Abstract

Social networks are seen to influence the use of health and social care services. In a secondary analysis of data from a longitudinal study of befriending of carers of people with dementia, we studied the relationship between network type and support from family/friends, voluntary sector befriending and residential/nursing care. Using Wenger’s typology of social networks, findings suggest that the pattern of support use varies by differences in the structure of networks. It is recommended that questions on social networks should be widely incorporated into carers’ assessments to help identify need for social support interventions and to enable the sensitive selection of appropriate types of carer support to be provided.

Key words

social networks  befriending  family carers
caregiving  dementia
Social networks, befriending and support for family carers of people with dementia

Carers of people with dementia are increasingly recognised as engaging in a vital but challenging job in which the context of caring activities may affect the kinds of support accessed. A long tradition of research in social anthropology and sociology has suggested that support-seeking behaviour is mediated through social networks whose structure and content will affect access to resources and capacities to cope (Wenger, 1996). However, until the 1990s there was relatively little research examining the relationship between social support and health, including mental health. Bowling’s (1991) review of evidence relating social support, network structure and health status highlighted the limits on such research imposed by the restriction of social network measures to frequency and type of social contacts, and a move towards the assessment of quality and structure of social networks was recommended. Structural characteristics of networks are seen as having greater importance than network size, and support is believed to be mobilised in different ways depending on those structural characteristics. Ties between spouses, children or friends cannot be simply interchanged in relation to whether or not they mobilise support (Seeman & Berkman, 1988). Definitions of social network go beyond dyadic relationships to take account of relationships between individuals and groups (Felton & Berry, 1992).

There is now a growing body of literature documenting the influence of social relationships on the physical and mental well-being of older people (Blaxter & Poland, 2002) and carers (Pillemor K & Suitor JJ, 1996), and social networks was one of the five themes found to be of particular relevance for mental health and well-being in later life in the recent Mental Health Foundation/Age Concern survey (2005).

Family carers

Carers of people with dementia may experience a reduction in their social network due to a lack of opportunities to socialise and/or the stigma associated with a dementing illness. Carers report less social interaction and fewer friendships (Lofgren et al, 1992; Croog et al, 2006). The emotional and physical burden of caring can result in family role conflicts that may reduce the amount of emotional support available, and a carer’s family and friends may ‘distance’ themselves physically and/or psychologically from the carer and care-recipient contributing to reduction in social support for the carer (Jones & Peters, 1992; Upton & Reed, 2006; Clyburn et al. 2000).

Befriending and network support

Volunteer befriending has become increasingly popular as one means of helping socially excluded groups including carers of people with dementia to extend their social networking within their communities. This is seen as emerging directly from the relationship built with another member of a local community and, less directly, in helping the befriended to re-build their confidence in gaining social relationships and signposting to other sources of social support (Baines et al, 2006). Some studies have highlighted the scope of befriending to foster ‘friendship’ and the reciprocities entailed in this (Taggart et al, 2002; Andrews et al, 2003) with concomitant gains experienced by peer-befrienders (Brown et al, 2003). For befriendedees, a volunteer visit may be experienced as very different from that of a professional – perhaps without fear of the institutional intervention in their control of family or care choices, which may be especially welcomed by older people trying to maintain their independence. Other studies, as with the cross-organisational examination of the role and impact of befriending carried out by Dean and Goodlad (1998) identified that, while users may regard volunteers as ‘friends’, volunteers are more likely to differentiate between ‘friendship’ and ‘befriending’ as less reciprocal and entailing rather specific responsibilities. Other users of befriending schemes have valued the boundaries set on the type and extent of commitment of volunteers (Bradshaw & Haddock, 1998). Such research suggests that befriending may offer older people and family carers a useful alternative for sustaining and diversifying their social networks, but that their choice, to seek or accept befriending, will, in turn, need to take into account other factors in their lives. These may include the nature of the social networks in which they are involved.

Network typology

Wenger’s longitudinal research (Wenger, 1991) used mainly qualitative methodology to
distinguish patterning of constituent features of support networks of older people, including close kin proximity, and proportions of family, friends and neighbours, involved and levels of interaction with family, friends and community groups was used to distinguish five network types:

- family dependent
- locally integrated
- locally self-contained
- wider community focused
- private restricted.

These network types demonstrated some predictive power about how self-sufficient members of each type were likely to be coping with life changes and the characteristic types of demands that each might make on health and social services.

Locally integrated support networks, which extended beyond tighter family or household groups, appeared more open to gaining new information and able to adapt to a greater range of changes and pressures, leading to later admission of older members to residential care. People with dementia or other mental illness were found most likely to remain in the community where their support networks are ‘locally integrated’ or ‘local family dependent’. Carers were seen to be most likely to require face-to-face support in ‘locally self-contained’ and ‘private restricted’ support networks.

Litwin’s (1997) cluster-analysis-based research on network types also found network types to be associated with levels of take up of health services. This found that members of neighbour-focused and restricted networks were most likely to seek formal home care.

**Aim**

The aim of this paper is to test the robustness of Wenger’s network typology in being able to indicate which family carers of people with dementia are most likely to be in receipt of support from family, friends and neighbours. In addition, the predictive power of the network types are tested using longitudinal data on the use of a voluntary sector befriending intervention (emotional support), and on admission of the care-recipient (person with dementia) into permanent residential or nursing care. Data are drawn from the Befriending and Costs of Caring (BECCA) project, which was a cost-effectiveness randomised controlled trial of befriending for family carers of people with dementia. Our hypotheses were that:

1. regular support from family and friends would be most available for carers with family-dependent and locally integrated network types
2. admission into permanent residential/nursing care would be less common for carers with locally integrated and family-dependent networks
3. the befriending intervention would be most likely used by those carers with locally self-contained and private restricted support networks.

**Methods**

**Participants**

Participants were carers of people with dementia recruited for the Befriending and Cost of Caring (BECCA) randomised controlled trial. Recruitment for the BECCA trial took place through primary, secondary and voluntary sector care in Norfolk and Suffolk (East Anglia, UK), and the London Borough of Havering, with some self-referrals following media publicity or word of mouth. Selection criteria for the trial limited participants to carers providing 20 or more hours per week of care for a person with a primary progressive dementia living in the community. The BECCA trial was approved by the Eastern Multi Regional Ethics Committee (MREC), by the five local ethical research committees (LRECs) in Norfolk and Suffolk and by the Barking and Havering LREC. A total of 236 carers were randomised into the BECCA trial. All participants gave informed consent for their anonymised responses to be pooled with others for analysis and dissemination.

**Measures**

**Demographic information** was collected from the carer, including: carer age; gender; kinship to the person with dementia; duration of caring; cohabitation with the person with dementia; person with dementia age.

** Practitioner Assessment of Network Typology (PANT; Wenger, 1994; 1996)**

The eight items assess frequency of contact with family, friends and neighbours, geographical proximity to family and
information on local social ties (participation in social clubs, groups, religious meetings). Responses are used to categorise the individual as being in one of five types of social networks:
1. family dependent
2. locally integrated
3. local self-contained
4. wider community focused
5. private restricted.

Where an individual’s responses do not fall within one of the five categories, they are classified as ‘inconclusive’. Network data reported in this paper are from the baseline (pre-randomisation) interview.

Support from family, friends or neighbours (‘informal support’) was assessed using two dichotomous (yes/no) questions to the carer as part of the wider resource use interview schedule at baseline: ‘Do any relatives, friends or neighbours currently provide daily and/or weekly help or support?’ (regular support) and ‘During the last six months of caring, have you had any help or support from relatives/friends/neighbours on an occasional basis?’ (occasional support). Participants receiving regular and occasional support were classified as regular. Support data reported in this paper are from baseline.

**Admission into permanent care**
Information on the location of the person with dementia was collected at each follow-up point (six, 15 and 24 months post-randomisation) as part of the wider resource use interview with the carer. The key variable in this paper is whether or not the person with dementia entered institutional care on a permanent basis prior to the final follow-up research interview (24 months post-randomisation). Therefore, information on institutionalisation at an early follow-up would be available at the end of the trial, even if a participating carer withdrew from later follow-ups, or the person with dementia died. No significant differences were found between intervention and control arms of the BECCA trial on institutionalisation, and therefore all trial data can be used.

**Use of the befriending scheme**
Information on use (or otherwise) of the befriending service by the 116 carers randomised to intervention was derived from records kept by voluntary sector based ‘befriender facilitators’, and therefore available even if carers had withdrawn from the research interviews. Befriender facilitators had the role of recruiting, screening, training, matching and supporting trained lay volunteers. The duration of each befriender–carer match was calculated from start and end dates. The variable of interest in this paper is whether or not carers received six months’ befriending prior to their final follow-up research interview. A duration of six months had been considered an appropriate time for the befriending relationship to develop into a friendship.

**Analysis**
Data were entered into SPSS version 12.0.1 for Windows (2003). Baseline network data was missing for six carers and baseline informal support data missing for 10. Data were tabulated and Chi-square analyses were conducted.

**RESULTS**
The mean age of participants was 68 years (range 36 to 91 years) and the mean age of the person with dementia was older, at 78 years. Two thirds of carers were female, predominantly wives, and the mean duration of caring was just under four years. Most participants (over 80%) were cohabiting with the person with dementia.

All five network types were represented in the sample, with between 40 and 54 carers in all, except the wider community-focused network, which had less than 30.

Approaching half of all carers received some form of regular (daily or weekly) support from family, friends or neighbours, and just under one third received no such support. The pattern of support from family, friends and neighbours is shown in Table 1 for each network type. Carers in the family-dependent and locally integrated networks received regular support. Carers in the wider community-focused network, characterised by having distant rather than local social contacts, received support on an occasional basis. The majority of carers in the private restricted network, characterised as having no or limited local family or friends, received little or no support. The observed distribution of patterns
of support by network type was in keeping with what would be expected from the network typology, and statistically significantly different from the mathematically expected distribution ($\chi^2(8)=27.70, p=.001$).

**Table 2** shows the use (within two years of baseline) of permanent institutional care for the person with dementia by carers in each of the (baseline) network types. Carers in the locally integrated and local self-contained categories were most likely to see their relative institutionalised. The difference in observed and expected distributions of carers’ network type at baseline and institutionalisation of the person with dementia was of marginal significance ($\chi^2 (4)= 8.70, p=.069$).

Carers’ network and receipt of at least six months’ befriending support is shown in **Table 3**. Carers with private restricted network types made the greatest use of the service, but the overall pattern of use did not significantly differ from the mathematically predicted pattern ($\chi^2 (4)= 5.16, p=.271$).

**DISCUSSION**

In a unique study of the predictive power of network typology, we found that patterns of family support, use of befriending and institutionalisation of the person with dementia vary with carer network typology.

As hypothesised, carers in the family-dependent and locally integrated networks, characterised by having regular contact with local family, received regular support from family, friends or neighbours. Also, the carers with private restricted networks were most likely to use the befriending intervention. In contrast to the hypothesised relationship between network type and institutionalisation.

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**Table 1**: Network type for each level of support from family, friends and/or neighbours

<table>
<thead>
<tr>
<th>Network type</th>
<th>Regular support (n=98)</th>
<th>Occasional support only (n=59)</th>
<th>No support (n=69)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family dependent</td>
<td>24 (24.7%)</td>
<td>8 (13.6%)</td>
<td>8 (12.1%)</td>
</tr>
<tr>
<td>Locally integrated</td>
<td>28 (28.9%)</td>
<td>11 (18.6%)</td>
<td>6 (9.1%)</td>
</tr>
<tr>
<td>Local self-contained</td>
<td>16 (16.5%)</td>
<td>18 (30.5%)</td>
<td>12 (18.2%)</td>
</tr>
<tr>
<td>Wider community focused</td>
<td>7 (7.2%)</td>
<td>10 (16.9%)</td>
<td>9 (13.6%)</td>
</tr>
<tr>
<td>Private restricted</td>
<td>18 (18.6%)</td>
<td>9 (15.3%)</td>
<td>25 (37.9%)</td>
</tr>
</tbody>
</table>

**Table 2**: Carer network type at baseline and care-recipient use of residential care

<table>
<thead>
<tr>
<th>Network type</th>
<th>Person with dementia institutionalised (n=55)</th>
<th>Person with dementia not institutionalised (n=162)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family dependent</td>
<td>11 (20.0%)</td>
<td>30 (18.5%)</td>
</tr>
<tr>
<td>Locally integrated</td>
<td>15 (27.3%)</td>
<td>33 (20.4%)</td>
</tr>
<tr>
<td>Local self-contained</td>
<td>16 (29.1%)</td>
<td>30 (18.5%)</td>
</tr>
<tr>
<td>Wider community focused</td>
<td>2 (3.6%)</td>
<td>26 (16.0%)</td>
</tr>
<tr>
<td>Private restricted</td>
<td>11 (20.0%)</td>
<td>43 (26.5%)</td>
</tr>
</tbody>
</table>

**Table 3**: Baseline network type and use of befriending scheme for at least six months

<table>
<thead>
<tr>
<th>Network type</th>
<th>Befriended for at least six months (n=36)</th>
<th>Not befriended for six or more months (n=70)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family dependent</td>
<td>5 (13.9%)</td>
<td>16 (22.9%)</td>
</tr>
<tr>
<td>Locally integrated</td>
<td>6 (16.7%)</td>
<td>15 (21.4%)</td>
</tr>
<tr>
<td>Local self-contained</td>
<td>7 (19.4%)</td>
<td>12 (17.1%)</td>
</tr>
<tr>
<td>Wider community focused</td>
<td>3 (8.3%)</td>
<td>11 (15.7%)</td>
</tr>
<tr>
<td>Private restricted</td>
<td>15 (41.7%)</td>
<td>16 (22.9%)</td>
</tr>
</tbody>
</table>
of the person with dementia, carers in the family-dependent and locally integrated networks were more, rather than less, likely to see their relative admitted into permanent care. Befriending was therefore seen to be taken up by precisely the group of carers for whom gaining such a relationship would have made a notable difference in their social network type and level of social isolation. This demonstrates the greater willingness of this social network type to accept face-to-face rather than other types of social support as highlighted in Wenger’s developmental studies on network assessment.

**Practice implications**

The findings reported in this paper have implications for both assessment and intervention.

Carers’ assessments were introduced following from the Carers Acts (1995, 2000), which gave carers the right to an assessment of their needs. Wenger’s (1994) assessment guide for practitioners could be used in individual cases to address needs and problems commonly faced by older people with different types of networks available to them. These could take account of whether informal networks were likely to continue to provide appropriate levels of types of support and whether home-based service support could complement network functions and member preferences. Identifying network types of those with whom they work can help practitioners to confirm early judgements and to assess risks in decision-making. Further research (Wenger, 1997) suggested that the protective potential of well developed social networks in the face of bereavement, loss of mobility and other life stresses associated with getting older is most readily seen in the area of the mental health of older people. Here, knowing a carer’s support network type may help predict risk to the carer and/or the person with dementia in relation to a wide range of practice eventualities such as increasing frailty or hospital admission of the carer.

Network type assessment could also be used as the starting point for developing network-directed interventions, including befriending. Such work has already been undertaken in the field of mental illness where network-directed interventions were devised to help clients and their carers to modify their social networks as a way to help them to increase their use of preventive services and improve their well-being (Pinto, 2005).

**Policy implications**

The government has invested in support for carers, with a focus on funding respite and short breaks. For carers of people with dementia, respite care generally involves the person with dementia spending time in a residential or nursing home for extended breaks, or making use of sitting services for short breaks of a few hours. A policy development would be to consider the potential for developing the carers’ own networks to provide respite. This may already occur among those with the family-dependent and locally integrated networks but may need to be developed for those with the private restricted network type. Befriending may have potential in extending and diversifying networks.

**Future research**

The interplay of support from different sectors (family, voluntary and statutory) has not been studied for family carers of people with dementia. The findings reported here indicate the potential value of considering network type of carers in understanding differing patterns of support uptake. Also, the relationship between social networks and mental health of carers would be a valuable area of research, as has been demonstrated when predicting the mental health of older people. For example, Fiori (2006) tested the robustness of previous social research in relation to predicting the mental health of older adults in 1,669 adults aged 60 upwards. This suggested that it was more informative to distinguish diverse, family and friends network types following Litwin’s (1997) typology than to concentrate on network size. They found that those based in diverse networks with many sources of support or performing many roles had the best outcomes in relation to depression and that the absence of friends in the context of family was more detrimental than the absence of family in the context of friends. They suggest that while family relationships may be important, they are usually obligatory, and that if friendships are optional, they may be important for affirming a sense of autonomy, self-worth and
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for enabling social integration. The contribution of befriending in facilitating carers to extend their networks and experience of perceived support by including such ‘optional’ relationships merits more detailed examination. This study also found that perceived support partially mediated the association between network type and symptoms of depression, consistent with research indicating that the quality of social relations may have a greater impact on well-being than the structural characteristics of social networks.

CONCLUSIONS

The caring activities of carers of people with dementia put their support networks under threat. The BECCA study provided a unique opportunity to test the predictive power of network typology. Family support, use of befriending, and institutionalisation of the person with dementia were all shown to vary with carer network typology. The carers most likely to experience social isolation, those with private restricted networks, were shown to be most likely to use the befriending intervention. Befriending was, therefore, seen to be acceptable by the group of carers to whom such an intervention might have most potential for affecting their social network type and level of social isolation. However, in contrast to predicted outcomes, carers in the family-dependent and locally integrated network types were more, rather than less, likely to see their relative admitted into permanent care. Considerations for policy and practice may be to include assessment of carers’ networks as part of carers’ assessment of need and also to develop carers’ own networks to provide respite.

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