Social Support, Caregiver Burden, and Life Satisfaction in a Sample of Rural African American and White Caregivers of Older Persons With Dementia

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This article reports the findings of a study of African American and White dementia caregivers (n = 141) living in rural areas of Alabama that examined the relations between the participants’ receipt of informal social support, and their levels of caregiver burden and life satisfaction. The sample, as a whole, reported high levels of social support with no reported differences in social support by race. Female caregivers reported higher mean scores on 3 of the 4 dimensions of social support than their male counterparts. Two of the 4 dimensions of social support accounted for 32% of the variance of the caregivers’ reported level of life satisfaction.

KEYWORDS Caregivers, dementia, rural, social support, caregiver burden, life satisfaction
INTRODUCTION

Data for this article come from a larger study, funded by the Agency for Health Care Research and Quality, the purpose of which was to examine the experiences of African American and White family caregivers of older persons with dementia who live in rural communities. In this article, we were interested in learning whether there were relations between informal social support, caregiver burden, and life satisfaction for study participants.

Social Support and Caregiving

Theorists and researchers generally agree that informal social support, as a construct and a process, is multidimensional. Conceptual definitions of informal social support often fall short of adequately capturing the nature, quality, or range of behaviors and activities that have been associated with this construct. Researchers identify several dimensions that should be considered when assessing or measuring informal social support. These dimensions include the structural characteristics of the informal social networks from which social support emanates, the types of supportive activities or behaviors exchanged by network members, and the informal social network members' subjective evaluations of the supportive behaviors and relations that occur between network members (Barrera, 1986; Krause, 2001; Lakey & Cohen, 2000; Streeter & Franklin, 1992; Vaux, 1988).

It is important to note a distinction between formally and informally provided social support. Formal social support is defined here as assistance provided by paid helpers or volunteers who are affiliated with social or health service agencies. Informal support, which is the focus of this article, is defined as assistance provided by family members or friends based upon feelings of affection or personal obligation toward the recipient(s) of the assistance. Informal social support activities may take many forms such as concrete assistance with personal or household tasks, the provision of monetary assistance or other resources, advice or guidance, companionship, and the provision of emotional encouragement. Throughout the remainder of this article, where we use the term social support, we are referring to the types of social support exchanged by members of informal social networks.

Social support has been found to influence a variety of complex human behaviors and the way people perform their social roles. Epidemiological studies have found links between some individuals' health conditions and emotional states, and the nature or degree of their received social support (Cohen & Syme, 1985). Much research interest has focused on the potential beneficial effect that social support may have for persons who experience stress. Two theoretical hypotheses have been proposed to explain the relations between stress and social support (Cohen & Wills, 1985). The direct effect hypothesis states that social support has a beneficial effect on
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peoples’ health and well-being, regardless of how much stress they may be experiencing. The stress-buffer hypothesis states that social support acts to protect people from the potentially harmful effects of stressful situations or stressful life events.

Social support is a familiar construct to most gerontological social work practitioners and researchers. An increasing level of gerontological research is being focused on gaining a better understanding of social support as a dynamic process that has important potential outcomes for older persons and members of their informal social networks. There is mounting research evidence that the health, well-being, and life satisfaction of older persons may be positively impacted by the structure of their informal social networks, as well as the nature of the supportive activities of those networks (Bishop, Martin, & Poon, 2006; Levitt, Antonucci, Clark, Rotton, & Finley, 1985; Litwin & Shiovitz-Ezra, 2006; Pinquart & Sorensen, 2000; Yang, 2006).

Social work practitioners have a long history of working with the informal social networks of older clients. The rapid growth of the aging population, especially that segment with chronic health problems and functional limitations, has created an increasing imperative for social work practitioners to be knowledgeable about the circumstances and needs of family caregivers of older persons, and the variety of services and interventions that can assist those caregivers to effectively manage the stresses and burdens associated with their provision of care (Berkman, Gardner, Zodikoff, & Harootyan, 2005; Family Caregiver Alliance, 2006). The potential importance of social support to the well-being of those family members and friends who provide care to older persons, and their ability to continue providing for the needs of their elderly care recipients, is gaining increasing attention from researchers (Drentea, Clay, Roth, & Mittelman, 2006; Roth, Mittelman, Clay, Madan, & Haley, 2005; Stewart, Barnfather, Neufeld, Warren, Letourneau, & Liu, 2006). Those family members who provide care to older persons with Alzheimer’s disease or other forms of dementia are a subgroup of caregivers who may face particularly difficult caregiving challenges. Persons with moderate to severe levels of dementia often need extensive help with most of the basic and instrumental activities of daily living, and family members who provide care to this population have reported high levels of caregiver burden and stress (Navaie-Waliser, Feldman, Gould, Levine, Kuerbis, & Donelan, 2002; Schulz et al., 2003; Yee & Schultz, 2000).

ETHNICITY, SOCIAL SUPPORT, AND CAREGIVING

Studies that have examined ethnic and racial differences in caregiving outcomes have had mixed findings. Janevic and Connell (2001) found that White caregivers reported greater depression and appraised caregiving as
more stressful than ethnic minority caregivers. Pinquart and Sorensen (2005) found that African American caregivers had lower levels of burden and depression than White caregivers, and that members of ethnic minority groups provided more care than did Whites. Lawton, Rajagopal, Brody, and Kleban (1992) report finding lower levels of caregiving burden for African Americans compared to White caregivers, as well as more favorable scores on caregiving ideology and caregiving satisfaction. African American caregivers appraise caregiving as less stressful, and report greater caregiving mastery, self-efficacy, and satisfaction (Haley, Wadley, West, & Vetzel, 1994). From their analysis of data from the Resources for Enhancing Alzheimer’s Caregiver Health Project (REACH), Roff et al. (2004) found that African American caregivers report more benefits from caregiving than do Whites, greater satisfaction in caregiving roles, and perceive less subjective burden and intrusion on their lives as a result of their caregiving activities. Covinsky, et al. (2003), in their study of depression among primary caregivers of patients with moderate to advanced dementia, found that African American caregivers, when compared to the Hispanic and White caregivers, had the lowest rates of depression.

Other studies have found that although African American caregivers of dementia relatives appear to receive more instrumental support from family and friends than White caregivers, they report greater negative consequences of caregiving for their physical health than do White caregivers (Haley, et al., 1996). Wallsten (2000) suggested that this might result from the fact that African Americans are in poorer health, and that they may not necessarily have more social supports than their White counterparts.

In their 20-year review of caregiving studies, Dilworth-Anderson, Williams, and Gibson (2002) found that the informal social support systems of African American caregivers were more diverse than those of White caregivers, and that ethnic minority caregivers used fewer formal services than their White counterparts. In their survey of the literature, Janevic and Connell (2001) reported mixed findings with regard to size of support systems between African American and White caregivers.

Cantor (1983) has suggested that the homogenization of key social or demographic caregiving variables might obscure important issues in the caregiving experience, and—as examples—referred to type of relationship, gender, age, health, and work status. Agreeing with Cantor, Dwyer and Miller (1990) added the need to control for area of residence of caregivers. In explaining reasons for variations in research findings on differences in the caregiving experiences between White and African American caregivers, Haley et al. (2004) suggested that such findings may be due to differences in recruitment strategies, inclusion/exclusion criteria, and regional locations of studies, rather than to actual differences between White and African American caregivers. Janevic and Connell (2001) mentioned variations in research instruments, measurements, and samples in explaining variations
in findings on racial differences, and emphasize the need for using mixed qualitative and quantitative methodologies.

DEMENTIA IN RURAL COMMUNITIES

Most studies of dementia care providers have been limited to urban dwelling, White, affluent, service-utilizing caregivers, and have not examined the subject of diversity with regard to the dementia caregiver population in rural areas (Barker, Morrow, & Mittness, 1998; Connell & Gibson, 1997). The 2000 US Census (Administration on Aging, 2003) indicated that 22.6% of older persons live in nonmetropolitan areas of the country. With younger people leaving rural areas to pursue education and employment, the proportion of older persons living in rural communities is growing (Administration on Aging, 2003). It has been estimated that of those older persons who are most at risk for developing dementia, 25% live in rural areas of the country, and the number of older people with dementia in such communities will likely increase in the future (Keefover, Rankin, Keyl, Well, Martin, & Shaw, 1996; Vissing, Salloway, & Siress, 1994).

Cuellar and Butts (1999) questioned the often-held assumption that older persons who live in rural communities enjoy a better quality of life than their urban counterparts. These researchers have suggested that the reality of living in many rural communities is often a stark contrast to many persons’ romanticized vision of a rural lifestyle as being tranquil, stress free, and harmonious. Many older persons who live in rural communities are challenged by economic deprivation, inadequate housing and transportation, limited access to health professionals and community-based programs, and may not receive adequate care for physical or mental health problems. Bull (1998) discussed barriers to the provision of human services in rural areas related to problems associated with geographic isolation, economic deprivation, and poor human infrastructure. Buckwalter, Russell, and Hall (1994) indicated that most rural areas lack a diversified health and mental health system, and few have services for persons with dementia. Older rural-dwelling persons may also experience a loss of informal social network support due to the out migration of family members from their rural communities.

Thus, the focus of this article is on a somewhat invisible and understudied population of dementia caregivers: those living in rural areas. The data for this article come from a larger study of African American and White family caregivers of older persons with dementia who live in rural communities of Alabama. The study was guided by the well-known caregiving and stress model developed by Pearlin, Mullan, Semple, and Skaff (1990) that posits relations between caregiving stressors, stress mediators, and caregiving outcomes. The authors of this model suggested that caregivers’ receipt of instrumental and expressive social support has the potential to mediate
those caregiving stressors that can negatively impact the health and emotional well-being of family caregivers and, ultimately, adversely affect the quality of care received by care recipients.

METHODS

Design

The study used a cross-sectional survey design. Data were gathered from 141 rural-dwelling dementia caregivers (52% White, 48% African American) through structured telephone interviews conducted by highly trained interviewers from the University of Alabama’s Institute for Social Science Research. Interviews took between 60 and 90 min to complete. Participants were provided $50 gift certificates for participating in the study. The sample was selected using a computer-facilitated random digit dialing technique that drew on telephone numbers from non-Metropolitan Statistical Area counties in Alabama. Forty-five of Alabama’s 67 counties are located in non-Metropolitan Statistical Areas and, thus, are considered rural. The final sample of participants chosen for the study came from 39 of the 45 rural counties in the state. Based on the probability sampling methods used for this study, we think that the sample has high external validity and is likely to be representative of the state’s population of rural-dwelling family caregivers of persons with dementia.

Participants

To be eligible for inclusion in the study, family caregivers and their dementia care recipients must have either lived together in a rural community-based, noninstitutional setting or must have lived within commuting distance of each other. The eligible caregiver’s care recipient had to be 60 years of age or older and had to show evidence of at least a mild level of dementia. All survey respondents were self-described primary family caregivers who provided at least 10 hr a week of face-to-face assistance to meet the physical and/or emotional care needs of the care recipients. All respondents had to be cognitively intact, have access to a telephone, and be conversant in English.

Measures

Demographics. Data were obtained for the following caregiver demographic characteristics: age, gender, race, education, marital status, family composition, household monthly income, and employment status. Data were obtained for the following care recipient demographic characteristics: age, gender, race, marital status, residential situation, and relationship to caregiver.
**Caregiver cognitive competence.** The cognitive competence of potential caregiver study participants was assessed through the use of the Short Portable Mental Status Questionnaire (SPMSQ) developed by Pfeiffer (1975). The SPMSQ is a 10-item instrument used to assess cognitive deficits in adults. Individuals who had less than three incorrect responses to the ten items were considered eligible for participation in the study.

**Patient severity of dementia.** We used a revised version of the Dementia Severity Rating Scale (DSRS; Clark & Ewbank, 1996) to measure the care recipient’s level of dementia. This informant-based (caregiver) 11-item instrument employs a multiple-choice response format to obtain an assessment of the severity of an individual’s dementia based upon the following dimensions: orientation, memory, judgment, recognition, language, social interaction, home activities/responsibilities, personal care, incontinence, mobility, and eating. The DSRS was used as a screen to initially identify family members who are providing care to older persons who exhibit symptoms of dementia. Scores over 7 on the DSRS are usually indicative of some level of dementia. Accordingly, we established DSRS scores of 8 or more, as reported by the caregiver, as an entry criterion for inclusion in the study.

**Informal social support.** To measure the level of the caregivers’ informal social support, we used the Interpersonal Support Evaluation List (ISEL), a widely used, theory-based, psychometrically sound instrument developed by Cohen, Merzelstein, Kamarck, and Hoberman (1985). The ISEL is composed of four scales that measure subjects’ perception of the availability of the following domains of informal social support: (a) tangible material assistance, (b) someone to discuss problems with, (c) positive regard and self-esteem from others, and (d) others with whom to “do things with.”

**Caregiver burden.** We used the Consequences of Care Index (CCI; Kosberg & Cairl, 1986) to measure caregiver burden. This widely used 20-item instrument provides measures of subjective caregiver burden in five domain areas: (a) personal and social restrictions, (b) physical and emotional problems, (c) economic costs, (d) value investment in caregiving, and (e) perception of the care recipient as a provocateur. The CCI has been shown to be a valid and reliable instrument (Kosberg, Cairl, & Keller, 1990).

**Life satisfaction.** To measure life satisfaction, we used the 16 item Quality of Life Inventory (QOLI; Frisch, 1992); a measure of an individual’s subjective well-being. According to the model upon which this instrument is based, the objective factors that influence an individual’s life satisfaction are mediated by the importance or value attached to them by the individual. The reported test–retest reliability of the QOLI was .73 and the reported coefficient alpha was .79. The QOLI obtains data regarding respondents’ degree of life satisfaction in the following domain areas: health; self-regard; philosophy of life; standard of living; work; recreation; learning; creativity; helping; love relationships; friendships; relationships with children; and relationships with relatives, home, neighborhood, and community.
Analysis

All statistical analyses were conducted using SPSS version 15.0. An alpha level of .05 was used for determining statistical significance.

Categorical demographic differences between Whites and African Americans and between men and women were tested for statistical significance using chi-square tests. Group differences for the continuous variable age were tested for significance with a two independent sample t-test because normality requirements were met. The Mann-Whitney, a nonparametric test, was used to test the significance of group differences for the variable caregiving hours, because those data were markedly skewed.

Mann-Whitney tests were used to test for group differences on the ISEL scales because of nonnormality. Relations between each of the ISEL scales and the QOLI were tested for statistical significance with both Pearson and Spearman nonparametric correlations because of a concern for nonnormality. A stepwise linear regression analysis was conducted to determine the joint effects of the ISEL scales on QOLI. Residual analyses determined that normality requirements were met.

FINDINGS

The study sample contained 141 rural dwelling family caregivers of older persons with dementia. Categorical demographic data for the total sample and for White and African American respondents are presented in Table 1. For the total sample, 52% (n = 74) were White and 48% (n = 67) were African American. Women comprised 85% (n = 120) of the total sample. Most participants (60%, n = 85) were married, and most (61%, n = 86) were not employed outside of the home. The largest subgroup of caregivers in the sample were adult children (59%); 10% of the sample were spouses. Most participants (82%, n = 115) had at least a high school education, most reported (73%, n = 103) family incomes of $40,000 a year or less, and half (50%, n = 71) of the sample reported some degree of economic difficulty meeting basic needs.

As noted in Table 1, when the categorical demographic characteristics of the White and African American respondents were compared, the African American respondents as a group were more likely to be single, less likely to be an adult child of the care recipient, and reported lower incomes and more difficulty paying bills.

As noted in Table 2, when the categorical demographic characteristics of the male and female respondents were compared, the male respondents as a group were more likely to be single. There were no other significant differences.
Table 3 presents differences in age and caregiving hr. White caregivers were significantly older and provided significantly fewer caregiving hr than African American caregivers. There were no significant gender differences. Overall, the mean age of the caregivers was 52, with the ages ranging from 23 to 82. Participants reported providing an average of 50 hr of care a week to their older dementia care recipients.

In Table 4, we present the mean scores and standard deviations for each dimension of the ISEL for the total sample, and for male and female respondents separately. Table 5 presents the mean scores and standard deviations for each dimension of the ISEL, for White and African American respondents separately. For the total sample, respondents reported moderately
TABLE 2 Demographics by Gender of Caregiver

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Men</th>
<th>Women</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>7</td>
<td>33.3</td>
<td>78</td>
</tr>
<tr>
<td>Widowed/divorced/separated</td>
<td>6</td>
<td>28.6</td>
<td>26</td>
</tr>
<tr>
<td>Never married</td>
<td>8</td>
<td>38.1</td>
<td>16</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>9</td>
<td>42.9</td>
<td>46</td>
</tr>
<tr>
<td>Unemployed</td>
<td>12</td>
<td>57.1</td>
<td>74</td>
</tr>
<tr>
<td>Relationship to care recipient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult child</td>
<td>17</td>
<td>81.0</td>
<td>66</td>
</tr>
<tr>
<td>Spouse</td>
<td>1</td>
<td>4.8</td>
<td>13</td>
</tr>
<tr>
<td>Grandchild</td>
<td>1</td>
<td>4.8</td>
<td>12</td>
</tr>
<tr>
<td>Child-in-law</td>
<td>1</td>
<td>4.8</td>
<td>11</td>
</tr>
<tr>
<td>Nephew/niece</td>
<td>0</td>
<td>0.0</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4.8</td>
<td>12</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>2</td>
<td>9.5</td>
<td>24</td>
</tr>
<tr>
<td>High school</td>
<td>10</td>
<td>47.6</td>
<td>42</td>
</tr>
<tr>
<td>Some college</td>
<td>5</td>
<td>23.8</td>
<td>36</td>
</tr>
<tr>
<td>College graduate</td>
<td>4</td>
<td>19.0</td>
<td>18</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>10</td>
<td>50.0</td>
<td>46</td>
</tr>
<tr>
<td>$20,000–40,000</td>
<td>3</td>
<td>15.0</td>
<td>39</td>
</tr>
<tr>
<td>&gt;$40,000</td>
<td>7</td>
<td>35.0</td>
<td>30</td>
</tr>
<tr>
<td>Meet basic needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not difficult</td>
<td>9</td>
<td>42.9</td>
<td>36</td>
</tr>
<tr>
<td>Not very difficult</td>
<td>0</td>
<td>0.0</td>
<td>24</td>
</tr>
<tr>
<td>Somewhat difficult</td>
<td>8</td>
<td>38.1</td>
<td>35</td>
</tr>
<tr>
<td>Very difficult</td>
<td>4</td>
<td>19.0</td>
<td>24</td>
</tr>
</tbody>
</table>

TABLE 3 Age and Caregiving Hr by Race and Gender of Caregiver

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Age</th>
<th>Caregiving Hr.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>53.5</td>
<td>11.8</td>
</tr>
<tr>
<td>African American</td>
<td>49.4</td>
<td>11.9</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>51.3</td>
<td>12.6</td>
</tr>
<tr>
<td>Women</td>
<td>51.6</td>
<td>11.9</td>
</tr>
</tbody>
</table>

*p-Test. **Mann-Whitney test.

high scores on each of the four dimensions of social support with mean scores of 8.7 for tangible (the availability of concrete help and material assistance from social network members); 6.9 for appraisal (the availability of persons to obtain advice from and with whom to discuss problems);
7.7 for *belonging* (the availability persons to talk to or socialize with); and 7.8 for *self-esteem* (receipt of positive regard and self-esteem from others). These scores were well above the midpoint of the possible range of scores (0–10) for each of the dimensions.

Female caregivers (n = 120) reported significantly higher mean scores than their male counterparts (n = 21) on three of the four dimensions of social support: tangible (*p* = .01), belonging (*p* = .002), and self-esteem (*p* = .006). No significant differences were found between African American and White caregivers on any of the four social support dimensions measured.

We tested for correlations of the respondents’ scores on the CCI with their scores for each dimension of the ISEL using Pearson’s *r* to determine if there were any relations between caregiver burden and social support. We found no significant correlations between caregiver burden scores on the CCI and any of the four dimensions of social support.

Correlation analyses were run on participants’ QOLI scores and their scores on each dimension of the ISEL to determine if there were relations between the participants’ reported life satisfaction and their reported levels of social support. As we note in Table 6, we found statistically significant positive correlations between the participants’ life satisfaction scores and their scores on each of the four dimensions of social support. The weakest relation was between the participants’ scores for *appraisal* (the availability of persons to obtain advice from and with whom to discuss problems), and

### Table 4: Interpersonal Support Evaluation List (ISEL) Differences by Gender

<table>
<thead>
<tr>
<th>ISEL component</th>
<th>Men M</th>
<th>SD</th>
<th>Women M</th>
<th>SD</th>
<th>Total M</th>
<th>SD</th>
<th><em>p</em> Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangible</td>
<td>7.8</td>
<td>2.7</td>
<td>8.8</td>
<td>2.2</td>
<td>8.7</td>
<td>2.3</td>
<td>0.010</td>
</tr>
<tr>
<td>Appraisal</td>
<td>5.8</td>
<td>3.1</td>
<td>7.1</td>
<td>2.0</td>
<td>6.9</td>
<td>2.3</td>
<td>0.100</td>
</tr>
<tr>
<td>Belonging</td>
<td>6.1</td>
<td>2.7</td>
<td>7.9</td>
<td>2.3</td>
<td>7.7</td>
<td>2.5</td>
<td>0.002</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>6.7</td>
<td>2.1</td>
<td>8.0</td>
<td>1.9</td>
<td>7.8</td>
<td>2.0</td>
<td>0.006</td>
</tr>
</tbody>
</table>

*Men versus women (Mann-Whitney Test).*

### Table 5: Interpersonal Support Evaluation List (ISEL) Differences by Race

<table>
<thead>
<tr>
<th>ISEL component</th>
<th>White M</th>
<th>SD</th>
<th>African American M</th>
<th>SD</th>
<th><em>p</em> Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangible</td>
<td>8.8</td>
<td>2.0</td>
<td>8.5</td>
<td>2.5</td>
<td>0.97</td>
</tr>
<tr>
<td>Appraisal</td>
<td>7.2</td>
<td>2.4</td>
<td>6.6</td>
<td>2.1</td>
<td>0.08</td>
</tr>
<tr>
<td>Belonging</td>
<td>7.8</td>
<td>2.5</td>
<td>7.5</td>
<td>2.4</td>
<td>0.17</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>7.8</td>
<td>1.8</td>
<td>7.9</td>
<td>2.2</td>
<td>0.39</td>
</tr>
</tbody>
</table>

*Mann-Whitney Test.*
their QOLI scores which had a Pearson Correlation Coefficient of .26 \( (p = .002) \). Their scores for tangible (the availability of concrete help and material assistance from social network members) and their QOLI scores had a correlation coefficient of .36 \( (p < .001) \). Scores for belonging (the availability persons to talk to or socialize with) and scores for self-esteem (receipt of positive regard and self-esteem from others) both had correlation coefficients of .49 \( (p < .001) \) with participants’ QOLI scores.

Table 7 shows the results of a stepwise multiple regression analysis of the QOLI with each of the four ISEL dimensions. In that analysis, belonging \( (p < .001) \) and self-esteem \( (p < .001) \) accounted for 32% of the variance of the caregivers’ life satisfaction scores.

### DISCUSSION

As we noted, our sample of rural dementia caregivers living in Alabama reported fairly high levels of social support. Our literature review did not uncover any normative data regarding levels of social support reported by urban or rural dwelling caregivers of cognitively impaired older persons. We, therefore, have no way of assessing whether the level of social support reported by our sample of caregivers is typical of the informal social support received by dementia caregivers in other rural or urban areas of the country. Because normative data are lacking, we think that the high level of social support reported by our participants is an important addition to the caregiver literature. In view of the lack of clear, consistent, and definitive findings among those studies that have attempted to assess possible geographic differences (rural/urban) in the experiences of caregivers of
older persons, we encourage continuing research efforts to examine this important question (Goins, Spencer, & Byrd, 2009).

Our finding does support the popular perception that characterizes rural communities as containing active and supportive social networks that have the potential of helping persons who live in these communities deal better with some of the challenges of living in rural areas. More specifically, in this study, two dimensions of social support—the availability of having persons with whom to talk or to socialize, and the receipt of feelings of positive regard and self-esteem from others—appear to have a mediating effect upon our respondents' feelings of life satisfaction.

This finding has several potential practice implications for social workers working with dementia caregivers in rural communities. It is important that when working with caregivers who live in rural areas, social workers not automatically assume that such caregivers are recipients of high levels of informal social support from their families, friends, and neighbors. Given the potential importance that certain dimensions of social support may have for the well-being and life satisfaction of such caregivers, social workers should consider routinely conducting assessments of caregivers' social networks to more precisely determine the extent and the nature of the caregivers' network relations, and to identify the types of social support that they actually receive from network members. Such assessments should consider the willingness and ability of network members to provide social support, the actual supportive relations that take place, and the potential support available to caregivers' from their social networks. Additionally, such assessments should also examine the willingness and ability of caregivers' to actually utilize the informal support that is available to them (Kaufman, 1990). Where such assessments either identify a lack of social support resources, or uncover problems related to accessing or utilizing available sources of social support, social workers may be able to provide interventive approaches to assist in overcoming such problems. One approach might focus on helping to facilitate improved communication between caregivers, care recipients, and certain key social network members. Other interventions might focus on enabling specific social network members to more effectively manage time or resource constraints that act as actual or potential barriers to their providing assistance to the primary caregiver(s).

Our finding that the African American and White caregivers in this study reported no differences in their social support scores for any of the ISEL dimensions contributes to the discussion regarding if and how the receipt of informal social support by caregivers of elderly persons may be differentially affected by race and culture. Research has indicated that racial and cultural minority populations are characterized by strong social network ties that provide high levels of social support. As noted earlier, some researchers have suggested that African American dementia caregivers receive higher levels of instrumental support than White caregivers.
However, other studies have suggested that where differences in social support have been found between White and racial minority populations, those differences may be more related to methodological artifacts or to socio-demographic factors such as income and education, rather than to ethnic or cultural differences between population groups. Our findings lend support to this latter position, especially with regard to the receipt of social support by rural dwelling African American and White dementia caregivers.

We found no relations between social support and caregiver burden. This finding is contrary to the findings of other caregiving studies in which informal social support has been found to mediate the stress and burden experienced by caregivers. Caregiver stress, which we did not measure in this study, and burden, although likely related, are qualitatively different psychological states. It may be that burden, as an emotion, may not be responsive to the types of social support provided by informal social networks. Additionally, it may be that measurement issues impact the findings in our cross-sectional design related to our use of the CCI as a proxy for caregiver burden. Because there are no published normative data for the CCI, we cannot readily interpret the level and meaning of burden reported by our respondents, and lacking longitudinal data for our sample, we do not know if the respondents’ feelings of burden have been affected over time by their high levels of social support.

The finding that the female caregivers in our study reported higher levels of social support than their male counterparts is consistent with similar findings in other caregiver research studies. As we had a small number of male caregivers in this study, we were precluded from conducting analyses that might have allowed us to examine possible explanations for this finding. Historically, in part, because caregiving was more likely to be provided by women, little research attention has been given to the experiences, needs, and challenges faced by male caregivers (especially those men who care for older persons with dementia). In view of data suggesting that the proportion of male caregivers of older persons has been significantly growing in recent years, there is ample justification for increasing research attention on this important subgroup of family caregivers (Wegner & Niles-Yokum, 2006).

Researchers who have examined the needs and challenges faced by male caregivers have identified several important practice implications for those working with this population. Yee and Schulz (2000) concluded from their analysis of caregiving research findings that male caregivers may experience similar levels of burden and depression to those that have been found for females. This suggests the need to obtain thorough psychosocial assessments for both female and male caregivers, and to provide appropriate interventions for those whose caregiving experiences are contributing to negative outcomes. It is important that psychosocial assessments for male
Caregivers include an assessment of their specific knowledge and ability to engage in certain caregiving activities such as cooking, housekeeping, financial management, and the provision of personal care to their care recipients, and to provide training or assistance to those lacking the skills to perform these tasks. Kaye (1997) has suggested that many men continue their caregiving roles long after they are able to provide the necessary needed care to a spouse or other family member. Professionals need to be sensitive to such situations that can result in the provision of ineffective or inadequate care to care recipients that can adversely affect the health and well-being of both the caregiver and the care recipient. Finally, it is notable that little attention has been given to gender differences in the provision and receipt of social support of caregivers. We encourage researchers to explore this issue in the future.

We note the following limitations of this research effort. Because our study used a cross-sectional, rather than a longitudinal, design, we cannot posit any causal relations between the levels of social support experienced by the caregivers and their reported levels of life satisfaction. A further limitation of this study relates to our exclusive use of traditional survey methods to obtain the data reported here. The provision of care to persons with dementia, and the social, psychological, and biological effects of those activities on caregivers encompass a complex phenomenon for those involved. The standardized instruments and the survey interview techniques used in studies such as this one typically gather somewhat superficial data that do not allow for a full and in-depth understanding of the lives and experiences of the study participants. Finally, as we noted previously, the sampling techniques we used provided us with a sample that we think is likely to be representative of Alabama’s rural dwelling dementia caregivers. However, the findings of this study cannot be generalized to rural dementia caregivers in other states or regions of the country, or to dementia caregivers who live in urban or suburban settings.

**CONCLUSION**

We found that two dimensions of social support (the availability of persons with whom to talk or to socialize and the receipt of feelings of positive regard and self-esteem from others) were predictors of the life satisfaction of the caregivers in our study. Further research is needed to identify other factors that contribute to the life satisfaction of rural dwelling caregivers of persons with dementia. It is important that such research be conducted with rural dementia caregivers in other regions of the country, as well as studies that examine and compare the social support experiences of rural caregivers and their urban counterparts. Such research efforts could enable those in all communities to develop new services and interventions that may contribute
to increased quality of life for caregivers of persons with dementia. As the rates of Alzheimer’s disease and related dementias continue to rise, the need for such research is critically important. Helping dementia caregivers to deal better with the burdens and stresses associated with their caregiving activities, and helping them to experience higher quality of life and enhanced levels of life satisfaction, can enable them to continue providing quality care to their loved ones which, in turn, is likely to enrich the lives of the persons for whom they care.

REFERENCES


