

Association between social support and quality of life of relative caregivers of elderly dependents

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Abstract *Objective: to ascertain the association between the social support and the quality of life of relative caregivers of elderly dependents at home. Method: a cross-sectional study conducted with 58 relative caregivers of elderly dependents, registered in the Family Health Strategy. Data were collected from the Katz instrument, sociodemographic, Zarit Burden Interview, WHOQOL-bref, and analyzed using descriptive statistics and multiple linear regression. Results: the majority of caregivers were women, who took care full-time and presented moderate to severe burden. Most caregivers are satisfied with their social relationships and the social support received. It is found that the burden and the time of care correlated with the social relationships domain, which is associated with social support, and consequently, reduced quality of life. Conclusion: social support for caregivers is important to prevent health implications, burden, biopsychosocial stress, and provide favorable conditions for quality of life, by allowing greater freedom to develop their daily activities.*

Key words *Caregivers, Family, Elderly, Quality of life, Social support*

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Introduction

Increased longevity and reduced mortality are associated with the increase of technological advances of curative and preventive medicine. At the same time, reducing mortality and fecundity emphasizes the aging process. Aging is a complex process of biological evolution of living organisms, as well as psychological and social development of human beings. This is a normal, universal, gradual and irreversible process, in which there is deterioration of endogenous functional abilities of the body; with an increasing tendency among elderly people whom, despite living longer, present an association with chronic diseases¹.

Therefore, it is assumed that the elderly progressively lose functional abilities, thus favoring the limitations from the emergence of chronic non-transmittable diseases and its consequences, or the cognitive and functional losses of advancing age, which require home care and change the daily lives of various family members².

Changes because of aging cause numerous elderly people to require assistance in carrying out daily activities. From this need arises the figure of the elderly caregiver, who in different situations, passes under an inattentive gaze and without training related to care, resulting in stress for both the elderly person and the caregiver³.

The family becomes the fundamental support of care for the elderly⁴ and represents an informal support network, because the care is performed voluntarily, being a partner of the formal social support networks, which consist of professionals trained to provide care for these individuals. In this context, relative caregivers are the individuals who perform elderly care in their own family.

The relative caregiver feels satisfaction in providing care, but this is also work⁵. Providing care for a dependent individual involves considerable biopsychosocial commitment, beyond the financial burden that commonly falls on the caregiver's family⁴. The existence of strategies, such as social support networks, can reduce the negative implications related to this act of caring, in which family members find help and assistance to meet their needs in everyday situations and/or crises⁴.

Social support covers the structure of the social relationships network and the adequacy of its function, particularly the degree of the person's satisfaction with the support they receive. Its existence has been strongly associated with positive outcomes⁶ and related to the structural and institutional dimension linked to the individual⁷.

Moreover, social support includes features provided by others such as: 1) emotional, involving expressions of love and affection; 2) instrumental, regarding to assistance, provision of material needs, and help with practical and financial work; 3) information, which may be used to deal with problems and solving them; 4) and positive social interaction, including the availability of people with whom one can have fun and relax. In this context, social support is one of the intervening variables in the quality of life (QOL) of the relative caregiver and the dependent person, granting the family freedom to return to their normal life⁸.

Studies on the influence of social support on the QOL of relative caregivers of people with dependency have identified the fact that caregivers who receive some kind of support from family and friends associated themselves with better satisfaction in interpersonal relationships. In addition, caregivers who were dissatisfied with their social relationships had increased burden⁷.

This fact may be associated with the subjective assessment of the caregiver regarding the definition of QOL, which according to the World Health Organization, is the perception that the individual has about their position in life, concerning the culture and value system in which they live and in relation to their goals, expectations, standards, and concerns⁹.

Note that this study⁷ included relative caregivers of patients served by the Family Health Strategy (FHS), located in the Southeastern part of São Paulo state, which has a high human development index (HDI)¹⁰. On the other hand, the current study was conducted with caregivers residing in a city in the interior of the state of Bahia with a low HDI¹⁰.

This study aimed to ascertain the association between the social support and the QOL of relative caregivers of elderly dependents at home.

Methods

A cross-sectional study conducted with residents in an urban area, assigned to two FHSs, in the municipality of Manoel Vitorino, located in the interior of the state of Bahia. The participants in the study were all relative caregivers of elderly patients with cognitive and/or functional dependence, attended by the FHS teams, in the period of January to February 2013.

The municipality of Manoel Vitorino, where these FHSs are located, is positioned in the

Southwestern region of Bahia and has an area of 2,254.42 km². The population is composed of 14,387 individuals; there are 7,359 people in the urban area, and 871 of these are elderly¹¹. The Municipal Human Development Index (MHDI) is 0.566, ranking in the 4,921st position relative to the 5,565 municipalities in Brazil, and in relation to the other 417 municipalities of Bahia, occupies the 312th position. The Gini coefficient is 0.51, and the per capita income is R\$ 226.95, with 26.47% of individuals extremely poor and 46.92% poor¹⁰.

There are two FHSs in the municipality, which consists of 14 micro areas, home to 871 enrolled elderly people (aged 60 or over). From this survey, together with the Community Health Agents, visits were conducted in the homes of the elderly people to identify those with functional dependence and caregivers.

Among the 871 elderly, 62 (7.1%) were dependent on care. In four of the households, two elderly individuals were found with dependence on a caregiver, which totaled 58 relative caregivers. It is noteworthy that some caregivers referred to support from family and friends, in specific moments and requests, however, claim to be the main caregivers. During the research, it was observed that some elderly needed caregivers and did not have one, and so, were not included because they did not meet the inclusion criteria of the sample.

Participants in the study included 58 relative caregivers of dependent elderly who met the inclusion criteria: relative caregivers of elderly with cognitive and/or functional dependence; cohabiting the same household; aged 18 years or over; performing the role as the main caregiver of the elderly; and enrolled in one of the FHSs. In this study, the family was considered as people with bonds, not always characterized by blood ties, but who performed activities of caregivers, this because they are taking on the responsibility of caring for the dependent elderly at home, so not to be renumbered.

To identify the elderly people with functional dependency, the Index of Independence of Activities for Daily Living (ADLs) developed by Sidney Katz was used to assess functional independence in the performance of ADLs. It includes the assessment of six functions (bathing, dressing, toilet hygiene, functional mobility, personal hygiene, and self-feeding)¹². The value obtained can vary from 0 to 6 points. The instrument analysis assigns one point for each "Yes" response, being classified as independent in all functions; or de-

pendent in one, two, three, four, five, or six functions (depending on all functions)¹³.

To identify the sociodemographic and health characteristics of the relative caregivers, we applied a form designed by the authors. The Zarit Burden Interview (ZBI) was used to measure the objective and subjective caregiver burden, in relation to the care of the elderly, which is composed of 22 items that assess health status, psychological well-being, finances, and social life¹⁴. It varies from 0 to 4, including: 0 = never, 1 = rarely, 2 = sometimes, 3 = quite frequently, and 4 = nearly always. The exception is the last item, in which the interviewed person is asked if they are feeling burdened by performing the role of caregiver (0 = not at all, 1 = a little, 2 = moderately, 3 = very, 4 = extremely). The total score ranges from 0 to 88, wherein the higher the score, the greater the burden¹⁴.

The caregiver's QOL was assessed by the World Health Organization Quality of Life (WHOQOL-bref) questionnaire, containing 26 questions, two general (general QOL and satisfaction with health) and 24 encompassed in the physical, psychological, social relationships, and environment domains. The two general questions are calculated together to generate a single score, regardless of the other domain scores, which is called the General Quality of Life Index (GQLI)¹⁵.

For statistical treatment of the data, the Statistical Package for the Social Sciences (SPSS) version 21.0 was used. Data were explored from the descriptive statistics of the GQLI and the domains of the WHOQOL-bref, using mean, median, variance, and standard deviation (SD).

Furthermore, the Spearman correlation between the domains of the WHOQOL-bref and quantitative variables of the caregiver and the elderly was performed, as well as the model of multiple linear regression (stepwise forward), having the social relationships domain as the dependent variable, which encompasses issues in relation to personal relationships and support (social support), and, sociodemographic characteristics of the caregiver and elderly, as well as the Zarit score, were independent variables¹³. The score from the social relationships domain was chosen, because it is considered as an adequate and comprehensive indicator for the purpose of the study. The significance level adopted for this study was 5% (i.e., $p < 0.05$).

This study was approved by the Research Ethics Committee of the State University of Southwest Bahia at the Jequié campus in Bahia.

Results

The characterization of the dependent elderly who received care were females (65.5%), older than 72 years (76.1%), and a mean age of 79.8 years (± 11.5). The most commonly reported disease was hypertension (48.3%). From the classification, according to the Katz scale, it was identified that 36.2% of the elderly were dependent in 1-3 functions, 44.8% in 3-6 functions, and 19% in 6-7 functions (completely dependent upon care), with a median range of 5.0 (± 1.85).

In the case of caregivers, the majority were female (84.5%) with a mean age of 47.41 (± 16.8), ranging from 18 to 80 years. Regarding the relationship, 77.6% were daughters, followed by 15.5% spouses. In relation to race/color, 74.1% declared themselves as non-white (brown/black), and 60.3% were married or in a consensual union. As for education, 22.4% were illiterate, and 53.5% had incomplete and/or completed primary school.

The average time as a caregiver was 7.4 years, and it was identified that 68.8% were dedicated to caring for the elderly between two and ten years, and 20.8% were dedicated for over ten years. Concerning the hours dedicated to care, 88% cared for 13-24 hours a day, with a mean of 21.9 h (± 4.9).

Of the caregivers, 36.2% reported not having an individual income, 31.2% earned less than minimum wage, and 24% had an income equal to a salary. In terms of occupation, 55.2% were unemployed, and 27.6% never performed paid work.

The family arrangement indicated that 25.9% of caregivers lived alone with the elderly, and 56.8% with three to five people in the same household (spouse, child, grandchild, daughter/son-in-law), ranging from two to eight individuals, with a median of 3.0 (± 2.3).

It was observed that 87.9% of the caregivers self-reported a health impairment with at least one disease. Of these, 25.9% presented three associated diseases, 20.6% with four or more, and 51.7% were using some daily medication. The diseases most cited were back pain (63.8%) and hypertension (41.4%).

Caregivers unanimously reported never having attended a course or support group to help them develop the daily care of the elderly. Among the caregivers, 60.3% reported receiving support from others to care for the elderly, mainly citing family members: the elderly's child (24.1%), caregiver's child (17.2%), and neighbor (8.6%);

and 39.7% did not receive informal support. It is emphasized that the social support received was related to direct care of the elderly. Caregivers declared that they do not receive formal social support.

When evaluating burden, based on the Zarit scale, it was observed that all caregivers have some level of burden, and 51.7% had scores between 4-60; 29.3% between 21-40; and 19% between 61-88, with the scale variation of 22-72 and a mean of 47 (± 12.3). The Zarit scale was negatively correlated with all of the WHOQOL-bref domains, which predicts that the higher the score on the Zarit, the lower the perception of QOL among caregivers.

Table 1 presents the scores of the WHOQOL-bref domains, showing that the highest mean was presented in the physical domain 54.8 (± 15.5), while the lowest was in the environment 41.4 (± 13.9). Moreover, we observed a mean of 55.1 (± 19.8) for the GQLI.

The social relationships domain of the WHOQOL-bref showed that 64.4% of the caregivers reported being satisfied or very satisfied. By associating the social support informally received, 60.3% of the caregivers showed higher scores in the physical domain and worse scores in the environment domain. Concerning support and social support, 41.4% of the caregivers reported satisfaction. As for recreation/leisure and spirituality/religion/beliefs 14.4% and 66.5%, respectively, reported being satisfied.

Table 2 presents the final multiple linear regression model and shows the independent variables statistically related to the social relationships domain, which involves questions associated with social support. It is observed that the

Table 1. Descriptive statistics of the General Quality of Life Index and the WHOQOL-bref domains from the associated study between social support and the quality of life of relative caregivers of dependent elderly at home. Manoel Vitorino, Bahia, Brazil, in 2013.

Domains	Mean (sd)	Median	Observed variance
GQLI	55.1 (19.8)	50.0	0.0 - 87.5
Physical	54.8 (15.5)	53.5	10.7 - 85.7
Psychological	54.5 (14.9)	58.3	12.5 - 83.3
Social relationships	50.4 (17.2)	50.0	8.3 - 83.3
Environment	41.4 (13.9)	42.1	6.2 - 68.7

Table 2. Model of the final multiple linear regression for the social relationships domain of the study, an association between social support and the quality of life of relative caregivers of dependent elderly at home. Manoel Vitorino. Bahia. Brazil. 2013.

Variable	Regression Coefficient β	P
Zarit	-0.296	0.020
Time of care (months)	-0.269	0.034

Zarit scale and the time of care remained to the end of the model, indicating that the two variables alone were able to explain the reduction in the social relationships domain. This allows us to state that the greater the burden of the caregiver's activities and time devoted to care for the elderly, the worse their perception of QOL.

Discussion

As for the characteristics of caregivers of the elderly Manoel Vitorino, despite some peculiarities of the city, such as the everyday difficulties experienced by these individuals regarding access to health services, low HDI, low education, and high unemployment rate, they are not very different from studies conducted in different regional, cultural, and social contexts. In this context, a prevailing consensus in national^{7,16} and international literature^{4,17} on the predominant profile of elderly caregivers are women, daughters or wives, married or in a consensual relationship, and with low education levels.

This finding seems to be related to the fact that when a family member becomes ill, the woman usually assumes the responsibility to provide care, viewed as a natural activity - culturally and socially assigned to the role of mothers¹⁸. Men rarely assume responsibility for direct care, contributing only secondarily¹⁹. However, although a minority, male participation in elderly care exists and is consistent with other studies^{4,20}.

The caregiver's age is a relevant variable, because the caregiver often belongs to the same generation as the individual being cared for. They are independent elderly caring for dependent elderly²⁰. This situation often arises from the caregiver's role being attributed to spouses². In contrast, the results from Manoel Vitorino showed that the majority of caregivers are children of the

elderly, and only 15.5% are spouses. The mean age identified (47.41 ± 16.8 years) coincides with the mean age of caregivers observed in other studies^{16,21}.

Elderly caregivers are called "hidden victims," since in many situations - besides living with isolation, loneliness, activity overload, responsibilities to take care of, and financial difficulties - still deal with the aging process. This can trigger stressful situations and health problems in these individuals²², because over the years feel that they do not have the same ability as before for some activities, raising concerns and distress regarding the future of the person who is cared for and their own future².

The variable of race/color has been rarely reported in national^{7,19} and international^{17,20} studies involving caregivers. A study conducted in Ribeirão Preto, São Paulo²³, identified that most caregivers declared themselves as white in skin color, which can be associated with the South-eastern region of Brazil where the research was conducted. On the contrary, the results of this study found that most caregivers were of brown skin color, and this finding may be related to the miscegenation characteristic from the Northeast region of the country, where the research was conducted.

A study conducted in Chile found that most caregivers dedicated more than five years to care, on a full-time basis, and receive social support for this activity²⁰. These results coincide with the results of this study, identifying the needs of the caregiver to provide long periods of care for the elderly. This continuous dedication and for long periods can expose health risks to the caregiver, mainly due to the stressors associated with care, as well as the reduced perception of QOL.

Regarding the living arrangement, a mean of 3.7 persons reside with the elderly, ranging from two to eight individuals. There was a positive correlation between the number of people living at the same locale and the social relationships domain. In this context, it appears that the number of people residing in the same household also seems to mean a better support network; since the more people around, the greater the likelihood of help and alternation of care, although it is not guaranteed that caregivers will receive help⁷.

Social networks are social support resources and are related to solidarity and social action that strengthen democracy, because of the ties and interdependence contrary to the fragmentation of the "social fabric" in modern society. Social sup-

port is not a static experience, as the moral and ethical values that feed it, presented as flexible, changeable and in constant construction²⁴.

Among caregivers, a significant portion present low economic conditions, declared that they have no income^{20,21} and exercise the role of a housewife²⁵. Of those who reported an income, the mean per capita income was less than the minimum wage¹⁶. This fact may be related to the time needed to devote caring for the elderly, as several families have to give up extra home and personal activities to care for their family. Similar to the city's characteristics, since most of the population is considered poor or in extreme poverty, most caregivers declared only receiving income from the family allowance and the retirement of the elderly to sustain the household.

As noted, most caregivers claim to be affected by a chronic or acute disease, perceive their health as fair or poor, and present severe or mild burden²⁰. This study found a worse health condition in people who were dedicated to informal care of family members, when compared to people who did not perform such activity, assuming that this deterioration in health may be associated with a greater burden of activities of these individuals²¹. Caregivers assume multiple social roles, the example of a mother, wife, employee, daughter⁴, caregiver of a dependent elderly, and often without formal or informal support.

A study reported that several caregivers showed signs and psychosomatic symptoms or chronic diseases including: spinal pain, hypertension, herniated disk, and osteoporosis. More worrisome is the fact that a significant part of caregivers referred to worsening health problems after taking on the caregiver role²⁶.

In this context, there is the importance of social support for the elderly caregivers in relation to health, disease, and care - especially recognizing the culture and value system for the regulation of exchanges, obligations, and providing support to families. Hence, the proposal to include social support in the social protection policy of non-governmental organizations aim to encourage solidarity practices to socially weak and vulnerable groups as a means of social participation, exercise of citizenship, and democracy²⁴.

The results show that formal social support (i.e., derived from structured support networks) is non-existent in this population studied, with informal social support only made possible by family members, which may be associated with increased activity overload and a worse perception of QOL among caregivers. This lack of for-

mal social support is supported by results from other studies^{16,19,25}. The informal nature of this kind of support (i.e., family support) may not be enough, because it generally occurs momentarily, by setting specific actions in times of need and emergency, therefore, not a distribution of care². What was demonstrated in this study is that the majority of caregivers (60.3%) received informal instrumental support (direct care for the elderly) and in a timely manner.

Social support is organized by means of bonds between people. Its structure is composed of a network of formal relationships that include, for example, health professionals, and informal social relationships such as family, friends, and neighbors²⁷. This is configured as a type of help that is part of exchanges, obligations, and reciprocal patterns among individuals, groups, families, and institutions, bearing meaning for those involved in the experience and contexts. On the other hand, giving, receiving, and returning the support influences and are influenced by political, economical, social, and cultural changes that affect contemporary societies²⁴.

Caring for elderly with a chronic disease is a stressful activity, and when undertaken by only one family member becomes even more stressful, which can cause frustration and social losses because of the time dedicated to this activity. This physical strain can be greater if associated with the lack of help, in the sense of shared responsibility with other family members, and not with the function of care itself⁹.

The search for formal and informal social support is a strategy used by caregivers to cope with the stress caused by caring for a dependent elderly. However, it occurs in a timely manner, and the resolution focuses on the health needs of the elderly. Requesting informal support may occur through a discussion with family, friends, and neighbors, as well as the alteration of care. In this perspective, the nurse has the possibility of expanding their professional activities with families of dependent elderly, and at the same time, the challenge to reclaim the care from family caregivers²⁸.

It is important that caregivers receive psychological support to alleviate emotional hardship; to obtain financial and material resources to take care of their elderly relative; to help perform activities of daily living, at home, and caregiving; and to receive more information about the disease and guidance to perform the care⁴. In this context, interaction networks expose individuals to trade the tangible medium of exchange, emo-

tional and informative. This is relevant because the breakdown of social networks and the deficit of support can lead people to reject the caregiver condition, since care influences the physical and psychological health of the caregiver²⁹.

This study shows that caregivers with greater family articulation had greater informal support. The cohesive family networks, their structure, and size are factors that contribute and determine the type of support that they receive. In addition, it was observed that African-American caregivers might be at risk of negative health problems because they generally do not use formal support as an aid strategy, which can heighten their limitations in everyday life³⁰. The results showed that the informal support received by caregivers may be associated with the quantity of people residing in the same household, and the non-adherence to formal support, such as a support/aid strategy, may be due to the absence.

The functions assigned to the caregiver, often without proper guidance – without the health institutions that support routine modifications and time spent for caregiving – has negative impacts on the QOL of the primary relative caregiver¹⁶. Other factors are related to the overload of activities, which may influence the QOL, such as performing another work-related activity, or when the caregiver beyond the elderly, cares for children (their own children)²⁰.

The act of caring for elderly suffering from chronic diseases can cause burden, and stressful situations that may cause burden for the caregiver, the elderly, and their families. This fact varies according to the degree of autonomy of the elderly¹⁹. It appears that the social support which the caregiver has, in order to meet the practical needs related to emotions and information for care, may influence their well-being - since the perception of assistance may help reduce tension associated with caregiving, allowing the caregiver to maintain their health⁴.

A study about the influence of social support on the QOL of relative caregivers showed lower scores of burden among female caregivers; those who received one form of help for the elderly care reached the highest scores in the social relationships domain of the WHOQOL-bref⁷. In this study we identified that the greater the burden of caregivers and time (months) dedicated to caring for the elderly, the worse the perception of QOL in all domains of the WHOQOL-bref and especially in the environment domain, which can be associated with the deficit of informal support and lack of formal support received.

Beyond that, it became clear that most of the caregivers reported satisfaction in the social relationships domain, especially those who received support from family members to provide care. This may be related to the readjustment of the caregiver's daily life, often times imposed by the situation and the perception of QOL, which involves cultural and environmental aspects, beliefs, values, health conditions, and biopsychosocial factors.

Note that social support can contribute to the preservation of the physical and mental health of the caregiver, protecting it from consequential exposures to feelings of helplessness and confinement, imposed by the assumed responsibility. Moreover, this favors the recovery of the autonomy of the person being cared for and influences the binomial QOL, for the relative caregiver and dependent person, specifically when related to the caregiver's freedom to resume their daily life⁸.

A study conducted in São Paulo showed that the Zarit scale presented a statistically significant correlation inversely proportional to the mean score in social relationships, indicating greater activity overload of negative impacts of QOL in the social relationships domain⁷. Another study conducted in Portugal found that the QOL was negatively related to burden and morbidity, and positively correlated to satisfaction of friends. Furthermore, the environment dimension was positively correlated with the social support received³¹.

In assessing the QOL of caregivers, the study found that the GQLI had a mean of 54.6, and the physical and social relationships domains showed the highest scores, while the Environment domain had the lowest. The Zarit scale results had a mean of 32.1 points, indicating that caregivers did not report high levels of burden⁷. These results are similar to physical and environment domain outcomes in this study. There is a disagreement regarding burden, as the results showed that among caregivers, most presented a moderate to severe level of burden.

QOL has a comprehensive character and recognizes the importance of people's participation in activities of leisure, economical, cultural, spiritual, social, and civil. However, it was observed that elderly caregivers have experienced adverse conditions that affect their lives, evidenced in the overall mean of QOL, which was 38.83 among caregivers and 41.81 for non-caregivers³².

Caring for a dependent relative leads to changes in the biopsychosocial areas of the caregiver. One of the aspects affected is the social

support and network, mainly due to the lack of recreational opportunities and the possibility of extra-domestic work. If on one hand, the caregiver is deprived of part of its network of living, then on the other hand, the inner circle of intimate relationships can be strengthened, that is, caring for a relative can be more meaningful and rewarding than the social losses caused by burden and isolation that caregiving can cause caregivers⁷.

Regardless of regional or cultural aspects, care causes limitations and challenges for the caregiver. In this context, the implementation of public policies aimed at greater social support, especially from health professionals working in primary care for caregivers, is necessary – because from this, one can identify factors that negatively influence the biopsychosocial conditions of these individual³³.

Another study indicated that caring for an elderly with a chronic disease may pose a threat and cause stress. Success in dealing with this situation will depend on *coping*, a process used to control demands related to the individual and the environment. The greatest stress is associated with the lack of social support from family members and not the distribution of responsibilities. Encouraging family involvement and providing basic guidelines that can reduce the difficulties of care can contribute to the well-being of caregivers, as well as their quality of life¹⁹.

It is considered that informal care conducted by family members is a social function, which acts as a determining factor and can generate health inequalities. Policies to complement formal and informal care, and evenly distribute loads of care in a family network, can minimize negative implications on the well-being of caregivers²¹. Most often, caregivers do not receive training for daily care of the elderly, only medical information about the disease²⁵. Guidelines from a healthcare team are essential and relevant to support caregivers and to encourage better quality of care for the elderly, as well as the binomial QOL of the elderly and caregiver.

Final Considerations

It was evident that the majority of relative caregivers of dependent elderly were women, with poor economic conditions and low levels of education, who devoted themselves to full-time care and presented moderate to severe burden. These characteristics are corroborated with studies conducted at the national and international levels, regardless of regional and/or cultural aspects.

The lowest score of QOL was in the environment domain, although most caregivers were satisfied with social relationships. The burden and time dedicated to care for the elderly were relevant predictors of satisfaction with social relationships, having an inverse relationship between these variables and the perception of QOL. This influence may be associated with the deficit of informal social support, and above all, the absence of formal support received, as well as the readjustment of the caregiver's daily life and perception of QOL. It was also evident that social support influences the QOL of relative caregivers because it allows them greater freedom to develop their daily activities.

Therefore, guidelines and formal and informal social support are important to prevent health implications, burden, and biopsychosocial stress on caregivers, by providing favorable conditions for the QOL of these individuals. These data provide subsidies to the healthcare team in planning and implementing health strategies focused on the specific demands of the dependent elderly and their caregivers.

Due to the limitations of this study, as to not using a specific tool to assess social support, as well as the lack of exploration about the type of social support, it is suggested to conduct new studies capable to further investigate the matter, which may broadly and comprehensively identify the influence of social support on the caregiver's QOL.

Contributors

KF Anjos participated in all stages of preparation of the article; RNSO Boery participated in the orientation, analysis, and interpretation of data; R Pereira participated in the analysis and interpretation of data; LC Pedreira, ABA Vilela, VC Santos, and DO Santa Rosa worked on the writing, critical revision, and final text.

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