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Dementia Caregiving in the Context of Late-Life Remarriage: Support Networks, Relationship Quality, and Well-being

Caregiving research has not accounted for increasingly diverse and complex marital and family histories of older Americans. The authors examined social relations and care-specific positive and negative support networks among late-life remarried wife dementia caregivers (N = 61) to determine associations among network structure, relationship quality with and support received from network members, and global assessments of family and stepfamily disagreement on caregiver well-being. Own family and friends predominated in the social relations and positive networks. Although over half (54%) of respondents included a stepfamily member in their positive networks, stepchildren comprised the largest group (35%) in the negative networks. Larger negative networks and actively negative interactions were related to greater caregiver burden, and more global disagreement with stepfamily was associated with greater depression and burden. The findings illustrate the complex nature of support and the value of targeted examinations of caregiving support dynamics among late-life remarried older adults and stepfamilies facing health demands.

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Older adults and families are experiencing more complex marital and stepfamily transitions over the life course (Manning & Brown, 2009; Teachman, Tedrow, & Crowder, 2000). Over one third (38%) of all marriages in the United States are remarriages for one or both partners (Deal, 2011), resulting in 35 million remarried Americans. Furthermore, nearly 500,000 adults over age 65 remarry every year (U.S. Census Bureau, 2006). This trend of older adults repartnering through legal remarriage, cohabitation, or other arrangements is a new reality of aging (Brown, Bulanda, & Lee, 2005; de Jong Gierveld, 2004).

Americans are also living longer, with increasing levels of chronic disease and disability. In particular, Alzheimer's disease (AD) and related dementias are the sixth leading cause of death in the United States. Currently, one in eight older Americans has AD/dementia, and rates are expected to triple by 2050 (Hebert, Scherr, Bienias, Bennett, & Evans, 2003). Health policy in the United States relies heavily on family and close ties to provide the long-term care required by adults with dementia (Bookman & Kimbral, 2011). Currently, more than 15 million Americans provide such care for a family member with AD (Alzheimer's Association, 2012). Moreover, aging Baby Boomers are expected to have fewer people to care for them compared to prior cohorts of older adults (Ryan, Smith, Antonucci, & Jackson, 2012). This situation may be exacerbated in cases of remarriage and stepfamily, with potentially adverse

effects for remarried older adults. Furthermore, the significant physical and psychological challenges of providing spousal dementia caregiving are well documented (Fratiglioni, Wang, Ericsson, Maytan, & Winblad, 2000; Gaugler, Davey, Pearlin, & Zarit, 2000; Pearlin, Mullan, Semple, & Skaff, 1990; Zarit, Femia, Kim, & Whitlatch, 2010). It is, therefore, critical to understand the availability and nature of social support networks of older caregivers living in complex family structures.

The present study focused on the spousal dementia caregiving experiences of late-life remarried wives ($n = 61$). *Late-life remarriage* was defined in this study as a second (or higher order) marriage occurring after children from prior relationships were 18 years of age or older. A primary aim of this study was to document remarried wife caregivers' general social relations convoys as well as to document their caregiving-specific support networks. These care-specific support networks were conceptualized as two separate networks, including those individuals who provided positive caregiving-related support (i.e., positive caregiving support network) and those who demonstrated negativity with respect to care support (i.e., negative caregiving support network). We examined the proportion of family and stepfamily membership in each of these three networks and assessed relationship quality with key network members as well as the global level of care-related disagreement with family and stepfamily members. Finally, we examined whether distinct network characteristics, quality of the relationships with members from these three networks, and care-related support were associated with remarried caregiver well-being. We also explored how global assessments of disagreement with family and stepfamily were related to well-being. By exploring how networks, support dynamics, and disagreement with family and stepfamily influence well-being among older remarried dementia caregivers, this study provides an innovative understanding of the role of family and stepfamily in the provision of caregiving support. Furthermore, this study contributes to a growing literature on outcomes among unique and vulnerable categories of dementia caregivers.

REMARRIAGE AND STEPFAMILIES IN LATER LIFE

Remarried adults report better health and well-being compared to divorced or unmarried adults (Bulcroft, Bulcroft, Hatch, & Borgatta, 1989), and remarriage reportedly increases perceived social support among adults over 65 (Curran, McLanahan, & Knab, 2003). Nevertheless, adverse health effects of marital dissolution have been shown to linger after remarriage (Hughes & Waite, 2009). Additionally, marital dissolution has been linked to reductions in intergenerational transfers (Eggebeen, 1992), especially among fathers. Remarriage can compound this trend among elderly parents and their adult children (Pezzin & Shone, 1999) and negatively affect the quality of the parent–child relationship (de Jong Gierveld & Peeters, 2003).

Theorists have asserted that a lack of social norms with respect to remarriage and stepfamily life contribute to such intergenerational disruptions. For example, Cherlin (1978, 2004) has labeled remarriage as an ''incomplete institution'' due to the absence of shared understandings of kinship or mutual responsibility among stepfamily members. Indeed, stepfamily members report higher levels of ambiguity regarding family boundaries and intergenerational expectations (Berger, 2000; Pasley & Ihinger-Tallman, 1990; Stewart, 2007) compared to first-marriage family members. Ganong and Coleman (2006) and others (Pew Research Center, 2011) have found that young adults and remarried parents report greater perceived obligation and responsibility toward biological family members compared to stepfamily ties.

To date, the majority of research on stepfamily relations has focused on middle-aged adults (Ganong & Coleman, 2006; Stewart, 2007). In addition, remarried and stepfamily relationship status or history among older adults has generally been obscured by standard measures in large representative data sets. Some recent studies, however, reflect an encouraging trend toward greater focus on stepfamily relations among older adults. For example, Suanet, van Tilburg, and van der Pas (2012) examined stepparents' notions of family membership and boundaries in the Netherlands and found that whereas inclusion of biological children in the family network was greater compared to stepchildren, inclusion of stepchildren in the networks increased over time. Another study, however, found

that American adult stepchildren were more likely to be disengaged and to live farther apart and were less likely to move closer to older stepmothers compared to biological adult children (Seltzer, Yahirun, & Bianchi, 2012). Such findings offer insight into the context of later life stepfamily dynamics in distinct settings, but research on actual support for older remarried couples—especially in the face of serious chronic illness—remains rare. This study's focus on remarried wife caregivers' social and caregiving-specific support networks offers new insight into the role of family and stepfamily support for remarried older couples facing a chronic, progressive illness such as AD.

SOCIAL NETWORKS AND SUPPORT AMONG OLDER ADULTS

The *convoy model of social relations* (Antonucci, 2001; Kahn & Antonucci, 1980) provided the conceptual framework for this study. According to the convoy model, a person's social network, or convoy, provides a protective base that moves with the person through the life course. Convoys are understood to be responsive to normative developmental shifts as well as changes in situational characteristics. Convoys can be described in terms of their structural characteristics (i.e., network size and composition) as well as *function*, which refers to the exchange of different kinds of support (e.g., emotional, instrumental) between network members. Related research on the role of health and illness in shaping social networks (Durkheim, 1951; Pescosolido & Levy, 2002) asserts that whereas larger, integrated networks are more easily ''activated'' to protect individuals when health problems occur, disjointed or attenuated networks may lack sufficient regulation to be responsive to health needs. Such networks may leave individuals at risk of inadequate or inappropriate support.

Research using the convoy model has documented that social support for older adults most often comes from existing social and familial networks and that such support is given according to levels of closeness (Antonucci, 1990; Antonucci, Birditt, Sherman, & Trinh, 2010). Thus, older adults generally turn to spouses, adult children, other close family members, and friends for support, with formal services being less preferred (Cantor, 1979). Nonetheless, although close social ties

are the most common source of positive support, they are also a frequent source of negativity, including tension, conflict (Newsom, Rook, Nishishiba, Sorkin, & Mahan, 2005; Rook, 2001), and ambivalence (Birditt, Miller, Fingerman, & Lefkowitz, 2009; Connidis & McMullin, 2002; Luescher & Pillemer, 1998). Negative interactions and support appear to be particularly salient and influence well-being more significantly than positive interactions and support (Antonucci, 2001).

SOCIAL SUPPORT FOR DEMENTIA SPOUSE CAREGIVERS

AD and dementia are a leading cause of death in the United States and a growing concern among older adults and their family members (Alzheimer's Association, 2012; Hebert et al., 2003). The adverse physical and mental health consequences of dementia caregiving have been extensively documented. In fact, dementia caregivers experience significantly greater depressive symptoms (Gaugler et al., 2000; Pearlin et al. 1990), sustained grief (Adams & Sanders, 2004), burden (Zarit et al., 2010), and depletion of extant or prior social networks (Hough, Magnan, Templin, & Gadelrab, 2005) compared to other caregivers. Women provide over 70% of such care (Teri, 1997), and spouse dementia caregivers provide the most intensive and greatest amount of care. They must negotiate new understandings and expectations of their partner, marital relationship, and the future (Gubrium, 1988; Hellstrom, Nolan, & Lundh, 2005). There is a growing recognition that family conflict can influence levels and quality of social support for care dyads (Mitrani et al., 2006; Peisah, Brodaty, & Quadrio, 2005). Studies have found that family members disagree about disease severity, medical intervention, and long-term care plans, escalating family-related stress (Pearlin et al., 1990; Semple, 1992). The ambiguous nature of loss and identity associated with dementia can be especially difficult for family to accept and navigate (Boss, 2011).

Although negative interactions and failure to provide support can arise for caregivers regardless of marital status or family structure, the extant literature on the impact of divorce, remarriage, and stepfamily on intergenerational exchanges suggests that this group of caregivers may face unique vulnerabilities with respect to

support. Moreover, researchers who study caregiving are increasingly interested in identifying the challenges that face categories of caregivers who are providing care in unique contexts (La Fontaine, Ahuja, Bradbury, Phillips, & Oyebode, 2007). The initial research conducted on remarried caregivers suggests that these caregivers may experience additional or amplified caregiver burden. Qualitative studies have documented the fluid nature of caregivers' supportive relationships (Carpentier & Ducharme, 2005, 2007) as well as caregivers' experiences of unfulfilled expectations of assistance from close social ties and negative interactions with relatives in regard to care issues (Neufeld & Harrison, 2003). Research specifically on remarried wife caregivers has documented reports of minimal support from adult stepchildren (Sherman & Boss, 2007) and substantial tension and conflict with stepchildren regarding care-related finances, inheritance, and husband's medical needs (Sherman & Bauer, 2008).

The present study expands on this literature by focusing on AD/dementia caregiving support in the context of remarriage. Specifically, we examined own family and stepfamily participation in support for remarried wife dementia caregivers and the support dynamics associated with remarried caregivers' well-being. We sought to extend prior research by documenting and assessing family and stepfamily membership in remarried caregivers' general social relations convoys, as well as the positive and negative care-specific support networks. The three guiding research questions were as follows:

Research Question 1: How does the structure (i.e., size and composition) of remarried dementia caregivers' social relations network and the caregiving-specific positive and negative support networks compare and contrast? We expected social relations and positive networks to be larger and comprise a larger proportion of own family compared to the negative networks. We also hypothesized that stepfamily, in particular adult stepchildren, would predominate in the negative network.

Research Question 2: To what extent are own family and stepfamily members represented in one or more of the remarried caregivers' networks? We hypothesized that there would be limited overlap between the social relations and negative network but that family and stepfamily members nominated to the social relations network would also be included in the positive network.

Research Question 3: How are network structure, relationship quality with network members, and global family/stepfamily disagreement associated with caregiver well-being? We hypothesized that larger social relations and positive networks would be associated with better caregiver well-being. We also expected that greater positive and less negative relationship quality, more positive and less negative support, and less disagreement with family or stepfamily would be associated with better caregiver well-being.

METHOD

Participants

Sixty-one legally remarried wife caregivers participated in this study between spring 2008 and fall 2010. The average age of the women was 66 years and ranged from 45 through 67. The majority of women were White (89%) and had an average of 15 years of education and a family income of between $40,000 and 60,000. Eighty-five percent of these women had been divorced prior to remarriage, and the remaining 15% were widowed. Seventy-seven percent of women were in a second marriage, and 23% were in higher order remarriages. The average duration of the present remarriage was 17 years, although 25% of these women had been remarried for fewer than 10 years. Nearly all of the women (80%) had grown children of their own from previous marriages or relationships, and 87% had adult stepchildren from the current remarriage. The husbands' mean age was 76 years, and over three quarters (76%) of them had been divorced prior to the remarriage. The majority of husbands were in the mid-stage (average of 3.4 years post diagnosis) of disease progression.

Procedure

This study defined late-life remarriage as one that occurred in the post-childrearing years. In keeping with the theoretically driven sampling, all participants were required to be the primary caregiver of a spouse with AD/dementia and still living in the community. Multiple modes of recruitment were used to identify the unique study population. Remarried spouses were recruited via study flyers posted at regional dementia and aging organizations, community

libraries, health care clinics, and on caregiving-related websites. Special efforts were made to recruit minority participants by advertising at clinics and through health promotion programs serving racial/ethnic minority populations. Interviews were conducted by telephone and took between 1.5 to 2 hours to complete. Respondents were sent a response booklet prior to the interview to consult during the interview. Participants received a $20 gift card for their time.

Measures

Social relations network. We used the hierarchical mapping technique (Antonucci, 1986) to assess the structural aspects of respondents' social networks. The diagram contains three concentric circles, with a center circle with the word *You*. Respondents are asked to place the people to whom they feel closest in the innermost circle of the network diagram; those to whom they feel not quite that close in the middle circle; and, in the outer circle, the people not already mentioned but to whom they are close enough to include in their personal network. Respondents were then asked detailed questions about the first three people named in their network age 13 years or older.

Positive and negative care support networks. Two modified versions of the hierarchical map were used to assess care-specific positive and negative support networks. Respondents were asked to name the ''person(s) who have given you support or assistance in your caregiving role'' in the first circle. People who had given some support, but not as much as the first group, were placed in the second circle. People who gave less support or assistance but still belonged in the network went in the outer circle. For the negative network, respondents were asked to name the person(s) who had been difficult or disappointing with respect to support (i.e., ''You expected [person's name] to give you support/assistance, or they have not provided such support, or they offer unwanted kinds of support/advice, etc.''). Those deemed ''most difficult or disappointing'' were placed in the inner circle, and so on.

Network structure. Five indicators of network structure were created: *Total network size* indicates the total number of people the

respondent included in his or her network map. In addition to the total number, the size of each respondent's *inner*, *middle*, *and outer circles* were calculated. Finally, one measure of network *composition*, documenting relationship type, was used. Each network member named was placed into the following relationship categories: own children, other own family, adult stepchildren, other stepfamily, friend, other, and professional.

For each of the seven relationship categories, we created a variable that documented the proportion or percentage of the total network comprised by the specific relationship category. Specifically, we created these variables by counting the number of people in the network identified as that relationship (i.e., child), which was then divided by the total number of people in the network, and multiplied by 100. These variables are continuous in form and can range from 0 (indicating that relationship is not present in the network) to 100 (indicating the network is composed entirely of that relationship). We present descriptive statistics for all seven relationship categories for all three networks.

Social relationship quality. Respondents were asked to rate the overall positive and negative aspects of their relationship with specific people, including the sibling to whom they feel closest, child on whom they rely most, and best friend. *Positive relationship quality* consisted of five items (e.g., ''I feel [person name] *supports* me/is there for me, *encourages* me'') scored on a scale of 1 (*disagree*) to 5 (*agree*; sibling $\alpha = .88$, child $\alpha = .70$, friend $\alpha = .67$). Negative relationship quality consisted of two items (e.g., ''[Person name] gets on my *nerves*'' and ''[Person name] makes too many *demands* on me''; sibling $\alpha = .46$, child $\alpha = .83$, friend $\alpha = .42$). We created composite relationship quality scores by averaging item score averages across the three reported relationships.

Types of support received from positive and negative networks. Multiple aspects of support received from the first three people nominated in the positive care support network were measured. *Instrumental support* was assessed with two items (e.g., helps with practical or hands-on things; helps you take action). Items were scaled from 1 (*not at all*) to 5 (*a great deal*; Person 1 $\alpha = .59$, Person 2 $\alpha = .56$, Person 3 $\alpha = .48$). *Emotional support* was assessed with two

items (e.g., ''How much does [person's name] listen to you, comfort you?''; Person 1 $\alpha = .89$, Person 2 $\alpha = .80$, Person 3 $\alpha = .74$). Responses ranged from 1 (*not at all*) to 5 (*a great deal*). A mean composite score was computed, averaging the first three people nominated for each of these three measures.

For the negative care support network, different types of negativity were measured for the first three people nominated. *Active negative* interactions were those such as unwanted advice; interference/meddling; questioning caregiver's decisions; inconsiderate, angry, or critical interactions. Response options were made on a 5-point scale that ranged from 1 (*not at all*) to 5 (*a great deal*; Person 1 $\alpha = .89$, Person 2 $\alpha = .91$, Person 3 $\alpha = .96$). *Failure to provide* was assessed with three items rated on the same 5-point scale (e.g., ''How much did [person name] *let you down* when you needed help? *fail to spend time* with you or your spouse? and *fail to give you assistance* you counted on?''; Person 1 $\alpha = .75$, Person 2 $\alpha = .78$, Person 3 $\alpha = .82$). A mean composite score was computed, averaging the first three people nominated for both aspects of negative care support.

The Family Disagreement Scale. This measure (Pearlin et al., 1990) assessed each participant's global perceptions of how much disagreement she had experienced with members of the family regarding care for the husband with dementia. A parallel version was adapted for this study to record caregivers' appraisals of caregiving-related disagreement with stepfamily members. Both scales consisted of 12 items that ranged from 1 (*no disagreement*) to 4 (*quite a bit of disagreement*), including how much disagreement the respondent had with anyone in her family/stepfamily (e.g., not spending time, not doing their share, interfering, etc.). Mean composite scores of disagreement with own family ($\alpha = .87$) and stepfamily members ($\alpha = .94$) were computed.

Caregiver well-being. Depressive symptomatology was measured using the 20-item Center for Epidemiological Studies Depression measure (Radloff, 1977). Participants were asked to report the experience of depressive symptoms in the past week, ranging from 0 (*rarely/none of the time*) to 3 (*most of the time*). Item scores were summed to create a total depression score ($\alpha = .90$). Higher scores indicate greater depressive

symptoms, and scores of 16 or above have been identified as discriminating between groups with clinically relevant versus nonrelevant depressive symptomatology (Radloff & Teri, 1986). *Life satisfaction* was assessed using a single item that asks respondents ''How satisfied are you with your life as a whole these days?''; responses are given on a scale that ranges from 1 (*completely satisfied*) to 7 (*completely dissatisfied*). *Caregiver burden* was assessed using the short eight-item Zarit Burden Interview scale (Bedard et al., 2001), which evaluated burden on a 5-point scale ranging from 1 (*rarely*) to 5 (*nearly always*), with higher scores indicating more burden experienced from caregiving ($\alpha = .82$).

Analytic Strategy

To address Research Question 1, we conducted comparative descriptive analyses on the structural aspects of the three networks and used paired-samples t tests to examine differences among the three networks with respect to size and composition. To address Research Question 2, we examined network membership across the three networks to document whether caregivers nominated specific family/stepfamily members to one, two, or all three networks. We calculated the frequency and relationship of network members (i.e., own family, stepfamily, nonfamily) nominated to only one of the three networks, two of the three, and all three networks and examined the frequency of which two (or more) networks they were nominated to (i.e., social relations and positive, positive and negative, etc.). To address Research Question 3, we conducted a series of regression analyses to examine the influence of each network's size, composition, and relationship quality/type of support on caregiver well-being (i.e., depressive symptoms, life satisfaction, and caregiver burden). Because of this study's focus on own and stepfamily dynamics, the relationship composition variables included in the analysis were percentage own family and percentage stepfamily. Model 1 examined these associations within the social relations network, and Models 2 and 3 focused on the positive and negative support networks, respectively. Model 4 examined the unique influence of global disagreement with own family and stepfamily on caregiver well-being.

We present descriptive statistics of the sample followed by network analyses of the social relations and positive and negative support networks. We then present findings on the associations among network characteristics, support quality, and global disagreement with family and stepfamily on remarried caregiver well-being.

As shown in Table 1, caregivers reported higher levels of positive relationship quality ($M = 4.4$, $SD = 0.6$) compared to negative ($M = 2.0$, $SD = 0.9$). Similarly, network members nominated to the caregivers' positive support network were rated as exhibiting low levels of critical/demanding support ($M = 1.6$, $SD = 0.5$), moderate levels of instrumental support ($M = 3.1$, $SD = 0.8$), and high rates of emotional support ($M = 4.1$, $SD = 0.5$). Members nominated to caregivers' negative support network were reported to exhibit relatively low levels of actively negative support ($M = 2.2$, $SD = 0.9$) but more often failed to provide support ($M = 3.5$, $SD = 1.1$). Ratings of global family and stepfamily disagreement revealed that caregivers, on average, reported low levels of care-related disagreement among their own family ($M = 1.3$, $SD = 0.5$) compared to stepfamily ($M = 2.2$, $SD = 0.9$). Finally, this sample of caregivers reported experiencing, on average, relatively high levels of depressive symptoms ($M = 18.0$, $SD = 10.0$), caregiver burden ($M = 3.1$, $SD = 0.7$), and low life satisfaction ($M = 3.8$, $SD = 1.5$) compared to the general population.

Research Question 1: Structure of the Social, Positive, and Negative Support Networks

The structural characteristics (i.e., size and composition) of the social relations and positive and negative care-related support networks are summarized in Table 2. As expected, remarried caregivers nominated significantly more people to their overall social relations networks compared to the care-related networks, and respondents' positive support networks were significantly larger than their negative support networks. Interestingly, no stepfamily members were nominated to the majority of the remarried caregivers' social relations (66%) and positive (54%) networks. Conversely, at least one stepfamily member was nominated to nearly two thirds (61%) of the negative networks. It is

Table 1. *Descriptive Statistics on Support, Family Disagreement, and Well-being*

Variable	M	SD	Range
Support from social relations network			
Positive relationship quality	4.4	0.6	1.6–5.0
Negative relationship quality	2.0	0.9	1.0–5.0
Support from positive network			
Instrumental	3.1	0.8	1.0–4.8
Emotional	4.1	0.5	2.8–5.0
Critical/demanding	1.6	0.5	1.0–2.8
Support from negative network			
Active negative	2.2	0.9	1.0–5.0
Failure to provide	3.5	1.1	1.0–5.0
Family disagreement			
Own family	1.3	0.5	1.0–3.3
Stepfamily	2.2	0.9	1.0–4.0
Well-being			
Depression	18.0	10.8	2–38
Life satisfaction	2.8	1.5	1–7
Caregiver burden	3.1	0.7	1.5–4.8

interesting to note, however, that six respondents nominated an adult stepchild (five stepdaughters and one stepson) as the first person in their positive caregiving network.

Our expectations regarding network composition were partially supported. As predicted, the social relations networks had significantly greater representation from own family compared to the two care-specific networks. Caregivers' own children comprised a significantly larger proportion of their social relations network compared to their negative networks. There were, however, no significant composition differences between the social relations network and the positive care-related network.

As predicted, adult stepchildren were the largest group represented in the negative network. They comprised a significantly larger proportion of the negative and positive networks compared to the social relations network. Other stepfamily members were also represented in the negative networks significantly more often compared to the other networks. Friends and others (e.g., neighbors, colleagues, dementia support group members) were nominated at significantly higher proportions in the social relations and positive networks compared to the negative network, whereas professionals (e.g., doctors, health providers) comprised a

Table 2. *Structure of Social Relations, Positive, and Negative Networks*

Variable	Social relations (SR) network			Positive (P) network			Negative (N) network			Paired samples *t* tests between network means		
	M	*SD*	Range	*M*	*SD*	Range	*M*	*SD*	Range	SR vs. P	SR vs. N	P vs. N
Size												
Total network size	12.1	6.8	1–30	7.2	5.4	0–23	2.9	2.7	0–10	***	***	***
Inner circle size	4.7	3.0	0–10	3.5	2.5	0–10	2.3	2.1	0–10	**	***	**
Middle circle size	4.5	3.0	0–10	2.2	2.4	0–10	0.5	1.0	0–4	***	***	***
Outer circle size	2.9	3.0	0–10	1.5	2.1	0–9	0.1	0.4	0–2	**	***	***
Composition by relationship (% of network)												
Children (own)	16.4	20.9	0–100	10.3	18.6	0–100	7.7	20.4	0–100	*ns*	*	*ns*
Other (own) family[a]	25.8	19.3	0–75	14.0	15.7	0–55	7.8	22.2	0–100	***	***	*ns*
Adult stepchildren	7.5	16.0	0–100	13.1	22.9	0–100	34.9	39.3	0–100	*	***	***
Other stepfamily[b]	1.9	5.7	0–30	3.0	7.7	0–33	12.0	26.9	0–100	*ns*	**	*
Friends	27.5	23.4	0–86	23.4	24.1	0–100	7.8	20.6	0–100	*ns*	***	***
Other[c]	11.2	20.8	0–100	10.9	17.0	0–67	3.5	12.4	0–67	*ns*	*	**
Professionals[d]	2.4	5.2	0–20	19.5	25.7	0–100	7.1	20.8	0–100	***	*ns*	*ns*

[a]Includes stepbrother/sister, brother-/sister-in-law, son-/daughter-in-law. [b]Includes stepgrandchild, stepnephew/-niece, step-in-laws. [c]Includes neighbors, coworkers, church members, support group members, and club members. [d]Includes pastors, lawyers, therapists, care aides, support group leaders, and so on.

*p < .05. **p < .01. ***p < .001.

substantial proportion of the positive support networks only.

Research Question 2: Representation of Network Members in Multiple Networks

By incorporating the three distinct networks, we were able to examine whether and to what extent respondents nominated the same family/stepfamily and other network members to multiple networks. Mapping such overlap provided additional insight into how caregivers perceive close social ties' involvement, or lack thereof, in care-related support.

There were a total of 1,127 unique network members nominated across the three networks. Over three quarters (78%, 873) were nominated to only one network, and 22% (243) were nominated to two of the three networks. Only 1% (11) were nominated to all three networks. The vast majority (86.6%, 208) of network members nominated to two networks were nominated to the social relations and positive care support networks. It is noteworthy that over half (51%, 105) of dual-nominated or ''overlapping'' members were nonfamily relationships (i.e., friends, neighbors, a therapist, etc.), followed by

own family (42%, 87). Stepchildren represented a small proportion (8%) nominated to both social relations and positive networks.

The relatively small number of members nominated to both the social relations and negative networks (13%, 31) included own family (45%, 14) or stepchildren (42%, 9), specifically. The remaining 13% (8) comprised other relationship types. Similarly, stepchildren accounted for half (55%) of those network members included in all three networks (*n* = 11), whereas one third (35%, 4) were own family and 9% (1) other relationships. Stepchildren represented virtually all of the small percentage (2%,4) nominated to the positive and negative care-related networks.

Research Question 3: Predictors of Well-being: Structure, Quality, and Disagreement

Using regression analyses, we examined whether and how network structure (e.g., network size, proportion family/stepfamily), quality, and support-type variables predicted caregiver well-being outcomes (see Table 3). Models 1a through 1c examined the social relations network size, composition, and relationship quality on caregiver well-being

Table 3. *Regression Results Predicting Well-being*

Model	Depression			Life satisfaction			Caregiver burden		
	b	*SE*	*β*	*b*	*SE*	*β*	*b*	*SE*	*β*
Model 1: Social relations network									
Total network size	−0.24	0.24	−0.15	−0.02	0.03	−0.07	−0.00	0.02	−0.01
Network proportion own family	0.14	0.07	0.28*	−0.01	0.01	−0.11	0.00	0.00	0.09
Network proportion stepfamily	0.14	0.12	0.16	0.01	0.02	0.04	0.00	0.01	0.02
Positive relationship quality	−2.70	2.41	−0.16	0.79	0.34	0.33*	−0.12	0.15	−0.12
Negative relationship quality	2.81	1.65	0.22	−0.26	0.23	−0.15	0.23	0.10	0.29*
Adjusted R^2		.11			.04			.02	
Model 2: Positive network									
Total network size	−0.12	0.29	−0.07	0.05	0.04	0.19	−0.01	0.02	−0.05
Network proportion own family	−0.01	0.08	−0.02	0.01	0.01	0.22	−0.00	0.00	−0.08
Network proportion stepfamily	0.03	0.07	0.07	−0.00	0.01	−0.01	0.00	0.00	0.10
Instrumental	3.06	2.14	0.24	−0.39	0.29	−0.21	0.32	0.12	0.43**
Emotional	−3.91	3.31	−0.20	0.30	0.44	0.11	−0.33	0.17	−0.29
Adjusted R^2		−.05			.03			.07	
Model 3: Negative network									
Total network size	1.49	0.73	0.34*	−0.22	0.09	−0.40*	0.08	0.03	0.34*
Network proportion own family	−0.04	0.08	−0.11	0.01	0.01	0.15	−0.01	0.00	−0.49**
Network proportion stepfamily	−0.01	0.07	−0.05	0.00	0.01	0.04	−0.01	0.00	−0.29
Active negative	2.05	2.03	0.17	−0.02	0.27	−0.01	0.20	0.09	0.29*
Failure to provide	1.04	1.66	0.11	−0.08	0.22	−0.06	0.09	0.07	0.16
Adjusted R^2		.12			.07			.41***	
Model 4: Family disagreement									
Own family	5.36	2.79	0.25	−0.47	0.42	−0.16	0.12	0.17	0.09
Stepfamily	4.36	1.52	0.37**	−0.35	0.23	−0.21	0.26	0.10	0.36**
Adjusted R^2		.22**			.05			.13*	

Note: Models and coefficients not marked with asterisks were not significant.

*$p < .05$. **$p < .01$. ***$p < .001$.

outcomes (e.g., depression, life satisfaction, and burden). None of these models were significant. Similarly, Models 2a through 2c examined the positive network's size, composition, and support quality on caregiver well-being outcomes. These models were also not significant. In light of the low alphas for the instrumental support scale, we examined whether using a single item (i.e., provides help with practical or hands-on things) would yield different results. Because this was not the case, the results using the two-item scale are presented.

The third group of models considered the negative network to examine whether and how network size, composition, and the negative interaction quality (e.g., active negative, failure to provide) predicted caregiver well-being. Although Models 3a through 3b were not significant, Model 3c was statistically significant, explaining 41% of the variance in caregiver burden. Specifically, larger negative network size and more active negative interactions were significantly associated with higher caregiver burden, whereas having a higher proportion of own family in the negative network was significantly associated with lower caregiver burden.

Finally, Models 4a through 4c examined the influence of global disagreement regarding caregiving-related issues with own family and stepfamily on caregiver well-being outcomes. Model 4a was significant, explaining 22% of the variance in caregiver depression. Model 4c was also significant, explaining 13% of the variance in caregiver burden. For both outcomes, higher levels of stepfamily disagreement were significantly associated with greater depressive symptoms and burden.

Discussion

This exploratory study is the first to examine the social relations and caregiving-specific

networks of remarried AD/dementia caregivers. An innovative contribution of this study was the inclusion of both positive and negative care-specific versions of the convoy model's hierarchical mapping technique. Although the findings identify important factors in shaping remarried caregivers' well-being, future studies using larger samples may be able to highlight the influence of additional aspects of support within social and care-specific networks. Nonetheless, this study suggests that in-depth documentation and analysis of context-specific convoys can provide valuable nuanced information regarding the type and quality of support from individual network members.

Negative interactions were especially predictive of remarried caregivers' depression and sense of burden, consistent with our expectations and prior research (Mitrani et al., 2006; Neufeld & Harrison, 2003; Newsom et al., 2005; Semple, 1992; Sherman & Bauer, 2008). These findings offer new and contextualized documentation of the influential nature of negative social relations and their consequences for well-being. Moreover, the outcomes indicate that interactions with stepfamily members can pose an added source of burden on remarried caregivers, who likely face unique vulnerabilities with respect to support in serious illness and caregiving situations.

Research Question 1: Structural Aspects of the Social Relations, Positive, and Negative Networks

We examined the relative contribution of other context-specific networks compared to the general social relations network. Our goal was to document the structure of these networks and examine whether they predict general well-being and other context-specific outcomes among older remarried wife caregivers.

Although older adults' social relations convoys are typically more family focused compared to younger adults', they also tend to focus on their most satisfying relationships (Carstensen, 1992). Members of the remarried caregiver's own family featured prominently in the social and positive support networks, but the networks generally included a diversified array of social ties, including friends, professionals, and others. Such diversity in

membership may reflect the dynamic nature of the convoy yet also convey the importance of situational characteristics, such as marital and family structure, in shaping social support or context-specific networks. Indeed, the absence of stepchildren in two thirds of the caregivers' social relations network suggests a lack of connection or integration that likely influences support dynamics. Such findings appear to support prior research on remarriage and stepfamily as an ambiguous (Boss, 2011; Stewart, 2007) or ''incomplete'' (Cherlin, 1978, 2004) context in which support provided to stepparents is more limited and/or more negative in nature (Ganong & Coleman, 2006). Future research on remarried caregivers and remarried older adults in general would benefit from determining whether omissions reflect long-standing estrangements or more recent tensions within stepfamilies. Such information could inform the development of interventions provided to remarried older adults facing health and caregiving demands.

Nonetheless, diverse networks with family and friends and/or friend-focused networks have been assumed to offer more opportunities for well-being than do restricted networks (Fiori, Antonucci, & Smith, 2007; Litwin, 2001). This may be especially true for older remarried adults and provide much-needed benefits to this population as they face increased stressors from negative interactions with step- and family members. Moreover, women who remarry later in life may be more likely to invest in friend and other peer ties and/or seek professional and context-specific support more readily compared to other older women.

Several intriguing findings emerged with respect to stepfamily members' representation in the study's three networks. It is noteworthy that stepfamily members were nominated by some remarried caregivers to the social relations and positive networks, but the high proportion of stepfamily members nominated to the negative network was striking. This pattern supports qualitative findings (Sherman, 2012; Sherman & Bauer, 2008) and may endorse assertions by Cherlin (1978, 2004) and others (de Jong Gierveld & Merz, 2012; Vinick, 1998) that stepfamily members lack shared social understandings or norms regarding provision of assistance and support, even in the face of serious parental illness and caregiving demands.

Research Question 2: Network Members in Multiple Networks

The addition of the positive and negative care-specific networks enabled an analysis of multiple network nomination that would be lost or obscured if only the social relations convoy had been assessed. Interestingly, the overwhelming majority of network members were nominated to only one of the three networks. The findings confirmed earlier qualitative studies of remarried caregivers that a majority of stepfamily, specifically stepchildren, are perceived as ''absent'' or divested from relationships and support of their father and the remarried wife, even in the face of dementia (Sherman, 2012; Sherman & Boss, 2007). It appears that many remarried caregivers compartmentalize their overall social world from their more care-specific networks.

Such compartmentalization may reflect a longer term legacy of marital and family dissolution and transition as well as a more general pattern of social network transition and isolation associated with dementia caregiving (Carpentier & Ducharme, 2005). Further study of context-specific convoys, especially over time, with regard to specific or multiple nominations of family/stepfamily members across networks will contribute to a better understanding of older adults' support patterns in specific health contexts such as dementia caregiving.

Research Question 3: Predictors of Caregiver Well-being

Overall, the negative network was significantly associated with caregiver well-being, but the social relations and positive networks were not. As expected, larger network size and more active negative interactions were significantly associated with greater caregiver burden. Moreover, higher rates of global disagreement with stepfamily members contributed to significantly more depressive symptoms and burden among remarried caregivers. These findings support prior research and provide additional contextual detail to our understanding of the salience and association of negative interactions on caregiver well-being (Neufeld & Harrison, 2003; Rook, 2001; Semple, 1992; Sherman, 2012; Sherman & Bauer, 2008; Zarit & Gaugler, 2000). It is noteworthy that caregivers' own family in the negative networks did not affect caregivers as adversely as stepfamily. Remarried caregivers have reported (Sherman) expecting less overall from their own children regarding caregiving support, given that their husband with dementia was not the children's father. They may also feel that positive ties with their own children, as illustrated by high rates of inclusion in the social relations and positive support networks, outweigh their negativity or failure to provide support. Patterns of support/nonsupport from their own children are likely to be familiar and thus may be experienced as less egregious or burdensome compared to negativity expressed by the stepchildren.

As with any study, limitations must be noted. First, recruitment for this study was theoretically driven to include late-life remarried wife caregivers, an understudied subgroup of AD/dementia caregivers. The resulting convenience sample, however, may limit this study's generalizability in that the study participants may represent a distinct group among remarried wife caregivers. Future studies of remarried caregivers should include a comparison or control group of caregivers in first marriages to allow for comparison and broader generalization of findings on caregivers. Similarly, sample size was another study limitation and allowed for the detection of only larger effect sizes. More comprehensive measures of marital status, including remarriage, in larger, nationally or regionally representative samples would allow for greater generalizability of results. Given the low alphas for the two-item instrumental support measure used in this study, incorporating additional items to assess instrumental support is advised for future research.

This study's findings were restricted to the perspectives of late-life remarried wives, the majority of whom were White, middle class, and relatively well educated. Research that incorporates diverse samples as well as multiple family members' perspectives is needed to represent inclusive depictions of support in complex families. The majority of respondents were in the mid-course of their husband's disease progression at the time of interview. This fact may have affected the makeup and nature of their caregiving-specific convoys as well as the nature of support experiences. Disease timing as well as the length and quality of the remarriage may influence the types and nature of the caregiving

support or lack of support experienced by respondents. Longitudinal or even prospective studies of transitions in and out of older adults' support convoys are needed to address this limitation.

Finally, this study focused on couples who were legally remarried. Given the trends of alternative modes of repartnering among older adults, future studies should strive to include couples who live apart or cohabit without legal marriage to reflect the full spectrum of repartnering among older couples. Considering that stepfamily membership is established as the ''new normal'' for a growing segment of American families, researchers must continue to map the potential resources and fault lines in more representative samples in order to understand and address the issues that shape stepfamily support experiences in later life.

Conclusion

As our society ages, an increasing number of older Americans will need caregiving and assistance from family and close social ties. Sustained rates of concurrent divorce and repartnering across the life span create increasingly complex family systems. For these reasons, the stepfamily is considered a ''strategic site for family research'' (Sweeney, 2010). Family psychologists have noted that stepfamilies ''illuminate, like no other family form, the subterranean moral domain of family life, the world of fairness and unfairness, loyalty and betrayal, commitment and abandonment, selfishness and altruism'' (Doherty, 1999, p. 38). It is imperative, therefore, to understand the potential risk factors and protective resources of older remarried and repartnered couples. Exploring how remarriage and stepfamily dynamics are enacted with respect to roles and responsibilities across the life course will enable scholars to adequately anticipate and provide for the full spectrum of support needs that arise among late-life caregivers and their spouses. Such information can inform interventions and guide clinicians in work with aging remarried couples and stepfamily members as they anticipate health and care issues.

NOTE

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