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Sustaining Sociability and Keeping It Alive in Residential Long-Term Care for People With Dementia

Abstract: Nursing homes, especially those caring for people with dementia, are often perceived as “cold” or “silent” places where conversation is rare and the main tasks of professionals are to help residents with their daily activities. This article presents an analysis of ethnographic data collected in a nursing home in French-speaking Switzerland and links it to Georg Simmel’s analyses of sociability. It focuses mainly – but not exclusively – on scenes involving members of the sociocultural team and demonstrates that the care provided by professionals to create and support exchanges between and with residents is a valuable resource for community building, benefiting both residents and professionals.

Keywords: *sociability, nursing homes, dementia, chit-chat, care, social relationship, Simmel*

1 Introduction: Sociability and Silence in Institutions

Nursing homes are regularly described as “cold” institutional spaces, often opposed to a romanticised idea of “warm” familial care (Thelen, 2021). That coldness is supposedly due not only to their physical environment, but also to the silence that reigns there. In 1986, Stuart Sigman observed in his ethnography of a Philadelphia nursing home that residents spoke with staff for no more than 20 minutes a day, and much more in short bursts than in elaborate conversations. More recently, in a survey carried out in England, Richard Ward and his colleagues (2008) showed that residents with dementia spent less than 10% of the day in direct communication with other people, only 2.5% of whom were professionals. Given that 77% of that communication was related to care tasks performed either by healthcare professionals or social workers, he scathingly points out that “silence is the dominant mode of caring encounters” (Ward et al., 2008, p.636).

This lack of verbal communication is partly linked to the organisation of such institutions, where professionals, whose schedules are tight, are essentially employed to carry out care tasks related to basic needs, while the number of staff in charge of social and cultural activities is very limited (Lambelet,

2022). In such circumstances, residents who require assistance to walk are “observed to move around [...] less and to exercise less choice over where and with whom they s[i]t” (Ward et al., 2008, p. 636). In the specific case of dementia, communication difficulties are also closely tied to the progression of neuro-cognitive impairments. In addition to memory loss, cognitive problems include forms of agnosia (i.e. an inability to recognise and identify objects or persons), apraxia (an inability to perform purposeful, learned movements or tasks, even though the person has the desire to do them) or aphasia (a language disorder that makes it hard to speak), making interaction, communication, and understanding of the environment difficult. Social relationships with people with dementia are therefore not something that can be taken for granted. Indeed, in terms of sociability, this disease can be described as the weakening or even the loss of social and interpersonal abilities that are part of the ordinary fabric of human relations, resulting in a “progressive alteration of the order of interactions” (Brossard, 2023). Herman Coenen (1991, p. 317) succinctly articulates the key reasons why: “The normal rules and techniques of everyday interaction do not work with [these people], because the essence of their handicap is the very collapse of these rules and techniques”. Consequently, communicating, but even more building relationships with older people with dementia, requires more than ordinary interactional methods and skills.

Aware of the challenges, the nursing literature offers extensive guidance on communication (see for example Snow, 2012; Haute Autorité de Santé, 2012; Gineste & Péliissier, 2013) or even stresses the benefits of “relationship-centred approaches” for supporting people with dementia (Nolan et al., 2004; Bourbonnais et al., 2020). Amongst other recommendations, (future) professionals are taught that it is advisable to stand in front of the person being cared for, at their height, to establish eye contact and gain their attention by, for example, gently taking their hand; to use short sentences and to prefer closed questions; to use gestures (or categorisation material) to facilitate the transmission of the message; to repeat the message if any doubt persists as to its comprehension; to allow time for the person to express themselves; to draw on body language and stay relaxed and smiling; to include the person in the conversation; and to bear in mind the importance of remaining patient.

Although this literature is useful for all professionals working in nursing homes, it focuses exclusively on “communication in healthcare” and is based above all on instrumental rationality: good communication should enable care tasks to be performed better. Hence, communication is thought of as a “means”, not an “end”. Furthermore, this literature has a blind spot since it says nothing about the importance for people with dementia of maintaining social relation-

ships and sociability, all things that are at the heart of social work assumptions. Indeed, one of the core aims of social work is to foster social ties and enable individuals to engage in forms of social relations and reciprocity (Folgheraiter, 2004; Chaniel, 2022; Paugam, 2023). Such objectives are also pursued by social workers caring for people living with dementia in nursing homes. With this in mind, it appears that the guidelines found in the nursing literature reflect a partial and limited view of the reality of care work carried out in the specific contexts that interest us, as they overlook the broader work involved in creating and sustaining social life within longterm institutions dedicated to dementia care.¹

During the numerous ethnographic fieldworks we have conducted over the past few years, we have observed that social work plays a central role in promoting and developing social life in nursing homes of this type. In this regard, our paper aims to show that even if they are significant, the barriers to communication sketched out above do not imply the disappearance of what Georg Simmel (1949 [1910]) called the “impulse to sociability”, that is, the deeply rooted desire among human beings living in society to connect. However, although still present and lively, this “impulse” always runs the risk of being frustrated, as people with dementia no longer know how to make social contact and are unable to create forms of association on their own. This means that it is up to professionals, foremost among them social workers, to give this impulse a socially recognisable and acceptable form, as otherwise, the institution – and its residents – will indeed fall into “silence” and “coldness”.

The purpose of this article is to draw attention to this subtle and delicate work, which often goes unnoticed despite the intense effort it requires and its immense importance; it is indeed the very condition that makes social relationships possible. After returning to the concepts of the “impulse to sociability” and “pure sociability” as defined by Simmel,² we will show, based on three emblematic scenes observed during a long-term ethnographic study in Swiss nursing homes, how useful these concepts can be in shedding light on, but also in supporting, the practices of professionals in their work to maintain social life there. We will demonstrate that, while the ability to chat and to keep someone engaged in a gathering is often regarded as trivial, both of these abilities can clearly be resources for supporting people with dementia. This is why we will ultimately argue that they deserve to be valued as skills and taught and learned as such.

2 Theoretical Elements: Simmel’s Notion of “Sociability”

In “The Sociology of Sociability”, a seminal article in sociology and, more specifically, in interactionist approaches to sociology, Georg Simmel examines sociability as a specific form of interaction. He suggests that, just as biologi-

cal life is based on the innumerable and incessant reciprocal actions of individual cells, so the reciprocal actions of individuals constitute society. These actions are linked to the incessant flow of life: humans enter into relationships because they are guided by the “impulses of life” (Simmel, 1949 [1910], p. 254). This vital flow gives rise to forms of association that “shape” reciprocal actions, in return channelling and configuring them. For Simmel, they are innumerable and can be identified on all “scales”, from an exchange of glances or a conversation between friends, to “large systems” such as a state or a company. Each form relates individuals to each other in a certain way, configuring and regulating social relationships around specific issues, or what Simmel calls “contents”. So, beyond the initial “impulses” that give rise to them, each social form acquires a certain autonomy and becomes a kind of institution that everyone can get involved in depending on their particular interests.

However, remarks Simmel, even when directed and sustained by specific interests, these forms of association can also be enjoyed for the sheer pleasure of being together. For example, a person can enjoy playing with others, whatever the game, and whatever its outcome, simply because they like the kind of relationship created between them; they can enjoy a family meal not so much for its content in terms of food as for the exchanges to which it gives rise. This is why Simmel speaks of “a common element, a likeness of psychological reaction and need, [that] is found in all these various things – something that is easily distinguished from the particular interest that gives each of them its distinction” (1949 [1910], p. 254). What all forms of association have in common is that they can be enjoyed for their own sake, whatever their purpose, simply for the pleasure of coming together with others. Simmel calls this tendency to desire and appreciate the relationship as such, regardless of its content, the “impulse to sociability” (1949 [1910], p. 254): “the associative process [itself being considered] as a value and a satisfaction” (1949 [1910], p. 255).

As Simmel also noted though, achieving this pure sociability is not an easy task. “The personal traits of amiability, breeding, cordiality, and attractiveness of all kinds determine the character of purely sociable association. But precisely because all is oriented about them, the personalities must not emphasize themselves too individually” (1949 [1910], p. 255). Furthermore, such a nuance being particularly meaningful in the case of nursing homes for people with dementia, it should be noted that for Simmel, this “pure sociability” requires a “sense of tact” from the individual (1949 [1910], p. 256) which consists in not bringing one’s particular or “egoistic” interests into the exchange too much; an “individual shall not present his peculiarities and individuality with too much abandon and aggressiveness [...] the most personal things – character, mood,

and fate – have thus no place in it. It is tactless to bring in personal humor, good or ill, excitement and depression, the light and shadow of one's inner life" (1949 [1910], p. 256). Although personal traits partly determine the character of purely sociable association and the fact that, within an institution a given resident enjoying talking about jazz or their children or displaying a particular affinity with a staff member constitutes resources for this sociability and gives it its specific tone, individuality cannot be excessively emphasised, for that would destroy sociability itself.

Finally, to be fully realised, pure sociability requires treating other individuals as equals. As Simmel writes, "Riches and social position, learning and fame, exceptional capacities and merits of the individual have no role in sociability" (1949 [1910], p. 256). Everyone must be committed to it as an individual on an equal footing with one another. The individual enters pure sociability, "with nothing but the capacities, attractions, and interests of his pure humanity" (1949 [1910], p. 256), that is, as a generic human being, who has the same aptitudes and attractions as any other. Thus, in pure sociability, "everyone should have as much satisfaction of this impulse as is consonant with the satisfaction of the impulse for all others" (1949 [1910], p. 257). So we can see that, according to Simmel, pure sociability is opened up, as a social form, to the greatest number possible. In this sense, and to use Simmel's own formulation, it is "democratic", as it does not require any specific individual quality in order to be realised.

In the field of care for persons with dementia – and this is why we are interested in it – pure sociability appears to be a possible form of association for people with cognitive disorders, as it is based on the aptitudes one possesses by virtue of being part of humanity, and it is by definition indifferent to specific disorders or communication problems. However, while its "cost of entry" is low, from this point of view, pure sociability nevertheless assumes that individuals have mastered basic skills, both interactional and moral, such as tact, discretion, courtesy, and the ability to play "a game in which one 'acts' as though all were equal, as though he especially esteemed everyone" (Simmel, 1949 [1910], p. 257), that is, to play out "the forms of society" (Simmel, 1949 [1910], p. 259). The notion of play is crucial here, and not only because sociability is "the play-form of association" (Simmel, 1949 [1910], p. 255). According to Simmel, there is an important place for sociability in any game, whatever it may be.

Therefore, there is a fruitful tension to be highlighted here. As we noted in our introduction, for people with dementia, knowing how to regulate their emotions, set aside their immediate interests, and see others as themselves, are not things that can be taken for granted. Nonetheless, even in cases of dementia, the "impulse to sociability" remains intact. There is no mystery to it: as

emphasised by Levinson (2006), “human interactional abilities” are skills that pre-exist language and can be observed both in newborn babies and in people with aphasia. This interactional infrastructure – Levinson calls it “interaction engine” – on which the ability to communicate is built, remains even when the capacity to start talking – and more generally to associate appropriately with somebody else – has vanished. What Coenen observed in his ethnography of a nursing home for people with dementia, thanks to his phenomenological approach, is precisely the ability of this infrastructure to endure beyond actual inabilities that are immediately obvious: “Old people sit on couches and armchairs, or go wandering around. Now and then I see someone look at us with a questioning expression that clings to you. I get the feeling that it is us who have to take the initiative, we have to decide whether there should be any contact. They just wait. But as soon as you do make contact by answering that look by looking back, they go into motion and they visibly take pleasure in having contact” (Coenen, 1991, p.318).

As we can see, it is the socially acceptable and recognisable “shaping” of interaction that is problematic for people with dementia, since such shaping requires skills such as “tact”. In this context, these skills involve a certain way of looking at somebody else that is engaging or at least understandable as a willingness to open up an exchange. These are all things that people with dementia may no longer be able to master. The “we” used by Coenen refers of course to people with full cognitive capacity, whoever they may be. As professionals are the ones whom people with dementia living in nursing homes have the most opportunity to meet, part of their job is to do this work of regulating interactions and to initiate all kinds of ordinary types of social relationship. It is up to them to transform the impulse to sociability into actual sociability, by inventing forms of association that encourage it, while keeping in mind the care issues that remain at the heart of their mission. Indeed, their support is essential if the “pure pleasure” of being together is to exist, and if living a human life, with and among others and not apart from them, is to be seen as something to which people with dementia can also lay claim.

In the light of these clarifications, it turns out to be fully heuristic to consider the “impulse to sociability” and “pure sociability” within the field of dementia care. Both concepts relate to realities which, once they are considered, are possible resources for nursing home professionals, since people with dementia are “in principle” not only interested in this form of sociability, but still capable, subject to certain conditions, of entering into it. It is also a key challenge in professionals’ work, since it is up to them to compensate for people’s lack of “tact” or difficulty in communicating (among other things).

Methods

We develop our argument by describing two scenes that took place one day during breakfast, and one that occurred at lunchtime. These three scenes have been chosen because they show how professionals proceed: they are situations where the phenomenon we want to identify and analyse can be “particularly clearly observed” (Vom Lehn, 2014, p. 109). A close look at the two interaction sequences within the same course of action (scenes 1 and 2) will allow us to better highlight the work that transforming an impulse into sociability requires from professionals. As for the lunchtime situation (scene 3), it enables us to outline how playing, as an activity embedded in everyday care interactions, can foster sociability.

The data was collected as part of a 3-year ethnographic research study funded by the SNSF called “Investigating the hidden meaning of conduct. An ethnography of ordinary knowledge of dementia in long-term care institutions” (Project n° 200537) conducted by two of the three authors. The material used here comes from a 16-week period of participant observation, from May 2022 to December 2022, in a long-term nursing home in the French-speaking part of Switzerland.³ Participant observation, audio recordings, and informal and formal interviews are the main ethnographic methods employed in the project. With respect to ethnographers’ own investigative tools, ethnographic inquiry enables researchers to “experience” (Wolcott, 1999, p. 46) how professionals relate to dementia in the context of day-to-day care. In this respect, and because “we only grasp people’s multiple binds when we try to do their activities ourselves, as best we can” (Eliasoph, 2011, p. 262), and then describe and analyse them, ethnographic inquiry, more than any other methodological approach, makes it possible to face and understand the practical dilemmas and problematic situations experienced by professionals (nursing assistants and social workers especially) when caring for people with dementia (Malbois & Tremblay, 2026). While we have chosen, for this article, to focus on scenes in which we participated during the fieldwork, the analysis draws on all the observations and interviews that were carried out.

The selected interaction sequences are not particularly specific or “anecdotal”. On the contrary, they are emblematic of our data as a whole and reveal, perhaps better than others, the conception or the logic of what constitutes good care (Lopez, 2006; Mol, 2008) since in this nursing home interacting as much as possible with residents is actually one of the “codes of conduct” (Wieder, 1974) that professionals are invited to adopt, even when they are members of the healthcare team. More precisely, the first two selected scenes are “rare” in the sense that they show particularly well the work carried out by

a social worker to bring about forms of sociability; they are also “remarkable” in that the various professionals who were present referred to them as such, congratulating the professional involved for what she had been able to “achieve”, i. e. “make happen” that day, namely a particularly warm, sociable atmosphere and a lively gathering, although the participants all experienced severe difficulty in creating social bonds. The third and last scene is revelatory in the sense that it highlights how promoting sociability is a way of granting an impaired resident the status of a moral actor capable of initiating slightly incongruous but still recognisable actions and, then, enabling him to interact genuinely with others. It is also relevant in that it sheds light on how an end that is normally considered a priority within such an institutional context, given that satisfying a basic need is at stake, can be put on hold by a nursing assistant in favour of a moment of sociability that depends on her professional ability to play along with a spontaneous game proposed by a resident.

4 Data

Scene 1 – Making breakfast a context for reciprocal action

Elodie, a social worker, prepares breakfast in a unit. She sets up the tables, one of which is large enough for each resident to sit down. Soon plates, cups, glasses, a small jug of milk, cutlery, and napkins line the tables. She prepares plates of cut fruit (bananas, kiwis, and pears) as well as French toast, which she places on the tables. She also prepares a pot of coffee. As she observes, “when we set the tables, all the residents huddle together”. Once the table is set, Elodie sits down with the residents who are arriving. *Her job is not only to help those who need it, but first to chat and support the residents’ desire to chat.* A resident gets bolder and starts talking about something that happened the day before with another resident. The professional responds, stimulating and supporting this initial exchange. She does this with short questions, approvals, signs of curiosity, and smiles. Another resident enters the room. She invites him to have coffee with the others, offers him a seat beside her, and immediately compliments him on his belt. As breakfast takes place in an open space, surrounded by the different rooms, the caregivers, even if very busy in the morning with personal care for residents, make brief stops when they pass through this area. This is an opportunity for them to say a few words to one or other of the residents, as a way of creating or maintaining contact and relationships, but also of participating in the creation of a warm, inclusive atmosphere.

In this sequence, Elodie, the social worker whose job it is to stay with the residents and help them with their breakfast, works to make the place feel lived-in by endowing it with visual stimuli (a tablecloth, a pot of coffee on the table, ready-made toast, “just like at home”), but also olfactory stimuli (the smell of coffee and French toast), and sound (exchanges initiated with residents, laughter, anecdotes about last night, gossip “like in a restaurant”). She works, along with the other professionals around, who come and go briefly in the room, to create “affordances” (Gibson, 2015) that are perceptible by people with dementia, and then to produce an environment that encourages communication, the desire to connect and exchange. The table acts as a magnet: residents can approach it and pick up fruit, stand at a distance and observe the scene, or settle into a chair and comment, from afar, on what they hear, see, or smell.

Within this breakfast situation, talking is an end in itself, and “the content [the food and drinks laid out on the table in this specific case] is merely the indispensable carrier of the stimulation, which the lively exchange of talk as such unfolds” (Simmel, 1949 [1910], p.259). All the forms in which this exchange develops have their meaning in themselves; that is to say, in the excitement of the interplay of relations which they establish between individuals.

The work accomplished by the social worker, including by endowing the situation with sensory properties, creates a network of reciprocal actions: from resident to resident, from professional to resident. Thanks to the dynamics of the group, each action generates new reactions, new acts, new associations. The professional constantly takes initiatives in that direction, whether by proposing opportunities for exchange, or by establishing contact. She enables residents to initiate interactions and make contact. To put it in Simmel’s terms, she is attentive to the “sociability impulses” perceptible in residents (looks, gestures, and movements, however sketchy, summary, and uncertain they may be) and makes them constitutive resources of the collective moment that the breakfast is: a moment of “sociability” in the sense that appreciation or the quality of its form (the warm atmosphere, the laughter and smiles, the progressive emergence of bonds, etc.) comes first.

It is anything but “easy”. On the contrary, it is hard work, because the emergence and maintenance of these sociable conversations is not random. For a stimulus to turn into an affordance, it must be interesting, gripping, even significant enough to stimulate the continuation of this exchange or to encourage further exchanges. That is why, while the breakfast was going on, and as colleagues of Elodie saw her working, they expressed their admiration for the successful breakfast, for its atmosphere, and the exchanges (or the “life”) it gave rise to.

Scene 2 – Keeping the gossip alive and circulating

While breakfast was taking place, Elena, a resident, starts talking to us [Elodie, the professional, and the ethnographer], clearly expecting a reaction. “Yesterday,” she says, “I gave Mr Pull lots of kisses”. “Here, on the arms,” she insists. Elodie plays along, and I instantly follow suit. I exclaim: “Really? But that’s great!”, and ask her: “And was he happy?” “Yes,” Elena replies, as if my question were silly. Elodie and I laugh, and I continue the conversation: “But I thought it was over with Mr Pull, that the pianist [who comes to the nursing home to play music once a week] was now your boyfriend”. Elena: “Oh, no, the pianist is too old!”. I agree and add: “And Mr Pull is always very classy, very well dressed”. Elodie laughs and says to me in confidence: “The pianist can’t walk anymore”. *Elodie and I continue our light-hearted banter, creating a relaxed atmosphere similar to that of a trio of girlfriends chatting in a café.*

But Elena still has a problem, which she formulates with a bored expression: “But Mr Pull, yesterday, he called me Madam, that’s not right!” We start by reassuring Elena: if Mr Pull says “Madam” to her, it is because he tends to forget things: he has a bad memory. We then advise Elena not to hesitate to often remind Mr Pull that her name is Elena; he won’t take it the wrong way. But before long, her concern returns: “Yes, yes, but he called me Madam”, she says again *in an angry, grandiloquent tone. Elodie and I try again to reassure her.* Somewhat jokingly, I suggest that Elena put a badge – like the professionals have – on her sweater, with her name on it, to help Mr Pull remember her first name. I then suggest to Elena that we go with her to see Carle [the receptionist] later. While I’m not sure she can make her request clear enough for Carle to give her what she wants, there are other reasons for this proposal: the fact that going with her is an opportunity to strengthen our complicity by doing something together. Above all, my presence at Elena’s side enables me to tell Carle the reasons why Elena needs a badge, and if it is important to me that Carle knows these reasons, it is *because then Carle too would be likely to enter the story that is being woven for Elena, around Mr Pull. To know this story is to have as many opportunities as possible to interact with Elena later, with questions that we know will please her.* These questions will continue to give her feelings of love a tangibility and maintain the idea that what matters to her also matters to “us” – i.e., the professionals who surround her daily.

In this second sequence, the social worker and the ethnographer work to include the resident in an ordinary exchange of jokes, gossip, and chatter. Through their activity, questions, and comments they bring to life the emotions expressed

by the resident, giving them consistency, making them a shared and shareable story, with a joyful tone, and all this by systematically drawing on the resident's "world", on what Elena is "here and now". It is also a relationship, in part, between "equals". Their respective status as professional, ethnographer, and resident has no relevance to the situation they share; they are chatting like friends do. Creating such a hospitable situation demands many social skills. If the exchange offers the possibility of fully enjoying the pleasure of presence, if it encourages and prolongs contact with the resident, it is because hard work is carried out to ensure the resident's participation – the professional slows down the interaction and communication, keeps looking at her, so that the person with dementia can act and react, take their turn in dialogue and interaction, and so participate competently (Moser, 2010, p. 200) – and to ensure forms of regulation of the resident's emotions, amplifying her joy when she expresses it, reassuring her when her tone becomes "irritated" and might jeopardise the pleasure of exchanging. In the same way, by approving what she says, rephrasing it and asking questions, the professional and the ethnographer give shape to Elena and Mr Pull's story (regulate it in this sense): it thus takes the form of a typical "love story" with its share of new protagonists (Carle), intrigues (the badge creation), and new developments.

It is worth noting that, while at first glance some of these exchanges may well appear to be "chit-chat" with nothing at stake, or confidences between friends – in other words, "pure sociability" as envisaged by Simmel – they are nonetheless interwoven with care relationships and oriented towards long-term support goals. Those goals do not, however, take pre-eminence over the pleasure of being together. Indeed, taking on the role of "friends" means shifting the relationship between professional and resident, or temporarily (at least in appearance) suspending the care relationship. However, it is this displacement, which can be likened to a professional "role distance" (Goffman, 1972 [1961]) that allows the resident to experience the pleasure of sharing her story, and at the same time enables the professionals to discover this pleasure. What is at stake for professionals, then, is not so much the "content" of the story as such, as the positive consequences of telling it: from now on, this story, if known and enriched by others, can become a resource in Elena's care.

Beyond the present moment, this chatter also takes on more long-term consistency, as when the ethnographer – reproducing the "code" (Wieder, 1974) in force in the care work in this nursing home – suggests going to make a badge, to continue the exchange by including the receptionist. We can see how one of the activities in which the professionals are engaged consists of relating anecdotes to each other – little stories that are deemed relevant, particularly because

they convey edifying, emblematic, or funny stories – from their interactions with the residents. In this sense, the residents' lack of speech – and therefore their limited ability to give an account of what is happening to them, what they like or want, what they need, etc. – is compensated for in some way by the words of the professionals and their reports.

Scene 3 – Playing in order to care

At the end of a meal, Mary, a nursing assistant, thinks that it would be a good idea for Ben, a resident, to drink a little. Given that the resident would not think to drink on his own, she offers him a glass of water. After taking a few sips, Ben puts the glass back on the table, shoves it away, and slides it in Mary's direction. His gesture, which displays a certain brusqueness (*the gesture is carried out vigorously, as if Ben were angry*), is difficult to understand. Does Ben mean he is no longer thirsty? (*He has stopped drinking even though there is still water in the glass*). That he does not like what is in the glass (*water*)? Or does he want to give Mary back what she gave him? Ben comments on his gesture, saying as he moves his arm "tuc tuc tuc". (*The glass does indeed slide on the wooden table, making a slight noise*). Mary laughs and asks: "What do you want, Ben?" In response, Ben utters a few completely incoherent words. But Mary does not break off the exchange. She turns Ben's gesture into a game: reproducing it, she in turn slides the glass in Ben's direction. Ben catches the glass and slides it back towards Mary. The ping-pong continues for a while, until Mary suggests that Ben drink a little more. In response to her words, Ben immediately pauses to take another sip of water.

At the beginning of this situation, there is a discordance between the professional's (Mary) and resident's (Ben) perspectives. While Mary intends to get Ben to drink, the latter adopts an approach that could completely undermine the achievement of the goal pursued by the nursing assistant. However, the professional does not try to get the resident to change his mind. Indeed, by imitating Ben's behaviour, Mary in fact tries, in collaboration with him, to find a shared definition of the situation. So, instead of correcting Ben's behaviour so that it becomes socially or institutionally appropriate (since, according to social codes, one is not supposed to play with food and drink), she chooses to consider Ben's erratic behaviour as valuable, and to give it an interpretation that refers to a standard and widely shared social form, that of the game, whose structure

is profoundly dialogical. It is reasonable for Mary to assume that Ben has previously mastered the social form of the game, and that he is still capable of recognising it, which is indeed the case since Mary's interpretation is accepted by the resident, and a ping-pong sequence with the glass ensues. This moment of sociability, which is based on the "content" of an act of care aimed at satisfying a primary need (hydration) while radically transforming it, ultimately produces the expected effects. At the end of the sequence, the resident seems more willing to accept the care gesture with which Mary had opened the sequence. He drinks the water that the nursing assistant offers him once again, showing his full understanding of her words.

By initiating a game with Ben, Mary positions herself towards him not as a carer whose job is to help him perform everyday tasks that he cannot do on his own (a social role which has lost its relevance), but as a simple participant in a social relationship. In fact, in the game, Ben and Mary are on an equal footing. What defines them is that they are both human beings who take equal pleasure in participating together in a playful activity that is essential not only to sustaining human life, but also social life. However, selecting only those stimuli in one's environment that support a playful way of interacting, and neglecting those that would lead to hydration, as the resident seems to be doing here, would in fact be inconsistent, since it would amount to acting in a way that threatened one's own life. In contrast, the nursing assistant values two ends, which are correlated in her conduct: playing, the sole end sought by the resident, and drinking water, the end she also seeks. This means that her care consists simultaneously, of on the one hand paying attention to the resident's goals and her efforts to establish a play activity; and on the other, of temporarily endorsing the resident's definition of the situation (having fun rather than drinking water) in order to transform, in and through a moment of "pure sociability", the resident's primary goals.

By making sociability the lever for her care, Mary guides Ben's actions and enables him to voluntarily drink the glass of water she has offered him. In this regard, sociability serves here the goal of autonomy sought by care for people with dementia. Properly relational, the ethics of this care rely on a deeply rooted human capacity that remains even when interactional skills have become weakened. In fact, by interacting with Ben as she would have done with any other person capable of reciprocal action, Mary enabled Ben to participate in the situation as a competent actor and interacting with Mary through play not only allowed Ben to show what he is capable of, but also to reveal what he values, appreciates, and even cherishes, thereby revealing *who he is* as a moral actor.

The Challenges of Sociability for Institutions

Each in its own way, the three situations above reveal the same phenomena: care professionals, even when they are health caregivers, are busy “weaving” relationships and making that “weaving” happen, since it does not just happen; it is work which is so to speak a non-metaphorical, extremely concrete way of creating social relationships. In nursing homes where residents with dementia live, professionals have to be prepared to make an effort – it can be laborious, and it is not always successful – to make it happen. If all the professionals, especially the social workers who play a fundamental role, fail to weave the threads, the weaving does not happen. The impulse will remain, at least for a while, until it gradually fades away due to a lack of contact, but without a direct intervention to make it real, it will never be transformed into sociability. That is where the transition from a *dead* to a *lively* nursing home takes place.

These three scenes are thus interesting for what they show of the work done by professionals to give residents’ “sociability impulses” opportunities to come to fruition. Indeed, when it comes to people with dementia, establishing relationships and maintaining interactions cannot rely solely on their goodwill or their own investment, but are rather the product of professional “arts of doing” (Malbois et al., 2024).

Generally speaking, this work consists above all of keeping residents in continuous exchange circuits, based on reciprocal links. Rather than proposing preconceived activities, professionals work throughout the day to integrate the residents they meet into their activities (such as preparing lunch, cutting up fruit, etc.). What professionals work on and value is the frequency of these interactions, their rhythm, their dynamic, i. e. the multiplication of forms of association or forms of socialisation. It is by encouraging this proliferation of *seemingly* “superficial” exchanges, of hellos, smiles, jokes, or short conversations, that professionals work to enable residents to “continue to live in an inhabited world” (Zaccai-Reyners, 2022, p. 140). In the eyes of professionals, these interactions are far from meaningless, without consequences, or disconnected from care issues. On the contrary, the constant work they are the subject of testifies to the fact that they are seen as constitutive of the residents’ quality of life: recounting witticisms and anecdotes, although often a stopgap and evidence of conversational poverty, can still demonstrate a subtle level of tact in which all the motives of sociability are apparent. The conversation thus remains above all a form of individual intimacy, purely personal, gentle, and without risk.

What is important, then, is that this work is based on a multiplication, superposition, or embedding of roles taken on by professionals such as caregivers, of course, but also partners, friends, confidants, and so on. This ability to

juggle several roles, sometimes over a very short space of time, makes it possible to develop several forms of association, which go beyond conventional caregiver-client interactions, even if basic needs form the backdrop of every care relationship that unfolds in any nursing home. In other words, in this specific institutional context, care consists in bringing back into a sociability register – or, to use Loffeier’s expression (2015, p. 44), into a “domestic register” – what constantly risks slipping into a caregiver-client or an “industrial register”.

That is why chatting or playing, far from being considered unproductive, take a central place in this kind of care work, that values the very act of interacting. It is an art whose sole purpose is enjoyment, as when, around a table, “diners take pleasure in being together, and in staying together, while it lasts: chattering or playing amounts to consuming the pleasure of presence, fostering and sustaining contact with others so as to feel that we are really there with them, and that we share the same apprehension of time” (Vérilhac, 2024, pp. 23–24). The sphere of chatter is characterised by ideas of “non-seriousness” and the pleasure of contact (phatic). This pleasure is most often disconnected from the usefulness of the information exchange; it is a “time for oneself” as opposed to the “constrained time” of care; it is also public or semi-public time, which allows the professionals to collaborate and work as a team, and move away from the dyadic relationship that most of the time structures the care interaction.

For this kind of care to be effective, the social environment is just as important as the material environment. Beyond the cases of breakfast and lunchtime, in all the care work offered in the collective spaces of this nursing home, there is a concern for the simultaneous presence of different professionals and the often expressed desire to increase their presence (or, because resources are limited, that of trainees, volunteers, or ethnographers) in the units. We can see why this “massive” presence is needed: because the work involved in maintaining this sociability, in chatting for instance, is challenging to carry out, it most often involves several professionals. It is their interactions that serve as a focus of attention, or when there is interaction between a professional and a resident, it is thanks to the presence of another professional that this interaction can be energised, nurtured, and completed. While ordinary care activities – such as administering medication or helping with personal grooming – can be dialogical, creating sociability when alone with a resident is demanding work, often too hard to carry out without external assistance. The simultaneous presence of two professionals (or trainees or volunteers) changes the structure of the relationship, which is no longer dialogical but trilogical, with the other professional acting as “support” or “relay”, and when dialogue becomes complicated,

the third person can stand in for the resident who is struggling to keep it going. This third party can also show their complicity with the resident when they take over the dialogue, carrying on the line initiated by the first professional, and recounting something shared with the resident. They can also, through meta-communication and attitude, connote or give meaning to what is happening in the exchange, and thus help the resident know how to behave when they seem to be saying “I don’t understand what is expected of me”. They can take turns ensuring that what is said does not become a monologue and self-feedback.

Of course, this does not work every time: residents may at times be oppositional and attempts at emotional regulation, as well as efforts to meet the resident where they are and to enter their world, may fail. But when they do work, such exchanges have a self-generating dynamic, in the sense that the fact that professionals initiate them, respond to them, or encourage them, motivates residents in turn to engage in and initiate them. They therefore have a public dimension as they are not exchanges which, like certain care times, take place in the privacy of a bedroom. On the contrary, they take place in full view of everyone, everyone being invited, encouraged, or having the opportunity to participate in one way or another. This also means that these “play-form associations” (Simmel, 1949 [1910]) are rarely conducted face-to-face, in a one-to-one relationship, but rather collectively, as a group, with several professionals and one or more residents, thus preserving different roles and different registers of exchange, while fostering the “relay” between professionals to manage the interaction. Finally, the public dimension of the play-form mode of being together is supported, as we have seen with the breakfast scenario, by the sensory properties of the physical environment, which is also the subject of constant work.

Amongst all the “play-form associations” that arise from interactions between residents and professionals, chat appears to be the very embodiment of the “pure sociability” of which Simmel speaks. It produces and takes the form of a virtuous circle, based on roles linked to close, generic, ordinary, shared social relations but which, in nursing homes, are neither obvious nor spontaneous. Getting residents to “socialise” requires professionals to succeed in “‘feeding’ social chatter [...], which explains why socializing is so frequently accompanied by games, rituals to stimulate or revive conversation, that is to say, pretexts to renew the flow of speech and the pleasure of contact” (Vérilhac, 2024, pp. 36–37). This is why achieving a cheerful “chat”, *a fortiori* with people with dementia, requires a particularly consistent effort on the part of professionals, and an ability to respond to each proposal for interaction from residents. Simmel insists on the skills needed for this pure sociability: “the finest sociably told story is that

in which the narrator allows his own person to remain completely in the background” (Simmel, 1949 [1910], p. 260). For his part, Kitwood (1993) compared professionals to

a very resourceful tennis coach, keeping a rally going with a novice (or – an even closer parallel – a deeply discouraged older person); whatever shot is attempted, provided it goes over the net, the coach will create something from it, and make a return that can enable the rally to continue. The coach needs attitudes and skills very different from those required to win a game with a player of the same standard; but this kind of play can be creative, demanding and intensely satisfying. (Kitwood, 1993, p. 59)

This last quotation is interesting in that it shows just how much this work benefits both residents and professionals as it can be at the same time creative, demanding and intensely satisfying. In all cases, this way of being together, in a joyful atmosphere, offers residents and professionals alike the ability to lighten, for a time, the burden of illness or the material reality of work in such institutions (low wages, intense work, etc.). Above all, according to these professionals, it helps to pacify relationships, and responding to a too often compromised need or impulse (Algase et al., 1996) without recourse to drugs facilitates day-to-day care work.

6 Conclusion

As we outlined in the introduction, the nursing literature on communication with people living with dementia tends to conceptualise communication as a *means* to provide care, rather than as an end in itself. In the situations presented here, on the contrary, communication and, more largely, reciprocal action, is not thought of as a “means”, but as an “end”. The relationship has no other end than the relationship itself, or more precisely, it has great value in itself. It is the expression of a particular conception of the needs of the people being cared for: namely, that people, even those with dementia, need many, varied relationships and that it is through relationships that they become and remain human (Lambelet et al., 2026). In Simmel’s language, people have an impulse to sociability, a pleasure in experiencing pure sociability and on that basis, it is important to give substance to this sociability within nursing homes, rather than thinking of relationships in purely instrumental terms.

As Nolan wrote (2004, p.49), if people have needs that institutions must meet – 1) security: to feel safe within relationships; 2) belonging: to feel “part” of things; 3) continuity: to experience links and consistency; 4) purpose: to have

a personally valuable goal or goals; 5) achievement: to make progress towards a desired goal or goals; 6) significance: to feel that “you” matter – those needs can be met in other ways than those typically institutionalised in caregiver-client relationships. For example, and as we have tried to show here, by seeing chatting not as “unproductive dawdling”, but as a resource for generating “pure sociability” and thus fostering the real desire and pleasure of “living together” within the nursing home.

With people living with dementia however, and because communication difficulties are a major result of the progression of neurocognitive impairments, making an institution a place of joyful neighbourliness requires work and social skills geared towards group dynamics and maintaining relationships. These are not specialised skills, but rather ordinary skills that are forged through the various and numerous reciprocal actions that constitute everyday life in society. In the case of the institution in which we have spent time, although very different from the standard professional norms, they are promoted as necessary care skills and without them keeping residents engaged in exchanges and social interactions would be impossible. In this regard, the key role played by social relationships in this nursing home is remarkable. While it is often considered – particularly in the sociology of professions – that the value placed on skills used in everyday interactions runs counter to professionalisation (Lechevalier, 2014, p. 104), it is precisely the value placed on those skills, as part of professionalism, that enables the development of sociability as a tool for care. This means that the assumptions at the heart of social work define the norms of dementia care practised there.

Ultimately, this nursing home is thus emblematic in that it shows that social workers have a key role to play in enabling people with dementia to maintain social ties, that is, to remain fully human. In any case, their work, which sets the tone for all professionals, is recognised as such, that is, as fully part of what counts as care work. Indeed, one type of professional expertise that every professional, from nurses to housekeepers to nursing assistants should possess in such an institutional context is that of nurturing and maintaining often fragile interactions without “interrupting” them, encouraging and directing speech (and all other forms of expression), and producing forms of coherence in exchanges independently of, or rather in spite of, topics of conversation that often, and literally, tip over into the extraordinary.

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Notes

- 1 It is interesting to note that while support for people living with dementia has evolved considerably in recent years – notably thanks to the development of the Montessori approach (Camp, 2010) – the issue of the relational and collective dimensions of life in such nursing homes has remained largely unaddressed. The “implicit anthropology” (Rigaux, 1998) or “social philosophy” (Stimmer, 2020, p. 49–50) that underpin the Montessori approach prioritise the preservation

- of autonomy, the opportunity to participate in activities, and the ability to make choices (Lambelet et al., 2024; Lambelet et al., 2026) and pay little attention to the relationships that each resident should be able to develop, or how people living together in these nursing homes can maintain or develop bonds with each other.
- 2 The purpose of this article is not to discuss Simmel's sociology. We limit ourselves here to drawing on his thinking on sociability to show its value for interpreting the care work carried out by professionals in nursing homes for people with dementia. In other words, we assume that the care relationship, especially when it involves care receivers with neurocognitive impairments, is a concrete social context in which sociability is particularly observable, as in the case of coquetry (when it unites men and women) and conversation, the two major examples given by Simmel. For
- a broader discussion of the place of the notion of sociability in Georg Simmel's work, see David Frisby (2002).
- 3 This nursing home, specialised in psycho-geriatric care, is a private institution recognised as being of public utility. It is subsidised by the authorities of the canton in which it is located and operates under a service contract. At the time of the study, the nursing home accommodated 85 residents, two-thirds of whom, according to current classification systems, fell into the two categories requiring the highest level of daily care (i.e., more than 200 minutes). Among the approximately 85.4 fulltime equivalents (FTEs), 4.5 positions were allocated to social workers and 2 to social care workers (ASE/FaBe). The remaining staff consisted of nursing assistants, registered nurses, housekeeping and administrative personnel, as well as other support staff.

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