THE UNIVERSITY OF CHICAGO

FROM LIABILITY TO ASSET: UNDERSTANDING THE MUTUALLY BENEFICIAL RELATIONSHIP BETWEEN SENIORS WITH DEMENTIA AND HIGHLY VULNERABLE YOUNG ADULTS

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Chapter 1: Introduction

Globally, there is a growing concern about mental health challenges affecting millions, with this crisis impacting multiple generations (American Psychological Association, 2020). Particularly affected are young adults grappling with mental health symptoms and seniors diagnosed with dementia, whose numbers have increased rapidly (Courtney & Dworsky, 2006; Alzheimer's Association, 2022). Traditionally, these groups have been perceived as social liabilities, often seen as passive recipients of services rather than active contributors to society (Chen et al., 2020; Gimeno et al., 2021; Kong et al., 2022). Current interventions for these vulnerable young adults are often insufficient in supporting their transition from adolescence to adulthood (Gulliver et al., 2010; McGorry et al., 2014; Vanheusden et al., 2008), while the individual needs of seniors with dementia frequently remain unaddressed on a large scale (Cohen-Mansfield, 2001; Hofmann & Hahn, 2014; Szmukler & Appelbaum, 2008; te Boekhorst et al., 2013). Recent perspectives have begun to acknowledge the potential agency and skills within these populations (Kitwood, 2015; Jolliffe & Farrington, 2006; Munford & Sanders, 2021a), challenging the notion of their passive role in societal structures. The key challenge, however, is finding a context that enables their resilience to manifest.

In the Netherlands, a well-known nursing home recognized for its pioneering intergenerational programs serves as an insightful case study. Starting in 2019, this facility employed a select group of highly vulnerable young adults (HVYAs) aged 18 to 35 to work toward enhancing the well-being of seniors with dementia (SwD). These HVYAs were eager to work, yet the opportunities available to them were significantly constrained by their vulnerabilities, which included a combination of multiple mental health symptoms, a lack of job skills, and social skills. The support available to them was limited to government subsidies and job coaching at work. It might be expected that these young adults, whose disadvantages could be exacerbated by working with SwD—a population unfamiliar to them and known to be challenging to assist—would struggle at work. Unless they can find a source of support sufficient to overcome the various risks, their difficulties will persist (Spencer et al., 2006). However, I found that these young adults reported not only positive work experiences in their assistance to the seniors but also substantial personal development, particularly in forming their emergent identities and achieving productive coping outcomes, such as pursuing caregiving as their professional career. With these positive developmental outcomes, the HVYAs have become newly resilient young adults, successfully overcoming significant challenges and showcasing new strengths that were not previously apparent.

To deeply understand the coping experiences of these young adults, which suggests a mutually beneficial relationship with SwD, this qualitative study employs the Phenomenological Variant of Ecological Systems Theory (PVEST) as its guiding framework. This approach centers on the perspectives of highly vulnerable populations, uncovering their subjective meanings and interpretations within a complex and layered context (Spencer, 1995, 2006; Spencer et al., 1997).

Having undertaken ethnographic work at the nursing home for three consecutive years, spanning nine months, this study encompasses in-depth observations and over 50 interviews that include the HVYAs, staff members, and senior residents at the nursing home. This comprehensive approach was adopted to thoroughly understand the nursing home's context and the experiences of both populations involved. Specifically, the study seeks to understand the nature of the young adults’ coping experience and to unravel the mechanism underlying this mutually beneficial relationship.

Contrary to the conventional view of these groups as social liabilities, it was found that

SwD play a crucial role in HVYAs' positive coping experiences through genuine interactions and a rewarding work environment, further reinforced by shared mental health symptoms. Interestingly, staff members, typically expected to be a source of support, were perceived by the young adults as a source of challenge. Despite the undervaluation of the difficulties inherent in their job, the young adults exhibited remarkable resilience, committing themselves wholeheartedly to their work and becoming an essential component in the well-being of the seniors. This commitment persisted even amidst the challenges of the pandemic, which significantly impacted the nursing home with high staff turnover.

This study sheds new light on caregiving and interventions for highly vulnerable populations. It reveals that nursing homes are not merely care facilities but have unique characteristics that can foster the resilience of highly vulnerable groups like young adults with mental health challenges and seniors with dementia. For these young adults, it provided a rare job opportunity that not only aligned with the need for meaningful employment but also catered to their needs for mental health recovery, making their work experience distinctly different from other types of employment. In addition, from the young adults' viewpoint, working with SwD allowed them to perceive themselves as less vulnerable, thereby fostering intrinsic motivation (White, 1959). This shift away from seeking external validation, such as from therapists, toward self-awareness and self-directed healing is a significant aspect of their experience. This approach resonates with contemporary therapeutic practices where the therapist's role is more about facilitating rather than directing the healing process, as highlighted by Cooper & Di Malta (2024) and Rogers (1951). Hence, this study not only uncovers a mutually beneficial relationship between two traditionally marginalized groups but also offers a fresh perspective on how nurturing environments like nursing homes can be instrumental in empowering these individuals.

This research makes a significant contribution to the understanding of highly vulnerable populations by shifting the focus from their traditional portrayal as predominantly vulnerable to recognizing their potential and resilience. It underscores the concept that resilience is highly context-specific, emphasizing the need to identify the right environments to foster and nurture such resilience. Additionally, this study enriches the literature on human development by exploring the parallels and shared experiences between two distinct groups at different life stages - young adults with mental health challenges and seniors with dementia. Instead of examining these groups in isolation, the study provides a novel perspective by looking at the intersection of their experiences, thereby offering a more holistic understanding of their shared experiences and needs.

This study holds considerable practical implications. It reveals a mutually beneficial relationship that redefines formerly perceived social liabilities as valuable, untapped resources. Facing the global challenge of transitioning to person-centered care (PCC), particularly amidst a growing population of seniors with dementia (SwD), nursing homes can benefit greatly from this study's proposed model. This model not only supports the well-being of two highly vulnerable populations—seniors with dementia and young adults with mental health struggles—but also enhances the overall functioning of nursing homes. With millions of these previously overlooked vulnerable individuals worldwide, this study highlights their potential to significantly contribute to their well-being and improve society at large.

Dissertation Chapters

This study aims to gain an in-depth understanding of the work experiences of a group of highly vulnerable young adults (HVYAs) who assist seniors with dementia (SwD) in a nursing home. The hypothesis posits that a mutually beneficial relationship exists between SwD and

HVYAs, contributing to the latter's positive coping outcomes despite their own vulnerabilities and workplace challenges. To comprehensively explore this relationship, the study focuses on three main topics: the nursing home as the context where this relationship unfolds, the SwD who are central to shaping this interaction, and the HVYAs’ coping experience. Being a study highly relevant to the caregiving industry, this research also provides an overview of the industry and assesses the potential implications of this unique intergenerational relationship.

Consequently, the dissertation is structured into five chapters: Chapter 1 provides the Introduction, Chapter 2 presents the Literature Review, Chapter 3 details the Methods employed, Chapter 4 reveals the Findings, and Chapter 5 discusses these findings and draws Conclusions.

Chapter 1: Introduction

Chapter 1 presents an overview of the dissertation and outlines its structure. The study encompasses three principal themes: nursing homes, seniors with dementia (SwD), and highly vulnerable young adults (HVYAs). To maintain clarity, these themes are systematically addressed in separate sections, presented sequentially in the order of nursing homes, SwD, and HVYAs. Each of these main topics consistently follows the same sub-section order, facilitating a coherent and structured progression of content throughout the dissertation. This organization ensures that questions introduced in the literature review (Chapter 2) are methodically explored and analyzed using field data in the Findings section (Chapter 4), and then comprehensively discussed in the Discussion section (Chapter 5). A visual representation of this layout can be found on the next page (Table 1), illustrating the consistent and logical flow of information across the chapters.

This research positions the nursing home as the central context in which the intergenerational relationship between seniors with dementia (SwD) and highly vulnerable young adults (HVYAs) unfolds. Understanding the nursing home's environment is crucial, as its distinct culture and the attitudes of staff members toward vulnerable populations can significantly impact both SwD and HVYAs, either directly or indirectly.

Chapter 2 Literature Review	**Chapter 4 Findings**	**Chapter 5 Discussion**
2.1 Nursing Homes in Transition • The Transition to Person-centered Care (PCC) • Direct care relies on disadvantaged caregivers • The Influx of SwD	**4.1 An Intergenerational Approach to Person-centered Care** • HCare and its needs for transition • Implementation of intergenerational programs • The HVYAs' job and the reported positive experiences	**5.1 The Potential for Nursing Homes to Transform** • A unique work environment • Redefining dementia care • The advantages for HVYAs to provide dementia care at nursing homes
2.2 Seniors with Dementia (SwD) • A highly vulnerable population • Existing care model being insufficient • SwD's potential as a source of support	**4.2 Dementia Care at HCare** • Describing the SwD at HCare • Institutionalized care at the nursing home • The HVYAs' job and reported positive experience	**5.2 The Mechanism of the Mutually Beneficial Relationship** • Similarities between HVYAs and SwD • Unique Characteristics of SwD • A Suitable Job for HVYAs
2.3 Highly Vulnerable Young Adults (HVYAs) • Describing the HVYAs • Existing interventions are insufficient • A more positive angle: HVYAs' agency and skills	**4.3 HVYAs' Coping Experience at Work** • Net vulnerability and stress • Unexpected sources of support • Adaptive coping processes • Emergent identities and productive coping outcomes	**5.3 The Importance of Recognizing the HVYAs' Perspective** • Vulnerability is relative • Intrinsic motivation of the HVYAs • The HVYAs' perspective on their coping outcomes

Table 1. Structure of Chapter Sections

The characteristics of SwD are also particularly influential in this study. They define the nature of the HVYAs' work and shape their coping mechanisms. The interaction with SwD offers unique challenges and opportunities for the HVYAs, influencing how they perceive their role and manage their responsibilities. Due to their dementia, however, the seniors could not be informative interviewees.

Therefore, the primary focus of the study lies in exploring the coping experiences of the HVYAs using their perspective. By delving into their narratives and experiences, the study aims to uncover the various factors that shape their coping mechanisms in this complex ecological system. This includes understanding the influence of the nursing home environment, their interactions with SwD, and the broader socio-cultural context in which they operate. The goal is to shed light on the broader implications of these findings for HVYAs globally, offering insights into how similar intergenerational relationships can be fostered and nurtured in other nursing home settings, thereby enhancing the well-being of both HVYAs and SwD.

Chapter 2: Literature Review

Chapter 2 of this dissertation, 'Literature Review', comprehensively examines the current research landscape surrounding the three main topics of this study: nursing homes, seniors with dementia (SwD), and highly vulnerable young adults (HVYAs). This chapter aims to understand the ongoing trends in these areas, identify the bottlenecks hindering progress, and explore potential solutions suggested in existing literature. Additionally, it seeks to uncover the intersections among these topics, pinpointing a common focal point that underlies all three areas.

The first section of the Literature Review delves into the global transformation that nursing homes are currently undergoing. This involves a critical transition from traditional, institutionalized care models to a more holistic person-centered care (PCC) approach. This paradigm shift is riddled with challenges: the entrenched nature of institutionalized care practices, a deep-rooted caregiver deficit, and a significant rise in the population of seniors with dementia. These factors collectively exacerbate the demand for a larger and more effective caregiver workforce, especially to cater to the nuanced needs of the increasing number of SwD in nursing homes (Moore & Haralambous, 2007; Mueller et al., 2006; Spilsbury et al., 2011). This section aims to provide a thorough understanding of these dynamics, highlighting the complexities and potential strategies for navigating this crucial transition in nursing homes.

The rising number of seniors with dementia worldwide presents a significant challenge for nursing homes (Alzheimer's Association, 2019; Kuske et al., 2009; Zimmerman et al., 2005). These individuals, often characterized by limited verbal communication abilities and disruptive behaviors, are considered difficult to care for (Algase et al., 1996; Colomer & de Vries, 2016; Volicer & Hurley, 2003). Despite the recognition of their need for individualized care, society frequently views them as a burden, leading to their placement in nursing homes when family care becomes untenable (Bremer et al., 2015; Schulz et al., 2008). Research on dementia predominantly adopts a pathological perspective, focusing on disease cure or prevention(Kumari et al., 2023; Selkoe, 2001). However, as of now, no cure exists for dementia, making effective care crucial (Feng et al., 2009; Linna et al., 2019).

Most research on dementia care focuses on the difficulties encountered by caregivers, with a particular emphasis on issues like compassion fatigue and burnout (Bishop et al., 2009; Radey & Figley, 2007). To improve care for seniors with dementia, nursing homes frequently implement short-term staff training programs. Despite reporting beneficial outcomes, these programs do not adequately address a key challenge in dementia care: the severe shortage of caregivers across the Western world (De Veer & Kerkstra, 2001; Harrington & Edelman, 2018; K. Moore & Haralambous, 2007; Mueller et al., 2006; Spilsbury et al., 2011).

The second section of this chapter delves into understanding seniors with dementia (SwD). SwD are commonly perceived as a societal burden than active contributors (Algase et al., 1996; Colomer & de Vries, 2016; Volicer & Hurley, 2003; Wimo et al., 2017). While some research advocates for societal recognition of the agency of these individuals, this acknowledgment often springs from sympathy, rather than a true recognition of their potential as social contributors (Lin & Lewis, 2015; Ready & Ott, 2003; Hebert & Scales, 2019; Heward et al., 2017; Mitchell et al., 2004). Yet, a handful of studies have highlighted the positive outcomes stemming from interactions with SwD (Cheng et al., 2016; Kitwood, 2015; Taylor, 2008). These insights primarily originate from nurse aides, who are responsible for most of the direct care provided to these seniors despite their lack of extensive professional training.

Nurse aides, often from disadvantaged backgrounds, have been found to develop a deep sense of connection with seniors in their care, deriving fulfillment and engagement from their work (Band-Winterstein et al., 2019; Bishop et al., 2009). This insight highlights that seniors with dementia, despite their vulnerabilities, can act as significant social resources, providing support to other marginalized groups. This revelation suggests that the positive experiences of nurse aides with seniors with dementia might also benefit other vulnerable groups like highly vulnerable young adults (HVYAs), urging a reconsideration of SwD as potential contributors to the well-being and growth of others.

The third section focuses on HVYAs. The American Psychological Association (2020) identifies a national mental health crisis, significantly impacting disadvantaged young adults (Courtney & Dworsky, 2006; Sapiro et al., 2019). This group often faces challenges in transitioning to adulthood, particularly in finding meaningful employment and establishing a stable career (Armstrong et al., 2003; Goodman et al., 2011; Gralinski-Bakker et al., 2005;

Vander Stoep et al., 2000). Current interventions struggle to effectively address the complex needs of these young adults, as traditional therapeutic approaches often fail due to insufficient professional competence, inability to establish lasting supportive relationships, and young adults' perception of therapy as disempowering (Newell & MacNeil, 2010; Olfson et al., 2014; Gulliver et al., 2010). This has led to a significant trust deficit in these interventions, leaving many young adults' mental health needs unmet.

Similar to the stigma SwD have to face, the capabilities of HVYAs are frequently undervalued due to their mental health vulnerabilities. Some studies, though few in number highlight that HVYAs, due to their disadvantaged backgrounds, may possess unique strengths such as empathy, advocacy skills, acute self-awareness, and caregiving abilities developed through familial responsibilities (D’Zurilla & Nezu, 2010; Kaufman & Sternberg, 2010; Rochat, 2023; Jolliffe & Farrington, 2006; Garmezy, 1993). The potential of these young adults, when recognized and harnessed, could have significant implications for their personal development and broader societal contribution.

Reviewing the three sections of this chapter collectively reveals a parallel between HVYAs and nurse aides, with similar disadvantaged backgrounds and skill sets. As shown in the literature, nurse aides leverage their personal experiences of providing care at home to care for seniors effectively (Band-Winterstein et al., 2019). This parallel suggests that HVYAs could similarly transfer their unique skills and experiences to contribute meaningfully in nursing homes. The literature review also highlights the importance of improving the well-being of seniors with dementia (SwD) as a critical component of transitioning to person-centered care (PCC). However, a significant challenge in this transition is the shortage of personnel equipped to support SwD without imposing financial or administrative burdens on nursing homes.

Consequently, this chapter suggests a potential role for HVYAs in transferring their skills to assist SwD within nursing home settings, provided they demonstrate their capabilities. This study aims to explore this possibility by conducting qualitative research at a nursing home, where such a relationship has been established. The overarching research question, therefore, seeks to understand the coping experiences of a small group of HVYAs who assist SwD in their well-being within a nursing home context.

Chapter 3: Method

Chapter 3 outlines the theoretical framework, research questions, hypotheses, and the methodologies employed in this study. The Phenomenological Variant of Ecological Systems Theory (PVEST), as developed by Dr. Margaret Beale Spencer (1995, 2006; Spencer et al., 1997), is the foundational theory guiding this research. The individual-focused approach enables a comprehensive examination of the intricacies involved in young adults' coping experience throughout a developmental phase within a nuanced context, from the onset to the conclusion of this period (Spencer, 1995, 2006; Spencer et al., 1997).

Another key strength of PVEST is its emphasis on resilience amidst adversity, shifting the narrative from solely the challenges faced by vulnerable groups to highlighting their capacity for resilience (Spencer et al., 1997). This perspective aligns perfectly with the aim of this study, which is to delve into the coping experiences of highly vulnerable young adults in work environments that may not always be welcoming. PVEST facilitates a nuanced exploration of these experiences by enabling the breakdown of individual experiences into subsections (Spencer, 2006), with particular emphasis on their perceived sources of challenges and support. Thus, this theoretical framework therefore enables the formulation of comprehensive research questions aimed at explaining the young adults’ coping outcomes. While the overarching question seeks to understand the coping experiences of young adults at the nursing home, more specific inquiries attempt to elucidate the mechanisms underlying these experiences.

Specifically, this study explores the coping experiences of a small group of highly vulnerable young adults (HVYAs) employed by HCare, a well-known nursing home in the Netherlands, aimed at enhancing the well-being of its senior residents. Utilizing a qualitative methodology, including ethnographic methods such as interviews and observations, this study seeks to understand the nursing home’s context and the young adults’ coping experience at work. Over a period of three consecutive years, I spent a total of nine months at the field site and recruited over 50 informants from various roles within the nursing home. To ensure confidentiality, pseudonyms are used for all names, and certain details are deliberately omitted to prevent informant identification. Data analysis was performed using grounded theory principles and MAXQDA, a software tool frequently employed for qualitative data analysis.

Preliminary research indicated that HVYAs experienced positive interactions with SwD, yet perceived the nursing home environment as "toxic." The study hypothesizes that SwD, typically viewed as disruptive and a social liability, may actually provide substantial socio-emotional support, aid symptom recovery, and foster growth in these young adults. Conversely, nursing home staff members, who were expected to support the HVYAs, might inadvertently pose psychological challenges and contribute to maladaptive coping methods. Despite these challenges, the support from SwD is believed to be significant enough to counterbalance the stress from staff interactions, leading to productive coping outcomes for the HVYAs in their work with the seniors.

Chapter 4: Findings

This chapter seeks to answer overarching questions by applying the key concepts of the

Phenomenological Variant of Ecological Systems Theory (PVEST), thereby gaining a comprehensive understanding of the context and the young adults' perceived experiences at work.

Structured in three parts, the chapter first introduces the nursing home, HCare, focusing on its distinct environment, an increased proportion of SwD, and its efforts to transition to person-centered care (PCC). What sets HCare apart from other nursing homes is its adoption of innovative intergenerational programs, especially involving HVYAs to foster their development—a novel approach in nursing home settings. During the pandemic, when staff turnover was high, these young adults demonstrated an unwavering commitment to the seniors, highlighting their potential to play a crucial role in the nursing home's transition to PCC.

The second section delves into the characteristics of SwD and the care they receive at HCare. The first subsection finds that the seniors at HCare align with the literature's depiction of typical symptoms and individualized needs in the broader industry. However, there are also positive aspects of the seniors, such as their responsiveness to stimulation and agency, which were relatively unnoticed. The second subsection depicts the typical services provided by nursing staff, which are characterized by a stressful work environment and an institutionalized care model that falls short of meeting SwD's needs but is also typical in the industry. The last subsection gives an overview of the HVYAs' role, which makes HCare unique among its counterparts. The focus is particularly in the dementia ward, where the young adults’ primary task is to enhance the well-being of the seniors—a job more challenging than often perceived.

Finally, the third section closely examines the HVYAs' overall coping experience from their perspective, following PVEST's framework. This includes exploring their net vulnerability, unexpected sources of challenges and support, adaptive coping methods, emergent identities, and coping outcomes. It reveals that both the vulnerability and resilience of the young adults are often underestimated. The hypothesis that SwD play a critical role in the HVYAs' coping experience is confirmed by their experiences, suggesting a mutually beneficial bond within a nursing home context. This part concludes that the young adults' resilience indeed flourishes in this unique setting, leading to life-changing coping outcomes.

Chapter 5: Discussion

With a focus on the mutually beneficial relationship between highly vulnerable young adults (HVYAs) and seniors with dementia (SwD), this chapter explores the mechanism behind this unique bond and its implications for the wider world, emphasizing practical applications.

The first section examines nursing homes' potential to transition to person-centered care (PCC) by nurturing this intergenerational relationship. A key aspect is a shift in mindset: from viewing nursing homes as synonymous with institutionalized care to recognizing their beneficial characteristics for the mental health recovery of young adults. Similarly, the prevailing view of focusing on vulnerabilities must evolve to appreciate and utilize the potential of these social assets.

The second section explores the mechanism behind the mutually beneficial intergenerational relationship. For the young adults, SwD fulfilled a supportive role akin to that of a therapist: nonjudgmental, supportive, and consistent. In exchange, the young adults dedicated themselves to the seniors' well-being, finding fulfillment in working with them. To understand why the young adults feel this way, the study highlights the often-ignored similarities between the two vulnerable groups, the seniors' unique characteristic traits, and the features of the job, making it suitable for HVYAs. By providing a rare opportunity that bridges healing and career development, the work proves both engaging for the young adults and can be easily adapted at other nursing homes.

In the final section, the study considers the unique perspective of the HVYAs in their experiences. Despite their vulnerabilities, they perceive the SwD as being more vulnerable, which, coupled with their intrinsic motivation, provides them with a sense of validation and fulfillment. This section argues that even highly vulnerable populations can feel empowered in the right context. It emphasizes that coping experiences and outcomes should be evaluated through the lens of the HVYAs themselves, recognizing that these processes take time and may not align with conventional expectations.

Consequently, a deeper understanding of the experiences of highly vulnerable young adults (HVYAs) reveals that they are not social liabilities but rather untapped social assets. The mutually beneficial relationship observed between HVYAs and seniors with dementia (SwD) within nursing homes suggests that the traditional model of institutionalized care can be effectively replaced with more inclusive and empathetic approaches. This study, therefore, offers a practical and replicable model for other nursing homes, demonstrating a method that is both effective in enhancing care quality and cost-efficient. By shifting the focus from the vulnerabilities of these populations to their potential contributions, nursing homes can transform their care practices in a way that benefits both residents and caregivers alike.

Chapter 2: Literature Review

A comprehensive review of the literature reveals that the three main topics in this study—nursing homes, care for seniors with dementia, and support for highly vulnerable young adults—are currently facing critical challenges, with each struggling to meet increasingly complex needs.

Nursing homes are undergoing significant transitions that will redefine the service they provide (NASEM, 2022; Tolson et al., 2013; Zimmerman et al., 2014). Firstly, there is a trend to transition from the conventional institutionalized care model to a more person-centered approach (Colomer & de Vries, 2016; McCormack & McCance, 2016; Tellis-Nayak, 2007). Secondly, in countries like the U.S., the shortage of licensed nurses has led to undertrained nurse aides becoming the main providers of direct care (Castle et al., 2020; Edwards, 1997; Mercer et al., 1994). Lastly, there is a growing population of residents diagnosed with dementia, underscoring the urgency of providing individualized care (Alzheimer's Association, 2022; Kong et al., 2022; Kröger et al., 2015).

When examining the domain of SwD, much of the existing research adopts a pathological focus aiming at finding a cure (Cummings et al., 2014; Howard et al., 2012; Linna et al., 2019) while the dominant care model remains largely institutionalized (Lind et al., 2019; Luppa et al., 2008; Saarnio & Isola, 2010). Although there is an emerging body of work spotlighting the potential agency of these seniors and the positive interactions they can have with their caregivers, the overarching narrative often regards them as a societal liability (WHO, 2012; Wimo et al., 1997; World Health Organization, 2023).

Similarly, for young adults with mental health struggles, the primary research focus has been on addressing their symptoms through the help of therapists (Cabral & Smith, 2011; Skovholt & Rønnestad, 2003; Vanheusden et al., 2008). Even though there is an emerging recognition of their developmental needs for independence and agency (Barrett et al., 2008; Havighurst, 1972; Sapiro et al., 2019), there remains a gap between this acknowledgment and its practical implementation in therapeutic and work contexts (Ellison et al., 2015; Subramaniam et al., 2022).

Considering these two particularly vulnerable demographics, a common theme arises: both groups are often perceived not as social assets but as liabilities. The prevailing notion is that they are not “assets,” which in this context means individuals capable of contributing to others. Rather, they are perceived as “liabilities,” for their well-being depends on the intervention of others, like caregivers and therapists, who are mentally healthy and thus deemed more capable (Geller & Greenberg, 2002; Riffin et al., 2017; Rosenberg & Pace, 2006). While there is acknowledgment of the inherent agency within these populations (Ingard et al., 2023; Subramaniam et al., 2022), there are few studies that explore in what context their agency can be effectively utilized, benefiting both themselves and others.

Nursing Homes in Transition

Across the Western world, nursing homes are going through a period of profound transition (Blake et al., 2020; Rahman & Schnelle, 2008; Zimmerman et al., 2014). This study focuses on the prevalent trend of nursing homes’ transition to Person-centered Care (PCC), particularly as an answer to the challenges and demands stemming from the “dementia crisis” (Brooker, 2008; Downs & Bowers, 2014; Kong et al., 2022). This transition is known as shifting the traditional care model centered on physical care to a more person-centered approach, placing greater emphasis on seniors' holistic well-being, particularly through tailored social interactions that meet their diverse individual needs (Kitwood & Bredin, 1992; Kontos & Naglie, 2007). This transition, however, has proven to be challenging, particularly due to the insufficient number of caregivers and the increasing demand for individualized care (Alzheimer's Association, 2022; Castle & Ferguson-Rome, 2015).

In the U.S., for instance, working at nursing homes is not a sought-after job, and as a result, the majority of direct care in these facilities is provided by nurse aides, who often come from disadvantaged backgrounds and have limited formal training (Bowers & Becker, 1992; Stone & Wiener, 2021; Zysberg et al., 2019). While the retention of these workers is already a pressing concern (Castle et al., 2020; Schulz et al., 2008), it is intensified by the rising influx of the number of seniors with dementia (SwD) entering these facilities (Castle & Engberg, 2005; Waterschoot et al., 2022; Waxman et al., 1984). Given the specialized care needs of these seniors, their growing presence presses nursing homes to rethink traditional practices and explore innovative solutions (Chung, 2009; Kennedy et al., 2019; Kontos & Naglie, 2007).

The Transition to Person-Centered Care

While the definition of nursing homes varies globally, they are generally recognized as residential care facilities offering continuous care from professional caregivers for individuals unable to live in their own homes due to non-acute, long-term conditions (Eckert, 2009). Admission into such a facility signifies a significant life transition (Pratt, 2010). Typically, residents enter nursing homes due to physical or mental impairments that prevent independent living, and for most of them, this move represents the final chapter of their lives (Eijkelenboom et al., 2017). Currently, nursing homes across the world serve a vast population of seniors. In the United States alone, there are over 15,000 nursing homes, serving more than 1.3 million residents (Sengupta et al., 2022).

Institutionalized Care. Despite the huge responsibility, the quality of nursing home care is an international concern, prompting a global agenda for clinical practice improvements and research (Castle & Engberg, 2005; Harrington & Edelman, 2018; Zysberg et al., 2019). One prominent issue affecting service quality in nursing homes is institutionalization. Nursing homes have a dual nature as institutions and as homes (Eijkelenboom et al., 2017). Traditionally, the nature of being an institution was emphasized, because nursing homes were based on a medical–somatic model of care, emphasizing illnesses and treatments of underlying pathology as well as rules and routines to keep the seniors safe (Foldes, 1990). Consequently, nursing homes resembled hospitals, incorporating design features, such as receptionists, nursing stations, and staff in uniforms (Eijkelenboom et al., 2017). Within the realm of nursing homes, institutionalization describes the tendency for residents to conform to a regimented lifestyle, often resulting in a diminished quality of life, especially in terms of cognitive and physical health (Luppa et al., 2008; Moyle et al., 2011). This phenomenon is not only exacerbated by inadequate physical environments, characterized by uniform rooms, poor lighting, and a lack of outdoor spaces but also by the social setting (Eijkelenboom et al., 2017; Zimmerman et al., 2005). Residents often face restricted social interactions and scarce opportunities for meaningful engagement (Moore & Haralambous, 2007; Saarnio & Isola, 2010). Therefore, they encounter a lack of stimulating activities and find their autonomy eroded by rigid schedules. Over time, residents might increasingly view themselves less as distinct individuals and more as mere patients (Jones et al., 2003; Luppa et al., 2008).

Due to institutionalization, various adverse symptoms can manifest. Depression, for example, is widespread among residents in nursing homes (Hofmann & Hahn, 2014; Jones et al., 2003; Snowdon, 2010). According to the American Psychiatric Association (2013), depression is characterized by persistent feelings of sadness, hopelessness, and a lack of interest in most activities. Globally, depression is responsible for almost 12% of all years lived with disability, making it the leading cause of non-fatal health burden (Üstün et al., 2004). In the Netherlands, seniors in nursing homes were found to be at a higher risk of developing depression compared to their community-dwelling counterparts (Boorsma et al., 2012). In the United Kingdom, the percentage of residents in nursing homes with significant depressive symptoms can be as high as forty percent (Potter et al., 2018).

It is therefore not a surprise that across the globe, nursing homes have earned a poor reputation for unsatisfactory services (Carlstedt, 2020; Castle & Engberg, 2005). Reports of understaffing, physical abuse, use of physical restraints, and antipsychotic medications are deep-rooted concerns found across the world (Eckert, 2009; Feng et al., 2009; Pillemer & Moore, 1989). Studies consistently find family members hesitant to send their loved ones to nursing homes as they do not trust the service provided at nursing homes (Mahoney et al., 2005; Taşcı et al., 2012).

Transition to PCC. In response to the negative effects of traditional institutionalization, nursing homes have been trying to shift their service toward person-centered care (McCormack & McCance, 2016). Person-centered care (PCC), also known as patient-oriented care, can be generally described as an approach that emphasizes the importance of placing patients at the center of their healthcare experience and tailoring care to meet their unique needs and preferences (Mead & Bower, 2000; Hughes et al., 2008; Downs & Bowers, 2014). It is a care model in which an individual's agency is preserved, their emotions are recognized, and their abilities are actively engaged (Kitwood, 2015).

Globally, nursing homes have rushed to adopt PCC, or at least claimed so (Boersma et al., 2015; Zimmerman et al., 2014). In care-forward countries like the Netherlands, an increasing number of nursing homes assert that they have adopted PCC to enhance the well-being of their residents (Berkhout et al., 2004). In the U.S., person-centered care was a key component of the nursing home culture-change movement – an effort to radically transform nursing homes by delivering resident-directed care and empowering staff (Grabowski, Elliot, et al., 2014; Miller et al., 2010; Rahman & Schnelle, 2008). The goal was to create caring communities where both empowered frontline staff and residents could flourish and have an enhanced quality of life (Grabowski, O'Malley, et al., 2014). Examples of such endeavors include, but are not limited to creating environments that appear more homelike, enhancing the dining experience, soliciting resident opinions on daily routines, and writing up care plans in the voice of the resident (Rahman & Schnelle, 2008).

Staffing Issues. Nevertheless, nursing homes' effort to transition to PCC was found to struggle to gain a solid foothold in the industry (Capitman et al., 2005; Miller et al., 2010). It is believed that a wide gap exists between policy and practice, making the ideas of PCC difficult to implement (Kong et al., 2022). One of the most noticeable challenges includes unclear expectations surrounding PCC, caregivers' lack of training on the approach, and insufficient time allotted for individual seniors (Al Sabei et al., 2020; Hasbollah et al., 2019). It needs to be emphasized that PCC does not aim to replace the conventional procedure-driven model but rather add new expectations (i.e. quality time with the seniors) to it (Edvardsson et al., 2014). While the concept is commendable, it imposes extra responsibilities on caregivers, intensifying a fundamental challenge in nursing homes – staffing (Chen et al., 2023; Harrington & Edelman, 2018; Xu et al., 2020).

A dilemma faced by the industry is that while the qualifications of caregivers are considered low, they cannot justify it because the principles of PCC remain unclear. Research often argue that caregivers are underqualified for their jobs, particularly lacking training, skills, support, and experience in dealing with challenging behaviors (Oppert et al., 2018). In the U.S., for example, caregivers in nursing homes are more disadvantaged compared to workers in other health sectors (McMullen et al., 2015). Predominantly female, they represent over 90% of the workforce, are generally older, have lower incomes, and are less educated (Yamada, 2002; Korczyk, 2004; Buerhaus, 2009; Chou et al., 2009). Many are employed part-time with irregular hours and are less likely than other care workers to have health insurance (Yamada, 2002). Instead of receiving adequate training at work, they believed in intuitively applying PCC principles, arguing that the most valuable learning occurs on the job (Kontos & Naglie, 2007; Venturato et al., 2013). Given some researchers' rigorous requirements from caregivers to provide PCC, which include professional competence, commitment to the job, and well-developed interpersonal skills, they argue that without targeted PCC training, caregivers may revert to providing task-oriented service delivery (Kong et al., 2022; McCormack & McCance, 2016; Skaalvik et al., 2010). Nevertheless, considering the complex nature of senior care, PCC cannot offer explicit guidelines for caregivers (Waterschoot et al., 2022). The core principles often come down to fostering close care relationships by listening attentively, demonstrating empathy, displaying unconditional regard, and remaining sensitive to individual differences (Colomer & de Vries, 2016). However, these qualities may not necessarily need to be or can be acquired through formal training (Rochat, 2023).

Another commonly felt struggle faced by nursing homes worldwide, hindering the transition to PCC, is the shortage of caregivers, including nurse aides and nurses (Harrington et al., 2000). Feelings under-compensated and undervalued, turnover rate in nursing homes has been estimated at an alarming rate of 78% (Gandhi et al., 2021), with annual exits from direct care work approximated at around 40% (Smith & Baughman, 2007). The shortage of caregivers leads to a vicious cycle of additional challenges, including more caregiver burnout, compassion fatigue, and the necessity of overtime work, further exacerbating the problem (Castle et al., 2020; Mercer et al., 1994; Radey & Figley, 2007). As seniors rely heavily on care services, the shortage of caregivers, especially those who provide direct care to the residents, severely impacts the quality of care provided to the elderly (Brooker, 2008; Eckert, 2009). As a result of the twin problems of understaffing and high staff turnover, nursing homes have gradually shifted their attention from recruiting to retaining workers (Bowers, 2008; Castle & Engberg, 2005). This reality raises more questions about the practicality of PCC and the culture-change movement, which are believed to require more caregivers and result in higher costs (Wiener et al., 2007).

Therefore, as increasing staffing levels is identified as a primary means to improve the quality of care (Bostick et al., 2006; Harrington & Edelman, 2018; Hyer et al., 2011; Schnelle et al., 2004), it can be concluded that the broad adoption of PCC in nursing homes is likely to continue to be hindered by the lack of caregivers and the resulted vicious cycle unless a new workforce can be identified (Capitman et al., 2005).

Direct Care Relies on Disadvantaged Caregivers

Increasingly, nursing homes are relying on nurse aides, often unlicensed and from disadvantaged backgrounds, to provide the majority of direct care (Harrington et al., 2012). Traditionally, the common expectation is that care within nursing homes would be primarily delivered by professionals with extensive medical training (Eijkelenboom et al., 2017). However, the increasing presence and reliance on nurse aides has challenged this conventional belief.

It is important to distinguish between registered nurses and nurse aides because they perform different roles. Typically, registered nurses attend to clinical issues, medication management, and supervisory roles, whereas nurse aides attend to a wide range of activities of daily living from assisting with basic needs like eating, bathing, and dressing, to more complex tasks such as caring for residents with cognitive impairments (McMullen et al., 2015; Passalacqua & Harwood, 2012). As the demand for direct care hours increases in various countries, the ratio between registered nurses and nurse aides is expected to shift toward a greater number of the latter, as already found in some of the leading for-profit nursing home chains in the U.S. (Dass et al., 2022; Harrington et al., 2012). Since nurse aides spend more time with care recipients than nurses it is important to acknowledge nurse aides' critical role in providing PCC to seniors (Oppert et al., 2018).

Various terms are used for this workforce, including health care aide, unlicensed assistive personnel, care assistant, nursing assistant, and nursing aide (Band-Winterstein et al., 2019; Bureau of Labor Statistics, 2020; McMullen et al., 2015). The use of varying names and titles reflects the lack of consistency and wide variations in the definition of responsibilities, tasks, and authority across settings and institutions (Eldercare Workforce Alliance, 2014). According to the National Academies of Sciences, Engineering, and Medicine (2022), despite the various names, they are responsible for most hands-on care given to nursing home residents. Some scholars believe these aides carry out a staggering 80% to 90% of all direct-care tasks in these settings (Brooker, 2008; Zysberg et al., 2019). While they play a crucial role in ensuring quality care in nursing homes, these essential workers are often underrepresented in nursing literature (Secrest et al., 2005).

Considering their demographic details and working conditions, nurse aides are among the more disadvantaged groups in the workforce (Zallman et al., 2019). In 2020, more than 527,000 nurse aides were employed by nursing homes across the U.S. (BLS, 2020). Delving into the demographic makeup of this group, the median age stood at 38, 91% were female, people of color constituted 58% (with 38% being African American, 13% Hispanic, 5% Asian or Pacific Islanders, and 2% from other backgrounds) and 21% were born outside the United States (PHI, 2021). As for educational attainment, over 90% held a high school diploma as their highest qualification, while a smaller percentage, 13%, possessed an associate’s degree or higher (PHI, 2021).

Another disadvantage faced by nurse aides stems from workplace risks (Hoskins, 2006; Squillace et al., 2009). In the U.S., for example, the Bureau of Labor Statistics (2006) reported that between 1995 and 2004, close to 800,000 individuals working as "nursing, psychiatric, and home health aides" were injured or fell ill due to work-related causes, and more than half of the cases were related to overexertion. In 2004, the subgroup "nursing aides, orderlies, and attendants" ranked third in the number of reported work-related injuries and illnesses, following only truck drivers and laborers (Hoskins, 2006). A more recent national survey from 2009 revealed that 56% of nurse aides experienced at least one injury while at work in the preceding year. Among the nurse aide injuries, nearly half (45%) had scratches, open wounds, or cuts; roughly one-fifth reported back injuries (18%), bruises such as black eyes (16%), or other muscle strains (16%); and around one in ten experienced human bites (12%) or other types of injuries (7%) (Squillace et al., 2009). Yet, despite the prevalence of these injuries, 29% of nursing assistants lacked health insurance coverage (Yamada, 2002).

Despite the high risks, nurse aides are often inadequately compensated and lack health insurance coverage, leading to financial struggles (Moyle et al., 2003; Waxman et al., 1984; Yamada, 2002). According to the Bureau of Labor Statistics, in 2020, nurse aides worked an average of 36.8 hours each week, yet almost two-thirds earned an annual family income below $30,000. Their earnings are only slightly higher than those of cashiers, food service workers, or retail sales associates (BLS, 2020). Of these aides, 28% bear the added financial burden of providing for at least one child in need of childcare. The National Nursing Assistant Survey's criteria, which requires nurse aides to work at least 16 hours weekly to be eligible, may not fully represent the part-time worker demographic (NASEM, 2022). Yamada (2002) pointed out that while the full-time labor force participation rate was 58%, 12% of nurse aides could only find part-time employment, averaging 37 hours a week. Nearly half of nurse aides rely on a single income, often because they are separated, widowed, divorced, or have never married (Squillace et al., 2009). Due to their limited earnings, 34% of direct-care workers need some form of public assistance, and a significant number live in poverty. Notably, direct-care workers who are women of color are more prone to needing public assistance, living in poverty, or residing in low-income households compared to their White counterparts (PHI, 2021).

Amidst the myriad challenges faced by nurse aides is the surging demand for caregivers globally. In the U.S. alone, nursing homes are confronted with the need to fill an estimated 561,800 nursing assistant positions between 2019 and 2029, signifying a deficit of 400,000 roles (PHI, 2021). Bridging the workforce gap, however, remains a significant challenge (Bowers, 2008). This situation is nothing new, as the industry has long struggled with the difficulties of recruiting and retaining sufficient nurse aides (NASEM, 2022). Many of these recruitment challenges stem from structural and systemic issues, which manifest as low wages, minimal training requirements, and a lack of respect and recognition (Drake, 2021; Ryosho, 2011; Squillace et al., 2009; Truitt & Snyder, 2020). Furthermore, due to economic constraints, political challenges, and the pursuit of higher profits, healthcare systems and nursing homes are constantly being pressed to reduce costs (Band-Winterstein et al., 2019; Harrington et al., 2012). Given the present circumstances, increasing staffing levels in the caregiving industry is too a slow and costly an endeavor to achieve PCC at a global scale (Castle et al., 2020).

Therefore, for nursing homes to transition to PCC, it is essential to have a potential workforce readily available at an acceptable cost. Furthermore, considering the changing demographics at nursing homes, this workforce needs to adapt to, or ideally, appreciate the increasing number of SwD.

The Influx of Seniors with Dementia

Nursing homes' transition to PCC is further complicated by an increasing number of seniors with dementia (SwD). With an aging global population, the number of dementia cases is growing exponentially (Lin & Lewis, 2015). It was estimated that in 2010, there were 35.6 million people with dementia worldwide and it is projected that by 2050 this figure will increase to over 130 million (Kelly et al., 2012)

In Western countries, nursing homes are becoming pivotal centers for dementia care (Grauel & Spellerberg, 2008). In nations such as the United States, Canada, and Germany, it is estimated that around 60% of long-term nursing home residents are diagnosed with some form of dementia (Alzheimer's Association, 2019; Kuske et al., 2009; Zimmerman et al., 2005). Given the increasing prevalence of dementia globally, the Alzheimer's Association (2022) estimates that this figure is only expected to rise with the aging population.

The progression of dementia highlights the extensive care required in nursing homes. A person who lives from age 70 to age 80 with Alzheimer's dementia will spend an average of 40% of this time in the severe stage, most of which will be spent in a nursing home (Arrighi et al., 2010). By the age of 80, approximately 75% of people with Alzheimer's dementia live in a nursing home compared with only 4% of the general population of the same age bracket (Arrighi et al., 2010). Recognizing the unique needs of individuals with dementia, many care facilities have begun to adapt. As of recent data, over fifteen percent of nursing homes have incorporated dementia care units. These specialized sections, whether a unit, wing, or entire floor, are tailored to offer services specifically designed for those with dementia (Harris-Kojetin et al., 2016).

This demographic shift reflects broader changes within the industry. On the one hand, meeting the highly individualized needs of the SwD expects nursing homes to transition to PCC by having more caregivers (Eckert, 2009). On the other hand, the complexities associated with caring for these individuals contribute to a high staff turnover rate at nursing homes (Cohen-Mansfield, 2001; Packer, 2000). Considering the rising number of SwD, which has profoundly impacted nursing homes, a nuanced understanding of SwD is critical to facilitate nursing homes' transition to PCC.

Seniors with Dementia

The global increase in the number of individuals diagnosed with dementia and the challenges associated with this rise has been described as the "dementia crisis" (WHO, 2023). According to the World Health Organization (2023), in 2023 there are more than 55 million people worldwide have dementia, with nearly 10 million new cases every year. The global cost of dementia care, which encompasses medical care, social care, and informal care was estimated at around $1 trillion in 2018. This number is likely to double by 2030 (WHO, 2023).

Dementia is not just a health concern; it is a significant social issue (Alzheimer's Association, 2019). Due to the challenges associated with caring for individuals with dementia, they have often been viewed as a social liability (Algase et al., 1996; Colomer & de Vries, 2016; Volicer & Hurley, 2003; Wimo et al., 2017). Individuals with dementia frequently encounter discrimination, maltreatment, and violations of their rights, presenting daily challenges to their well-being (Edvardsson et al., 2014; Kitwood & Bredin, 1992; Taşcı et al., 2012). Given the severity of dementia and the entrenched negative perceptions surrounding the disease, research has largely adopted a pathological perspective (Kelly et al., 2012; Logsdon & Teri, 2018; Rabins et al., 2006). However, for most forms of dementia, there is still no cure (Kumari et al., 2023; Mark & Brehmer, 2022). Available treatments can at best alleviate some of the symptoms but cannot halt or reverse the disease's progression (Cummings et al., 2014). Given that a cure for dementia may not be available in the immediate future, it is critical to shift the research focus toward enhancing dementia care, an area that has received relatively less attention (Cheng et al., 2016).

While much of the existing literature on dementia care has tended to focus excessively on the challenges posed by individuals with dementia (Al Sabei et al., 2020; Andela et al., 2021; Taşcı et al., 2012; Wang et al., 2019), there is an emerging perspective that views SwD through a lens of empowerment (Secrest et al., 2005). This perspective acknowledges their agency and recognizes the enriching experiences and positive aspects of caregiving for this population (Cheng et al., 2016; Taylor, 2008). Exploring the more positive traits of dementia care can provide valuable insights into understanding the possibility of transforming SwD from social liabilities into assets.

A Highly Vulnerable Population

By definition, dementia is a chronic disorder best known for the resulting loss of memory, personality changes, and impaired reasoning. The term "dementia" is derived from the Latin words "de" meaning "away" or "apart" and "mens" meaning "mind." Thus, "dementia" can be translated to mean "away from the mind" or "without mind," reflecting the loss of cognitive abilities associated with the condition (Berrios, 1987). Dementia includes various types of diseases, with Alzheimer’s being the most common type (Wimo et al., 2017).

For seniors aged 65 or older, dementia is degenerative, meaning that it becomes worse with time and renders individuals more vulnerable to the effects of coexisting medical conditions (Rabins et al., 2006). As the disease advances, cognitive debilitations lead to functional deficits, and eventually round-the-clock care (Alzheimer's Association, 2019). The significance of dementia lies in its degenerative effects. According to the Global Deterioration Scale (GDS), there are seven stages to the progression of dementia, and not all individuals with dementia will experience each stage in the same way (Reisberg et al., 2010). The accompanying decline in memory and cognitive faculties not only affects individual autonomy but also places considerable strain on families and healthcare infrastructures (Plassman & Potter, 2018).

Dementia disproportionately affects certain segments of the population, rendering vulnerable groups even more so. The prevalence of dementia escalates with age. For instance, while 5.0% of individuals aged 65 to 74 are diagnosed with Alzheimer's dementia, this proportion jumps to 13.1% for those aged 75 to 84, and surges further to 33.2% among those aged 85 and older (Alzheimer's Association, 2022). Beyond age, gender and ethnicity also play significant roles in dementia prevalence. Women bear a disproportionate burden, constituting nearly two-thirds of the American Alzheimer's population. Furthermore, racial disparities persist, with older African Americans being roughly twice as likely as their white counterparts to develop Alzheimer's or other dementias (Alzheimer's Association, 2019). Additionally, socioeconomic disparities further intensify the vulnerability of certain communities to dementia, a reflection of broader health inequities. Such discrepancies underscore the pressing need for equitable healthcare strategies and interventions, ensuring that high-quality dementia care is accessible to all, irrespective of age, gender, ethnicity, or socioeconomic status (Glymour & Manly, 2008; Mayeda et al., 2016).

Seniors with Dementia as a Liability. As SwD gradually lose their ability to live independently, they rely on care provided by either informal (often family members) or formal caregivers. Costs of dementia care constitute a great part of the total costs of care for the elderly (Wimo et al., 1997). The global cost in 2010 was estimated to be United States (US) $604 billion (bn). This figure equated to around 1% of the aggregated world gross domestic product (GDP), indicating a particularly significant global socioeconomic impact for this one disorder (Wimo et al., 2015). Just five years later, in 2015, the worldwide costs of dementia were estimated to be $818 billion an increase of 35% since 2010. Considering the rapid growth of the dementia population, the overall cost to care of them will also grow (Wimo et al., 2017)

Seniors with dementia can present significant challenges to care. Their disruptive behaviors, such as yelling, wandering, aggression and paranoia not only pose a threat to their own safety, but also those of caregivers (Algase et al., 1996; Colomer & de Vries, 2016; Volicer & Hurley, 2003). For caregivers, supporting SwD often feels like a significant "burden" (Cohen et al., 2014; Luppa et al., 2008). In this context, caregiving refers to attending to another person’s health needs with various daily activities, such as bathing, dressing, and shopping (Bremer et al., 2015; Gaugler et al., 2002). Beyond physical assistance, caregivers offer vital emotional support, facilitate communication and care coordination among family members and healthcare professionals, ensure safety in various environments, and oversee health conditions. Currently, there are over 16 million Americans who offer unpaid care to more than 6 million individuals diagnosed with Alzheimer’s or other dementias (Alzheimer’s Association, 2019).

Caring for these patients at home is a stressful and demanding process that affects caregivers’ psychological and physical well-being and jeopardizes the feasibility of continued home care (Luppa et al., 2008). This is often contributed by the fact that caring for seniors with dementia (SwD) often proves overwhelming for informal caregivers, who are predominantly family members (Grauel & Spellerberg, 2008). The cognitive and functional challenges faced by SwD not only make their care demanding but also place a significant toll on caregivers in terms of physical and mental health, social interactions, finances, and overall quality of life (WHO, 2012). In the U.S., the weight of dementia care predominantly falls on women. About two-thirds of dementia caregivers are women, and over one-third are daughters (Kasper et al., 2014; Friedman et al., 2015; Riffin et al., 2017). Wives more frequently assume the role of informal caregivers for their husbands than the other way around, and on average, female caregivers invest more time in caregiving than their male counterparts (Kasper et al., 2015). The chance for these informal caregivers to help with daily activities such as transferring, dressing, bathing, feeding, and toileting was found to be higher than caregivers for other diseases (Alzheimer's Association, 2019). For some of the family caregivers, especially in developing countries, caring for SwD is a full-time responsibility without a break (Chen et al., 2020). Furthermore, the challenge of caring for SwD extends beyond daily routines; it is a prolonged commitment. In 2014, it was reported that 86% of informal dementia caregivers had been in their caregiving role for at least a year (Alzheimer's Association, 2019). Among the participants in the study over 60% anticipated that their caregiving duties would persist for the next five years, a sentiment shared by less than half of caregivers for individuals without dementia (Alzheimer's Association, 2019). Such long-term commitment undeniably has profound implications for family caregivers. Prevalent issues include anxiety (63.4%), depression (63.4%), feelings of worthlessness (29.7%), and episodes of crying (27.1%), which often stemmed from the SwD's memory challenges and disruptive behaviors (Schulz et al., 2008). Some of the caregivers even turned to smoking as a coping mechanism (Taşcı et al., 2012). Clearly, these family caregivers are in dire need of more structured professional support or relief from their demanding roles (Peeters et al., 2010).

As a result, transitioning SwD to nursing homes is a preferable option for both family caregivers and the seniors themselves, even considering the high cost. Research indicates that the health care and nursing home costs for those with dementia were $28,501 per person per year in 2010 dollars ($38,470 in 2021 dollars) (Hurd et al., 2013). Yet, other than freeing the informal caregivers, relocating SwD to a structured care environment can have its advantages. A study in China, for example, found that over 77% of family caregivers admitted various kinds of abuse directed at SwD (Wang et al., 2019). In contrast, another study in China indicated that formal caregivers in nursing homes were less likely to have such abusive behaviors compared to family caregivers (Wang et al., 2018). This might be attributed to the structured support and oversight formal caregivers receive from their colleagues and supervisory staff, making them less likely to use extreme measures (Chen et al., 2020). Nevertheless, the care responsibility is shifted onto nursing homes whose overall capability of providing care is a global concern (Grauel & Spellerberg, 2008; Harrington & Edelman, 2018; Tolson et al., 2013).

Dementia Research Focuses on Cure. Due to the huge burden of dementia at different levels, various countries have taken action. In the U.S., for instance, the National Alzheimer's Project Act was signed in 2012, being the first national plan to address dementia. It is worth noticing that among its five major goals, the foremost priority was to prevent and effectively treat Alzheimer's disease by 2025, even before the enhancement of care quality and efficiency (Logsdon & Teri, 2018).

Historically, dementia research has been predominantly centered on its pathological dimensions, with a key focus on discerning its causes, mechanisms, and prospects for treatments or prevention (Selkoe, 2001). Despite considerable financial investments, groundbreaking outcomes have been relatively sparse. In the U.S., a significant contributor to dementia research funding is the National Institutes of Health (NIH). As reported by the NIH (2014), they allocated over $3.1 billion to Alzheimer's disease and related dementia research in the fiscal year 2011 alone. Studies have found over time that numerous factors, such as genetics, hypertension, diabetes, and lifestyle can all influence dementia risk (Livingston et al., 2017). Following the pathological way of understanding and treating dementia, numerous pharmaceutical companies have invested billions into Alzheimer's drug development. However, with many potential treatments failing in late-stage trials, the success rate has been notably low (Cummings et al., 2014). While certain medications, such as donepezil and memantine, alleviate symptoms to an extent, they do not halt the progression of the disease (Howard et al., 2012). Since no breakthrough in cure can be expected anytime soon, some researchers advocate for a more holistic understanding of dementia that considers the lived experiences of the SwD and prioritizes person-centered care over seeking a cure alone (Kitwood, 1997; Kong et al., 2022; Swaffer, 2014).

The Existing Care Model is Insufficient

To provide better care for SwD, it is critical to recognize their unique needs, which differ from those who are mentally healthy (Estabrooks et al., 2015). Being a highly vulnerable population, they need a sense of security, meaningful interactions, and acknowledgment of their autonomy. When their needs are not met, the seniors’ disruptive behaviors are further exacerbated and lead to worsened physical and mental health (Phillips & Guo, 2011). However, meeting these needs is a challenge to the current care structure. Due to their lack of resources many nursing homes continue to provide institutionalized service, which is incapable of meeting their highly individualized needs. As a result, practices often resort to confinement and medication as strategies to manage the seniors' challenging behaviors. Across the industry, the overall image of SwD remains as a liability, whose behavior contributes significantly to caregiver burnout and turnover (Chen et al., 2020; Gimeno et al., 2021; Kong et al., 2022).

SwD's Needs for Improved Well-being. Life in nursing homes represents a significant transitional phase for seniors with dementia. Due to the progression of their cognitive decline, they often have to cope with a range of emotions, including anger, frustration, diminished self-esteem, and the difficult acceptance of their irreversible condition (Steeman et al., 2006). Therefore, their needs are distinct from those who are mentally healthy. Specifically, among the many needs, their distinct needs for security, meaningful interactions, and agency are not only critical to their well-being but also raise new expectations for caregivers (Kolanowski et al., 2005).

A Sense of Security. For seniors with dementia, ensuring a sense of safety in their immediate environment—both physically and personally—is crucial (Kitwood, 2015). Given that nursing homes serve as their final sanctuary, it is critical that these facilities avoid introducing disorienting changes and disruptions (Kitwood, 2015). Just as children have an intrinsic need for secure attachments, a similar sentiment can be found in individuals with dementia. These needs, which are often newly formed within the care facility, are crucial for their well-being (Miesen, 1993). Due to their cognitive impairments, seniors with dementia are particularly sensitive to the changes in the familiar faces around them, heightening their anxiety more than seniors who are mentally healthy (Browne & Shlosberg, 2006). Being highly dependent on caregivers, the well-being of these residents is inseparably tied to the welfare of their caregivers (Tellis-Nayak, 2007). High turnover rates among caregivers at nursing homes, however, not only disrupt these crucial bonds but can also lead to negative health outcomes for residents(Castle & Engberg, 2005). Kitwood (2015), therefore, argues that the quality of care can only reach its zenith when caregivers are consistently respected, supported, and offered long-term security, thereby allowing them to engage deeply and authentically in their roles.

Meaningful Interactions. Numerous studies highlight that seniors' life satisfaction is significantly linked to their involvement in social activities (Cornwell & Waite, 2009; Litwin & Shiovitz-Ezra, 2006). Such involvement acts as a predictor: Seniors engaged in social activities tend to exhibit higher levels of happiness (Havighurst, 1961). Conversely, feelings of loneliness are closely associated with adverse health outcomes (Caldwell et al., 2019). Consequently, mentally healthy seniors are often advised to volunteer as a means to expand their social connections, fostering both personal and societal benefits (Taghian et al., 2019). In contrast, due to their loss of cognitive abilities, especially their ability to recognize others, SwD's ability to initiate interactions is greatly hindered, which leads to disengagement from everyday habits and activities (Górska et al., 2018; Holst & Hallberg, 2003). As a result, their social circles shrink dramatically (Bózzola et al., 1992; Taylor, 2008). Not just friends distance themselves; even close family members tend to visit SwD infrequently and briefly (Yamamoto-Mitani et al., 2002). Thus, their opportunities for social interactions are largely dependent on what nursing homes have to offer, which is predominantly the caregivers.

The seniors' need for meaningful interactions is simple but critical to their well-being. In this study, "meaningful interaction" refers to any form of social engagement with depth, purpose, and significance to the senior (Beer et al., 2012). Such interactions are characterized by genuine communication, mutual respect, understanding, and a sense of being recognized as an individual with unique needs (Adkison, 2014). These interactions can be brief or prolonged, but they leave a lasting, positive impression on the senior, often promoting their emotional and psychological well-being (Bennett, 2002).

For SwD, meaningful interactions revolve around sharing quality moments with another person. This can manifest as reminiscing over a photo album, engaging in conversation, or enjoying a leisurely walk together (Moyle et al., 2011; Øye & Jacobsen, 2020). Researchers, however, found fostering meaningful interactions with SwD challenging. Caregivers, from their perspective, often demonstrate a reluctance to engage with the unique, subjective realities of those with dementia, leading to a loss of shared experiences (Hertogh et al., 2004). Moreover, each SwD possesses distinct social interaction needs, necessitating individualized approaches from caregivers (Colomer & de Vries, 2016). When nursing homes are understaffed or caregivers are pressed for time, these essential needs of the seniors may go unaddressed.

Autonomy. Respecting the seniors' autonomy has been identified as crucial to their well-being (Hertogh et al., 2004). In this study, autonomy is referred to senior’s right to make decisions on various aspects of their life, such as their daily routines, free from external influence or coercion (Agich, 2003).

In the past, nursing home care often presumed that many seniors, particularly those with dementia, were not competent to participate in decisions related to their care, treatment, or residency (Hertogh et al., 2004). The shift toward PCC, however, advocates for empowering residents by granting them the autonomy to make choices about their daily activities (Rahman & Schnelle, 2008). This perspective is supported by research suggesting that disruptive behaviors exhibited by SwD are not merely symptoms of neurological decline but might also be forms of communication, especially when their rights are disregarded (Kitwood, 1997; Miesen, 1999). Moreover, autonomy, particularly the ability to access outdoor spaces, has been found to enhance the well-being of seniors and is associated with fewer depressive symptoms (Potter et al., 2018). In countries like the Netherlands, ‘respect for autonomy’ has become a moral principle of central importance in current healthcare ethics embedded in various legislations, such as the Medical Treatment Act (WGBO) (Hertogh et al., 2004).

The Institutionalization of Care. Although the unique needs of SwD are well-documented, the care they receive often remains institutionalized in nature (Heggestad et al., 2013). This care is characterized by a standardized approach, confinement, and excessive medication use (McCabe et al., 2011; Saarnio & Isola, 2010). Such methods, rooted in ignorance and restraint, can evoke negative emotions in seniors, such as fear, humiliation, and anger, ultimately exacerbating their health conditions (Hofmann & Hahn, 2014; Szmukler & Appelbaum, 2008; te Boekhorst et al., 2013).

Structured, but not Individualized Care. Institutionalized care for SwD primarily encompasses care provided in facilities like nursing homes, long-term care facilities, and specialized dementia care units. These settings aim to offer structured environments and round-the-clock supervision to ensure the seniors’ safety. However, the care is often more generic than individualized, causing depersonalization of care, neglect, and social isolation (Glendenning, 1999; Kitwood & Bredin, 1992; Wood & Stephens, 2003). Even attempts to implement PCC can fall short of true individualization. For instance, a study in the Netherlands observed that nurses would simply aim to keep the seniors engaged with any activity, rather than tailoring the activities to the individual's preferences or needs (Hertogh et al., 2004). In addition, caregivers’ work is marked by routine and ‘control in the details,’ such as certain tasks need to be done at a particular time, and a seniors’ room should look a particular way (Secrest et al., 2005). Consequently, activities that may jeopardize their routine need to be prevented.

Restrictions on Freedom. Another notable limitation of the existing model is the widely used restrictions on SwD. The use of restrictions for residents in nursing homes living with dementia has been described as limiting residents' freedom of movement, autonomy, decision-making and life choices while institutionalized (McCabe et al., 2011; Saarnio & Isola, 2010).

Some of the most common forms of restrictions include limiting a person's movement in a chair, restricting their movement outside their rooms or designated dementia wards (Øye & Jacobsen, 2020; Steele et al., 2020). A study from the Netherlands reported that nearly half (49%) of nursing home residents were subject to one or more forms of restraint. The most frequently used physical restraints included the use of bed rails, waist belts, and chairs fitted with tables. In almost all cases (90%), residents were continuously restrained for over 3 months. The primary justification for these restraints, cited in 90% of instances, was fall prevention (Hamers et al., 2004). Even though the safety of the residents is often used to justify these forms of restrictions, they are nonetheless actions by staff against residents' will, limiting residents' freedom of movement and their autonomy (Øye & Jacobsen, 2020). In fact, research has indicated that allowing SwD the freedom to wander around and access the outside is beneficial to their overall well-being (De Veer & Kerkstra, 2001; Kong et al., 2022; Wigg, 2010).

Over-Medication. Over-medication of SwD is another major concern caused by institutionalized care (Kröger et al., 2015; Rochon et al., 2008; Thompson Coon et al., 2014). In an exploratory survey of nursing home care in 30 countries it was reported that medication use was high, with 82% of countries reporting residents taking 6 or more medicines a day (Tolson et al., 2013). In Australia, it was found that 80% of dementia patients were taking some form of psychotropic drug but they were only useful in 10% of cases (Martin, 2019). These medications are often used without the senior's consent (Steele et al., 2020).

Often seen as an expedient means to manage challenging behaviors and ensure patient 'compliance', this widespread practice is primarily employed to pacify individuals, ensuring tranquility within care facilities (Horwitz & Wakefield, 2007). While this might provide a short-term solution for caregivers, it raises pressing ethical, health, and care quality concerns. Over-reliance on medication, especially antipsychotics, can lead to a series of more grave issues like stroke, cardiac complications and even premature death (Martin, 2019). Moreover, this approach undermines the principles of PCC, where the focus should ideally be on understanding the individual needs of each patient, acknowledging their autonomy rather than resorting to a temporary solution (Kales et al., 2014). Many caregivers have voiced a preference for more holistic care strategies over pharmaceutical interventions (Lewis et al., 2021). To truly reduce the prevalence of such prescriptions in the long term, there is a need to amend the prevailing care culture and also evaluate the accessibility of non-pharmacological alternatives (Thompson Coon et al., 2014)

Limitations of Interventions. Many nursing homes have attempted to shift from institutionalized care to Person-Centered Care (PCC). However, this transformation has proven to be challenging. A study analyzed a range of nonpharmacological interventions, which spanned categories such as sensory stimulation, social interaction, behavior therapy, staff training, structured activities, environmental changes, medical/nursing care methods, and combined therapies. Most of these interventions had a positive, albeit not significant effect (Cohen-Mansfield, 2001). Among the interventions, staff training emerges as particularly notable due to its widespread adoption and apparent practicality.

To address the multifaceted needs of seniors with dementia (SwD) without incurring additional costs, many nursing homes prioritized training caregivers. Such training is considered vital because caregivers often feel overwhelmed by the demands of dementia care (Chen et al., 2020). A study from a chronic care facility in the U.S. highlighted that 66.7% of caregivers experienced physical aggression, such as being hit or bitten by patients. Furthermore, approximately 75% reported feelings of frustration and being overwhelmed by dementia care (Marx et al., 2014).

Evidence also indicates that many caregivers do not have adequate training in dementia care, which can lead to poor care outcomes and misunderstandings about the disease (Fazio, Pace, Maslow, et al., 2018). This concern is more prevalent in nursing homes, where caregivers generally receive less formal training compared to professionals in other health-related sectors. Apart from a few countries like Sweden, Germany, and the Netherlands, the predominant skill base in many nations is derived from personal experiences or previous employment in similar settings. This lack of structured training casts these workers in an unprofessional light and contributes to the undervaluing of their role, leading to lower wages (Fujisawa & Colombo, 2009). Consequently, dementia care lacks competitiveness compared to other healthcare positions, making it challenging to attract potential recruits (Bowers, 2008).

The primary objective of these training programs is to reduce staff stress, increase job satisfaction, and decrease worker turnover (Bowers, 2008). There is a shared belief that while caregivers might possess basic knowledge about care, they often lack the hands-on skills necessary for nonpharmacological behavioral management. Most training initiatives are short-term, leaving questions about their lasting impact. Instead of addressing the core needs of seniors, such as a sense of security, meaningful interactions, and acknowledgment of their autonomy, many educational programs predominantly focus on 'behavior management.' This is largely to assist caregivers in dealing with seniors' disruptive behaviors, which are frequently cited as significant stressors by caregivers globally.

While some positive outcomes such as reduced stress were reported, the long-term effectiveness of these training programs is questionable (Marx et al., 2014). Cromwell and Kolb (2004) emphasize that for enduring changes in caregiving practices, training programs must be well-structured, accompanied by thorough learner preparation, and followed by sustained post-training support. However, most existing programs lack consistent reinforcement, supervisory backing, and tailored learning approaches (Beer et al., 2012; Chang et al., 2006). Therefore, the implementation of PCC cannot be achieved by training alone but by more systematic changes in the industry.

Upon examining the needs of SwD and the challenges nursing homes confront in providing quality care, it is clear that the difficulties are multifaceted. While various interventions attempt to provide solutions, a pivotal concern remains: the shortage of care staff. For PCC to be firmly established, the question on the staff level is unavoidable and cannot be circumvented by mere interventions (i.e., staff training). Without enough caregivers, dedicating quality time to understand, interact, and engage with each individual senior, the latter’s needs cannot be met (Harrington & Edelman, 2018). Research consistently affirms that an adequate caregiver-to-resident ratio facilitates more personalized and attentive care (Castle & Anderson, 2011; Schnelle et al., 2004). Specifically, adequate staffing is more likely the grant the caregivers time to interact, understand, and build genuine relationships with the seniors, which is central to the PCC model (Bowers et al., 2000). A shortage of caregivers, on the other hand, not only compromises care quality; it also contributes to staff burnout, reduced job satisfaction, and high turnover rates, eventually resulting in institutionalized care (Moore & Haralambous, 2007; Mueller et al., 2006; Spilsbury et al., 2011).

Therefore, meeting the seniors' individualized needs cannot be done through training caregivers. One of the most pressing needs is to have more caregivers involved in assisting SwD with their highly individualized needs (Bowers et al., 2000; Wiener et al., 2007). An increase in caregiver numbers is more than just a quantitative boost; it is a qualitative leap toward higher staff satisfaction and improved well-being for seniors.

SwD's Potential as a Source of Support

While dementia presents challenges to both SwD and their caregivers, contemporary perspectives encourage a more positive outlook on dementia (Colomer & de Vries, 2016). There is a growing body of literature transitioning from viewing dementia purely as a pathological condition needing treatment to understanding it as a natural aspect of aging. A study from China underscored this shift, revealing that 45% of respondents perceived dementia as a normal aging process, while a mere 15% firmly disagreed (Li et al., 2011). It is widely recognized that SwD are transitioning to the last stage of life, a phase that expects considerable adaptability such as coming to terms with cognitive deterioration, overcoming the stigma associated with needing help, and forging new social connections (Kitwood, 2015; Phinney et al., 2007; Van Dijkhuizen et al., 2006). Despite the challenges, some seniors navigate these mental health challenges and emerge into 'a new serenity' marked by agency and prosocial behaviors (Kitwood, 2015).

The emergence of terms such as "dementia-friendly," "dementia-capable," and "dementia-positive," highlights this shift of mindset at a practical level. Often used interchangeably, these terms advocate not just recognizing the capabilities and strengths of those living with dementia but also fostering an environment that is inclusive to SwD (Lin & Lewis, 2015). Contrary to traditional measures that often emphasize the deficits and pathology associated with dementia, these concepts align with a growing trend that advocates for recognizing the agency and 'personhood' in dementia (Ready & Ott, 2003). This perspective interprets disruptive behaviors, such as wandering, not as mere symptoms but as meaningful expressions or communications from SwD (Petty et al., 2020).

In 2017, the World Health Organization adopted the global action plan on the public health response to dementia. A key proposal from the plan is for member states to work toward improving the physical and social environments to promote social inclusion, which gave rise to dementia-friendly communities (World Health Organisation, 2017). A dementia-friendly community enables those people living in the community to remain engaged in their usual daily lives and continue to contribute as valued community members (Shannon et al., 2019). There is a promising development of dementia-friendly communities globally (Arthurton et al., 2022). In England, for example, more than 280 communities have been identified as dementia-friendly communities since 2012 (Buckner et al., 2019). These communities emphasize education and awareness, aiming to both inform the public about dementia and ensure that environments and services are safe and accessible for SwD (Hebert & Scales, 2019; Heward et al., 2017; Mitchell et al., 2004).

However, a significant shortcoming of these communities is that their interventions often prioritize symptoms associated with dementia (Odzakovic et al., 2021). Typically, activities are not crafted with direct involvement from SwD but rely more on the input of informal caregivers (Hung et al., 2021; Mathie et al., 2022). Therefore, these efforts do not challenge the prevailing notion that SwD are recipients rather than contributors, or that SwD are incapable of being productive members of society (Kitwood, 2015).

A perspective that is often overlooked when viewing SwD is through a more positive angle of caregivers. While there is limited qualitative research on this topic (Cheng et al., 2016), it is noteworthy that, despite the undeniable challenges, many caregivers did identify rewarding aspects in caring for SwD. Some have observed that certain individuals with dementia can manifest and even develop prosocial qualities such as increased concern for others, increased sociability, or a deepened capacity for friendship (Kitwood, 2015; Taylor, 2008). Beyond the potential for these positive personal developments, many SwD also express a desire to contribute and be of assistance to others (Lin & Lewis, 2015). Taylor (2008), for instance, recounts an experience where an individual with dementia attempted to console another person in distress. Their desire to help can also manifest in the continuation of tasks they used to perform such as assisting with cleaning the room (Phinney et al., 2007; Van Dijkhuizen et al., 2006). Such tendencies underline the inherent need for meaning and purpose in their lives. However, the limited social environment and cognitive challenges often leave many SwD struggling with how they can be of service to others (Menne et al., 2002).

Other than recognizing the prosocial tendencies of SwD, the challenges inherent in dementia care can also offer benefits for caregivers. While burnout is not uncommon among caregivers, some family caregivers have highlighted the positive facets of their caregiving journey (Cheng et al., 2016; Yu et al., 2018). Some of the most noticeable benefits are a deepened bond with the family member living with dementia and personal growth. Many caregivers experience resilience as they continuously adapt to new caregiving challenges. The experience of providing care is also described as a process of discovering one’s strengths, a sense of accomplishment and finding purpose in life (Netto et al., 2009; Peacock et al., 2010; Sanders, 2005). Therefore, navigating the intricacies of caring for someone with dementia can give caregivers a sense of competence and satisfaction (Peacock et al., 2010).

Similar to family caregivers, some studies highlight that nurse aides too can have positive experiences from caring for SwD (Band-Winterstein et al., 2019; Secrest et al., 2005), even though they represent a disadvantaged population at multiple levels. In the U.S., nurse aides are predominantly women over 30, many of whom belong to racial and ethnic minorities and come from disadvantaged socioeconomic backgrounds, including both documented and undocumented immigrants, with minimal training in healthcare (Castle & Ferguson-Rome, 2015; Mercer et al., 1994; Stone & Wiener, 2021).

Positioned at the lower end of the professional hierarchy, with minimal formal authority, but experiencing high rates of burnout and turnover rate, the work of nurse aides is typically seen as difficult and unfulfilling (Band-Winterstein et al., 2019; Castle & Engberg, 2005; Secrest et al., 2005; Zysberg et al., 2019). The age difference and demanding tasks further cast doubts on the potential for a meaningful bond between SwD and their caregivers (Miesen, 1999). However, despite these adversities, some research suggests that nurse aides can still find moments of fulfillment and positive aspects in their caregiving roles (Band-Winterstein et al., 2019; Bishop et al., 2009; Secrest et al., 2005).

A study conducted in the U.S. by Secrest and her colleagues (2005) unveiled a stark contrast in how nurse aides perceive their relationships with staff members as opposed to their relationships with SwD. While some nurse aides recounted experiences marred by hostility and disrespect from certain coworkers, nurses, the administration, and even the seniors' families, their interactions with SwD formed a contrasting picture. These nurse aides’ relationship with SwD was characterized by intimacy and closeness, with the term 'family' being recurrently emphasized. Despite feeling marginalized by others, these nurse aides viewed the seniors as extensions of their own families and derived a sense of pride from their caregiving roles. In addition, assisting SwD gave them a sense of empowerment and control in an environment where their formal authority was minimal. Remarkably, even physical assaults by patients were not perceived negatively. Instead, the aides demonstrated understanding, forgiveness, and a protective stance toward the residents. Thus, amid an environment that often bordered on hostility, the self-reported experiences of these nurse aides centered around familial ties, pride, and a sense of agency (Secrest et al., 2005).

The results align with a study from Israel. In this research, despite the challenges in their work environment, nurse aides frequently referred to the seniors they cared for using familial terms like 'father,' 'parent,' and 'family' (Band-Winterstein et al., 2019). Additionally, evidence suggests that nurse aides derive greater satisfaction from their roles when faced with challenges, provided they have adequate time to address them (Bishop et al., 2009).

It is also worth noting that from the perspective of caregivers, certain personal-psychological traits, such as self-control, patience, flexibility, modesty, empathy, dedication, peacefulness, and attention to detail, are sometimes deemed more crucial for delivering quality care than formal education or training (Band-Winterstein et al., 2019). In fact, some nurses believe that if nurse aides exhibit strong work ethics, show love, demonstrate a willingness to give, and treat seniors with warmth, they may not require specialized professional knowledge beyond their commitment and psychological qualities (Band-Winterstein et al., 2019).

Even though the studies that look at the positive aspects of dementia care are modest in number (Cheng et al., 2016), they nonetheless support a shift from the conventional focus on burdens to a more holistic approach that considers the possibilities for caregivers to benefit from the caregiving experience (Netto et al., 2009). Considering this potential, it is plausible that beyond family caregivers and nurse aides, other groups might also find value in caring for SwD.

Highly Vulnerable Young Adults (HVYAs)

In this study, Highly Vulnerable Young Adults (HVYAs) are defined as young adults eager to contribute productively to society but are hindered by a significant imbalance between the risks they face and the limited support available, which prevents them from coping effectively and achieving positive identity development (Spencer et al., 2006). Specifically, the study focuses on a group of HVYAs aged 18 to 35 who face numerous challenges such as living in disadvantaged neighborhoods, lacking adequate home support, and dealing with mental health issues, including depression, anxiety, OCD, ADHD, and PTSD—though they exhibit no antisocial behaviors. At a critical stage of establishing independence, they lack opportunities that blend career advancement with healing experiences tailored to their vulnerabilities and fostering resilience. While conventional support such as talk therapy and medication, primarily provided by government welfare services, serves as their main source of support, these measures are often inadequate for overcoming the risks that impede their development. Given the global prevalence of this demographic, which includes millions, understanding their coping mechanisms and developmental trajectories is crucial due to the significant societal implications (Spencer & Patrick, 2009).

While these young adults have received much attention from researchers, the emphasis has been placed on their vulnerabilities (Sapiro et al., 2019). Researchers undoubtedly recognize these young adults' potential for positive coping. Yet, the prevailing narrative leans heavily toward their service requirements, overlooking their ability to function as active agents like others their age (Kim et al., 2012; Vanheusden et al., 2008). Essential aspects like their need for autonomy, self-worth, and identity stemming from positive experiences often go unaddressed (Sapiro et al., 2019). Lately, there has been a shift among researchers toward a more affirmative perspective, valuing these young adults' agency and capabilities (D'Zurilla & Nezu, 2010; Kaufman & Sternberg, 2010; Rochat, 2023). This resonates with the prevailing view that resilience is shaped by context, emphasizing that a supportive environment is pivotal for these young adults to adopt effective coping strategies and, in turn, achieve desirable developmental outcomes (Spencer, 2001). Nonetheless, an environment that holistically addresses these young adults' needs and fosters resilience remains unidentified.

Describing the HVYAs

According to the American Psychological Association (2020), the nation is facing a national mental health crisis, one that could have long-standing health and societal implications. Their 2020 survey showed that the prevalence of mental illness among young adults is alarming, and Gen Z adults (ages 18-23), in particular, reported the highest stress level compared to other generations (American Psychological Association, 2020). Based on findings from the Substance Abuse and Mental Health Services Administration (2014), approximately one in five young adults in the U.S. struggle with a mental illness, not counting substance disorders. The statistics are even more concerning for disadvantaged young adults, such as those from underprivileged neighborhoods, where the incidence of mental illnesses can surge to as high as 30% (Courtney & Dworsky, 2006).

Research on vulnerable young adults has focused on various aspects of their vulnerability using a variation of terms (i.e. young people with complex needs and marginalized youth) (Almqvist & Lassinantti, 2018; Munford & Sanders, 2021a; Sapiro et al., 2019). In this study, the term “highly vulnerable young adults” (HVYAs) refers to a specific group of young adults, predominantly aged 18 to 30, who are struggling with mental health issues such as depression, anxiety disorder, obsessive-compulsive disorder (OCD), attention-deficit/hyperactivity disorder

(ADHD), and post-traumatic stress disorder (PTSD), but no antisocial symptoms.

Since these HVYAs often exhibit multiple overlapping symptoms, this study does not focus on identifying specific symptoms. Instead, it explores the shared experiences of these young adults, whose transition to full-fledged adulthood is hindered by various challenges. Before working at the nursing home, most of them have struggled to secure regular employment or have been unable to work for about a year due to the severity of their symptoms. Despite these challenges, they remain eager to find opportunities that allow them to manage their symptoms and work, which is crucial for achieving their developmental goals (Ellison et al., 2015; Subramaniam et al., 2022).

The global significance of mental disorders cannot be overstated, with depression and anxiety disorders standing out as prime examples due to their profound impact on individuals and society as a whole. Depression, clinically referred to as major depressive disorder, depression is characterized by enduring feelings of sadness and hopelessness, as well as a diminished interest in previously enjoyed activities (World Health Organization, 2017). It can manifest in numerous physical and emotional issues, impairing an individual's functionality both at work and at home (Rapaport et al., 2005). Some examples include low educational attainment, increased teenage pregnancies, marital disruptions, and inconsistent employment (A. K. Cohen et al., 2020; Cuijpers et al., 2014; Kessler & Bromet, 2013).

Depression is one of the most prevalent forms of mental disorder. According to the World Health Organisation (2023), depression affects 332 million individuals worldwide. Compared to other age groups, rates of mental illness can be higher for young adults ages 18–25 (Kessler et al., 2005). A Dutch study in 2017 reported that the percentage of young adults who self-identified as experiencing symptoms of depression was as high as 9% (van Dijk et al., 2022). Notably, the condition was more prevalent among females, affecting 5.1%, compared to 3.6% of males. Furthermore, the number of depression cases has been on the rise. From 2005 to 2015 there was an 18.4% surge in the number of people living with depression (World Health Organisation, 2017). The increase in depression cases means heavier burdens. In a Swedish study conducted in 2008, the average yearly cost per patient with depression was estimated at €17,279. The bulk of these costs, accounting for 88%, stemmed from productivity losses, while outpatient care contributed to 6% of the total costs. The costs varied with the severity of depression: those with mild depression incurred costs averaging €14,200, while patients with severe depression had costs averaging €21,500 (Ekman et al., 2013). In the U.S., the economic strain due to major depressive disorder had a notable rise; from 2005 to 2010, the financial burden increased by 21.5%, amounting to an inflation-adjusted $210.5 billion from $173.2 billion (Greenberg et al., 2015).

Another common form of mental disorder is anxiety disorder. Anxiety disorders refer to a group of mental disorders characterized by feelings of anxiety and fear. The effects of an anxiety disorder can be pervasive and touch on various aspects of an individual's life. Symptoms can range from overwhelming and uncontrollable concerns about everyday scenarios to challenges with concentration, a preoccupied sense of impending threats, and a propensity to recognize and recall negative information over positive ones. Persistent anxiety has the potential to initiate or exacerbate various health complications, such as heart ailments, respiratory conditions, and gastrointestinal issues (American Psychiatric Association, 2013). According to the World Health Organisation (2017), 3.6% of the global population had anxiety disorders in 2015. In a survey conducted in the continental U.S., as many as 31.9% of adolescents aged 13 to 18 years were found to have anxiety disorders (Merikangas et al., 2010). Gender disparities are apparent in the prevalence of anxiety disorders, with females more likely to experience them (4.6%) compared to males (2.6%) (World Health Organisation, 2017).

Anxiety disorders not only impose a substantial emotional strain but also bring significant economic burdens (Smoller et al., 2009). In Europe, they account for at least 35% of all disability and sick leave days related to mental disorders (Andlin-Sobocki & Wittchen, 2005). This prevalence underscores the high indirect costs and substantial burden of illness associated with these disorders (Smoller et al., 2009). Despite this, anxiety disorders often go unrecognized and untreated, leading to relatively low direct treatment costs (Andlin-Sobocki & Wittchen, 2005). Nevertheless, the total cost for anxiety disorders in Europe was recorded at 74.4 billion Euros in 2010 (Olesen et al., 2012).

Mental health challenges disproportionately affect disadvantaged populations, with socioeconomic status (SES) being a significant factor. Numerous studies have consistently demonstrated that adolescents from lower SES backgrounds—characterized by factors such as low parental income, manual occupations, limited education, and not owning the family home—experience more mental health issues compared to their counterparts from higher SES groups (McLaughlin et al., 2012; Reiss, 2013; Russell et al., 2016). This association persists even in affluent and egalitarian societies. For instance, in the Netherlands, a research observed the same trend where those from lower SES backgrounds faced heightened mental health challenges (Duinhof et al., 2015). Specific factors, such as limited education, were found to link to externalizing problems, including conduct issues, hyperactivity, and problems with peers (Weinberg et al., 2019).

Due to the combined challenges of mental health struggles and lower SES, the transition from adolescence to adulthood is particularly challenging for these highly vulnerable young adults. During this pivotal transition, the young adults’ critical developmental tasks include developing a mature view of self, making choices about education and career paths, achieving independence from parental households, establishing intimate relationships and assuming personal responsibility (Erikson & Erikson, 1997; Gralinski-Bakker et al., 2005). A significant aspect of this period is the shift in primary support sources—from familial ties to self-established social connections, such as friendships and romantic partnerships (Leung et al., 2020). The effectiveness of this transition will have lifelong implications (Arnett, 2007; Cohen et al., 2019).

However, HVYAs frequently lack the necessary skills to form and maintain social connections. Research indicates that those with mental health difficulties often struggle with communication and social skills, resulting in limited interpersonal relationships with friends, family, and romantic partners (Armstrong et al., 2003; Goodman et al., 2011; Gralinski-Bakker et al., 2005; Vander Stoep et al., 2000). Due to these deficits, highly vulnerable young people are often marginalized and excluded from participation in ordinary and normative experiences (Munford & Sanders, 2021b). Consequently, they often experience poor developmental outcomes including lower education achievement, fewer full-time employment opportunities, and continued struggles with mental health (Osgood, 2005)

The Existing Interventions are Insufficient

Distinct Needs of HVYAs. HVYAs are at a development stage that marks a delayed transition from a dependent adolescent to an independent adult. It is characterized by an exploration of identity, self-focus, and instability, which requires them to seek independence from parents, explore close relationships, pursue higher education or vocational training, enter the workforce, and solidify personal values and beliefs (Arnett, 2000; Erikson & Erikson, 1997). To fulfill these developmental tasks, certain needs are particularly important to HVYAs due to their mental health struggles. Specifically, they include having a secure environment, social support, and empowering experiences rooted in trust and continuity. The simultaneous challenges of managing mental health struggles while transitioning to adulthood make their coping experience especially complex. While present academic research and practical strategies emphasize the role of social workers, especially therapists, studies consistently indicate that these professionals cannot fulfill HVYAs' developmental needs on their own. This fact can be demonstrated by the low percentage of young people with high levels of depression or anxiety symptoms who seek professional help in Western countries (18-34%) (Gulliver et al., 2010). Unless the young adults' needs are clearly understood and addressed, the "mental health crisis" will not be addressed at a large scale.

Secure Environment. A secure environment, both physically and emotionally, is considered foundational for HVYAs' healing and developmental journey. Essential components of such an environment include consistency, a non-judgmental atmosphere, and the freedom for them to be themselves. Barton et al. (2012), pointed out that only when an HVYA feels at ease can they form attachment and engage in therapeutic relationships.

Young people typically seek out older figures for guidance, protection, and a sense of security (Barton et al., 2012). Yet for HVYAs, many of their mental health issues can be traced back to problematic interactions with these older figures, such as a lack of family cohesion, reduced parental involvement, and insufficient community backing (Kaltiala-Heino et al., 2001). This can deeply erode their trust in others, making it challenging to rebuild. Without this fundamental sense of security, it becomes increasingly difficult for them to cultivate the social support needed for their transition.

Social Support. Young adults with mental health challenges are often marginalized and lack a sense of belonging. Meaningful interactions, which are genuine and supportive can create a sense of community for these young adults to feel more integrated and acknowledged (Cacioppo & Cacioppo, 2014). These interactions not only validate the feelings and experiences of young adults but can also reduce symptoms, such as depressive symptoms and risky behaviors (Hankin, 2006; Rice et al., 2012). When individuals are going through particularly challenging times or are at risk, a reliable social support network can act as a safety net and help the HVYAs develop resilience and adopt productive coping strategies (Piko et al., 2013). The coping process provides opportunities to help young adults develop essential life skills, such as interpersonal skills, problem-solving skills, and empathy. From a long-term perspective, social support plays a vital role in young people's developmental trajectory, assisting them in understanding their identity and their place in the world.

Empowering Experiences. For HVYAs, internal empowerment is as crucial as external support. Other than seeking safe and secure connections, finding opportunities to test out identities and building a sense of agency is also significant in contributing to positive identity development for them (Munford & Sanders, 2015). As the HVYAs transition into adulthood, one of the most transformative experiences is employment. Defined as a medium through which individuals offer services or tasks in return for financial compensation (Boardman, 2003), employment embodies the values of autonomy and self-determination—ideals held in high regard in modern Western societies (Kitwood, 2015). Beyond the tangible benefit of income, employment facilitates access to resources, encourages social interaction, helps individuals recognize their strengths, nurtures interests, and establishes a sense of purpose and identity (Arnett, 2000; Boyce et al., 2008; Kennedy-Jones et al., 2005). Therefore, some scholars believe that one of the best indicators of recovery for adults with mental illness is the ability to obtain and maintain meaningful employment (Bond et al., 2016; Ellison et al., 2015).

In the realm of mental health, the distinctions between 'work' and 'employment' is significant. Activities such as childcare, house chores, or caregiving for elderly or sick family members qualify as 'work', given they are tasks set by others. However, as they usually do not provide formal payments, they are not ‘employment’. This distinction is paramount for those with mental health issues, as a significant majority desire to engage in meaningful activities that both tap into their skills and at the same time, facilitate their need to achieve independence (Boardman, 2003). Beyond achieving developmental milestones, employment offers HVYAs numerous benefits, facilitating effective management of their mental health concerns and ensuring positive developmental trajectories (Liljeholm & Bejerholm, 2020).

Although employment can offer numerous benefits to HVYAs, ensuring their jobs remains a global challenge (Gmitroski et al., 2018). Research indicates that young adults with mental health conditions are significantly less likely to be employed compared to their age-matched peers from the general population (Gmitroski et al., 2018; Slade et al., 2014). Other than their lack of skills, stigma and discrimination are frequently cited as major barriers to employment (Subramaniam et al., 2022). While training and support for these young individuals are seen as potential solutions to these barriers (Subramaniam et al., 2022), the reality suggests the idea sounds simpler than can be done.

Limitations of Existing Interventions. While young adults ardently desire independence, much of the prevailing research focuses on their vulnerabilities rather than their resilience. This lens often results in practices that highlight HVYAs' reliance on interventions, particularly those provided by therapists. While addressing the mental health challenges of young adults undeniably requires therapeutic interventions, it is also crucial not to overstate its role (McGorry et al., 2014; Vanheusden et al., 2008).

In the United States, a significant number of individuals with mental disorders either go untreated or receive suboptimal treatment, indicating a pressing need for improved interventions to promote initiation and enhance the quality of treatment (Miranda et al., 1998; Wang et al., 2005). A study in the Netherlands found that only 34.5% of young adults aged 19–32 years with clinical levels of psychopathology had used mental health services. The rate was even lower (28%) for those aged 19–25 years (Vanheusden et al., 2008). Similarly, studies in Australia, New Zealand, and Finland reported a low rate of young adults help-seeking for mental health problems (Aalto-Setälä et al., 2002; McGorry et al., 2014; Newman et al., 1996). In addition, it is estimated that about 20% to 50% of clients in the U.S. terminate therapy prematurely, often within the first three to four sessions (Swift & Greenberg, 2012). Many factors could influence the low help-seeking rates among young adults and early termination of therapy. The factors range from perceived stigma, financial limitations, mismatch or lack of connection with the therapist, and conflicting schedules, to lack of trust in the efficacy of therapy (Barrett et al., 2008; Vanheusden et al., 2009). However, the most important factors are the ones that fall short in addressing the distinct needs of HVYAs. Key concerns include the absence of a secure environment conducive to therapy, challenges in establishing a sustained, meaningful therapist-client relationship, and the unintended disempowering nature of some therapeutic approaches.

The Quality of Therapies is Questionable. Given the limited resources available to HVYAs, social workers and therapeutic environments are anticipated to offer a vital safe space for recovery. However, many mental health clinics are perceived as 'risky' due to incidents of theft, intimidation, and aggressive behavior (Johnson & Delaney, 2006; Ros et al., 2013). These issues not only impact the patients directly but also tarnish the reputation of therapeutic settings, potentially diminishing trust in therapeutic interventions (Kindy et al., 2005).

The safety of therapeutic settings is not the only concern; the competence of therapists also factors into young adults' lack of trust in therapy. The intricate task of understanding and enhancing human emotional well-being renders the therapist's role demanding and stressful (Bradley et al., 2017). Several issues, such as insufficient training, compassion fatigue, and burnout, can hinder therapists' effectiveness when treating HVYAs.

In the U.S., a significant majority, 55%, of mental health therapists receive their academic training from community colleges or two-year institutions (Gallon et al., 2003). Yet, the intricate nuances of therapy can take years to fully grasp, and the challenges are often underestimated by those new to the profession (Skovholt & Rønnestad, 2003). This disparity between their training and the time required to achieve proficiency leads many therapists to doubt their capabilities as they do not feel thoroughly prepared for clinical practice (Skovholt & Rønnestad, 2003).

The well-being of therapists themselves is a critical factor influencing the quality of therapy. Continual exposure to the traumas and distress of clients can exact a heavy emotional toll on therapists, potentially leading to conditions like compassion fatigue and, in more severe cases, burnout (Newell & MacNeil, 2010). Compassion fatigue, also known as secondary traumatic stress, emerges from chronic exposure to clients' stressing narratives and their aftereffects. This phenomenon is particularly pronounced in treatments for conditions like post-traumatic stress disorder, where therapists are expected to deeply empathize by drawing from their personal reservoirs of pain, uncertainty, anxiety, and past traumatic experiences to comprehend the client's inner turmoil and altered worldview (Wilson & Thomas, 2004). As therapists immerse themselves in the traumas of their clients, there is a risk of absorbing the emotional aftermath of these stories, culminating in substantial emotional, physical, and mental fatigue. Symptoms can range from diminished empathetic capacities and heightened cynicism to feelings of burnout and even physical ailments (Figley, 1995). Research indicates that as many as 70% of mental health professionals show signs of compassion fatigue at some point in their careers (Bride, 2007; Figley, 1995; Thompson et al., 2014). This not only compromises the quality of therapy but also has broader implications for the entire mental health industry.

Unresolved stressors, such as anxiety and compassion fatigue, can result in therapist burnout (Newell & MacNeil, 2010). This burnout is characterized by emotional exhaustion, a sense of detachment, and a decreased feeling of personal accomplishment (Lim et al., 2010). It is often a consequence of prolonged job stress. Studies indicate that professionals in helping professions, like therapists, may have higher occurrences of personal trauma or mental health challenges in their past (Paris & Hoge, 2010). Regarding their compensation, it is widely recognized that social workers and therapists generally earn less compared to other professionals with similar educational backgrounds (DiNitto & McNeece, 2008; Rupert & Morgan, 2005). This disparity in income can lead to feelings of undervaluation and dissatisfaction, further heightening the risk of burnout. Data indicates that burnout rates among social workers can be up to 75%, and for clinical psychologists, these rates fluctuate between 21% and 67%, depending on the workplace and role-specific pressures (Maslach et al., 2001).

The high turnover rate of professional workers poses a major challenge to the social work field in general (Mor Barak et al., 2001). Among many factors, stress and burnout are found to be major contributors to poor morale and subsequent turnover (Geurts et al., 1998). A 2017 survey by the American Psychological Association (2017), highlighted that almost two-thirds of psychologists (66%) reported their work caused them "some" or "a great deal" of stress, and about 4 in 10 psychologists (43%) said they felt burned out as a result of their professional demands. Such challenges not only affect professionals' mental well-being but also affect the whole industry, resulting in increased absenteeism, reduced productivity, elevated turnover rates, and compromised quality of care (Acker, 1999; Lloyd et al., 2002).

A prevailing concern that threatens the quality of therapy is the over-reliance on medication in treating young adults. Prescription rates for psychiatric medications, including antipsychotics, antidepressants, and mood stabilizers, have been found increasing among young adults (Olfson et al., 2014). Several factors contribute to this trend, such as the substantial economic incentives for pharmaceutical companies, limited access to alternative treatments, and the quest for rapid solutions to the multifaceted nature of mental health diagnoses (Wang et al., 2005; Whitaker, 2011).

Over time, various complications can arise from medication use. Some medications might lose their effectiveness, necessitating increased dosages. This can intensify side effects or even lead to conditions that are resistant to treatment (Carvalho & McIntyre, 2015). Beyond efficacy issues, prolonged use of certain psychiatric medications can pose long-term health risks, such as diabetes, cardiovascular issues, and cognitive decline (Gallacher et al., 2012; Votaw et al., 2019). Take benzodiazepines as an example: these are commonly prescribed for anxiety disorders and specific depressive symptoms (Baldwin et al., 2014). With over 5% of the U.S. population filling a prescription annually, they are among the most frequently used psychiatric medications (Bachhuber et al., 2016; Moore & Mattison, 2017). Alarmingly, benzodiazepines rank third in the list of most commonly misused substances, whether illicit or prescription, in the U.S. From 1996 to 2013, there was a more than 400% increase in benzodiazepine-related overdose deaths (Bachhuber et al., 2016). Furthermore, extended use of benzodiazepines has been linked to a heightened risk of Alzheimer's disease, a leading form of dementia (Gage et al., 2012; Gallacher et al., 2012).

Due to concerns about the limitations of conventional approaches, a growing number of young adults with mental health challenges show a preference for alternative treatments (Barnes et al., 2004; Elkins et al., 2005; van der Watt et al., 2008). Animal-assisted therapy (AAT), for instance, has proven effective for individuals with mental health disorders who have not experienced improvement through traditional psychotherapy (Johansen et al., 2014). Within AAT, Equine Facilitated Psychotherapy (EFP) stands out by utilizing the therapeutic qualities of horses, which align closely with the principles of attachment-based psychotherapy due to their natural attributes (Bachi, 2013). Horses, known for being nonjudgmental, empathetically tuned to human emotions, and facilitators of non-verbal communication, foster an environment conducive to genuine interactions (Bachi, 2013; Johansen et al., 2014; McCormick & McCormick, 1997; Vidrine et al., 2002). These qualities are instrumental in creating a secure space that nurtures the formation of meaningful connections between individuals and horses (Nilson, 2004; Vidrine et al., 2002). Benefiting from these traits, individuals facing various conditions, including depression, autism, and PTSD, have experienced positive outcomes from EFP. Notable benefits reported include reductions in stress, facilitation of trauma recovery, and significant enhancements in self-esteem (Ewing et al., 2007; Frederick et al., 2015; Lentini & Knox, 2009; Vasher et al., 2017).

Despite being in the early stages of development, alternative therapies like animal-assisted therapy indicate a growing public awareness of conventional therapy's limitations and a shift toward exploring innovative treatment options (Kessler et al., 2001; van der Watt et al., 2008). Given the developmental needs of young adults, such as beginning a career to achieve self-sufficiency (Havighurst, 1972), there is also a demand for options that integrate both therapy and vocational training, which this study intends to explore.

Difficulties in Forming a Lasting Relationship. Therapy is often viewed as a long-term endeavor. Beyond receiving advice and prescriptions, establishing a sustained relationship with the therapist is a key element in effecting positive changes for HVYAs (Munford & Sanders, 2021a; Valent, 1999). This relationship should be characterized by authenticity and a respectful helping partnership that remains nonjudgmental and consistent over time (Cahill et al., 2016; Ungar et al., 2012; Zlotowitz et al., 2016). In reality, however, many young adults find it challenging to cultivate such enduring supportive connections with their therapists (Gulliver et al., 2010). From the young adults' perspective, some most notable factors include lack of trust, mismatch of therapeutic style, and lack of long-term consistency.

While young adults with mental health challenges deeply need support, often display a deep-seated mistrust toward others. On one hand, those with histories of abuse and neglect intensely desire genuine connection, love, and attention in relationships (Abel & Wahab, 2017; Munson & Lox, 2012). Conversely, those who have experienced unstable relationships in their past often struggle with trust issues and identifying their own emotional needs (Manuel et al., 2018; Munford & Sanders, 2015). encountered repeated empathic failures, HVYAs come to view themselves in a negative light, perceive relationships as consistently disappointing, and see the world as an insecure place (Sapiro et al., 2019). This ingrained sense of vulnerability often keeps them away from openly sharing their feelings and experiences, making it challenging to deepen the therapeutic relationship (Levitt et al., 2006).

Due to the young adults' trust issues, the therapist's aptitude becomes critical for building connections with HVYAs in the therapeutic relationship (Almqvist & Lassinantti, 2018).

This requires more than the therapist's good intentions, but also the right match in both demographic background and therapeutic style. Specifically, young adults are not only seeking therapists who understand their struggles but also adopt a therapeutic style they resonate with (Swift & Callahan, 2009). However, achieving this in practice can be difficult.

The therapeutic relationship can be influenced by many factors, including the demographic backgrounds of both the therapist and the client. Disparities or mismatches in demographics such as race, ethnicity, gender, socio-economic status, and cultural background can potentially affect the therapeutic relationship (Sue et al., 2003). A survey by the American Psychological Association (2016) disclosed that the median age of practicing psychologists in 2015 was approximately 56 years. This age discrepancy could sometimes render therapists out of touch with young adults, whose contemporary upbringing is drastically different from previous generations. Other aspects, such as gender compatibility, could also play a significant role in the degree of self-disclosure in therapy for some young adults (Zane & Ku, 2014). Furthermore, not every therapeutic technique is universally applicable. This poses concerns, especially since mental health settings often enforce rigorous protocols surrounding assessments. While the guidelines, protocols, and instruments assist social workers in evaluating and addressing a young person's situation, HYVAs often feel confined to checkbox categories, which tend to emphasize their pathologies and deficits rather than recognizing their distinct experiences and requirements (Jones, 2002). As a result, many young adults view these methodological constraints on social workers as obstacles to establishing a genuine relationship (Abel & Wahab, 2017). A disconnect in therapeutic style can further leave the young adult feeling that the therapy is not beneficial or might even be detrimental (Beutler, 1998; Cabral & Smith, 2011). If HVYAs feel a lack of progress or believe the therapist is not providing the necessary support, they may become discouraged and discontinue therapy (Lambert & Barley, 2001).

Another critical factor that makes HVYAs build lasting supportive relationships with their therapists is the high therapist turnover rate (Abel & Wahab, 2017). Research shows that mental health agencies experience significant turnover rates, ranging from 25% to 50% annually (Aarons & Sawitzky, 2006; Gallon et al., 2003). Such frequent staff changes negatively impact the quality, consistency, and stability of services offered to the already vulnerable young people (Mor Barak et al., 2001; Woltmann et al., 2008; Woltmann & Whitley, 2007). Moreover, these elevated turnover rates can exacerbate clients' distrust in therapy and may deter professionals from remaining in or even joining the field (Mor Barak et al., 2001).

Therapy as a Disempowering Experience. One of the primary limitations of current therapeutic approaches is the feeling of disempowerment that many young adults experience. At their developmental stage, young adults inherently seek autonomy and independence (Goodkind et al., 2011). They aspire to be decision-makers, to assert their preferences, and to be recognized and respected for their individuality. However, within the therapeutic setting, many HVYAs perceive therapists as authoritative figures, which can place them in a subordinate position (Proctor, 2017). This imbalance in the therapeutic relationship can hinder the sense of agency the young adults should ideally feel, as decision-making powers are not equitably distributed between the therapist and the HVYA. Often, young adults do not feel they have adequate input regarding the services they receive or the therapeutic modalities employed (Barton et al., 2012). This dynamic often leads to feelings that their emotions, experiences, or insights are undervalued or outright dismissed. Furthermore, societal or self-perceived stigmas around seeking therapeutic intervention can exacerbate these feelings. Feelings of stigma can transform into feelings of shame and further feelings of disempowerment, creating an additional layer of complexity in their therapeutic journey (Latalova et al., 2014). To address these issues, it is suggested that age-appropriate care for young adults should integrate the collaboration between HVYAs, mental health professionals, and relevant support agencies, including those focused on housing, education, and employment (Patel et al., 2007). In other words, the developmental needs of young adults require them to be active agents at workplaces, not passive recipients of therapeutic services.

A More Positive Angle: HVYA’s Agency and Skills

To address the pressing "national mental health crisis," the American Psychological Association (2020) advocates for the establishment of meaningful support systems, easier access to mental health services, and tailored educational, work, training, and employment opportunities designed specifically for HVYAs. Historically, the focus on understanding HVYAs has been centered on their vulnerabilities and the prevention of retraumatization. Yet, a key characteristic of young adults at their age is their drive to recognize their own strengths and to seek acknowledgment of their autonomy (Munford & Sanders, 2020). As the report suggests, other than receiving therapies, the young adults need to see a constructive path for themselves. A critical aspect of assisting the HVYAs is shifting the dynamic from being passive recipients of services to recognizing them as active contributors in our society.

Due to their vulnerability, particularly in terms of mental health, the capabilities of HVYAs are often underestimated and overlooked. Contrary to common perceptions, many young adults with mental health struggles do cultivate strengths and skills from their adverse experiences. These can include empathy, creativity, advocacy capabilities, acute self-awareness, and problem-solving skills (D’Zurilla & Nezu, 2010; Kaufman & Sternberg, 2010; Rochat, 2023). For example, research found that those who have experienced trauma often show higher levels of empathy toward others in challenging situations (Ong et al., 2006). Female HVYAs in particular are found to display higher levels of empathy and prosocial behavior (Jolliffe & Farrington, 2006). In nuanced social interactions that transpire "in silence," where emotions, thoughts, and intentions are implicitly communicated, adult females typically outperform male (Jolliffe & Farrington, 2006). These traits are even more pronounced when interacting with individuals of their own gender unless the females have autism (Baron-Cohen et al., 2015; Wacker et al., 2017).

Beyond these general capabilities, it is also important to note the specialized skills that vulnerable young individuals develop, such as caring for siblings or other family members (Garmezy, 1993). These skills often stem from their early exposure to challenging circumstances, compelling them to assume greater responsibilities and mature rapidly within difficult family situations (Munford & Sanders, 2021a).

Acknowledging and celebrating the innate strengths of HVYAs can bolster their self-esteem and confidence. Such recognition is not merely an affirmation; it can be critical in therapy and support, redirecting the focus from solely addressing challenges to making use of individual strengths (Smith, 2006). Two notable approaches that align with this perspective are empowerment-oriented practices and Acceptance and Commitment Therapy (ACT).

Empowerment-oriented practices refer to approaches, typically in social work, therapy, and community development that aim to help individuals, especially the highly vulnerable groups to recognize and use their power to effect personal and collective change. Building on their resources and capacities, it is a practice that emphasizes the strengths of individuals and communities, (Lee, 2001; McMackin, 2012).

Acceptance and Commitment Therapy (ACT) is a therapeutic approach that merges both acceptance and behavioral commitment strategies to enhance the HVYAs' coping outcomes. Rather than trying to suppress or alter distressing feelings or thoughts, ACT encourages individuals to accept these experiences and recognize them as a natural part of the human experience. At the same time, it emphasizes the importance of committing to meaningful activities, even when personal challenges are not yet resolved (Hayes et al., 2011).

While empowerment-oriented practices and Acceptance and Commitment Therapy (ACT) intend to recognize young adults' strengths and encourage agency through action, they still maintain the therapist's role as the authoritative figure to direct the young adults to cope with their challenges (Munford & Sanders, 2021a; Strosahl & Robinson, 2017). Moreover, while therapists promote the adoption of a positive lifestyle, they often lack the resources to help young adults forge a foundational identity central to young adulthood - a sense of independence derived from work and financial independence.

Increasingly, researchers began to acknowledge that at their developmental stage, young adults prefer self-reliance over dependence on others (Goodkind et al., 2011; Propp et al., 2003; Samuels & Pryce, 2008). For example, even though new policies allow young adults to remain in the foster care system up to the age of 21, most young adults choose to leave after they turn 18 (Dworsky & Havlicek, 2009). Other than the system constraints, the young adults' choice is heavily influenced by a desire for autonomy and independence associated with adulthood (Goodkind et al., 2011).

Western culture places a significant emphasis on independence, individualism, and personal autonomy, often pathologizing the need for assistance, especially in terms of emotional support (Samuels & Pryce, 2008). For HVYAs, a sense of agency and control is crucial, particularly in the transition from having little to no control, such as during therapy sessions, to actively shaping their life outcomes through work (Barton et al., 2012; Hingley-Jones & Ruch, 2016; Munford & Sanders, 2021a). While these young adults have a strong desire for independence, seeking to demonstrate their abilities and self-sufficiency, they will also grow more receptive to the idea of seeking help from others over time (Goodkind et al., 2011). For HVYAs, the significance of work extends beyond just financial independence; in certain contexts, it offers a deeply emotional reward of acceptance and support that they may have missed during their upbringing (Secrest et al., 2005). By looking at both sides of their needs, the notion of "connected autonomy," which recognizes everyone's need for some measure of self-determination, as well as the importance of relationships, connections, and supports is particularly applicable to HVYAs (Goodkind et al., 2011). The question is, therefore, about how to utilize the overlooked skills and agency in an environment that provides security, meaningful interactions, and empowerment.

After examining the literature on nursing homes, care for seniors with dementia, and support for highly vulnerable young adults collectively, there is potential for highly vulnerable populations to be of service to each other in the context of nursing homes. Intergenerational programs have long recognized the mutually beneficial relationship between the younger and the older generations (Taghian et al., 2019). However, studies on intergenerational programs for those who have mental health struggles are few. One study of this kind discovered that by transferring a group of three-year-olds with low I.Q. from an orphanage nursery to be under the care of older girls at a school for the intellectually challenged, who showed much love and devotion to the children (Skeels & Dye, 1942). Within a year, these young children showed significant gains in intelligence compared to a control group. The researchers attributed this remarkable progress to "a close bond of love and affection" between the two groups with intellectual challenges, as the children had more intense personal bonds with older girls and had greater gains than those being limited to the more general contacts (Skeels & Dye, 1942).

Needless to say, the older girls in this study, despite their age, only possessed an average intelligence equivalent to 10-year-olds and had no professional training as caregivers. Nevertheless, their genuine affection and dedication made a huge impact on the children's mental development (Skeels & Dye, 1942). This raises the possibility that similar positive outcomes might occur between HVYAs and SwD. Given the increasing demand for caregivers in nursing homes, researchers have suggested recruiting caregivers from underrepresented or less active populations (Fujisawa & Colombo, 2009). Nursing homes can, therefore, provide a readily secure environment, an advantage of such institutions. Within this protective setting, the young adults' overlooked abilities and skills can be used to care for SwD. Similar to nurse aides in many aspects, HVYAs may also find an enriching experience that allows them to heal and fulfill their developmental needs in the context of nursing homes.

Chapter 3: Methods

The Phenomenological Variant of Ecological Systems Theory (PVEST) serves as my theoretical framework (Spencer, 1995, 2006; Spencer et al., 1997) for this qualitative research. The theoretical strategy interrogates the coping experiences and socioemotional outcomes of a group of disadvantaged young adults struggling with mental health symptoms; the latter are referred to as highly vulnerable young adults (HVYAs). The ecology of the effort is a renowned care home in the Netherlands.

In this study, I hypothesize that seniors with dementia (SwD), normally considered a social liability and often viewed as unpredictable and disruptive, support these young adults' socio-emotional functioning, symptom recovery, and growth. At the same time, nursing home staff members, who are expected by the management team to provide support to these HVYAs may communicate psychological challenges to youth. Specifically, they may communicate sources of risk that lead to the young adults' maladaptive coping methods. Nevertheless, in this coping process, the young adults receive sufficient support from SwD, which outweighs the stress created by staff members. As a result, the hypothesis was that HVYAs developed productive coping outcomes through assisting the seniors with their well-being.

Ethnographic methods used in this study include interviews and observations. In total, more than 50 interviewees across various positions at the nursing home were included in the study. The data collected was analyzed using a grounded approach and MAXQDA, a software widely used for analyzing qualitative data.

Theoretical Framework

The Phenomenological Variant of Ecological Systems Theory (PVEST) (Spencer, 1995, 2006; Spencer et al., 1997) is an ideal theoretical framework for this study. Developed by Dr.

Margaret Beale Spencer, PVEST represents both an inclusive and process-oriented human development framework (Spencer, 2008). With an emphasis on understanding the perceived experiences of highly vulnerable populations in multi-layered individual-context interactions (Spencer, 2008), it is particularly effective for understanding this group of young adults' coping experiences. In addition, PVEST offers insights on how to engage the needs of young people from a strengths-based, rather than deficits-centered, frame of analysis (Lodato et al., 2021). With its emphasis on exploring processes and explanations that potentially inform constructive change (Spencer, 2008), the theory also allows the study to examine the implications of its findings.

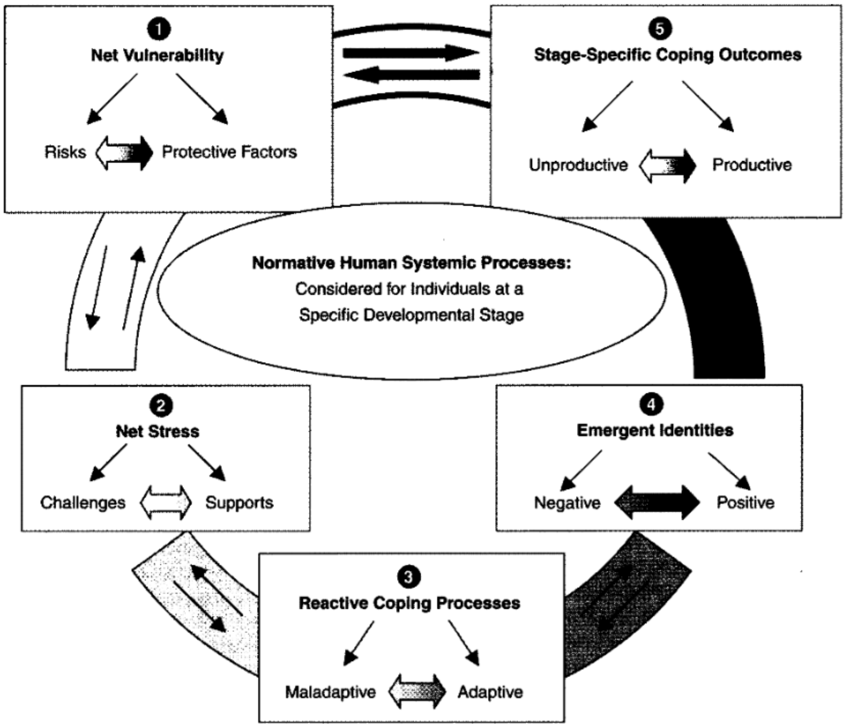

Figure 1. PVEST (Spencer et al., 2006)

Specifically, following Spencer's (1995) PVEST (Figure 1), five main research focuses are developed to describe the HVYA's complete coping experience in chronological order. The research questions, therefore, focus on the well-being buddies' *net vulnerability* (Status 1), *net* *stress* (Status 2), *reactive coping processes* (Status 3), *emergent identities* (Status 4), and *stage-specific coping outcomes* (Status 5). These research focuses serve to guide the design of observations and interview questions (see Appendix). According to Spencer and her colleagues (2006), *net vulnerability* consists of the contextual and personal characteristics that can potentially pose challenges during an individual's development. In this context, it represents questions on an HVYA's risks and protective factors, as well as symptoms requiring coping. It needs to be mentioned that these young adults suggest a high vulnerability status because they face severe risks with little protective factors available either at work or home. *Net stress* refers to the actual experiences that challenge an individual's well-being, which requires social support (Spencer et al., 2006). In this research, it is critical to understand what challenges and supports the HVYAs identify, as well as how they describe their experiences. I hypothesize that the HVYAs' understanding of *Net Stress* is very different from those identified by others (e.g., managers), who tend to overlook the support from seniors. *Reactive Coping Processes* represent problem-solving strategies one adopts to resolve dissonance-producing situations (Spencer et al., 2006). To an HVYA, adaptive solutions allow her to face challenges and maintain a high work ethic, while maladaptive solutions are those that make her avoid challenges or result in more difficulties in the long run. Questions for this status will explore what solutions the HVYAs tend to use more consistently and why. Over time, coping processes shape an individual's sense of identity, which is represented as *emergent identities* in PVEST (Spencer et al., 2006). This requires an HVYA to develop stable coping responses, which define how the self is perceived both in and out of the nursing home. Specifically, I intend to explore their perceptions of themselves, and how that has changed over time. As coping outcomes (Status 5) are life-stage-specific, this research also aims to understand their life course implications to the HVYAs (e.g., pursuing higher education).

Other than capturing the HVYAs’ perspectives in this coping process, PVEST also recognizes the importance and complexity of the context (e.g., the seniors and staff members) (Spencer 1995, 2006). While the young adults are the main informants in this research, data from other informants serve to provide a thorough description of the context at the nursing home, as well as supplement the young adults’ narration and explanation of their experiences. For example, a notable change of context is the drastic changes inside the nursing home evident from 2019 to 2021. Considering the scale and complexity of the change (e.g., resignation of important staff members and further dissensions that ensue), data from the HVYAs alone are not sufficient to interpret the changes and their implications. It is, therefore, critical to include other informants holding various positions to construct the complex ecology at the nursing home, which explains the significance of the overlooked intergenerational relationship.

Research questions

The overarching research questions of this study are: *What are the coping experiences of a group of highly vulnerable young adults (HVYAs) employed to improve the well-being of seniors with dementia (SwD) in a nursing home environment*? To comprehensively understand this complex coping experience, the study dissects it through three key themes: the nursing home context, the SwD at the nursing home and the care they receive, and the experiences of the young adults perceived from their angle.

The study employs ethnographic methods to delve into several critical questions. The first set of inquiries focuses on the unique aspects of the nursing home as a workplace, which significantly differs from conventional work environments like restaurants. Taking place at a renowned nursing home in the Netherlands, the study asks what the characteristics of a nursing home are as a work environment. This involves examining the broader picture of the nursing home industry, such as its challenges, needs, and ongoing major transitions. Understanding changes in the context, notably the demographics and care approaches, is crucial to comprehending the young adults' coping experiences in this unique setting. By addressing related questions, the study seeks to uncover the ecological system within the nursing home that facilitates the intergenerational relationship between HVYAs and SwD.

Questions aimed at unraveling this context, therefore, include: *What challenges do nursing homes face*? *What are the emerging trends within the nursing home industry*? *Which population represents an untapped resource that can help address these challenges?* This exploration leads to the consideration of SwD, whose increasing numbers have significantly altered the demographic landscape within nursing homes.

The second set of questions in this study centers on seniors with dementia (SwD). The underlying hypothesis was that SwD unexpectedly act as a source of support for the highly vulnerable young adults (HVYAs), significantly influencing their choice of adaptive coping processes. Despite the inherently challenging nature of the job and their vulnerabilities, this support from SwD is believed to contribute to the young adults' productive coping outcomes. The pertinent questions are: *Compared to their mentally healthy counterparts, what are the distinctive characteristics of SwD? What kind of services do they typically receive? What distinct role did the HVYAs play in dementia care at the nursing home?*

Current research has begun to focus on the agency of SwD; however, this study also seeks to uncover whether there are positive aspects of SwD that have been previously overlooked.

Once the context of the nursing home and the characteristics of SwD are unfolded, the study aims to capture the perspectives of the HVYAs within this setting. Key questions involve:

Who are the HVYAs and what make them highly vulnerable? *What do their coping experiences and outcomes look like, as analyzed through the lens of the Phenomenological Variant of Ecological Systems Theory (PVEST)*?

By addressing these questions, this study intends to unravel the mechanisms underpinning the mutually beneficial relationship between HVYAs and SwD. It aims to understand the implications of this relationship for vulnerable populations and the nursing home industry. Should the study validate that the HVYAs' productive coping outcomes are indeed fostered by their unique work context, and the support received from SwD, it would imply that such environments can transform perceived social liabilities into valuable social assets. This revelation holds significant implications for both academic literature and practical implementations in caregiving settings.

Context of Study

HCare (pseudonym) was chosen as my field site because, before the pandemic, the nursing home enjoyed a worldwide reputation for its intergenerational living program, which attracted professionals across the globe to learn from them. As my research deepened, the context unfolded itself, becoming more complex, and requiring detailed study and explanation.

The Fieldsite: HCare

HCare is located in a small industrial city in the eastern part of the Netherlands. Built in 1963, it was originally part of a national project encouraging retirees to live collectively. As a result, the number of care facilities increased rapidly across the country. Currently, the city has more than 15 nursing homes, which are mostly managed by large organizations. HCare, however, remains to be one of the few public nursing homes that operates independently. On the one hand, this gives the nursing home, especially its chief executive officer (CEO), more flexibility in decision-making. On the other hand, the nursing home has fewer resources than other nursing homes to cope with difficult situations (e.g., shortage of nurses).

The Dutch population is aging rapidly, which is reflected in the demography at HCare. Considering the limited capacity of its nursing homes, the Dutch government introduced a policy in 2012 that only seniors who have lost their ability to live independently, and thus need round-the-clock care can be admitted as new residents. As a result, compared with 20 years ago, the percentage of senior residents who struggle with mental and physical problems increased significantly at the nursing home. The positive side is that since the government pays the care home based on the level of needs of each senior resident, the nursing home makes more profit serving these seniors. Currently, the nursing home's 160 residential units are fully occupied, and the care home is considered financially "healthy" by its chief financial officer (CFO).

In 2020, HCare was among the most sought-after care homes in the city with a long waiting list. After the new CEO introduced its first intergenerational program in 2012, the care home acquired a worldwide reputation. Journalists, government officials, and professionals in the industry from across the globe came to the nursing home to learn about administrative practices and residents' experiences. It also needs to be mentioned that the CEO welcomed researchers and those interested in their innovation. For example, researchers were allowed to stay in the guestroom for a reasonable price before the pandemic, which shows a rare hospitality among care homes. Other than its fame, HCare is also appealing for more practical reasons. It is only a 10-minute drive from the city center and is close to a shopping mall and a park. In addition, thanks to the liveliness provided by its intergenerational programs (to be introduced in the following section), HCare is often described as a nursing home that has a lively atmosphere, which "doesn't feel like a nursing home."

The context of the nursing home, however, started to change in 2020. Its management team shrank significantly, and for the first time in 10 years, the nursing home started to experience a shortage of nurses, which is often used as an indicator of the staff's level of satisfaction. Despite these difficulties, the CEO is still in charge, and the intergenerational programs remain. Although the future of the care home is uncertain, its intergenerational programs still make it a distinctive facility, setting it apart from others.

Description of Informant Groups within the Nursing Home

For clarity, members who form the ecology at this care home are divided into three main categories: senior residents, staff members, and participants in intergenerational programs.

Senior Residents. The care home's 160 senior residents are mostly former blue-collar workers or housewives who lived their entire lives in the province. According to the current government policy, only seniors who need round-the-clock care can live in public care homes. As a result, the average age of the residents at HCare is 83. They are predominantly females and more than 80% of them have dementia. To serve the seniors who have late-stage dementia, the care home has two dementia floors serving a total of 30 seniors. Their behaviors vary depending on the individual and his/her stage of dementia, but unless accompanied by someone, their activities are limited within the dementia ward. The seniors who do not live inside the dementia ward have more freedom, but most choose to spend most of their time inside their rooms. Unless outside stimulations are present, they are either reluctant or unable to initiate social activities.

Seniors with dementia are no longer capable of forming a clear train of thought to participate in interviews. Therefore, I only recruited seniors who were mentally clear as my informants during my preliminary research in 2019. These seven informants I had were among the most active and experienced seniors at the care home, who had lived at the care home for over five years before the government policy changed. My questions at the time focused on their life experiences and level of satisfaction at the care home, which was critical for me to understand the demography and changes inside the care home over the years. However, they know little about the intergenerational programs, particularly the well-being buddies.

The care home has more than 300 staff members and volunteers. For this research, the staff and volunteers are divided into three categories, namely the management team, staff members, and nurses.

Management Team. In this context, the management team includes managers, and assistant managers, who represent the decision-makers who can affect the young adults' coping experience either directly or indirectly. Most members in this group are over forty-five and completed college-level education. In 2019, the care home had five managers and more assistant managers. For various reasons, including the upheaval caused by the pandemic, four of the managers left the nursing home by 2021.

Staff Members. In this study, 'staff members' refer to individuals employed at the nursing home, either on a full-time or part-time basis, occupying a range of roles such as job coaches, nurses, psychologists, receptionists, janitors, and kitchen staff, but do not decide the policies implemented at the nursing home. They come from diverse backgrounds, but the majority have been with the nursing home for more than two years and reside either in the city or the suburbs. Apart from the two job coaches, the informants from this group often did not work directly with the disadvantaged young adults. Nonetheless, their varied work experiences and positions afford them a comprehensive understanding of the nursing home's context, an aspect often not fully grasped by HVYAs.

Among the staff members, nurses, particularly those who work directly with the disadvantaged young adults played an important role in the latter's coping experience. At this nursing home, most of the nurses are over forty, and with a few exceptions, they are predominantly females with a two-year diploma in nursing. Their duty is to take care of the seniors' physical health, including getting them dressed, bringing food to their rooms, administering medication, maintaining accurate and detailed records, and assisting the seniors in getting up and going to bed. In the U.S., these tasks are typically performed by nurse aides, who often come from disadvantaged backgrounds with limited professional training (Castle et al., 2020; Edwards, 1997). Although nurses in the Netherlands do not share the same demographic characteristics, they face many similar workplace challenges as nurse aides. For instance, at HCare, a single nurse is frequently required to manage the daily needs of at least five seniors, keeping them constantly busy and engaged. In 2019, the care home was not short of nurses, but the situation started to change in 2020. Considering their heavy workload, the nurses believe they are underpaid and underappreciated. Their attitude toward work undoubtedly affects their relationship with the HVYAs. As a group, the nurses were friendly toward me but showed little interest in my research or HVYAs' well-being. Some nurses initially agreed to participate in my study but later withdrew. The excuses given to me were either a lack of time or a lack of confidence in their English proficiency. Overall, it was challenging for me to recruit nurses as my informants.

Participants in Intergenerational Programs. The care home has three intergenerational programs for young adults between 18 and 35: the Student Residents Program, The Neighborhood Program, and the Well-being Buddies Program. In this study, more than half of the HVYAs interviewed were form the Well-being Buddies Program.

The Student Residents Program. Student residents formed the first intergenerational program at the care home in 2012, which was the year when the current CEO took her position at HCare. The purpose of the program was to bring more liveliness to the care home, which was filled with “low energy,” as one manager described. In exchange for living at the care home for free, a student resident is expected to spend at least 30 hours of quality time with seniors at the care home every month. No manager evaluates these activities, and the students have complete freedom to choose with whom they want to spend time. At a given time, six full-time college student residents live at the care home. Most of them had no mental health symptoms and preferred to bond with mentally healthy seniors. When a student resident’s full-time student status ends, he/she is expected to leave within half a year. Since the program started, more than 10 students have participated in the program, and their stay varies from half a year to five years. Among my informants, the average of their stay is two and a half years. They are not my main informants because, according to most student residents, their experiences at the care home were not considered critical to their personal development. As several of them acknowledged, their primary benefit from residing in the care home was the advantage of living there independently without incurring any cost.

The Neighborhood Program. After the Student Residents Program, the care home officially started another program in 2016, which aimed at assisting young adults who are unable to find work due to serious mental health struggles, such as autism. In this study, the program itself is referred to as the “Neighborhood Program,” as participants in this program were provided government housing across the street from the nursing home. The program was designed to have six members at a given time. Most of the members in this program are male in their 20s and have multiple symptoms such as autism, ADHD, and PTSD. As a result, they normally prefer taking positions that require little social interaction, such as doing laundry, washing dishes, and collecting trash. Therefore, in this study, they are referred to as “facility workers.” Initially, I considered including these young adults as my main informants and the well-being buddies. However, as my research deepened, I realized that their coping experience was not as consistent as their female counterparts. For example, despite their overall positive attitude toward the program in 2019, some became unsatisfied with the nursing home in 2020. By by early 2021, less than half of my informants from this group remained in the program. Considering the complex nature of their symptoms and uncertainties in their coping outcomes, I did not have these young adults as my main informants. Nevertheless, they still offered an important perspective to understand the context, and how disadvantaged young adults were treated at the nursing home.

The Well-being Buddies Program. In 2019, this nursing home launched its third intergenerational program, which aims at improving the well-being of seniors with dementia (SwD) through individualized services provided by young adults. The original plan for the program was to recruit six young adults who exhibit mental health symptoms annually. The recruiting process, however, was disrupted by the pandemic in 2020 and 2021. As all the young adults expressed a desire to continue their work with the seniors, the nursing home extended their contracts, allowing them to work for a longer period. Although often referred to me colloquially as "youth" or "youngsters," their ages range from 18 to 35. Each participant dealt with multiple mental health issues, including depression, anxiety disorder, obsessive-compulsive disorder (OCD), attention-deficit/hyperactivity disorder (ADHD), and post-traumatic stress disorder (PTSD). Most of them only had a high school education and little work experience. They were typically referred by government therapists to work at the care home because they could not find jobs elsewhere.

The well-being buddies were hired to improve the seniors' emotional well-being, a task the nurses did not have time for. Unlike the facility workers, these young adults did not have autism and wanted to work with people. By answering to the seniors' needs, the buddies' jobs included but did not limited to going for a walk, having a conversation, and shopping together. Depending on the needs of the care home, each well-being buddy worked at an assigned floor, which can be the dementia ward, standard service floors, or the kitchen. Before working at this care home, none of the buddies had previous experience working with mentally challenged seniors. The buddies were expected to learn the work by shadowing another buddy or nurse, but no structured training is provided. Other than a job coach who checked their work performance regularly, no therapists or nurses were assigned to support them. In the dementia ward, it was common for one buddy to provide service to five seniors on their own. In addition, the administrators did not show particular interest in the buddies' performance or coping experiences. The former rarely came to the buddies' working area, and no direct means of communication was established between the two. Therefore, it was a part-time job that often required a buddy to work with several seniors simultaneously and handle difficult situations (e.g., seniors' disruptive behaviors) singlehandedly.

Highly Vulnerable Young Adults (HVYAs). In this research, the primary informants are six highly vulnerable young adults (HVYAs), who were selected for their involvement in caregiving roles at a nursing home. The small sample size is largely due to the disruption caused by the pandemic. When the Well-being Buddies program launched in 2019, it initially did not have six members. The recruiting process was then disrupted by the pandemic. Additionally, considering the vulnerability of the young adults, I had to be introduced to them through their job coaches. Due to the pandemic and the added stress on the job coaches, I was not introduced to as many HVYAs as I had hoped. However, given the size of the program, I will have no more than nine informants.

Four of these HVYAs were actively participating in the Well-being Buddies Program, where their primary responsibility was to work in dementia wards, closely assisting seniors with dementia (SwD) in enhancing their well-being. The other two HVYAs did not work in the dementia ward, but worked closely with SwD either in the kitchen or on the standard service floor. Like the Well-being Buddies, they identified the same sources of support and challenges, as well as similar coping outcomes.

Given the risks (e.g., mental health symptoms) faced by the HVYAs and their lack of structured support at the nursing home, they represented a highly vulnerable population that struggled to develop positive coping outcomes without adequate support (Spencer et al., 2006). In my initial interactions with some of the HVYAs, I was both impressed and intrigued by their reported positive coping experiences and outcomes, as well as their clear recognition of seniors with dementia as a crucial source of support.

During my research trips, I found the HVYAs' positive coping outcomes consistent over the course of three years. Individually, they attribute their positive experiences to the same source of support: seniors with dementia, which is regarded by the staff members (e.g., the management team) as being particularly challenging. It also needs to be mentioned that the young adults' positive coping experiences took place during a time when the care home itself is regarded as a "toxic" environment, which further illustrates the significance of this unexpected intergenerational relationship.

Before this research, no in-depth study had been conducted to understand the relationship between HVYAs and SwD in the context of a nursing home. Additionally, unlike the student residents who received much more public attention from journalists, the hardworking HVYAs remained in the background and were relatively unknown.

Research Design

Using Spencer’s (1995, 2006) PVEST as my framework, this qualitative research is designed to understand the HVYAs’ subjective coping experiences working at HCare, supplemented and triangulated by information from other informants.

Qualitative research is designed to capture participants’ subjective experiences and meaning-making processes while providing detailed descriptions and flexibility that allow theories to emerge (Power et al., 2018). It is ideal for this study, as it tries to explore the phenomenological experiences of a small population in a particular context. Conducting a quantitative study was not feasible due to the small sample size and the complexities of the young adults' symptoms, making related information unrealistic to quantify. By using ethnographic methods, namely interviews, and observations, I conducted the study by situating myself in their ecosystem. These methods were feasible because most Dutch people speak English fluently, especially those under 40. In 2019, the care home assigned a student resident to help me translate during my interviews with the senior informants. Besides the seniors, I could communicate with most of my informants directly using English.

Recruitment of Interviewees

Interviews are the primary source of my data, enabling me to delve deeply into the dynamics of the nursing home context and the experiences of the informants within this setting. For this study, I recruited over 50 interviewees (see *Table 2* on the next page), holding various positions at the nursing home to ensure a comprehensive understanding of the context. While I aimed to include informants from diverse positions, it was crucial to track and observe the evolving dynamics and experiences by conducting multiple interviews with a select group of particularly insightful interviewees each year of my fieldwork. Even though some staff members and volunteers did not know the HVYAs in person, their data helped both contextualize the study and validate the information gathered from the HVYAs. Their contributions were key to triangulating and enriching the understanding of the dynamics at play in the nursing home environment.

Interviewee Positions	**Numbers Recruited**
Senior residents (mentally clear)	7
Management team, including assistant managers	6
Frontline staff (including both full- and part-time non-management staff) and volunteers	23
Participants from the Intergenerational Programs	15
Total	51

Table 2. Interviewee Positions and Numbers Recruited

Considering their high vulnerability, HCare required me to have a job coach's consent before recruiting an HVYA. The two job coaches' main responsibility was to make sure the HVYAs fulfilled their duties at work. Therefore, they were familiar with the buddies' comfort level with strangers, which was a critical indicator of whether they are suitable of participating in my research. After getting the HVYA's consent the coaches would send me the HVYA's contact information, normally a phone number. With the contact information, I still had to establish a connection, often on my own. I would normally introduce myself first through text messages, then invite the person to have coffee or tea together. The purpose was to provide an opportunity for us to get to know each other, so I could have opportunities to shadow them at work.

Even though I tried to recruit as many HVYAs as I could, the sample size remained very small. The biggest challenge came from the pandemic, which limited the number of HVYAs that could participate in the intergenerational program. Initially, participants in the Well-being Buddies Program only had a one-year contract. The expectation was that the young adults would recover within that period of time, and the program would recruit another group of young adults the following year.

This process, however, was interrupted by the pandemic in 2020. Instead of recruiting more young adults, their contracts were extended. While the young adults welcomed the change, which enabled me to conduct a long-term study tracking their coping experiences, the number of HVYAs I could recruit was capped at nine. In addition, the pandemic brought unexpected upheavals to the nursing home. As a result, the support I was supposed to receive for recruitment and my access to the nursing home became limited. In addition, it took time to have some HVYAs participate in my study. Due to their symptoms, it was critical to keep the recruitment process voluntary – I never added any pressure to the HVYAs. It was only after we were on friendly terms that I asked for their participation. Therefore, even though I already knew some of them since 2019, I was not able to conduct interviews with them until 2021.

Recruiting staff members and student residents had fewer barriers as I did not need to acquire permission from the management. In addition, some of them were more comfortable with researchers like me. Similarly, mentally clear seniors participated in my research willingly. However, the number of this group was limited, and I realized that they had little knowledge of the HVYAs, as the latter mostly worked with SwD.

Regarding ethical considerations, the informants were notified that the data collected was only to be used for my thesis. It would not be shared with others, and I did not explore sensitive or personal information from third-party sources. No one felt uncomfortable or triggered during my interviews. I also informed my interviewees that if they no longer felt comfortable sharing the information, I would erase the recording and communicate with the informant to make sure his/her interests were protected. Furthermore, pseudonyms are used in all my notes and the data (including the recordings), which will be saved to Chicago Box, a cloud-based encrypted storage service.

Data Collection

Data collection in this research was conducted through interviews and observation. It was approved by the Institutional Review Board (IRB) as an amendment and continuation of my trial research in 2019 (IRB19-0946-AM001).

All interviews were semi-structured using open-ended questions (see Appendix), which allows the informants to divert and elaborate on the points they consider important. Due to their differences, the interview questions will be tailored accordingly. Therefore, the interview questions attached as the Appendix only provided a guideline of the topics explored, but do not represent the exact questions asked. Before the interview started, I went over the necessary protocols, which informed the informant about the focus of the questions, his/her rights to pause the interview, and the usage of the data collected. In this case, it is strictly for my study and will not be published anywhere. After getting the informants' consent, I recorded the conversation using a digital voice recorder. A typical interview lasted from an hour to an hour and a half. With some key informants, especially the HVYAs, I had multiple interviews to acquire a comprehensive and long-term understanding of their experiences. For the informants' privacy and convenience, the interviews took place at the informant's preferred location, which guaranteed that we would not be interrupted. The recordings were saved to UChicago Box, a cloud-based encrypted storage service under pseudonyms.

Other than interviews, I also used observations to understand the informants from different angles, which served to supplement and triangulate their responses. Specifically, I collected data on the seniors' everyday behavior (e.g., wandering) and their interactions with the HVYAs. The seniors' behaviors were recorded, categorized, and described regularly to lay out the context of the HVYAs' work environment. Data collection often took place when I worked alongside the HVYAs in different settings, such as the dementia ward, kitchen, or dining hall. Initially, the data was manually recorded in a notebook during the observation phase, and subsequently transcribed and stored in digital format. In addition to serving as data, this information informed the design of interview questions. Some of the data, such as the HVYAs' experience leading board games were be shared during interviews for verification and elaboration. Like the interview data, I did not share or report my observations to the management team. Therefore, my presence did not add any pressure to the informants or affect their performance.

Analytic Design

In this research, data analysis included four stages. The first stage was incorporating data into MAXQDA, a data analysis software with versatile analytical functions (Saldaña, 2013). Before doing that, interview data was transcribed verbatim and organized by data sources. Individual files were created for each interviewee, which included both interview and observation data directly related to the interviewee. After the data collection was completed, these codes were analyzed again and recoded to adapt to new research questions.

The second stage of analysis was open coding, which aimed at organizing raw data into concepts (codes) that are meaningful to the research questions. In qualitative research, codes are expressions (either a single word or short sequence of words) used to name and describe certain information (Charmaz, 2014). Following a grounded approach, the coding process allows themes and arguments to emerge from data (Tavory & Timmermans, 2014). For this stage, I used an inductive approach to produce a wide variability of codes, particularly those that represent shared experiences across different data sources and are relevant to answering my research questions. For example, when an HVYA helps a senior calm down by going for a walk, I used “calming walk” as the code. If a buddy can calm down a senior by playing a board game together, the code was “calming board game.” This process was conducted for every transcript, and passages of the same content used the same code.

In the third stage, codes from the same data source were merged or categorized to form subthemes, which were used to construct the buddies’ coping process demonstrated by PVEST (Spencer et al., 2006). Therefore, the subthemes were designed to answer the research questions with the coping process in mind. The two codes “calming walk” and “calming board game,” for example, are similar because they demonstrate the buddies’ ability to turn difficult situations into positive experiences. These codes therefore belong to the same subtheme of the “adaptive coping process” from Stage 3. This process was repeated to capture all the subthemes in every transcript.

The last stage of data analysis was organizing these subthemes under PVEST to construct the young adults’ contextualized coping experiences. The young adults’ adaptive coping processes, for instance, were part of Status 3. Together with codes from maladaptive coping processes (the other subtheme in Status 3), it provided a complete picture of the HVYAs’ Reactive Coping Processes (Status 3). Following a similar procedure, all the codes were merged into subthemes and then incorporated into PVEST from Status 1 to 5 (Spencer et al., 2006). Considering the complexity of all the data sources, this process above was repeated several times until a thorough and objective understanding of the HVYAs’ coping experience and outcome were fully captured.

The goal of constructing the coping process was to provide a clear and detailed demonstration of the HVYAs’ experience at the nursing home from 2019 to 2021. Through understanding how the HVYAs achieved positive coping outcomes with support from an unexpected source, this research aimed at providing a news lens to understand highly vulnerable populations and innovative suggestions for effective intervention.

Chapter 4: Findings

This chapter addresses the overarching research question: *What are the coping experiences of a group of highly vulnerable young adults (HVYAs) employed to improve the well-being of seniors with dementia (SwD) in a nursing home environment*? Acknowledging one's vulnerability while emphasizing factors that foster resilience, the Phenomenological Variant of Ecological Systems Theory (PVEST) provides an ideal theoretical framework for developing a comprehensive understanding of the coping experiences of highly vulnerable populations within a multi-layered context, utilizing their own perspectives (Spencer, 1995, 2006; Spencer et al., 1997).

The study begins by outlining both the general characteristics HCare share with the rest of the industry and its unique approaches to answer the following questions: *What challenges do nursing homes face*? *What are the emerging trends within the nursing home industry*? By examining its intergenerational programs, *Which population represents an untapped resource that can help address these challengs*? Notably, despite the challenges brought about by the pandemic, HVYAs demonstrated a remarkable commitment to the seniors, consistently reporting positive experiences in their interactions with a population often perceived as challenging.

Subsequent inquiries delve into the nature of the SwD at HCare: *Who are the SwD*? *What kind of services are provided to them*? Most importantly, *how did they define the young adults' work experience*? The research uncovers that the involvement of HVYAs significantly alters the conventional institutionalized care approach. Contrary to expectations, the HVYAs found the SwD to be a major source of support, which positively influenced their coping experiences. In contrast, staff members were seen as a source of challenges that made their coping experiences more difficult.

The initial hypothesis—that SwD play a crucial role in fostering HVYAs' positive coping mechanisms—is therefore substantiated by the young adults' experiences. The evidence points to a mutually beneficial relationship between the two groups within the nursing home environment. The HVYAs' resilience is context-specific, and SwD plays a critical role in it.

An Intergenerational Approach to Person-centered Care

HCare (pseudonym) served as an ideal research site due to its combination of typical and unique characteristics. Like many other nursing homes, it faced the challenges of a high proportion of seniors with dementia (SwD) and the need to transition to person-centered care (PCC). However, HCare distinguished itself with its positive atmosphere, significantly bolstered by its diverse intergenerational programs. During the pandemic, as the nursing home faced a high turnover rate and support for the HVYAs waned, their commitment to the well-being of the seniors prompted them to stay. This blend of typical challenges and unique approaches to PCC made HCare a valuable case study for examining the dynamics of nursing home care and the potential of intergenerational programs.

HCare and Its Needs for Transition

The Netherlands is known for being at the forefront of innovations in the care industry (AARP International, 2017). Among the many groundbreaking concepts, such as neighborhood care (Buurtzorg) and dementia villages, HCare's intergenerational approach gained global attention before the pandemic. Its intergenerational model was reported worldwide and drew the interest of researchers, journalists, and nursing home executives (AARP International, 2017). When I arrived at the nursing home in 2019, I came to understand why HCare had gained such a remarkable reputation. As one of my interviewees described, the nursing home was "full of life." Unlike other nursing homes I had visited, there was a constant flow of people in the bustling hallways, exchanging smiles and greetings. Most of the seniors had to use walkers to move about, but they appeared positive and content. It was no surprise that all my informants agreed that HCare was "a nursing home that doesn't feel like a nursing home."

First built in the 1960s, it is difficult to imagine how much change has taken place in HCare over the past 60 years, reflecting the transformation in the care industry. The nursing home itself appears unremarkable, located in a small city in the east, being the less developed part of the country. It is a typical example of a medium-sized nursing home, functioning independently but receiving government funding to serve 160 working-class retirees. It was part of a national project after the Second World War when the country aimed to create space for new businesses and the younger generation. Being a relatively new concept then, it was also the first time nursing homes were built on a large scale in the Netherlands. When HCare was built in 1963, retirees were encouraged to move to nursing homes while still mentally and physically healthy. During that time, a high percentage of seniors in nursing homes were able to take care of themselves. However, since the early 2000s, the situation in nursing homes began to change. As the Netherlands aged at a rapid rate, the overall capacity of nursing homes could no longer keep up with the growing number of seniors. In 2012, the national policy changed, and new residents can only be accepted in public nursing homes if they have physical or mental illnesses that prevent them from living on their own. At HCare, for example, the most notable change was the high concentration of senior residents with dementia. By 2021, the number had already risen to more than 80%, which was believed to be much higher than before 2012. According to experienced staff members, the number of seniors who were able to take care of themselves dropped from more than half to around 10 within a decade, which is becoming the new norm across the industry. As the older population continues to grow in the Netherlands, the percentage of seniors with dementia is expected to remain at this level, if not higher, in the next 30 years.

Amidst these drastic changes in the residents’ demographics at nursing homes, the nature of care had to change accordingly. The conventional model of care matched seniors' problems and needs with existing services, primarily focusing on physical health assistance (Oppert et al., 2018). Like other nursing homes in the Netherlands, the service HCare could provide was largely dependent on its nurses. Back when senior residents at the nursing home were more capable, nurses only assisted them when necessary, leaving ample time for social interactions to address their emotional needs, which were not considered a priority. However, as the percentage of seniors with dementia and comorbid conditions such as cardiovascular diseases, diabetes, and osteoporosis increased, they require more direct care but are less capable of initiating meaningful interactions (Biessels et al., 2006; Chang et al., 2014; Panza et al., 2010). With the substantial demographic changes in the nursing home, nurses can no longer balance emotional and physical care, as the demand for the latter has become much heavier. Simultaneously, the social circle of SwD is very limited, as it is typical for SwD to receive fewer visits from friends and family than their mentally healthy counterparts (Poey et al., 2017; Taylor, 2008). Consequently, the seniors' well-being has become almost entirely dependent on increasingly occupied caregivers in nursing homes.

In response to the changing needs of seniors, person-centered care emerged as the new culture of care in the industry (Edvardsson et al., 2014; Fazio, Pace, Flinner, et al., 2018; Kontos & Naglie, 2007). Person-centered care (PCC), also known as patient-oriented care, can be generally described as an approach that prioritizes the individual, especially the emotional well-being at the center of care (Colomer & de Vries, 2016, Mead & Bower, 2000). While many nursing homes attempt to transition to PCC, the main providers of care remain the same, namely the preoccupied nurses (Kindy et al., 2005; Tellis-Nayak, 2007). As the overall context of nursing homes changed, the transition to PCC meant a heavier workload for nurses. At HCare, nurses had to give up quality time with seniors as more seniors needed assistance. To make the situation more difficult, the volunteering culture in the Netherlands is disappearing. Previously, as informal caregivers, volunteers were an important complement to the nurses' work, playing an essential part in the residents' social lives. At HCare, for instance, before 2015, the nursing home had over 300 volunteers, primarily comprising young retirees from the neighborhood. They dedicated their time to spending quality moments with the older seniors, as community service used to be part of the Dutch tradition. However, according to the volunteer supervisor, as these volunteers aged and had to move to nursing homes themselves, the number of regular volunteers at HCare declined to around 150 in 2019. Finding replacements was difficult, as the younger generation did not hold the same values as their predecessors. In addition, after the aged volunteer supervisor had a stroke in 2020, her position at HCare was not filled. Instead, her responsibilities were divided among the managers, who lacked relevant experience in working with the volunteers. Consequently, due to the lack of caregivers and their time, nursing homes like HCare had to focus on the basic physical needs of seniors. At HCare, there is a widely held belief that overlooking the emotional well-being of seniors can lead to increased conflicts between them and the nurses. This results in a vicious cycle typical in nursing homes, such as nurse burnout, compassion fatigue, more conflicts with seniors, nurses quitting their jobs, leaving other nurses to work extra hours, and their eventual burnout (Moyle et al., 2003). The challenges faced by nurses in nursing homes ultimately lead to a decline in the quality of care and well-being of senior residents.

Due to the shortage of nurses and difficulties in retaining them, Dutch nursing homes have been exploring solutions such as merging to form larger organizations, as one manager explained to me. By 2019, most nursing homes in the country operated in this manner. As a result, it is common for multiple nursing homes in a city to be under the same management, despite having different names. However, the overall nursing shortage persists, leading to difficulties even in providing routine-based care. During my visits to other nursing homes in the city, it was evident that some facilities lacked vitality due to a shortage of caregivers, and the odor of urine was noticeable in some seniors' rooms. Therefore, the presence of an adequate number of nurses in a nursing home is considered a crucial indicator of its quality of care and the length of its waiting list for seniors seeking admission. Since public nursing homes primarily rely on government funding, their ability to provide quality care and maintain a positive reputation directly impacts their financial stability.

HCare, like many other public nursing homes, faced similar challenges but opted to remain an independent entity with a single location. This decision has its pros and cons. While HCare may lack the support of larger organizations, it enjoys the autonomy to implement changes more efficiently, such as bringing in more “caregivers” by introducing intergenerational programs. In contrast, as their managers told me, larger organizations formed through mergers may benefit from mutual support but often struggle with cumbersome organizational structures and are less willing to enact changes. The independence of HCare was thus a crucial factor in fostering a positive work environment that retained nurses and positioned it as one of the most sought-after nursing homes in the city.

Implementation of Intergenerational Programs

What truly sets HCare apart from other nursing homes is its commitment to creating a person-centered environment characterized by warmth and inclusivity, actively welcoming visitors and integrating individuals from diverse backgrounds. The pivotal moment in the nursing home's trajectory occurred in 2012 when a new CEO, a nursing professional, assumed leadership with a clear mandate to revolutionize the approach to PCC. Rather than isolating seniors, she envisioned a respectful and inclusive environment where residents felt seen and valued. Despite facing resistance from the management team, the CEO remained steadfast in her vision, leading to significant changes including the termination of five out of six managers who opposed the transformation. Additionally, the introduction of receptionists to greet visitors and well-being officers to assess residents' quality of life, though uncommon in Dutch nursing homes due to cost concerns, became integral to HCare's operations.

However, perhaps most notably, HCare gained renown for its implementation of three intergenerational programs within a span of six years, further enriching the lives of its residents. The initial program, known as the Student Residents Program started in 2012. It offers a free unit to a full-time college student who, in return, needs to spend quality time with the senior residents by fulfilling two obligations. The first obligation involves spending a minimum of 30 hours of quality time with senior residents every month. The student is given autonomy to decide which residents to interact with and how they would like to spend their time together. The program is self-regulated, and no personnel from the nursing home monitor the hours. The second obligation involves hosting a weekly bread meal in the nursing home's cafeteria. The cafeteria provides bread, butter, and drinks for the meal, and approximately ten senior residents attend at a designated time. The student's responsibility is to interact with the seniors and assist them with getting drinks and spreading butter if needed.

The program was an immediate success and was praised by every staff member I interviewed. It not only brought a youthful "energy" into the nursing home but also transformed the overall "vibe," fostering a welcoming culture rarely seen in other nursing homes. This unique initiative gained national and international recognition for the nursing home. Encouraged by its success, the nursing home launched two additional programs in 2014 and 2019 to assist young adults with mental health struggles. The Neighborhood Program was launched first, recruiting mostly young men from disadvantaged family backgrounds, who had multiple symptoms, including depression, attention-deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and often autism. Due to these struggles, they were not able to find work in the job market and HCare accepted them via referrals from their therapists. As of 2019, the program consisted of six members, with an average age of 25. As part of their contract, the government offered them housing near the nursing home and a monthly allowance to work part-time at HCare. Apart from two members, most participants preferred utility tasks like kitchen work and laundry, allowing them to work independently and minimize social interaction.

The Well-being Buddies Program, launched in 2019, was the third intergenerational initiative at the nursing home. It was designed to provide direct assistance to seniors and specifically targets young adults facing mental health challenges, with the dual aim of aiding their recovery and equipping them with fundamental job skills. Participants in this program are selected for their high vulnerability and limited work experience, with half of them referred by government therapists.

They often come from disadvantaged backgrounds and exhibit a range of symptoms, including depression, obsessive-compulsive disorder (OCD), attention-deficit/hyperactivity disorder (ADHD), and post-traumatic stress disorder (PTSD), but no autism. Despite the challenges, these young adults are characterized by a strong inclination to help others and a desire to prove their capabilities. The average age of participants in this group is around 25, and the program is comprised exclusively of females.

Introducing young adults with mental health struggles to a nursing home work environment was a daring and unprecedented move in the Netherlands, and it was met with continuous doubts and objections from both nurses and the seniors’ family members. Given the specific challenges faced by these young adults, the intergenerational programs at HCare were designed to offer additional support and flexibility. This approach included allowing certain leniencies, such as tolerating late arrivals and providing options to switch job positions if needed.

To further support this initiative, HCare created two job coach positions. These coaches played a pivotal role in the programs, with responsibilities that included helping the young adults choose suitable job roles, addressing work-related challenges, and ensuring that the young adults met the necessary work criteria. This supportive framework was tailored to accommodate and nurture the unique needs of these young adults, aiming to integrate them effectively into the nursing home environment.

In addition to the structured intergenerational programs, HCare also tried to invite people in more casual ways. For example, job coaches organized an event called "Chill Hours" to assist a group of marginalized young people to come inside the nursing home for group dinners every week. The nursing home also provided space for a group of teenage mothers to meet regularly. Moreover, the nursing home has an open-door policy, and everyone is welcome to enter freely to use their coffee machine near the entrance.

HCare's commitment to these innovative efforts transformed it into a nursing home that exuded positivity and vitality. My informants, encompassing a range of roles from managers to nurses, unanimously praised the nursing home person-centered approach. This approach aligned well with the broader transition toward person-centered care in the caregiving industry, a shift that has been increasingly advocated for by societal and governmental entities.

One of the highly vulnerable young adults from the Buddies Program had previously worked at another nursing home and said, “HCare is really unique because you have a lot of programs, like students. There is always something to do. It’s so much fun and full of life. It is so different from places I have seen.” Having worked at HCare for three months, she was still impressed. “Every day it keeps on surprising me. It’s happening so much. There are a lot of outside groups that come in here, teenage moms, for example. If I walk to the front (outside of the dementia ward), I have no idea who I will meet.” From the managers' perspective, they noted that the nursing home's inclusive culture helped reataining nurses. Consequently, unlike other nursing homes, HCare did not face a shortage of nurses. The nursing home had a long waitlist of seniors eagerly waiting for admission. During my stay that year, the nursing home stood out for its implementation of person-centered care in the care industry.

This aspect of HCare is particularly noteworthy considering that, despite the nursing home's active promotion of its intergenerational programs, other nursing homes were hesitant to adopt similar practices. By the conclusion of my fieldwork, HCare continued to stand out for its systematic and intentional integration of young adults with mental health challenges into its daily operations, a practice that remains unique in the broader nursing home industry.

Drastic changes at HCare and the HVYA’s positive coping outcomes

For nursing homes in the Netherlands, 2020 was an impactful year. Due to the strict regulations implemented during the COVID-19 pandemic, the industry in general, experienced a high turnover rate (Segelman et al., 2021). At HCare, work-related stress increased substantially for nurses, which pushed them to pursue jobs elsewhere. In 2020 and 2021, many staff members including nurses, maintenance staff, and kitchen staff left the nursing home. Four of its five managers left in those two years. The last manager who worked at the nursing home for over ten years left in early 2022. As a result of these drastic changes, HCare was no longer the same.

When I returned to the nursing home for the third time in 2021, the nursing home was in disappointing shape. While pandemic restrictions had already been lifted, the facility was much emptier, and there was a sense of pessimism among staff members. Elevator cleanliness was one example of a problem that had been neglected, with one interviewee noting that the elevators had not been cleaned in over two months. Given the number of changes that occured, staff members were unsure of who to address their concerns. During my stay, an interim manager was hired to help manage the situation. Despite his positive attitude in the first couple of weeks, he was soon found smoking by himself frequently. Seeing that, some staff members joked that given the decrepit state of the nursing home, the job was too much for him. It was not a surprise that he too, did not choose to stay.

The intergenerational programs, which were the pride of the nursing home, also changed. Several of the students who moved out felt they were not treated right. While the number of college residents stayed the same, the new students were thought to be not as committed as their predecessors. The two programs assisting the highly vulnerable young adults also did not look very promising. One of the job coaches had two burnouts in 2020 and 2021. She was absent for months without informing the young adults about the situation. As my assigned contact person, her absence also made my research more difficult. The other job coach left in early 2021 without communicating with the HVYAs about his decision. They were told that he was “on vacation” but he never came back. By 2021, the Neighborhood Program was falling apart. The job coach responsible for the program left during that period of time. The program had 6 members in 2019, but only two stayed in the program by 2021. The members who left had mixed feelings about the program. On the one hand, they liked the intergenerational model at the nursing home and believed that more nursing homes should adopt similar approaches. On the other hand, they did not feel appreciated and felt disheartened by the staff members there.

While many staff chose to leave the nursing home, the HVYAs genuinely enjoyed their experiences at HCare and were grateful for the opportunities they had. These were the HVYAs who assisted the seniors directly, whose dedication was often overlooked. All of these young adults were highly vulnerable with multiple mental health conditions and consequently, lacked the necessary skills to handle a normal job. Even though the average age of young adults was around 25, they could not support themselves financially without government subsidies. Therefore, they were highly vulnerable when they began working at HCare. Having worked at the nursing home for an average of two years, these young adults developed positive coping outcomes such as reduced symptoms, decreased reliance on medication, increased confidence, and a renewed desire to pursue further education.

Eefje, for example, was a member of the Buddies program. She started working in the dementia ward in 2019. She was in her late 20s and struggled with depression, OCD and ADHD. As a member of the Buddies program, she only had a one-year contract. “This is a project for a year, then you go out, find a job, it’s a training really,” she said. But everyone in the program liked the job and wanted to stay for longer. When she learned that her contract could be extended, she said she cried her eyes out. “I was so happy. So happy,” she said, still trying to control her emotions even though that happened in early 2020, nearly half a year ago before the interview took place. In 2022, she was promoted at HCare and began working on her post-secondary degree part-time.

Another example of the highly dedicated HVYA is Natalie. Natalie was in her early 20s when she started volunteering at the nursing home in 2017. She was most passionate about spending quality time with the seniors, but as the kitchen was short-staffed, she ended up working part-time in the kitchen. I got to know her in 2019 when I helped with the dishes. From the way she interacted with the seniors in the cafeteria, it was clear that she was very committed to them. She was one of the few people who knew every senior by their full name, which the managers could not accomplish. Natalie's long-term goal was to be a nurse. A manager promised her that if a part-time nurse training vacancy opened, she would refer her to the opportunity. The manager, however, left in 2020, and along with her, the promise to Natalie. When the opportunity finally opened up, it was given to someone with less experience. Natalie was very disappointed, especially considering the immense effort she had invested in her work. Due to the high turnover rate, the kitchen was further short-staffed in 2021. Despite her mental health struggles, Natalie had to work for over 40 hours a week, and she had not had a vacation in two years. Some of the managers, however, would have multiple vacations in a year. One time, two managers came to the kitchen and praised a male intern for his work, which made Natalie feel that her hard work at the nursing home was overlooked. According to her, the intern only worked there for two months, and "They (the two female managers) liked him because he was a guy. Guys get more attention here." Despite her disappointment, she did not complain to the managers and continued to work with her usual positivity. When I asked her if she thought about seeking opportunities at another nursing home, she had tears welling up. "But how can I leave my 160 grandparents?" By 2022, she still worked at HCare and desired to pursue higher education.

Eefje and Natalie were just two examples from the six HVYAs who enjoyed their experiences at the nursing home because of the seniors, and Natalie was not the only one who regarded the senior residents as "grandparents." In fact, without any prompting, two HVYAs referred to the seniors as “grandparents,” while another two used terms like “cuties” and “cute” to describe them." The other two HVYAs did not use any particular terms but talked about their interactions with seniors, especially those with dementia very passionately. This was a surprise because the nursing home has a very high percentage of residents with dementia, who were typically seen as difficult to take care of. Before interviewing the HVYAs, the managers and nurses told me that the HVYAs struggled with their jobs. The HVYAs, however, tended to express how much they enjoyed working with the seniors, which was challenging and rewarding at the same time.

At first glance, this mutually beneficial relationship seems counterintuitive. Highly vulnerable populations such as seniors with dementia and HVYAs were often characterized as difficult and unpredictable, seemingly having little to provide for others (Sapiro et al., 2019; Galvin et al., 2020). A closer look at the seniors’ needs, the young people’s job responsibilities, and the latter’s coping experience is necessary to help us understand the mechanism behind this relationship. In addition, this mutually beneficial relationship provides new angles to understand the strengths of highly vulnerable populations and the role nursing homes can play.

Dementia Care at HCare

The senior residents at HCare represent the typical demography of the population in other public nursing homes in the Netherlands. A close examination of them allows us to understand some key questions: *Compared to their mentally healthy counterparts, what are the distinctive characteristics of SwD*? *What kind of services do they typically receive*? Due to the assistance of HVYAs, however, some SwD, especially those in the dementia ward, do receive distinct services not available at other nursing homes. It is therefore important to ask: *What distinct role did the HVYAs play in dementia care at the nursing home*?

The interaction between HVYAs and SwD at HCare significantly affects both groups. The seniors, characterized by their high vulnerability and unique needs, highlight the limitations of traditional caregiving models that focus solely on routine-based care. HVYAs, tasked with enhancing these seniors' well-being, often found the job very challenging. Despite initial struggles, however, the HVYAs reported positive experiences and successful adaptation to their roles, demonstrating their ability to meet the needs of SwD effectively.

Seniors with Dementia (SwD) at HCare

With the dementia population increasing steadily, there has been a corresponding increase in the percentage of individuals with dementia (SwD) residing in nursing homes (Alzheimer's Association, 2019; Kuske et al., 2009; Zimmerman et al., 2005). SwD are recognized for their complex care needs, and their growing presence not only places added pressure on existing care facilities but also presents significant challenges to the global transition of nursing homes toward person-centered care (Chen et al., 2020; Gimeno et al., 2021; Kong et al., 2022). Since the influx of SwD to nursing homes is irreversible, some questions are critical to understanding how to improve their well-being. Specifically, *what makes SwD different from other seniors in the nursing home? What kind of care do they receive? Who reports positive experiences working with them?* As one of the nursing homes currently undergoing this transition, HCare offers valuable insights into the SwD population and the care they typically receive.

HCare represents a typical nursing home in the Netherlands, both for its size and the demographic it caters to. It can accommodate 160 senior residents whose average age is above 80. Other than a few examples, most of the residents were working class from within the province and ethnically Dutch. Most of the residents face either mental or physical challenges that necessitate round-the-clock care. Notably, more than 80% of these residents had dementia, and the number was expected to rise in the future. Being a difficult disease, SwD in the nursing home were in a stage of transition, which made caring for them particularly challenging. Nevertheless, as the literature suggests, there is a positive aspect to this population that has often remained unrecognized (Kitwood, 2015; Phinney et al., 2007; Taylor, 2008; Van Dijkhuizen et al., 2006).

To understand the seniors' experiences thoroughly, it is essential to explore the contextual difference between the dementia floor and the regular one. Due to the high percentage of SwD in the nursing home and its lack of human resources to provide individualized care, HCare adopted a commonly employed strategy of transferring some seniors to dementia wards. In 2019, it was estimated that there were over 120 seniors at various stages of dementia in the nursing home. During my fieldwork, a total of 37 seniors resided in two dementia wards located on two different floors. More women than men have dementia. In the U.S., it was found that two-thirds of Americans with dementia were women (Alzheimer's Association, 2019). At HCare, this ratio was similar, if not higher, as most of the residents with dementia were females. These seniors lived in the wards either due to the advanced stages of their dementia or because they exhibited disruptive behaviors that required more extensive care and attention. This distinction in their conditions resulted in varying levels of care and services.

Seniors residing on standard service floors typically spent most of their time in their units, designed like studios. These units featured private bathrooms, living rooms, bedroom areas, and stoves for their convenience. The units were ample in size, with large windows allowing an abundance of natural light to filter in. Additionally, the nursing staff diligently maintained these units, ensuring they remained clean, and foul odors were rare.

However, besides tending to the seniors' fundamental needs like dressing, washing, and administering medications, the nursing staff was often absent most of the day. Unless there were visitors or scheduled group activities, they typically remained in their rooms independently. Consequently, it was common to observe seniors sitting on their couches in front of the television, occasionally dozing off. Many of these seniors were coping with dementia, but as long as they did not exhibit disruptive behaviors such as wandering or aggression, they continued to reside on the regular floors.

Seniors in dementia wards received more direct supervision, as they spent most of their time in the “common areas,” which were spacious living rooms. Each of the dementia floors had two common areas with large windows that provided serene outdoor views and allowed in natural light. The common areas also had large-screen televisions, chairs, couches, and tables. According to one of the managers, the setting at this nursing home was typical of the past century, characterized by a spacious and serene ambiance, embodying simplicity and comfort. The seniors’ units were not that different from the standard service floors. Their rooms were a bit smaller, and they did not have their own stoves. While the seniors' units in the dementia wards had slightly smaller rooms and lacked stoves, they generally met the expectations associated with dementia care.

However, the physical environment of the dementia ward did not appear to hold much significance for the seniors. Following their daily grooming and dressing routines, most seniors were transported out of their rooms to spend their time in the common areas. This arrangement was put in place to ensure continuous supervision by the nursing staff. While existing literature often highlights disruptive behaviors among seniors, my observations revealed that most of the seniors remained quiet, seemingly awaiting some form of stimulation. This complex phenomenon will be further elucidated in section three.

Despite the seniors in the dementia ward being in closer proximity to the nursing staff, there were limited interactions between the two groups. Nurses were primarily focused on their tasks, moving swiftly with a serious demeanor. They rarely initiated conversations with the seniors unless it was necessary. Consequently, apart from occasional exchanges among the nurses, the dementia floor remained predominantly quiet. It is important to note, however, that this quietude does not necessarily reflect the seniors' preferences. It is a result of their diminished capacity to initiate meaningful interactions. For seniors, dementia is undoubtedly a challenging disease, both for themselves and those who care for them.

A Difficult Disease for the Seniors. At the nursing home, there was a unanimous understanding that dementia was a distressing condition, and discussing it was a somber experience. For the seniors, dementia signified a transition into another phase of life, one that often deprived them of their independence and communication abilities, leading to changes in their behavior that could be perceived as "rudeness."

Moving into nursing homes is a significant event for seniors, as it often marks the beginning of the final stage of their lives (Kitwood, 1997; Van Dijkhuizen et al., 2006). This transition is particularly challenging for individuals with dementia (SwD) due to their cognitive decline. Dementia is typically categorized into seven stages based on the severity of cognitive deterioration (Reisberg et al., 2010). However, at HCare, instead of viewing dementia solely through these pathological stages, generally speaking, the staff members perceive it as a two-stage process: the first stage is not accepting dementia, while the second stage means accepting it.

Many of the staff members at HCare lacked formal training in dementia care, but they held unique perspectives that differed from mainstream interpretations. In the literature, disruptive behaviors exhibited by seniors are often pathologically viewed as symptoms of dementia (Howard et al., 2012). In the eyes of some nurses and the HVYAs, however, these seniors' “rude” behaviors were perceived as stemming from a transitional period in their lives. During this phase, the seniors experienced a loss of independence, and self-esteem, accompanied by confusion and frustration. Instead of perceiving this transition negatively as an irreversible decline, some caregivers consider it a necessary process for the seniors could eventually come to accept themselves and find inner peace. Therefore, from their perspective, dementia was not solely a disease but also a journey of letting go and self-acceptance. It, however, often begins with a painful struggle.

The seniors typically begin their transition by resisting dementia in the first stage. During this stage, they become aware that something is amiss within themselves, often manifesting as memory loss, confusion, and emotional outbursts. While they sense that something is wrong, they struggle to identify the cause. Consequently, the seniors attempt to "fight" these challenges, which can manifest in disruptive behaviors such as wandering, yelling, and aggression.

When it comes to dementia care, Johanna held a position of authority at the nursing home. In her 50s, she had dedicated her entire career to nursing and was the sole individual in the facility certified as a "dementia whisperer." Her approach to understanding dementia centered on establishing an intuitive and emotional connection with individuals with dementia for the caregiver and the senior to "live in the moment." Before the pandemic, when the nursing home had visitors from the healthcare industry, Johanna was frequently invited to share her caregiving experiences, a clear acknowledgment of her expertise and contributions.

When Johanna tried to give me a holistic understanding of dementia as a difficult transition, she drew up her mother’s experience, who went through the typical stages. The most distinct feature of the first stage was being uneasy and aggressive toward others. According to

Johanna, her mother was a very caring and independent person before she had dementia. People in her community recognized her for her kindness, often exchanging greetings with her wherever she went. After she got dementia, however, her personality changed completely. She no longer greeted people with a smile, and when offered assistance, she responded with anger, even at times displaying violent reactions. Similarly, another caregiver recounted an incident when she attempted to accompany an individual with dementia for a walk. The senior turned to look at her, and retorted, "I'm not a child; I can walk." Other typical behaviors associated with dementia, such as demanding to go home are also common (Cohen-Mansfield, 2001). These anecdotes underscore the challenging nature of the transition experienced by individuals with dementia, marked by notable shifts in behavior and personality that can be profoundly distressing for seniors.

"In the beginning, we didn't understand why she was so angry at us, angry at herself, angry at the whole world," Johanna continued. Then she realized that her mother could not accept the fact that she had become incapable. As someone who had always seen herself as a helper to others and valued her independence, she initially clung to her past. For instance, she used to go swimming every week before she developed dementia, and she obviously missed it, as she would tell people she was still going swimming every week. Therefore, in the initial stage of dementia, Johanna explained, "The world of dementia and the world she came from were mixed. They are struggling with letting go of this world." As her mother's dementia worsened and she lost more abilities, such as the ability to recognize a sewing machine, she became aggressive toward everyone around her, including her close relatives, especially when their view of the world did not align with hers. The caregivers interpreted these behaviors of individuals with dementia as signs of an internal struggle. Another caregiver expressed it by saying that individuals with dementia appeared to have a deeper awareness of their illness than one might expect. "Something isn't working, but what isn't working? They know something’s wrong, but they can’t tell what is wrong," the caregiver remarked.

Once a senior learned to accept that they had dementia, they often became more at ease. “In stage two you accept, so you go experience this new world where you are living in," Johanna explained. She used "Alice in Wonderland," to describe the imaginary world SwD created for themselves. "In stage two, she (her mother) became quiet, but she told you everything she felt," Johanna noted. As the daughter of someone with dementia, Johanna found this stage to be both "good and bad." On one hand, her mother was no longer aggressive, but on the other hand, she had a diminished sense of boundaries. For example, she would openly make comments about another person’s body shape, something she would not have done before she developed dementia.

While some caregivers categorize the stages based on whether SwD accept dementia or not, Johanna believed that the second stage could extend to a final stage of peacefulness. In this final stage, when a person with dementia turns inward, external perceptions, such as how others view them, diminish in significance. While verbal communication remains challenging, they exhibit increased openness and receptivity toward others. In Johanna's experience, it was as if her mother, the caring person she used to be, emerged once more. She became joyful at the sight of her family and displayed a more positive attitude. This was especially prominent toward the end of her life before she passed away.

It should be emphasized that the three stages described above are based on the caregivers’ (e.g. Johanna and the HVYAs) experience in caregiving, which adopts a more holistic and human-centered perspective, but differ from the mainstream approach of categorizing dementia based on the level of cognitive decline and required care levels (Reisberg et al., 2010). It is also important to note that the stages above are generalizations. For caregivers working with individuals with dementia, the boundaries between these stages were not always clear-cut. It was common for them to witness rapid shifts in the seniors' behavior, transitioning from extreme kindness to sudden anger within minutes. In general, the journey through these stages was often marked by numerous challenges, both for the seniors and their caregivers.

Providing PCC at the Nursing Home. From the nursing home's standpoint, delivering Person-Centered Care (PCC) for SwD presents a significant challenge due to the demanding nature of dementia care. It necessitates a very high level of dedication from caregivers. Given the seniors’ unique and individualized experiences of dementia, the care provided must also be tailored to meet their specific needs. This customization is especially challenging because as seniors' social circles diminish, the well-being of individuals with dementia becomes increasingly reliant on the nursing home's support.

Requiring a High Level of Dedication from Caregivers. Dementia care requires a high level of dedication from caregivers for various reasons. Some of the most common ones include difficulties in communication, the need to navigate shifting temperaments, and the ongoing effort to maintain a positive attitude.

Among the various symptoms of dementia, the loss of the ability to communicate is one of the most prominent, which results in an inconsistency of thought and difficulty in finding the right words to express messages clearly. For caregivers, this means they may struggle to comprehend the needs and desires of individuals with dementia, potentially leading to further agitation in the seniors. As an example from the dementia ward, a caregiver asked if a senior wanted a sandwich. The senior mumbled a response. Although the caregiver could not discern the exact words, she assumed it was a "yes." However, when she brought the sandwich to the senior, the senior was angry at the caregiver.

In other situations, the seniors can lead the caregivers into confusion. As another caregiver shared, she was still trying to get to know the seniors despite having worked there for several months. She remarked, "They are different every day. Sometimes, I don't know if what they say is real or not." For instance, when one lady told her that her mother was still alive and later mentioned that her sister lived in the city and expressed her willingness to visit her, the caregiver was uncertain about the truthfulness of these statements.

It is, therefore, widely acknowledged within the nursing home that engaging in clear and straightforward communication with SwD is very challenging. Renske, an experienced staff member with over fifteen years of experience in various roles at the nursing home, expressed this sentiment. According to her, seniors frequently provided varying responses to the same question depending on who posed the question and the context in which it was asked. For instance, when asked if they liked the food in the dining hall, the response was often affirmative. However, when questioned privately, the answer might be negative. Consequently, truly understanding the seniors requires a significant amount of dedicated time and effort.

While clear communication can be difficult between the seniors and their caregivers, SwD rely on the latter for interactions meaningful to them. Having lost the ability to initiate social engagements and struggling to express themselves, caregivers need to be present for the seniors to interact with. For instance, one caregiver had worked closely with a senior who frequently complained about various aspects, such as the food, room decorations, or the need to adjust her bed. The caregiver initially busied herself to address these concerns with the responsible parties. However, as they spent more time together and the senior shared more about her life, it became apparent that these requested changes held little importance to her. What the senior truly desired was attention and the companionship of the caregiver. The need for companionship was reaffirmed by several caregivers who reported that seniors, when given the chance to have a conversation, often preferred it to be prolonged. This necessitates patience on the part of the caregiver, as well as a continued positive attitude toward the senior, even when the same story has been recounted many times.

At the nursing home, there was a widespread belief that caring for individuals with dementia requires a high standard. Other than the traits mentioned above, the seniors were believed to be very sensitive to the “vibe” around them and could get anxious easily. As one HVYA said, “The old ladies, they just want to talk to someone. It doesn’t matter (who you are). But you (must) have a good energy. Because I do think they are very sensitive to energies.” According to Johanna, it means the caregivers should be “People with calmness inside; people who work from the heart.” By the “calmness inside,” she explained that unless the caregiver is calm, the seniors could be easily disturbed. “The calmness inside is very important. When you go inside the room with people with dementia, and you are very high in your own energy, the senior feel when you are (disturbed).”

This necessitates that caregivers remain exceptionally composed and attentive, even in the face of seniors' disruptive behaviors. Based on my observations at HCare, it seemed to be an unspoken practice to speak softly to individuals with dementia from proximity. Often, caregivers needed to bend down and closely monitor the seniors' reactions. Since many of the seniors had lost their ability to express their thoughts verbally, it was crucial to discern their true emotions through their eyes.

Being considerate also entailed ensuring the seniors felt secure at all times, especially when changes in their environment were imminent. For instance, if a senior appeared somewhat agitated but did not wish to converse, and it was time to escort them to the dining hall for a performance, the caregiver would describe the event to the senior, inquire if they wanted to attend, and gently hold their hand. This exemplifies what Johanna meant by "working from the heart," as the role requires caregivers to consistently empathize with the seniors and view situations from their perspective.

Requiring Individualized Care. In addition to demanding a high level of dedication, dementia care is recognized for its need to be highly individualized. This is because there are multiple types of dementia, and individuals' experiences can vary significantly based on their unique life experiences (Colomer & de Vries, 2016).

As Johanna aptly put it, “The dementia umbrella is so big, there are so many different kinds of dementia and that’s why I say you stand ten different people with dementia and those ten persons are different.” In other words, “Every case is different. Not one person has the same dementia experience.” This strongly resonated with Valerie, one of the quality-of-life officers, who specialized in dementia care at HCare. Being in her 40s and having worked at HCare for over five years, her job involved speaking individually with seniors to understand their specific needs and then conveying those needs to the nursing staff. In contrast to the common belief that dementia care weighs a person down, Valerie was always smiley. Being very passionate about her work, she spoke openly about both their achievements and challenges of her work, emphasizing the importance of understanding each senior's unique requirements.

Valerie shared an example where two seniors had lived in the same town before moving to HCare. In their late-stage dementia, they were unaware that they were in a dementia ward and frequently expressed a desire to return to their hometown. Upon learning of this, Valerie printed the town's name on a piece of paper and taped it to the wall. When she guided the seniors to the sign, they became elated, believing they had arrived back in their town. They enjoyed their coffee and engaged in cheerful conversations beneath the sign, feeling as though they were living in their town rather than a nursing home. Valerie recounted this story with a mixture of humor and a sense of accomplishment, highlighting the significance of getting to know each senior individually in her line of work.

Dependent on Nursing Home for Their Well-being. Another factor that renders Person-Centered Care (PCC) challenging for individuals with dementia is their heightened dependency on services provided by caregivers. Compared to mentally healthy seniors, their social network tends to diminish over time, with friends and even family members gradually becoming less involved. Consequently, their overall well-being becomes almost entirely reliant on the care and support provided by the nursing home.

It is widely agreed that social interaction is vital to the SwD's quality of life (Cornwell & Waite, 2009; Litwin & Shiovitz-Ezra, 2006). As one HVYA said, "I think people all like the same things in very basic ways. They like it if you touch them on the shoulder, you ask them about their past, in the end, everybody is the same. I think people do want the same things: to be loved and feel loved." Similarly, another HVYA said that the seniors wanted to "feel heard and get attention." However, very few people in the community can provide them with the attention needed. In many cases, family members, who are typically expected to support seniors through the struggle do not always fulfill these expectations, and at times, their involvement may even have a negative impact.

When talking about dementia care, Liam half-jokingly said that some family members of the SwD should stop visiting them. Liam was a young adult from the Neighborhood Program. He had a close bond with a senior with late-stage dementia who resided on a standard service floor due to her non-disruptive behavior. When I went to visit the lady with Liam, we found her seated at her table next to a doll. When she saw us, her face lit up. Before visiting her, Liam told me that as her dementia progressed, the lady thought the doll was her son and often held the doll tenderly in her arms. Upon entering the room, Liam asked the lady if he could see a photo she had on the bookshelf, and inquired about the picture. The lady pointed at different things in the photo and talked excitedly. I could not understand what she was saying in Dutch, but Liam exchanged a knowing glance with me indicating that what she said was not true. Nevertheless, he listened patiently without ever interrupting her.

In contrast to Liam's patience and understanding, the lady's son struggled to come to terms with his mother's dementia. Liam had witnessed a particularly heated argument between the two during one of his visits. While the lady was trying to describe a tree in a photograph, her son grew impatient and interrupted her, trying to remind her of their trip to the island together. When the lady showed no signs of remembering, her son became frustrated and went on to provide her with more details about the trip, seemingly expecting her to recall them. According to Liam, the son appeared unwilling to accept his mother's perspective, and when this persisted, it had a detrimental impact on the senior's well-being.

Regarding the seniors’ family members, especially their children, Johanna held the belief that family members should learn to "let go" and accept their dementia symptoms. She expressed that “In some families, it would be better if a nurse does it (providing care). Not every family is (capable of being) loving and kind.” Johanna shared a personal story to illustrate her point. Both she and her older sister were nurses, but their reactions to seniors with dementia differed. Johanna felt a sense of calm when caring for seniors with dementia, while her sister would become agitated. Deep down, Johanna's sister struggled to accept the fact that their mother had dementia, leading to frequent conflicts in their interactions as they both sought to be right. “But what is right or wrong?” Johanna shrugged her shoulders. “Letting go is very difficult for a lot of family members. The world can learn about it (dementia) more letting go.”

In contrast to the literature that encourages reluctant family members to become more involved in dementia care, the prevailing belief at the nursing home is that dementia care should be primarily entrusted to the facility itself. This perspective places added responsibility on the nursing home, which is already grappling with a shortage of caregivers. Nonetheless, in the pursuit of Person-Centered Care (PCC), industry-wide changes are imperative.

Unrecognized Positive Aspects of SwD. The literature often depicts caregivers of seniors with dementia (SwD) as being significantly burdened by their responsibilities (Cohen et al., 2014; Luppa et al., 2008). Although there is an emerging trend to acknowledge the agency and 'personhood' of those with dementia (Ready & Ott, 2003, Petty et al., 2020), there remains a scarcity of studies that adopt a perspective that views the seniors as agentic without pathologizing them.

At HCare, seniors were viewed much more positively. Examples of this include their typically positive response to stimulus, being more active participants than commonly thought, and enjoying harmonious relationships with their caregivers, rather than strained ones. As one HVYA remarked, “We (staff members) look too much at dementia, and not the person behind dementia.” By trying to understand the seniors using their perspective, it was clear that SwD was not seen as a liability.

Respond Positively to Stimulation. Contrary to the popular belief that SwD are disruptive, I found them to respond positively to stimulation, provided the person interacting with them remains calm. Here, "stimulation" refers to the act of being present or attempting to engage with a senior, even if the senior does not explicitly indicate a need for interaction. This tendency was largely evidenced by the seniors' generally positive reactions to encountering new faces.

One particular instance stands out to me as unexpected and enlightening. One evening in 2020, while I was chatting with a senior in the common area of the dementia floor, another senior whom I had never interacted with before approached me. I had only seen her sitting quietly about ten feet away and did not pay much attention to her. As she came closer, I noticed that she was probably in her 80s, and had an anxious demeanor. Her body slightly trembled as she extended her arm, clearly wanting me to come closer.

Feeling needed, I wrapped up my conversation with the other lady and stood up to attend to her. As she could no longer speak, I held her hand, which seemed to be her wish. I guided her back to her seat and sat beside her, with one hand holding hers and the other placed on her shoulder. Soon after, her trembling stopped. Nevertheless, I still felt needed, so I stayed with her in the same position for over 30 minutes. Neither of us talked during this time, and the nurses did not intervene.

This incident would seem trivial to others, but it was deeply informative for me. It made me feel needed and made me realize that seniors often require more “stimulation” than we usually acknowledge. Moreover, as similar incidents repeated many times during my research, I was convinced that SwD welcomed stimulations, especially those from young people under 30.

Overlooked Agency. Psychological research emphasizes the importance of recognizing SwD’s agency, best demonstrated by their continual effort in striving to comprehend their changing world, cope with the challenges of their condition, and address the emotional difficulties that arise from the dementia process (Kitwood, 1997; Miesen, 1999; Droes, 1997; Verdult, 1993). This perspective, however, stemmed more from sympathy than regarding them as a source of support for others (Petty et al., 2020; Ready & Ott, 2003). During my fieldwork, I observed not only this active engagement with the self but also their agency in offering warmth and assistance to others.

Tom, for example, enjoyed moving around the nursing home in his wheelchair despite his dementia. In contrast to practices in the U.S. where confining seniors with dementia (SwD) is common, restricting seniors' movements became illegal in the Netherlands in 2012. Unable to speak, Tom relished social interactions and always greeted people warmly in the corridors. Staff members would often pause to greet him with smiles and shake his hand, a gesture he greatly appreciated. He responded with a firm handshake for men and a chivalrous kiss on the hand for women. The caregivers at the home enjoyed their encounters with Tom, and these simple, heartwarming interactions often brought smiles to everyone's faces.

Other than simple greetings, the seniors retained the ability to forge connections and exhibit their agency by extending care to others like myself. In the nursing home, I felt a special bond with two seniors in the early stages of dementia: one I came to see as my 'teacher' and the other as an ‘aunt.’ Both exhibited disruptive behaviors typical of the early stages of dementia, yet notably, both remembered me. During our interactions, they consistently showed me warmth and their desire to help me, actively demonstrating their agency despite their conditions.

When I met my 'teacher' in 2019, she was a retired elementary school teacher in her early 80s. Before becoming a resident due to her dementia, she had been an active volunteer at the nursing home. From our first meeting, she was exceptionally kind to me. No matter where she stood, she always greeted me with a smile and a wave when she saw me, a connection that lasted throughout my time at the nursing home. Each time I waved back, I marveled at her ability to remember me so distinctly, especially considering that the lost ability to initiate interactions is often seen as a common sign of dementia (Beer et al., 2012; Burns & Winblad, 2006).

The caregivers and I began to refer to her as my ‘teacher’ following an interaction where she inquired about my presence at the nursing home. That was in 2020 when her unexpected mental health decline sent her straight to the dementia ward. Upon learning that I wanted to learn Dutch, she enthusiastically offered to teach me. Despite her dementia, she sometimes recalled her teaching role and endeavored to help me with the language. For instance, when discussing her son, a truck driver, she spoke slowly and clearly for me, even writing down words in my notebook with her shaky hand.

Clearly, due to her dementia, my 'teacher' did not always remember her role. However, when she was calm and I spoke slowly, she seemed to remember the special bond between us. Although her early-stage dementia made her more prone to agitation, often displaying hostility toward other seniors, she never directed any unfriendly feelings toward me.

Besides my ‘teacher,’ I formed a deep connection with another senior whom I fondly referred to as my ‘aunt.’ She, like my teacher, was in her 80s with early-stage dementia and had been moved to the dementia ward due to her disruptive behaviors. She could walk with the aid of a walker and was more mobile than many others in the ward. She, therefore, often teased others, who sat immobile in the common area, by loudly asking, “Where am I? Is everyone dead?” and then walked away proudly. Though the other seniors could not physically respond, it was evident they disliked her remarks. However, I regarded her as my ‘aunt’ because she saw me as a family member.

This bond began in 2020 during our second meeting when I came to the dementia ward to shadow an HVYA. My ‘aunt’ had been friendly during our first encounter and seemed to recognize me the second time. Due to my limited Dutch, she mistook me for her nephew who lived in England and was unfamiliar with his ancestral language. She insisted on showing me around, introducing me to everyone as her nephew, despite our racial differences. The nurses smiled and played along without correcting her.

In one of the common areas, she expressed disdain for the other seniors in a somewhat derisive manner, then led me to her room, asking about her family members. To ease her mind, I praised her room and reassured her about her family’s well-being. Afterward, she guided me to another common area, softly asking if I wanted coffee after we sat down. I declined as I already had some, but she snapped her fingers and called for a nurse rudely, thinking the nurse was a waitress. After she “ordered” her coffee in a curt manner, she turned back to me, her demeanor filled with affection, and asked if I needed anything. As I shook my head, she waved off the nurse, who had been waiting patiently without showing any signs of discontent.

As we waited, she mockingly imitated a dozing senior sitting in front of us. Her expressions and gestures were reminiscent of a young woman in her 20s. A different nurse brought her coffee and, kneeling beside her, asked who she was speaking with. To the nurse's amusement, she replied, “This is my husband,” believing it was the day before her wedding. We spent over two hours together that day, during which she remained content and at ease with my presence. Even though I could barely speak Dutch, she kept trying to converse with me. When I eventually had to leave, she held my hand tenderly and softly asked me to return. From that day on, I seemed to hold a special place in her heart. While her dementia might have led her to assign me various roles, in her mind, I was always a family member.

From these examples, it is evident that SwD are still capable of social engagement and forming new connections, provided they have the right stimulations. When I was learning Dutch, it was not just my teacher who offered help. Other ladies, even in the late stages of dementia, showed their willingness to assist. Despite their inability to speak, they looked at me with compassion and tried to guide my pronunciation by moving their lips. Some caregivers suggested that my presence as a young male in an environment predominantly occupied by middle-aged or older females made me stand out, which could have influenced this bond. Regardless of the reason, these seniors recognized me and actively demonstrated their agency by attempting to help in their own way.

Being Accepted at the Nursing Home. Despite the seniors occasionally displaying behaviors that would be deemed unacceptable in typical social contexts, they were met with more than just tolerance at the nursing home; they were received with compassion.

In a particular instance, a student resident at the nursing home inadvertently touched a senior's wheelchair with his foot while seated next to her in the dining hall. The senior became agitated, repeatedly calling him “stupid” and kept on criticizing him for his carelessness. As he could not bear it any longer, the young man stood up and exited the dining hall without saying a word. However, a few minutes later, he returned to sit beside the lady again. When I inquired about his choice to return, he explained that the senior's dementia had deprived her of nearly everything in her life, giving her ample reason to be upset and that he should not take her outburst too personally. This incident is just one of many where individuals in the nursing home made an effort to see things from the seniors' perspective. During my time there, I never heard anyone complain about the seniors' behavior, even when it was sometimes inappropriate.

While the majority of personnel at the nursing home were ethnically Dutch, there were exceptions, including some Muslim caregivers who wore hijabs. This cultural diversity, familiar to the younger generation, was often unfamiliar to the seniors. A widely discussed incident involved a SwD instructing a caregiver to remove her “rag,” in reference to her hijab. When discussing this with a young adult who also wore a hijab, she mentioned that she had not experienced such remarks, even after working there for over a year. As I inquired how she might react in such a situation, she replied, “I may cry,” with a smile. She paused but continued “Their generation is not used to it, so it is not their fault.”

In another case, a male volunteer with long hair frequently received comments from the seniors saying “It’s too long. Your hair is like a girl.” He responded to these remarks with a smile and never showed anger. Such verbal comments were common, yet I never witnessed anyone becoming upset or irritated by them. This tolerance and understanding of the seniors' perspectives was a common thread among the nursing home staff and volunteers.

Another, more concerning aspect of the seniors' behavior is harassment. This occurs with both male and female caregivers, especially when they are alone with the seniors in their rooms and the seniors become "touchy." These incidents were relayed to me with smiles as if they could do nothing about it, but never anger. When such situations arise, the more experienced nurses often offer to swap shifts with their younger colleagues to spare them the discomfort.

Therefore, in contrast to the mainstream depiction of SwD, they respond to stimulations and are more agentic than often expected. Despite their occasional problematic behaviors, they are nonetheless accepted as who they are at the nursing home.

The Existing Care Model is Insufficient

Excluding its intergenerational programs, HCare aligns with the standard model of a Dutch nursing home. The traditional care approach, primarily nurse-driven with volunteer assistance, is proving inadequate. This is largely due to the increasing prevalence of seniors with dementia who require substantially more care than residents did two decades ago. With the nursing staff numbers stagnant or even decreasing, coupled with a rapid decline in volunteer participation, the industry is struggling to cater to the individualized needs of these seniors.

Additionally, the workload for nurses is often seen as overwhelming, and their relationship with colleagues can be so tense that the work environment is frequently labeled as “toxic.” This atmosphere significantly undermines the nurses' motivation. As a result, even though there is a growing demand for more personalized care in the industry, the practice of rigid, institutionalized care remains deeply entrenched. These issues are not confined to HCare but reflect a wider pattern observed in the eldercare sector, both in the Netherlands and in other Western countries.

Describing the Nurses at HCare. In the Netherlands, senior care is primarily delivered by nurses, who are either professionally trained with a minimum of two years of education or are still in training. Distinguished by their uniforms and often serious demeanor, they exude professionalism. However, it is widely acknowledged that the educational requirements for nursing are relatively modest. The Dutch high school system categorizes students into four tiers based on their prospective career paths. While the top tier is intended for university-bound students, the qualifications for nursing fall into the lower tier.

Within the nursing staff, there exists a well-defined hierarchy based on both education level and experience, forming a pyramid structure with only a few highly qualified nurses at the top. A nurse at Level 1 functions as an assistant or trainee. Those at Level 2 handle tasks like bathing and helping patients out of bed independently. Level 3 encompasses responsibilities like administering medication. At HCare, out of over 200 full- and part-time nurses, fewer than 10 have attained Level 4 qualifications. Nurses at Level 4 are capable of handling all tasks and are often referred to as “the queen of the house” by other staff members, reflecting their comprehensive skill set and authority.

Staff members at nursing homes often reminisce that nursing was considered a more esteemed profession before the turn of the century. The workload was lighter then, and the profession attracted more young people. In recent years, however, this trend has reversed – the job has become more demanding, and nursing is not viewed as highly as it once was. At HCare, for instance, most nurses are over forty, with a female-to-male nurse ratio of approximately 10 to 1. Many of them work part-time, hold jobs elsewhere, or pursue different careers. This shift comes at a time when the senior population has been rapidly increasing, not just in the Netherlands but across other Western countries as well. This demographic change presents significant challenges for nursing, as fewer people want to commit themselves to this increasingly difficult profession.

An important sign that the current model is failing is the high turnover rate among nurses. In 2019, a manager revealed that over half of the dementia ward's nursing staff had left within four years. The manager also noted a lack of dementia-specific knowledge among the nurses and observed that among the new recruits, “not everyone is (was) capable.” The situation worsened during the pandemic, with the nursing home experiencing a substantial loss of nurses in 2020 and 2021. While in 2019, HCare could proudly claim to have sufficient staffing unlike other nursing homes, by 2021, it found itself grappling with the same staffing challenges.

With the shift in care focus to Person-Centered Care (PCC), there was an increased expectation for nurses to engage more meaningfully with seniors. Inquiring about how to enhance the seniors' well-being, I found that staff members, especially managers, often criticized the nurses. One manager expressed her frustration visibly, suggesting that instead of spending quality time with seniors, nurses preferred to congregate and drink coffee among themselves. This sentiment, that nurses should be doing more, was prevalent among many staff members. A young adult, for instance, emphatically spoke about the nurses' work ethic, saying, “What they do is really important stuff, but sometimes a person’s diaper is full, and the nurse has no time for it. I mean skip your break, if he’s having a full diaper, he’s not feeling good.”

At the nursing home, it was commonly observed that the nurses seemed dissatisfied with their jobs. They were often in a rush, forming their own groups, and seldom smiled. From the nurses' perspective, another side to the story revealed a different set of challenges and experiences.

Stressful Work. Nursing is a highly stressful job, a fact not just acknowledged within HCare but throughout the Netherlands (Hertogh et al., 2004). The rising proportion of nursing home residents requiring 24-hour care has significantly increased nurses' workloads over the past decade. At HCare, for example, nurses assist between 5 to 10 seniors daily with various activities in their rooms, including but not limited to bathing, dressing, and eating. Additionally, they are tasked with administering and tracking medications, conducting regular health assessments, and keeping records of the seniors’ conditions. Other less noticeable duties involve changing bed sheets, cleaning tables, caring for dentures, etc.

Every nurse is responsible for several seniors and carries a beeper to alert them when help is needed. Due to the stress, nurses at HCare are accustomed to moving quickly and maintaining a serious demeanor as they navigate their duties. During their short breaks, they often gather to update seniors' records on their tablets, noting medications administered, visitors received, and any unusual occurrences. While it may appear to an observer that the nurses are simply congregating, they are often managing more administrative work, which was more burdensome than 20 years ago.

With an increasing number of residents suffering from dementia, nurses are facing more challenges in their interactions with them. These difficulties range from trying to put a senior to bed against their will to encouraging a senior to eat during a tantrum. During my time at the facility, there were instances of nurses being physically attacked by residents. This contributes to the reluctance among many nurses to work full-time in such a demanding and stressful environment.

When I learned that Jeff left HCare in 2020, I was quite surprised. Among the nursing staff, he not only stood out for being one of the few male nurses but also constant smile and willingness to engage in conversation with me. In contrast, most other nurses maintained a friendly but distant demeanor. I had mistakenly assumed he was more content in his role than his colleagues.

By the time I interviewed Jeff, he had already departed HCare after a six-year commitment. Reflecting on his experience and the general atmosphere in nursing homes, he said with a wry smile, “This isn’t a job for years after years. The smart ones leave after several years.” He did not just leave the nursing home; he switched to a completely different profession, even though it paid less. Jeff had always been drawn to helping others since childhood and initially thought nursing would involve PCC with activities like sharing meals, taking walks, and playing board games. According to what I was told, this was how nurses worked at the turn of the century. However, he found the current reality to be quite different – the job was routine and far more stressful than he had anticipated.

Toxic Work Environment. Burnout, compassion fatigue, and a sense of being underappreciated are widespread among nurses, a sentiment not limited to HCare but prevalent throughout the industry. It is important to note that these negative experiences stem not solely from the workload but also from the work environment itself, often described as "toxic."

Apart from his assigned duties, Jeff noted an underlying pressure always to appear busy. According to him, nurses would rather pretend to be busy than be seen as idle. They often chose to walk quickly or engage in repetitive tasks unnecessarily instead of interacting with a senior, as the latter could be perceived as avoiding work. This mentality fostered a sense of constant anxiety, unease, and dissatisfaction among the nurses. To cope with this stress, gossip became a common outlet.

The pervasive gossip culture was a prominent issue highlighted by many of my informants. Often, it was depicted as groups of nurses congregating to discuss colleagues or voice complaints about their work. Jeff identified this as a major factor in his decision to leave both HCare and the nursing profession. The constant feeling of being watched and judged made him uneasy. “Imagine you sit with two nurses. When you have to get up and leave, they will immediately start talking about you,” he explained.

Another recurring topic was the nurses' dissatisfaction about long hours and low pay. Jeff, who moved to a lower-paying and more hazardous job, observed that the nurses' complaints were less about the actual conditions and more a part of the work culture – a habitual expression of dissatisfaction.

Deeply rooted, this gossip culture extended beyond the nurses to the management level. Informants often appeared visibly stressed when discussing managerial conduct. An assistant manager described how managers would act amicably in meetings only to speak ill of each other afterward. He recalled an incident where a manager returned from a meeting and began disparaging another manager’s professional and personal life. Eventually, the assistant manager, exasperated by the constant negativity, told the manager to stop as he was sick and tired of not just the incident, but the culture altogether.

James, a career coach at the nursing home, provided a comprehensive view of the gossip culture prevalent there. His role was to facilitate staff growth, both personally and professionally. As the first career coach at HCare, he found himself the subject of gossip. The staff, unfamiliar with his position, regarded him with curiosity and often spoke about him when he was not around. “When you walk inside the building, you feel watched and judged,” James recounted. Those who did not seek his services labeled him as “dangerous” and “weird.” His lack of a dedicated office and the need to move around to establish connections led to him being described as “floating” like a ghost.

This negative perception was confirmed by Jeff. He explained that rather than seeing the career coach as a resource, the nurses viewed him as akin to a therapist, suggesting that only those with problems would consult him. As a result, making an appointment with James was considered taboo. Despite this, some nurses, including Jeff, chose to seek his guidance, though often secretly.

During his two years at HCare, James talked with about half of the staff members. He noted that the gossiping culture had a detrimental impact on many. Often, when nurses sought him out, their struggles centered around their colleagues or managers, feeling devalued in the work environment. A common sentiment was feeling underappreciated and overwhelmed by the workplace hierarchy. James observed that the more educated head nurses wielded significant influence, leading to a sense of inferiority among other nurses. “In the way they talk to them, talk about them, you start to feel small,” he explained.

With managers spending most of their time in offices and rarely interacting on the floors, the head nurses effectively became authoritative figures. “They know more things about the elderly, and they know the plan they are sticking to,” James noted. This hierarchical system raised concerns about the adaptability and appropriateness of the care provided. Jeff, the nurse mentioned above, verified James's observation. According to Jeff, the head nurses were often reluctant to change their established methods to meet the seniors' needs better. This inflexibility contributed to a general feeling of demotivation, frustration, and a loss of enthusiasm among the staff. James concluded that the work culture was toxic, affecting everyone. “It's so clear to me what's happening. It's a spreading effect,” he said.

Another informant, Andrea, left the nursing home in 2021 after working there part-time for over three years, and shared a similar view about the toxic environment, believing it originated from the top, particularly the management level. Andrea, involved in launching one of the intergenerational programs, worked closely with the managers and had an insider's perspective.

Discussing the prevalent stress at HCare, she observed, “Stress isn't just in the hierarchy, but (among the) equals.” She was referring to the management's lack of effective communication. Instead of addressing issues, they often chose to act as if everything was fine, a strategy that only masked problems temporarily and led to long-term burnout. She shared an instance where a friend conducted research at the nursing home to explore living and working with purpose. After interviewing several management team members, the conclusion was that many staff lacked work enthusiasm. "That was heavy," Andrea said, pausing to take a deep breath. “And it's coming from the head. If you want to clean a company, you start from the head” Her words highlighted a belief that the root of the issues lay in the leadership.

Consequently, there was a consensus among the staff that the nursing home had become a toxic environment. By 2022, most of the staff members I interviewed had left HCare, except some HVYAs who still desired to work with SwD. Although the HVYAs might not have experienced all the aforementioned issues, these factors nonetheless shaped the overall context in which they operated, impacting them either directly or indirectly.

Institutionalized Care. The widespread stress and struggles at the nursing home significantly impacted the quality of care provided to the seniors. Reflecting on the institutionalized nature of the services, a manager acknowledged the rapid onset of institutionalization in such settings: “The danger with this kind of facility is that residents become institutionalized very quickly.” He observed, “When a senior moves in, she can lose her freedom within two weeks. We don’t intend for it to happen, but it does.” Here, “institutionalization” refers to a standardized service model that primarily focuses on routine physical care like changing diapers and feeding, without adequately tailoring to each senior's individual needs (Kong et al., 2022). This issue was a common concern among staff members at the nursing home, though it was not frequently discussed openly.

Valerie, who worked as a quality-of-life officer and closely collaborated with the nurses, observed discrepancies between the nurses' focus and the seniors' desires. She noted that the nurses often prioritized aspects like ensuring the seniors were well-groomed and presentable, which included getting them up in the morning and dressed in clean clothes, and maintaining clean rooms, regardless of the seniors' personal preferences. “But it's about what the seniors want,” she emphasized, highlighting the need for a more resident-centered approach to their care. “If they don’t want to get up at eight, they don’t have to.” In real life, however, unless the senior is physically able, they cannot make these decisions for themselves.

Jeff, as a nurse, also expressed dissatisfaction with his role at the nursing home. Beyond providing rigid, institutionalized care, he was particularly dissatisfied with some nurses' lack of respect toward the seniors. He firmly believed that paperwork should be handled away from residents. “If you have to do your paperwork, do it in an office. Do not do it in front of the seniors!” This view aligns with my observations, where I have seen nurses engrossed in paperwork in communal areas. On one occasion, a nurse was so focused on her tablet that she deliberately ignored a senior talking to her. It was one of a few incidents I witnessed that clearly illustrated Jeff’s point.

Given the staffing limitations, it is understandable that nurses would focus on institutionalized care. An implicit agreement seemed to prevail that their main goal was to ensure a safe, quiet, and orderly environment for the seniors. On one hand, nurses were grappling with significant stress and a general lack of motivation. On the other, their experiences had inclined them to minimize the "stimulation" of the seniors, who could react unpredictably and potentially exacerbate challenging situations.

This approach challenges the common belief that nurses, with their professional training and experience, are fully equipped to manage all aspects of senior care. In reality, they often encountered situations that were difficult to handle within their existing framework and resources.

On a particular Christmas Eve, a situation arose where a SwD (my “aunt”) became extremely disruptive and aggressive, leaving the nurses unsure of how to respond. Their first step was to contact the hospital, and when that proved unhelpful, they reached out to the police, but neither could provide the necessary assistance. Ultimately, with no other options available, the nurses resorted to isolating the senior in her room, where she remained without supervision for 2 to 3 hours. Instead of promoting understanding or empathy, which are critical to implementing PCC, incidents like this often had the opposite effect, compelling the nurses to further withdraw from engaging with seniors who exhibited challenging behaviors.

Volunteers have traditionally played a crucial role in the nursing home's services, particularly in the evenings when many nurses finish their shifts. The manager who spoke about institutionalization at the facility initially joined as a volunteer before becoming an employee. Before the pandemic, the nursing home depended on 100 to 150 volunteers, mostly retirees from the local area, reflecting a key aspect of Dutch culture that values community service. But as the manager recounted, “They knock on your door, 8 pm in the evening, and they give you coffee. It’s also institutionalizing.”

This volunteer-based care model was more effective when the majority of nursing home residents were more independent. At that time, volunteers' routine offerings of coffee or tea often sparked lively conversations with the seniors. However, when I worked alongside some volunteers, the situation had changed significantly. Even on standard service floors, many residents were suffering from dementia and showed little interest in the volunteers' services. Additionally, volunteers were not involved in dementia wards, further limiting their interaction with a population that needed them the most.

However, as pointed out by one HVYA, the contribution of volunteers was still essential for the well-being of the seniors. “If the volunteers were to leave, the (nursing) home would fall apart,” the HVYA stressed, underlining the significant impact volunteers have on the overall functioning and atmosphere of the nursing home.

Before the pandemic, an assistant manager at the nursing home was responsible for coordinating the volunteer program. Despite her rich experience, she confided that maintaining the volunteer team was becoming increasingly challenging. The commitment to volunteering, once a tradition among seniors, was not as prevalent in the younger generation. With the aging of the current volunteers, keeping up the numbers was already a struggle. In the subsequent year, the assistant manager fell ill and had to step down from her role. The pandemic brought significant changes, both globally and within the nursing home, leading to the redistribution of her responsibilities among other managers rather than appointing a replacement. This approach, however, proved ineffective in sustaining the volunteer team, leading to a gradual decline in their numbers. One of my informants noted that this shift was one of the reasons the nursing home felt "not the same" after the pandemic.

The situation at HCare, characterized by high stress, a toxic work environment, and institutionalized care practices that even the nurses viewed as problematic, demonstrates that the traditional care model – dependent on nurses and supplemented by volunteers – is inadequate for addressing the drastic changes in the industry. Discussing potential solutions, Jeff, a nurse, emphasized, "We don't need more people, but better people." He suggested that instead of continuing with their current practices, he believed that "they (nurses) need to what the 'buddies' (HVYAs) do," whose work focuses on providing individualized care to improve the seniors' well-being.

The HVYAs' Job and the Reported Positive Experience

As I sought to get involved in the nursing home, my initial step was to participate in the tasks typically handled by the HVYAs before they agreed to sit for interviews with me. Therefore, to reflect on my journey there and how I experienced it, I will first describe the nature of the HVYAs' work before delving into their phenomenological coping experiences, which is the next section.

Even though not widely acknowledged at the nursing home, the role of the HVYAs is crucial for the well-being of seniors, particularly in the dementia ward. Despite the job's inherent challenges, it was surprising for me to find that the young adults consistently reported positively about their work experiences. This unexpected finding provides a new perspective on understanding SwD and suggests the possibility of viewing them as sources of social support rather than solely as liabilities that require services.

Background and Job Description. The HVYAs' positions were initially created to offer employment opportunities that would otherwise be unavailable. Instead of performing routine nursing tasks like dressing the seniors, doing laundry, or putting them to bed, their primary responsibility was to enhance the seniors' quality of life by spending meaningful time with them. This focus on the seniors' well-being defined their role, which was a unique practice at HCare.

"It's making their life as comfortable as it can be with a very uncomfortable disease," said Eefje, one of the most experienced HVYAs in dementia care. "It (dementia) is really really heartbreaking, dehumanizing, hurtful disease. And make the most out of it." Essentially, their task involved understanding and responding to what the senior wanted at any given moment and helping them fulfill that wish. Common activities included engaging in conversation, taking walks, or playing games with the seniors.

Senior staff members, especially those in management positions, often portrayed the HVYA's role as relatively straightforward. They typically characterized the tasks as informal, such as sharing a coffee or going for a leisurely walk with the seniors. The role's perceived primary challenges were managing the HVYAs' symptoms and handling the seniors' disruptive behaviors. There was an assumption that collaboration with experienced nurses would help to mitigate these challenges effectively.

It is important to note that most managerial staff seldom visited the dementia floor or kitchen to engage with the frontline teams directly. Though seemingly plausible, their descriptions of the HVYA role were more based on assumptions than firsthand observations.

However, my interactions and interviews with the HVYAs revealed a different reality. Contrary to the managerial perspective, the unpredictability inherent in the work, combined with the need for constant sociability and a lack of adequate training or support, rendered the HVYAs' tasks significantly more complex and demanding than initially perceived.

A Difficult Job Underestimated. Alongside handling the well-known disruptive behaviors of SwD, HVYAs face distinct challenges stemming from the role's unstructured nature, the demands for them to venture beyond their comfort zones, and the lack of support around them at work. Uninformed, the young adults often start this job with minimal knowledge of its demands, which makes adapting to the role particularly challenging.

A Job without Protocols and Cannot be Planned. The dementia ward was located at the backside of the nursing home and is only accessible through a long corridor. As a researcher, I was advised to only go there when someone accompanied me. As I became more involved in the dementia ward, I frequently shadowed Eefje, who had been working on dementia floors since 2019. She was among the most experienced HVYAs, whose dedication and expertise were praised by nurses on the floor. By shadowing her, I wanted to observe how she managed her work. However, in the dementia ward, we often found ourselves working independently. It was common for us to be pulled in different directions upon entering the floor; she would typically need to address an unexpected 'incident,' often involving a senior who was agitated or grumpy. Simultaneously, another senior would seek interaction with me. As a result, we spent most of our time in the dementia ward separately, each of us continually engaged in addressing the immediate needs around us.

The HVYA’s work, while seemingly routine, is quite complex. As Eefje explained, the seniors' conditions changed daily, even hourly. For a caregiver, it is crucial to continually assess their well-being by observing their eye contact and body language. This is especially important given the higher likelihood of disruptive behaviors among the seniors they work with. As mentioned earlier, there are two common areas on each dementia floor. On the floor where I volunteered, the seniors were divided based on their stages of dementia. In essence, those in earlier stages who were more prone to disruptive behavior were brought to the area where the HVYAs worked. This area normally comprised of six or seven seniors. The nurses took care of the quieter group in the other common area with about ten seniors.

The seniors were arranged this way mainly to avoid disruptive behaviors. If one senior became disruptive, it often triggered a domino effect, impacting the others. An HVYA recounted an incident where one senior's uncontrollable crying led others to weep and express a desire to go home. It took hours for calmness to be restored, not because the crisis was resolved, but rather because the seniors were exhausted. To avert such situations, HVYAs had to be vigilant and proactive in taking preventive steps. The challenge lies in the absence of set protocols and the necessity to learn and adapt through experience.

The HVYAs' roles differed significantly from those of the nurses, primarily because their tasks could not be pre-scheduled or rigidly structured. It is well-recognized that each individual with dementia (SwD) experiences the condition uniquely, leading to varied and personalized needs. A technique or approach that soothes or pleases one senior, such as combing their hair, might be ineffective or even unwelcome for another. Additionally, the success of any given approach depends not only on the senior’s mood at the moment but also on who is suggesting or implementing it.

Speaking of the underestimated pressure of the job, Eefje shared a personal experience. On one occasion, she stepped in for a nurse who could not make it to work. “It was so nice!”

Eefje exclaimed, her eyes lifting as though it was enjoyable to recall the experience. “I didn’t have to think. When I did that shift, I realized how hard being a buddy is. Because being a buddy I have to think all the time. I don’t have a list of tasks, I just come, see what’s going on, and improvise, every step that I take. Nurses prepare food, clean the dishes, get coffee. It was so...” She paused to take a deep breath, reliving that moment of relative relaxation. “It feels so good. It is hard physically, you can’t sit by someone and talk but you know. I also get tired from being social. It’s so nice to just know what to do. Those are the moments when I think I have the best job in the world, but it’s hard.”

Therefore, while the HVYAs’ job might seem easy for an outsider, it was full of challenges.

Work as a Group Leader. Working in the dementia ward required that the HVYAs, already a highly vulnerable group, not only adapt to unpredictable situations but also step outside their comfort zone by assuming leadership roles. This was unexpected for me, as my discussions with the managers had given the impression that the HVYAs' work was primarily directed by the nurses. However, this was not true. Since there were only a few HVYAs and they worked part-time, their shifts often did not overlap. As a result, one HVYA was often in charge of the well-being of several seniors. Being the "leader" of the group involved making decisions for several of SwD, resolving conflicts, and ensuring that each person's individual needs could be addressed. For these marginalized young adults, many of whom struggle with social skills and self-esteem, these obligations often meant challenging themselves by undertaking roles they were not used to.

As the group leader, making decisions for the seniors entailed determining how they would spend their time, involving both group and individual considerations. For the group aspect, the HVYA needed to closely monitor the seniors to preempt disruptive behaviors and, when feasible, organize group activities. At the same time, they must also be attentive to any individual needs or preferences. For instance, if the seniors were calm and showed no animosity toward each other, the HVYA might suggest a group game. Participation was usually voluntary, and such activities helped keep the seniors engaged and active. Eefje sometimes led a simple board game where seniors pressed a button to roll dice, determining how many spaces their pieces moved on the board. The game's simplicity was key to maintaining involvement, as the seniors could easily grasp and remember the rules.

The HVYAs' challenge in facilitating the game was the social interaction, which included reminding the seniors of their turns, ensuring pieces were moved correctly, engaging in conversation, and using humor. With the HVYA's guidance, the seniors could stay focused for about an hour. These activities typically left the seniors tired but content, marking such days as peaceful and uneventful.

If any seniors exhibited early signs of restlessness and the weather was favorable, the HVYA might propose a walk outside. Such outings provided the seniors with fresh air and often positively affected their mood. Given that some of the seniors were physically frail, typically only three or four would opt to join. Those who required wheelchairs would be assisted by the HVYAs, who also made decisions about the destination (i.e. a park adjacent to the nursing home), the duration of the outing, and the order in which seniors went outside. Priority was usually given to those showing early signs of agitation.

The scenarios described above pertained to times when the seniors were relatively calm. However, if a senior becomes agitated, they can sometimes act out negatively toward others. In such situations, it is crucial for the HVYA to step in as a mediator, addressing the issue and helping to restore harmony. This aspect of their role requires sensitivity and the ability to deescalate tense situations effectively.

Research on relationships within nursing homes often focused on the dynamic between SwD and their caregivers (Taşcı et al., 2012), with less attention given to the interactions among the seniors themselves. During my research at HCare, however, this was an important theme the HVYAs had to deal with regularly. It was widely acknowledged that SwD could be “mean” to one another, leading to verbal insults and, in some cases, physical aggression. While I did not witness any aggressive behaviors, I observed instances of seniors behaving unkindly toward each other. For instance, my ‘teacher’ and my ‘aunt’ did not get along. On one occasion, when we were all seated at the same table, my aunt tried to converse with me. My ‘teacher’ reacted by sneering at her and giving me looks that seemed to suggest I should avoid engaging with my ‘aunt.’ This subtle but apparent animosity highlighted the complex social dynamics that can exist among seniors.

In another instance, I was informed of a senior who subtly but intentionally tried to trip another. Where conflicts arose, situations like these required the HVYAs to step in and mediate, balancing the need to maintain harmony with the sensitivities of each individual involved. This aspect of the job demands not only patience and empathy but also leadership skills such as demonstrating authority, quick thinking, and effective conflict-resolution skills.

It is important to mention that the seniors looked up to the young adults as their group leaders and from what I witnessed, never challenged their authority. During one evening, Eefje organized a game for some seniors at a table. She positioned herself at the center with a stack of question cards, such as “Where is the capital of Germany?” As she read out the questions, the seniors tried to answer. Even though it was a simple game, it could get heated, as some seniors competed for recognition from the HVYA. At one point, when a senior answered a question incorrectly, my ‘aunt’ muttered something jeeringly in Dutch. Eefje responded in a manner reminiscent of a teacher addressing a mischievous student. She looked at my ‘aunt’ intently and called her name in a tone that was gentle yet firm. Much like a student who got caught in a misdeed, my ‘aunt’ reacted by looking down. However, once Eefje shifted her focus away, my ‘aunt’ playfully grimaced at me, showing a mixed feeling of embarrassment and relief.

After our shifts, Eefje and I would often talk about the day’s work outside the building. To me, these conversations were particularly enjoyable and enlightening. It was fun for us to discuss what we did during the shifts and as I could not speak Dutch, I appreciated gaining insights into her work and the seniors. Talking about my ‘aunt,’ Eefje acknowledged that she was known as the "problem child" on the floor, often walking around and making comments like “Don’t fall asleep,” or “Be normal.” As Eefje noted, “She (my ‘aunt’) was not aware that she was not treating people right.” However, it was not possible to ask her to change her behavior. “It’s easier for me to have fun with her instead of arguing with her. But I do get mad at her when she’s mean to other seniors. You can be mean to me but you can’t be mean to my other babies,” she laughed. “They are my sweethearts. That’s the challenging part. Just figuring out which way works best with which individual because they are so different from each other. You know what works best to give the best of their last years possible.”

Amalia, another HVYA at the dementia ward, shared similar feelings. Never felt that she was a leader, she found the role of mediator to be the “hardest part (of the job).” She observed that the seniors often did not understand each other and “just don’t really like each other.” Discussing the various dramas that unfolded among the seniors, Amalia smiled with some distress. “I don’t want to pick sides,” she explained. “Cause I don’t want to pick a side. I just want them to understand that everyone is different. But some of them don’t understand and they can be really direct.” From what I witnessed, both Eefje and Amalia were comfortable with acting as the group leader when needed. The stress did not come from the role itself, but from the disappointment that the seniors failed to like each other.

In general, the HVYAs were perceived as authoritative figures by the seniors, despite their younger age. The young adults were the seniors’ go-to people for assistance and as confidants. This dynamic highlighted the seniors' considerable trust in the young adults. As previously mentioned, the agency of SwD might appear different compared to individuals without dementia, but they are still capable of discerning and expressing their preferences for certain people. This trust extended beyond the perceived authority of the HVYAs; it was also a testament to the effort the young adults invested in recognizing and addressing each senior's needs through attentive and effective communication.

When asked about the essential aspects of their role, three HVYAs highlighted the importance of fairness in their interactions with the seniors. Although their specific duties varied, leading to different examples, they all emphasized striving for fairness and considering the needs of each senior.

Fairness in this context involves acknowledging the varied vulnerabilities of the seniors and tailoring services to meet their individual needs. Angel, another HVYA who worked on the dementia floor, provided an informative example. During a group breakfast that she was organizing, several seniors asked for help spreading butter on their bread. One of these seniors had been advised by his doctor to continue doing this task himself as a form of exercise. When he handed his bread to Angel, she chose to assist him, not wanting him to feel left out or different from the others. As Angel explained, her job required her to “care about all the people,” which in her view, meant treating each senior fairly and with consideration to their unique circumstances.

Without having talked to Angel about her work experience, Amalia was of the same opinion. She liked to take the seniors outside of the nursing home so their lives would not be as confined. She accompanied some seniors to go shopping, drinking coffee at a café. When the need was expressed, she also risked driving a senior to visit her sister in town, even when Amalia was not sure if the information provided by the senior could be trusted or not. While telling me about her work with joy, she also added that there were about 20 people on her floor. “So you need to keep in mind that that person has been out three times this week already,” she added, so she had to make sure that every senior’s need was taken care of. As she encouraged the seniors to tell her what they wanted, a quiet old man said he wanted to go to a concert, but he did not want to go with other seniors. Therefore, Amalia went with the man alone, which allowed the old man to feel that he was not overlooked.

Eefje, too, was diligent in ensuring inclusiveness during group activities, especially among seniors who were prone to causing disruptions or collisions. For example, one group activity involved using foam tubes, often found at swimming pools, to hit a balloon – a game in which both Eefje, myself, and the seniors participated.

Before the game, Eefje cautioned me to pay special attention to Tom, the friendly old man known for his enthusiastic greetings, as he tended to take the game too seriously. Despite their advanced age, the seniors held their foam tubes tightly, eagerly trying to hit the balloon whenever it came near. Their excitement was evident as they remembered the game and became instantly animated. Naturally, the balloon often strayed away from the table due to the seniors' vigorous hits from various directions. In such cases, Eefje and I would gently guide it back toward a senior who had not had a turn in a while.

A few times, Tom grew increasingly frustrated as he struggled to hit the balloon as often as he wished. His attempts usually resulted in him hitting another senior’s foam tube, drawing displeased looks from others. I stayed close to Tom, intervening to prevent his tube from colliding with others by placing mine in between. Eefje and I also exchanged signals to ensure the balloon reached seniors who were less involved.

The game lasted about forty minutes. We focused on making sure everyone was included, and the seniors appeared to enjoy themselves, with smiles and a few hearty laughs. When the activity was over, I felt a sense of relief that the game proceeded without any major issues. To an observer, it might have seemed like a simple game with the seniors, but for us, it was more about facilitating than participating.

Without a break, we swiftly moved the seniors back to their usual spots, where they felt most secure, and began cleaning the tubes and table with wet wipes. This experience underscored the demanding and attentive nature of organizing such activities, far removed from simply playing a game.

The intricacies of the HVYA role were challenging enough but taking on a leadership position proved to be a particularly demanding aspect for these young adults, who were more accustomed to playing supportive or submissive roles. Five out of six HVYAs reported that they could not work long hours because of the job's intensity.

For instance, Amalia, who appeared energetic and engaged when interacting with the seniors, revealed in our interview that even 16 hours a week felt like a stretch. At that time, she was recovering from a major depressive episode, but the demanding social nature of the job was the primary challenge. Mediating conflicts among the seniors, understanding their individual needs, and ensuring fairness were taxing for her, especially considering she had been unable to work for over a year due to her depression. “This (job) is really really social, that is always tricky for me. I can’t turn it off. I’m so invested, if I do that too many hours a week, I’m going to be messed up again,” she explained.

Similarly, several other HVYAs reported needing to rest for the remainder of the day after working “a long shift” of just four or five hours, underscoring the emotional and mental toll the role could take on individuals who were still navigating their own vulnerabilities.

A Difficult Job with Little Support. In addition to the challenges already outlined, the HVYAs also faced the difficulty of navigating the work largely on their own. They generally had limited knowledge about dementia and were expected to learn the intricacies of their job through trial and error, often with diminishing support from the nursing home. These factors compounded the complexity of their role, making it even more challenging for this vulnerable group.

Despite the program's well-intentioned goals, the support provided to the young adults was insufficient. One HVYA highlighted this issue, saying, “I don’t think you can hire someone and say ‘Oh, you can learn here and we have a place for you,’ and just leave them be.” The lack of adequate support made the HVYAs' positive reports about their work experiences all the more intriguing and worthy of further exploration.

The belief that working with dementia patients necessitates professional skills is widespread (Eijkelenboom et al., 2017). However, before working at HCare, the HVYAs had very limited knowledge about this population. More than half of them had no prior exposure to individuals with dementia, and when they first started, five HVYAs found it “painful” to see the seniors struggle with dementia, a distressing experience that led some of the empathetic HVYAs to cry at home.

Before working at HCare, Eefje had volunteered at another nursing home, assisting seniors with physical disabilities. She found that working with seniors with dementia had a much more profound emotional impact on her. “It’s painful, painful and it’s bad. Even though people seem really normal and ok, it’s bad. Especially when people are really really forgetting things, so confused and you can see them struggling, but can’t express themselves.” When Eefje told me this, it was as if she was going through the struggles herself. “‘Why am I feeling like this? I want to die if I have to feel this way the rest of my life.’ They (SwD) really get depressed because they are so off. And it’s painful.”

Apart from the seniors' struggles, the HVYAs also had limited knowledge about the seniors' past, such as their occupations before retirement, family dynamics, or their personalities before developing dementia. There was a lack of information sharing about the seniors and no meetings were held with the nurses to discuss these details. For instance, Eefje only discovered the occupation of my ‘teacher’ after a year into her job, which happened by chance: her son came for a visit during her shift. Had it not been for this incidental encounter, she might have remained unaware of this important aspect of the senior’s life.

Therefore, when the young adults first started the job, they were uninformed. They possessed a limited understanding of the specific challenges faced by the senior population and lacked detailed information about the individual seniors residing in the nursing home.

To make the job more challenging, the HVYAs had to learn the intricacies of the job almost independently. Apart from one HVYA who held a certificate in nursing, the others indicated that they lacked the support they needed, particularly in the early stages of their employment. According to some informants, the nursing home provided only two or three meetings to debrief the HVYAs about dementia. These sessions lacked comprehensive protocols, guidelines, or learning materials. None of the HVYAs I interviewed found these meetings particularly useful, as they were unable to recall any significant details from them.

Beyond these meetings, the HVYAs were assigned mentors to shadow in the initial stages of their employment. These mentors were typically experienced nurses or community helpers. However, I was told repeatedly that many mentors lacked enthusiasm for assisting the young adults. Furthermore, given the hectic and unpredictable nature of the work in the nursing home, especially the dementia ward, the HVYAs often found themselves working independently rather than closely with their mentors.

In terms of learning the job by themselves, Eefje's experience was typical among the HVYAs. Her expertise and dedication were broadly recognized by the staff, with some nurses even considering her a “natural” at working with the seniors. Despite this, Eefje shared with me that she had to learn the job on her own. “It’s something you have to experience. You have to know when it’s time when they need to rest. Now they need triggers (stimulation), they have too much rest,” she explained. Her learning process was self-initiated, driven by her passion rather than a formal requirement. Instead of consulting the nurses, she took the initiative to buy books and watch documentaries about dementia, finding validation and encouragement when these resources echoed her own experiences at work.

Despite her enthusiasm, there was a time when the job was too overwhelming; she nearly decided to quit. When I brought up the nurses' praise, which they never communicated with her directly, she appreciated it but was hesitant to believe it. According to Eefje, since she had to learn everything by herself, it took her over two years to develop a sense of confidence in her role.

Like Eefje, Beatrix came to HCare with no prior knowledge of dementia. It was only later that I learned she had attended a high school designed for students with learning disabilities. Beatrix had always enjoyed helping others, but her only job post-graduation had been dishwashing in a hotel. At the nursing home, while staff members recognized her commitment, Beatrix did not know what exactly was expected from her at work. Eefje worked on the same floor as Beatrix. She observed that Beatrix was too eager to prove her dedication, which led her to be “all over the place,” cleaning mugs and dishes but overlooking the seniors’ individualized needs. Relating to her struggle, Eefje volunteered to be Beatrix’s mentor to give her the necessary support and guidance. It took Beatrix several months to learn to pace herself at work. Had it not been for Eefje’s help, it would have taken her even longer.

The work for the HVYAs was further complicated by a gradual reduction in available resources, which went largely unnoticed. According to the management team, the young adults had access to a range of support, including job coaches, community helpers, volunteers, and nurses. However, this support system, robust in theory, was less effective in practice. The Buddies Program, for example, initiated in 2019, encountered the unexpected challenges brought about by the pandemic in 2020, leading to a reduction in support for the HVYAs.

A key indicator of this dwindling support was the high turnover rate experienced by the nursing home during this tumultuous period. It needs to be mentioned that amidst these upheavals, the HVYAs demonstrated their commitment and reliability. Despite the diminishing support and increased difficulties, they continued to devote themselves to the well-being of the SwD.

The two job coaches played an important role in helping the HVYAs adjust to their work at the nursing home. Given the young adults' lack of professional experience, two job coach positions were established in 2019, with each HVYA being assigned a coach. The job coaches' responsibilities were multifaceted, but some of their most important tasks included managing the HVYAs' schedules, monitoring their attendance, and resolving conflicts with other staff members.

Both job coaches were certified for their roles but lacked experience in working with the SwD or mental health struggles.

When discussing their experiences with the job coaches, the young adults often responded with a bittersweet smile. They appreciated the dedication and efforts of the job coaches, recognizing their commitment to assisting them. However, there was also a sense of dissatisfaction due to the coaches' lack of experience in understanding their needs, both in terms of the mental health challenges and struggles at work.

Sophie, one of the job coaches, was in her late 20s and initially joined HCare as a nurse. When the intergenerational programs were being developed, she embarked on a one-year online course to obtain her coaching certification. With the launch of the Buddies Program in 2019, Sophie began working as a job coach for 28 hours a week, while simultaneously dedicating around 10 hours weekly to her training course.

The job coach role, especially in a new program like this, was both demanding and unstructured. When the program was fully fledged, she was the coach for six or more HVYAs at a given time. The coaches not only worked with a highly vulnerable population requiring extensive support, but they also handled various administrative tasks. This included paperwork, communication with family members of the HVYAs, scheduling for the young adults, communicating with their colleagues, etc. Beyond her role with the HVYAs, Sophie also participated in facilitating other group activities aimed at supporting marginalized young adults in the community. One such initiative was leading a weekly group dinner, which sometimes involved assisting with cooking. Therefore, her role was by no means a simple one.

Sophie's commitment to assisting the highly vulnerable population was unquestionable, but many at HCare felt that having a certificate for the job did not necessarily equate to having the requisite credentials. Renske, a staff member in her 50s with over ten years of experience at HCare, expressed this sentiment: “It’s not an easy job. It’s a difficult job. They (job coaches) don’t have enough experience for that. You have a program for 6, or 7 weeks, then you are a job coach. I think the duty is much more than 6 or 7 lessons. It’s much bigger,” she said. “(They need) more experience with people with baggage. Really know what someone is looking for. Sophie, she was a nurse. I think it (the training) is too short.”

Bart, the other job coach, was in his mid-50s. He was mainly responsible for the young adults from the Neighborhood Program, but he was also the coach for two HVYAs. As he refused to participate in my research, my understanding of his background came solely from what other informants shared. When inquiring about Bart with a young adult from the Neighborhood Program, the response was a sarcastic smile. “He refilled coffee machines, things like that.” This characterization of Bart as a utility worker with no prior experience in working with either the seniors or HVYAs was verified by other informants.

Helena, one of the HVYAs, was well-acquainted with both job coaches. Discussing her experiences with them, she gave a bittersweet smile. “There’s no knowledge about real problems. There’s no knowledge about depression, about addiction, about trauma, about PTSD, all the stuff that we suffer from. There’s no knowledge. Only caring.” By “caring,” Helena referred to the coaches' open and trusting nature, allowing for candid discussions about personal struggles. Nevertheless, the support provided by the coaches was generally limited to their offices, as they rarely visited the areas where the HVYAs worked. Helena appreciated the coaches' efforts, saying, “Their support really helped. They’re good people trying to be helpful, but they lack the necessary education and experience. They’re trying hard, but I worry it might eventually overwhelm them.”

Helena's concerns were not unfounded. As the intergenerational programs grew, the job coaches found their workload increasingly burdensome. Consequently, their regular meeting schedule with the HVYAs was reduced, shifting from weekly to sometimes only monthly sessions, yet they still faced challenges in managing their tasks. In 2020, Sophie, already overwhelmed by work, was additionally assigned as my contact person to aid in my research by facilitating interactions with the HVYAs. During this period, however, she began to miss appointments and eventually had to take an extended sick leave.

Eefje, as one of the more experienced HVYAs, felt the pressure intensify during this time. She remarked, “You know the problem is that in the last couple of weeks, they (job coaches) were all gone and sick, and not working. The assistant manager was gone for a while. Everybody was gone so it was all up to us.” This situation was particularly acute at the height of the pandemic, a time when the young adults required even more guidance and support than usual. Unfortunately, it was during this critical period that the job coaches' presence and support started to wane significantly.

In early 2021, Bart left his position, and the reasons behind it were not publicly disclosed. Helena, caught off guard by this change, was particularly upset by the lack of professionalism and mannerisms from him. She had an appointment scheduled with Bart, which was abruptly canceled without any prior communication. When we had the interview, her disappointment was evident. Having known the job coach for three years, she expected at least a farewell from him. However, she did not hear anything from him nor was she informed of why he left. According to Renske, she heard rumors that Bart “made a mistake and then was fired.” "It is what I heard. I don’t have the facts,” she emphasized. As a colleague, she sent him an email to wish him good luck, but she never received a response.

By the time I returned to the nursing home in fall 2021, Sophie was the sole person in charge of overseeing both intergenerational programs, which involved more than 10 young adults. Assigned as my contact person, I managed to meet her only once before she went on sick leave. There were initial rumors of her returning in two weeks, which then extended to a month and eventually two months. It turned out she experienced burnout and did not return to work until much later. Consequently, the group dinner for marginalized young people in the community had to be paused, although Sophie encouraged them to continue meeting independently.

Thus, while the role of the job coaches was crucial in supporting the HVYAs, especially in the early stages, the young adults often found themselves without this support when actually working on the floor. Instead, they were left in the hands of community helpers, whose ability to assist effectively was overestimated.

The support system at the nursing home was structured so that job coaches facilitated the HVYAs' general work readiness, while community helpers assisted them with specific tasks on the floor. However, from the HVYAs' perspective, the community helpers were not as supportive as anticipated. These helpers were typically volunteers from the local community, lacking a professional background in care. With the nursing home often requiring additional support for organizing group activities, about 10 experienced volunteers were hired into the role of community helpers, a common part-time position in Dutch nursing homes.

Community helpers at HCare were mostly identifiable by certain characteristics. The majority were women over 50, dressed in casual attire but sometimes wearing name tags. They were frequently seen in common areas across various floors, assisting with tasks like setting up tables and distributing silverware. Unlike the HVYAs, these helpers generally adhered to a more traditional approach to care, focusing on conducting group activities such as games or tea time.

However, they tended to pay less attention to addressing the individualized needs of the seniors. In addition, similar to volunteers, they did not work inside dementia wards.

The division of responsibilities between job coaches and community helpers in relation to the HVYAs was somewhat ambiguous, even to the management team. While the management viewed the HVYAs as primarily the job coaches' responsibility, the coaches often counted on community helpers to assist the HVYAs during their shifts.

A manager, when attempting to clarify the system to me, seemed to grapple with its intricacies herself. She explained that the intended model was similar to the traditional master-apprentice relationship “In the old days you have master and apprentice, that’s what we try to do here,” she said. This implied that HVYAs were expected to shadow community helpers, learning from them as they worked.

However, she then noted that for some HVYAs, just arriving at work on time was a significant achievement. “Sometimes, the goal for the youngster (HVYA) is to arrive to work on time. That’s the first step if you want to get a job, you have to make sure. For some young people it’s already a challenge,” she added. This aspect of ensuring punctuality and basic work readiness fell under the purview of the job coaches, not the community helpers. The overlap and occasional confusion between these roles highlighted a need for clearer delineation and communication of responsibilities within the support system.

The confusion regarding the HVYAs’ work responsibilities and the resources available to them was not unique to one senior staff member; it was widespread confusion. In addition, there was a general lack of clarity and interest in the HVYAs’ experiences among the staff members. While community helpers were skilled in their roles, they typically were not trained to work specifically with HVYAs, or the enthusiasm in supporting them.

Eefje, who began as an HVYA and was later promoted to a community helper in 2021, took proactive steps to support Beatrix. “I stole her (Beatrix) from a community helper, I noticed that she had no guidance, no goals,” Eefje explained. After discussing with Beatrix’s job coach, who agreed to the arrangement, Eefje assumed the mentorship role. However, like others, she did not have specific training in guiding an HVYA. The blurred lines between the responsibilities of a job coach and a community helper meant that Eefje had to navigate this mentorship based on her own experience. “We started this conversation every week because I think it’s important that the one guiding her in work knows how she’s doing. So, I did things for her that Sophie did for me.”

During a period of significant change at the nursing home, with job coaches frequently unavailable, Eefje essentially filled both the roles of a job coach and a community helper for Beatrix. Both Eefje and Beatrix felt that this arrangement worked well, indicating a successful adaptation to the challenges presented by the existing support structure.

Other than this singular example, however, the HVYA questioned the guidance they could get from the community helpers. Eefje, with her insider perspective as a community helper, highlighted this issue. “They (community helpers) should be trained more. We got this class, two times, where we learned shallow things about how to work with someone with issues (HVYA). I think there is a lot more to it,” she said. “From what I hear is that not everyone put as much time and energy in their buddies as I do. And I think that’s a problem.”

Angel shared a similar viewpoint. She acknowledged the good intentions behind the program at HCare but felt that the support was only effectively maintained for the first year. Her concerns extended to the work ethic of some community helpers, stating that most seemed disinterested in genuinely assisting her. This lack of commitment from some community helpers to fully support and understand the HVYAs' needs was a recurring theme, indicating a gap in the effectiveness of the program's implementation.

Following the high turnover rate at the nursing home during the pandemic, some unstructured support for the young adults began to disappear. Helena and Natalie who worked on standard service floors felt this particularly strongly. During this period, a few managers and assistant managers left, leaving a void in leadership. This directly impacted Natalie, who had previously worked closely with an assistant manager for guidance and support. In addition, Natalie's situation was further challenged by her preference for limited working hours due to her symptoms, coupled with her discomfort in communicating her needs to authority figures. The high staff turnover resulted in increased workloads for the remaining staff, including Natalie. Instead of working her regular part-time hours, there were weeks when she had to work over forty hours. Natalie quietly complied, but there was a particularly distressing incident. One day, a manager who never came to the floor confronted Natalie about working overtime, unaware that it was her own scheduling error that had caused this. Although the manager acknowledged the mistake, the situation did not change for Natalie. Without anyone noticing, Natalie had not taken a holiday since 2019, reflecting the ongoing strain and lack of adequate support in her work environment.

Similar to Natalie, Helena also noticed that support around her gradually disappeared. Being an HVYA, Helena said she was undervalued by staff members. The volunteers, however, treated her as an equal, and she found working with them an enjoyable experience. In 2020, the situation changed dramatically when the manager responsible for overseeing the volunteers suffered a stroke and was unable to return to work. Her position was not directly replaced; instead, her responsibilities were split among other managers. Helena noticed a marked difference under this new arrangement, stating, “It was not the same.” The volunteers, who were integral to her positive experience at work, began to leave, including those she had formed strong connections with. This shift in the volunteer dynamic affected Helena's engagement with her job, leading to a decline in her interest and enjoyment. Eventually, these changes at the nursing home contributed to her decision to leave the program in 2021.

Positive Report on the Work Experience. Contrary to the management's portrayal, the HVYAs found that the longer they worked at the nursing home, the fewer resources and support they received from staff members. Nevertheless, despite these challenges, each HVYA derived a deep sense of fulfillment from working with the seniors. They expressed gratitude for the program, which not only provided them with employment but also facilitated personal healing and growth.

In 2020, there were about six individuals participating in the Well-being Buddies Program. Originally designed as a one-year commitment, all of them were eager to extend their contracts. This opportunity materialized unexpectedly when the onset of the pandemic made new recruitments challenging for the nursing home. Eefje, recounting this experience to me, was still very passionate. If your job is something you’ve learned (studied) for, or makes a lot of money, I can understand you keep doing that,” she said. “But if you don’t need to learn for it, you don’t make a lot, I think you have to like it a lot to do it.” Not only did they enjoy working with the seniors at the time of my interviews, four out of the six of them wanted to continue working with this population in the future. Among the other two young adults, one left the nursing home to work with teenagers with severe mental health struggles. For privacy reasons, the other young adult’s career choice is not disclosed.

Given the complex work environment, challenging job requirements, and limited support provided, the positive experiences of the young adults initially appear enigmatic. The next section, framed using the Phenomenological Variant of Ecological Systems Theory (PVEST), focuses on understanding the young adults' work experiences using their perspective. Specifically, it tries to understand the underestimated vulnerabilities of these young adults, their coping experiences, and how the intergenerational relationships formed in this setting contributed to their positive coping outcomes.

HVYAs' Coping Experience at Work

The first two sections of this chapter detailed how the nursing home was navigating a challenging transition period, particularly in its efforts to provide Person-Centered Care (PCC) to Seniors with Dementia (SwD), who had become the majority of its residents. The pandemic exacerbated these challenges, and consequently, management held modest expectations regarding the young adults' ability to cope in this environment. It was, therefore, surprising to discover that the High Vulnerability Young Adults (HVYAs) not only reported positive coping outcomes but also expressed their desire to pursue caregiving as their career plan.

This finding indicates a mutually beneficial relationship between HVYAs and SwD. If similar programs can be adopted globally, they have the potential to profoundly improve the existing care model. To better understand this relationship, we need to first explore: *Who are the HVYAs, and what makes them highly vulnerable? What do their coping experiences and outcomes look like, analyzed through the lens of the Phenomenological Variant of Ecological Systems Theory (PVEST)*?

This section utilizes the Phenomenological Variant of Ecological Systems Theory (PVEST) as a framework to thoroughly analyze the coping experiences of the young adults. The analysis follows a structured sequence, starting with an assessment of their net vulnerability prior to entering Hcare (Status One). It is then followed by net stress (Status Two), which includes identifying the risks they perceived and the support available to them, and, afterward, an exploration of the coping strategies (Status Three) they employed in response to these factors. Finally, the focus shifts to the outcomes of these coping efforts (Status Four and Five). Despite variations in the backgrounds and specific job roles of the young adults, a significant finding is that their coping experiences and outcomes displayed considerable similarities, highlighting common threads in their resilience and adaptation within this challenging environment.

Name	**Symptoms**	**Places Worked at HCare**	**Duration of Work at Hcare (by the end of 2021)**	**Coping Outcomes**
Amalia	Depression, possibly PTSD	Dementia ward	1 year	Found a job outside of the nursing home
Natalie	Depression, possibly PTSD	Kitchen	More than 3 years	Continued to work at the nursing home; wanted to be a nurse to continue working with the seniors
Angel	Depression, anxiety disorder, PTSD	Dementia ward, standard service floor	2 years	Found a job outside of the nursing home
Helena	Depression, ADHD, anxiety disorder, PTSD	Kitchen, standard service floor, front desk	More than 3 years	Found a job outside of the nursing home
Eefje	Depression, OCD, ADHD, anxiety disorder	Dementia ward	3 years	Promoted at the nursing home; working on her college degree (part-time)
Beatrix	Private	Dementia ward	2 years	Continued to work at the nursing home; working on her college degree (part-time)

Table 3. Information about the HVYAs.

The six main informants (*Table 3*) in this study had an average age of around 25. While each had unique struggles with symptoms and varying family backgrounds, they shared common challenges related to their symptoms and held similar perspectives on their experiences with the seniors. Notably, all of them demonstrated positive identity development and coping outcomes.

In terms of emergent identities, they exhibited competency in their jobs, enhanced self-esteem, and a reduction in symptom severity. Regarding stage-specific coping outcomes, they either transitioned to other employment opportunities or secured positions within the nursing home. This collective experience underscores that highly vulnerable populations, rather than being liabilities, can become valuable social resources when placed in supportive and appropriate contexts. Their phenomenological perception of challenges and supports, however, can be very different from that of others.

Net Vulnerability (Status 1)

The concept of net vulnerability in PVEST, as described by Spencer et al., emphasizes the importance of recognizing both visible and hidden factors that contribute to an individual’s developmental challenges (Spencer et al., 1997; Spencer, 2006). The young adults' net vulnerability (Status One), being the first component of the framework, includes both contextual and personal characteristics that could potentially pose challenges in their development prior to working at HCare. The disadvantages of the young adults often originated from a lack of protective factors at home, which then contributed to their mental health struggles either directly or indirectly.

It should be noted that the young adults' level of net vulnerability was underestimated by their colleagues, who were often unaware of the complexity of their mental health struggles. All HVYAs experienced severe depression, and nearly every one of them also suffered from anxiety disorders. Additionally, toward the end of my fieldwork, several informants confided that they grappled with Post-Traumatic Stress Disorder (PTSD), a fact that few at the nursing home knew.

These struggles, combined with a lack of sources of support available to them, made them highly vulnerable compared with others their age.

Their High Vulnerability. In the developmental journey of children and adolescents who have not yet reached independence, the family unit often plays a pivotal role in providing support and fostering positive outcomes (Hankin, 2006; Najman et al., 2010). Bronfenbrenner (1979), for example, believes that family is expected to act as a buffer, outweighing potential risks and aiding young people in achieving successful coping results and a smooth transition to adulthood

However, for the HVYAs in this study, the role of the family was more complex and, at times, contradictory to these expectations. Rather than perceiving their family as a source of protective factors, over half of the HVYAs attributed their symptoms to either genetic predispositions or direct family influences. This perception aligns with research indicating that family dynamics and genetic factors can significantly impact mental health outcomes (McLaughlin et al., 2012; Reiss, 2013). The HVYAs' view of their family's role highlights the nuanced and sometimes adverse impact that familial relationships can have on the developmental trajectories of young individuals at an early stage.

Two of the HVYAs in the study attributed their mental health symptoms to genetic factors. "It started from the very beginning," said one of the young adults. "A lot of members in the family have it (mental health struggles)," including her mother. 'My grandfather died when I was in her belly. I think that's where it all started. My mother is anxious but high functioning, so she never got help for it, but she raised me to be anxious."

Another HVYA shared similar struggles of having genetic and multiple symptoms. "I have ADHD, probably autism, PTSD, depression is coming back every now and then, anxiety disorder." Similar to the first HVYA, mental health problems also ran in her family. When she was a teenager, her whole family struggled with mental health issues. While dealing with her own suicidal thoughts, one HVYA recounted that her uncle committed suicide during that period of her life. Understandably, these deeply personal and painful aspects of their family history, especially regarding mental health struggles, were not commonly shared with colleagues. This discretion highlights the sensitivity and privacy surrounding such issues. These narratives indicate that the inheritance of mental health challenges may be a more prevalent experience among HVYAs than is widely recognized.

In addition to genetic factors, half of the young adults in this study came from challenging family backgrounds. Despite most of their parents not being divorced, these young adults often did not receive the necessary support at home. For instance, one young adult emphasized the importance of maintaining distance from her family to protect her mental health. Another informant observed that while her parents might appear responsible and caring to outsiders, she felt they never truly understood her. She explained that her childhood misbehavior was a cry for validation she did not receive at home. Out of all the informants, only one felt a sense of support from her parents, despite their own mental health struggles.

Struggle with Mental Health Symptoms. Besides their difficult family backgrounds, the young adults' risks were intensified by their complex, intertwined mental health symptoms. These symptoms, often not fully understood even by the HVYAs themselves, are challenging to isolate and describe each symptom individually. In this study, the focus is on understanding their cumulative effect on the young adults. Common among them was a significant impact on daily functioning, which resulted in low self-esteem and delayed transition from adolescence to adulthood.

Furthermore, the extent of the young adults' struggles was often underestimated by colleagues due to their attempts to appear normal. Eager to avoid negative perceptions, they concealed the true extent of their challenges. Eefje was one of the young adults I met since 2019.

During our interactions, she presented a demeanor that made it challenging to grasp the complexity of her struggles. She often greeted me with a genuine smile and laughed heartily during our conversations about work. Additionally, she consistently exhibited perceptiveness and patience, even during our lengthy discussions. This outward appearance belied the array of symptoms she was managing, including depression, anxiety disorder, OCD, and ADHD. Although Eefje appeared normal during our initial conversation, I later discovered that engaging with a stranger was extremely taxing for her, often leading her to spend hours in bed recuperating afterward.

Among the HVYAs, depression, and anxiety disorders were particularly prevalent. The young adults described depression as being closely tied to self-perception, characterized by low self-esteem, profound disappointment in themselves, and a lack of purpose in life. When Eefje experienced depression in her early 20s, she was unable to leave her room for days, as she could not let go of the feeling that her life was a disaster. This state was exacerbated by her OCD, which drove a need to control every aspect of her life. For instance, waking up even a minute later than planned at 8 o'clock would lead her to label herself as a ‘loser,’ and she felt her entire day was “ruined.” Consequently, she would end up crying and isolating herself from the outside world for the rest of the day. This combination of symptoms profoundly affected her self-esteem. Speaking of her struggle, she said the symptoms were the reason why she could not handle a regular job.

Similar patterns were observed in other HVYAs, with several experiencing depression so severe that it had incapacitated them for months before they started working at the nursing home. Helena was another young adult who I first met in 2019. However, she did not step forward to participate in my study until 2021. She described herself as being “really depressed” and suicidal during her adolescent years. After high school, Helena spent four years in a government intervention program designed for young people with mental health struggles to learn independent living skills. During this period, Helena lived in a small studio apartment and received regular visits from social workers who assisted her with laundry, housekeeping, and discussed her social and financial needs.

While she found the program beneficial, Helena also experienced episodes of deep depression. Such periods of depression were more than just feeling sad or unmotivated; they were debilitating. For her, a depressive episode meant being paralyzed, unable to control their bodies enough to even get out of bed or face the prospect of social interaction. This severe depression, which renders daily routines unmanageable, was a common experience for at least five of the HVYAs if not all.

Anxiety disorder was another symptom that significantly impacted the young adults, particularly in social interactions. They frequently felt concerned about their performance and were preoccupied with how others perceived them. This constant worry about others' judgments made social interactions a taxing experience for them. Speaking about her anxiety disorder, Eefje said “It’s the way my brain works, always trying to find something negative.” When she heard people laugh, for example, her immediate reaction was “Are they laughing at me?” If someone praised her, her first reacion was not to believe it and tried to find fault in herself.

This pattern was not unique to Eefje; other young adults shared similar experiences. Their fear of judgment or rejection led them to avoid social situations or to acquiesce too readily in an effort to please others. Far from building resilience, these coping strategies tended to further erode their self-esteem and deepen their feelings of disappointment in themselves.

In addition to depression and anxiety disorder, three HVYAs disclosed traumatic experiences, including sexual abuse. One of them shared a particularly distressing account, revealing she had a two-year memory gap between the ages of 16 and 18. She believed this was the result of a protective psychological mechanism after a traumatic event. Consequently, she had intense depression periodically without understanding its cause. Just before I concluded my fieldwork, another HVYA disclosed that she had been sexually abused during her teenage years. She described the profound impact this had on her life, saying, "Everything changed after that." From being an outgoing individual, she transformed into someone struggling significantly with emotional regulation.

In addition to the symptoms previously mentioned, some of the young adults exhibited less commonly recognized conditions. Notably, half of them identified as Highly Sensitive Persons (HSPs), a term indicating heightened sensitivity to others' emotions and a tendency to become easily overwhelmed by environmental stimuli that are often difficult to pinpoint (Aron, 1997). Angel, for instance, found taking the train too overwhelming due to the emotional energies of fellow passengers. She often refrained from sharing this aspect of her experience, as people typically struggled to understand it, dismissing her as overly sensitive instead.

In summary, this high level of vulnerability often lay concealed beneath their outwardly nonchalant demeanor. However, their symptoms profoundly impacted their overall health and daily functioning. These challenges significantly hindered their ability to lead a normal life and complicated their transition into adulthood, particularly in achieving employment and independence.

Lack of social skills. The disadvantaged backgrounds of the young adults significantly impeded their successful transition into adulthood. Although they were in their mid-20s, they had not reached the levels of identity development and career readiness typically expected of adults at this age stage (Havighurst, 1953; Neugarten, 1979). Their vulnerabilities were especially evident in their deficient social skills, job-related competencies, and low self-esteem, all necessary for effective job performance (Erikson & Erikson, 1997).

The young adults' struggle with social skills was evident in their difficulty interacting with others. When discussing the disadvantages these young adults had to face, a job coach gave me an example of "A girl from a poor family, low education, no role model, and she doesn’t see she can do more." This young adult required guidance even in basic tasks like shopping for appropriate work attire and personal hygiene products, due to her limited understanding of workplace norms. As the job coach told me, the young adult’s unease in social situations was also apparent, as she always avoided eye contact with others. During one of her first shifts at Hcare, which I witnessed, her nervousness was so pronounced that her hands shook visibly while distributing silverware to seniors, causing the utensils to clatter. This level of anxiety was not unique to her alone; I observed similar behaviors in other young adults. They too often spoke with shaky voices and avoided eye contact with their colleagues, clearly uncomfortable and anxious in their interactions with others.

Eefje resonated with these challenges. “I’m not really used to interacting with people. They always scared me,” she said. Her anxiety disorder heightened her fears of judgment and unfair treatment from others. Rather than seeking employment during her transition to adulthood, as many do, she isolated herself, living in her "own bubble" and remaining inactive for over four years. Upon starting her job at HCare, she was frequently anxious about whether her words and actions would be deemed appropriate by her colleagues and those around her. This constant worry about others' perceptions significantly impacted her ability to comfortably engage in her new work environment.

Lack of Professional Skills. In addition to their lack of social skills, the HVYAs also faced deficiencies in professional skills. Among the group of six HVYAs, only two had received professional training. The majority either possessed a high school diploma or had not completed high school. It is important to note the tiered nature of the Dutch high school system, which categorizes schools based on varying levels of academic rigor and future career trajectories. Most of the HVYAs came from the lower tier of this system, reflecting their limited access to advanced educational opportunities and professional skill development. This background further contributed to their challenges in acquiring job-related competencies.

Beatrix, for example, due to her lack of skills, worked as a dishwasher in a hotel before joining HCare. She did not enjoy that job and eventually lost it during the pandemic. Similarly, for two other HVYAs, working at HCare marked their first job after recovering from major depression episodes that had previously kept them out of the workforce. For three other HVYAs, their role at the nursing home was their first formal employment experience. Initially, their motivation varied; some were drawn to the opportunity of working with seniors, while others simply sought to regain stability in their lives. However, they typically lacked specific job skills or a clear career trajectory at the start of their employment at Hcare.

Given these circumstances, the HVYAs were clearly highly vulnerable. Their lack of social and professional skills, coupled with low self-esteem, made them feel ill-equipped to secure employment with confidence. Their vulnerability can be verified by the fact that half of these young adults were referred to work at HCare by their public therapists, who found it difficult to introduce them to regular work opportunities.

Lack of Societal Support. Given the increasing global prevalence of mental health challenges, the young adults in this context required more societal support than they were receiving. Despite living in a welfare state like the Netherlands, these young adults found that the assistance available to them was confined mainly to public therapy and financial aid. Opportunities that viewed them not merely as liabilities but as individuals with agency and potential to contribute positively were notably scarce. In other words, there were few job opportunities designed for them as a stepping stone for recovery and career development.

The primary form of support for these young adults was free therapy sessions provided by public therapists, a service funded by the government. During their adolescence, this support was considered beneficial, offering both the necessary attention and medication. However, as they matured, some HVYAs began to doubt the qualifications of these "government therapists," who only required certification to practice. These therapists were often perceived as disinterested in the HVYAs' individual experiences, mechanically diagnosing symptoms through a checklist approach. Two HVYAs expressed their frustration with the service quality using strong language. They also questioned the appropriateness of the prescribed medications, suspecting that these drugs might not align with their best interests.

Beyond these therapy sessions, the young adults encountered limited societal support. In the Netherlands, most government intervention programs target adolescents, leaving a gap in services for adults with mental health issues. The few existing adult programs often focus on manual skills like bicycle repair and suffer from negative perceptions, leaving few viable alternatives. The inception of the Neighborhood Program at the nursing home, aimed at assisting disadvantaged young adults, including those with autism, was initiated by a mother who expressed her challenges to the CEO about finding suitable employment for her son with mental health struggles.

Therefore, these young adults' high vulnerability stemmed from their significant risks and limited support. It is understandable that they needed opportunities that were tailored to their struggles. Taking the young adults’ vulnerability into consideration, their job at HCare presented a rare work opportunity, giving them time to adapt.

At HCare, the approach toward the HVYAs was notably more lenient compared to typical workplace standards. This was exemplified in how Sophie, a job coach, dealt with an HVYA's repeated lateness. “Do you know how lucky you are at HCare? If you work at a supermarket and you are late three times, they are going to say ‘Bye bye,’ said Sophie to the young adult seriously. “But here you were (are allowed to be) late 10 times in three months.” When her colleagues asked her how she could be so patient, Sophie said she looked at the matter differently: “If we don’t help her at HCare, where does she (the HVYA) go then?”

Reflecting on their experience at HCare, all HVYAs expressed gratitude for the opportunity. During the challenging times of the pandemic, when complaints spread about the program, one HVYA remarked “It’s a shame if this program stops.” In fact, there was a consensus that there should be many more similar programs in other nursing homes. However, even though HCare has been promoting its intergenerational programs for years, few other care homes have adopted similar programs, particularly those aimed at assisting the HVYAs.

The hesitation of other nursing homes to support the HVYAs is understandable. Considering the symptoms the HVYAs had and their lack of skills, it is only logical to assume that they will struggle at work. Their reported experience, however, was surprising. The HVYA mentioned earlier, who used to make up excuses for coming late to work, changed substantially over time. Within three months, she not only came to work on time but, in fact, made sure she arrived early. In two years, the HVYA found a regular job outside of the nursing home. Therefore, with some leniency and the right support, their complicated symptoms could be overcome and positive coping outcomes could be achieved. The support, however, can come from a most unexpected source.

Unexpected Sources of Challenges and Support (Status 2)

Traditionally, individuals with mental health challenges have been seen as liabilities, with their potential to contribute and exercise agency often underestimated (Association, 2019; Cornegé-Blokland et al., 2012; Deb et al., 2017). At HCare, the management team echoed this sentiment, perceiving the young adults as highly vulnerable and in need of staff support to manage interactions with seniors who have dementia (SwD). The job coaches, dedicated yet lacking a deep understanding of the young adults' perspectives, oversaw their coping experiences. This left the young adults' perceptions of challenges and support at work (Status 2 in PVEST) largely unexplored and unaddressed.

Contrary to these traditional views, my research revealed a surprising finding: the young adults consistently credited their positive coping outcomes to the support they received from the SwD. In contrast, they often viewed their colleagues, not the seniors, as sources of risk and challenge.

Among the HVYAs, Angel and Eefje's experiences were particularly insightful in understanding why the SwD was seen as a source of support, contrasting with the challenges posed by staff members. Both were early participants in the Buddies Program and had worked with both SwD and mentally clear seniors but expressed a preference for working with SwD.

When I revisited Angel in 2021, after she had left her job at HCare, she was visibly excited to discuss her work experiences there. “The seniors with dementia lift me up. The staff members push me down,” she said with her hands pushing down as if crushing something. “The dementia people are much better for me to grow up. Out of my depression. The colleagues put me in depression." She repeated this a few times, making sure I understood her correctly. As she said, most people could not understand why she felt that way.

This perspective was quite different from what a nurse shared about Angel. Angel first worked in a dementia ward, but then she was transferred to a different floor to work with seniors who were mentally healthy. At that time, I did not yet know Angel. When I asked the nurse why Angel's transfer, the nurse perceived her as unsuitable for working with SwD due to her "many problems" and believed she would be less burdened working with mentally healthy seniors. However, it appeared that the nurse, despite working alongside Angel, had not engaged in a deeper conversation with her about her work or understood her struggles.

Angel, however, had a completely different story to tell. According to her, she had to leave the dementia floor not because of the seniors whom she preferred to work with but because she could not get along with the nurses on that floor. Suffering from depression, anger management issues, and PTSD, Angel had previously worked as a nurse at HCare but faced severe depression due to conflicts with her colleagues.

Passionate about her work, Angel prioritized the seniors' well-being over routine tasks, which often led to disagreements with other nurses. Additionally, identifying herself as a Highly Sensitive Person, Angel struggled to regulate her emotions. When conflicts with colleagues arose, she tended to internalize her feelings rather than express them, leading to eventual emotional outbursts.

This complex dynamic revealed a contrast in Angel's interactions at work. With the seniors, she was confident and friendly, effectively engaging with them and their needs. However, in the presence of her colleagues, she adopted a more reserved, even nervous demeanor, reflecting her struggle to navigate the workplace's social environment.

When I first met Angel, it was just before Christmas in 2020. At that time, her role involved managing meals for seniors undergoing physical health recovery on a standard service floor. Her primary task that morning was to set up the dining area, arrange plates, and assist the seniors with various tasks, such as spreading butter on bread. However, the most crucial aspect of her job was fostering a fun and friendly atmosphere for the ten seniors on her floor. These social interactions were vital since they occurred only a few times a week, dictated by Angel's schedule. Outside of these events, the seniors spent much of their time isolated in their units.

I arrived that morning to find Angel already immersed in her duties in the public area on the floor. In her early 30s, her hair was noticeably grey, and while there were evident signs of stress on her face, her greeting was cheerful and welcoming. It was a cloudy day, and the nurses were preoccupied with their routine tasks. I attempted to introduce myself to them, but they often hurried past with solemn expressions, seemingly oblivious to my presence.

At 9:00, the nurses escorted the seniors, all of whom were mentally clear men, to the dining table. Without engaging in any conversation with either Angel or me, the nurses quickly departed, leaving us solely responsible for the care and engagement of the seniors.

Angel's expertise and enthusiasm in her role were evident. With the nurses out of the dining area, she transformed the atmosphere into one that was both energetic and comforting. She enlivened the space by playing Dutch folk music from a speaker and engaging with each senior to ensure they felt included and cared for. As I was there to assist, she guided me through various tasks, such as making tea and buttering bread patiently. In addition, she facilitated my interactions with the seniors, translating their questions about my background and interests.

When it became known that I was from Chicago, Angel inquired if I was familiar with the band "Chicago" and specifically, their song "You’re the Inspiration." Unprompted, she played the track. Humming that 1980s love song softly, she danced in her seat, swaying her shoulders and arms while making eye contact with the seniors. Her smile and youthful energy lit up the dining table, letting the seniors smile joyfully. Angel, in that moment, was more than a caregiver; she was a cherished and confident cheerleader, elevating the mood of the whole group.

In the presence of the seniors, Angel exuded confidence and vitality, but this demeanor shifted noticeably when she engaged with her colleagues. This was particularly evident during an incident when, one day, we needed to ask a staff member for a key. We approached a group of staff members who were taking a break at a table. As Angel inquired about the key, she stood stiffly, and her voice wavered slightly, betraying a hint of nervousness that was uncharacteristic of the confident persona she displayed around the seniors. The staff members' response to Angel further accentuated this difference. Their demeanor carried an undertone of superiority, and their gazes toward Angel were near jeering. If I had not seen the contrast in person, I would not have believed the impact different people had on an HVYA like Angel.

Unaware of Angel's experience, Eefje identified the same sources of challenges and support as Angel. Prior to working at Hcare, Eefje had volunteered at a different nursing home with physically disabled seniors. Even though she could communicate with the seniors there clearly, she found a much deeper sense of belonging and connection with SwD at HCare, which, according to her, gave her a feeling of home. "I really really strongly feel no matter how messed up I feel, just the seniors, I don't have a problem working (with) at all," said Eefje.

When speaking of the nurses, however, her attitude changed. "I have a problem working with all the other stuff (i.e. the nurses) that come with working there." At one point, Eefje worked with Angel on the same dementia floor. Having witnessed how the nurses treated Angel, Eefje used to cry after she got home. She later moved to a different dementia floor and advised her job coach never to send another HVYA to work there - not because of the SwD on the floor, but the nurses.

Despite the differences in their symptoms, Angel and Eefje shared a common experience in their work at the nursing home. Angel encapsulated this shared sentiment by stating, “People with dementia help me very well. People who don’t have dementia don’t help me. That’s my experience.” This perception was not unique to Angel and Eefje but was echoed by all the HVYAs.

For these young adults, their interactions with the seniors with dementia were empowering and supportive. They valued the genuine relationships they were able to establish with these seniors, relationships that were distinct from those they had with mentally healthy individuals. The HVYAs felt a strong connection with the seniors due to shared experiences and needs stemming from their mental health challenges. Additionally, they found the act of assisting seniors with dementia to be particularly rewarding, which played a crucial role in their identity development and positive coping outcomes.

In contrast, the staff members were often seen as a source of challenges. The young adults perceived a disconnect with the staff due to differing approaches to care, the prevalent gossip culture within the industry, and feelings of marginalization at work.

Seniors with Dementia as a Source of Support. “From my experience, even though it (helping a senior) is hard I do feel like the seniors are a medicine to me. No matter how bad I feel, how anxious I feel…” Eefje said, “When the nurses are not around. I don’t feel judged by them (SwD), I can really do my thing. I can really zoom into their whole being and energy and feelings and be there with them.”

Eefje’s experience at the nursing home highlights a unique therapeutic aspect of her interactions with seniors with SwD that is counterintuitive. Contrary to the commonly held belief that SwD is unpredictable and could potentially be aggressive, the HVYAs, including Eefje, found themselves at ease and authentic in the presence of these seniors. This comfort stemmed from the unique supportive context created by the seniors with dementia. The key elements of this support were the genuine relationships they were able to form, the shared experiences they had, and a profound sense of fulfillment derived from their interactions. These factors collectively contributed to a therapeutic environment for the HVYAs, allowing them to be themselves and acquire a sense of fulfillment at work.

Genuine Interactions. SwD offered HVYAs a genuine relationship, which means the young adults could trust them fully. This type of relationship is significant as it instills a sense of security in the young adults, allowing them to communicate transparently and feel truly welcomed and accepted. The HVYAs valued these interactions as they felt accepted and appreciated for who they were, without the pressure of being judged or made fun of behind their back. The transparent and straightforward nature of their communication with SwD, devoid of complex social nuances, provided a comforting and straightforward interaction that was less stressful and more rewarding for the HVYAs.

For people with mental health struggles, security is fundamental for their recovery and growth (Barton et al., 2012). Despite common perceptions of seniors with dementia (SwD) being unpredictable and potentially aggressive, the HVYAs at HCare consistently reported feeling safe and unthreatened in their presence. One HVYA, who transitioned to work as an assistant in a school for adolescents with severe mental health struggles after leaving HCare, noted the contrast in her experiences. “I have never been hit by an elderly during my time (more than three years) in HCare. The teenagers are more aggressive,” she said. The contrast highlights the relative calmness and safety she experienced with the SwD.

In addition to physical safety, the HVYAs found emotional security in their interactions with the seniors. While most workplaces value fast-paced efficiency, the HVYAs’ work with SwD requires a person to be calm and relaxed. When Beatrix first started working in the dementia ward, she busied herself with chores such as washing dishes and cleaning the tables. Speaking of her performance at the time, Eefje, her mentor, said “She had to learn to take it slow, as a buddy, being there is just enough.” Beatrix’s actions of making herself busy came from her insecurity of working in a hotel, where a fast-paced rhythm was valued. In addition, she also felt insecure as she did not want to be seen as being lazy in front of the nurses.

When I returned for my research in 2021, Beatrix had managed to overcome her anxiety at work. She could sit comfortably next to the seniors, make eye contact, and no longer rush at work. As Beatrix explained, it was not that hard after she got to know the seniors better. She enjoyed “Taking a walk, having some coffee, and being friends with the seniors.” In other words, she felt secure and relaxed with the seniors.

In this context, transparent communication refers to an honest exchange of feelings without boundaries, fostering a moment of connection between the two groups. This unguarded style of communication is sought by the young adults and is provided by the seniors, influenced by their condition. The term 'transparent' is used to describe the seniors' unguarded sharing of their true emotions, which the young adults appreciate as being "pure," "real," or "direct." Unlike individuals who might habitually mask their true feelings for reasons like social courtesy, SwD typically express their likes and dislikes without restraint. This unfiltered honesty, though potentially perceived as offensive by some, is highly valued by the HVYAs. These young adults, who often struggle with interpreting hidden meanings in social interactions, find reassurance in the straightforward communication style of SwD. This shared experience, as explained to me from various perspectives, centers around a common theme – you can trust the seniors with what they say.

Due to Eefje’s low self-esteem and anxiety disorder at the time, she constantly tried to find fault in what she did. Even if someone gave her compliments, she would doubt it, thinking that person was just being polite. “It’s the way my brain works, always trying to find something negative,” she said. However, she could trust the SwD, who really meant what they said. “When I see that someone (SwD) is really happy to see me, it’s so genuine,” said Eefje. “One woman, she’s sad all the time, when I go around the corner and say ‘Hi, beautiful,’ she’s like ‘Are you working today? I’m so happy to see you!’ And every day we have these little moments. I feel goosebumps when I think about it.” This feeling of being genuine was mutual. “I am really happy to see her. I’m not lying about that,” Eefje continued. “That gives me so much energy. You can just completely be yourself.”

Angel, sharing a similar appreciation for the SwD's genuineness, looked at it from another perspective. As a Highly Sensitive Person, she was acutely affected by others' emotions and found it challenging when someone's words did not align with their feelings. She explained that it was mentally and emotionally taxing when she perceived a discrepancy between what someone said and what they truly felt. For instance, if a colleague complimented her work but she sensed insincerity, it became a significant emotional burden. In contrast, the straightforward and heartfelt expressions of the SwD provided a sense of emotional clarity and simplicity that Angel valued greatly.

Another characteristic that made this intergenerational relationship genuine was that the seniors let the young adults see who they were, especially their vulnerabilities by holding “no boundaries." The young adults, particularly those who worked in the dementia ward, appreciated this characteristic, citing the absence of boundaries as a significant factor in their preference for working with SwD compared to other groups.

From the perspective of the young adults, the absence of boundaries in the SwD showcased freedom of expression they yearned for, yet societal norms compelled them to suppress such unrestrained expression within themselves. "Everything they have learned, you can't do this you can't do that, you can't burp in public, you can't shout in public. Dementia breaks that all away," said Eefje. "So those boundaries are gone, a lot of the time. They are really direct. It's a challenge I really love to work with." Similarly, even though this characteristic could make the seniors say "mean things," Helena still appreciated it, which presents a huge contrast to the young adults' insecurity in everyday life. "They just talk whatever they want to. That's what I really like because they don't have any rules in life."

Speaking of why she liked the seniors for having no boundaries, Eefje said "Maybe it's the freedom to be with those people. Maybe we all secretly want to get rid of the boundaries we are forced to live by." Without having discussed her experience with anyone, Amalia was of the same opinion. "They don't follow rules anymore. I really admire that. I wish we can live like that!"

This transparent and unrestricted relationship allowed the HVYAs to view the SwD positively, despite their occasional judgmental comments. "They can't see that I have chronic depression, but they can see what I wear," said Eefje, trying to explain why she did not mind the seniors being mean. "We have a volunteer with long hair, the senior was so mean about his long hair. 'It's dirty. How can a guy look like that? She said your nose ring, why would you do it? It's dirty." "Cause I like it," Eefje would answer. "They are judgmental, and they are real about it.

Everyone is judgmental, as much as we try not to judge, we do. But we are more sneaky about it, and they are not. So that’s kind of beautiful!” she added with a laugh.

Eefje's commitment to being herself was further illustrated by her decision to get a unicorn tattoo on her forearm. Due to the generational differences, she was aware that the seniors in the dementia ward would associate it with outlaws or see it as a taboo. Nevertheless, she showed her tattoo to the seniors happily. Initially, the seniors were not impressed until one day, my ‘aunt’ held her arm and kissed her tattoo. “Your ‘aunt!’ Gosh, she was so sweet to me this weekend. She was fighting with everyone (other seniors) but me. We cuddled a whole lot this weekend.” She messaged me one day after her shift excitedly. “She was so cute to my unicorn (tattoo) yesterday. She kept on kissing it.” It was not only a sign of the senior accepting her tattoo but also a sign of Eefje’s desire to be herself being validated. To Eefje, this was a relationship that allowed both the seniors and the young adults to be themselves. Her excitement reminded me of another quote from her: “Where else can I find a job like this?”

Being accepted by SwD was another aspect of the relationship that the HVYAs appreciated. Due to their history of marginalization, they deeply valued it and found it profoundly meaningful. Helena and Natalie, for example, both expressed feelings as though they had gained an additional hundred "grandpas and grandmas" who accepted them as who they were.

Furthermore, the seniors demonstrated a preference for interacting with young adults rather than with older individuals, a dynamic not widely explored in the literature. It was widely acknowledged at the nursing home that the seniors could be mean to each other. Their various conflicts range from making fun of each other, refusing to sit close to another person, and occasionally, showing physical aggression. Although the seniors could be unfriendly or even aggressive toward each other, they showed a different, more caring side to the young adults. This was particularly meaningful for individuals like Betje, a student resident from the intergenerational living program.

Despite being perceived as mentally healthy, Betje grew up in a toxic family environment that lacked care and love for her. She told me that before she came to live in the nursing home, she was very insecure and introverted. Knowing nothing about the nursing home or the senior population, she simply wanted a place to keep her away from her parents. As a student resident, her next-door neighbor was an old man with dementia. He would come to check in on her every day, asking her how she was doing. As Betje told him about her struggles with her family, the old man shared his stories. To Betje, this was the first time when she felt that another group of people truly accepted and cared about her, which had a huge impact on her life. According to her, living at the nursing home made her become an extrovert, and she started enjoying social interactions thanks to the attention she received from seniors like her neighbors.

Therefore, seniors with dementia (SwD) provided these young adults with genuine relationships that accepted them for who they were, offering a sense of security and belonging. Given the importance of these factors in therapy (Cooper & Di Malta, 2024; Proctor, 2017), this genuine relationship played a critical role in their coping experience.

Shared Struggles and Needs between the Two Groups. In addition to genuine interactions, the young adults also found a sense of shared struggles and needs with the seniors, fostering a deeper understanding that their challenges were not unique to them. This realization, while not always a direct source of support, provided a significant perspective shift for the young adults.

Albert, a participant in the Neighborhood Program, had a particularly enlightening experience with the seniors. Troubled by the divorce of his parents and always labeled as problematic, Albert was sent to a government intervention program for his mental health and behavioral problems since he was a teenager. This experience, however, was retraumatizing for him. When the first opportunity became available, he left the program and ended up being homeless for over a year, during which time he also became addicted to drugs. His motivation to join the program at HCare was to find a place to stay. Isolated and distrustful, Albert told me he still had a deep-seated anger toward the world, feeling that he was not treated right. In his own words, he was "angry at the whole world." Albert's perspective, however, changed profoundly when he was spending time with a SwD. The senior told him excitedly about her house near the coast and her family. But suddenly, she started crying uncontrollably, telling him how much he missed them. It was a moment of revelation for him. Not only did he start to appreciate how much he had as a young man, he also came to see the problem at the core of his mental health struggles. "I realized, all that I missed was love," said he.

Amalia, who also came from a divorced family since her adolescence, found she could empathize deeply with seniors who had similar experiences of familial disconnection or loneliness. "There are people who have problems with their family, lost contact with their kids. There is a loner, I really have a strong connection with him," said Amalia. When I asked how the seniors and her generation differed, Amalia did not talk about the differences but the similarities. "In the end, everybody is the same. I think people do want the same things, to be loved and feel loved."

Other than the shared needs for emotional support, or love, the two groups also share symptoms as a result of their mental health struggles. Among these symptoms, depression and anxiety are particularly prominent. Literature commonly recognizes depression in seniors as stemming from their loss of abilities and deteriorating quality of life that cannot be regained (Kitwood, 2015). However, the HVYAs identified more deeply with the emotional aspects of the seniors' depression. Questions like “Who am I? Where am I? Where is everyone in my family?” frequently uttered by the seniors in moments of despair, resonated with the young adults.

During my interview with Eefje, she talked about her experience with depression; during periods of time when she did not see her self-worth, she kept on asking herself similar questions: “Where am I? Do I exist? Am I just living for other people? Why am I doing this?” Despite the generational gap, both the SwD and HVYAs exhibit similar emotional responses and inquiries stemming from their respective struggles with depression and anxiety, highlighting the shared human experience underlying their different circumstances.

Anxiety is another symptom commonly shared by both highly vulnerable populations. Amalia, for example, observed that it is common for SwD to become anxious, often worrying about their belongings or becoming suspicious of others. When I asked Amalia if the seniors’ anxious behaviors made her work more difficult, expecting an affirmative answer, her answer surprised me. “People (SwD) get sad or mad sometimes, all the emotions regular people have. They (SwD) deserve to have those emotions.” As she explained, it was the seniors’ right to have those feelings of anxiety. In a normal context, people are expected to suppress these “negative” emotions. However, with dementia, the seniors no longer needed to suppress their emotions.

As someone who had similar symptoms, when Amalia was defending the seniors, she was also defending her own vulnerability – it is a universal experience. “We always try and fix everything; I’m like, if someone is angry, just let that person be angry for a while. Try and talk it out of course, but you can have those emotions. It’s pretty healthy,” she said. Normally, when SwD’s moments of anxiety arise, caregivers tend to distract them. Amalia, however, had a different approach. “I don’t really want to distract him in that way, like ‘Look at the weather.’ Sometimes it’s also good to make contact when someone is stressed, mad or sad, try and talk about it, instead of trying to dismiss it and move on to a different subject.”

Therefore, due to their own high vulnerability, the young adults had a unique understanding of the SwD’s symptoms. Not only did they share needs and symptoms, but some young adults recognized that they had the same struggles. Speaking of the seniors’ disruptive behaviors, Eefje said, “People (SwD) seem to be very angry. Actually, they are very sad and more aware of their dementia.” In one example, she observed that a lady was very upset and sad. “She cried in a way that I could recognize, when I was young, when I wanted to kill myself, at my lowest,” said Eefje. “And I just recognize the way she cried and her panic. I cried with her. It was this precious little moment between us. I just let her cry and talk; she just got easier and easier.” When Eefje recounted the story, she was very emotional, on the verge of tears. “And I thanked her. ‘Thank you for being so open with me,’ I complimented her with the way she put it into words. And we had this lovely chat as two humans, instead of a caretaker and a woman with dementia.” When I heard Eefje tell me the story, it felt as if while she was helping the senior, she was also healing herself.

Feeling Appreciated and Fulfilled. Another unique feature of the SwD’s support to the HVYAs is a profound sense of fulfillment, which is derived from feeling appreciated and finding purpose in their work. Despite the inherent challenges in assisting SwD, most HVYAs reported a strong sense of commitment and necessity in their roles, which played a crucial role in their continued dedication to this work.

On one occasion, a senior’s wife had to leave after paying him a visit, and the senior cried as he could not understand why she had to leave. For Eefje, the senior’s sadness was difficult for her to watch. When I asked her if cases like this made her feel more depressed, Eefje answered "No," affirmatively. "It gives me a good feeling to help them," she said.

Speaking about what work meant to her, Amalia said the seniors definitely needed her, but their relationship was not one-sided. Rather, it was mutually beneficial. "I also feel like I get something out of it. Definitely. They also make me feel seen. They are always like, 'Hi, sweetie. You have such a cute top on. You always smile.' It's really both sides," said Amalia. "I'm always happy to go to work. I'm like I get to see my people again. It doesn't feel like I'm only taking care of them. I don't feel that hierarchy. It's way more like we are just like people who like to see each other. It's a job but it doesn't really feel like a job. I really like spending time with them."

A unique trait of this relationship was that SwD communicated their liking and appreciation to the HVYAs directly and timely. In another example, Amalia spent time with an old lady (SwD) in her room for an hour. They talked about the pictures hanging on the wall and her life, which kept the senior very happy. "Do you want a cookie; do you want anything?" the senior kept asking. When Amalia had to go, the old lady said, "Thanks for the conversation." Another time, a man got really confused. Amalia walked with him to make sure he was safe, as he could get really angry. "All of a sudden, he grabbed my arm and said to me, 'You are really my friend.' That was so sweet, and I was like 'Aww, you are so cute!' I think he could really feel that I was trying to connect to him," Amalia recounted the story, still feeling touched. In another example, Amalia was with a group of people, but an old lady grabbed her arm as if she recognized Amalia as someone whom she could trust and find a sense of security. As Amalia said, it was "small" interactions like that that made her feel not only needed but also appreciated.

Similarly, Eefje described this intergenerational relationship as one that "Gives you a good feeling about yourself." The example she gave me was from the angle of overcoming herself. “I feel very good about myself to have the patience,” she said. After hearing the same story for the 20th time, instead of getting tired of it, her sense of fulfillment comes from feeling “I did it!” To Eefje, this was a “nice, little circle of happiness” – by overcoming herself, she could make the senior happy, which consequently made her happy. This was particularly fulfilling for her because as she observed, not everyone could be as patient. Many family members and nurses would tell the senior that the same story has been repeated many times and the senior must stop. “It happens a lot. It’s shocking.” Being able to stay patient, Eefje had gradually come to realize that she was “really good with people,” which gave her a sense of confidence she did not find elsewhere.

The sense of fulfillment experienced by the young adults while working with SwD is not exclusive to those at HCare. Barbara, for example, had a similar experience working at another nursing home in the Netherlands. Similarly, she was also highly vulnerable and struggled with depression, ADHD, and PTSD. I learned about Barbara through a mutual acquaintance from HCare. She worked part-time as a community helper in a dementia ward in a different city, a role she found well-suited to her because of her symptoms.

Like the HVYAs at HCare, Barbara faced similar challenges with low self-esteem and uncertainty about her strengths. However, she discovered a sense of purpose and satisfaction in her work with SwD. Her patient demeanor and willingness to listen made her effective in calming agitated seniors. In one example she shared with me, a senior was agitated, and Barbara suggested they go for a walk in the garden. During this walk, the senior reminisced about the flowers she used to grow, leading to a noticeable improvement in her mood.

Similar experiences of making a positive impact on someone else's life provided Barbara with a deep sense of fulfillment, which she found critical to her own well-being. Similar to

Amalia, Barbara also found her relationship with the seniors mutually beneficial. Not only did she try to help the seniors feel better, but the latter also tried to help her.

In retrospect, Barbara's experience of making a positive impact on the lives of SwD provided her with a profound sense of fulfillment. When the shift was over, she was exhilarated by the feeling that she had helped someone, which she considered also critical to her own well-being. This mirrors Amalia’s experience, highlighting the mutual benefits inherent in their interactions with the seniors. Furthermore, Barbara also reported the seniors’ agency extended help to her, which further strengthened their bond.

Being Comforted by SwD. Another aspect of the relationship that made SwD a source of support was the seniors’ agency to provide emotional support when the HVYAs struggled. This support extends beyond the family context, traditionally highlighted in the literature (Taylor, 2008), demonstrating the broader scope of SwD's empathetic capabilities.

Barbara strongly felt this during one of her shifts. Upon learning of the passing of a senior in the dementia ward, she was deeply upset and wept quietly. To her surprise, an elderly lady reached out, placing a comforting hand on Barbara's, offering her support despite her inability to speak. Needless to say, Barbara was very touched by the senior’s gesture.

Eefje had a similar experience during the first year of her work. During one shift, her depression overwhelmed her, making her feel very sad and wanted to cry. Noticing her distress, the seniors came forward. “They said ‘We know that. Don’t worry about it. Come sit, have a cup of coffee,’” recounted Eefje. “That’s also the beautiful part that you work with people, and you don’t always feel like you are taking care of them. Allow them to take care of you; just tell random stories about your life, tell them about your house, your boyfriend, or your girlfriend. And your parents, your struggles. And you will make them feel good by just being yourself.”

Therefore, SwD played a vital role as a source of support for HVYAs. Their strong connection can be verified by the affectionate terms the young adults used to describe the seniors. Among the six HVYAs interviewed, two frequently described the seniors with terms such as "cute" and "cuties", while two others referred to them as their grandparents. The remaining two HVYAs, despite their limited English proficiency, expressed their fondness for the seniors through their narratives.

In contrast, the young adults from the Neighborhood Program, who did not work with the seniors, had a very different experience at HCare. Tess's case exemplifies this. Diagnosed with autism, he felt working directly with SwD would be "too heavy" for him. Having worked at the nursing home in the laundry area for over three years, he had become more sociable and wanted to do more for HCare. A self-made expert in computer-related technologies, Tess helped some staff members, including a manager, to troubleshoot their computer problems. In addition, he even helped with optimizing a food delivery tracking process, enhancing operational efficiency.

The problem, as observed by another young adult, was that despite these contributions, he lacked the recognition and appreciation that might come more naturally in interactions with SwD. Unlike the seniors, who would often express gratitude openly without hesitation and provide emotional comfort, his coworkers, who were mentally healthy, did not offer the same level of acknowledgment or support. This lack of appreciation and recognition from his colleagues, in contrast to the potential affirmations he might have received from SwD, could explain why he ultimately left the program feeling disappointed and unmotivated about his future.

It needs to be noted that staff members often did not recognize the mutually beneficial relationship between seniors and HVYAs at HCare. Unlike the Student Resident Program, which received much publicity, the strong bond between the two highly vulnerable populations remained unknown for several reasons.

First, the influence of HVYAs on SwD can be subtle and not immediately apparent. As both Barbara and Eefje noticed, a critical part of the HVYAs' work was being present, and that already helped the seniors. One time, Barbara was late to work. When a nurse saw her, she was very relieved. “Thank heavens you are here!” the nurse exclaimed. As she told Barbara, her presence made a huge difference to the seniors. Barbara was confused. When she was with the seniors, they typically sat there quietly; they did not seem particularly happy about her presence. The nurse, however, explained to her their calmness was due to her presence. When she was there, 'Nothing terrible took place,' the nurse said. But when she was not, the seniors often became uneasy, exhibiting wandering behaviors and becoming easily agitated. Therefore, her presence actually had a huge positive impact on the well-being of the seniors, which was too subtle for many, even Barbara herself to notice.

Even though none of the nurses at HCare reported similar findings, my observation was in line with what Barbara told me. When the young adults were present, I never witnessed any disruptive behaviors of the seniors. The young adults' positive impact could be supported from another angle. According to Eefje, the lead nurse on the dementia floor told her that even though the SwD in the dementia ward were at a later stage of dementia, they received less medication than the SwD on standard service floors. “Other floors, they (nurses) can't deal with them, so they get lots of medication. But when they come to us (at the dementia floor) they do get a lot less medication because there's more specialized care,” said Eefje. Therefore, it was highly likely that the young adults at HCare also had a calming effect on the seniors.

Second, due to the small number of the HVYAs (6 out of more than 200 staff members), only a few staff members worked with them directly on the floor. This limited interaction resulted in a lack of awareness or interest in the HVYAs' backgrounds or experiences with the seniors.

Third, both HVYAs and seniors with dementia faced stigmatization, making it challenging for others to comprehend the depth of their bond. An example of this misunderstanding was evident when I shared with a staff member at the management level my preliminary findings on this mutually beneficial relationship. Upon hearing the idea that the seniors could help the young adults heal, he humorously dismissed the idea. “Yes, they (HVYAs) can learn from the seniors to forget,” he laughed and never took the matter seriously.

With her passion for the intergenerational program, Helena noticed that their connection with the seniors was overlooked. “I don’t think if they (staff members) saw the real connection we had (with the seniors), or the meaning of the bond we had,” she said. “Not that what that means or what that includes. I think they know that,” she said, referring to their positive coping outcomes were noticed, to some extent. “But they don’t know what’s the story behind it,” Helena continued, referring to the staff members not aware of the significance of the mutually beneficial relationship. “It’s fine. It’s their job. They go home by the end of the day. But that (HCare) is our home,” said Helena, expressing both an understanding of the staff members’ perspective and also, to some extent, a frustration that such a critical aspect of their experience was overlooked.

Staff Member as a Source of Challenges. While the HVYAs considered the SwD a source of support, they saw the staff members, particularly the nurses as a source of challenge that made their experience at the nursing home more difficult. The literature suggests that suspending assumptions and judgments and striving to understand the 'back story' of young adults, is crucial in social work to facilitate their healing process (Munford & Sanders, 2021). Even though staff members at HCare were not social workers, they were expected by the management to support the young adults. However, they generally lacked both knowledge of and interest in the HVYAs' backgrounds and personal journeys.

Helena, who had already left the program by 2021, was candid during her interview about her experiences at HCare. She expressed gratitude for the opportunity and acknowledged the personal growth she experienced but was also open about the program's shortcomings. “If you wanna talk about HCare and the programs, I am gonna be honest and not only positive about it,” She continued. “Don't get me wrong, I am really grateful that I had this opportunity to be a part of such a wonderful experience. I grew a lot as a person and I am thankful for the chances I got, but I also have seen the bad side.” Specifically, she was talking about the staff members being a challenge. “We have a saying in Dutch, ‘You play and miss completely.’ The idea (of the program) is really good, but no,” she gave a bitter laugh, which revealed her mixed feelings about the program.

Beatrix's experience with the program mirrored similar sentiments. She found comfort and ease in working with the seniors, appreciating their kindness and the compliments they offered. However, her interactions with the nursing staff were less positive. Beatrix was aware that the nurses on her dementia floor were not pleased with her, and during the interview, she did not want to talk about it. Eefje, who was Beatrix's mentor, observed that the nurses did not address their concerns with Beatrix directly. "There is a lot of judging," Eefje said disapprovingly. Instead of trying to help Beatrix, the nurses talked about her behind her back during staff meetings, which clearly hurt her feelings.

The tension between the young adults and the nursing staff can be attributed to a few key issues: differing approaches to care, a prevalent culture of gossip in the industry, and the marginalization of young adults in the workplace. These factors created a challenging environment for the HVYAs, affecting their experience and potentially hindering the program's overall effectiveness.

Different Approaches Toward Care. As mentioned in the previous chapter, the roles of HVYAs and nurses at HCare were distinctly different: while nurses were responsible for routine tasks, HVYAs focused on enhancing seniors' well-being through quality time. Furthermore, the nurses received structured training on care, requiring them to follow pre-established rules. In contrast, the young adults worked intuitively as they received no formal training. The differences between the two groups led to distinct approaches to care, which sometimes led to conflicts. A similar scenario was found in research in the Netherlands, which indicates instances of senior nurses exhibiting unfriendly behavior toward new staff more enthusiastic about person-centered care for SwD (Kong et al., 2022). Such disagreements over work methodologies at HCare adversely affected the young adults' overall coping experiences.

Despite the challenges at work, the HVYAs generally found their work interesting and fulfilling. A majority of them, four out of six, expressed a preference for their roles over the nursing tasks. The other two young adults wanted to be nurses in the future, but their main motivation was spending quality time with the seniors. Amalia, for instance, preferred well-being versus routine-based tasks. She took pleasure in engaging seniors in activities such as going for a walk or shopping together. When they went shopping at a secondhand store together, she thought, "I can’t believe I’m getting paid for this job!” Similarly, talking about how her job was different from the nurses’, Eefje said “I’m there for the fun stuff,” implying that her job involved more interactive and playful engagement with the seniors.

In contrast, the nurses' tasks were more structured, which could lead to disagreements with seniors more easily. For example, the seniors were required to go to bed between nine and ten in the evening. When they did not want to comply, verbal and even physical conflicts would arise. The HVYAs' shifts typically concluded before these potentially contentious periods, sparing them from these conflicts. Consequently, some nurses viewed the HVYAs less favorably, partly due to the differing nature of their responsibilities.

During one outing where Eefje and Amalia took some SwD to a parade, the event went smoothly. Upon their return to the dementia ward, both young adults were relieved and elated with the success of the trip. However, they sensed a certain "hostility" from the nurses, perceiving it as displeasure for being left out of the activity. One of the HVYAs even speculated that the nurses might be "jealous" of their opportunity to engage in such enriching experiences with the seniors, while they were left behind.

Other than the differences in their jobs, the two groups also differed in their understanding of dementia care. Despite not having formal discussions with the nurses, five HVYAs believed their approach to care was more beneficial to the seniors and were resistant to altering their methods due to nurse pressure.

The core difference in approach can be summarized as follows: while the nurses prioritized keeping the seniors quiet and compliant, the HVYAs advocated for allowing the SwD to express themselves freely, even if it meant handling more disruptive behaviors. The HVYAs justified this stance for various reasons, such as respecting seniors' rights or their need to process emotions. Regardless of their rationale, the HVYAs were committed to not imposing restrictive measures on the seniors.

The difference could be well explained by one experience Eefje had. Having worked at the dementia ward for over a year, some SwD saw Eefje as their confidant. The incident happened when my ‘teacher’ invited both Eefje and me to sit in her room while she was visibly uneasy. After staying there for about 10 minutes, my teacher looked more agitated. She asked me to leave but wanted Eefje to stay. Eefje later told me that after I left, my ‘teacher’ began to weep, expressing feelings of being lost and unsure of her whereabouts or the location of her son. Eefje sat by her side and tried to comfort her, assuring her she was safe and everything would be fine. This intimate and comforting session lasted around thirty minutes, during which my ‘teacher’ gradually calmed down. Even though she still had tears in her eyes, she was clearly feeling better. However, the situation took a sharp turn when a nurse entered the room. Frustrated with what she saw, the nurse informed Eefje that when a senior got agitated, it was protocol to notify the nursing staff so they could manage the situation. This incident underscores the differing approaches between the HVYAs and the nursing staff: Eefje focused on providing emotional support and comfort in a personal, one-on-one setting, whereas the nurse adhered to a more procedural approach to handling agitation in seniors.

“Because we have a different take on how to care, I felt so hurt,” said Eefje. “I took it so personally. You have no idea how many times I’m taking care of her. You don’t see her getting emotional because I’m taking care of her, and this one time you came in you see her so upset.” The nurse’s solution to this was to give the senior more medication so the senior could be quiet, which Eefje did not approve. “It is also a question I have because they (nurses) always searching for ‘How can we shut her up.’ And I’m searching for what does she need? And sometimes I get carried away by ‘how I make you shut up.’ Because that’s what I hear.”

As HCare tried to transition toward PCC, many staff members agreed that crying, for example, is healthy for the seniors. Eefje noted a clear divide in perspectives. “Everybody I speak to that’s not a nurse, the people work on well-being, like the well-being officer, manager, everybody I speak with agrees.” Continued Eefje. “But the nurses are more about ‘We have this way to treat them and so we have to do this every time.”

To nurses, adhering to rules and protocols was a priority. This sometimes led to conflicts with the HVYAs' approach to care, which tended to be more flexible and responsive to the seniors' immediate needs. For instance, Angel faced criticism from a nurse for a well-intentioned act. When a senior requested help with spreading butter on bread, Angel assisted him, despite knowing the senior was advised to perform such tasks as long as possible for exercise. Her decision was based on empathy, inclusion, and a desire to ease the senior's struggle.

When a nurse witnessed this, however, she reacted strongly, indicating that Angel should not have intervened. Angel felt upset by this response, seeing it as a lack of flexibility and compassion. She believed that when seniors find simple tasks challenging, caregivers should offer assistance to make their lives easier. Angel interpreted the nurses' rigid adherence to the rule not as a reflection of medical advice but as their lack of work ethics and commitment-setting a precedent could increase the nurses' workload in the future.

In both cases, the HVYAs did not agree with the nurses on how care should be provided to the seniors. Even though they did not confront the nurses directly, they were discontent with their approach to care. “I think most people (nurses) don’t know much about dementia care,” said Eefje. “If they do know, they are not open to other approaches. They study so they think they know how to do it, and that’s what everyone should do. But I think studies don’t answer these questions (about dementia care).”

Jeff, who had worked alongside Eefje in the dementia ward, shared this opinion. He entered the nursing profession expecting to engage in meaningful, quality interactions with seniors. However, he found the reality different, dominated by routine tasks and a rigid hierarchy that stifled any deviation from established methods. This lack of flexibility and an entrenched gossip culture contributed to his decision to leave the profession.

The Gossiping Culture. The prevalence of workplace complaints and gossip among nurses, a common phenomenon in the Dutch healthcare sector (De Veer & Kerkstra, 2001), posed significant challenges for the highly vulnerable young adults (HVYAs) at HCare. In this context, 'gossiping' refers to discussing someone's personal matters negatively without their knowledge or making complaints that do not solve the problem but spread negativity. In contrast to SwD, who remained detached from workplace dynamics, the nursing staff were deeply engaged in gossiping. This culture particularly affected the HVYAs, exacerbating their feelings of insecurity and their struggles with skill deficits.

Helena, an HVYA, expressed her appreciation for the opportunity to work at HCare but found the behavior of her co-workers, especially some nurses, distressing. “I like it (working with seniors), it’s challenging. But I don’t like my co-workers (nurses); I have two; there’s one who just had a breakdown, and she’d scream, cry, and call you things. When she’s not there, they (other nurses) are going to spend all that time talking about how nice it is she’s not there. I’m like, get over with it!”

Speaking about how she coped with the gossiping culture, Helena took a deep breath. “It’s important not to let yourself be the punching bag,” she said firmly. According to her experience, the nurses looked for “targets to bully.” The reason behind it, as she explained, was that “It’s because they are women. That’s a really important reason not to forget, that HCare (the staff members) is 85% women. And it’s ‘Pfft,’” said Helena pulling her hair. Speaking of her positive coping outcome, she attributed part of it to her being able to defend herself from becoming a ‘punching bag,’ but she also mentioned that not everyone was capable of it.

Angel's experience at HCare was marked by challenges similar to those faced by Helena, particularly in relation to interactions with her colleagues, mainly nurses. She found the workplace dynamics, characterized by extensive gossip, to be a major source of distress. “My work was very good, but I have a problem with colleagues (nurses). There are too many wives, they gossip about everything! That was my problem (struggle); the whole problem,” Angel explained. The challenging culture at the nursing home ultimately led her to resign, as she could no longer tolerate the negative atmosphere fostered by the nurses and sought a workplace that would value her contributions.

With the same concern, Eefje told her job coach not to send another HVYA to that dementia floor. “It worked for me but it could be a really dangerous environment for other people (HVYAs),” said Eefje, talking about the effects of gossiping. “Discussing things or being mean are two different things. Gossiping is talking behind people’s backs in a really mean way. If you gossip about one person, it goes from one person to another to another to another. It becomes a big thing. And you can get annoyed by things you would not normally get annoyed by.” Due to the symptoms she had, Eefje suffered much from the toxic environment. “I think I am way too sensitive for that kind of thing. I can feel really shitty, it does not even have to be about me. But when I hear people being injustice, I can take it home and cry about it.”

The gossiping culture took a heavy toll on Eefje in 2019, which significantly affected her mental well-being. “I actually thought about taking it to the manager. Because it annoyed me so much, and I was so sad. I was so sad,” she repeated. “It bothered me a whole week and I cried every night. I gotta do something about this.” However, since the HVYAs were not used to making their voices heard, she did not bring the matter to the table. In 2021, Eefje finally found the strength to address these workplace challenges.

As it happened, some nurses were particularly displeased with an HVYA. As a nurse told me, they did not like that HVYA because she did not fit in. Eefje was aware of it. “There’s a lot of complaints about her (the HVYA) on the floor. They complain with each other and gossip about it.” This lasted for a while during the meeting until Eefje thought she needed to intervene. “I brought it up in a meeting. I said ‘She is here to learn. If you need to complain about it, talk it to me, talk it to her, don’t gossip about it.’” “There is a lot of judging,” continued Eefje. “Because we get paid to do jobs that volunteers usually do, and I think people forget if you are really passionate about it, you really put a lot of energy into it, you forget how hard the job really is, or they (nurses) don’t know.”

While Eefje mustered enough strength to confront the gossiping culture, it is unlikely to be resolved soon. In fact, it is connected to an ingrained marginalization of the HVYAs at the nursing home.

Marginalization at Work. The feeling of being marginalized was a shared experience among the HVYAs, who often felt unsupported and overlooked in the nursing home environment.

Renske, who had worked at HCare for over a decade, provided insight into this dynamic during an interview. She candidly stated that her colleagues generally had limited knowledge about the HVYAs and showed little interest in their well-being. Initially, the management team had intended to closely monitor and support the HVYAs, but according to Renske, this support was not effectively implemented. She observed that most staff members had limited interaction with the young adults and there were no significant initiatives to foster mutual understanding and cooperation.

Furthermore, I was told that some staff members derogatorily referred to the young men from the Neighborhood Programs as “potato boys,” reflecting a broader dismissive and judgmental attitude toward the HVYAs. This term not only illustrated the discriminatory mindset of some staff but also highlighted the broader challenges faced by the HVYAs in establishing their place and value within the nursing home community.

The overall sentiment among the HVYAs at the nursing home was a feeling of being unsupported in their workplace. This was particularly evident in the way the nurses handled disruptive seniors. Eefje, for instance, never complained about the nurses directing challenging seniors to her section of the common area, which undoubtedly made her work more difficult. Her primary concern, especially during the challenging period of 2021, was the potential cancellation of the Buddies Program. “There are many complaints about the program,” Eefje said. “I feel people are very judgmental, and that’s not an environment to learn for the HVYAs. It could be a great place, but everyone working here, they have to keep an open mind, that there is someone with certain issues and to create a safe place for that person to learn.” During our interviews, Eefje would occasionally become emotional, and this was one of those moments, expressing a mixed feeling about the potential and reality of the program.

Helena, who participated in the client board, echoed similar sentiments. She noted that family members of the seniors often voiced skepticism about the capability and trustworthiness of the HVYAs during meetings. Furthermore, she reported instances of staff members making inappropriate comments about some HVYAs' appearances. Despite facing such challenging attitudes, the young adults typically chose to endure quietly, yet they yearned for fairer treatment and greater respect in their work environment.

Natalie's experience is another example of the young adults’ needs being overlooked. Although she joined the facility hoping to spend quality time with seniors, she was assigned to kitchen duties in the dining hall due to staff shortages. Despite her friendly demeanor and popularity among the seniors, her workload in the kitchen remained demanding and unchanged.

In fact, exacerbated by the staff shortages in 2020, she often had to work overtime. At a time when she still struggled with her mental health symptoms, she continued to come to work, as she did not want to leave her “160 grandparents” behind. Her dedication and sacrifice, however, seemed to go unrecognized. At one point, a manager promised to enroll her in a nursing program as long as she continued to work in the kitchen. However, when the opportunity arose, it was given to a newer employee instead. Although Natalie accepted the outcome quietly, it left her feeling overlooked and marginalized.

Similarly, Helena's experience at HCare was challenged by feelings of being undervalued. Despite the job coach's assertion that HVYAs could pursue any role within HCare, Helena's desire to work as a receptionist was not realized for two years. It was not until the pandemic necessitated additional staff at the registration desk that she was given the opportunity. This role, working alongside part-time college students from outside the nursing home, was significant for Helena. It allowed her to feel equal and capable, as she was treated just like any other team member. “I was in a group of people working there, not like, ‘Oh, you are from one of the programs, so you are not capable of working,’” recalled Helena. “I was as normal as everyone else in that group. I was on the same level.”

Other than feeling marginalized by their fellow staff members, the management team did not give the young adults the support they expected. At HCare, there were five managers. While all young adults in the intergenerational programs were all under the same manager, depending on their job (i.e., working at the registration table), they could also be placed under another manager simultaneously.

It would be reasonable to expect these managers to have significant authority to protect and support the HVYAs, as their job is to positively impact employee morale, job satisfaction, and overall workplace culture (Robbins & Judge, 2017). However, my conversations with the managers revealed that they lacked a comprehensive understanding of the HVYAs' roles or the challenges they faced. In addition, except for one occasion when I was first introduced to the dementia ward, I never saw managers working on the floor alongside the nurses or HVYAs. This lack of direct engagement on the floor suggests a disconnect between the managers and the day-to-day realities of the HVYAs. As a result, the HVYAs did not perceive the management team as a reliable source of support, as they knew little about each other.

The experiences of the HVYAs at HCare revealed more significant issues within the nursing home's structure. For example, despite the managers' perception of being approachable, evidenced by their open-door policy, the HVYAs frequently felt hesitant to engage with them. This attitude can be understood by stories of staff members scolded by managers in their offices, which circulated widely in the nursing home. One HVYA remarked, “It’s funny. Her (one of the managers) door is always closed, or it’s open, but no one is coming in.” When I asked another HVYA why she did not go to her manager to discuss her work, she withdrew her body and said, “I don’t want to,” feeling intimated just thinking about it.

Angel's experiences further illustrate this problem. As her conflict with colleagues intensified, her job coach had to ask a manager to intervene. The manager, however, said, “I’m not a police officer,” and sent Angel away. She was then transferred to a standard service floor under a different manager but did not find that manager supportive either. The manager was not interested in Angel’s background or the details of her work. It was, therefore, a period that was particularly distressing for her. “I am not so good. I am very of my own, I am shaking, no good feeling,” said Angel. On one occasion, she ran into the manager in charge of the intergenerational programs in the corridor. It was a time when she needed support and encouraging words.

However, instead of greeting her, the manager just looked away, pretending she did not see Angel. “She didn’t say ‘Hi,’ she was not interested (in me),” said Angel, looking at me, as she still found the manager’s reaction hard to believe. “Is that a manager?” she asked with so much disappointment; her voice was shaky, and her eyes were wet with tears.

Therefore, the young adults' overall feeling was that the staff members did not care much about them. As one HVYA said, the management team did not want to recognize their symptoms or struggles. “If you are like refusing to acknowledge my ADHD, depression, then you are not seeing me and who I am.” When I asked nurses about an HVYA, they knew little about her symptoms and believed that it was a therapist’s job to help her, not theirs.

Considering their different approaches toward care, the gossiping culture at the nursing home, and being marginalized, all HVYAs consider staff members a source of challenge to their overall coping experience.

It is also worth mentioning that even though the nursing home had close to 20 young adults from three intergenerational programs, namely the Student Residents Program, the Neighborhood Program, and the Buddies Program, the integration and mutual support among these groups of young adults appeared limited. For example, when college students had social events, they rarely invited the HVYAs as a group. In addition, there was a noticeable disparity in resources, such as funding for group dinners, which the college students received but were not extended to the HVYAs. Among the HVYAs, there was a lack of solidarity. They seldom spent private time together and knew little about each other’s work experiences. On the one hand, it was surprising that, knowing little about each other, their reported coping experiences were so similar. On the other hand, this indicates a missed opportunity for peer support and community building among the young adults. It can be said that while the young adults were very committed to the seniors’ well-being, this devotion was not always extended to other HVYAs.

In analyzing the HVYAs' overall challenges and support at work, it becomes evident that the seniors with dementia (SwD) were their primary, if not only, source of support. Contrary to expectations, staff members, who might typically be expected as role models or mentors for young adults, were instead viewed as sources of challenge. This imbalance between the support received from the SwD and the challenges posed by staff members significantly influenced the HVYAs' coping methods. Understanding these coping strategies is crucial to comprehending the more substantial impact on the HVYAs – whether the SwD's support or the staff members' challenges leave a more profound imprint on their experiences.

Adaptive Coping Processes (Status 3)

In PVEST, *Reactive Coping Processes* represent problem-solving strategies one adopts to resolve dissonance-producing situations (Spencer et al., 2006). To the HVYAs, adaptive coping methods allow them to face challenges and maintain a high work ethic, while maladaptive coping methods are those that make them avoid challenges or fail to achieve positive coping outcomes in the long run. In this research, all HVYAs utilized adaptive coping methods. A key indication of this is their continued work attendance despite numerous challenges.

Despite their roles being part-time and only offering minimum wage, these young adults remained dedicated to the well-being of the seniors without raising concerns about their work conditions. “Even though it (helping a senior) is hard, I do feel like the seniors are a medicine to me,” said Eefje. “They help me. Because of them I still go to work, and I don’t fall back to depression. And they keep me going, I guess.” This statement illustrates that resilience is highly dependent on context – their engagement with SwD fostered the resilience of these young adults.

The positive coping methods they adopted included finding meaning in their work, learning to accept both themselves and SwD, and developing an appreciation for the program despite its shortcomings. Through adopting these positive coping methods, all the young adults developed positive coping outcomes.

Making Sense of Their Work. The HVYAs found profound significance in their work, driven by the goal of enhancing the happiness and comfort of seniors during their final life stage. This deep-seated conviction endowed their roles with purpose and spurred their resilience in the face of various challenges. In the young adults' eyes, their work was more than merely a job. “It's making their life as comfortable as it can be with a very uncomfortable disease. It's really really heartbreaking dehumanizing, hurtful disease. And make the most out of it,” said an HVYA. Specifically, they approached their role with a sense of mission, embraced workplace challenges positively, and viewed it as a valuable developmental experience.

A Sense of Mission Derived from Work. The nature of dementia as a degenerative disease presents a poignant reality for caregivers, especially for the young adults working in dementia ward. Their understanding that the seniors in their care are in the final stages of their lives adds a layer of profundity and significance to their work. For these young adults, the inevitable ending of their bonds with the seniors does not diminish their commitment; instead, it imbues their roles with a deeper sense of purpose and meaning.

Beatrix's experience is a testament to this. When I asked Beatrix what gave meaning to her work, Beatrix said it was about “helping them spend their last years more comfortably.” Just a couple weeks before our interview, one of her favorite seniors in the dementia ward passed away. The senior was described as being very nice and friendly, always caring to the young adults. Speaking about the senior's death, Beatrix was still feeling sad about it. What gave her comfort was that the evening before she passed away, Beatrix had a good time with her and made the senior laugh. It made Beatrix "feel really good" that she could make the senior happy just before she passed.

All of the HVYAs shared this sense of mission. Natalie, for example, made it very clear to me: Due to her occasional depression, she may not get back to my messages, and she hoped that I would understand. However, she always showed up to work on time and greeted the seniors with smiles. It also needs to be mentioned that the young adults were not educated to understand their role in a particular way due to the lack of training. Instead, it seemed to be an inclination the young adults developed as they worked alongside the seniors. Their ability to maintain a positive attitude and dedication to their roles, despite personal challenges, highlights a deep-seated sense of mission and responsibility toward the well-being of the seniors.

Perceiving Challenges at Work Positively. Contrary to the mainstream narrative in caregiving literature, where disruptive behaviors by SwD are often seen as a significant stressor (Cohen-Mansfield, 2001; Luppa et al., 2008), the young adults in this study viewed these behaviors as an essential aspect that made their job both enjoyable and fulfilling.

Talking about her experience at Hcare, Helena said that although the young adults had various symptoms, "We are not dumb. We need to be pushed and challenged." She used the tasks assigned to young adults in the Neighborhood Program as an example. Young men in that program often did the same job, such as dishwashing or laundry folding for more than two years. "That's not what challenge is," she said. Speaking of the tendency to offer the young adults stability, but not challenges, she considered that "a national problem."

When I asked Beatrix, who initially struggled with her work, to describe the seniors, she said they were "really fun" to work with and mentioned a diverse range of behaviors and symptoms they exhibited – from sadness and unpredictability to directness and forgetfulness.

According to Beatrix, the seniors' various symptoms made the job "way more fun because you can help them," indicating that the unpredictability of the seniors contributed to a sense of fulfillment and variety in her work. Deriving from the challenges, Beatrix said, "It feels good to make them happy."

Similarly, it was a shared feeling that the job was never dull because of the seniors' unpredictability and not knowing what would happen next. When I asked Amalia if the job could be repetitive, she answered "No." "Of course, some stories. I've heard them 88 times. I also feel like I challenge myself to really listen to it again. Maybe you hear a different word," she laughed.

Interestingly, one of the job coaches also used the word "unpredictable" to describe the young adults she found challenging and fun to work with at the same time. "I really really love it. I just love my job," Sophie said. "People can be unpredictable, that makes the work very fun. It's every time you need to think about how am I going to make it work today. I like challenges. So I'm very grateful HCare gave me the challenges to grow myself."

This shared perspective of unpredictability as a positive aspect not only underscores the young adults' underestimated resilience but also plays a critical role in keeping them engaged at work. Consequently, aspects of the job that nurses found undesirable were actually appealing to these young adults.

Viewing the Job as a Learning Experience. For many HVYAs at HCare who lacked formal work experience, their roles were seen as a vital learning opportunity. Speaking of her experience, Helena was adamant in saying, "Every youngster from 18 to 21 needs to be the buddy for a year for an older person. Because I think you can learn a lot about them." This was a shared belief among the young adults. While their diverse backgrounds meant their specific focus areas differed, their learning experience prominently featured in three areas: learning about caregiving, establishing personal boundaries, and collaborating with colleagues.

When asked what they had learned from the jobs, three young adults’ first answer was caregiving. This was a significant achievement, especially considering they had no professional skills in the field or received any formal training. Their approach to caregiving was characterized by a deep understanding and empathy toward the seniors' perspectives. They emphasized the importance of getting to know the seniors' world from their point of view rather than imposing their own perceptions. “You have to get to know them, not the other way around,” is a shared belief of the young adults. Over time, they had learned to understand the needs of SwD, both as a group and at an individual level, when they needed stimulation and when they should be left undisturbed. Gaining such insights and skills in caregiving was a notable accomplishment for these young adults, which greatly boosted their self-esteem.

In terms of their personal growth, three young adults identified learning to maintain boundaries. Undoubtedly, these young adults were very committed to their jobs. I have never seen them growing impatient or trying to argue with the seniors. Instead, I heard more stories of them coming to work early or staying after work when needed. Nevertheless, while Beatrix expressed her liking for the job, she said it was not for everyone. According to her, one has to work because they like the seniors, not for money, and at the same time, they should not get too emotionally attached to the seniors: “Everyone you work with will die.” Therefore, while she believed in the importance of working with a genuine affection for the seniors, she also emphasized the necessity of maintaining a professional detachment.

This is particularly important considering the HVYAs' tendencies toward being 'people pleasers' due to their anxiety disorders and other mental health challenges. They often found it difficult to refuse requests or assert their own needs, even when their well-being was at risk. “I think I’m giving too much,” Eefje said. “At a certain point, you have to stop.” Her struggle was that she did not want to say “no,” which meant pushing people away. Once, a SwD kept Eefje in her room for over an hour after her shift because the senior wanted to talk. When Eefje finally got home, she was “really” drained. In another example she gave me, a senior was in her early stage of dementia and demanded a lot of attention. Having invested a lot of time in her, Eefje realized that there needed to be a boundary: Other seniors also needed her.

Despite some differences in their symptoms, Amalia had similar experiences. “I should have some boundaries,” said Amalia. “That’s the whole reason I got so depressed, so tired.” This has two aspects, both at work and in private life. Speaking of her work, which was 16 hours per week, she said that was enough for her to handle. “I’m so invested. If I do that too many hours a week, I’m going to be messed up.”

Another layer of boundary-setting means protecting themselves in everyday situations in their private life, which Amalia has learned from this work experience. “I was so busy with other people in my private life, and there wouldn’t be anything left being me. If that happens I get so down. It’s like where am I? Do I exist? Just living for other people? Why doing this?” she questioned. This part-time job, therefore, was the catalyst for Amalia to delve into the reasons behind her mental health struggles.

Beatrix also learned to keep boundaries with her family. Instead of trying to understand her struggles, her family often demanded too much from her, such as taking her sister to school and doing chores, which wore her out. Through work, she had learned to take care of herself first and say “no” to her parents. In another example, a young adult was advised by her therapist that if she wanted to recover from her mental health symptoms, she had to set boundaries with her mother. According to her therapist, her mother was manipulative and did not have the young adult’s best interest in mind. Therefore, the meaning behind setting boundaries is not only important at a professional level but also critical to this highly vulnerable population’s overall well-being.

For these young adults, learning to set boundaries was one task, and learning to communicate was another. Initially, Beatrix struggled with internalizing negative feedback from nurses, perceiving it as a personal attack. However, over time and through her work experience, she developed the ability to engage in constructive conversations with her colleagues, seeking clarification and understanding their perspectives. As her mentor, Eefje noted Beatrix's remarkable growth in communication skills. “Now she’s asking, she’s listening. She’s a completely different person in terms of that,” said Eefje, feeling very happy about Beatrix's progress.

The learning experiences of the young adults at HCare were enriched not only by their professional duties but also through learning from SwD. Amalia, for instance, admired the seniors' ability to live in the moment, a trait inherent to those with dementia. “If you want to see people living the moment, you should see people with dementia. They don’t have a different moment. They are just there. Sometimes they are more like stuck in the past, but they are really down to earth.” In addition, Amalia was excited when discussing the prospect of learning skills from the seniors. “If someone on my (dementia) floor can tell me, I can teach you (handcraft), that would be awesome,” said Amalia. “I’m absolutely clumsy. I cannot craft things. I don’t have the patience.”

The seniors, in turn, were not just passive recipients of care but actively contributed to the young adults' learning. For example, a young adult and I tried to learn Dutch from the seniors. They were certainly aware of our needs and tried to help us. On another occasion, Eefje said a senior could yodel. She smiled and asked politely if the senior could yodel for us. This was one of the seniors who almost lost her ability to speak and often sat at the same spot, rarely communicating with anyone. Therefore, I did not even expect the senior to understand Eefje. To my surprise, the senior did yodel for us after we waited for about five seconds. As I stood there clapping for the senior, I was still surprised that the senior could not talk but understood us perfectly well and made an effort to respond to us. It reminded me of what Amalia said: she found it exciting to learn something new about the seniors and the nursing home daily. To me, that moment was quite a learning experience by itself – the seniors' agency has been severely underestimated.

This interaction underscored a key insight shared by Johanna, an experienced nurse who specialized in dementia care. She believed that the world had much to learn from SwD. As her mother's dementia got worse, she made up stories and lived in her own world. "I was (initially) ashamed of my mom," said Johanna. "But maybe we should do it around. Maybe (we need to be) more open to the world of others. The world can learn about it (dementia) more by letting go and living in the moment."

Learning to be Themselves Through Acceptance. In this study, the young adults also showcased resilience through acceptance. In this context, "acceptance" involved two critical aspects: accepting themselves and SwD just as they are. This aligns with the principles of Acceptance and Commitment Therapy (ACT), which advocates for acknowledging and accepting personal experiences as an integral part of human existence (Hayes et al., 2011). However, unlike traditional ACT, where therapists guide this process, the young adults in this study autonomously navigated this journey of acceptance through working with the SwD. This approach places the young adults in a position of authority over their own process of self-acceptance and personal growth, distinct from external influences (Munford & Sanders, 2021; Strosahl & Robinson, 2017). In other words, in this study, the young adults learned to be themselves through their own agency, not outside influence.

Accepting Themselves for Who They Are. HVYAs often find it hard to stay true to themselves due to their vulnerability, which they seek to hide. This can be understood from PVEST, as they wanted to acquire more support and, at the same time, avoid challenges (Spencer, 2006). Gaining support, in Eefje's words, involves "(getting) validation, being understood, and wanting to matter." Conversely, avoiding challenges involves complying with instructions without protest, staying silent, and fitting in. As Eefje had come to realize, the challenges did not matter. “It’s my ego that makes it matter," she said. In this context, being authentic is about finding their own way at work, not just maintaining an image they want to project to others. This demonstrates the young adults’ resilience because it means they have to actively reevaluate and adjust themselves to achieve a goal – in this case, to better serve the seniors within their capacity.

At work, the young adults often felt a need to prove their worth by positively impacting seniors. This was especially true for Beatrix when she started her job in the dementia ward. Beatrix had always wanted to be a nurse but never had related experience or education. Eager to show her dedication to the job, she moved quickly and stayed busy, not knowing what was expected but hoping to gain approval. However, her fast pace was stressful for herself and often agitated the seniors and displeased the nurses. It took her about a year to finally learn to slow down, which not only served the seniors better but also healthier for her mental health.

Like Beatrix, Eefje initially felt compelled to hide her vulnerabilities at work, aiming to maintain a consistently cheerful façade. This stemmed partly from her desire not to let her symptoms impact others and partly from fear of being perceived negatively due to her vulnerabilities. However, her experience at work led her to an important realization: the seniors did not expect or require her to uphold this constant cheerfulness. The dementia ward was, therefore, an environment that allowed Eefje to be herself without having to worry about being judged for her vulnerability, especially her mental health symptoms. "Where can you do that right now? Where can you make people happy by being yourself? Nowhere, right? That’s the easiest job," Eefje remarked with a smile.

For the HVYAs, another aspect of accepting themselves is recognizing their limits at work—trying is enough. Due to their mental health symptoms, a common challenge for the young adults was the desire to shape their lives in a specific way. In the workplace, this translated into a strong wish for positive outcomes when they assisted the seniors. Yet, they had to learn to accept that their efforts might not always be successful. In this context, being themselves also involves balancing their aspirations and what is realistically attainable.

In discussing her journey toward acceptance, Eefje reflected on her tendency to exert excessive effort. "I want to help so bad. Sometimes I can’t accept the fact that I’m not able to help them, and I just keep trying," she admitted. This deep-seated desire to aid the seniors often clashed with the realities of her abilities and the seniors' state of mind.

In 2019, Amalia, grappling with depression, had been out of work for over a year. The part-time nature of her job (16 hours a week) at the dementia ward was recommended by her therapist as a way to facilitate her recovery. “It’s really good. I’ve never experienced anything that kind of slowness,” Amalia said, appreciating the pace allowed by the dementia ward. Despite being deeply invested in her job, she recognized the need to balance her commitment to the seniors with her well-being.

“There’s a lady; she keeps on asking for her dad, she’s like shouting ‘papa, papa,’ so we just took her in a wheelchair, and I said let's go find him." As they went around inside the nursing home, she kept on checking with her. "I was like 'Is he here?' She's like 'I don't think so.' So we spent an hour, she didn't really feel any better, she didn't calm down after that." As Amalia recounted the story, she was obviously disappointed that she was not able to make the senior feel better. Nonetheless, she has learned to accept it. "You just keep on trying and trying and that's enough," she said, underscoring the importance of acknowledging one's limit.

Accepting the Seniors for Who They Are. Another facet of the young adults' resilience was accepting the seniors in their entirety, beyond just their symptoms, and embracing their own role in the seniors' lives. HVYAs, who are often acutely sensitive, desire acknowledgment and can be burdened by presumptive behaviors. Yet, in their interactions with SwD, these young adults learn to relinquish the external validation they typically seek, developing an inner fortitude to manage such challenging situations effectively.

A typical example of accepting SwD happened when Helena served coffee to Leslie. Leslie was a SwD known for her challenging behaviors. Not only did she like to make mocking remarks, she also liked to sit in the lobby with others, making her comments especially embarrassing for those around her. One particular afternoon during the pandemic, Helena worked at the lobby's registration table. Seeing Helena, Leslie called out for "young girl" in a tone that was demeaning. It took a moment for Helena to realize Leslie was addressing her. Leslie then told Helena she wanted some coffee. Complying with Leslie's request, Helena brought her the coffee without showing any annoyance. However, Leslie reacted with anger, demanding, "Where is my cookie?" Again, Helena responded calmly, without displaying any irritation.

I came to know about this episode through Albert, a young adult from the Neighborhood Program, who was struck by both the seniors' rudeness and Helena's respectful patience. Upon discussing the incident with Helena, she responded with laughter, indicating such occurrences were frequent and no longer bothered her. She said if she was uncomfortable with it when she started the job, she had already learned to accept the seniors as they were.

For caregivers across the industry, learning to overlook the SwD’s inappropriate and hurtful comments is a shared experience (Secrest et al., 2005). One of the HVYAs was an immigrant and was still learning Dutch. When one time she tried to learn Dutch from my ‘teacher,’ she kept on saying the young adult’s Dutch was bad, which would affect her children in the future. In the end, the HVYA had to leave, and she cried. But when we discussed the incident, she approached it with a sense of detachment. Having worked there for over a year, she said that was the first time it happened to her. “You can’t cry every time the senior says something mean,” she said. “It can’t work if you take everything personally.” In fact, she was able to rationalize it: It was not about her Dutch; “it was her dementia talking.”

Speaking of the seniors’ behaviors, Eefje said she also had to learn to accept. One lady, for example, used to speak negatively about her, whether it was her clothes or her hair. It hurt Eefje at the time. “Back then I did take it personally. I was very anxious on ‘why I can’t work with her and I avoided her.” Over time, however, Eefje became more used to her and dementia symptoms in general. “They (SwD) can be judgmental, hurtful, mean to others, and in a split second be super careful (caring), making sure everyone has enough to eat and drink.” Speaking of her relationship with that lady, she said they got along “really well” now. “One time she loves you another time she hates you,” said Eefje with a smile, no longer feeling hurt by the senior’s comments.

In terms of the seniors’ symptoms, she found it hard to tell whether it was attributed by their personalities, dementia, or other psychiatric disorders. “But we can have messed up personality. Why can’t they have it? Why does a dementia patient have to be sweet why is that a problem?” she said. Instead of finding the seniors’ behaviors problematic, Eefje has learned to accept them as they were.

Positive Attitude toward the Program. Resilience, as defined by Spencer (2006) and Spencer et al. (1997), embodies the dynamics of navigating through adversity with positive adaptation. This concept of resilience was exemplified by the HVYAs, who kept a positive outlook on their program despite facing numerous challenges they had to overcome. They generally expressed gratitude for the opportunity, viewing it as a fortunate experience to heal and grow. This attitude reflects the core of resilience: finding value and maintaining a positive stance despite challenges.

The HVYAs' positive attitude toward the program was best demonstrated by their belief that this program was mutually beneficial for both seniors and young adults. When I asked Helena about her experience in the program, she began by saying the program provided her with a precious opportunity “to grow.” She also felt that focusing on the seniors’ well-being instead of the routine work “gives strength to it,” and “That’s such a good thing to do.” Even though Helena had much to say regarding the specifics of the staff members’ attitude toward the young adults and the program’s lack of structure, she was nonetheless grateful. Upon leaving the program, she gave her job coach a flower as an expression of her gratitude, underscoring her ability to focus on the positive outcomes of her experience.

The young adults shared the belief that the intergenerational program provided a unique and valuable opportunity for therapy and growth. Therefore, it was difficult for them to fathom why this program was unique at HCare but not adopted by other nursing homes.

Despite the difficulties presented by staff members, the young adults tried to empathize with their perspective. Beatrix and Eefje, for instance, perceived the nurses as supportive, particularly when she sought their help. This ability to separate personal discontent from professional assistance is a positive approach that highlights their growth and understanding.

Not one young adult complained about the seniors, whose behaviors might be deemed challenging. Instead, they recognized the seniors' vulnerabilities as the very reason for their presence and work. This sense of purpose and necessity fueled their resilience, enabling them to navigate their symptoms and workplace challenges with a steadfast commitment to their roles.

Therefore, despite the challenges they faced, all the young adults valued the program and praised its focus on the seniors’ well-being. This not only validates the effectiveness of the intergenerational approach but also serves as a testament to the young adults' resilience.

Emergent Identities and Productive Coping Outcomes (Status 4 and 5)

In this study, all highly vulnerable young adults (HVYAs) demonstrated positive emergent identities and productive coping outcomes that allowed them to become newly resilient young adults. Their emergent identities were marked by newly developed job skills, enhanced self-esteem, and a significant decrease in the severity of their mental health symptoms. These positive identity developments significantly contributed to their coping outcomes. They not only established career trajectories and fostered aspirations for higher education, but for some HVYAs, their coping experiences also helped them form stable intimate relationships. Their stories are a testament to the profound and life-altering influence that supportive work environments and meaningful employment can have, affirming the importance of such programs in aiding young adults through their transition into a successful and fulfilling adulthood.

Feeling Competent with Job Skills. The development of competent job skills among the young adults, who largely lacked prior job experience and formal training in dementia care, is a notable achievement. In a job where performance metrics can be nebulous, their ability and newfound confidence to work independently mark significant personal growth. My observations of these young adults at work revealed a consistent display of patience and understanding, with no instances of impatience or conflict with the seniors, despite the latter sometimes exhibiting challenging behaviors. Consistently, the young adults approached these situations with remarkable dedication and positivity, which speaks volumes about their commitment to the seniors and their growth in the role.

In the absence of conventional performance evaluations, the HVYAs’ sense of job competence stemmed from their own experiences and was reinforced by the seniors' feedback, making them judges of their own performance. Eefje, reflecting on her skill development, noted her initial reliance on observing nurses' methods but later developed those of her own. “When I first started here, it was my first time working with dementia. So, I had to learn from what I saw,” said Eefje. “Sometimes, when against my feelings, I thought they (nurses) knew better than me. Then I found out they don’t. They know certain facts better, but I think I have more patience. That’s not to say I’m better, but it’s whether you have it or not.” This realization boosted her confidence. “I do feel very good; I felt like I don’t care about what other people think; I know I’m doing good, I know my heart is at the right place, I know why I love my job, I was really strong in that.”

Similarly, despite her disagreements with the nurses, Angel felt validated in her abilities, thanks to the seniors' compliments. For example, a quality-of-life officer told her that when she talked to the seniors, they always mentioned Angel’s name and praised her work. The incident made Angel feel very emotional, and she cried. It was the first time a staff member recognized her dedication to work. “Positive things they (nurses) do nothing to me. It’s sad, but that’s true,” she told me. Thanks to the seniors' feedback, Angel was confident in her skills. Although she found the work environment at HCare too toxic, she was optimistic about finding a place where her abilities would be better appreciated. Ultimately, she succeeded in doing so.

In this study, which emphasizes the development of agency among young adults, it is important to notice how they developed their own understanding of dementia through personal experiences. Rather than viewing dementia merely as a disease, the young adults placed their focus on "understanding the person behind dementia." They not only discovered that SwD were capable of forming connections and possessed the agency to assist others but also strongly believed in their need for stimulation—a facet of care that is underexplored in existing literature. Their insights were grounded in empathetic interactions rather than academic study, providing a unique perspective on the needs and capabilities of the individuals they cared for.

Three young adults spoke to me about the importance of emotional stimulation for SwD. In this context, 'stimulation' refers to the seniors' responses to the presence or interaction with others. In many nursing homes, such as HCare, caregivers often limit interaction with seniors to avoid stimulations that can lead to unexpected disruptive behaviors. However, the young adults approached this differently. They observed that SwD often have fixations, such as repetitively sharing the same stories or making the same requests. "It seems like every person with dementia has something they are obsessed about," Eefje noted, seeing value in understanding, and addressing these fixations. "I think it's beautiful to try and find what is missing and help with that."

Interestingly, a manager affirmed the seniors' tendency to focus on certain stories or requests, highlighting the importance of young adults in meeting these unique needs. She shared an example where a senior in the dementia ward expressed a deep wish to visit her child's grave before she could die. Eventually, a young adult assisted her in fulfilling this wish, which relieved the senior, saying that she was finally “in peace.”

A nurse shared another touching story about a senior with dementia who often spoke about her deceased daughter, keeping her picture by her bed. During a walk, as the senior repeated her story, the nurse listened attentively and asked about the daughter as if hearing it for the first time. Suddenly, the senior turned around and, looking into the nurse’s eyes, thanked the nurse for being so patient with her. In the end, she added, “Now I can go.” The senior passed away shortly after.

When I shared the story above with some of the HVYAs, they were deeply touched but not surprised. They were fully aware that dementia has more profound implications than commonly perceived. For example, Amalia believed the seniors needed stimulation to process their innermost emotions. Therefore, the young adults never dismissed the seniors’ requests and considered their role a critical source of stimulation. Maybe it is essential to how SwD can finally find peace.

By engaging thoughtfully in their work, the HVYAs deepened our understanding of dementia in ways that cannot be achieved through pathology-oriented research alone. For the young adults, these findings not only strengthened their relationship with the seniors but also significantly bolstered their confidence at work.

Having More Confidence and Self-esteem. Another emergent identity of the young adults is their notable development in self-esteem. This improvement was evident in their transition from avoiding social interactions to becoming more comfortable and active in social settings, moving from a place of marginalization to greater social engagement.

Corrie, an HVYA, exemplified this transformation. When I first met Corrie, she was new to her role and appeared quite reserved, often avoiding eye contact and lowering her gaze during conversations. However, a significant change was noticeable when I met her again a year later. She was comfortably seated on a couch, actively conversing with someone. Curious to see if she remembered our last meeting, I approached and greeted her. She looked up, made eye contact, and with a smile, recognized our previous encounter. Excited about the noticeable changes in her manners, I shared my observations, which received little response from her. Later, one of her colleagues approached me to express gratitude for recognizing Corrie's significant progress. She confirmed that Corrie had indeed become more open and socially engaged. She particularly wanted to thank me because, working so closely with Corrie, her gradual change had slipped her notice. It was not until she heard my remark that she realized Corrie’s transformation. This shift from shyness to increased sociability is a powerful indicator of the young adults' growing self-esteem and confidence in social contexts.

This phenomenon of gradual transformation was quite prevalent among the young adults. However, similar to Corrie, they often did not recognize the extent of their personal growth. For instance, when I first inquired Beatrix about her changes since she started working at HCare, she said she had not changed. However, upon reflection, she acknowledged that she had indeed become more open to communication.

Eefje was an HVYA who was more aware of her transformation. “I tried to work as a receptionist somewhere else, it didn’t make me feel natural, didn’t give me confidence, my confidence only went down instead of up,” said Eefje. “I think I have a strong personality now for a couple of months. I was really easy to be pushed over back then. I was so insecure.” According to her, she used to put herself in a “victim position;” when others spoke with her, her immediate reaction was that she did something wrong. Working with SwD had given her a confidence that she did not feel before. She recounted a recent experience attending a meeting with nurses, which gave her an important realization. Before the meeting, she was very anxious, thinking that everyone was going to “attack” her. “I was just driving myself crazy,” she said. In the past, she would simply choose not to go: “I would be on my couch and hide from the world.” Having worked at the nursing home for two years, she finally gathered enough strength to attend the meeting. “I just went and experienced that everything was OK.” Not only did she attend the meeting, she used the opportunity to voice her own opinion. “I did dare to say things that bothered so that was nice,” she continued.

This notable shift in Eefje's attitude and behavior was verified by her colleagues, who observed that she was initially more introverted and took some time to become comfortable with social interactions. Moreover, reflecting on her personal growth, Eefje pointed out a significant change in her interests and values. She described her past self as being "shallow," attracted to things that no longer held significance for her. “Now I like completely different stuff from what I liked earlier. I like nature more. I changed so much, I can’t think of anything I still like when I was younger,” she said happily, glad with the changes she had gone through.

Angel's journey mirrored a similar transformation. Identifying herself as a "party girl" in high school, who only cared about having fun, her experience at HCare catalyzed a profound change in her identity and purpose. Within two years, she became a dedicated advocate for community and dementia care, a change that led her to view herself in a much more positive light.

The transformation of the young adults after working at HCare was truly remarkable. It is no exaggeration to say that through their interactions with SwD, they developed a new identity that significantly enhanced their ability to achieve productive coping outcomes.

Experiencing Significant Reduction of Symptoms. The young adults' emergent identity also includes a notable alleviation of their mental health symptoms, which gave them a new perception of self.

Helena and Eefje, for example, faced complex mental health challenges since adolescence. Helena had been diagnosed with ADHD at 13 and was on medication for an extended period. She also battled severe depression and anxiety, which compounded the complexity of her situation. Initially, her mental health diagnosis profoundly affected her. However, her perspective shifted significantly after working at the nursing home. “I was always like ‘I need to know what happened’ (that caused her mental health problems), now I’m like ‘yeah,’” she said with a smile, shrugging her shoulders. “I don’t really care anymore. They come and go in my diagnosis. It’s not defining me anymore. It has but not anymore.” Remarkably, since 2020, Helena had discontinued her medication and also ceased using cannabis, which is often employed as an alternative treatment in the Netherlands. In addition, she had secured a job outside the nursing home that she enjoyed, and there were no indications of her mental health symptoms resurfacing.

Eefje's journey at the nursing home was also a testament to significant personal growth and recovery. "If you told me about this (healing results) five years ago, I wouldn’t believe you,” she reflected. By 2021, she was no longer troubled by OCD, and only occasional depression and anxiety. The latter happened much less frequently and less intense than before. More importantly, Eefje said she had developed sufficient resilience and would no longer “give in.”

Both Helena and Eefje have discontinued their medication and moved away from government-provided talk therapy, which they had been using for over a decade. Similarly, other young adults in the group had reached a stable mental state and no longer depended on medication for their struggles. Only two of them occasionally used cannabis for relaxation or to manage anxiety, but it no longer played an important role in their coping strategies.

It needs to be mentioned that the young adults' coping experience often remained unnoticed by the staff members, and their emergent identities were likewise overlooked. Due to their underestimated vulnerability, their path to overcoming social withdrawal and depression was more intricate and time-consuming than initially anticipated. Despite their commitment at work, two young adults mentioned that they were so socially withdrawn that it took them more than a year to attend big social events like musical festivals after depression. By 2021, even though the young adults all reported positive identity development, some still felt hesitant to voice their opinions as they did not want to raise conflicts.

This intricate process of recovery highlights the need for extended support beyond the initially planned one-year program. For these young adults, the path to recovery is not just about returning to baseline functioning but involves navigating through their symptoms to understand and address the core of their struggles. Therefore, while the Buddies Program was originally designed to be a one-year program, it took much longer for the young adults to recover from their symptoms.

Productive Coping Outcomes. The high vulnerability status of the HVYAs had delayed their transition from adolescence to adulthood. Their work with SwD, however, provided them an opportunity to catch up and develop productive coping outcomes. Regarding PVEST's Status Five, these coping outcomes are notably reflected in their career prospects, aspirations for further education, and the ability to establish intimate relationships. These elements align with Havighurst's developmental task theory, which posits that establishing a career, pursuing education, and forming intimate relationships are key components of the transition from adolescence to adulthood (Havighurst, 1972; Manning, 2002).

The HVYAs' career choices highlight the profound impact SwD had on their professional aspirations. Among the six main young adults involved in the program, their future career paths reflect a strong inclination to continue working in care-related fields, particularly with vulnerable populations. Four of the HVYAs expressed their desire to continue working with elderly individuals, especially SwD. This decision underscores the deep connection and sense of commitment they found by working with SwD.

The decision of one HVYA to work with adolescents with severe mental health struggles reveals that the young adults' compassion for highly vulnerable populations is not limited to seniors. Similar to the other HVYAs, she wanted to work in a challenging environment where she could make a meaningful impact. "With dementia, they (the seniors) decline, the kids (adolescents) I work with, they don't develop much anymore. So it's the same with dementia, it goes down," she said. The adolescents could not have full conversations and needed to get help with almost every part of life. They were not going to be able to cook, to get groceries by themselves, or even to live independently. But according to the young adult, she could connect with them. "Kids don't know why they are acting out, seniors with dementia also don't know why they are acting out. In a way, I can understand what they are struggling with because I lightly experienced that myself," she said. Compared to the seniors, who never hit her, the adolescents were more aggressive. Nevertheless, she liked working with them more. "I like being challenged, I like to struggle with the angry kids," she said. "With the kids, you are investing something." Therefore, she wanted to continue to work with a highly vulnerable population because she related to them and found the work itself rewarding. With further education, she wanted to be a teaching assistant, or a teacher specialized in this field.

The development of stable intimate relationships among the HVYAs in this study is a significant marker of their transition to adulthood. Initially, in 2019, only one HVYA was in a stable relationship, but by 2021, this number had increased to four.

By assisting SwD and enhancing their well-being, the HVYAs received invaluable support that enabled them to overcome various challenges. This support allowed them to develop a new, resilient identity, transforming them into newly resilient young adults—now productive members of society. Through this intergenerational relationship, the roles of HVYAs and SwD are redefined. Instead of being viewed as social liabilities dependent on others for services, they now have the potential to become valuable assets that contribute support to others.

Chapter 5: Discussion

This chapter addresses a critical question: *What is the mechanism behind the mutually beneficial relationship between highly vulnerable young adults (HVYAs) and seniors with dementia (SwD)*? Furthermore, *what are its implications to the broader context, namely nursing homes, SwD, and HVYAs?* Through exploring this intergenerational relationship within a typical nursing home setting, this study finds that traditional shortcomings of nursing homes can be turned into advantages in fostering this relationship. While nursing homes can enable HVYAs to alleviate their symptoms and develop career skills simultaneously by assisting SwD, incorporating these young adults also benefits nursing homes by facilitating their transition to PCC, transforming them into centers of healing and growth.

Dementia, traditionally perceived as a disease, can be viewed differently as a coping experience with mental health challenges. Through the stimulation provided by young adults, seniors can process their unresolved struggles and eventually find a sense of "peace." Recognizing the significant role that HVYAs can play, family members and nurses may be relieved of unrealistic expectations placed upon them in terms of care. The study, therefore, suggests that HVYAs, traditionally perceived as social liabilities due to their vulnerabilities, can, in fact, be transformed into valuable social assets. Since the mechanism behind this mutually beneficial relationship can be explained, it provides a model that has the potential to be replicated relatively easily in nursing homes worldwide, thus bringing about positive change for HVYAs, SwD, and nursing homes.

This study contributes to the academic discourse by bridging the gap between different life stages and underscoring the need to study highly vulnerable populations from a strengths-based rather than deficits-centered lens (Lodato et al., 2021). Given the significant number of individuals in these highly vulnerable populations, recognizing, and fostering opportunities for mutual growth holds substantial implications for practical application in caregiving and mental health fields.

The Potential for Nursing Homes to Transform

Utilizing the mutually beneficial relationship mentioned above can be a powerful and transformative strategy for nursing homes to transition to providing Person-Centered Care (PCC). This approach, however, necessitates a fundamental shift in mindset. Specifically, it involves reinterpreting certain characteristics of nursing homes as positive attributes that support these intergenerational connections. Furthermore, recognizing highly vulnerable groups as valuable social assets rather than liabilities is essential. Such a change in perspective facilitates the transformation of nursing homes from places marked by restrictions, decline, and inadequate services (Eckert, 2009; Feng et al., 2009; Pillemer & Moore, 1989) into environments conducive to healing and personal growth.

A Unique Work Environment - Positive Aspects of Nursing Homes

In this study, the nursing home serves as a pivotal context for fostering the intergenerational relationship between SwD and HVYAs. This unique setting provides three key features that are instrumental in facilitating positive coping experiences for HVYAs: a safe environment, a slow-paced atmosphere, and diverse work opportunities. Collectively, these features create a nurturing and adaptable workspace that is unique and especially suitable for this group of young adults.

A Safe Environment. The emphasis on safety within nursing homes, while often criticized under the notion of institutionalization (Luppa et al., 2008; te Boekhorst et al., 2012), actually serves a vital and unique function, particularly for HVYAs. This is because, for HVYAs, who constantly worry about a lack of security and social skills, they need an environment that offers social interactions in a secure way (Barton et al., 2012).

Nursing homes are characterized by their constant supervision and structured environment (Grabowski et al., 2014; Hughes et al., 2008; Rahman & Schnelle, 2008), contrasting sharply with the more open and unpredictable settings of places like restaurants. This environment, where staff members diligently monitor the seniors, provides a secure and consistent backdrop. Within this framework, HVYAs mainly engage with people they know well, avoiding the stress of frequent interactions with unfamiliar faces. While the predictability of nursing homes may seem confining to some young adults, it closely aligns with the unique needs and vulnerabilities of HVYAs. As demonstrated in this study, working with seniors was already a massive leap out of the HVYAs' comfort zone. Considering their vulnerability, the young adults needed a sense of security, which Barton et al. (2012) identify as essential for successful recovery and adaptation. Nursing homes, therefore, have the unique potential to provide an environment where HVYAs can build confidence, develop skills, and participate in a meaningful recovery process.

A Slow Paced Work Environment. The slower pace of nursing homes distinguishes them from many other work environments, making them particularly beneficial for HVYAs. Unlike high-pressure settings characterized by frequent deadlines and performance evaluations, nursing homes typically operate with greater flexibility. As highlighted in the previous chapter, the seniors' needs expect the young adults to remain calm and patient instead of keeping themselves busy. Studies have shown that perceived job flexibility and satisfaction correlate with reduced levels of psychological distress among care staff (Chong et al., 2023; Young et al., 2022). The slow-paced work rhythm in nursing homes gives HVYAs a sense of flexibility and contributes to their overall job satisfaction. Given their tendency to grapple with anxiety that may be exacerbated by self-imposed performance expectations, these HVYAs need to have a work rhyme that makes them feel calm and relaxed.

This phenomenon is best demonstrated by the fact that although HCare imposed no evaluations on the young adults, it still took them time to adjust to slowing down and feeling less anxious about their responsibilities. Over time, they realized that the work environment allowed them to manage their responsibilities effectively by pacing themselves. This approach not only aids in coping with their symptoms but also fosters a gradual build-up of confidence in their abilities without feeling overwhelmed.

Therefore, the distinctive feature of the work environment in nursing homes plays a crucial role in alleviating pressures that can exacerbate depression and anxiety disorders. It provides a foundation for professional and personal development at a pace that accommodates the unique needs and circumstances of HVYAs.

Various Positions for Career Development. Another unique strength of a nursing home is the diverse work opportunities it offers HVYAs within a familiar environment. To serve the diverse needs of the seniors, many nursing homes have their own laundry station, supermarket, garden, kitchen, etc. This comprehensive nature of operations within nursing homes enables HVYAs to explore diverse work positions within a single institution, facilitating the discovery of where their skills and interests are most suited.

At HCare, thanks to the flexible nature of the programs, several young adults had the opportunity to engage in various roles, including positions in the kitchen, at the reception desk, on dementia floors, and on standard care floors. This diversity of opportunities proves especially advantageous for HVYAs, allowing them to discern their strengths through exposure to different experiences within a familiar environment. For a demographic in need of security yet lacking in job skills, this arrangement provides an ideal balance between familiarity and a range of job options. Finding another environment that offers both security and such diversity is challenging, making it another unique feature of a nursing home.

Supportive Structure at Nursing Home. Another critical feature of nursing homes is the existing supportive structure they offer to HVYAs. In this study, although HVYAs may not always recognize it, nurses played a pivotal role in providing a foundational support system. By managing routine care tasks such as assisting seniors in and out of bed, handling laundry, and other related duties, the HVYAs were spared from these obligations. This division of labor allowed the HVYAs to focus on their core responsibility: spending quality time with the seniors, which they found more fulfilling. In exchange, nurses could be freed from the unrealistic expectation that they should spend quality time with the seniors, allowing them to feel more relaxed and find the job more manageable. The broader implication is that the lessened workload can help address toxic traits widespread in nursing homes, such as nurses' tendency to complain. This, in turn, can help nursing homes retain nurses and improve the quality of care.

Furthermore, staff members, particularly nurses, serve as a psychological safety net for HVYAs, which was especially crucial during the early stages of their employment. Given their lack of training and experience, it takes time for young adults to develop their job skills. In this adjustment period, nurses undoubtedly become the primary support for these individuals. Despite their different understanding of care approaches, the extensive experience and knowledge of nurses still serve as irreplaceable resources for HVYAs.

Dementia Ward as a Unique Context. In this study, the group setting of dementia care in dementia wards, as opposed to individual interactions, was crucial in providing HVYAs with a broader understanding of dementia. This exposure to different stages of dementia among seniors in one environment enabled the HVYAs to grasp the complexity of the condition quickly, distinguishing both the shared experiences and individual differences among the SwD.

The second advantage of the group setting is that it kept the young adults engaged at work. As the young adults reported, the variation in seniors' symptoms and personalities in a group setting offered a dynamic and stimulating work environment. While it required the HVYAs to step out of their comfort zone to act as group leaders and intervene in unpredictable circumstances, the young adults appreciated the challenging nature of the job, which kept the work engaging. This balance between security and challenge is often less likely in one-on-one relationships, such as providing home care, which is another unique advantage that can only be found in a nursing home.

Redefining Dementia Care

The transformative potential of the relationship between HVYAs and SwD suggests redefining traditional perceptions of SwD. Conventionally viewed as a terrible disease, turning seniors into social liability and requiring constant care without contributing back to others (Alzheimer’s Assosication, 2022; Cohen et al., 2014), this study reveals a different narrative. At HCare, observations of seniors making peace with themselves led caregivers to believe that for seniors in their later years, as their health inevitably declines, dementia should not be viewed as a disease requiring treatment. Instead, it is regarded as a coping mechanism that allows SwD to address unresolved emotional issues, paralleling the journey of HVYAs in resolving their mental health symptoms.

In this relationship, SwD benefit from stimulation provided by the young adults, whose companionship addresses their needs and enhances their well-being. In return, SwD, often without conscious awareness, can offer a unique and invaluable source of support to HVYAs simply by being themselves. Based on the young adults' experiences, SwD embodied the qualities typically associated with a therapist, offering nonjudgmental acceptance, authentic engagement, and reliable support (Cooper & Di Malta, 2024; Geller & Greenberg, 2002). Through their involvement with the seniors, the young adults found not only a pathway to their own healing but also an opportunity to develop essential skills pivotal for their transition to independent adulthood.

Unlocking the potential of SwD as a valuable resource on a larger scale, however, requires a paradigm shift in societal attitudes toward them. This involves moving beyond traditional views and recognizing the positive dimensions of SwD. Key to this reorientation is understanding dementia differently, justifying their need for stimulation, and reevaluating the role family members can play in the care for SwD.

Understanding Dementia Positively. Dementia, typically characterized as a degenerative and challenging condition associated with much suffering, is viewed differently by some HVYAs and nurses. They perceive dementia not just as a biological disease but as a mental health journey. This perspective is similar to the understanding of some researchers who note a bidirectional relationship between PTSD and dementia (Kuring et al., 2018). Studies like those by Desmarais et al. (2020) suggest PTSD can increase the risk for late-onset dementia, and conversely, dementia can heighten the risk for delayed-onset PTSD in individuals with earlier life traumas. However, the HVYAs' view focuses on caregiving and extends beyond severe conditions like PTSD to include less intense unresolved issues, such as enduring desires or long-standing emotional voids, like missing a family member from early life.

In this light, the seniors' journey through dementia is seen as a process of coping with unresolved psychological matters, similar to the experiences of the HVYAs themselves. Both groups engage in a process of resolving negative life experiences, and by finally accepting themselves—whether it is a symptom or their past—they reach an internal peace marked by relief and often prosocial behaviors. As SwD have lost their ability to initiate meaningful social interactions, they rely on others, especially the HVYAs, for stimulation and a listening ear to process their struggles. In this context, although they did not intend to perform the role, the HVYAs effectively acted as talk therapists. HVYAs are unique in facilitating this healing process, as they have similar struggles with their mental health conditions and are more in tune with the seniors' experiences. Therefore, these caregivers, through their close interactions with SwD, reframe dementia from being solely a condition of loss and deterioration to one that also involves a process of psychological resolution, which will allow them to find "peace."

It also needs to be stressed that during the coping process associated with dementia, the experience is not solely characterized by sadness or difficulty. Numerous instances of joy and light-heartedness emerge between the seniors and their caregivers. For example, a well-being officer recounted with laughter an instance where she posted the name of a village on a wall, creating an illusion for the seniors that they were back in their hometown. This story, like many others shared by caregivers, was not told with any negative intent. Rather, these narratives reflect a deep fondness for the seniors and a genuine delight in being able to bring moments of happiness and comfort to their lives.

Such anecdotes underscore the positive aspects of dementia care that often go unnoticed. They reveal that dementia, while undoubtedly challenging, can also be a journey filled with meaningful interactions and uplifting moments. The caregivers' ability to find and create these moments of joy not only enhances the quality of life for those with dementia but also enriches the caregiving experience, fostering a deeper connection and understanding between caregivers and seniors.

Additionally, my observations of SwD revealed that they were much more at ease than anticipated. On standard service floors, when left without external stimulation, these seniors often spent extended periods sitting quietly in their rooms. While their quietness may give an impression of contentment in solitude, it is crucial to consider whether this is a result of a true preference for solitude or a lack of opportunity for meaningful interaction and engagement. This raises an important question: Should there be more stimulation?

SwD’s Well-being Requires Stimulation. In the context of dementia care, "stimulation" refers to social interactions designed to engage and activate the cognitive, sensory, and emotional capacities of individuals with dementia (Woods et al., 2023). The literature predominantly emphasizes the need for increased social interactions for SwD (Cornwell & Waite, 2009; Litwin & Shiovitz-Ezra, 2006), often overlooking the possibility of disruptive behaviors as a response to such stimulation, including confusion, weeping, and wandering.

As evidenced by the literature and data from this study, nurses consider these behaviors troublesome and commonly resort to medication to pacify the seniors (Thompson Coon et al., 2014; Tolson et al., 2013). In this study, the HVYAs did not perceive the challenging behaviors exhibited by the seniors as problematic. Instead, drawing from their own experiences coping with mental health struggles, they regarded such behaviors as a natural aspect of the seniors' emotional processing, which should be encouraged through stimulation. This viewpoint contrasts with that of some nurses and family members who prioritize the seniors' calmness and mental clarity but aligns with the principles of PCC (Hughes et al., 2008; Mead & Bower, 2000).

This divergence in understanding of care highlights a critical gap in perceptions. The broader acceptance of the HVYAs' viewpoint, which recognizes the therapeutic value of stimulation in facilitating emotional expression and processing in SwD, is essential. Without this shift in public perception, the potential of SwD as a valuable social resource in care settings will remain underutilized.

The Limited Role of Family Members in Dementia Care. While family members are often encouraged to take on caregiving roles for seniors, it is not always realistic to expect the same level of involvement from those whose loved ones have dementia.

A significant dilemma faced by family members caring for seniors with dementia is the feeling of obligation despite the burden it imposes on them (Bremer et al., 2015; Cohen et al., 2014; Gimeno et al., 2021). The reality is that they often struggle to find the time needed to adequately care for their loved ones, resulting in a lack of understanding of the seniors’ needs (Jutkowitz et al., 2017). Consequently, they may find it difficult to come to terms with the conditions of the seniors they care for (Mahoney et al., 2005).

It is important to recognize that family members are not to blame for these challenges. As seniors develop dementia, their personalities and needs undergo significant changes (Bózzola et al., 1992; Chen et al., 2020), potentially altering their roles within the family dynamic from sources of love to perceived burdens (Wang et al., 2019). The stress associated with caring for SwD is a leading factor contributing to their placement in nursing homes (Schulz et al., 2008). Feeling there is little they can do to help, research suggests that family members of seniors with dementia tend to visit less frequently compared to those whose family members do not suffer from dementia (Yamamoto-Mitani et al., 2002).

When family members visit SwD, they often lack the insights and experience of the HVYAs who work closely with them. For example, family members may expect a SwD to remember them and past events, a belief that can conflict with the HVYAs' approach, which prioritizes respecting the seniors' choices, including their right to "let go" of certain memories. While HVYAs can more easily disregard the seniors’ pasts, with which they are unfamiliar, family members find this challenging because shared memories are crucial to their emotional connection. As mentioned in the previous chapter, these discrepancies in perspectives often lead to heated arguments, causing distress for both parties when they do spend time together.

Given the profound changes of SwD and the family members' lack of time and experience, this study suggests that the well-being of SwD could be left to the HVYAs. This approach would relieve family members from the obligation of caregiving—a task for which they are often unprepared—allowing them to interact with their loved ones without the pressures of being responsible for their well-being.

This, however, requires a change in mentality: HVYAs are more suitable caregivers for SwD than their family members. In practice, as demonstrated at HCare, family members often have concerns about the involvement of HVYAs in care settings, perceiving them as potential safety risks due to their mental health challenges. Consequently, while the primary responsibility of caring for SwD has shifted toward HVYAs, family members continue to significantly influence the standards and expectations of care, which tend to align more with their own emotional needs rather than those of SwD. This dynamic underscores the need to reassess the role family members should play in dementia care, especially since HVYAs are the ones primarily managing the day-to-day well-being of these seniors.

The Advantages for HVYAs to Provide Dementia Care at Nursing Homes

In this study, Highly Vulnerable Young Adults (HVYAs) have emerged as a previously unrecognized resource in aiding the transition of nursing homes toward Person-Centered Care

(PCC). Despite their mental health challenges and lack of professional training, these young adults represent a significant opportunity for nursing homes to transition to PCC. However, fully leveraging this social resource necessitates a fundamental change in perspective. Several compelling reasons support the inclusion of HVYAs in the widespread implementation of PCC within nursing home environments, highlighting their critical yet previously overlooked advantages.

Firstly, there is a significant number of HVYAs who, as demonstrated in this study, are likely to appreciate SwD. The HVYAs described in this study—all of whom are females dealing with common mental health issues such as depression, anxiety, OCD, ADHD, and sometimes PTSD. Research indicates that this demographic may demonstrate greater empathy compared to their male counterparts and often gravitate toward caregiving roles (Baron-Cohen et al., 2015; Jolliffe & Farrington, 2006). Unlike disorders such as autism and disruptive behavior disorders, which can hinder social interaction, their conditions typically do not lead to antisocial behavior. Consequently, this substantial global group may be predisposed to forming mutually beneficial relationships with SwD.

Secondly, integrating HVYAs into nursing homes requires minimal training, allowing for easy adaptation into the existing infrastructure. As highlighted in the previous chapter, despite having no prior knowledge of dementia and receiving little training, the HVYAs exhibited strong work ethics and aligned their caregiving with the principles of PCC. It can be inferred that the young adults treated the seniors with devotion and respect because of a sense of empathy derived from their shared struggles—in the eyes of the HVYAs, the seniors are seen as their equals. This empathetic attitude, essential for Person-Centered Care (PCC), is considered by some caregivers to be more crucial for delivering quality care than formal education or training (Band-

Winterstein et al., 2019). Therefore, despite minimal training, HVYAs are able to adapt and commit to their roles, largely because of the mental health struggles they share with the seniors, a population that has allowed their empathy to flourish.

It needs to be mentioned that this can only be possible because of the division of labor at the nursing home, which freed the young adults from routine tasks provided by nurses. The latter's work, such as assisting seniors with mobility and medication management, requires more training to master. This means the young adults can be easily integrated into the existing structure of the nursing home, with their nursing staff already providing routine-based care.

Thirdly, from a financial perspective, incorporating HVYAs into the nursing home workforce is cost-effective. In a time when nursing homes face significant budgetary challenges, the inclusion of HVYAs offers an economical staffing solution. As this study shows, these young adults are driven more by the therapeutic and meaningful aspects of the work than by financial gain. During my interviews with them, their passion for their roles was evident, yet there was no mention of a desire for higher wages. Therefore, this approach reduces staffing costs and offers a valuable healing and development opportunity for HVYAs, enabling them to become productive members of society within a few years.

In addition, incorporating HVYAs into nursing homes can also help mitigate some prevailing issues in these facilities, notably the culture of complaints among nursing staff. In the Netherlands, for instance, the shortage of nurses and the increasingly complex health needs of senior residents have led to widespread complaints within the nursing profession (De Veer & Kerkstra, 2001). A crucial step toward altering this work culture involves alleviating the workload of nurses. In the context of HCare, the ratio of HVYAs to nurses is significantly low, at less than 1 to 30. Increasing the proportion of HVYAs, coupled with a clear delineation of their roles distinct from those of nurses, could substantially reduce the nursing staff's workload, thereby potentially improving job satisfaction and the overall work environment.

In summary, HVYAs possess the potential to play a pivotal role in the large-scale implementation of PCC in nursing homes worldwide. By tapping into this resource, nursing homes can address staffing challenges, enhance the quality of care for SwD, and simultaneously provide a transformative environment for young adults struggling with mental health issues.

Therefore, nursing homes have the potential to undergo a transformative change by effectively integrating seniors with dementia (SwD) and highly vulnerable young adults (HVYAs) into their care model. This integration can create a mutually beneficial environment that enhances the well-being of both populations. In addition, it provides a feasible solution to nursing homes' efforts to provide PCCs, who also benefit from this intergenerational relationship.

The Mechanism of the Mutually Beneficial Relationship

In this study, an unexpected yet profound relationship was found between SwD and HVYAs. Contrary to conventional perceptions of these groups as social liabilities due to their high vulnerability, the unique nature of dementia enables SwD to offer a supportive relationship characterized by authenticity, non-judgmental acceptance, and meaningful interaction, similar to the therapeutic relationships advocated by researchers in the field of mental health intervention (Cahill et al., 2016; Munford & Sanders, 2020; Zlotowitz et al., 2016).

Understanding the underlying dynamics of this mutually beneficial relationship is essential for recognizing why SwD can be a unique and significant source of support for HVYAs. Studied collectively, these two groups' shared similarities contribute to a deeper, more meaningful connection. The work environment is also critical, which presents a balanced mix of security and challenge, keeping the engagement level high for the young adults. Furthermore, the manageable nature of the work, characterized by a low threshold for engagement, is crucial for the development and reinforcement of the young adults' confidence. This dynamic fosters an environment where HVYAs can thrive and simultaneously contribute to the well-being of the SwD.

Similarities between HVYAs and SwD

Exploring the similarities between highly vulnerable young adults (HVYAs) and seniors with dementia (SwD), rather than examining them separately, is crucial for understanding the strong bond they share. These previously overlooked similarities play a pivotal role in explaining their deep connection. Specifically, both groups are navigating transitional stages in life, exhibiting similar symptoms and needs. Intriguingly, both demonstrate their agency intergenerationally, further solidifying the unique and mutually beneficial relationship they develop within the nursing home environment.

A Period of Transition in Their Lives. Both SwD and HVYAs are navigating critical transitional stages in their lives within the context of a nursing home. For HVYAs, this transition marks a shift from adolescence to adulthood, a time of identity formation and a move toward greater independence. In contrast, SwD are transitioning from a phase of independent living to one of high dependency as their cognitive abilities decline. These parallel shifts represent significant changes in their roles, responsibilities, and self-perceptions, co-occurring in the shared environment of a nursing home. This juxtaposition of life stage transitions for both groups fosters a unique dynamic and mutual understanding within the nursing home setting.

Adapting to new environments is a significant challenge for SwD and HVYAs in the nursing home setting. Being on their own, SwD faced the task of acclimatizing to a care facility, which often involved losing touch with familiar surroundings and routines and relinquishing their independence. Meanwhile, the HVYAs encountered their own challenges as they stepped into the workforce, particularly in a caregiving role. The new role required them to develop work-related skills and coping mechanisms while balancing their mental health needs.

Furthermore, the need for security, inclusion, and stimulation is crucial for both SwD and HVYAs within the nursing home environment. Security is paramount for these groups as they transition into their new roles and settings by themselves. For SwD and HVYAs, feeling safe and supported, both physically and emotionally, is essential for their well-being and effective functioning. In this context, inclusion involves creating a sense of belonging and community, which is especially important to combat feelings of isolation and loneliness that both groups might experience. Lastly, stimulation is key for both the group’s cognitive and social engagement. For SwD, stimulating activities and interactions, particularly with young adults, can help slow cognitive decline and process emotional needs. Conversely, for HVYAs, such stimulation is beneficial in developing social and job skills, enhancing self-esteem, and fostering personal growth. These shared needs underline a unique connection between SwD and HVYAs, where each group's presence and interaction can positively impact the other.

At the core of the relationship between SwD and HVYAs lies their commonalities, including the necessity for adaptation, supportive structures, and a nurturing environment that facilitates stability and growth. Recognizing and understanding these parallel transitions and their similar needs is fundamental to crafting effective care strategies.

Shared Symptoms and Struggles. Previously, SwD and HHVYAs were studied separately due to their different life stages and distinct support needs. However, in this study, the perceived shared struggles between young adults and SwD provide a compelling reason to examine these two populations and their symptoms more closely.

While dementia is commonly associated with seniors being forgetful, SwD also exhibit common behavioral symptoms such as depression, anxiety, agitation, psychosis, and disruptive behaviors (Gallagher et al., 2011; Kuring et al., 2018; Lyketsos et al., 2000). Similarly, among the HVYAs in this study, depression, anxiety disorders, and challenges in managing emotions were prevalent. Although the reasons for these symptoms differed between the two populations, the resulting behaviors appeared similar from the perspective of young adults, as discussed in the previous chapter.

Beyond the symptoms, the two populations also share similarities in other aspects. For example, the seniors' loss of filtering, leading to uninhibited but not always appropriate expressions, mirrors the young adults' struggles with social skills. Additionally, both SwD and HVYAs experience minimal social circles due to these symptoms.

In therapy, therapists are often encouraged to establish emotional connections with their clients, sometimes by sharing their own experiences of struggles (Geller & Greenberg, 2002; Safran & Muran, 2000). Although SwD may not intentionally fulfill this role, their similarities with HVYAs undoubtedly foster a sense of closeness between the two groups.

The Intergenerational Nature of Their Support to Others. Both seniors with dementia (SwD) and highly vulnerable young adults (HVYAs) exhibit a unique characteristic in their expression of agency: it manifests most effectively in an intergenerational context. This study observed that while SwD might display aggression or meanness toward each other, they seldom exhibited the same hostility toward the younger adults. Instead, they often sought out these younger individuals as confidants, turning to them for emotional support and companionship rather than others their age. Likewise, several HVYAs recounted sharing their struggles and stories with the seniors, preferring these interactions over confiding in their age group. This preference underscores the intergenerational nature of the social bonds formed in these settings, highlighting that despite their similarities with their respective age groups, both SwD and HVYAs find a unique sense of connection and support in cross-generational relationships.

Therefore, this cross-generational engagement has been a crucial factor in strengthening the resilience demonstrated by the HVYAs in this study. Without the unique dynamics and support offered by these intergenerational relationships, the HVYAs' resilience would likely not have developed to the same extent.

Unique Characteristics of SwD

In this study, the unique characteristics of Seniors with Dementia (SwD) played a vital role in facilitating their mutually beneficial relationship with the Highly Vulnerable Young Adults (HVYAs), offering the latter a form of support unavailable from mentally healthy individuals.

This study finds that characteristics typically viewed negatively, such as forgetfulness, insecurity, and dependence, were seen positively by the HVYAs. The HVYAs interpreted the seniors’ memory loss and lack of social filters as facilitating genuine interaction, unlike mentally clear seniors, who tend to be more selective and guarded in their social interactions. This acceptance is crucial for HVYAs, who often face challenges finding environments where they feel secure and valued. The seniors’ expression of gratitude and consistent welcoming of the young adults’ company reinforces a positive perception and fosters a deep connection. These young adults appreciate the nonjudgmental and welcoming nature of SwD, valuing their unconditional acceptance and gratitude—a sharp contrast to their interactions with mentally healthy seniors. This perspective highlights the unique role SwD can play in the lives of HVYAs.

The appreciation HVYAs have for SwD is evident throughout the study, where they affectionately refer to them as "cuties" and "grandparents" and report exclusively positive experiences. Even disruptive behaviors or inappropriate remarks from seniors are tolerated and understood within the context of their condition. Despite the challenges posed by the young adults’ own symptoms and staff members, the young adults remain dedicated to assisting the seniors, driven by their own needs for security, belonging, and professional fulfillment.

This study illustrates that SwD at HCare serve as a reliable source of support for HVYAs, offering a form of assistance that is uniquely beneficial and not found from other groups. In return, despite not being formally trained in PCC principles, they treat SwD with profound respect and understanding, viewing them as equals rather than individuals defined by their illness. Consequently, HVYAs emerge as a unique source of support for SwD’s well-being.

This study also posits that the HVYAs' dedication to practicing PCC is not acquired through training but rather stems from a profound connection with the seniors' symptoms. Witnessing the struggles of SwD prompts HVYAs to reflect on their own challenges, forging a deeper bond and instilling a sense of purpose. This empathetic understanding motivates HVYAs to assist seniors in managing these issues, setting their caregiving approach apart from that of other nursing staff and student residents at HCare. In contrast to merely addressing typical dementia symptoms like memory loss and condescension, the focus of HVYAs encompasses broader emotional struggles shared between the two groups.

Therefore, it is the unique traits derived from dementia that provided a basis for this mutually beneficial relationship to take place. Another angle to understand this relationship is through insights gained from equine-assisted therapy, which is better studied. Although nonverbal, the interaction between humans and horses can yield profound healing effects, such as fostering a sense of security and enhancing openness to social interactions (Nilson, 2004; Vidrine et al., 2002). This mirrors the experiences of the young adults in this study. Both the HVYAs and the seniors with dementia (SwD) find verbal communication challenging due to their mental health conditions. However, they effectively connect through an empathetic understanding of each other's emotions and, at times, through physical touch. Among my informants, two young adults (outside of the HVYAs) with mental health issues shared positive experiences with equine-assisted therapy, attributing their comfort to the non-requirement of verbal communication, which they found less demanding. Consequently, while both the HVYAs and SwD struggle with verbal communication, the young adults experience a sense of relief and comfort in this nonverbal interaction, finding it more accommodating to their needs.

A Suitable Job for HVYAs

It is widely acknowledged that HVYAs require career opportunities, yet finding a suitable job that accommodates their vulnerabilities and fosters a sense of agency has been challenging (Gmitroski et al., 2018; Williams et al., 2016). However, an examination of the HVYAs' experiences at HCare suggests that working with Seniors with Dementia (SwD) in nursing homes could be a viable solution. This study reveals that not only did the young adults find a sense of security and belonging with the seniors, but the job is also ideally suited for those new to the workforce. Requiring no specific skills and being accommodating, the position at HCare provides an accessible entry for these young adults and offers a unique balance between security and challenges, keeping the role engaging and meaningful.

Low Threshold for Job Entry. A significant challenge HVYAs face is that even though they seek opportunities to utilize their agency, they have few skills to offer (Rapaport et al., 2005). The mental health challenges HVYAs have often impede their development of professional job skills, social capabilities, and the mental fortitude necessary for a conventional nine-to-five job, making job acquisition a formidable challenge (Goodman et al., 2011; Vander Stoep et al., 2000). The role of assisting seniors at nursing homes, however, presents a more attainable entry point.

Focused primarily on seniors' well-being, this job's fundamental requirements are to remain calm and present. The needs of SwD are various yet basic, ranging from desiring company and conversation to needing assistance with walks or locating people or items. These are tasks that anyone with patience and empathy can fulfill. Distinct from typical jobs that might demand specific skills or training, such as operating a register, this role in a nursing home does not require specialized training. Furthermore, the slower pace of work in this environment is more about maintaining a peaceful and attentive presence with seniors, rather than engaging in continuous, active tasks. This aspect of the job is so aligned with the intrinsic qualities the HVYAs desire to have at work that two of them described the role as not feeling like a traditional job. This alignment not only provides a suitable work environment for HVYAs but also facilitates a sense of ease and natural engagement with their responsibilities.

This low entry threshold is advantageous for HVYAs in two significant ways. First, it implies minimal training is required to become effective, allowing them to adapt to their roles quickly—a crucial factor for enhancing their self-confidence and maintaining engagement. Second, the emphasis on calmness in the job aligns with their mental health recovery needs, thus allowing them to heal and develop job skills simultaneously.

An Accommodating Work Environment. The principles of Person-Centered Care (PCC) for people with dementia emphasize the importance of recognizing individual uniqueness, understanding emotions, and preserving autonomy and dignity (Edvardsson et al., 2008; Kitwood, 1997; Mead & Bower, 2000). Unlike routine-based care, achieving these goals requires a flexible culture. As shown by the HVYAs at HCare, a secure and relaxed work environment is crucial for promoting well-being.

The work environment must be accommodating to enable HVYAs to adapt to their routines before they can establish meaningful connections with the seniors. Given the hands-on nature of this challenging job, the initial struggles and adaptation difficulties faced by young adults should be acknowledged. As demonstrated at HCare, leniency that allows for mistakes and even signs of initial lack of commitment, such as arriving late in the early stages of employment, should be permitted. Moreover, caregivers must have the autonomy to make decisions alongside individuals with dementia—a difficult task given the unpredictable nature of SwD. Consequently, the performance of the young adults cannot and should not be strictly evaluated.

Although not deliberately designed as such, the accommodating structure at HCare has provided an environment that respects agency and fosters a sense of responsibility among the young adults. The absence of constant evaluation helps motivate them to take ownership of the seniors' well-being, making the job engaging due to the challenges it presents.

A Balance between Security and Challenge at Work. The relationship between SwD and HVYAs in nursing homes is uniquely characterized by providing a balance of security and challenge in the work environment. For HVYAs, who are in a critical transitional period striving to establish independence, finding a job that aligns with their needs for balance is essential. Security in this context implies an environment where they are not overwhelmed, free from judgment, and where their performance is not under constant scrutiny. In this study, the HVYAs reported feeling comfortable and unthreatened by the seniors, allowing them to be their authentic selves at work.

On the other hand, the challenge in the workplace comes from the job being dynamic and requiring decision-making. The unpredictable nature of the seniors' symptoms presents challenges, yet it also positions the HVYAs in leadership roles where they are in charge and make decisions for the seniors. This balance between a secure environment and challenging work keeps the young adults engaged and committed to serving the seniors.

This balance between security and challenge is crucial for job satisfaction, particularly in nursing homes. Research suggests that higher job satisfaction among employees leads to reduced absenteeism and lower turnover rates, a correlation that is especially evident among nursing home employees (Bishop et al., 2009).

As noted in studies of nurse aides by Secrest et al. (2005) and Bishop et al. (2009), the sense of being in control empowered the nurse aides despite their lower position in the hierarchy at nursing homes. It is also particularly crucial for HVYAs during this phase of their lives, where developing a sense of agency and control is key for their transition to adulthood. This transition from limited control, often experienced during therapy sessions, to actively influencing their life outcomes through work, is essential for their development and empowerment (Barton et al., 2012; Hingley-Jones & Ruch, 2016; Munford & Sanders, 2021a).

Therefore, a mutually beneficial relationship was uncovered between SwD and HVYAs at a nursing home. This interaction transcends traditional perceptions of both groups as social liabilities, highlighting the unique potential of SwD to foster a supportive, authentic, and non-judgmental relationship akin to therapeutic interactions.

Although the program was limited in scope and conducted within a specific setting, the mechanism of this relationship can be explained, suggesting broader applicability. This relationship is rooted in the shared characteristics between these two groups, including being in transitional life stages, experiencing similar symptoms, and possessing intergenerational agency. Particularly noteworthy are SwD's unique traits, enabling young adults to express themselves authentically and derive a sense of purpose and fulfillment from assisting the seniors. Furthermore, the nature of the job provides a conducive environment for the emergence of young adults' agency, free from concerns about performance evaluations, thereby fostering a sense of security and engagement.

The Importance of Recognizing the HVYAs' Perspective

This study reveals significant differences in perspectives on their work and coping experiences between HVYAs and other staff members in a nursing home setting. While the management team often showed limited awareness or concern regarding the HVYAs' experiences, the young adults found the work to have played a critical role in their recovery and transition to adulthood.

Utilizing the Phenomenological Variant of Ecological Systems Theory (PVEST) as a framework to understand the experiences of HVYAs, this study highlights the importance of viewing their experiences from their unique perspective. As a marginalized group, HVYAs often lack the confidence or motivation to voice their concerns or needs. The study gives them a voice by revealing these young adults' remarkable resilience when assisting SwD, which has been previously overlooked.

From the HVYAs' viewpoint, vulnerability is not a fixed state but relative to their context. In the company of SwD, they experience a sense of empowerment, a stark contrast to the marginalization they often feel in other social interactions. In addition, they possess an intrinsic desire to exert agency and be their authentic selves when assisting SwD. This study also emphasizes that the journey of coping and adaptation for HVYAs is a long-term process involving gradual changes in self-perception and the development of resilience.

This research underscores the significance of acknowledging and valuing the perspectives of HVYAs to fully appreciate their potential as a social resource rather than viewing them as a liability. Just as it is crucial to understand the experiences and needs of SwD, society must also endeavor to comprehend the viewpoint of HVYAs. By doing so, we can facilitate their recovery process and assist them in transitioning from a marginalized state to becoming valuable contributors to the community.

Vulnerability is Relative

Resilience, as illustrated in this study, is a context-specific phenomenon. The study argues that through working with SwD, young adults could transform their perception of themselves, acquiring a previously unrealized sense of agency. Bandura (1997), Bonanno (2008), and Masten (2001) all demonstrated that individuals who feel they have control over their lives and can make impactful choices tend to recover from challenging situations more effectively. Therefore, this realization of agency contributes to resilience and fosters productive coping outcomes.

At the critical age of establishing independence, young adults seek opportunities to feel capable (Arnett, 2000; Erikson & Erikson, 1997). However, due to their struggles, HVYAs often encounter challenges in finding environments where they feel valued without being judged for their disadvantages. Even within nursing homes, they frequently experience a sense of being undervalued by other staff members. In contrast, their time spent with SwD paints a different picture. In these interactions, HVYAs perceive themselves as the more capable party. Observing the struggles of SwD fosters not only a deep sense of connection due to shared challenges but also an awareness of their own mental and physical capabilities relative to the seniors. This realization gives HVYAs a new perspective on themselves, that they are much more capable than previously thought. It gives them a new understanding of self in this relationship, imbued with empathy and a sense of responsibility. Therefore, they find themselves in a role where they are both needed and capable of offering meaningful assistance to SwD, who accept and appreciate their help without judgment or criticism.

The transformation in HVYAs' self-perception derived from their interactions with SwD signifies a pivotal shift in the therapeutic dynamic. Traditionally, therapy has often been reliant on external validation and empowerment, primarily from therapists. The reality is that young adults lack faith in existing mental health services, and consequently, the participation rate in these services is low (Munford & Sanders, 2021; Vanheusden et al., 2008). As demonstrated in this study, however, therapy begins with a notable shift in self-perception through work experience.

This change is crucial for holistic recovery, aligning with contemporary understandings of therapy that emphasize self-awareness and self-directed healing. In this study, the HVYAs' newfound ability to draw strength and affirmation from within themselves is in harmony with the principles of positive psychology, which focuses on fostering a sense of well-being and personal growth rather than merely addressing pathologies (Seligman & Csikszentmihalyi, 2000). This approach aligns with the concept of "empowerment" in therapeutic settings, as discussed by Zimmerman (1995), who suggests that empowerment involves gaining mastery over one's life and a deeper understanding of one's status and prospects.

Moreover, this shift addresses the limitations often encountered in traditional therapy, particularly its effectiveness for individuals with complex mental health challenges. By fostering a scenario where the HVYAs are actively engaging in a process that allows for self-reflection and empowerment, the therapist's role transitions to a support role. This is more in line with contemporary therapeutic approaches that advocate for client-centered therapy, where the therapist acts more as a facilitator rather than a director of the healing process (Cooper & Di Malta, 2024; Rogers, 1951).

It is important to note that this sense of empowerment from feeling relatively less vulnerable is distinctly observed in HVYAs when interacting with SwD. Contrastingly, the young adults did not experience these feelings of empowerment in interactions with mentally healthy seniors. Moreover, this particular sense of empowerment was not a common experience among student residents at the nursing home. The exception to this was in cases where student residents themselves shared similar insecurities or vulnerabilities as the HVYAs. This suggests that the sense of empowerment is closely tied to the shared experiences and challenges faced by HVYAs and SwD, fostering a unique bond and understanding between them.

In summary, the HVYAs' ability to find empowerment and validation from within through their interactions with SwD suggests the potential for a significant change in therapeutic practice. It implies a model where therapy is not just a process of external guidance but also one of internal discovery and growth, offering a more realistic and sustainable path to recovery for those with complex mental health needs.

Intrinsic Motivation of the HVYAs

Other than the resilience awakened by the context, this study also reveals an intrinsic motivation of the young adults to assist the seniors. This intrinsic motivation is evident in the HVYAs' natural resilience, empathy, and willingness to help those more vulnerable than themselves, even when facing immense challenges from their colleagues. This sense of empowerment, derived from their efforts and interactions with the seniors, aligns with White's theory of effectance motivation, which posits that individuals are intrinsically motivated to interact effectively with their environment (White, 1959).

Contrary to the stigma often associated with young adults facing mental health challenges, which suggests a propensity toward moral failings or behaviors like drug addiction or theft, the HVYAs in this study demonstrate commendable work ethics. Their approach to caregiving responsibilities is marked by respect and care, reflecting an intrinsic motivation to contribute effectively and helpfully. Unlike the conventional drive for financial gains or elevated social status typically associated with work commitment, the HVYAs' primary focus is on achieving a sense of validation and fulfillment. This distinction in motivation stems from an inner drive toward competence and the gratification derived from successful, meaningful interactions, aligning with White's (1959) theory of effectance motivation. Their actions, therefore, are not dictated by external training or traditional incentives but by a deep-rooted desire to engage positively and effectively in their environment.

The observed behaviors and attitudes of the seniors toward the HVYAs further validate this intrinsic motivation, as the seniors always genuinely welcomed the young adults’ company. The trust and acceptance shown by the seniors toward these young caregivers are not just a testament to the latter’s important role but also to their integrity.

The HVYAs' intrinsic motivation extends to developing their own perspectives on work and self-identity. At a pivotal age where the desire for independence is strong, they find their agency ignited by the urge to contribute meaningfully to the well-being of the seniors. This awakening prompts them to critically evaluate their own circumstances and make autonomous decisions instead of merely following instructions. This attitude can sometimes result in very different approaches toward care, particularly when they do not perceive staff members as role models to learn from. This journey of self-discovery, as previously mentioned, occasionally leads to conflicts with colleagues. This, however, should not be viewed negatively but seen as a sign of the young adults' agency being awakened. The dissension, therefore, underscores the need for colleagues' empathy and understanding to support and facilitate the young adults' unique developmental process.

The HVYAs' Perspective on Their Coping Outcomes

It is essential to acknowledge that the HVYAs in this study have a unique perspective on their coping outcomes. Given their high vulnerability, their journey of engaging with a previously unfamiliar population and mastering a complex job in a nursing home setting has posed significant challenges. As newly resilient young adults, they have acquired a new identity and hold hopeful plans for their future. However, they still need to manage the remnants of their past challenges, such as occasional mental health symptoms and a slower acquisition of certain skills. Well aware of this, these young adults exhibit more modest aspirations, in contrast to conventional benchmarks of success, which often prioritize higher education in promising fields and climbing the corporate ladder. Their sense of achievement and satisfaction does not necessarily align with societal norms of ambition; instead, many find contentment and fulfillment in the simple act of being helpful to others, such as assisting SwD. This distinct perspective on success and fulfillment highlights the need to appreciate and validate their journey and achievements within the context of their individual experiences and challenges.

As highlighted by Havighurst (1972), there can be a divergence in aspirations across different social strata. It is important to recognize that the HVYAs' experiences working with SwD over two to three years, although transformative, do not equate to the credentials or life trajectories of young adults who have not faced similar mental health challenges. For the HVYAs in this study, their satisfaction and sense of achievement derived from regaining stability and pursuing practical qualifications, such as a nursing certificate. Unlike their more privileged counterparts, who might aim for managerial roles or pursue degrees in business or engineering, these young adults show contentment in their recovery and progress within their current scope. This perspective contrasts sharply with mainstream societal expectations but is equally valid and commendable. The study indicates that while the aspirations of HVYAs might evolve over time, their current state of satisfaction in caregiving should not be viewed as a lack of ambition but rather as a meaningful accomplishment in their stage-specific journey. Understanding and valuing their perspective is crucial in recognizing the strides they have made in their personal and professional development.

Therefore, society needs to both acknowledge the significant strides made by these HVYAs and maintain realistic expectations regarding their recovery and professional aspirations. The fact that they are committed to their job and making steady progress in their personal and professional lives is a testament to their resilience and the positive impact of their work experience. Expecting them to conform to conventional career trajectories overlooks the unique challenges they have faced and the specific context of their growth and development. Recognizing and valuing their perspective of the journey for what it is – a significant and positive transformation in their lives – is crucial.

Conclusions and Recommendations

This study finds that a mutually beneficial relationship exists between Highly Vulnerable Young Adults (HVYAs) and Seniors with Dementia (SwD) in the context of a nursing home. The findings are promising, revealing that despite their vulnerabilities, HVYAs not only play a pivotal role in the nursing home's transition to person-centered care (PCC) by contributing to the well-being of SwD but also demonstrate productive coping outcomes. Surprisingly, a critical aspect of this relationship is the unique support that HVYAs perceived from SwD, which played a significant role in the young adults' positive coping experiences. In return, the HVYAs offered the SwD care in line with the principles of PCC, helping them process their emotions and, consequently, reducing their need for medication. This study challenges traditional perspectives that primarily focus on the vulnerabilities of highly vulnerable populations while often neglecting their resilience. It posits that the lack of recognition for their resilience is largely due to the absence of a context that allows for its emergence. By improving the seniors' well-being, the young adults found a rare balance that could accommodate their vulnerabilities and foster a sense of agency at the same time. This indicates that nursing home provides a unique context that can foster a strong bond between these two highly vulnerable populations, turning them from social liabilities into assets.

Recommendations

Understanding the mutually beneficial relationship between Highly Vulnerable Young Adults (HVYAs) and Seniors with Dementia (SwD) not only offers promising opportunities for enhancing the well-being of both groups but also provides a feasible pathway for nursing homes to transition to Person-Centered Care (PCC). This model benefits all involved parties and holds significant feasibility. However, despite the advantages of including young adults in the nursing home, its implementation may encounter certain difficulties and challenges. Practical suggestions for nursing homes implementing similar programs, guided by the Phenomenological Variant of Ecological Systems Theory (PVEST) (Spencer et al., 2006), focus on amplifying support while minimizing challenges. Therefore, there are several measures nursing homes can consider to support the successful integration of HVYAs into their caregiving role, including orientation support, basic training, and fostering understanding of the young adults throughout the nursing home.

In this context, orientation support entails providing necessary assistance to HVYAs during their initial stages of employment. This assistance includes familiarizing them with the work culture, colleagues, and expectations. Given that some HVYAs may be entering the workforce for the first time and are highly vulnerable, they require guidance not only in understanding the work environment but also in adhering to dress codes and proper social etiquette. At HCare, job coaches played a crucial role in facilitating the orientation process, which the young adults considered essential. Although not required to act as therapists, ideally, these coaches should be able to relate to the young adults' experiences on multiple levels, particularly concerning mental health and work.

As discussed, assisting SwD with their well-being is full of challenges, making it difficult for young adults to navigate alone. While the HVYAs in this study demonstrated dedication in overcoming these obstacles, the process was time-consuming and mixed with struggles. As this study illustrates, it takes at least a year for young adults, even those with a prior interest in caregiving, to familiarize themselves with the seniors and adapt to the work environment. Their transition could have been smoother with additional support from experienced staff members. Basic training initiatives, such as job shadowing and regular learning or discussion sessions, could facilitate knowledge transfer from experienced staff to HVYAs. However, it is crucial that these initiatives do not become rigid protocols that standardize the care seniors receive; instead, they should empower young adults to assist seniors in ways that are personalized and tailored to their preferences.

Successful integration of young adults also necessitates fostering an understanding of them across the nursing home. Rather than confining them solely to the program, making them unknown to most staff members, they could be encouraged to participate in various activities if they feel comfortable. The intention behind including young adults should be clearly communicated—that they are employed to enhance the seniors' quality of life and alleviate caregiving stress among staff members. As nursing homes value orderliness and safety, including these young adults may be perceived as adding risks and unpredictability to the environment. It is, therefore, crucial for the nature of the young adults' work to be fully understood. For SwD, improving the quality of life may not always manifest as constant happiness; stimulation may sometimes result in outward behaviors of uneasiness or agitation. For the young adults, the significant changes may not be readily apparent to others who lack similar mental health experiences. Therefore, authoritative figures who may lack experience in assisting SwD or interest in the young adults’ coping experiences should not judge the effectiveness of this intergenerational relationship based solely on outward appearances. Instead, the program should be based on a deep understanding of the mutually beneficial mechanisms of this relationship and have faith in these highly vulnerable populations’ agency rather than rigid institutional rules or short-term evaluation to prove its effectiveness.

Therefore, while this intergenerational program presents numerous opportunities for enhancing the current care system, it necessitates a substantial shift in mindset that regards both SwD and HVYAs as social resources, not liabilities.

Limitations and Future Research

The limitations of this research are primarily due to the relatively homogeneous sample and the specificity of the context. The prospect of who else can benefit from this intergenerational study is, therefore, limited. This study focused on understanding the experiences of a group of young adult females, most aged between 20 and 30, who shared common mental health struggles and had little previous work experience. Exploring how these findings might benefit other populations, such as those with schizophrenia, disruptive behavior disorders, or different age groups, has not been conducted. From my observations at the nursing home, I infer that males with similar experiences might also benefit from this relationship, provided they are prosocial, although there is no empirical evidence to support this claim.

Another potentially relevant group is nurse aides. In the U.S., they are primarily responsible for direct care, unlike in the Netherlands, where all direct care is provided by trained nurses. Nurse aides are predominantly women, many of whom belong to racial and ethnic minorities and come from disadvantaged socioeconomic backgrounds, including both documented and undocumented immigrants, with minimal training in healthcare (Castle & Ferguson-Rome, 2015; Mercer et al., 1994; Stone & Wiener, 2021). Similar to the HVYAs in this study, the literature suggests that nurse aides report positive work experiences with SwD (Band-Winterstein et al., 2019; Bishop et al., 2009; Secrest et al., 2005). This raises some important questions: *Could this positive perception be attributed to their similarly disadvantaged backgrounds*? *How does their role in providing direct care influence their relationship with SwD*?

Being conducted in the Netherlands, where cultural attitudes toward care might differ significantly from other regions like the United States, poses another limitation of this study. In the Dutch context, there is a consensus that optimizing seniors' well-being involves granting them more freedom and accepting associated risks. This understanding of care contrasts sharply with the more restrictive environments often found in American nursing homes, where SwD's movements and activities are more limited. Therefore, this divergence in perceptions of what constitutes well-being needs to be carefully considered when adapting this model to different cultural contexts. Future research can thus explore the implications for other populations and examine how specific contextual factors might affect these relationships.

In summary, to make use of this intergenerational relationship, nursing homes ought to foster trust in the inherent motivation of both HVYAs and SwD to support one another. Establishing this reciprocal relationship and altering the entrenched mindset not only redefines the identity of highly vulnerable populations but also transforms nursing homes into hubs of healing and growth. Given the global mental health crisis, the practical significance of this study cannot be overstated.

Appendix

Interview Questions for Highly Vulnerable Young Adults (HVYAs)

1. Can you describe your experiences growing up?
    a) Who was in your family?
    b) What were some of the most significant experiences?
    c) What were some difficult situations you had to go through as a teenager?
    d) During those difficult time, who provided you with support?
    e) What are some of the symptoms you experienced before or are still experiencing?
2. Where did you work before coming to HCare?
    a) What did you like and dislike about those wrok experiences?
    b) How is it different from working here?
3. What do you like about working here?
    a) What is your job responsibility?
    b) How would you describe the seniors (SwD) you work with?
    c) How are they different from seniors who are mentally healthy?
    d) How would you describe other young adults in the program?
4. What do you find difficult working here?
    a) What are some of the seniors' disruptive behaviors?
    b) How do you handle these behaviors?
    c) How do others (e.g. other young adults or nurses) handle these behaviors?
5. How have you changed since you started working here?
    a) How would you describe your level of confidence and social skills now?
    b) What have you learned about job skills?

    c) Who helped you develop those skills?
    d) How are you coping with your symptoms?

6. What factors contribute to these (positive) changes?
    a) How would you describe the work environment?
    b) What do you like about working with the seniors?

7. What did you know about SwD before you started working here?
    a) What was your first impression?
    b) How has that impression changed over time?

8. What kind of experiences have you discussed with your colleagues (e.g. other young adults or staff members)?
    a) Which group do you feel closer to?
    b) What do they think about your performance working here?

9. What do you enjoy doing during your free time?
    a) Who do you enjoy spending time with?
    b) How has that changed over time?

10. How would you describe yourself now?
    a) What are some of your plans in the next five years?
    b) What steps do you need to take to get there?

Interview Questions for Staff Members, Volunteers and Other Young Adults in the Intergenerational Programs

1. Can you describe your work/life here at HCare?
    a) What is your overall impression of HCare?
    b) How is HCare different from other nursing homes?

   c) How has your experience changed over time?

2. How would your describe the senior residents at HCare?
   a) What are some of the most memorable experiences you had with the seniors?
   b) How has the demography changed over time?
3. What do you know about the HVYAs?
   a) How are they different from other young adults?
   b) What do you want to know about them?
4. What do you think about their performance at work?
   a) What are some of their strengths?
   b) What do they struggle with at work?
   c) How can they improve their performance?
5. How have they changed over time?
   a) What do you think about their social skills?
   b) What can be done at the nursing home to help them feel more supported?
6. What do you think about the compatibility between the HVYAs and needs at the nursing home?
   a) What are some advantages of including the HVYAs?
   b) What would be another environment that suits these young adults?
7. What is your vision for HCare?
   a) What kind of changes do you hope to see?
   b) What do you think about incorporating more HVYAs at HCare?

Interview Questions for Senior Citizens (Mentally Clear)

1. Can you tell me about yourself?
   a) How old are you and where did you grow up?

    b) How long have you lived in the nursing home?
    c) Who are in your family now?

2. How has your life changed since you moved here?
    a) How has your social circle changed?
    b) How would you describe the senior residents here?
3. How satisfied are you with living in this nursing home?
    a) What do you like about living here?
    b) What can be improved?
4. Why did you choose to live in this nurisng home?
    a) How is this care home different from other ones?
    b) How has the care home changed over time?
5. Can you describe your everyday activities to me?
    a) What are some of your favorite activities?
    b) What kind of activities do you hope to have?
6. What do you know about the intergenerational programs here?
    a) Who do you know from these programs?
    b) How have the programs changed your life?
7. What do you think about the staff members?
    a) What changes have you noticed?
    b) What do you think about the caregiving industry in the Netherlands?
8. What are some changes you would like to see at the nursing home?
    a) What do you think about incorporating more HVYAs?
    b) Which population do you want to see more at the nursing home?

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