All studies included were appraised for quality using the Cochrane Collaboration Risk of Bias Tool. Of the resulting 16 studies, most studies (n=11) targeted FCGs of older adults with dementia or cancer. Most FCGs were non-Hispanic white. PA interventions with mixed modes (e.g., aerobic and resistance exercise), mixed delivery methods (e.g., in-person and telephone) and mixed settings (e.g., supervised gym- and unsupervised home sessions) were used most frequently. PA interventions significantly improved psychological health but had inconsistent effects on physical health. Tailored PA programs, designed based on FCGs' goals, preferences and limitations, may improve upon physical health outcomes. Future PA studies should include samples of racially and ethnically diverse FCGs of older adults representing a broader range of chronic diseases.

CHARACTERIZING SUPPORTIVE SERVICES USE BY CAREGIVING RELATIONSHIP STATUS

Jasmine Travers,[1] and Chanee Fabius,[2] *1. New York University, New York, New York, United States, 2. Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, United States*

Informal caregivers of aging older adults experience a high degree of burden and strain. These emotional experiences often stem from stressful tasks associated with caregiving. Caregiving supportive services that target the provision of support for stressful tasks are instrumental in alleviating caregiving burden and strain. Research is limited on what types of caregiving supportive services caregivers are accessing by relationship status and their source of information. We sought to characterize caregiving supportive services use by caregiving relationship status. We analyzed cross-sectional data from the 2015 National Study of Caregiving limited to caregivers of older adults □65 years. Caregiver relationship status (i.e., spouse, child, other relative/non-relative) was the independent variable. Bivariate analyses were performed to examine the association with caregiver relationship status and 1) any use of supportive services, 2) type of supportive service used among users, and 3) source of information about supportive services. Our sample consisted of 1,871 informal caregivers, 30.7% reported using supportive services. By caregiver relationship status, children had the greatest use of supportive services compared to spouses and other relatives/non-relatives (33.3% vs. 22.5% vs. 22.1%, p=.02, respectively). Among users of services, there were no differences in type of services used. Spouses primarily received their information about services from a medical provider or social worker (73.8%, p=.004). Our findings highlight the need to ensure that other caregiving groups such as spouses have access to important supportive services such as financial support. Medical providers and/or social workers should be better leveraged and equipped to provide this information.

DESIGN THINKING AS A METHOD FOR DEVELOPING CAREGIVER (AND OTHER) INTERVENTIONS

Leila Aflatoony,[1] Molly Perkins,[2] Drenna Waldrop,[3] and Kenneth Hepburn,[3] *1. Georgia Tech, Atlanta, Georgia, United States, 2. Emory University of Medicine, Atlanta, Georgia, United States, 3. Emory University, Atlanta, Georgia, United States*

"Design Thinking," an innovative, human-centric approach to problem-solving, seeks to ensure that design efforts "solve the right problem." This presentation describes the Design Thinking process and illustrates its use in the context of three design studio sessions with of family caregivers of patients at the Integrated Memory Care Clinic (IMCC), a comprehensive medical home for persons living with dementia. The Design Thinking process entails five steps – Empathize, Define, Ideate, Prototype, Test – that engage consumers/end-users to identify, as precisely as possible, the issues or concerns that are most important to them and to further identify the possible solutions that seem to most fully address these concerns. The process can be described as one of divergent and convergent thinking. In the first session, the Empathize phase, IMCC caregivers were asked to think as broadly as possible about needs not being met by IMCC. These topics were reviewed more convergently in the second session, the Define phase; here the participants agreed on a shorter, prioritized list of needs to be addressed. In the third session (that combined the Ideate and pre-Prototype stages), participants identified 14 topics (interventions) they felt should be included in this program. Finally, in the Test phase, they assessed the topics and agreed that the most important need IMCC could address would be to provide a comprehensive orientation program for new caregivers. IMCC clinicians concurred with the salience of the problem to be solved and saw addressing it as contributing substantially to the improvement of IMCC clinical care.

ETHICAL AND METHODOLOGICAL CONSIDERATIONS INTERVIEWING DEMENTIA CAREGIVERS

Quinton Cotton,[1] Laura Block,[2] Clark Benson,[2] Amanda Friz,[3] Britta Chelgren,[4] Brady Stroik,[2] Emily Ploch,[4] and Andrea Gilmore Bykovskyi,[2] *1. University of Wisconsin - Medicine & Public Health, Fitchburg, Wisconsin, United States, 2. University of Wisconsin-Madison, Madison, Wisconsin, United States, 3. University of Washington, University of Washington, Washington, United States, 4. University of Wisconsin-Madison, University of Wisconsin-Madison, Wisconsin, United States*

Greater inclusion of people living with dementia (PLWD) and their caregivers in research is a global research priority and an expressed priority of dementia advocacy organizations. Absent inclusion of PLWD and caregivers, our understanding of dementia-related experiences and optimization of care and caregiving interventions is stymied. Qualitative interviewing techniques constitutes a primary method for obtaining PLWD and caregivers' perspectives. Yet, there is little guidance on use of qualitative interviewing techniques among PLWD and caregivers or discussion of potential challenges encountered, despite unique vulnerabilities faced throughout the research process, which may be further heightened among historically excluded groups. Meaningful progress toward inclusion of PLWD and their caregivers in dementia research necessitates broader examination of associated methodological and ethical considerations that arise in the conduct of interviews. Drawing from a large multi-site qualitative study of dementia caregivers with exposure to high levels of social disadvantage, we used a multiple-triangulation qualitative approach across

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interview transcripts, memos, and interviewer discussions to identify methodological and ethical challenges that arose during the interviewing process. Challenges were identified across all phases of research, and included relational concerns with PLWD and family members due to disclosure of sensitive information, risk of re-traumatization in discussing past experiences, multiple roles of caregivers with conflicting perspectives, variable recall capacity, limited prior appraisal of caregiving, and request of interviewers for medical advice or selecting services . We outline events evidencing these challenges and proposed strategies (i.e. use of research consults, interview debriefing) to strengthen research capacity to anticipate and respond to them.

PREDICTORS OF PARTICIPATION RESTRICTION IN MIDLIFE CAREGIVERS: AN EXPLORATORY STUDY

Tara Klinedinst,[1] Scott Beach,[2] Heidi Donovan,[1] and Grace Campbell,[1] *1. University of Pittsburgh, Pittsburgh, Pennsylvania, United States, 2. University of Pittsburgh, University of Pittsburgh, Pennsylvania, United States*

Mid-life family caregivers (CGs) are at risk for participation restrictions (reduced engagement in valued roles and activities) due to competing demands of work, parenting, and family caregiving responsibilities. When CGs experience participation restrictions, quality of care for care recipients (CR) decreases, yet CG burden and risk for poor health increases. The purpose of this study was to identify the factors contributing to decreased participation in midlife CGs. Participants were CGs aged 45-64 years (n = 677) from the National Study of Caregiving/National Health and Aging Trends Study. We used multivariate logistic regression to determine attributes of CGs, CRs, and the care situation that independently contribute to participation restrictions. We found that negative aspects of caregiving (OR = 1.51, 95% CI = 1.33, 1.71) and CR depression and anxiety (OR = 0.90, 95% CI = 0.83, 0.99) significantly predicted participation restrictions ($p < 0.05$). Positive aspects of care (OR = 0.87, 95% CI = 0.74, 1.01), frequency of helping with chores (OR = 1.30, 95% CI = 0.98, 1.70), frequency of providing personal care (OR = 1.24, 95% CI = 0.97, 1.59), and frequency of providing help getting around the home (OR = 1.30, 95% CI = 0.97, 1.75) showed trends for association with participation restrictions ($p < 0.10$). We identified factors that are related to participation restriction in midlife CGs. Some of these factors (e.g., positive and negative aspects of caregiving, frequency of assistance provided) are potentially modifiable intervention targets that could bolster participation in this at-risk group.

Session 3540 (Symposium)

FRIENDSHIP AND LONELINESS AMONG PEOPLE LIVING WITH DEMENTIA: TOWARD COMMUNITY AND SHARED HUMANITY

Chair: Daniel R. Y. Gan
Co-Chair: Habib Chaudhury
Discussant: Jim Mann

An increasing number of people living with dementia (PLWD) age in community. In North America, this number ranges from 61-81% of the total number of PLWD. As many as one in three PLWD do not live with a care partner. Since most PLWD do not drive, many may spend a significant proportion of time within half a mile of their homes. Yet, the neighbourhood may or may not provide "ways of being in the world that are more accepting and embracing of the kinds of disruptions that dementia can produce" (Hillman & Latimer, 2017). To support continued social participation, meaningful everyday networks are required. PLWD and care partners may identify more or less strongly with a community depending on their position in the network, its spaces, and activities. According to Nancy (1991), "community" has been conjured as an antidote to the loneliness of the human condition, which explains its allure. In response, Costello (2014) argued that "community" requires one to constantly try and "fall short" in caring for another's changing experiences. The value of a community thus depends on the quality of its friendships – the ability of otherwise lonely individuals to empathize – which may be threatened by challenges to PLWD's personhood. This symposium brings together expertise in community gerontology, philosophy, and neuropsychology to advance current conceptualizations of personhood in community amid cognitive decline. These will be discussed in relation to lived experiences, with the aim to inform future research and practice of dementia care and prevention in community.

AT-HOMENESS: RETHINKING PERSONHOOD-IN-COMMUNITY THROUGH THE LENS OF SOCIAL IDENTITY

Daniel R. Y. Gan,[1] Graham Rowles,[2] and Habib Chaudhury,[1] *1. Simon Fraser University, Vancouver, British Columbia, Canada, 2. University of Kentucky, Lexington, Kentucky, United States*

Since Chaudhury's seminal work (2008), spatial ethnographies of the everyday lives of people living with dementia(PLWD) have proliferated. From an experiential perspective, geographies of home (Blunt & Varley, 2004) and geographies of dementia may overlap significantly. We conducted a meta-ethnographic synthesis of n=28 articles to identify points of convergence and divergence in these literatures using comparative thematic analysis with NVivo 12. Whereas geographies of home highlight at-homeness (e.g., ontological safety and daily activities), geographies of dementia underscore communal and civic participation (e.g., social relationships). These themes converge around "social identity" which may be an important construct that helps PLWD feel at home. The quality of life of PLWD in the community may be influenced by prior (and present) experiences of at-homeness. These become more pertinent as older adults shelter in place. We discuss the implications of these findings in relation to relational models of personhood-in-community (Swinton, 2020) and community gerontology.

MUTUAL RECOGNITION: EMPATHY AS THE FOUNDATION OF COMMUNITY IN DEMENTIA

Peter Costello, *Providence College, Providence, Rhode Island, United States*

This paper explores the challenges of developing a healthy, genuine community as some of its members experience cognitive decline or dementia. I draw upon philosophical discussions on community (Stein, 2000) and Husserlian empathy

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