

“In the Time of Dementia”: Temporality, Care, and Confinement in Dementia Units of Nursing Homes

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As an age-related cognitive impairment, dementia is highly associated with time, particularly in medical and cultural discourses. Physicians and medical researchers are concerned with time of dementia onset, slowing the progression of dementia, and time from diagnosis until death. Family members and friends lament the "lost time" that their loved ones with dementia experience due to memory loss, and struggle to “reorient” people with dementia to the "reality" of the present day and time (Beard, 2004). Caregiving for someone with dementia has been described as so difficult that it feels endless, resulting in a book about caregiving titled "The 36-Hour Day" (Mace, 2012). Policy makers and advocate groups warn of the inevitable "dementia time bomb," and caution that society is unprepared to deal with the rapidly growing number of people with dementia and the social, physical, and financial burdens they place on others (Spencer, 2016). Thus, dementia is largely constructed in relation to timescapes, such as time frames, temporality, timing, tempo, and duration (Adam, 2008).

Dementia is not unique in this regard, as many forms of impairment and illness are framed within narratives of time. According to Kafer (2013), “Familiar categories of illness and disability-- congenital and acquired, diagnosis and prognosis, remission and relapse, temporarily able-bodied and ‘illness, age, or accident’--are temporal; they are orientations in and to time” (p. 26). My project, *“In The Time of Dementia”: Temporality, Care, and Confinement in Dementia Units of Nursing Homes*, centers the care relationships between institutionalized old women with dementia and the immigrant women of color employed to care for them. I focus specifically on temporality as a framework to understand the diverse ways old women with dementia and their caregivers are gendered, racialized,

classed, aged, and disabled within the context of the dementia unit, and the ways this subjugation often occurs relationally as well as culturally and structurally. Drawing on nine months of ethnographic research in the dementia unit of a nursing home in the Chicagoland area, I analyze how time simultaneously operates to reproduce gendered, racialized, classed, aged, and disability oppressions and serves as a site of solidarity, community-building, and resistance among old women with dementia and their caregivers.

I argue that while bureaucratic and institutional time serves as a nexus of power and a pervasive organizing principle of care structures and relations within nursing homes, old women with dementia and their caregivers disrupt these normative, dominant, and linear approaches to temporality by queering and crippling time. They do this by slowing institutional time to “make time” for connectivity, engaging in circular and repetitive forms of relationship building, and existing together in what I term “dementia time,” which is a temporal dis/orientation that explores alternate spacetimes and realities and finds meaning and value in self-contained, nonlinear, intermittent, irrational, and idiosyncratic moments.

I want to note that my broader project examines time and temporality in the dementia unit in diverse ways, such as the shared experience of confinement (i.e., “doing time”) between the care staff and people with dementia, how the State and institution define care in temporal terms and thereby limit the care relationships between the old women with dementia and the care staff, and the ways the frontline care staff, many of whom are immigrant women of color, are subject to debilitation (i.e., slow death) through their care work. I am happy to talk about these issues more in the question and answer. In this research presentation, I focus specifically on my theoretical intervention of dementia time. I first provide an overview of my research methodology and methods. I then define dementia

time, describing its tenets while illustrating it through interactive moments I shared with old women with dementia during my research. Next, I complicate dementia time by describing the challenges present in enacting it. Finally, I close by discussing the next steps in my research, after which I look forward to your questions and comments.

Methodology and Methods

Ethnography

I arrived at the notion of dementia time through the experience and practice of ethnography. Ethnography is a form of qualitative research in which researchers immerse themselves in the daily lives of participants for an extended period with the goal of understanding the experiences of a group of people in their cultural and social context (O'Reilly, 2012). My study specifically utilized feminist ethnography, which strives to explore questions of identity, difference, and power, situate participants' lived realities in social, cultural, and structural frameworks, and analyze gender, race, age, disability, class, and sexual orientation within the context of lived experience (Owen, 1998; Reinharz, 1992). Feminist ethnography is also a methodology that seeks to disrupt power, challenge racialized and gendered capitalism, and imagine more just futures. Utilizing feminist methodology for this project is particularly important since dementia and dementia care are gendered experiences. Most of the people diagnosed with dementia and confined in nursing homes are women, and most of their caregivers (paid and unpaid) are also women. Moreover, the majority of paid caregivers are women further marginalized by race, class, and immigrant status. Unfortunately, these multiply marginalized groups of women who are physically, socially, and economically confined in nursing homes have been excluded from scholarship and activism—an issue my project seeks to rectify by centering their experiences and care relationships.

Methods and Data Collection

Data collection occurred in the dementia unit of Cedarwood Care Center¹, a skilled nursing home in the Chicagoland area. Cedarwood Care Center is operated by a non-profit organization, and accepts private insurances, Medicaid, and Medicare. This study included 40 participants who were old women with dementia. Two of the participants were Latina (5%), four were Black (10%), three were East and Southeast Asian (7.5%), and the remaining 31 participants were white (77.5%). Approximately 38 (70%) of the participants were Jewish. The participants' ages ranged from 72 years old to 108 years old. The study also included 25 participants who were women care staff. Fourteen of the care staff were Black (56%); eight of them were American (32%), four were from African countries (16%), and two were from Caribbean countries (8%). Of the non-Black care staff, two were Latina (8%), three were Southeast Asian (12%), three were South Asian (12%), and three were white (12%). Sixteen of the participants were immigrants (66%). Seventeen were Certified Nursing Assistants (CNAs) (68%), three were Nurses (12%), two were Cleaning Staff (8%), and there was one Care Coordinator, one Activity Director, and one Unit Manager. Their ages ranged from 24 years old to 56 years old.

My study used three primary forms of data collection which are common to ethnography: participant observation, interviewing, and archival research. Data collection occurred from May 2018 to February 2019. Participant observation occurred almost entirely in the dementia unit. I engaged in participant observation three to five times per week for nine months and spent between two and nine hours in the unit at a time. I observed the daily routines of the residents, such as waking, receiving medications, sitting in communal areas, visiting with family members, friends or other guests, and dining. I also participated in activities and programs with the residents, assuming a volunteer or assistant role if needed. As time went on, I began to take on the role of an additional member of the

care staff, assisting with care tasks such as transporting, feeding, preventing falls, doing residents' hair, bringing residents water and other necessities, and comforting residents. In order to document field notes, I wrote in a small inconspicuous notebook or recorded voice memos. I conducted numerous informal interviews with the care staff and conducted four in-depth interviews with three CNAs and one nurse. I also did informal interviews with five old women with dementia. Lastly, I did archival research in the form of document analysis by examining external reports about Cedarwood Care Center, signs, displays, and fliers.

Ethical Considerations

Ethnography is a relational methodology, and thus, a key aspect of ethics is considering the effect one's research may have on others. Historically, people with dementia have been excluded from research, particularly if they are institutionalized (Ries, Thompson, & Lowe, 2017). Additionally, people with dementia have adopted the Disability Rights Movement framework of "Nothing About Us Without Us." Activists with dementia critique research that only includes the perspectives of doctors and caregivers, and advocate for people with dementia to be included in research. Consequently, in recent years, scholars and activists have increasingly argued that people with dementia can and should participate in research with proper accommodations (Novek & Wilkinson, 2017; Ries et al., 2017).

This study was approved by the Institutional Review Board at the University of Illinois at Chicago, and I engaged in multiple strategies to ensure that people with dementia were able to participate and the research was ethical. I received permission from administrators at Cedarwood Care Center to engage in research in communal, non-private areas of their dementia unit, such as the shared living space, dining space, and activity rooms. I distributed a study information sheet to the nursing home administrators and to all care staff in the unit. Every resident in the dementia unit had a

legally authorized representative (LAR) who acts as their proxy for informed consent. The nursing home administrators communicated to the residents' LARs that I would be conducting research in the unit and distributed my study information sheet to them. No care staff requested to be excluded, and no LARs requested that any person with dementia be excluded. I sought assent from the old women with dementia and care staff in multiple ways and used repetition, flexibility, creativity, and alternative forms of communication during my research. I found that my theory of dementia time actually informed my methodological choices in many ways and I realized I was using what I have termed a crip/dementia time methodology – and I would love to discuss that more in the Q & A.

Positionality

An essential aspect of ethnography and feminist praxis is engaging in reflexivity, which involves exploring one's social positioning, assumptions, and values and acknowledging the ways one's subjectivity may influence the research process and outcome (Madison, 2012). In my work, I reflect at length about my identities and the ways these position me in relation to the participants. While discussing this in detail is beyond the scope of this talk, I do want to note that as a person with a psychiatric disability and someone who has experienced trauma, I do not remember significant portions of my childhood, which is one of the reasons I relate to people with dementia. I do not believe that the ability to access memories or engage in linear narratives, which bring the past into the present, are prerequisites for personhood. Still, I am not a person with dementia, so I cannot theorize from that perspective. Instead, I draw on my relational experiences with people with dementia (and the relational experiences of the care staff) that occurred during my fieldwork. I use interactive moments from these relationships to center people with dementia while illustrating the tenets of dementia time.

Crip Time

Crip time is the part of disability culture that challenges normative views and constructions of time. Koppers (2014) drew from the work of Garland-Thomson (2002) and referred to these dominant systems of time as “normate time” (p. 29). Conversely, Koppers (2014) referred to crip time as a form of “temporal shifting” in recognition that normate time is difficult, and indeed oppressive, for disabled people (p. 29). Crip time asks us to change how we view and approach time rather than attempt to force disabled bodyminds to conform to “normate time” (Price, 2015; Samuels, 2017). As Kafer (2013) wrote:

Crip time is flex time not just expanded but exploded; it requires reimagining our notions of what can and should happen in time, or recognizing how expectations of “how long things take” are based on very particular minds and bodies...Rather than bend disabled bodies and minds to meet the clock, crip time bends the clock to meet disabled bodies and minds. (p. 27)

Thus, crip time promotes softness, a shifting of pace, and flexibility. As characterized by Price (2017) and Samuels (2017), crip time allows disabled bodyminds to be in space and time *as we are*, and thus potentially becomes a complex form of liberation.

From Crip Time to Dementia Time

The flexibility of crip time is important to consider in the context of dementia. Within the dementia unit, the needs of the old people with dementia were often changing moment to moment. This occurred partially because although dementia is overall progressive in its course, people’s experiences of memory, orientation, and sense of self, time, and place vary and shift, and subsequently, their needs change. However, scholarship on crip time does not frequently explicitly engage with aspects of normate time that affect people with dementia, such as memory,

coherence, linearity, and rationality. I extend crip time by forwarding a theory of "dementia time." Dementia time involves focusing on a particular moment in time and place and remaining flexible as moments pass and needs change. In normate time, individual moments are connected through a linear and progressive sequence, whereas in dementia time, individual moments may be self-contained, nonlinear, intermittent, irrational, and idiosyncratic - *yet they are no less meaningful or valuable.*

The Tenets of Dementia Time

In what follows, I forward four tenets of dementia time: (a) focusing on the moment, (b) maintaining rhetoricity to practice inclusion and affirm personhood, (c) acknowledging and respecting situated realities, and (d) emphasizing a politics of collectivity and care. I include stories of my experiences sharing interactive moments with old people with dementia within the dementia unit, in order to center them and delineate each tenet. Additionally, I discuss moments in which the care staff or family members chose to engage in dementia time, or chose not to, and discuss the effects these different choices had the individuals with dementia. I also want to note that I am still working through the complexities of using the term "dementia time," which I hope we can discuss more later.

Focusing on the Moment

An important tenet of dementia time is focusing on the moment. By moment, I do not necessarily mean the present. People with dementia in the dementia unit lived simultaneously in multiple timescapes - past, present, and future. Consequently, I use moment to mean an event, happening, or experience, which can be oriented to various points in time or situated realities. Dementia time asks us to suspend our ideas about memory and the assumption that memory is an essential aspect of building and maintaining relationships with others. Rather, dementia time asks

us to think about how we might perpetually (re)build relationships with people with dementia by focusing on feelings, thoughts, and ideas in that moment in time. To illustrate, I would like to share a story from my field notes about an interaction with Marlene², an 88-year old woman with dementia.

I am sitting with Marlene at dinner. Across the room, another resident, Aileen, is receiving her medication. "Go away, I hate you!" Aileen yells at the nurse. Marlene looks up. "I hate you? Wow!" "Does that bother you Marlene?" I ask. "Yes, I am so angry!" "That's understandable," I tell her. "I just want to get out of here!" She begins to sob. "I mean, I just can't take this anymore. I can't. I want to go home." "I'm sorry, I know you want to go home." I rub her back. "Yes, I want to go home! They're just junking around. I'm with my kids. You can go be with your wife or phone or whatever. I just feel like I have to get into my house." "What do you like about your house?" I ask. "Well, you were there. You saw it!" Marlene responds. "Oh right. It was nice!" I answer. "Yeah! It was everything." Marlene says. "Nothing good, and nothing bad. It's all there!"

During this interaction, I repeatedly sought to connect with Marlene - even if I was not quite sure what she was trying to communicate, such as when she told me I could go be with my wife or my phone. I validated her shifting feelings, from anger to sadness. I asked her a question about her home that invited her to offer an affective, emotional response rather than a description based solely on recall. And when she told me I had been there I affirmed her experience of my presence in her home. Rather than require individuals with dementia to access and communicate accurate memories as a part of relationship building, dementia time asks us to acknowledge that the important aspect of interactions is the connection being built between oneself and an individual with dementia in that moment in time.

Maintaining Rhetoricity to Practice Inclusion and Affirm Personhood

Another tenet of dementia time is maintaining the rhetoricity of people with dementia and other mental disabilities in order to practice inclusion and affirm personhood. Rhetoricity refers to the ability to be received as someone who rhetorically “makes sense”—and thus a valid human subject (Prendergast, 2001; Price, 2011). People with dementia are denied rhetoricity because of bodymind experiences associated with dementia, such as memory loss, disorientation, or aphasia. However, if we suspend the dominant rules of communication, we can recognize that the important aspect of dialogue with people with dementia is not logic, linearity, coherence, or rationality, but rather listening, engaging, and establishing connectivity. This story about Sylvia, an 81-year-old woman with dementia, exemplifies this tenet.

Sylvia looks over her shoulder at me. “Honey? Can you help me with something?” I approach her. “Yes, Sylvia, what is it?” “Can you wait a moment for that?” I am unsure what Sylvia would like me to do, but I agree. “Oh yes, of course!” I answer. “Just when you have the tone.” “No problem,” I reassure her. “Should I write it here for you?” Sylvia gestures to her hand. “Yes, that would help me remember,” I nod. Sylvia mimes writing a note on her hand. “Thank you, Sylvia!” “Thank you!” Sylvia responds. She then grabs my hand, and adds, “I took the ship, the friendship!” “Well friendship is always good to have!” I nod. “Right!” Sylvia smiles and laughs.

In this moment, I maintained Sylvia’s rhetoricity by taking her request seriously and agreeing. Sylvia felt connected to me after she asked for help and I agreed. She then shared she “took the friendship,” which made sense as an expression of friendship in this context. Rather than demanding that people present linear, coherent, rational narratives, dementia time asks us to consider how a person “makes sense” in that specific moment and context. I observed the care staff employing this tenet of dementia

time often. For example, one time as I was walking with Sylvia to the dining room, we passed Fiona, one of the cleaning staff. "How you doin' Sylvia?" she asked. "I'm just pobbling!" Sylvia smiles. "Well that's good! Keep on pobblin' Sylvia!" Fiona replied. This aspect of dementia time requires us to expand our understandings of what counts as "making sense," and recognize that people might make sense within their own frameworks, regardless of whether those uniform with our frameworks. In doing so, we can maintain rhetoricty, establish connection, and affirm personhood.

Acknowledging and Respecting Situated Realities

Another tenet of dementia time is the importance of attending to situated realities.

Dominant narratives dictate that time and reality are often viewed as interconnected objective and linear truths. Acknowledging situated realities allows us to focus on the ways in which realities emerge from individuals, and therefore it is their perceptions of reality that are important, regardless of whether their reality aligns with our reality. To demonstrate, I would like to share another story about Sylvia.

Sylvia has aphasia and cannot communicate much about her life in ways that I can understand. She has two children, but they never come to visit. One day, out of curiosity, I search her full name on the internet. Only one relevant finding appears - a photo of a grave in a nearby cemetery. There is a stone for Sylvia, with the date of death left blank, and a stone for her husband, Thomas, who died nearly 18 years ago. Sylvia often mentions someone named "Tom," and I realize she has been referring to her husband. The next time I see her, I ask, "Sylvia, how is Tom?" Her face lights up. "Oh, he is fine!" she laughs. "He's right there!" she gestures across the room. I look and laugh. "Oh, how silly of me, I should have just asked him myself. I'm sorry!"

“That’s okay!” Sylvia smiles, and pats me on the cheek. “He’s wonderful.” “He really is,” I agree.

Dementia time asks us to cast aside expectations regarding a singular, objective reality, and focus on the meanings expressed in situated realities. In my interaction with Sylvia, I focused on her situated reality: Sylvia experienced her husband Tom as being present with her in the room and doing well, which I affirmed. In the dementia unit, old women with dementia would often ask questions or talk about loved ones—particularly their mothers or partners—as if the person was still alive. Some of the care staff would respond by informing the person that their loved one was dead. They did not do this to be cruel, but because it was the “objective” reality. Despite their intent, such a response would severely distress the individual with dementia. Conversely, other care staff would affirm the person’s experience of their loved one being alive, and would respond in a way that respected their situated reality. For example, they might say, “I am going to go look for your mother as soon as I am done passing out these snacks,” or “You know Laurelle, I know I saw her around here somewhere, I will keep an eye out and tell her you’re looking for her.” Such responses would help the person with dementia feel comforted and reassured. By acknowledging and responding to situated realities through dementia time, we can enter the realities of others, and share meaningful and significant moments in which we are all included.

Emphasizing a Politics of Collectivity and Care

All of the stories I have shared thus far highlight the final tenet of dementia time, as they each forward a politics of collectivity and care. My focus on relationships between people with dementia and people without dementia draws from a vision of collective care and access—of moving toward being radically together (Price, 2017). The dominant imaginary of care for people with dementia is one

of total and utter dependency, in which people with dementia are completely dependent on a caregiver for their survival and well-being. Indeed, that is the justification for confining people with dementia in dementia units of nursing homes until they die. People with dementia, particularly advanced dementia, are often not perceived as capable of contributing to care relationships in ways that are traditionally understood as meaningful. By emphasizing a politics of collectivity and care, we can (re)imagine interactive moments that are interdependent and focus on each other's needs and our shared humanity. This story about Marlene demonstrates how dementia time can result in shared moments of care.

Marlene begins crying at dinner because she does not want any more of her food. "It's okay, Marlene," I try and comfort her. "It is?" she asks. "Yes! Just eat until you are done." "Oh, thanks kiddo!" Marlene puts her hand on my cheek. "Thanks so much." "You're welcome. You're having a hard day?" "Yes, I am," Marlene cries. "It's just so hard. It's all messed up in the car." She takes a bite of peaches. "I just can't find it!" she cries harder and places her head on the table. I tear up a little bit, as I feel Marlene's pain meld with my own. "I know what you mean. It's okay to have hard days. I have lots of hard days. I am having a hard day today," I tell Marlene. "You are?" Marlene lifts her head, looks me in the eyes, and smiles softly. "I certainly have mine. Thank you honey," she says. Marlene then leans across the table and presents her forehead for me to kiss, which I do, and I relish in how comforting this tender moment is for both of us.

In this moment, Marlene and I were engaging in an interdependent, caring relationship. Although Marlene and I were not engaging in normative communication or "socially acceptable" behavior, we both had our needs met in the moment. We can challenge dominant constructions of "totally dependent" relationships by highlighting and appreciating the ways we can care for each in dementia

time. Thinking through my time in the field, I appreciate all the ways care moved between people with dementia and people without dementia. The people with dementia would empathize with and comfort the care staff, such as when Ramona recognized that Essie “was working hard,” or when Lucile told Karina she thought she should get paid more. They would also express affection toward the care staff—holding their hands or telling them they loved them. I observed and took part in many other examples of constantly (re)building relationships in dementia time, by respecting each other’s feelings and pain, connecting through conversations that made sense in that moment (such as “taking the friend ship”) and laughing together. Dementia time centers collectivity by focusing on the needs of both individuals in the interaction or relationship, at that moment in time. Rather than viewing needs as somewhat static or stable, it helps us embrace the fact that needs are changing moment to moment and the way care occurs is changing moment to moment. And if we can focus on the moment, we can better engage in a politics of collectivity and care with people with dementia and other mental disabilities.

The Complexities of Dementia Time

Although dementia time encourages us to rethink how we interact with people with dementia and other mental disabilities, I do not want to romanticize dementia time. While, like crip time, it has liberatory potential, it is marked by complexities and challenges. Respecting situated realities as a part of dementia time also highlights the ways in which moments may be painful, difficult, and marked by trauma. Samuels (2017) discussed the many ways in which crip time can serve as a source of loss, alienation, and grief, and the same may be true of dementia time. People with dementia and other mental disabilities may relive trauma or understand themselves to be in arduous or agonizing situations that are different from the realities of those around them. For example, one of the men

living in the dementia unit, Amon, was a World War II veteran and would occasionally begin rocking back and forth and repeating phrases such as, “The atom bomb! What atom bomb? Just lay down! No, don’t! The atom bomb!” In these types of situations, applying the tenets of dementia time becomes the most difficult, as dementia time becomes entangled with trauma time (Carter, 2019). We must consider how we might move toward being radically together, even if we are in a different time and space. We must acknowledge the other person’s distress or trauma, while simultaneously trying to care for them, be present with them in their situated reality, and invite them to engage (or not engage) with us in whatever ways make sense for them in that moment.

Additionally, although the caregivers predominately engaged in dementia time with the residents to connect with them, ease their pain or suffering, and build relationships, dementia sometimes served as a site of containment and control. For example, in one moment, Anthena, an old woman with dementia suddenly stood up from her wheelchair and started to walk (something she was not supposed to do as she was labeled as a “fall risk”). Lorraine, a CAN, asked, “Miss Anthena, can you please sit down?” “I want to talk to your mother!” Athena demanded loudly. Lorraine responds, “Well, my mother wants you to sit down.” Athena stared at Lorraine for a moment and then says, “Oh, okay then,” and sits back down. In this case, Lorraine used dementia time but in a way that restrained Anthena and allowed Lorraine to fulfill her job duty of ensuring the residents stayed seated and did not fall.

Furthermore, there were moments when dementia time became a site of racialized, gendered, and classed violence for the caregivers. The majority of the CNAs were Black women, either from Chicago or from various countries in Africa. Conversely, most of the old women with dementia were white women, some with considerable wealth, whose ages ranged from 65 years old to 108 years old.

It is quite likely these women grew up with black domestic workers in their homes, cleaning their houses and caring for their children. As Flora, one of the old women with dementia, once told me, “I am used to Black women doing what needs to be done.” Given this historical and cultural context, the old women with dementia, particularly those from considerable privilege, would enter a situated reality in which they treated the Black caregivers as “the help.” They would call out, “Ma’am?” or “Miss?” when they needed something, they would at times misgender the black women and refer to them as boys or “sir”, or they would demand the CNAs do trivial tasks that were not a part of their job description such as fluffing their pillows. The CNAs in these situations dismissed their behavior in temporal terms—“Oh, they grew up in a different era,” or “They think they are in a time when this was normal,” but we must question what becomes of dementia time when it reifies gendered, racialized, and class oppression.

Conclusion

Moving forward, I am interested in exploring through my research how dementia time can be applied relationally and structurally. What would a care relationship that embraced dementia time look like? Is it possible to incorporate dementia time into the cultures and structures of dementia units, or is a potentially liberatory framework entirely at odds within a site of confinement? How does dementia time hold coalitional potential for people with diverse mental disabilities? For my next research project, I am also interested in understanding dementia in the context of other sites of confinement, such as prisons, which have rapidly aging inmate populations. How does dementia time operate (or not) in these spaces?

In our aging society, dementia is becoming more prevalent in people's lives. As Anne Basting (2009) wrote, "We are living in the time of dementia. As we live longer than ever before, dementia touches the lives of more of us than ever before." Despite this, personal and cultural fears of dementia abound. These fears are based in discourses that mark dementia as a "living death," largely due to its defining characteristic of memory loss. The individual, cultural, and societal anxiety around the presumed loss of self that accompanies memory loss supports narratives of control and discipline that materialize in the forms of erasure, isolation, marginalization, and institutionalization.

People with dementia, and all of us with diverse mental disabilities, are disabled by dominant notions and practices of time. However, dementia time serves as a possible way to move toward radical (re)imaginings of care. To think about practical ways to enact dementia time, what would it mean to introduce ourselves to people every time we met? What would it mean to ask questions that do not rely on others' ability to directly connect with the past, but that focus on feelings, thoughts, and sentiments that can be experienced in the moment? What if we cued storytelling by not asking, "Remember when..." but rather requesting, "Can I talk about one of my favorite moments we shared?" What if we acknowledge and enter the realities of others without judging whether they are "true" or "objective"? By using dementia time to challenge conventional understandings of time, memory, rationality, rhetoricity, we can cultivate access, foster relationships, and work toward justice for people with dementia and their caregivers who exist in the context of care and confinement. Thank you.

¹ Cedarwood Care Center is a pseudonym.

² All names of participants are pseudonyms.