussed how knowing more about dementia can help both the individual with dementia and the family members to accept the diagnosis, and can help to facilitate their resilience.

> *Well, in the onset, being informed so that you understand what's happening to you and why it's happening to you. If people don't accept your diagnosis or don't understand why you might act the way you act, I think it makes it more difficult. So I would just say, get yourself informed and learn how to help people with dementia, not have expectations of them being the way they used to be.*

'On-going learning' was also found to be factor that helped Joan to 'do ok' with her mother's diagnosis. Joan described how she has increased her knowledge of dementia by attending dementia conferences, keeping up to date with new dementia research: *My sisters and I have gone to a number of conferences on dementia and the work that's been done, and so we have kept ourselves informed.* Joan also discussed that she has been going to the conferences not only to have more knowledge about dementia but also to be able to share some information with the care facility: *This is why we started going to conferences and getting not just our "so called" expertise but from the people who know things and so we would bring back this information.*

Joan described 'Staff dementia training' in terms of a vulnerability factor, interfering with both her and her mother's resilience:

> *I certainly would hope that the people who are caring for her have enough education themselves to understand dementia and Alzheimer's so that they respond to them in a way that gets the most out of the resident. That's what I would hope for. . . . but you also have to be given enough information to do that job. And the training is not here. And really, it's beyond here as well. Like the courses that they take are so simplistic, and there's no accountability, as to whether or not they can accomplish these skills.*

Joan identified some specific areas of care in which she finds the training inadequate:

> *Sometimes they don't have training to see why that person doesn't wanna get dressed today, why they're anxious today, why they don't wanna eat today and it's not that they're being difficult. They look at that plate, they don't even see it as food. But if you don't have that kind of information…*

Joan described how the lack of 'Theory into practice' has impeded her resilience. Joan stressed that not seeing any changes in dementia care despite all the information that is available has been very frustrating: *And we go to these conferences, and I just think: "Well, why's there no change then? You guys know this, why's there no change?" so that's my frustration.* She discussed how she has shared information she learned in dementia conferences and how she has made many suggestions to the management at the care facility in which her mother resides with no result:

> *We went to the executive level and they: "M-hmm, yeah, oh, we never heard that, hmmm" and I thought: Well, you're not looking. And you're not listening. Because we've been saying this in… You act like you hear us and you act like you wanna do something but you're not doing anything". And that has created a lot of angst. . . . There's all the talk and there's the research and there's all of these things but it's not resulting in better care.*

Mary (family member). The interview with Mary revealed five themes. The themes and the associated categories can be seen in Table 7.

Values. For Mary, the theme 'Values' was comprised of three categories: 'Striving to be better', 'Helping others', and 'Lack of self-pity'. When asked what 'doing ok' means to her, Mary responded: *I'm not satisfied with just ok. . . It's better than not being ok but I'd like to be better than ok.* The category 'Striving to be better' was also reflected in Mary's discussion about the staff at the care facility: *They're always striving to be better, like from [coordinator of health services] on down. They're trying to make everything better.* It was found that Mary appreciated individuals who are striving to be better and that attitude in other people boosted her resilience.

Mary also discussed the value of helping people and how that value is part of her faith:

> *I also did a lot of volunteering. I was a volunteer at the church and I was a volunteer at the library, volunteered on meals-on-wheels when I was married and my kids were*

> *growing up, that kind of thing. I liked doing that. It's probably part of my faith that I like to help. Be helpful.*

The value of helping people was also reflected in Mary's response when asked why she decided to participate in the study: *Because I believe in helping students. I believe in what you're doing and I felt that I could be helpful and thought that the study would very interesting for me as well.*

Mary also described the perspective of 'Lack of self-pity', which was found to function as a protective factor for her:

> *I sure don't believe in feeling sorry for yourself. I think that's a losing. That just lets yourself down. If I feel that sneaking up on me, and there was time there couple of years ago when I was thinking [moan]. I thought "Oh my gosh, you're feeling sorry for yourself. Cut that out". I was like… it doesn't help. It doesn't help at all.*

Culture and language. The theme 'Culture and language' was comprised of one category for Mary: 'Cultural and linguistic differences'.

Mary described 'Cultural and linguistic differences' in terms of a protective factor, indicating that her interactions with foreign-born staff members have facilitated her resilience. When asked about her interactions with staff who are from a different country, Mary responded: *I haven't a single thing to say against anything those people do over there. And that's the truth.* It was clear through the interview responses that Mary was very pleased with the staff and with her relationship with them. Mary also mentioned that her husband does not seem to argue with the foreign-born staff members and that it is somehow related to their culture:

> *They, he certainly, there's something about. . . [the care staff members], because he does not argue with. . . [the care staff members] either. They have a way I think of…. He doesn't give them any problems. He doesn't.*

Mary found that there were times when she had some difficulty understanding what the foreign-born staff members were saying. However, these experiences did not seem to interfere with Mary's resilience:

> *Well, I guess, only a couple of times I suppose that I look them right in the eye and I say to them "Now you're telling me… What are you telling me?" And then she says it and I say "Are you saying this?" And 'cause I wanna know what they're saying if it's about Peter. And so, yeah, there's been couple of times where we've had little conversations*

> *where I'm trying to… And it has always come out ok. I haven't had unfortunate experiences.*

Community of support. The theme 'Community of support' consisted of five categories for Mary: 'Social isolation', 'Support from friends and family', 'Societal support', 'Relationships at care facility', and 'Faith'.

The category 'Social isolation' functioned as a vulnerability factor for Mary. When Mary's husband was diagnosed with dementia, she was determined to care for him at home for as long as she could. Mary shared some stories that illustrated how over time, she felt that she could not leave her husband alone in the house anymore as he got more impaired: *I forget what happened what sort of alerted me because I came home and I found him outside doing something that was… I don't know… but I just thought no, I better stay home. . . .* Mary ended up quitting one of her hobbies and stopped travelling when caring for her husband, which caused her to feel socially isolated. *So little by little there were things I wasn't doing anymore. And I was just mostly here.*

Mary described 'Support from friends and family' both in terms of a vulnerability and a protective factor. Mary identified that her family was important to her: *I'm strongly family oriented, part of my whole up-bringing, family was everything.* She talked about having weekly telephone conversations with her children, with whom she is very close. Mary also discussed how her husband's children were not able to help her when she was caring for him:

> *It's nothing on them but his family couldn't help. They're young people with young families. . . . And they both have full time careers and they're good marriages and everything but you can't ask them to come out and stay here for a year, a week or whatever.*

Mary also identified that she got some help from her friends in battling the feelings of social isolation:

> *And that's, [friend] invited me to try out for the book club and I did. She did, 'cause she said: "I think you need to get out". And, so I've been there now for three years and so, I got a little help from my friends that way.*

On the other hand, Mary also suggested that some of her friends did not truly understand her situation and what it is like to care for someone who has dementia:

> *Even people who mean well sometimes don't know what they're getting into. And I know that because, not often but I've had people say: "Oh well" you know. "You're only gone hour and a half at the choir. Can't you go for that long?"*

In addition to family and friends, 'Societal support' was identified as a factor that facilitated Mary's resilience when she was caring for her husband at home. Mary's cleaning lady was identified as an important source of support for Mary when she was caring for her husband, allowing her to continue with one of her hobbies:

> *And I was ok, I still went to the book club because my cleaning lady comes on Wednesdays so I could still do that. And we've had her for a long time and she's a lovely person. She's great. So that's how I solved that problem. . . . having my cleaner lady was a big help. 'Cause [cleaning lady]'s just, like one of my best friends really.*

Mary's doctor was also identified as a source of support, facilitating Mary's ability to 'do ok' when her husband was first diagnosed with dementia: *Also the fact that I really thought that he had a marvelous doctor. She turned out to be absolutely marvelous and she, very good for me as well. . . . Cares about you.*

Mary also described 'Societal support' in terms of a vulnerability factor, describing how the lack of appropriate respite care interfered with her resilience:

> *Well it was a failure of the health care system like I tried two or three times to get respite care. . . . Well, they did have it, so I can't say no they didn't. But you had to wait long time. And the other thing that kind of squashed it for me was. . . . it was gonna require me taking Peter there and seeing it all. . . . I thought: "He'll never wanna do that". And I couldn't see myself coping with it. So, I turned it down.*

The category 'Relationships at the care facility' was found to be especially important for facilitating Mary's resilience. When asked what currently helps Mary to 'do ok' with her husband's dementia diagnosis, she answered: *Well, the real God-send was being able to get him into [care facility].* Mary went on to describe the staff at the care facility and the relationships she has formed with them. Mary described several aspects of the relationships she has with her staff that support her resilience. Mary's descriptions revealed that she feels comfortable asking the staff questions: *I'm friends with all the nurses. . . . I don't interfere with them but I know what questions to ask them and I know when they're doing something good to tell them or, all that kind of thing.* Mary felt that she shares the same goal of looking after her husband with the staff: *They're looking after my husband. . . . It's my job to see that Peter is looked after. It's their job too so we're on the same page as far as I'm concerned.* She also discussed the mutual sharing between her and the care staff:

> *And she chats with me about how he's doing. And there's another little gal, she's not that young. But she's the one that seems to be looking after his clothes and helping him in the mornings and so on. I just love her. . . . and we get to a chat.*

Mary has been especially pleased with the coordinator of health services at the care facility and feels comfortable asking him questions and talking to him about any concerns she has. She has also been invited to participate in discussing the improvements planned in the facility, which she identified as meaningful to her:

> *I mean since Peter went in, we get things from them every so often about what's going on and they were doing a round table discussion, all about the new, you know how these places are assessed every once in a while. . . . It was going through all the different parts they did and assessed. So I was invited. That was very interesting and I was pleased to be asked.*

Mary indicated that she is happy with how the staff interacts with her husband, and that she gets to be involved in the activities in the care facility:

> *They all know him. They all have a friendly greeting for him. If I'm walking around you know with him out on the hall. I've been there when they've been, playing games or doing things out in the other part there. No, I have fun too.*

Mary's interview responses revealed that she trusts the care staff members, and that she does not feel guilty about having her husband in a facility: *When you can feel good about the staff, you, you don't come away with guilt for leaving him there, or anything like that. And they all are, right from [coordinator of health services] on down.* Even when Mary was not able to visit her husband for a while, she did not feel guilty because of the staff: *Maybe I should have been more concerned but I knew they would let me know and I didn't even call him.*

Mary stressed that she wanted to keep up the good relationship she has with the care staff: *I'm very happy with my relationship with [care facility] and I wanna continue with that.* Mary mentioned that she lets the staff know when they were doing a good job:

> *I think I've also let them know in many ways that I think they're great, which I do. I think it's important. To make, to let people know that you think they're... And I don't just say "You're good". I'll say "I like the way to do such and such". I like being more specific.*

Mary also described the category 'Faith' in terms of a protective factor, helping her to feel like she was not alone when she felt overwhelmed:

> *I have a strong Christian faith. And I say my prayers often, especially lately. [Laughs] It's good for me. I sang in church choirs all my life. . . . When I feel, sometimes I feel overwhelmed. I do, sometimes. I can read a psalm in the Bible, or it's there, I should say. I would say that helps a lot, too. I don't feel like I'm alone.*

Maintaining dignity and autonomy. For Mary, the theme 'Maintaining dignity and autonomy' was comprised of two categories: 'Appropriate communication' and 'Appropriate care'. Mary described 'Appropriate communication' in terms of a protective factor for her husband. For Mary, the factor 'Appropriate communication' included aspects of compassion and hope:

> *I watch out, you watch out… words are so important. . . . When I'm there, I never say "I'm gonna go home now". I never say that. . . . But I say: "Well, someone's gotta go back to the house. Someone's got to be there to look after it until you can be home again". And one day he said to me: "Well am I getting out? Am I going home again?" I said: "I think so". I said: "The doctors are thinking that you are doing well", which is true. [Laughs] . . . . I do lie to him lots of times [laughs] but it's in a good cause.*

Mary also described 'Appropriate care' in terms of a protective factor for her husband. When Mary was still caring for her husband at home, she found ways to maintain her husband's autonomy as much as possible: *I just learned to wait till he asked me for help.* Being mindful about when to end her visits with her husband, to avoid unnecessary anxiety was also part of 'Appropriate care' for Mary:

> *The only thing I do, I'm sure of when I go is I wanna be able to have a good hour's visit with him and I wanna be able to leave when he goes into with meals because when he goes into his meals, he's not anxious about me leaving.*

Understanding dementia. For Mary, the theme 'Understanding dementia' is comprised of two categories: 'Past experiences and training' and 'On-going Learning'. Both of these categories acted as protective factors for Mary. Because of her past dementia experiences and training, Mary felt prepared when looking after her husband at home. Mary's first husband had also been diagnosed with vascular dementia. The experiences Mary had when caring for him helped her when she learned of Peter's diagnosis. Mary had an idea of what to expect and how to prepare herself for the future. *And I've seen the same thing help me with my previous husband. And I also knew, like from my previous husband, not to worry about money because you have to buy things.* Mary was forced to learn some new skills and adopt some new roles when her first husband was diagnosed with dementia. When caring for her second husband, she learned she has been able to adopt these roles again:

> *You know there were some bonuses when my husband had his stroke and couldn't manage his business. I learned how to do it. That turned out to help me when Peter, I learned he wasn't paying the bills. . . . I thought "Oh, I've done this before. I can do it again."*

Mary's training as a nurse was identified as an important aspect of the factor 'Past experiences and training', which facilitated her resilience when her first and second husband were diagnosed with dementia:

> *But I never was daunted when… because I was a nurse. You have so many skills when you've been a nurse and in fact, made me glad I could look after him. I was so pleased that I, because I was a nurse it didn't frighten me as much as it would other people I think to find that your husband was lying on the floor and you know, there's a problem. . . . That's the top thing. I'm glad I'm a nurse. I know what's ahead of me. It's not pleasant but I know what to do when it happens and I know what to expect which a lot of people wouldn't know.*

Interestingly, Mary described how having extensive knowledge of dementia and knowledge of what is likely going to happen with someone who has dementia still did not prevent her from getting upset during difficult times:

> *But he, at the end, didn't know me. And told me to get out of his room. And I couldn't help it, I started to cry. But he actually only lived for a few months after that. Yeah, he kept deteriorating. But that was hard to take. I mean, when I got away from him I thought: "Oh gosh". It's like I lost him then.*

Mary described the category 'On-going learning' in terms of a protective factor. She discussed the importance of learning more about dementia when her second husband was diagnosed. She wanted to keep up to date with new information and review her knowledge from when she was nursing to help her to deal with the situation:

> *I look everything up. More than once. I had things all about dementia when he was diagnosed and now I have a whole bunch of stuff that I got off the computer for vascular dementia and all the other different kinds and what could be the difference 'cause it is a long time since I nursed but I thought "Well I'll just refresh it all" and I thought I'd see what's new and what there is to do. . . . If I have to deal with something, I have to know about it. I have to know what's liable to happen.*

Peter (individual with dementia). Asking questions about resilience and dementia from Peter was challenging because of his level of impairment. Because of this, only one theme, 'Maintaining dignity and autonomy', was found. The theme was comprised of one category, 'Appropriate communication'.

Throughout the interview, Peter talked about his interests and events that had happened in the past. He got excited when discussing his passions and appeared pleased when I asked him questions about his hobbies or commented on his stories: *MJS: Is there anything else that helps you to cope in life that you'd like to tell me? Peter: Yeah. Aviation. I mean I just love it and…* It was clear through the interview responses that Peter's hobbies had been important to him in the past and were important to him now, even though he was no longer able to be involved in them. *Peter: I like to do things like that [points to one of his paintings]. MJS: It's so beautiful. Peter: . . . I did this one myself and… so my… you know… I can't… I just love art.*

Peter used humour when answering questions throughout the interview and during the administration of the standardized measures. Using humour could be seen as part of 'Appropriate communication', helping Peter to 'do ok': *Peter: That sounded a bit rough… sorry I'm teasing you. [Laughs] MJS: That's ok… You have a good sense of humour… yep. Peter: Well… you gotta do something. [Laughs].* It was also found through the interview that Peter used many gestures and non-verbal vocalizations to communicate. Peter also changed his intonation and even voice quality when answering questions to express different feelings. These aspects of communication were intact with Peter and appeared to help him to express himself, making non-verbal communication as aspect of 'Appropriate communication' for Peter.

Conclusion. The interview data from the four participants revealed five themes: 'Values', 'Culture and language', 'Community of support', 'Maintaining dignity and autonomy', and ‘Understanding dementia’. These themes were found to be comprised of categories, some of which were shared between the participants and some of which were unique to an individual participant. The categories were described in terms of individual factors as well as factors external to the participants (i.e., family and societal factors) and were found to operate on a continuum from a vulnerability factor to a protective factor.

Discussion

The results of my study included standardized measure scores as well as themes and categories identified through the analysis of interview transcripts. These results will be discussed next. The standardized measure scores for family members, care staff member, and the individual with dementia will be interpreted for descriptive purposes. The themes and categories identified through the interviews will be discussed in terms of commonalities between the participants. The interactions within and between themes will also be reviewed and the findings of my study will be compared to established literature. Finally, recommendations for clinical practice as well as limitations, challenges, and future directions for research will be discussed.

While this is a complex and nuanced area of research in need of a more expansive investigation, my study suggested that cultural and linguistic differences have the potential to both facilitate and impede resilience in dementia. The categories ‘Sharing experiences’ and ‘Cultural adaptation’ were identified as protective factors, helping to counteract some of the negative influences of ‘Cultural and linguistic differences’. The cultural value ‘Respect for elders’ was identified as a protective factor, helping the care staff member as well as the individual with dementia and his or her family to ‘do ok’. Furthermore, the category ‘Values’ was one of the incidental findings of my study, suggesting that ‘Values’ defines what resilience means for individuals. Encouraging the sharing of cultural values and organizing supportive communication technique training were some of the recommendations drawn from my study for clinical practice in culturally and linguistically diverse care environments to help facilitate resilience of all of the parties involved.

Interpretation of Standardized Measures

Family members and care staff member. Both of the family members and the care staff member perceived their QoL to be relatively high. Sarah perceived her QoL to be higher than either of the family members. Her scores for all four domains were over 80. It is interesting to postulate as to why Sarah’s QoL score was higher than the family members. One possible reason could be that she moved to Canada fairly recently, and perhaps feels that her QoL is much better now than it was in her home country. For example, as Sarah has experienced living in conditions with less access to health care than in Canada, she rates the perceptions of what the advantage of accessible healthcare means to her higher than individuals that have lived here all their lives. Both of the family members had their lowest score in the physical domain (69 for Mary and 56 for Joan). During the interview, both of the participants identified some health problems, so the lower scores in this domain are not surprising. Interestingly, Joan's score for the social relationships domain was 69 whereas Mary scored 81. This differences was reflected in the interview responses the participants provided. For example, it was clear that Mary was for the most part very satisfied with her relationships whereas Joan identified problems with some of the relationships in her life, including the relationships she had with the staff and management personnel at the care facility. However, looking at the QoL scores across the four domains, all three participants viewed their QoL relatively high and also identified themselves in the interview as 'doing ok'.

Individual with dementia. Peter's score of 1 is 3.7 standard deviations below the mean obtained by typically functioning adults and 1.5 standard deviations below the mean (4.2) of individuals with moderate AD on the Object Description Subtest of the ABCD. As Peter reportedly had vascular dementia instead of AD, comparison of his scores to the norms of the ABCD should be interpreted with caution; however, Peter's score on the Object Description Subtest of the ABCD suggests that his language abilities were impaired. Despite my use of supported conversation strategies, Peter was also not able to finish the WHOQOL measure. This is also indicative of impaired language abilities. Peter's score of 2 in the GDS is considered typical, i.e., it implies that Peter does not suffer from depression. Even though Peter was not able to finish the MoCA standardized measure, based on his score of 0/8 in the first three tasks of the MoCA, Peter would have scored below 26 had he finished the assessment, indicating a cognitive impairment. Despite Peter's cognitive and language impairments, he was able to get through the interview and to provide some information regarding 'doing ok'. This gives further support to past research that suggests that there is value in asking individuals with dementia about their experiences (Snyder, 2001; Wolverson [Radbourne], Clarke, & Moniz-Cook, 2010). This also supports the practice of having speech-language pathologists involved in working with individuals with dementia as the training we receive can be of benefit in communicating with individuals with dementia and helping them share their experiences.

Commonalities in Themes between Participants

Five themes (‘Values’, ‘Language and culture’, ‘Community of support’, ‘Maintaining dignity and autonomy’, and ‘Understanding dementia’) were found through the interviews with the participants. The theme ‘Maintaining dignity and autonomy’ was identified through the data from all of the participants (Sarah, Joan, Mary, and Peter) and the other four themes were identified through the data from three of the four participants (Sarah, Mary, and Joan). The themes were found to be comprised of categories, some of which were common across the participants and some of which were unique to each participant. Table 8 shows the themes and associated categories for the participants with categories that were common to at least two out of four participants in bold.

Values. ‘Values’ was found to be a theme for Sarah, Mary, and Joan. The theme ‘Values’ is comprised of different categories for each of the participants. This is to be expected, considering the subjective nature of ‘Values’, defined in my study as “personal perspectives that the participants have identified as guiding principles”. However, similarities in the operation of the categories associated with ‘Values’ were noted across three participants. The associated category (category ‘Competence’ for Sarah and category ‘Advocacy’ for Joan) or one of the associated categories (category ‘Striving to be better’ for Mary) was found to define what resilience meant for Sarah, Mary, and Joan.

Table 8

Common Themes and Associated Categories

	Sarah (care staff member)	Joan (family member)	Mary (family member)	Peter (individual with dementia)
Values				
Advocacy		✓		
Competence	✓			
Helping others			✓	
Lack of self-pity			✓	
Striving to be better			✓	
Culture and language				
Respect for elders	✓			
Cultural and linguistic differences	✓	✓	✓	
Cultural adaptation	✓			
Community of support				
Faith		✓	✓	
Gratitude from residents	✓			
Partnership	✓			
Relationships at care facility			✓	
Sharing experiences	✓	✓		
Social isolation			✓	
Societal support			✓	
Support for staff		✓		
Support from friends and family		✓	✓	
Maintaining dignity and autonomy				
Appropriate care	✓	✓	✓	
Appropriate communication	✓		✓	✓
Understanding dementia				
Past experiences and training	✓	✓	✓	
On-going learning	✓	✓	✓	
Staff dementia training		✓		
Theory into practice		✓		

Culture and language. ‘Culture and language’ was found to be a theme for Sarah, Mary, and Joan. ‘Cultural and linguistic differences’ was found to be an associated category for all three participants. For Sarah and Joan, ‘Cultural and linguistic differences’ acted as a vulnerability factor. Sarah identified specific examples of ‘Cultural and linguistic differences’ that have interfered with her ability to ‘do ok’ at work (such as using terms of endearment for the residents and her accent). Joan described how her ‘Cultural and linguistic differences’ between the care staff and the residents in the care facility have impeded her resilience. Data from Sarah and Joan also suggests that ‘Cultural and linguistic differences’ can be a potential vulnerability factor for individuals with dementia. Interestingly, Mary described ‘Cultural and linguistic differences’ in terms of a protective factor for her, and potentially for her husband Peter. It should also be noted that even though the theme ‘Culture and language’ was not identified in Peter’s interview (as he did not share any aspects of his interactions with foreign-born staff members) when asked if the staff in the care facility help him to ‘do ok’, Peter indicated ‘yes’. It is hard to judge the reliability of his response, given his language impairment. However, given the data from Mary’s interview, ‘Cultural and linguistic differences’ could potentially be seen as a protective factor for Peter.

Community of support. ‘Community of support’ was identified as a theme for Sarah, Mary, and Joan. ‘Sharing experiences’ was found to be an associated category for Sarah and Joan. The participants discussed how sharing experiences facilitated their resilience, both in their personal lives and also at work/in the care facility. Mary also described sharing with the care staff as an aspect of ‘Relationships at the Care Facility’. It was noted that for Sarah, her colleagues formed an important part of her ‘Community of support’ and that she did not discuss the role played by the family members of the residents in her support network. ‘Support from friends and family’ was found to be a common factor for the family members. Both Mary and Joan described ‘Support from friends and family’ as both a protective and a vulnerability factor. ‘Faith’ was also a common category for Mary and Joan and an associated category for the theme ‘Community of support’ for both. Mary and Joan described ‘Faith’ in terms of a protective factor that operates on social or community level. For Joan, ‘Faith’ was a category that she shared with her mother, and for Mary, ‘Faith’ helped her to not feel alone.

Maintaining dignity and autonomy. ‘Maintaining dignity and autonomy’ was uncovered as a theme through all of the interviews. ‘Appropriate communication’ was found to be a common category for Sarah, Mary, and Peter. ‘Appropriate communication’ was found to facilitate the resilience of individuals with dementia. Sarah also identified several communication strategies, part of ‘Appropriate communication’, which facilitate her interactions with individuals with dementia, boosting her resilience at work. Some similar aspects of ‘Appropriate communication’ were discovered between Sarah and Peter (reminiscing about the past, using gestures) and between Sarah and Mary (being careful with words to preserve hope). ‘Appropriate care’ was seen as a common category for Sarah, Mary, and Joan. ‘Appropriate care’ acted as a protective factor for individuals with dementia by all three participants, and lack of ‘Appropriate care’ was identified as a vulnerability factor for Joan.

Understanding dementia. ‘Understanding dementia’ was a theme for Sarah, Mary, and Joan. ‘Past experiences and training’ and ‘On-going learning’ were identified as common categories for all three participants and were found to act as protective factors for them. Sarah described how the training and experiences she had in school prepared her for her future career in dementia care. She also indicated that she believed learning more about dementia would help her to do even better. Both of the family members had previous experiences with dementia as well as dementia training (nursing school for Mary and courses for Joan) and they both continued to learn more about dementia. Both of the family members indicated that ‘Past experiences and training’ and ‘On-going learning’ have helped them to ‘do ok’ with their loved ones’ dementia diagnoses and to feel more prepared for the future.

Categories unique to each participant. A number of factors unique to each participant were discovered through the interviews with Sarah, Mary, and Joan. These factors were found to be salient for the participant but not identified through the other interviews.

Culture and language.

Sarah. Two unique categories for the theme ‘Culture and language’ were found in the interview with Sarah, ‘Respect for elders’ and ‘Cultural adaptation’. ‘Respect for elders’ functioned as a protective factor for Sarah. Sarah described how she does not argue with the residents because of her ‘Respect for elders’. This helps to improve her interactions with the residents and to facilitate her resilience at work. On the other hand, as part of the Filipino culture, Sarah is also used to using terms of endearment for older individuals as well as touching or kissing them to show respect. This is different from Canadian cultural practices, and as described earlier, Sarah believes that these cultural differences interfere with her resilience at work.

‘Cultural adaptation’ acted as a protective factor for Sarah, helping to counteract some of the negative influences of the identified cultural differences. Interestingly, ‘Cultural adaptation’ functioned as both a protective and a vulnerability factor for Sarah. For example, Sarah described how conforming to the Canadian cultural norms by calling the residents by their first names allowed Sarah to do her work (facilitating her resilience) but at the same time, made her feel uncomfortable (interfering with her resilience).

Community of support.

Sarah. ‘Partnership’ and ‘Gratitude from residents’ were found as unique categories for Sarah. ‘Partnership’ acted as a protective factor when it was successful and as a vulnerability factor when it was unsuccessful. ‘Gratitude from residents’ was identified as a protective factor for Sarah, facilitating her resilience by giving her life meaning.

Joan. Joan described ‘Support for staff’ as a vulnerability factor for herself and for her mother as well as for the care staff. Joan indicated that the care staff was not supported enough by the executive level of the care facility. It was noted that Sarah did not describe the management personnel at the care facility as facilitating her resilience at work; however, a follow-up interview might have made that connection.

Mary. For Mary, the category ‘Relationships at the care facility’ was found to function as an important protective factor. Mary’s descriptions of her relationships with the care staff reflected a belief that there was reciprocity and trust. ‘Societal support’ was also identified as a category for Mary. Mary described the connections with her husband’s doctor and her cleaning lady in terms of a protective factor while describing the challenge of not having access to appropriate respite care as a vulnerability factor.

Understanding dementia.

Joan. Two unique categories for the theme ‘Understanding dementia’ were identified for Joan: ‘Staff dementia training’ and ‘Theory into practice’. Both of these categories made it harder for Joan to ‘do ok’ with her mother’s dementia diagnosis. Joan viewed the dementia care training the staff receives as inadequate for understanding the different aspects of dementia and dementia care. Joan also indicated frustration by what she perceived as a lack of best dementia care practices implemented in the care facility.

Interactions within and between the Themes

It should be emphasized that the categories identified are not mutually exclusive. However, in order to be respectful of the data received through the interviews, I derived the categories to reflect the perceived views of the participants. There are many connections and considerable overlap between the categories. In some cases, connections between the different categories were stated by the study participants but in many cases, the connections were inferred through the interview responses.

The categories that made up the theme ‘Values’ for Sarah, Mary, and Joan were found to influence the function of the other identified categories. For example, ‘Competence’ was identified as a value that defined resilience for Sarah. In order to achieve ‘Competence’, she shared experiences with her colleagues and friends, decided to adapt to Canadian cultural norms, used many strategies to provide appropriate care to the residents, and had the desire to continually learn more about dementia; hence, ‘Sharing experiences’, ‘Cultural adaptation’, ‘Appropriate care’ and ‘On-going learning’ acted as protective factors for Sarah. Mary described ‘Striving to be better’ as a value that defined what ‘doing ok’ meant for her. As with Sarah, Mary continued to learn more about dementia and to build a strong social network to help support her in order to, in her words, ‘do better than ok’. For Joan, ‘Advocacy’ could also be seen as a value that defined what resilience, in terms of ‘doing ok’ with her mother’s dementia diagnosis, meant for her. Advocating for the best care possible for her mother was important for Joan, and it also lead her to continually deepen her knowledge of dementia, to build a strong support network, and to share experiences with the staff at the care facility.

Another interesting interaction that my study uncovered was the connection between the categories ‘Support from friends and family’ and ‘Understanding dementia’. Mary described occasions when her friends did not understand that she was not able to leave the house for long periods of time when her husband was diagnosed with dementia. It could be argued that this is due in part to the friends’ lack of knowledge of dementia. On the other hand, Joan described how she went to dementia conferences with her sister. Although not overtly identified by Joan, sharing the experience of learning more about dementia could be seen as an aspect that would bring the sisters closer together. Through their shared understanding of dementia, the sisters may be able to support not only their mother but also each other more effectively.

Interactions with 'Cultural and linguistic differences'. Many categories were found to be connected to 'Cultural and linguistic differences'. Figures 4 and 5 summarize the interactions found through the interviews with Sarah and Joan which will be discussed in detail in this section.

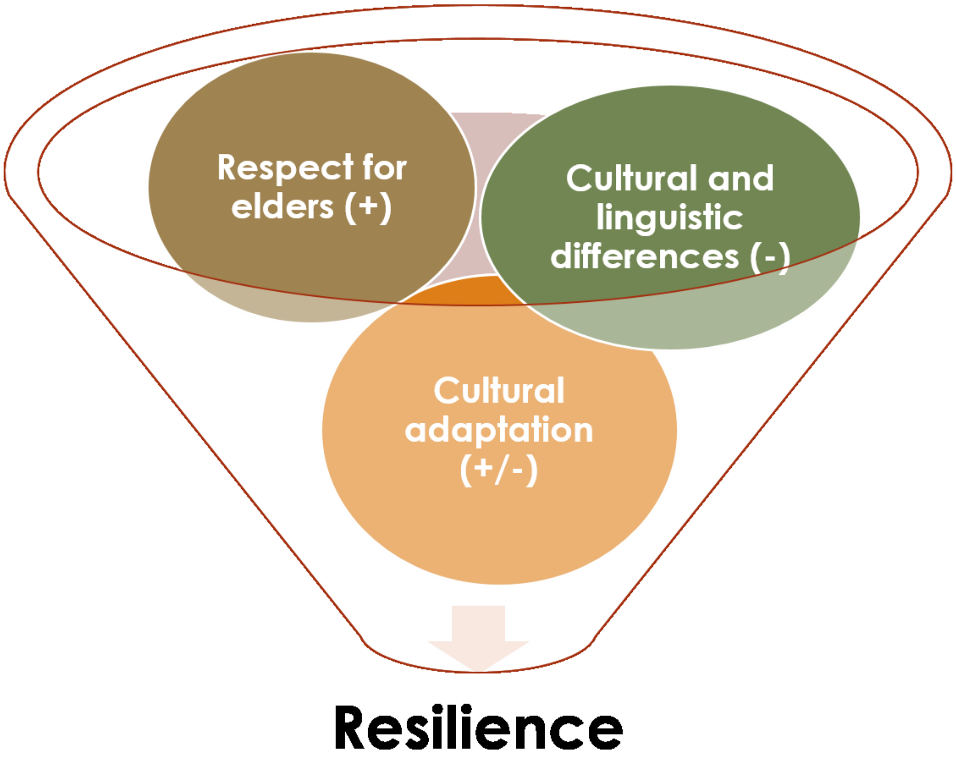

Figure 4. Interactions between categories related to 'Cultural and linguistic differences' (found through interview with Sarah)

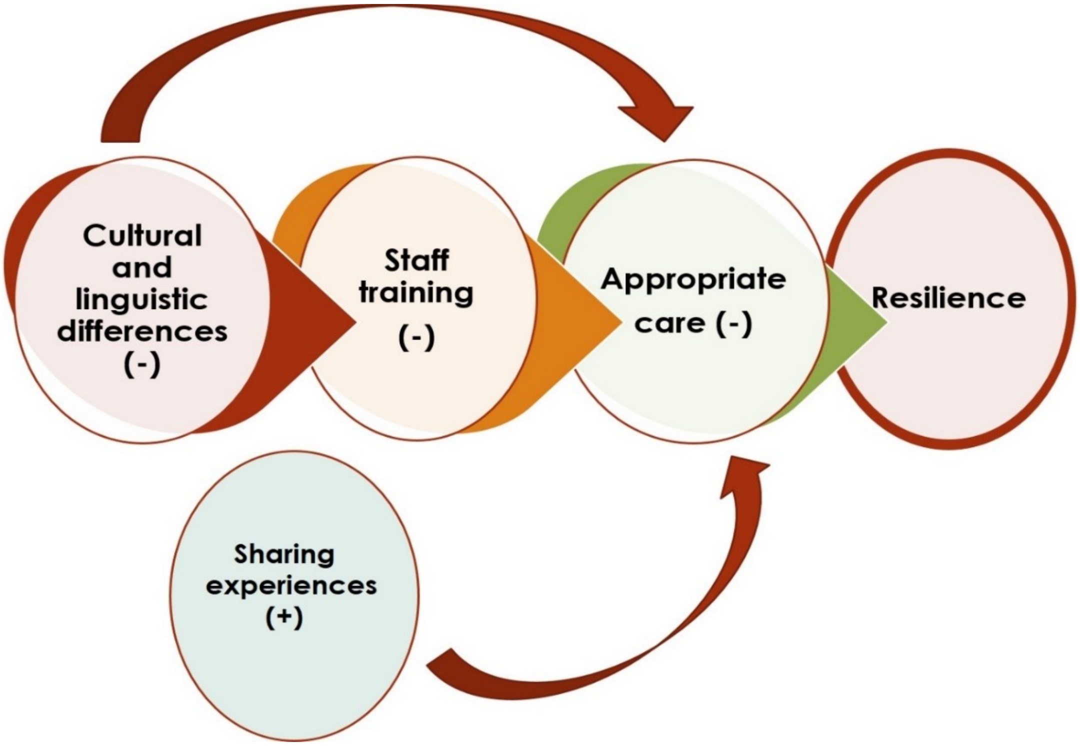

Figure 5. Interactions between categories related to ‘Cultural and linguistic differences’ (found through interview with Joan)

The category ‘Respect for elders’ was at first analyzed as a sub-category of ‘Cultural and linguistic differences’. However, it was clear through Sarah’s interview that ‘Respect for elders’ had great significance to her, and therefore, ‘Respect for elders’ was made its own category, separate from ‘Cultural and linguistic differences’. Sarah’s interview indicated that she perceives ‘Respect for elders’ as an important cultural value of the Philippines. Sarah described how the Filipinos use terms of endearment and touching as ways of overtly showing the high respect they have for older people. Sarah also described how the category ‘Respect for elders’ functioned as a protective factor that facilitated Sarah’s resilience at work (Figure 4). ‘Respect for elders’ was identified as interacting with ‘Appropriate communication’ by Sarah, facilitating the interactions between her and the individuals with dementia and possible boosting the resilience of both parties. Mary might have also been referring to the category ‘Respect for elders’ when she discussed how the care staff members did not argue with her husband.

The category ‘Cultural and linguistic differences’ was found to interact with ‘Appropriate communication’ and ‘Appropriate care’. As described by both Sarah and Joan, ‘Cultural and linguistic differences’ were perceived as interfering with the interactions of the care staff member and the individual with dementia. Both Sarah and Joan believed that this could in turn negatively influence the resilience of the individual with dementia, family member, and the care staff member (Figure 4 and Figure 5). The category ‘Cultural and linguistic differences’ was also found to interact with the category ‘Staff dementia training’ (Figure 5). Joan raised concerns regarding the training foreign-born staff members receive in order to work with individuals with dementia. She identified challenges with English as a potential barrier for learning the needed material when training is done in English alone.

‘Cultural adaptation’ and ‘Sharing experiences’ were both found to interact with ‘Cultural and linguistic differences’ (Figure 4 and Figure 5). Both of these categories were seen as counteracting the negative influences of ‘Cultural and linguistic differences’. Sarah also described ‘Cultural adaptation’ in terms of a protective factor. Even when it was hard for her, she decided to conform to the Canadian cultural practices to facilitate ‘Appropriate communication’. The category ‘Respect for elders’ was also found to interact with ‘Cultural adaptation’. Due to Sarah’s cultural value of ‘Respect for elders’, she is willing to, for example, risk personal feelings of embarrassment when calling the resident by their first name, in order to facilitate her interactions with them. The category ‘Sharing experiences’ functioned as a protective factor for Joan, to help counteract the perceived negative influences of ‘Cultural and linguistic differences’. Sarah also described the category ‘Sharing experiences’ but it was unclear if the sharing between her and her colleagues included aspects of ‘Cultural and linguistic differences’.

An interaction between the themes ‘Maintaining dignity and autonomy’ and ‘Culture and language’ was identified through the interviews with Sarah and Joan. Joan described how having a non-family member looking after her mom was more culturally appropriate and helped to maintain her mother’s dignity. Sarah did not specifically indicate what maintaining dignity means to her. She did, however, describe the cultural difference of family members doing the caregiving in the Philippines versus having facilities in Canada as well as the different roles older people have in each country. This suggests that Sarah and Joan may have different views on the theme ‘Maintaining dignity and autonomy’ and its associated categories ‘Appropriate communication’ and ‘Appropriate care’, partly from their different cultural backgrounds.

The Effects of Cultural Differences on Resilience

As the current study is a series of four case studies, it is important to relate the findings of my study to previous research to enhance internal validity and generalizability (Eisenhardt, 1989). In my study, cultural differences between the care staff members and the individuals with dementia were found to act as both a vulnerability factor and as a protective factor. This is consistent with findings from previous research, which suggests that cultural differences can both facilitate and impede the resilience of the care staff members, individuals with dementia, and family members (Earle, 2015; Nichols et al., 2015; Walsh and Shutes, 2013). Earle (2015) had identified cultural differences between the individual with dementia and the care staff members as a potential vulnerability factor. In her study, a family member had identified cultural differences as impeding good quality of care, and therefore interfered with the resilience of the individual with dementia and the family member. Similarly, the study by Walsh and Shutes (2013) found that not having a shared cultural background can impede the formation of a good care relationship. The findings from my study support the notion that cultural differences have the potential to act as a vulnerability factor. Both Sarah and Joan identified examples of cultural differences that interfered with the interactions between the individual with dementia and the care staff member that negatively affected their resilience, as well as the family member's resilience. Even though Sarah described some cultural differences in terms of a vulnerability factor, she did not report any examples of discrimination or intolerance from the residents when asked what makes it harder for her to 'do ok' at work. This is different than the findings from Nichols and colleagues (2015) and Walsh and Shutes (2013), in which discrimination was a commonly reported theme amongst migrant care workers.

In my study, 'Respect for Elders' was found to be a cultural value acting as a protective factor for Sarah at work. This supports the findings by Nichols and colleagues (2015). They identified respect for elders as an intrinsic factor to culturally and linguistically diverse participants, helping them to develop strong relationships with the care residents and to demonstrate resilience (Nichols et al., 2015). 'Respect for Elders' can also be seen as a facilitating factor for the individual with dementia (by facilitating the interactions between the care staff member and the individual) and the family member (through observing these interactions and feeling good about the care). This finding supports the study by Walsh and Shutes (2013) who found that older people who were cared for by migrant workers praised the workers' compassion and referred to workers from the Philippines as coming from 'a caring culture'. These positive cultural aspects were found to facilitate good care relationships (Walsh & Shutes, 2013). Walsh and Shutes (2013) also described how both the migrant care workers and residents appreciated friendship and familial-like aspects of care relationships. The researchers found that labels such as 'daughter', 'parents', and 'grandparents' were frequently used by both the care workers and the residents, and these labels signified the strength of the care relationships (Walsh & Shutes, 2013). This is different than what was found in my study, in which using labels such as 'grandmother' when addressing the residents was identified as interfering with the interactions between the individual with dementia and the care staff member. It should be noted that the participants in the study by Walsh and Shutes (2013) were not specifically identified as suffering with dementia. The cognitive status of a resident could potentially explain the reaction he or she might have to a label such as 'grandmother' or 'grandfather'.

Previous research suggests that culture can influence how dementia is viewed and can also affect treatment decisions and caregiving roles (Iliffe & Manthorpe, 2004; Mazaheri, 2013). Although not a major theme in my study, data from the interviews with Sarah and Joan support this notion. Sarah described how in the Philippines, an older person is seen as the person with the most wisdom in the family and is asked for advice, even if he or she is diagnosed with dementia. Sarah described the differences in dementia care between the Philippines (where individuals with dementia are cared for mostly in family homes) and Canada, and suggested that in the care facilities in Canada, individuals with dementia are not consulted on the decisions regarding their care. This implies that an individual who is from the Philippines is likely to make different decisions regarding care for a family member with dementia than someone born in Canada. This notion was supported by data from Joan's interview as she indicated that because of the private nature of the North American culture, having a person outside the family looking after her mother was seen as maintaining her mother's dignity. This illustrates that culture influenced Joan's decision about her mother's care. Bourgeois and Hickey (2009) suggested that being aware and supporting the differences in caregiving needs and challenges between the majority and minority cultures has been shown to lead to positive caregiving outcomes. The limited data from my study supports this idea. If Sarah was caring for a family member who had dementia, she would likely make different care decisions and would likely need different forms of support to help her with the process of caregiving than Joan, in order to achieve the best possible outcomes.

The interplay of an individual's culture and his or her context, following the terminology introduced by Ungar (2007, 2008), can also be seen in the current study. 'Respect for elders' is part of Sarah's culture and the practices resulting from 'Respect for elders' are important to her. However, because of her current context, i.e., Canada, she has decided not to follow all of these cultural norms and instead, conform to the Canadian cultural norms. Her resilience patterns as well as the positive outcomes resulting from resilience are influenced by both her culture and her context (Ungar, 2007). Furthermore, 'Cultural Adaptation' acted as a protective factor for Sarah, facilitating her resilience at work and also in her personal life. She described how she would conform to the Canadian cultural norms even if it was difficult for her (e.g., addressing the care facility residents by their first names), which helped her to counteract the possible negative impacts of the cultural differences in question. This finding is consistent with previous research on immigrants and resilience. Castro (2010) described the acculturation process of immigrants and how acquiring new cultural competencies can aid in attaining positive outcomes in the environment. Berry (2006) described how behavioural shifts during the acculturation process can be a mildly stressful experience for the individual but the long-term outcomes are generally found adaptive. Castro (2010) also described how positive outcomes can be attained if an immigrant is successfully integrated into the new culture while still maintaining aspects of his or her native culture. Berry (2006) called this acculturation style *integration.* In my study, Sarah demonstrated this when she described ways she could conform to the Canadian cultural norms while still retaining aspects of her culture which are important to her (e.g., using 'light touch' on the residents).

Joan described how she shared some aspects of cultural differences with the care staff (such as addressing her mother by her first name), bringing it to their attention, and taking responsibility in facilitating successful interactions between the staff and her mother. This finding suggests the need for further support in cross-cultural learning in a multicultural care environment (Nichols et al, 2015). The study by Walsh and Shutes (2013) found that reciprocity was an important aspect of a good care relationship between the residents and the care staff, and a way to learn from each other's cultures. Nichols and colleagues (2015) found that culturally and linguistically diverse workers valued the sharing of cultural information with the residents and also with other staff. In my study, Sarah did not discuss exchanges with the family members and did not describe these exchanges in terms of a protective or a vulnerability factor; however, relationships with her co-workers were an important source of support for her. Pung and Goh (2017) found in their literature review that international nurses were better able to cope with workplace adversities when they received support from fellow international nurses in their host countries. Sarah discussed how successful partnerships and sharing experiences with her coworkers helped her to ‘do ok’ at work and also outside of work. However, it was not clear from the interview if any cultural information was shared between the coworkers.

‘Past experiences and training’ was also found to be an important protective factor for Sarah. She described her HCA training and the experiences she had during her course in caring for individuals with dementia as contributing to her resilience at work. Nichols and colleagues (2015) found that many culturally and linguistically diverse workers had limited experience in dementia care. Therefore, offering training and mentoring programs that allow the workers to further their knowledge of dementia and skills in dementia care is especially important (Nichols et al., 2015). It is not known how much knowledge Sarah had of dementia care before coming to Canada but it was evident that she believed the training she received in Canada helped her to develop skills useful in dementia care.

The Effects of Linguistic Differences on Resilience

Linguistic differences between the individual with dementia and the care staff member were identified as a vulnerability factor. The differences interfered with the interactions between the two parties and as a result, hampered their resilience. It was also found that linguistic differences influenced the interactions between the family member and the care staff member, and therefore interfered with the resilience of the family member. These findings are consistent with previous research (Earle, 2015; McGilton & Boscart, 2007; Nichols et al., 2015; Walsh & Shutes, 2013). In Earle (2015), a family member had identified linguistic differences as a factor that can impede good quality of care and therefore have a negative influence on resilience. Similarly, McGilton and Boscart (2007) found that language differences between the care staff and care facility residents impeded the formation of a close care relationship. The participants in my study did not explicitly suggest that linguistic differences would inhibit the delivery of good care or prevent the formation of a good care relationship. However, it was clear through the interview responses from Sarah and Joan that linguistic differences between the care staff member and the individual with dementia made interactions between them more challenging, thereby interfering with their resilience, and also possibly influencing the care relationship. Walsh and Shutes (2013) found that the migrant staff's communication difficulties affected the conversational and social aspects of care, which made it more challenging for the care facility residents to connect with the staff members. In addition to challenges with comprehension and being understood by the residents because of a foreign accent, colloquial aspects of language were also identified as a possible challenge for foreign-born care workers in my study, which is consistent with previous research (Nichols et al., 2015, Walsh & Shutes, 2013).

Incidental Findings

In addition to the perceptions of cultural and linguistic differences and their impact on the resilience of the parties involved, my study identified other categories that appear to influence resilience in the dementia care environment. Many of these categories are similar to ones identified in previous studies.

My study found that the participants' values helped to define what resilience meant for the participants and motivated the participants in their attempt to 'do ok'. The associated categories of the theme 'Values' were also found to be linked to many of the other categories. Earle (2015) suggested that values influenced an individual's decisions regarding protective and vulnerability factors. Consistent with Connor and Becker (1975), she suggested that values affect an individual's perception regarding a good outcome, and therefore affect the individual's decisions regarding the placement of factors on the continuum from a protective to a vulnerability factor (Earle, 2015). This is similar to what was found in my study in that values appeared to affect individuals' perceptions of a good outcome, defined what resilience meant for them, and determined if the participants viewed categories in terms of protective or vulnerability factors.

In my study, the associated categories for the theme 'Community of support' acted as important protective factors. 'Support from friends and family' was identified as a protective factor for Mary and Joan. Support from friends and family has been found to be an important factor in 'doing ok' with dementia by many previous studies (Cherry et al., 2016; Duggleby, Swindle, Peacock, & Ghosh, 2011; Earle, 2015; Gaugler et al., 2007; Harris, 2008; Pesonen et al., 2013; Williamson & Paslawski, 2016; Wolverson [Radbourne] et al., 2009). In my study, 'Societal support' was found to be a protective factor for Mary, which is consistent with previous research (Earle, 2015; Harris, 2008). Interestingly, Mary identified her cleaning lady as a source of support for her. The care that her cleaning lady provided for her husband allowed Mary to pursue one of her hobbies. This notion of 'non-conventional' community caregivers helping with the burden of caring for someone with dementia has been identified in previous resilience research (Jett, 2005; Mahoney & Mahoney, 2010). 'Faith' was also found to be an associated category for the theme 'Community of support' for both of the family members in my study. 'Faith' was found to function as a protective factor for Mary, helping her to not feel alone, and for Joan and Joan's mother, acting as a shared protective factor. This is consistent with previous research which suggests that 'Faith' can be a protective factor for caregivers and individuals with dementia (Cherry et al., 2013; Earle, 2015; Harris, 2008).

'Past experiences and training' was found to be a protective factor for Sarah, Mary, and Joan. Knowledge of dementia has been found by previous research to be important in helping people living with dementia to 'do ok' (Cherry et al., 2013; Earle, 2015; Williamson & Paslawski, 2016). Earle (2015) found that having access to accurate information about dementia as well as having previous experiences with dementia helped caregivers to feel prepared and to know what to expect. Similarly, both of the family members in my study indicated that it was important for them to know about dementia in order to feel prepared. Earle (2015) also found that a perceived lack in translating theory into practice by care staff was found to be a vulnerability factor for the family members. In my study, Joan reported similar perceptions regarding the lack of putting theory into practice in the care facility and how this pushed her to advocate for her mother and other residents in the facility.

During the interview, Mary described how she was upset when her first husband, who also had dementia, eventually did not recognize her anymore and asked her to leave his room. Despite her extensive experience with dementia as a nurse, she was still shocked by the experience. Earle (2015) identified the difficulty in separating the person from the disease as a vulnerability factor for family caregivers. The family caregivers struggled especially with hurtful comments that were directed at them (Earle, 2015). My study implies that even with extensive knowledge of and experience with dementia, it can be challenging not to be affected by certain aspects of dementia and that separating the disease from the person is difficult no matter how well-prepared the family member is.

The categories ‘Appropriate communication’ and ‘Appropriate care’ were found to function on a continuum from a protective to a vulnerability factor for the family members. Joan felt that her mother was not receiving adequate care and that the staff in the care facility did not interact with her mother appropriately to meet her needs, which made it harder for Joan to ‘do ok’. On the other hand, Mary’s interview suggested that she felt that her husband was receiving appropriate care and that the staff interacted with him on an appropriate level, which facilitated Mary’s resilience, findings consistent with Earle (2015). Maintaining dignity was a concept that was identified as an important aspect of ‘Appropriate care’ by both Sarah and Joan. Maintaining dignity is an aspect of dementia care that has been discussed in previous literature and has been implied to influence the resilience of individuals with dementia (Earle, 2015; MacKinley, 2012; Smebye & Kirkevold, 2013).

Recommendations for Clinical Practice

It is recognized that my study had several limitations and challenges, which will be discussed in the next section. Regardless, a number of suggestions for facilitating resilience within the Canadian care environment that could help to lessen the potential negative impact of cultural and linguistic differences can still be drawn from my study and the existing literature. These clinical recommendations can be divided into three groups: 1) general strategies, 2) SLP involvement, and 3) framework and intervention.

General strategies. Using the terms introduced by Nichols and colleagues (2015), the general strategies for counteracting the negative influences of ‘Cultural and linguistic differences’ include sharing *intrinsic factors* and encouraging the use of *moderating factors*. Sharing intrinsic factors, including cultural beliefs and values that the care staff workers brought into the work place was seen as a factor that would help to build a cohesive multicultural workforce by Nichols and colleagues (2015). Sharing cultural differences as a general strategy was also supported my study. Joan described how sharing has helped to counteract the negative influences of ‘Cultural and linguistic differences’ and reciprocal sharing between the family members and the staff members could be seen as equally effective. For example, sharing with the family members of care facility residents that some of care staff members might call the residents ‘grandmother’ or ‘mama’ as a sign of respect because of their culture may be a beneficial practice. The care workers could still be coached to call the residents by their first names but if they accidently addressed the residents as ‘grandma’ or ‘mama’, the family members would know that there is a reason and a good intention behind these terms of endearment. By sharing cultural values, the focus is placed on the many positive aspects foreign-born care workers bring into the workplace, and could potentially start conversations about how to effectively utilize these positive cultural differences in order to provide compassionate care for individuals with dementia. My study also suggests that having the management of the care facilities more involved in the sharing process could be valuable in encouraging reciprocity. Having a ‘community of sharing’ between the management, care staff, family, and individual with dementia, with respect for the individual’s privacy, has potential to be beneficial for all of the parties involved. By having a community that is open to sharing and that welcomes questions, the care staff members may also feel comfortable asking questions regarding cultural and linguistic differences.

Nichols and colleagues (2015) also discussed the importance of moderating factors, such as training and mentoring programs, in helping foreign-born staff to improve their skills in the workplace. In my study, Sarah described how the training she received has helped her to ‘do ok’ in her current job, supporting the value of training programs in dementia care. Mentoring programs were not brought up as a category in my study but the value of having a mentor could be inferred from my study. It is not known how Sarah learned about the cultural differences described in my study but it was found that peer support was important for Sarah. Having a mentor, someone who understands the challenges a new foreign-born health care worker in Canada is facing, could be very valuable and would most likely facilitate the resilience of the care workers.

SLP involvement. SLPs have many roles in dementia care, including assessment and remediation of communication deficits and feeding and swallowing impairments, training staff in how to communicate with individuals with dementia, advocating for services for individuals with dementia, and facilitating interactions between the family members and the staff (Bourgeois & Hickey, 2009; Speech-Language & Audiology Canada, 2016). The current study supports the involvement of SLPs in multilingual and multicultural care environments in all of the roles described above. The training and the skill set SLPs acquire combines aspects that are beneficial in working in the culturally diverse Canadian care environment. In addition to having background knowledge of dementia and its impact on communication, feeding, and swallowing, SLPs are also expected to exercise cultural and linguistic sensitivity by acquiring and incorporating knowledge of cultural and linguistic differences and by recognizing the influences these differences can have (Alberta College of Speech-Language Pathologists and Audiologists, 2017).

Framework and intervention. The findings of the current study support using the WHO-ICF framework (World Health Organization, 2002) to help describe and organize client information when completing assessments and planning intervention. Many of the categories found in the current study fit either under the personal factors section (e.g., ‘Faith’), environmental factors (e.g., ‘Support from friends and family’), or activity/participation factors (e.g., ‘Cultural and linguistic differences’). If a clinician focuses on body functions and structures alone, he or she will miss many factors that can have a great influence on the resilience of the individual with dementia. Using the WHO-ICF framework in a culturally and linguistically diverse environment can be especially valuable as it ensures that the clinician will be mindful of factors such as ‘Cultural and linguistic differences’. When using the WHO-ICF framework, the clinician is also likely to note factors such as ‘Values’. The findings of my study suggested that personal values define what resilience means to individuals; therefore, knowing the personal values of an individual can be used to help boost the individual’s resilience. The importance of values has been recognized by the Alberta College of Speech-Language Pathologists and Audiologists. The College has indicated the importance of the clinician engaging the client to clarify his or her values and incorporating these values into service provision as part of the SLP competencies (Alberta College of Speech-Language Pathologists and Audiologists, 2017).

My study also demonstrates the value of using SCA^{TM} or similar supported conversation techniques in culturally and linguistically diverse care environments. The staff care member and the family members identified strategies that helped them to overcome the impact of linguistic differences. Sarah identified repeating herself using simple sentences and gestures as strategies that helped her to communicate with individuals with dementia, if they did not understand her. These strategies helped her to ‘do ok’ despite the linguistic differences between her and the individual with dementia. These strategies would also help the individuals with dementia to understand the health care worker more effectively as they help to compensate for the cognitive impairment (Aphasia Institute, 2015b; Bourgeois & Hickey, 2009; Mahendra & Hopper, 2013). Both of the family members also described some strategies they employ to overcome communication breakdowns with care staff members, such as confirming messages and speaking in simple terms. These communication strategies have been found to be useful when interacting with individuals who do not speak English as their first language (Aphasia Institute, 2015b). My study implies that SCA^{TM} or similar supported conversation training provided by SLPs for family members and care staff members could help to facilitate interactions, benefitting all of the parties involved.

Limitations, Challenges, and Directions for Future Research

My study explored the influence of cultural and linguistic differences between individuals with dementia and care staff members on resilience. However, despite significant efforts to attract participants, the sample size in my study was small, and I was unable to study 'dementia care triads' as initially planned. Recruiting participants for the study was found to be very challenging even though efforts were made to take as little of the care facility's time and resources as possible to recruit participants. Many care facilities were interested in the study and acknowledged the value of the topic of the study but stated that they did not have the staff or time to invest in recruitment. A number of facilities also indicated that they had never participated in a study and did not have any protocols in place, and so were unable to consider the proposal in the timeframe of the study.

Another limitation with my study was that I was unable to clarify with Sarah, Joan, and Mary if my interpretations of the data reflected their intended views as I only met with them one time. I considered revising the study methods to allow for subsequent meetings so that I could ask the participants follow-up questions and verify my interpretations with them; however, it was suspected that changing the study methods to include more than one interview would have made it even more challenging for me to recruit participants. Even though member checks (i.e., sharing the interpretations of the study data with the participants to verify the accuracy of the viewpoints expressed) have been found to be a useful strategy in enhancing credibility in qualitative research, researchers have also found that by presenting information, the researchers can affect the participants answers to subsequent questions (Krefting, 1991). When considering the sensitive nature of some of the topics explored in my study (for example, cultural differences), it may be especially challenging for the participants to answer follow-up questions truthfully. Asking follow-up questions without imposing meaning would also be challenging for the researcher, especially when the intention is to verify interpretations of data.

Since my study consisted of only four case studies, the data collected may not reflect the experiences of all individuals with dementia, their family members, and the care staff members Hodkinson & Hodkinson, 2001). It would be valuable to conduct a larger study with ’dementia care triads’ from different care facilities in order to further explore the influences that cultural and linguistic differences have on resilience and to potentially acquire data that is more generalizable or more likely to be truly representative of the Canadian care environment as a whole (Hodkinson & Hodkinson, 2001). Another challenge with my study was the limited amount of previous research on this topic, especially studies conducted in Canada. Most of the studies that have researched the influences of cultural and linguistic differences in care facilities to date have been conducted in Australia (Nichols et al., 2015) or Ireland and the United Kingdom (Walsh & Shutes, 2013), which could influence the compatibility between the findings in my study and established literature.

My study suggested that perceived cultural and linguistic differences can act as both a protective and vulnerability factor for all of the parties involved. Based on these results and the fact that these differences are not well studied to date, further research is recommended and warranted. It would be especially valuable to interview more individuals with dementia on the topic as their perspectives and their experiences are not well represented in research literature. It would also be valuable to have staff member participants with a variety of cultural backgrounds as this would help identify the unique beliefs, values, and cultural aspects care staff members from other countries bring into the Canadian care environment.

My study also suggested some clinical practices that could help to counteract the potential negative influences of cultural and linguistic differences. Research on the effects of mentoring programs or supportive communication workshops in supportive care facilities would be valuable as these are two practical ways that are likely to benefit culturally and linguistically diverse care environments. More research on cultural sharing would also be beneficial as previous research suggests that sharing cultural values and beliefs can help to facilitate resilience.

Cultural and linguistic differences were also found to be interconnected to categories, such as ‘Past experiences and training’. Further research on the potential protective and vulnerability factors that interact with ‘Cultural and linguistic differences’ is needed in order to have a better understanding of these complex networks and their interactions. With more understanding of the relationships between the different factors, researchers can potentially identify strategies that can help to facilitate resilience. My study also suggested that culture can influence the concept of maintaining dignity. Further research on what maintaining dignity means and how it is related to resilience as well as to culture would be interesting and valuable. Dignity is a term that is often used when discussing dementia care; however, if we do not have a solid understanding of its meaning or if we do not recognize that it can mean something different to each person, its use as a term may not serve its purpose of facilitating resilience in dementia care.

One of the incidental findings of my study was the role of non-conventional caregivers. The idea of individuals working in the community (such as mailmen or cleaning ladies) caring for individuals with dementia is intriguing. Further research on the potential roles of non-conventional caregivers would be valuable and timely, considering that the number of individuals that will be diagnosed with dementia is increasing. Since cultural views on dementia can influence the dementia care decisions of family members, research on non-conventional caregivers should also include cultural aspects. In the future, non-conventional caregivers may be a source of support for individuals to whom facility care is not a culturally acceptable care option.

Another incidental finding of my study was the theme of ‘Values’. The findings of my study suggested that personal values can define what resilience means for the individual. More research is needed to gain a better understanding of the relationship between personal values and resilience. The aspect of cultural values was also discussed in my study. Future studies on values could include both personal and cultural values to shed light on the relationships between different types of values and how they influence resilience.

Conclusion

Four individuals (one foreign-born health care worker, two family members, and one individual with dementia) were interviewed for my study. Thematic analysis was used to identify themes and associated categories in the interviews. The themes that were identified through the interviews included ‘Values’, ‘Language and culture’, ‘Community of support’, ‘Maintaining dignity and autonomy’, and ‘Understanding dementia’. The associated categories were interpreted as protective factors, vulnerability factors, or defining factors based on descriptions provided by the participants. The interactions between the categories were found to be complex.

The data regarding the identified categories and their interactions were compared to findings from past research. The findings from the current study supported many findings from past research and also identified some new avenues for future research. My study suggested that perceived cultural and linguistic differences have the potential to both facilitate and interfere with resilience in the Canadian care environment. The current study supports the notion of SLP involvement in dementia care in the Canadian care environment. SLPs could play a facilitative role in counteracting the possible negative influences of cultural and linguistic differences in the Canadian care environment through providing education, collaborating between the 'dementia care triad' members, promoting the sharing of cultural aspects, advocating for resources, continuing research, and acknowledging the complex issues related to cultural and linguistic differences when conducting assessments or providing intervention. Further research in this field would benefit the delivery of compassionate and person-centered dementia care that can help to facilitate the resilience in linguistically and culturally diverse care environments.

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Appendix A

Terms Related to Resilience

Competence

Luthar (2006) notes that both competence and resilience mean ‘doing okay’ and both can be thought of as being under the broad umbrella term of adaptation. However, the term competence is used when an individual shows effective performance in tasks that are developmentally appropriate and important for his or her society. The term resilience on the other hand is used when an individual’s functioning is defined in relation to adversity or risk (Luthar, 2006). Fergus and Zimmerman (2005) describe competence as an asset: an individual level protective factor that can be involved in the process of resilience. If an individual has competence, they are more likely to have a resilient outcome over stressful events or significant risk (Fergus & Zimmerman, 2005).

Coping

Resilience has been used interchangeably with the term coping (Fergus & Zimmerman, 2005; Greve & Staudinger, 2006). Greve & Staudinger (2006) argue that coping is an important part of the process of resilience. Coping is thought of as an immediate or short term outcome to a stressor, unlike resilience, which develops over time (Masten et al., 1991; Zimmerman & Brenner, 2010). An individual’s *coping style* is thought to affect the perception and the management of a stressful situation, making a successful coping style a protective mechanism, and part of the constellation of resilience (Beasley, Thompson, & Davidson, 2003).

Ego-resiliency

Ego-resiliency is considered to be a personality trait of resourcefulness, sturdiness, and adaptability. It is considered to be important when individuals deal with day-to-day changes in their lives (Windle, 2011; Luthar, 2006). Since ego-resiliency is considered to be a personality trait, it does not presuppose risk or adverse events, which are critical components of resilience. However, ego-resiliency can be a protective factor, and a potential predictor of resilience (Luthar, 2006; Windle, 2011).

Sense of Coherence

Sense of coherence (SOC) is a personality trait, which is relatively stable, and influences one’s perception of the world (Antonovsky, 1979; Shapiro, Schwartz, & Santerre, 2002). SOC resembles resilience, as both of the terms were developed by observing that individuals display positive adaptation while managing difficult life situations, and both involve protective factors (Windle, 2011). However, the term resilience can be applied to outcomes outside of health, such as academic success, whereas SOC is a term that is used exclusively for health outcomes. As a personality trait that can contribute to emotional strength and stability, SOC is seen as one of the individual protective factors in the resilience process (Fry & Debats, 2010; Windle, 2011).

Hardiness

Stress hardiness was a term developed by Kobasa (1979, 1990). Stress hardiness, or simply *hardiness*, is considered to be a fairly stable personality characteristic similar to SOC (Shapiro et al., 2002). Hardiness shares some characteristics with resilience. Hardiness presupposes risk, as does resilience (Luthar, 2006). Both of the concepts have also been used when studying the connections between stress and psychopathology (Windle, 2011). Unlike resilience, hardiness refers to a relatively fixed personality trait, and has been used to measure stability, whereas resilience is considered to be a dynamic process, changing across the lifespan (Luthar, 2006; Windle, 2011).

Self-efficacy

Self-efficacy has been described as “beliefs about whether one can produce certain actions” (Bandura, 1997, p. 20) Self-efficacy has been found to be important as a protective resource, when an individual faces a tragedy or trauma, and has been correlated with life-satisfaction and psychological well-being (Maddux, 2002). When an individual has strong self-efficacy, he or she has strong beliefs in his or her competence, ability to solve problems, and knowledge. Individuals with high self-efficacy might also be better at utilizing other resources, such as financial resources or family support at the time of need than individuals with low self-efficacy (Bandura, 1997; Fry & Debats, 2010). Self-efficacy can be viewed as part of the dynamic process of resilience, and is seen as a skill that can help promote resilience (Bandura, 1997; Fry & Debats, 2010).

Hope

Snyder, Rand, and Sigmon (2002) define *hope* as “the belief that one can find pathways to a desired goal and become motivated to use those pathways” (p. 257). Hope has been described as an active thinking process, facilitating an individual’ motivation to ‘keep going’, and promoting viewing life’s difficulties as challenges (Wolverson [Radbourne] et al., 2010). Resilience and hope are seen as similar constructs. Both hope and resilience are considered to be adaptive processes, and both are preceded by adverse events (Wolverson [Radbourne] et al, 2010). However, hope is often characterized as a trait, whereas resilience is a dynamic process leading to patterns of positive adaptations. While not directly discussed in the literature, it could be hypothesized that hope is another protective factor that helps to promote resilience during significant risk or adverse events.

Quality of Life

Quality of Life is a broad, multidimensional concept that has been defined and assessed in many different ways depending on context and purpose (Crespo, de Quiros, Gómez, & Hornillos, 2012). Most definitions of QoL include several domains, such as overall life satisfaction, general sense of happiness, and physical and mental well-being (Bourgeois & Hickey, 2009). The World Health Organization Quality of Life (WHOQOL) Group's definition suggests that QoL is a subjective concept. In their position paper, QoL was defined as "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHOQOL Group, 1995, p. 1405). QoL and resilience are related but not equivalent terms. Going back to the definition of resilience introduced earlier, resilience refers to either 'doing ok' or better than expected after an adverse event or despite risk (Luthar et al., 2000). This definition would suggest that resilience can lead to better QoL than expected considering the individual's circumstances. However, Williamson and Paslawski (2016) found that individuals with dementia who had low QoL scores still rated themselves as resilient. This suggests that the relationship between QoL and resilience is a complicated one, and requires more research.

Successful Aging

Successful aging has traditionally been considered to include three features: (1) low risk of disease and disease-related disability, (2) maintaining high physical and cognitive functioning, and (3) active life engagement (Rowe & Kahn, 1998). Windle (2011) argues that successful aging is a contrary term to resilience. Unlike the model of successful aging, resilience research acknowledges the possibility that the presence of illness and disability does not necessarily lead to a poor outcome (Windle, 2011). It has also been suggested that resilience may characterize successful aging for individuals who face chronic illness and disability (Lamond et al., 2008). Harris (2008) argues that successful aging is an exclusive term, whereas resilience is inclusive. Individuals with chronic illness or disabilities are not excluded from having resilience as a goal, and the influences of factors such as culture and ethnicity are also acknowledged within the concept of resilience (Harris, 2008).

Appendix B

Demographic Information Collected from Participants and Data Collected from the Supported Living Facility

Individuals with dementia

1. Age
2. Gender
3. Marital status
4. Level of education
5. Cultural background
6. Country of birth
7. Time of migration to Canada (if not born in Canada)
8. Languages spoken
9. Time of dementia diagnosis
10. Type of dementia

Family members

1. Age
2. Gender
3. Marital status
4. Relationship to the individual with dementia
5. Level of education
6. Cultural background
7. Languages spoken

Staff members

1. Age
2. Gender
3. Marital status
4. Level of education
5. Cultural background
6. Country of birth
7. Time of migration to Canada
8. Languages spoken

9. Jobs before entering Canada
10. Current job
11. Country where caregiving training took place
12. Description of caregiver training

Data collected from the facility:

1. Requirements for hiring foreign-born health care workers

Appendix C

Interview Questions

(Earle, 2015; McGilton & Boscart, 2007; Nichols et al., 2015, Ungar, 2010)

Questions for all of the participants:

1. What made you sign up for the study?
2. What does it mean to you to do ok?
    a. Do you think you are doing ok?
    b. Tell me what helps you do ok…
        i. At work.
        ii. At home.
        iii. With family.
        iv. With friends.
        v. Out in the community.
    c. Tell me what makes it harder for you to do ok…
        i. At work.
        ii. At home.
        iii. With family.
        iv. With friends.
        v. Out in the community.
3. What advice would you give to someone to help live well with dementia?
4. Is there anything else you would like to tell me?

Questions for individuals with dementia:

1. What helped you after your diagnosis of dementia?
2. What would have helped you to do better after your diagnosis with dementia? What would help you now?
3. Tell me about your relationship with [insert staff member name].
    a. Does [staff member] help you do ok? Can you tell me about that?
    b. What things about [staff member] help you?
    c. What things about [staff member] make it harder for you to do ok?

4. Tell me about your experiences with staff members who are from a different country.
    a. Did these experiences help you do ok?
    b. Did these experiences make it harder for you to do ok?
5. Tell me about your experiences with staff members who do not speak English as their first language.
    a. Did these experiences help you do ok?
    b. Did these experiences make it hard for you to do ok?

Questions for family members:

1. Can you share with me a story about someone who has coped well in [your country of birth] despite facing many challenges? (Ungar, 2010a, p. 420)
2. What helped you after your family member was diagnosed with dementia?
3. What would have helped you to do better after his/her dementia diagnosis? What helps you now? What would help you now?
4. Tell me about your interactions with long-term care staff members who are from a different country.
    a. Do these interactions with staff members from a different country contribute to your resilience? Tell me how.
    b. Is there anything about your interactions with staff members that interfered with your resilience? Tell me how.
5. Tell me about your interactions with staff members who do not speak English as their first language.
    a. Do these interactions with staff members from a different country contribute to your resilience? Tell me how.
    b. Is there anything about your interactions with staff members from a different country that interfere with your resilience? Tell me how.
6. How have you gathered information about dementia?
7. Would it help you to do ok if you knew more about dementia?

Questions for staff members:

1. Can you share with me a story about someone who has coped well in [your country of birth] despite facing many challenges? (Ungar, 2010a, p. 420)
2. Tell me about your experiences with individuals with dementia.
3. Do you think people with dementia can do ok?
    a. What helps them to do ok?
    b. What makes it harder for them to do ok?
4. Do you think caregivers of individuals with dementia can do ok?
    a. What helps them to do ok?
    b. What makes it harder for them to do ok?
5. Do you think it is easier for people with dementia to do ok in [your country of birth] or in Canada?
Tell me about that.
6. Do you think it is easier for caregivers of people with dementia to do ok in [your country of birth] or in Canada? Tell me about that.
7. Do you think culture impacts your ability to do ok?
8. Do you think language impacts your ability to do ok?
9. Tell me what dementia training you have?
10. Would it help you to do ok if you knew more about dementia?