

Practical Challenges in Assisting With Mealtimes for People With Dementia

A Qualitative Content Analysis of Caregivers' Experiences

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ABSTRACT

PURPOSE: The current study aimed to explore the practical challenges encountered by family caregivers when assisting community-dwelling people with dementia during mealtime.

METHOD: Using a descriptive qualitative design, 18 family caregivers of people with dementia who experienced feeding difficulties were recruited from the Neurology Outpatient Department and Memory Clinic of the First Affiliated Hospital of Wenzhou Medical University between November 2024 and May 2025. Data were collected through face-to-face semi-structured interviews and analyzed using inductive content analysis.

RESULTS: Data analysis identified four interrelated categories describing the day-to-day practical challenges encountered by caregivers during mealtime assistance: functional decline, problematic eating behaviors, communication breakdown, and resistance to care.

CONCLUSION: Mealtime assistance in dementia care involves multifaceted, practice-level challenges that extend beyond nutritional management. Findings provide an empirically derived framework to guide clinical assessments and inform targeted, skill-based caregiver support.

Dementia is a progressive neurodegenerative syndrome that imposes a growing global health burden (Alzheimer's Association, 2024). As the disease advances, feeding difficulties become increasingly prevalent, affecting approximately 48% of people with dementia (PWD; Ho et al., 2026). Feeding difficulties may manifest in various ways, including reduced self-feeding ability, loss of appetite or overeating, chewing and swallowing impairments, deterioration in table manners, and resistance during eating (Jung et al., 2021; Sharma et al., 2024). Stemming from

intertwined cognitive and functional impairments, these multifaceted difficulties are associated with serious adverse outcomes, such as malnutrition, aspiration pneumonia, and increased mortality (Ciliz et al., 2023). Beyond these physiological consequences, feeding difficulties transform mealtimes from social activities to high-stress caregiving tasks, thereby negatively affecting the quality of life of PWD and their families (Cai et al., 2026).

Given the high prevalence and significant consequences of feeding difficulties, day-to-day management is a criti-

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cal component of dementia care. In China, >80% of PWD reside in community settings, reflecting family caregiving norms, policy emphasis on home-based care, limited formal dementia services, and financial constraints (Xu et al., 2023; Zhou & Chan, 2024). Consequently, family members serve as primary caregivers. Without structured training and professional supervision, family caregivers are often overwhelmed by feeding-related problems at home (Li et al., 2020). Empirical evidence indicates that *aversive feeding behaviors*—behaviors that disrupt or impede oral intake, including food refusal, resistive behaviors during feeding, and dysphagia—are significantly associated with increased caregiver burden (Moreira et al., 2023). Furthermore, malnutrition and inadequate food intake remain persistent sources of distress (Juckett et al., 2024). However, many caregivers rely on experiential “trial-and-error” strategies to address these challenges (Juckett et al., 2024). Therefore, a clearer understanding of the specific practical challenges encountered in home settings is essential to develop context-sensitive support strategies.

Although research on family caregivers’ mealtime care experiences has increased, literature has focused predominantly on psychosocial adaptation, emotional burden, and coping processes rather than practical challenges. For example, in a U.K. study of family caregivers’ experiences in providing nutritional care at home, Mole et al. (2021) highlighted caregiving role transitions, changing family relationships, and the emotional challenges surrounding food provision. Similarly, a qualitative evidence synthesis by Li et al. (2020), largely based on studies conducted in Western countries, identified three key themes: the emergence of new roles and emotional responses in caregivers’ lives (injecting a new element), development of coping strategies to address progressive eating difficulties (moving forward in the challenge), and need for professional and peer support to enhance mealtime care (external support facilitating better coping).

Few studies have systematically examined concrete, task-level challenges embedded in day-to-day mealtime care (Ball et al., 2015; Hsiao et al., 2013; Keller et al., 2006). These studies have primarily described disease-related feeding behaviors and dietary changes that caregivers perceive as major sources of difficulty. For example, an Australian qualitative study (Ball et al., 2015) reported that family caregivers found it highly demanding to manage feeding problems arising from physiological, emotional, cognitive, functional, and behavioral changes. Frequently cited challenges included dysphagia, loss of appetite, forgetfulness, frustration, and aggression (Ball et al., 2015). Although

these studies identify symptom-related difficulties, they primarily emphasize patients’ impairments and give limited attention to how mealtime challenges emerge within caregiver–care recipient interactions. Misinterpretation of nonverbal cues during meals is common, and caregivers often struggle to respond appropriately, further complicating mealtime care (Moreno-Fergusson et al., 2023).

Nevertheless, transferability of these findings to the Chinese home care context remains unclear. Differences in cultural norms, household structures, and meal practices may substantially influence the organization and experience of mealtime assistance in Chinese households. Therefore, the current study aimed to explore the practical challenges family caregivers face in assisting community-dwelling PWD in China. Specifically, it sought to answer the research question: What practical challenges do family caregivers encounter during mealtime assistance, and how do these challenges manifest in daily practice?

METHOD

Study Design

The current study used a qualitative descriptive design based on a naturalistic paradigm to explore the practical challenges encountered by family caregivers in assisting community-dwelling PWD during mealtimes. This approach enabled a straightforward description of experiences and perceptions while remaining close to the data and participants’ accounts (Doyle et al., 2020), making it particularly appropriate for examining the underexplored practical complexities of dementia mealtime care.

Sampling and Recruitment

Purposive sampling was used to recruit family caregivers from the Memory Clinic and Neurology Outpatient Department of the First Affiliated Hospital of Wenzhou Medical University between November 2024 and May 2025. Recruitment occurred through advertisements displayed in clinical waiting areas, notices disseminated via the hospital’s official social media platform, and referrals from outpatient physicians during routine consultations. Caregivers who expressed interest were approached and screened by the first author (S.J.) according to predefined inclusion and exclusion criteria. Eligible participants were unpaid family caregivers aged ≥18 years who had provided daily mealtime assistance to PWD for at least 3 months and were able to communicate verbally in Mandarin or the local dialect. Eligible caregivers who consented to participate were scheduled for home-based interviews.

Data Collection

After obtaining written informed consent, face-to-face semi-structured interviews were conducted in the participants' homes by the first author (S.J.) between November 2024 and May 2025. Interviews were conducted individually in a quiet and private area of the home with only the participant and interviewer present to ensure confidentiality and facilitate open discussion. The interview guide was developed based on the aims of the current study and pilot interviews. Sample questions included: "Could you describe how your family member currently eats during mealtime?," "What kinds of difficulties or challenges have you encountered when assisting with mealtimes?," and "Could you describe how you and your family member usually interact during mealtime assistance?" Probing questions were used to elicit additional details. Interviews lasted 25 to 40 minutes (mean = 33 minutes, $SD = 4.8$ minutes). All interviews were audio recorded and supplemented with field notes. Data collection and analyses were performed simultaneously. Data saturation was reached after 16 interviews, when no new codes or categories emerged, and two additional interviews were conducted to confirm saturation. Eighteen caregivers participated in the current study.

Data Analysis

Data were analyzed using inductive content analysis, as described by Graneheim and Lundman (2004). This approach is particularly valuable because it allows categories to emerge from participants' reports, rather than shaped by preconceived categories or existing theoretical frameworks. NVivo software (Version 15) was used for data management. Interviews were transcribed verbatim and checked for accuracy against the audio recordings. Transcripts were read repeatedly to ensure data immersion. Meaning units related to the aims of the study were identified and condensed. Condensed meaning units were abstracted and labeled using codes, which were compared based on similarities and differences and grouped into subcategories. Subcategories were further abstracted into broader categories representing the manifested content of caregivers' experiences. The first author (S.J.) and another member of the research team, who had received formal training in qualitative research, independently conducted the coding and categorization. Any discrepancies in coding or categorization were resolved through iterative discussions within the research team until a consensus was reached. Data collection and analysis were concurrently performed, allowing emerging insights to inform subse-

quent interviews. To enhance credibility, preliminary findings were shared with a subset of participants, who indicated that their interpretations were consistent with their experiences.

Rigor

To ensure trustworthiness, the current study adhered to the criteria of credibility, dependability, confirmability, and transferability proposed by Lincoln and Guba (1985). Credibility was enhanced through purposive sampling for variation, concurrent data collection and analysis, independent coding by two researchers (S.J. and another), and member checking with a subset of participants. Dependability was supported by systematic analytical processes and documented team discussions. Confirmability was strengthened through investigator triangulation and consensus meetings. Transferability was facilitated by providing detailed descriptions of the study context and participants.

Ethical Consideration

The current study was approved by the Ethics Committee of Wenzhou Medical University (No. 2024037). Prior to the interviews, all participants were informed of the purpose of the study and provided written informed consent, including permission for audio recordings, and were assured of data confidentiality and the right to withdraw at any time.

FINDINGS

Caregivers were predominantly older, married women with relatively low educational level and income, who provided extended daily care and typically co-resided with care recipients, primarily older adults with Alzheimer's disease (**Table 1**). Data analysis identified four interrelated categories describing the day-to-day practical challenges encountered by caregivers during mealtime assistance: functional decline, problematic eating behaviors, communication breakdown, and resistance to care (**Table 2**).

Functional Decline

Functional decline was described as a multifaceted challenge during mealtime assistance that affected several basic functions necessary for eating. Caregivers reported difficulties in meal initiation, bringing food to the mouth, chewing, swallowing, maintaining attention, and sustaining an upright seated position during meals.

Several participants reported that initiating the feeding tasks was exceptionally challenging. Caregivers described recipients as unsure when to begin eating, whereas others

TABLE 1 Characteristics of Family Caregivers and People With Dementia (N = 18)	
Characteristics	n (%)
Caregivers	
Sex	
Female	10 (55.6)
Male	8 (44.4)
Marital status	
Married	14 (77.8)
Single	2 (11.1)
Divorced	1 (5.6)
Widowed	1 (5.6)
Educational level	
Bachelor's degree or college diploma	6 (33.3)
High school	2 (11.1)
Junior high school or lower	10 (55.6)
Work status	
Retired	12 (66.7)
Full-time	6 (33.3)
Income per month (yuan)	
<3,000	2 (11.1)
3,000 to 6,000	9 (50)
>6,000	7 (38.9)
Hours of care provided per day	
<8	8 (44.4)
8 to 16	1 (5.6)
>16	9 (50)
Living with patient	
Yes	15 (83.3)
No	3 (16.7)
Relationship with patient	
Spouse	10 (55.6)
Daughter	5 (27.8)
Son	2 (11.1)
Sister	1 (5.6)

noted difficulty in recognizing food, resulting in ignoring meals or holding food without eating:

When you tell her to go eat some foods, she just doesn't know. She won't go get the foods, or she picks foods up and holds in her hand... I see her just holding the foods, but she won't think to eat them. (P07)

Many caregivers described difficulties in assisting care recipients in bringing food into their mouths. Caregivers

TABLE 1 (CONTINUED) Characteristics of Family Caregivers and People With Dementia (N = 18)	
Characteristics	n (%)
Care Recipients	
Sex	
Female	14 (77.8)
Male	4 (22.2)
Disease type	
Alzheimer's dementia	13 (72.2)
Vascular dementia	2 (11.1)
Frontotemporal dementia	1 (5.6)
Dementia with Lewy bodies	1 (5.6)
Unclear	1 (5.6)
Duration of illness (years)	
<5	3 (16.7)
5 to 9	6 (33.3)
10 to 14	7 (38.9)
≥15	2 (11.1)
	Mean (SD) (Range)
Age of family caregivers (years)	63.66 (17.02) (32 to 84)
Age of people with dementia (years)	72.89 (9.17) (53 to 85)

noted that care recipients had trouble using the utensils properly and often failed to transfer food from plates to their mouths. Some mentioned that care recipients either refused to open their mouths or opened them insufficiently to prevent food from entering. Spillage from the corners was common, even when food was placed in the mouth:

When eating, oh, with chopsticks, two chopsticks, one end and the other end, that end facing up, the thinner one makes it easier to pick up food. He always does it like this, backwards. I tell him you need to turn them around; this end should face up. (P08)

He absolutely has to have warm water. He won't accept cold water—if it's cold, he just keeps his mouth shut tight and there's no way to get him to drink it. (P01)

Several participants reported chewing-related challenges and described care recipients as chewing insufficiently or not at all. A small number of participants also noted that food was retained in the mouth after minimal chewing:

It's mainly swallowing. She can't bite things down and has no chewing ability. (P02)

TABLE 2
Categories and Codes of Mealtime Assistance Challenges (N = 18)

Main Categories	Codes
Functional decline	
Difficulty with meal initiation	Unsure when to begin eating; ignores or fails to recognize food
Impaired ability to transport food to mouth	Inability to use utensils correctly; difficulty transporting food to mouth; not opening mouth or opening too small; oral leakage/spillage
Disruption of chewing process	Holding food in mouth; inefficient mastication; swallowing without chewing
Impaired swallowing and safety risks	Failure to initiate swallow; difficulty swallowing solids/liquids; choking, coughing, or aspiration
Inability to maintain attention to feeding task	Mealtime drowsiness; playing with food or non-food items; wanders away from table during a meal
Difficulty maintaining posture	Inability to maintain a seated, upright position
Problematic eating behaviors	
Appetite dysregulation	Hyperphagia (excessive appetite); hypophagia (poor appetite)
Eating pace dysregulation	Eating too fast; eating too slow
Aberrant food preferences	Craving sweet foods; mixing inappropriate foods together; does not consume a variety of food and eats one type of food
Unsightly eating behaviors	Using hands to grab food; spilling food and liquids; spitting out food debris onto surfaces
Disruptive eating-related behaviors	Pica (eating non-food items); hoarding or hiding food
Resistance to care	
Verbal resistance	Refusing to go to dining room; verbal refusal to eat; verbal refusal of assistance; verbal aggression toward caregiver
Behavioral resistance	Turning head or body away; pushing food or utensils away; refusing to open mouth/clenching teeth; spitting out food; biting utensils; agitation during meals (yelling, throwing plates); negative behavior toward caregiver
Communication breakdown	
Receptive communication deficits	Impaired comprehension of verbal cues; impaired comprehension of gestural cues
Expressive communication deficits	Inability to express needs clearly; lack of initiative to express needs

He eats quite slowly now, and his attention is not very focused. He takes a bite and then stops, holding the food in his mouth. (P09)

Swallowing difficulties were also described and associated with safety concerns. Few caregivers described care recipients as having difficulty in initiating swallowing, whereas others noted challenges in swallowing solids or liquids. Risks of choking, coughing, and aspiration were also frequently noted:

When drinking that sugar water, I tell him to swallow, swallow, but he won't swallow it down. He keeps it in his mouth, holding it in his mouth. (P09)

As for choking, occasionally it happens once during lunch or dinner. He occasionally chokes once in a while. (P07)

Caregivers reported challenges in maintaining care re-

cipients' attention during meals, describing care recipients as inattentive or drowsy, whereas others noted behaviors, such as playing with food or nonedible objects and wandering away from the table:

Her attention wasn't really focused on eating. She would look around here and there, take a bite of food and then stop chewing. (P09)

She gets up before finishing her meal and just walks back and forth in the living room. (P01)

Some participants reported difficulties assisting care recipients in maintaining an upright seated position during meals, which sometimes required physical support:

When it's time to eat, it's really hard for him to sit down on the chair by himself. Even after he gets on, he'll lean to one side. (P9)

Problematic Eating Behaviors

Participants described various problematic eating behaviors that increased the complexity of mealtime assistance, including appetite dysregulation, changes in eating pace, altered food preferences, unsightly eating behaviors, and other disruptive eating behaviors.

Several caregivers described changes in appetite of care recipients, with some exhibiting an increased desire for food and others showing reduced appetite or aversion to food, often losing interest in previously favored foods:

You put food there, and he just eats, he eats very forcefully, eating until he throws up. (P04)

Eating is the most difficult part. I think it's probably related to her emotions, and also her appetite. As she gets older, her digestive function has declined, and she doesn't exercise, so sometimes she just has no appetite for food. (P13)

Caregivers reported rapid eating by care recipients, which raised concerns about safety, whereas others described markedly slow eating, which significantly prolonged mealtimes:

The whole eating process is much slower than before, before it took about 7 or 8 minutes, around 10 minutes at most, and she would be finished eating. Now she eats very slowly. (P06)

Yes, she eats bread very fast. I'm afraid she'll choke to death. I'm so worried about this, it happens often like this. Hot things, sometimes she doesn't even know they're hot, she just puts the hot food right in her mouth. (P14)

Several participants also noted changes in food preferences of care recipients, including strong preference for sweet or specific foods, mixing foods in unusual ways, and restricting intake to a limited range of foods:

Things she didn't like to eat before, after she got sick, she would want to eat them. We know she doesn't eat certain dishes, so we didn't serve them to her, but she would actively reach for them herself. We all found it curious, why does she want to eat this now? And after eating it, she would say "These taste good." Then there are things she used to like eating, but now she says they don't taste good and doesn't want to eat them. So, it's like some things are reversed now. (P07)

Unsightly eating behavior challenges during mealtime were also frequently described. Caregivers described care recipients as grabbing food with their hands, snatching available food, or spitting food debris onto the floor:

Now he just eats things with shells and then spits them out randomly. He might spit on the table, or directly on the floor. (P06)

In addition, a small number of caregivers reported that care recipients engaged in abnormal eating behaviors, such

as attempting to eat non-food items or hoarding food:

Last time he even put his hearing aid in his mouth to eat it, bit it to pieces. The hearing aid cost several thousand yuan and was just bought. He doesn't know. He eats anything. When he feels itchy or wants something, he just puts it in his mouth to eat. (P16)

Whatever food you give him, he hides it away. Give him crackers, he hides them. Give him candy, he hides that, too. (P01)

Communication Breakdown

Many participants reported that communication barriers made it difficult to provide mealtime assistance. Caregivers described difficulties in care recipients' understanding of verbal or gestural cues that often resulted in delayed or absent responses:

When the meal is ready, I call her to come eat. She just sits there on the sofa, doesn't move at all, like she didn't even hear me. (P11)

When eating noodles, I tell him to eat the noodles first or it will get soggy. He just ignores me completely and only eats the vegetables. (P05)

Expressive communication challenges were among the most reported issues. Many caregivers reported difficulties in interpreting care recipients' needs. Some recipients were described as having difficulty expressing hunger, fullness, or discomfort, whereas others showed little initiative in communicating their needs:

When she's eating, she mumbles and mutters under her breath, and you have no idea what she means. Sometimes if you don't pay attention to her, she'll get angry. (P13)

He can't feel hunger. Actually, I don't think he gets hungry either. He should be hungry in the morning, but he doesn't call out or say anything. This morning, he ate at a little after 8 o'clock. (P05)

Resistance to Care

Many participants reported verbal resistance during mealtime assistance. Caregivers described a refusal to go to the dining area, rejection of food or assistance, and verbal aggression directed toward them:

The most devastating thing is that she just won't eat, won't cooperate, then she scolds you, throws the bowls and chopsticks on the ground, and keeps cursing. She won't eat, and she gets very angry. (P02)

Behavioral resistance was also reported. Caregivers described care recipients as turning away from the food, leaving the dining area, or pushing food and utensils away. Some refused to open their mouths or bit down on food or utensils, which made feeding difficult. Caregivers also reported instances of shouting or throwing plates and

utensils, with some cases involving aggressive behaviors directed at them, adding significant stress:

Sometimes when you feed her, just like when giving her medicine earlier, if she doesn't want to eat, she just pushes it out with her tongue, spits it out. And sometimes she won't even open her mouth, and uses her hand to push yours away, saying "I don't want it anymore." (P14)

Every day is like this. You hand it over and she won't eat; you hand it over and it doesn't work. You hand it over five or six times, and she still won't open her mouth. Can you imagine how exhausting it is when she only opens her mouth on the sixth try? It takes a very long time to finish one bowl of rice. (P17)

DISCUSSION

The current study explored the practical challenges encountered by family caregivers when assisting PWD during mealtime. Findings demonstrate that mealtime care is a multifaceted and cognitively demanding process shaped by functional decline, behavioral disturbances, communication impairment, and resistance to care. These difficulties require sustained vigilance, adaptive problem-solving, and emotional regulation, often resulting in prolonged meal-times and increased caregiver strain. Such challenges may compromise nutritional outcomes of care recipients and their overall caregiving experience (Sharma et al., 2024).

Foundational functional impairments emerged as a central challenge. Caregivers in the current study reported difficulties during mealtime, including meal initiation, food transport, mastication, swallowing, postural stability, and sustained attention. These impairments often co-occurred, requiring caregivers to manage multiple vulnerabilities simultaneously, as noted by Sharma et al. (2024). A progressive decline in executive and motor functions often means that care recipients require varying levels of support, ranging from verbal prompts and close supervision to partial or full physical assistance (Li et al., 2020; Sharma et al., 2024). Similarly, prior research has shown that caregivers may need to adapt utensils and food texture, provide ongoing reminders, and, at times, directly assist with feeding or guiding utensils to the mouth (Li et al., 2020). Mealtime was not a bounded task of food provision but a demanding and continuously negotiated caregiving practice.

Within this broad pattern of functional decline, swallowing impairment (dysphagia) was a particularly salient source of technical and safety complexities. Participants described the need for close attention and reported occasional choking episodes, underscoring the safety-sensitive

nature of dysphagia management. Dysphagia is associated with malnutrition, aspiration pneumonia, and an increased mortality risk (Chan et al., 2024). Effective management requires modifications to feeding techniques, body positioning, and food texture and consistency (Nakao-Kato & Rathore, 2023). However, family caregivers often assume responsibility for this complex task without adequate ability to recognize swallowing difficulties or adequate knowledge and skills in dysphagia management (Zhu et al., 2025). Managing dysphagia increases the time devoted to meal preparation and heightens concerns about nutrition, hydration, and choking risks (Cheng et al., 2023). In home settings, swallowing impairment extends beyond physiological deficits and becomes a practice-based challenge that demands sustained attention and ongoing judgment.

Problematic eating behaviors complicate mealtime care by disrupting established routines and increasing supervisory demands. Consistent with previous research documenting appetite changes and altered food preferences among PWD (Ahmed et al., 2021; Le et al., 2024), our findings show reduced appetite, selective eating, or abrupt preference make it difficult for caregivers to maintain nutritional adequacy. Caregivers are often required to closely monitor food intake and adjust meal preparation, balancing individual preferences with concerns about safety and nutritional sufficiency (Walters, 2023). Conversely, hyperphagia has been reported across different stages of dementia, with a prevalence of 18.6%, and is characterized by behaviors such as repeated requests for food, persistent reports of hunger, food stealing, continuous eating, rapid eating, swallowing without chewing, and overfilling the mouth with food (Shea et al., 2018). Repetitive food requests sometimes reflect memory impairment, whereas in frontotemporal dementia, excessive eating can manifest as compulsive overeating. Such behaviors introduce the risks of weight gain, metabolic complications, and choking, shifting caregivers from providers of assistance to regulators of dietary intake.

In communal dining settings, which are common in Chinese households, behaviors such as grabbing food from shared dishes or smearing food residues onto tables or surrounding surfaces may have social and hygienic implications. Caregivers face a culturally mediated dilemma; separating the individual may be perceived as exclusionary, whereas inclusion may disrupt family harmony. These dynamics suggest hygiene management may involve sociocultural considerations embedded within family dining practices.

More severe behaviors, such as pica (i.e., eating non-food items) and food hoarding, complicated mealtime

care. Cognitive impairment, agnosia, and changes in taste and smell may contribute to pica, whereas food hoarding is associated with patients' social and family backgrounds and current life circumstances (Wang et al., 2012). Caregivers in the current study emphasized the need for intensive supervision to prevent injury or contamination. Sustaining this level of supervision was described as demanding in home environments. Collectively, these behaviors extend mealtime care beyond nutritional provision to include behavioral regulation and preventive management.

Communication deficits introduced additional challenges by disrupting the interactive nature of mealtime care. Mealtime assistance is inherently relational, requiring a shared understanding between caregiver and care recipient. As communication ability declines, coordination becomes increasingly fragile. Caregivers in the current study reported that recipients often had difficulty understanding instructions and were unable to express their needs, thereby hindering the delivery of care. These findings align with prior work that identified communication breakdown as a major caregiving stressor (Volkmer et al., 2024). However, the current study uniquely highlighted its specific effect on mealtime interactions, in which effective communication is critical for ensuring safety and adequate nutritional intake. As dementia advances, progressive language impairments—ranging from word-finding difficulties and poor comprehension to severely reduced speech or global aphasia—prolong the time required for mealtime care and exacerbate caregiver stress and burden (Dhanda & Scaria, 2025). Notably, such communication problems may also trigger resistive behaviors, further complicating the management of mealtime care (Backhouse et al., 2026).

Resistance during mealtime represents a distinct interactional challenge that alters the structure and tone of feeding encounters. In the current study, resistance was described in two primary forms: verbal and behavioral. Findings are consistent with those of previous studies documenting resistance to care among PWD (Backhouse et al., 2023; Partel Araujo et al., 2025). In an analysis of care plans involving 553 nursing home residents with dementia, resistance to care was recorded in 44.9% of residents (Sefcik et al., 2020). Emergence of resistive behaviors may require feeding routines to be re-sequenced or delayed, disrupting the temporal flow of meals and substantially contributing to caregiver burden (Spigelmyer et al., 2021; Villar et al., 2022). The Need-Driven Dementia-Compromised Behavior model provides a useful theoretical framework for understanding such resistance, suggesting that these behaviors may arise in response to unmet needs (Algase et al., 1996).

Understanding resistance in this manner highlights why management can be inherently complex. Strategies proposed to address resistive behaviors during feeding include reinforcement and prompting techniques, modification of feeding routines, adjustments in food preparation and presentation, behavioral interventions, environmental modifications, and person-centered approaches (Villar et al., 2022). However, translating these principles into practice may be challenging in home settings, particularly when access to structured training or professional guidance is limited (Pritchard & Denning, 2022). Family caregivers frequently experience difficulty in consistently responding to resistive behaviors (Konno et al., 2014). When resistance persists, caregivers may continue the feeding task despite opposition or temporarily suspend the activity (Zhang et al., 2024). Rather than representing isolated behavioral symptoms, resistive behaviors reshape the relational dynamics of feeding and substantially increase the complexity and time demands of care provision.

LIMITATIONS

The current study has limitations. Although data saturation was achieved, the relatively homogeneous sample recruited from a single clinical setting may limit the transferability of findings to other caregiving contexts. In addition, potential for participant bias, such as social desirability bias, may have influenced the responses, as participants may have provided answers that they believed were expected. Furthermore, underrepresentation of caregivers supporting care recipients who are confined to bed or those with advanced severe dementia limited the exploration of challenges specific to more intensive care contexts.

IMPLICATIONS

Structured support systems addressing practical mealtime challenges should be strengthened for community dementia care. At the clinical level, caregiver education and training programs should prioritize task-level competencies, including managing functional decline, responding to problematic eating behaviors, navigating communication breakdowns, and addressing resistance during feeding. Emphasis should be placed on safe feeding, dysphagia management, and practical techniques for responding to resistance during meals. At the service level, expansion of community-based support, including in-home mealtime assistance and accessible respite services, may facilitate the translation of evidence-based strategies into daily practice. Encouraging shared family responsibilities may enhance the sustainability of home-based care. Such integrated sup-

port may improve caregivers' practical competence and reduce the complexity of mealtime assistance.

CONCLUSION

Mealtime assistance for PWD in home settings is a complex and practice-intensive caregiving task. Four inter-related domains—functional decline, problematic eating behaviors, communication breakdowns, and resistance to care—collectively reshape the organization of feeding assistance. In addition to nutrition provision, mealtime care involves continuous monitoring, interactional coordination, and risk management. Recognizing these embedded practical demands is essential for informing caregiver assessments and developing context-sensitive support strategies for community dementia care.

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