Meaning, Purpose, and Post-Diagnostic Adjustment in Early-Stage Dementia: A Positive Psychology Perspective

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Review

Meaning, Purpose, and Post-Diagnostic Adjustment in Early-Stage Dementia: A Positive Psychology Perspective

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Abstract

Dementia affects approximately 55 million people worldwide, yet the psychological experience of diagnosis and the determinants of post-diagnostic wellbeing remain underexplored relative to biomedical research priorities. The existing literature has been predominantly deficit-oriented, focusing on cognitive decline, neuropsychiatric symptoms, and carer burden, with limited attention to preserved psychological capacities and what supports flourishing following diagnosis. This narrative review applies a positive psychology framework to synthesise evidence on meaning, purpose, hope, and post-diagnostic adjustment in early-stage dementia. A central empirical observation motivating the review is the wellbeing paradox: the consistent finding that subjective wellbeing in early-to-moderate dementia is frequently higher than carers and clinicians predict, and is more strongly associated with psychosocial variables than with objective cognitive status. Evidence from the IDEAL cohort and related longitudinal research demonstrates that emotional responsiveness, need satisfaction, and capacity for meaning-making are preserved in early-stage dementia and constitute clinically relevant assets. Four positive psychology constructs are identified as evidence-based targets for intervention: hope, self-compassion, social identity, and meaningful engagement. Clinical implications include the integration of strengths-based assessment, meaning-centred group interventions, structured peer support, and validated positive outcome measures into post-diagnostic care pathways. Health equity considerations and research priorities are addressed, including the underrepresentation of minority ethnic communities and people with young-onset dementia in existing research. The review argues that meaningful progress requires deliberate reorientation of clinical, commissioning, and research priorities toward a positive psychology framework for dementia care.

Keywords: dementia; positive psychology; wellbeing paradox; post-diagnostic adjustment; meaning-making; hope; self-compassion; social identity; early-stage dementia; person-centred care

1. Introduction

The introduction Dementia currently affects approximately 55 million people worldwide, with close to one million living with the condition in the United Kingdom alone [1]. Prevalence is projected to reach 139 million by 2050, driven primarily by global population ageing [1]. Despite the scale of this public health challenge, the psychological experience of diagnosis and the determinants of post-diagnostic wellbeing remain relatively underexplored in comparison to biomedical research priorities.

The existing psychological literature on dementia has been predominantly deficit-oriented, with research and clinical frameworks largely concerned with cataloguing depression, anxiety, behavioural disturbance, and functional impairment as primary outcomes of interest [2]. Whilst this focus has generated important clinical knowledge, it has produced a correspondingly limited evidence base regarding what supports psychological adjustment, preserved functioning, and subjective wellbeing in people living with the condition. Here, positive psychology, defined by Seligman and Csikszentmihalyi [3] as the scientific study of positive subjective experience, positive individual traits, and positive institutions offers a theoretically grounded and empirically tractable framework to address this gap.

Specifically, Seligman's PERMA model, encompassing positive emotion, engagement, relationships, meaning, and accomplishment (PERMA), provides a multidimensional account of wellbeing that extends well beyond the absence of psychopathology [4]. Applied to chronic illness contexts, constructs including hope, meaning, post-traumatic growth, and self-compassion have demonstrated measurable associations with health outcomes across a range of conditions including Parkinson's disease [5,6]. Their systematic application to dementia, however, remains limited.

Advances in diagnostic technology and the progressive implementation of memory assessment services mean that increasing numbers of individuals are now receiving dementia diagnoses at earlier disease stages, whilst retaining substantial cognitive, emotional, and social capacities [7]. This creates a clinically significant window for psychological intervention during a period when engagement with support remains feasible. The lived experience advocate Kate Swaffer [8] for instance has argued that people with dementia are frequently subjected to what she terms 'prescribed disengagement', e.g., an implicit encouragement toward passivity and withdrawal at the very juncture when active psychological engagement would be most beneficial.

A further observation motivating this review is the so-called 'wellbeing paradox' in dementia: the consistent empirical finding that subjective wellbeing among people with early-to-moderate dementia is frequently higher than carers and clinicians predict and is often inconsistent with objective measures of cognitive or functional impairment [9]. This paradox challenges foundational assumptions about the relationship between cognitive capacity and psychological flourishing and therefore warrants a more nuanced theoretical account than the deficit model affords.

2. The Wellbeing Paradox and Preserved Psychological Capacities in Early Dementia

A foundational assumption in both clinical practice and lay understanding of dementia is that subjective wellbeing declines in direct proportion to cognitive impairment. This assumption underpins the almost exclusive use of cognitive test scores, functional assessments, and carer-reported behavioural measures as primary outcome indices in dementia research and service evaluation. A growing body of evidence, however, demonstrates that this assumption is empirically incorrect.

The most comprehensive longitudinal data on this question are provided by the IDEAL (Improving the experience of Dementia and Enhancing Active Life) cohort study, conducted in the United Kingdom. Lamont et al. [9] report that a substantial proportion of participants with mild-to-moderate dementia returned positive self-ratings of life satisfaction, sense of purpose, and quality of life that were inconsistent with their objective cognitive status. Critically, psychological and social variables including self-esteem, optimism, and perceived social support were stronger predictors of wellbeing trajectories than cognitive test scores, even after adjustment for depression and functional impairment [10]. These findings suggest that the determinants of wellbeing in dementia are substantially psychosocial rather than neurobiological in nature.

The theoretical foundation for this reframing was established by Tom Kitwood's [11] landmark reconceptualisation of dementia, articulated in Dementia Reconsidered: The Person Comes First. Kitwood argued that the experience of dementia could not be reduced to neuropathology alone, and that personhood, defined as the 'standing or a status that is bestowed on one human being, by another in the context of relationship and social being', constituted both a determinant of and a buffer against psychological deterioration [11] (p. 8). His concept of 'malignant social psychology', describing the ways in which care environments inadvertently undermined personhood through depersonalisation and disempowerment, anticipated key concerns of contemporary positive psychology regarding

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autonomy and dignity. Whilst Kitwood did not employ the language of positive psychology explicitly, his framework is widely regarded as its direct precursor in dementia studies [12].

A neuropsychological basis for the wellbeing paradox is provided by research on the differential vulnerability of brain systems to dementia pathology. Episodic memory, e.g., the capacity to encode and retrieve specific autobiographical events, is compromised early in the course of Alzheimer's disease. Emotional memory, however, follows a distinct and relatively preserved trajectory. Feinstein et al. [13] demonstrated that people with severe amnesia, including those with dementia-related memory impairment, retained full affective responses to emotionally significant stimuli long after the declarative memory trace had dissolved. Positive and negative affect were experienced with full intensity in the moment, regardless of the individual's capacity to subsequently recall the experience. This finding has important implications for how wellbeing in dementia should be conceptualised: if emotional experience is preserved independently of episodic memory, then moment-to-moment positive affect constitutes a legitimate and clinically meaningful wellbeing outcome in its own right.

Self-determination theory (SDT), developed by Deci and Ryan [14], provides a further framework through which preserved psychological capacities in dementia may be understood. SDT holds that wellbeing depends upon the ongoing satisfaction of three universal psychological needs: autonomy, competence, and relatedness. Research applying SDT principles to dementia contexts has found that need satisfaction remains predictive of positive affect and engagement even in moderate stages of the condition, and that care environments which actively support rather than undermine these needs by involving residents in every-day decision-making produce measurable improvements in wellbeing outcomes [15]. These findings suggest that dementia does not abolish the fundamental psychological architecture of wellbeing but instead generates, via cognitive limitation, social stigma, and disempowering care cultures, conditions that constrain the satisfaction of core psychological needs.

Historically, measurement methodology has largely contributed towards the underestimation of wellbeing in dementia. Proxy-reported outcomes, whereby carers or clinicians rate the wellbeing of the person with dementia on their behalf, systematically underestimate subjective wellbeing relative to self-report across multiple published studies [16]. The development and validation of self-report instruments specifically designed for use with people with cognitive impairment including the DEMQOL [17] and the Bath Assessment of Subjective Experience of Dementia (BASQID) [18], have recently provided more appropriate measurement tools. Their consistent adoption in research and clinical practice, however, remains varied to date.

Taken together, the available evidence suggests that the relationship between cognitive decline and subjective wellbeing in dementia is neither linear nor inevitable. People with early-to-moderate dementia retain emotional responsiveness, a need for autonomy and social connection, and a capacity for meaningful subjective experience. Taken together, these findings establish the empirical foundation for the positive psychology framework proposed in this review (Figure 1), the constituent constructs of which are addressed in Sections 3–5.

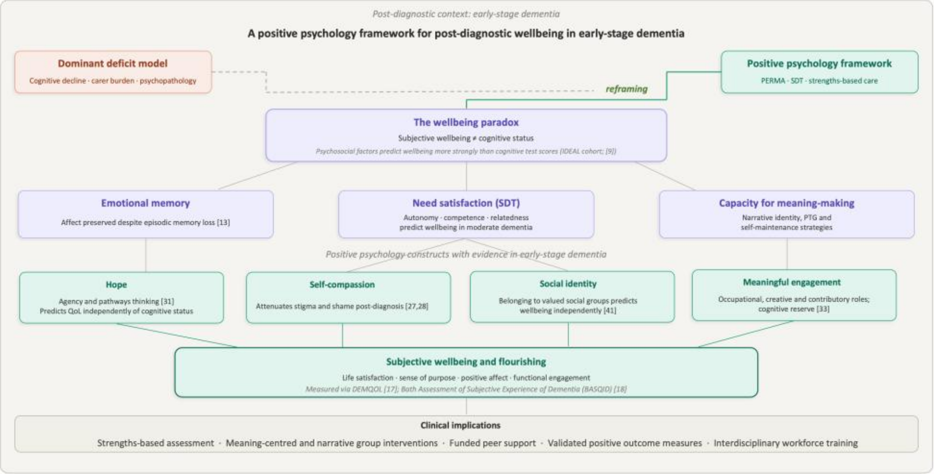

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Figure 1. A positive psychology framework for post-diagnostic wellbeing in early-stage dementia. The figure illustrates the conceptual pathway from the wellbeing paradox through preserved psychological capacities, evidence-based positive psychology constructs, and convergent wellbeing outcomes, to clinical implications for post-diagnostic care as explained through a positive psychology lens rather than the dominant deficit model. SDT, self determination theory; PTG, post traumatic growth.

3. Meaning-Making and Identity Reconstruction Following Dementia Diagnosis

The psychological impact of a dementia diagnosis is well-documented and includes threat to personal identity, anticipatory grief, stigma-related distress, and adjustment difficulties [19]. Whilst these responses are clinically significant, the diversity of post-diagnostic experience is less well-represented in the literature. Indeed, a subset of individuals still report positive psychological adjustment, identity continuity, and, in some cases, post-traumatic growth following diagnosis, findings that warrant systematic attention.

Narrative identity theory provides a useful framework for understanding post-diagnostic psychological adjustment. According to McAdams [20], individuals maintain a coherent sense of self through the ongoing construction of a personal narrative that integrates past, present, and anticipated future experiences. A dementia diagnosis understandably constitutes a significant disruption to this narrative, threatening the individual's sense of autobiographical continuity and future self. Research by Clare et al. [21] with people with early stage Alzheimer's disease identified a range of self-maintenance strategies including reframing, selective comparison, and drawing on established strengths, all of which constitute strategies directly consistent with positive psychology principles of adaptive coping and meaning-making which would seem transferable to individuals at early stages of dementia.

Post-traumatic growth (PTG), defined as positive psychological change emerging from the struggle with highly challenging life circumstances [22], has been identified in a proportion of people following dementia diagnosis. Wolverson, Clarke, and Moniz-Cook [23] were amongst the first to apply positive psychology constructs explicitly to dementia, identifying resilience, humour, positive reappraisal, and the maintenance of a valued social role as active contributors to psychological wellbeing in this population. Subsequent studies report experiences of enhanced appreciation of relationships, reprioritisation of values, increased present-moment awareness, and a deepened sense of personal agency among individuals with early-stage dementia [24].

Acceptance and Commitment Therapy (ACT), a third-wave cognitive behavioural approach grounded in positive psychology-adjacent principles, has demonstrated preliminary efficacy in supporting post-diagnostic adjustment in dementia. ACT emphasises psychological flexibility, e.g., the capacity to accept difficult thoughts and feelings without excessive avoidance, and values clarification as a basis for meaningful engagement with life [25]. Small-scale feasibility trials of ACT-based interventions in early-stage dementia have reported improvements in psychological wellbeing and quality of life, with participants reporting a clearer sense of what mattered to them and greater capacity to act in accordance with those values [26].

Self-compassion, a construct identified within the proposed framework (**Figure 1**) as a key buffer against post-diagnostic distress, is defined by Neff [27] as a stance of kindness, shared humanity, and mindful awareness toward one's own suffering has been gaining attention as a psychological resource in dementia. Unfortunately, shame and self-stigma frequently associated with dementia diagnosis, along with cultural narratives that equate cognitive decline with loss of personhood, represent significant barriers to positive adjustment. Preliminary evidence suggests that self-compassion attenuates the relationship between stigma and psychological distress in people with dementia, and may in fact support engagement with post-diagnostic support services [28,29].

Lastly, biographical and narrative approaches to dementia care that support meaning making including life review, reminiscence therapy, and life story work, represent positive psychology-aligned interventions with established clinical application. Haight and Haight [30] documented beneficial effects of structured life review on wellbeing and sense of identity in older adults with cognitive impairment. These approaches support psychological adjustment by explicitly leveraging autobiographical memory, narrative continuity, and recognition of personal strengths, all constructs central to positive psychology. Their integration into post-diagnostic care pathways and across services, however, remains inconsistent and limited.

4. Hope, Future Orientation, and Engagement with Life

Hope, conceptualised within Snyder's [31] agency-pathways model (**Figure 1**) as the perceived capacity to identify routes toward desired goals and the motivation to pursue them, has been identified as a clinically relevant psychological resource in chronic illness contexts. Its application to dementia is relatively recent but theoretically and empirically warranted. A dementia diagnosis is commonly associated with anticipatory loss and curtailed future planning. Research, however, suggests that hope distinct from denial is both measurable and psychologically functional in people with early-stage dementia.

Hunsaker et al. [32] assessed hope in a cohort of people with mild-to-moderate dementia using the Herth Hope Index and found that hope scores were positively associated with quality of life and inversely associated with depression and anxiety, independent of cognitive status. Participants described hope in terms of maintained relationships, continued contribution to family and community, and engagement with personally meaningful activities. Such framings are consistent with Snyder's agency and pathways thinking. These findings indicate that hope is not merely an emotional state but an active and measurable psychological parameter that shapes behaviour and engagement with support.

Engagement with meaningful activity constitutes a further positive psychology outcome of direct relevance to dementia care as captured in the proposed framework (**Figure 1**). Occupational engagement, defined broadly to include creative, social, physical, and contributory activities, is associated with higher levels of positive affect, greater functional independence, and slower rates of cognitive decline in longitudinal studies [33]. The cognitive reserve hypothesis proposes that sustained engagement with stimulating activities confers neurological resilience against the functional consequences of dementia pathology [34], though the precise mechanisms remain under investigation.

Creative arts interventions represent another domain of particular interest, given evidence that aesthetic and expressive capacities are relatively preserved even in later stages of dementia. Musical engagement, visual arts participation, and dance movement therapy have each been associated with improvements in positive affect, reduced agitation, and enhanced social connection in people with dementia across multiple controlled trials [35,36]. The phenomenon of 'paradoxical lucidity' or 'islands of clarity', whereby individuals with moderate-to-severe dementia demonstrate striking increases in communicative capacity and social engagement during or following music engagement, has been documented anecdotally and is the subject of growing empirical interest.

The growing movement of people with dementia engaging in lived experience advocacy, peer support facilitation, and public awareness activities represents a further dimension of purposeful engagement with demonstrable psychological significance. Organisations including global Dementia Alliance International (DAI), the Scottish Dementia Working Group (SDWG), UK Dementia Research Institute (UK DRI) and Dementia Platform UK (DPUK) provide structured opportunities for people with dementia to contribute meaningfully to policy, research design, and public discourse, thereby providing access to roles directly associated with a sense of purpose and social value. Whilst the importance of patient and public involvement in dementia research has become increasingly common and recognised for its contribution to health research [37], evaluation of contributing dementia ambassadors and peer supporters suggest that these roles confer psychological benefits to participants themselves, in addition to their broader social and policy impact [38].

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5. Social Connectedness, Belonging, and the Role of Relationships

Social connectedness is a well-established determinant of psychological wellbeing across the adult lifespan, with evidence of associations between social isolation and both accelerated cognitive decline and increased mortality in older adults [39]. In the context of dementia, the mechanisms through which social connection influences wellbeing are both psychological and neurobiological, and the evidence base is sufficient to identify social engagement as a modifiable protective factor of clinical relevance. Indeed, more robust social relationships in midlife may exert protective effects on dementia risk [40].

The social identity approach to health, developed by Haslam and colleagues [41] and represented as a core construct within the framework presented here (**Figure 1**), proposes that belonging to valued social groups constitutes a fundamental human need that contributes independently to both physical and psychological wellbeing. Applied to dementia, this framework predicts that the maintenance of valued social identities including as a spouse, parent, friend, community member, or professional will buffer against the psychological consequences of diagnosis, independent of cognitive status. Empirical support for this prediction is provided by the IDEAL cohort, in which social participation and the maintenance of pre-diagnostic roles were among the strongest predictors of positive wellbeing ratings [10].

Peer support on the other hand, defined as the provision of practical and emotional assistance by individuals with shared lived experience, has an established evidence base in long-term condition management, and its application to dementia is expanding. Post-diagnostic peer support groups have been associated with reductions in isolation and depression, improvements in self-efficacy and quality of life, and the facilitation of post-traumatic growth in people with early-stage dementia [42]. The peer relationship itself, grounded in shared experience, mutual recognition, and the reciprocal provision of support, provides a context for identity validation and purposeful engagement that is qualitatively distinct from professional support.

Dementia-friendly community initiatives, promoted internationally by the Alzheimer's Society, the World Health Organisation (WHO), and national dementia strategies, represent structural attempts to extend social belonging beyond the clinical encounter. Evaluations of dementia-friendly community programmes have reported improvements in perceived social inclusion, reduced stigma, and greater community participation among people with dementia, though methodological limitations including small samples and absence of control conditions constrain the strength of conclusions that can be drawn [43].

The dyadic nature of dementia experience warrants specific attention. The wellbeing of the person with dementia and their primary carer are interdependent: carer positive affect, adaptive coping, and psychological flexibility predict the wellbeing of the care recipient, and reciprocally, the wellbeing of the person with dementia influences carer outcomes [44]. Consequently, positive psychology interventions targeting the couple or dyad rather than the person with dementia or the carer in isolation represent an underexplored but theoretically well-motivated avenue to post-diagnostic support.

6. Clinical and Policy Implications

6.1. *Current Post-Diagnostic Support Landscape*

Post-diagnostic support for people with dementia in the United Kingdom is largely governed by the National Institute for Health and Care Excellence (NICE) dementia guidelines NG97, published in 2018 and last reviewed in October 2025. Whilst the guidelines acknowledge the importance of psychological wellbeing and person-centred care, they have not been substantively updated since 2018 and draw upon an evidence base that remains predominantly deficit-focused, with psychosocial interventions positioned largely as adjuncts to pharmacological management and symptom control. The routine integration of positive psychology principles such as strengths-based assessment, meaning-centred intervention, peer support, and wellbeing measurement into post-diagnostic care pathways is not yet reflected in national guidance.

An additional structural constraint is the widespread reliance on proxy-reported outcomes across clinical and research settings. As noted in Section 2, proxy reports systematically underestimate subjective wellbeing in dementia. The continued use of carer- or clinician-reported measures as primary outcome indices in service evaluation perpetuates an underestimation of the psychological assets and wellbeing capacity of people living with dementia, with consequences for resource allocation and service design.

6.2. *Proposed Clinical Recommendations*

Collectively, the evidence reviewed here supports several specific recommendations for clinical practice and service design, organised around the framework presented in Figure 1. First, the incorporation of strengths-based psychological assessment into post-diagnostic review processes alongside established cognitive and functional measures using tools such as the DEMQOL [17] and narrative-based assessment approaches, can provide accessible and validated options for capturing subjective wellbeing from the perspective of the person with dementia.

Second, evidence of feasibility, acceptability, and preliminary efficacy support trialling meaning-centred and narrative group interventions including life story work, reminiscence therapy, and ACT-based programmes as a standard component of post-diagnostic care on a larger scale, rather than as specialist or discretionary provision.

Third, the psychological benefits of shared experience, mutual recognition, and reciprocal contribution, mechanisms underpinning peer support in dementia are consistent with positive psychology theory regarding meaning, belonging, and purpose. Therefore, funding such structured programmes for integration into core post-diagnostic service offerings rather than voluntary or informal supplements could increase wellbeing and support disease management.

Fourth, the integration of positive psychology frameworks into dementia care training for all professional groups is warranted. While existing workforce training focuses largely on symptom recognition and risk management, the present evidence highlights the importance of practitioner competence in recognising and fostering psychological strengths, retained capacities, and adaptive coping in individuals with dementia.

6.3. *Health Equity Considerations*

There are notable health equity considerations which must not be overlooked. Positive psychology interventions may risk replicating broader health inequalities if not designed with equity as an explicit priority. It should be acknowledged that the existing evidence base on positive psychology and dementia is disproportionately drawn from White, English-speaking, and relatively educated populations. People from minority ethnic communities, those with young-onset dementia, individuals with intellectual disabilities, and those in later stages of the condition are underrepresented in current research and in most intervention trials [45,46]. Future research and service development needs to address these gaps actively, through community-embedded co-production methods and culturally adapted intervention designs.

6.4. *Research Priorities*

Several research priorities are indicated by the evidence reviewed here. Longitudinal studies tracking positive psychology variables including hope, meaning, post-traumatic growth, and social identity alongside standard dementia outcomes are required to establish the predictive validity and causal relevance of these constructs. Adequately powered randomised controlled trials of positive psychology-informed interventions, co-produced with people with lived experience of dementia, are needed to generate the evidence base required for guideline integration. Furthermore, the development and validation of dementia-specific positive psychology measurement tools represent

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a methodological priority, particularly tools accessible to individuals with moderate cognitive impairment.

7. Conclusions

Dementia is amongst the most prevalent and burdensome conditions associated with ageing, and its psychological dimensions remain incompletely addressed within current care frameworks. This review has synthesised evidence demonstrating that subjective wellbeing in early-to-moderate dementia is neither a direct nor inevitable function of cognitive impairment, and that psychological and social variables including meaning, hope, social belonging, and self-determination are the stronger predictors of wellbeing outcomes. These findings are consistent across multiple study designs and theoretical frameworks, and support a fundamental reorientation of how the field conceptualises and measures success in dementia care.

The so-called wellbeing paradox, e.g., the repeated finding that people with dementia report higher subjective wellbeing than external observers predict, is not an artefact of measurement error or a consequence of impaired self-awareness. On the contrary, it reflects the genuine preservation of emotional responsiveness, social need, and capacity for meaning that characterises early-stage dementia, and that current post-diagnostic care frameworks largely fail to recognise or support. Kitwood's [11] early insight that personhood persists in dementia, and Seligman's [4] argument that flourishing is a distinct and measurable dimension of human experience, together provide the theoretical foundation for a more adequate account of what it means to live well with dementia.

The clinical implications are direct. Post-diagnostic support should incorporate and emphasise strengths-based assessment, meaning-centred intervention, structured peer support, and validated positive wellbeing measurement as standard components of care. Research needs to prioritise co-produced longitudinal studies and adequately powered intervention trials that include positive psychology outcomes alongside established clinical endpoints. Equity must be an explicit design principle at every stage. To conclude, the evidence discussed provides a foundation; implementing these approaches will require deliberate action and prioritisation of equity across clinical, commissioning, and policy decisions.

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Abbreviations

The following abbreviations are used in this manuscript:

PERMA	Positive emotion, Engagement, Relationships, Meaning, and Accomplishment
IDEAL	Improving the experience of Dementia and Enhancing Active Life
SDT	Self-Determination Theory
BASQID	Linear dichroism Bath Assessment of Subjective Experience of Dementia
PTG	Post-Traumatic Growth
ACT	Acceptance and Commitment Therapy
DAI	Organisations including global Dementia Alliance International
SDWG	Scottish Dementia Working Group
UK DRI	UK Dementia Research Institute
DPUK	Dementia Platform UK
WHO	World Health Organisation

NICE National Institute for Health and Care Excellence

References

1. World Health Organization (2023) *Dementia: Key Facts*. Geneva: WHO. Available at: https://www.who.int/news-room/fact-sheets/detail/dementia (Accessed: 19 March 2026).
2. Orgeta, V., Qazi, A., Spector, A. and Orrell, M. (2015) 'Psychological treatments for depression and anxiety in dementia and mild cognitive impairment', *Cochrane Database of Systematic Reviews*, Issue 1, Art. No.: CD009125. https://doi.org/10.1002/14651858.cd009125.pub3
3. Seligman, M.E.P. and Csikszentmihalyi, M. (2000) 'Positive psychology: an introduction', *American Psychologist*, 55(1), pp. 5–14. https://doi.org/10.1037//0003-066x.55.1.5
4. Seligman, M.E.P. (2011) *Flourish: A Visionary New Understanding of Happiness and Wellbeing*. New York: Free Press.
5. Aspinwall, L.G. and Tedeschi, R.G. (2010) 'The value of positive psychology for health psychology: progress and pitfalls in examining the relation of positive phenomena to health', *Annals of Behavioral Medicine*, 39(1), pp. 4–15. https://doi.org/10.1007/s12160-009-9153-0
6. Yao, Y., Wang, C.J., Yin, S.Y., Xu, G.Z., Cheng, Y.F., Huang, Q.Q. and Jin, Y. (2024) 'Effects of positive psychology intervention based on the PERMA model on psychological status and quality of life in patients with Parkinson's disease', *Heliyon*, 10(20). https://doi.org/10.1016/j.heliyon.2024.e36902
7. Prince, M., Wimo, A., Guerchet, M., Ali, G., Wu, Y. and Prina, M. (2016) *World Alzheimer Report 2016: Improving Healthcare for People Living with Dementia*. London: Alzheimer's Disease International. https://doi.org/10.13140/RG.2.2.22580.04483
8. Swaffer, K. (2015) 'Dementia: prescribed disengagement?', *Dementia*, 14(1), pp. 3–6. https://doi.org/10.1177/1471301214548136
9. Lamont, R. A., Nelis, S. M., Quinn, C., Martyr, A., Rippon, I., Kopelman, M. D., ... & Clare, L. (2020). Psychological predictors of 'living well'with dementia: findings from the IDEAL study. *Aging & mental health*, *24*(6), 956-964. https://doi.org/10.1080/13607863.2019.1566811
10. Clare, L., Wu, Y.T., Jones, I.R., Victor, C.R., Nelis, S.M., Martyr, A., Quinn, C., Litherland, R., Pickett, J.A., Hindle, J.V., Jones, R.W., Knapp, M., Kopelman, M.D., Morris, R.G., Rusted, J.M., Thom, J.M., Lamont, R.A., Henderson, C., Rippon, I., Hillman, A. and Matthews, F.E. (2019) 'A comprehensive model of factors associated with subjective perceptions of living well with dementia: findings from the IDEAL study', *Alzheimer's Disease and Associated Disorders*, 33(1), pp. 39–45. https://doi.org/10.1097/WAD.0000000000000286
11. Kitwood, T. (1997) *Dementia Reconsidered: The Person Comes First*. Buckingham: Open University Press. https://doi.org/10.1136/bmj.318.7187.880a
12. Baldwin, C. and Capstick, A. (eds.) (2007) *Tom Kitwood on Dementia: A Reader and Critical Commentary*. Maidenhead: Open University Press. https://doi.org/10.1017/S0144686X08008210
13. Feinstein, J.S., Duff, M.C. and Tranel, D. (2010) 'Sustained experience of emotion after loss of memory in patients with amnesia', *Proceedings of the National Academy of Sciences*, 107(17), pp. 7674–7679. https://doi.org/10.1073/pnas.0914054107
14. Deci, E.L. and Ryan, R.M. (2009) 'The what and why of goal pursuits: human needs and the self-determination of behaviour', *Psychological Inquiry*, 11(4), pp. 227–268. https://doi.org/10.1207/S15327965PLI1104_01
15. Colclough, C., Perach, R., Harris, P., Rusted, J., Banerjee, S., & Miles, E. (2026). Decision-making involvement and quality of life in people with dementia: the mediating role of psychological needs. *Aging & Mental Health*, *30*(2), 267-276. https://doi.org/10.1080/13607863.2025.2541188
16. Griffiths, A. W., Smith, S. J., Martin, A., Meads, D., Kelley, R., & Surr, C. A. (2020). Exploring self-report and proxy-report quality-of-life measures for people living with dementia in care homes. *Quality of Life Research*, *29*(2), 463-472. https://doi.org/10.1007/s11136-019-02333-3
17. Smith, S.C., Lamping, D.L., Banerjee, S., Harwood, R.H., Foote, L., Smith, P., Cook, J.C., Murray, J., Prince, M., Levin, E., Mann, A. and Knapp, M. (2007) 'Development of a new measure of health-related quality of

doi:10.20944/preprints202604.0202.v1

life for people with dementia: DEMQOL', *Psychological Medicine*, 37(5), pp. 737–746.- https://doi.org/10.1017/S0033291706009469

18. Surr, C.A. (2006) 'Preservation of self in people with dementia living in residential care: a socio-biographical approach', *Social Science and Medicine*, 62(7), pp. 1720–1730. https://doi.org/10.1016/j.socscimed.2005.08.025
19. Clare, L. (2003) 'Managing threats to self: awareness in early stage Alzheimer's disease', *Social Science and Medicine*, 57(6), pp. 1017–1029. https://doi.org/10.1016/S0277-9536(02)00476-8
20. McAdams, D.P. (2001) 'The psychology of life stories', *Review of General Psychology*, 5(2), pp. 100–122. https://doi.org/10.1037/1089-2680.5.2.100
21. Clare, L., Rowlands, J. and Quin, R. (2008) 'Collective strength: the impact of developing a shared social identity in early-stage dementia', *Dementia*, 7(1), pp. 9–30. https://doi.org/10.1093/geront/gny018
22. Tedeschi, R.G. and Calhoun, L.G. (1996) 'The Posttraumatic Growth Inventory: measuring the positive legacy of trauma', *Journal of Traumatic Stress*, 9(3), pp. 455–471. https://doi.org/10.1007/BF02103658
23. Wolverson, E., Clarke, C. and Moniz-Cook, E. (2010) 'Remaining hopeful in early-stage dementia: a qualitative study', *Aging and Mental Health*, 14(4), pp. 450–460. https://doi.org/10.1080/13607860903483110
24. Wolverson, E.L., Clarke, C. and Moniz-Cook, E.D. (2016) 'Living positively with dementia: a systematic review and synthesis of the qualitative literature', *Aging and Mental Health*, 20(7), pp. 676–699. https://doi.org/10.1080/13607863.2015.1052777
25. Hayes, S.C., Strosahl, K.D. and Wilson, K.G. (1999) *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change*. New York: Guilford Press.
26. Robinson, A., De Boos, D., & Moghaddam, N. (2023). Acceptance and commitment therapy (ACT) for people with dementia experiencing psychological distress: A hermeneutic single-case efficacy design (HSCED) series. *Counselling and Psychotherapy Research*, *23*(4), 1108-1122. https://doi.org/10.1002/capr.12646
27. Neff, K.D. (2003) 'Self-compassion: an alternative conceptualisation of a healthy attitude toward oneself', *Self and Identity*, 2(2), pp. 85–101. https://doi.org/10.1080/15298860309032
28. Sabat, S.R. (2002) 'Surviving manifestations of selfhood in Alzheimer's disease: a case study', *Dementia*, 1(1), pp. 25–36. https://doi.org/10.1177/147130120200100101
29. Neff, K.D. and Germer, C.K. (2013) 'A pilot study and randomized controlled trial of the mindful self-compassion program', *Journal of Clinical Psychology*, 69(1), pp. 28–44. https://doi.org/10.1002/jclp.21923
30. Haight, B.K. and Haight, B.S. (2007) *The Handbook of Structured Life Review*. Baltimore: Health Professions Press. https://doi.org/10.1080/01924780902947645
31. Snyder, C.R. (2002) 'Hope theory: rainbows in the mind', *Psychological Inquiry*, 13(4), pp. 249–275. https://doi.org/10.1207/S15327965PLI1304_01
32. Hunsaker, A. E., Terhorst, L., Gentry, A., & Lingler, J. H. (2016). Measuring hope among families impacted by cognitive impairment. *Dementia*, *15*(4), 596-608. https://doi.org/10.1177/1471301214531590
33. Stern, Y. (2012) 'Cognitive reserve in ageing and Alzheimer's disease', *The Lancet Neurology*, 11(11), pp. 1006–1012. https://doi.org/10.1016/s1474-4422(12)70191-6
34. Liu, Y., Lu, G., Liu, L., He, Y. and Gong, W. (2024) 'Cognitive reserve over the life course and risk of dementia: a systematic review and meta-analysis', *Frontiers in Aging Neuroscience*, 16, 1358992. https://doi.org/10.3389/fnagi.2024.1358992
35. Särkämö, T., Tervaniemi, M., Laitinen, S., Numminen, A., Kurki, M., Johnson, J.K. and Rantanen, P. (2014) 'Cognitive, emotional, and social benefits of regular musical activities in early dementia: randomized controlled study', *Gerontologist*, 54(4), pp. 634–650. https://doi.org/10.1093/geront/gnt100
36. Hannemann, B.T. (2006) 'Creativity with dementia patients: can creativity and art stimulate dementia patients positively?', *Gerontology*, 52(1), pp. 59–65. https://doi.org/10.1159/000089827
37. Miah, J., Dawes, P., Edwards, S., Leroi, I., Starling, B. and Parsons, S. (2019) 'Patient and public involvement in dementia research in the European Union: a scoping review', *BMC Geriatrics*, 19(1), 220. https://doi.org/10.1186/s12877-019-1217-9
38. Bartlett, R. (2012) 'Modifying the diary interview method to research the lives of people with dementia', *Qualitative Health Research*, 22(12), pp. 1717–1726. https://doi.org/10.1177/1049732312462240

39. Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T. and Stephenson, D. (2015) ‘Loneliness and social isolation as risk factors for mortality: a meta-analytic review’, *Perspectives on Psychological Science*, 10(2), pp. 227–237. https://doi.org/10.1177/1745691614568352
40. Groechel, R.C., Liu, A.C., Lutsey, P.L., Palta, P., Kucharska-Newton, A.M., Koton, S. and Gottesman, R.F. (2025) ‘Associations between mid-life social relationships and the risk of incident dementia: The ARIC study’, *Alzheimer's & Dementia*, 21(7), e70365. https://doi.org/10.1002/alz.70365
41. Haslam, S.A., Jetten, J., Cruwys, T., Dingle, G. and Haslam, C. (2018) *The New Psychology of Health: Unlocking the Social Cure*. London: Routledge. https://doi.org/10.4324/9781315648569
42. Cheston, R., Jones, K. and Gilliard, J. (2003) ‘Group psychotherapy and people with dementia’, *Aging and Mental Health*, 7(6), pp. 452–461. https://doi.org/10.1080/136078603100015947
43. Phillipson, L. and Hammond, A. (2018) ‘More than talking: a scoping review of innovative approaches to qualitative research involving people with dementia’, *International Journal of Qualitative Methods*, 17(1), pp. 1–13. https://doi.org/10.1177/1609406918782784
44. Donaldson, C., Tarrier, N. and Burns, A. (1998) ‘Determinants of carer stress in Alzheimer's disease’, *International Journal of Geriatric Psychiatry*, 13(4), pp. 248–256. https://doi.org/10.1002/(sici)1099-1166(199804)13:4%3C248::aid-gps770%3E3.0.co;2-0