POSITIONING IN A SUPPORT GROUP FOR SPOUSES OF PERSONS WITH DEMENTIA

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ABSTRACT

The overwhelming nature of caregiving for a person with dementia leads many caregivers to join a support group. Support group conversations shape how members understand their circumstances and themselves. Patterns of support group conversations may facilitate ways of thinking of oneself as a caregiver that ease negative impacts of caregiving. Guided by positioning theory, this participant observation case study examines how spouse caregivers of persons with dementia are positioned in patterns of support group conversations. Five patterns of conversations are identified—change, continuity, negative impacts, management, and caring for oneself. Through these five patterns of conversations, dementing spouses and their caregivers are constructed as objective/subjective dualities. The implications of this duality for caregivers and support groups are discussed.

Caregiving is becoming a common experience in the United States—an estimated 44.4 million persons provide help to adult relatives and friends (Link, Dize, Folkemer, & Curran, 2006). These numbers will increase markedly over the next two decades with approximately 8,000 baby boomers turning 60 every day (U.S. Census Bureau, 2007). Further, between the years 2000 and 2050 there will be an increase in the 85 and older population from 4.3 million to 20.9 million

(Johnson & Weiner, 2006). Nearly 50% of these older adults will be diagnosed with some form of dementia, most commonly Alzheimer's (National Institute on Aging, 2007). Family members are the nation's greatest resource in helping frail older adults as they provide roughly 80% of all long-term care services in the United States (Gitlin, Reever, Dennis, Mathieu, & Hauck, 2006). On this basis we can expect family caregivers to play increasingly important roles in providing care to older adults. We need to be much better prepared to assist them in doing so.

Caregivers, particularly for persons with dementia, have a wide range of experiences. These can include satisfaction with caregiving (Lawton, Kleban, Moss, Rovin, & Glicksman, 1989), but also negative consequences. Depression, anxiety, health problems, isolation, and financial difficulties are common (Gitlin et al., 2006; Pinquart & Sorenson, 2007; Schultz & Beach, 1999). Much caregiving research is now moving beyond descriptions of caregivers' problems and needs toward examinations of interventions and services, including internal processes (Gitlin et al., 2006; Schulz et al., 2003; Sorenson, Pinquart, & Duberstein, 2002).

The data analyzed in this article focus on one form of intervention for caregivers—the support group. Specifically, this article focuses on support group processes. Guided by positioning theory and examining actual patterns of support group conversations, this article demonstrates how identity work by individuals within a support group can combat negative consequences of dementia caregiving. Describing and understanding how conversational processes can help caregivers is a step toward designing yet more effective interventions.

CAREGIVER SUPPORT GROUPS

Participation in support groups has been identified as one of the top six services used by family caregivers (National Alliance for Caregiving & AARP, 2004). Research regarding support groups for caregivers of persons with dementia specifically has detailed numerous positive outcomes. Research has shown that after participating in support groups many caregivers have an improved understanding of dementia and Alzheimer's, increased awareness of community resources, and a sense of universality as they realize they are not alone (Cuijpers, Hosman, & Munnichs, 1996; Gonyea, 1989; Gonyea & Silverstein, 1991; Wright, Lund, Pett, & Caserta, 1987). Improved self-identity (Nathan, 1986), improved morale (Gonyea, 1990), and confidence in caregiving ability (Cummings, Long, Peterson-Hazan, & Harrison, 1998) have also been linked to caregiver support group participation.

Support group attendees are typically among the most stressed and vulnerable of all caregivers (Burks, Lund, & Hill, 1991). Their unique problems, situations, and needs become their motivation for seeking help. We know for example that caregivers with significant health problems or who attribute their health problems to the stress of caregiving are more likely to attend support group meetings

(Martichuski, Knight, Karlin, & Bell, 1997; Monahan, Greene, & Coleman, 1992). This holds as well for caregivers with lower levels of life satisfaction (Burks et al., 1991), higher levels of burden (Goodman, 1991; Martichuski et al., 1997), and higher levels of emotional distress due to caregiving (Farran & Keane-Hagerty, 1994; Monahan et al., 1992). Hence, support groups can potentially affect the emotional and physical well-being of the most vulnerable caregivers.

Though much is known about outcomes of support group participation, research is needed regarding the process of receiving and providing support, i.e., the patterns of conversations within these groups. Caregiver support group conversations shape how members understand their circumstances and themselves (Kennedy, Humphreys, & Borkman, 1994).

Support can positively affect well-being (Albrecht, Burleson, & Goldsmith, 1994; Burleson, Albrecht, Goldsmith, & Sarason, 1994); hence, understandings of self and situation created within caregiver support groups may positively impact caregivers. This study examines how patterns of support group conversations influence caregiver identity and the uses of this knowledge in improving support group processes and outcomes.

Identity, or one's sense of self, provides a blueprint for action. For example, if a caregiver thinks of self as the person who must provide all of the care for a person with dementia, then he or she is not likely to utilize respite opportunities. If a caregiver thinks of self as the person who must ensure that a person with dementia is well cared for, then utilizing home care, adult day care, and other forms of respite become more accessible. Patterns of support group conversations may facilitate ways of thinking of oneself as a caregiver so as to ease negative impacts of caregiving. By focusing on these patterns of support group conversations, we can better understand how such groups may benefit caregivers and potentially facilitate improved caregiver services.

THEORETICAL FRAMEWORK

Positioning theory provides a useful framework for examining how caregiver identity is constructed in patterns of support group conversations. "Position" is a dynamic alternative to the concept of "role" (van Langenhove & Harré, 1999). In interactions, we position ourselves and, relatedly, position others. We are also positioned by others and can take up or refuse positions made available to us (Davies & Harré, 1990). Because interactions are multiple and contradictory, positions can be multiple and contradictory (Davies & Harré, 1990). Sabat and Harré (1992), for example, describe how interactions at an adult day care center position a woman with dementia identified as I.R. as a helper and nurturer, while interactions with her spouse at home position her as incapable, confused, and helpless.

By applying positioning theory to a caregiver support group, we can learn more about the dynamic nature of caregiver identity. Given that a support group is meant to help caregivers in need, we may better understand through this research how more positive identities that lead to better mental and physical health are made available in patterns of conversations. Caregivers turn to support groups for help; thus, this study focuses on the powerfully influential knowledge that group members create about who they are. The conceptual question guiding this research is: How are group members positioned in patterns of caregiver support group conversations?

METHOD

Data were collected through the first author's attendance at 20 meetings of a spouse support group over five months. The group met weekly for 90 minutes at an adult day service and counseling center in a large metropolitan area. The group had 10 members at a time and members stayed as long as they needed the group.

At the start of the research period, the group was comprised of six women and four men. Composition shifted to seven women and three men when one member, Frank, left the group and a new member, Joy, joined. Later in the research period, Anna left the group, shifting composition to six women and three men. Hence, a total of 11 group members participated in this research. Group members ranged in age from 67 to 82 years old ($M = 74.8$), had been group members from 2 months to 5 years ($M = 2.5$ years), and had been married from 12 to 59 years ($M = 40.9$).

Members of the group were caring for spouses ranging in age from 67 to 86 years old ($M = 78.8$). Five spouses were diagnosed with Alzheimer's or probable Alzheimer's. Two spouses were diagnosed with Parkinson's disease as well as dementia or Alzheimer's. One spouse was diagnosed with vascular dementia, while another was diagnosed with corticobasal ganglionic degeneration. Finally, one spouse was diagnosed with "dementia" and one spouse's diagnosis is unknown to the authors.

Six spouses resided at home during the research period. In Anna's case, however, her spouse lived at home, but was hospitalized for several weeks. He was brought home briefly before returning to the hospital where he died. Anna attended six meetings after her spouse's death. Another spouse also spent time in a hospital, but returned home with an increased level of in-home care. Group members with their spouse at home all had some level of hired caregiving help. Three spouses resided in a skilled nursing or residential care facility. One spouse resided at home for the first half of the research period, then was placed in a residential care facility. Frank's spouse died prior to the research period, but he continued to attend group meetings and was present for 11 of the 20 meetings in the research period.

Data were collected through participant-observation. The first author sat with the group, listened, and occasionally contributed information and experiences. All meetings were tape-recorded and transcribed. Transcripts were near verbatim and notations regarding speech patterns were minimal as this research emphasizes topical content, not the technical organization of speech (Lindlof, 1995). All proper names were changed to pseudonyms.

Topics of conversations was the unit of analysis used to organize data. "Topics" was selected as the unit of analysis because conversation (i.e., the discussion of a topic) is central to positioning theory (Davies & Harré, 1990) and because the group organized around topics. Group members took turns speaking, raising and discussing various topics (i.e., what was going on) within their turn. Some topics were discussed in only one group meeting; thus, all talk in that meeting pertaining to the topic was one unit for analysis. Other topics were discussed across group meetings. In these cases, all talk from all meetings regarding that topic was one unit for analysis.

Positioning happens within conversations regarding support group topics. After topics were identified, coding procedures appropriate to participant-observation data were used to identify patterns of conversations. Open coding was the first step in analysis. Open coding involves writing words and phrases alongside transcriptions in order to categorize small segments of those transcriptions (Emerson, Fretz, & Shaw, 1995). For example, in a conversation where Faye spoke of "trying to get out more," a category of behavior, "getting out," was identified.

The second step in analysis was selecting themes (Emerson et al., 1995). This means linking open codes to core themes, an evolving process. For example, "getting out" and "going away" were open codes identified throughout the data. Seeing these recurring codes, the core theme "getting a break" was initially considered. However, this did not capture the heart of what the group was discussing, which was *why* getting a break was important. This led to consideration of the core theme "making a difference." However, comparing conversations in which getting out or getting away was discussed, the difference the group was referring to was protecting their mental and physical well-being; group members were talking about how to take care of themselves. Thus, "caring for oneself" was selected as a core theme to link open codes.

The third step in data analysis was focused coding. Focused coding involves comparing incidents and identifying variation (Emerson et al., 1995). Most significantly for this research, core themes linked together in varying ways. "Change" and "continuity," for example, were parallel themes as they both described spouses. However, another theme, "negative impact," was not parallel as change leads to negative impact. The outcome of coding procedures is a thematic narrative supported by fieldnotes regarding how support group members are positioned within patterns of group conversations.

FINDINGS

Five patterns of support group conversations were identified—change, continuity, negative impact, management, and caring for oneself. Group members were positioned through these five patterns of conversations. Specifically, group members position their spouses as objective/subjective dualities through patterns of conversations regarding change and continuity. Patterns of support group conversations position group members as negatively impacted by change; therefore, group members are positioned through patterns of conversations regarding management and caring for oneself as needing to become objective/subjective dualities in relation to their dual spouses. Paradoxically, the group suggests that it is due to deep emotional connections (i.e., subjectivity) that group members must objectify themselves and that by objectifying themselves, group members nurture deep emotional connections.

Change and Continuity

Patterns of support group conversations regarding change and continuity position spouses as objective/subjective dualities. Group members are positioned in relation to their spouses. Hence, the positioning of spouses is the necessary starting point for how group members are positioned within patterns of support group conversations.

Group members spend a good deal of time reporting on their spouse's conditions. For example, Joe said of his wife, Lynn, ". . . she has no short-term memory at all. . . . None. Long-term memory is, I don't think that's there anymore. I think the memory's gone." Mary said of her husband John, ". . . he's slowing down physically. Markedly. And, bending over farther and farther." Change is a pattern of conversation in the group. By reporting mental and physical changes in their spouses, group members, collectively objectify their spouses as collections of symptoms and disabilities.

Reports regarding spouses are generally met with acknowledgment, but some reports prompt challenges. One example of such an interaction focused on Sy after he reported asking his wife about the musical *Fiddler on the Roof* immediately after she had seen it. Sy told the group that she had already forgotten the experience. Rose, the group's leader, challenged Sy, saying that he should not be surprised and that, ". . . [the brain] . . . says if it's important enough for ten seconds, it'll go to one place . . . and then it'll go into . . . long-term memory. . . . She is . . . missing that initial step. . . . There's no way Laura can access the *Fiddler* or anything else."

By asking Laura about the show, Sy positioned her as someone with recall who can evaluate experiences. Rose positions Laura objectively in terms of her disability and challenges Sy to see her in those objective terms. Rose's challenge is a sanction that signals Sy has violated the group's discourse (Shotter, 1991). Challenges do more than provide information regarding dementia; challenges

indicate that group members must discard long-established subjective understandings of their spouses and take up objective understandings of them as persons with dementia.

A wholesale positioning of one's spouse as an objective collection of symptoms and disabilities could be dehumanizing. Patterns of support group conversations regarding continuity ensure that spouses are positioned as having some subjective qualities and abilities. Hence, spouses are positioned in patterns of support group conversations as objective/subjective dualities.

Like change, continuity is a pattern of conversation created through reports. Joy, for example, spoke of an experience with her spouse, saying, ". . . I was reading the paper. I still ask him questions. And I [asked], 'What is a palindrome?' And he told me. . . . I knew he knew it, because he's very, very highly educated. A very brilliant [man]." Joy positions her spouse as changed when she says that she "still" asks him questions; the implication is that she asks questions, despite changes that might impair his ability to answer. However, Joy also positions her spouse as having, to some degree, the subjective qualities and abilities he has always had.

That spouses with dementia are changed and continuous is not surprising from a pathological perspective. Progressive neurological diseases and conditions progressively create change. The key here is that group members come to a support group with long-established subjective understandings of their spouses, but patterns of support group conversations strip away the past. Through years of marriage, group members have known their spouses in terms of subjective abilities and qualities. Patterns of conversations regarding change offer group members a new way of positioning spouses—they are objective collections of symptoms and disabilities. Challenges are especially revealing because group members who try to position their spouses as they were are steered toward an objective positioning. Patterns of conversations regarding continuity ensure, though, that spouses are not dehumanized.

Negative Impacts

Group members position themselves as negatively impacted by changes in their spouses. Joe, for example, told the group that he had begun taking an antidepressant and that it was helping to take away "that dark and gloomy outlook." Describing what he had been experiencing prior to taking the antidepressant, Joe said, "You're okay one minute and the next minute you're not." Anna spoke up in response saying, "And you feel isolated." Joe agreed with Anna and added loss of concentration and loss of sleep to the list. Frank agreed with Joe's description of the impact of an antidepressant and added his experience, saying, "I'm not anxious. I'm not tense."

Existing literature establishes impacts of caregiving in objective terms, but the key here is that group members collectively position themselves as negatively

impacted (i.e., as dark, gloomy, isolated, anxious, and tense). The group creates a logic wherein, given negative impacts, group members cannot position themselves in relation to their spouses as they always have (e.g., as conversation and social partners, as shared decision makers). If patterns of group conversations suggest that spouses must be positioned in new terms, it does not make sense to position oneself in old terms; hence, patterns of support group conversations offer group members a different position. Patterns of support group conversations position group members as needing to be objective/subjective dualities in relation to their spouses as dualities.

Management and Caring for Oneself

Patterns of support group conversations regarding management and caring for oneself position group members as objective/subjective dualities in relation to their dual spouses. Group members are positioned as needing to objectify themselves in relation to spouses who are objective collections of symptoms and disabilities. Paradoxically, positioning oneself as objective simultaneously positions oneself as deeply subjective.

Patterns of conversation regarding management (i.e., controlling or attempting to control a spouse's circumstances, care, or behavior/condition) position group members as dualities in relation to dual spouses. Mary, for example, told the group that her husband John's vocabulary is still good and that, though what he says does not always make sense, he does speak in sentences. Mary also told the group that John's voice has become very soft and she has difficulty hearing him. She told the group that she usually has to ask, "What did you say?" or "Would you say that again?" Mary said, ". . . eventually I get . . . angry at him and tell him, 'Well, if you don't speak up, John, I'm not going to answer.'" Mary explained her anger, saying, "I get tired of saying, 'What did you say?' or 'Would you say it more loudly?'" She asked the group, ". . . what can I do? Do you have any suggestions at all? I feel so guilty when I just ignore him."

Mary positions John as a duality. On one hand, she positions him objectively as moving along a symptomatic continuum. On the other hand, she positions him subjectively as a conversation partner who is trying to engage her. Mary asking John to repeat himself or speak more loudly positions her as a conversation partner, part of her long-standing spouse identity. Positioning herself and John as conversation partners leads to anger because John is not just a conversation partner; he is changed and cannot hold up his end. Mary is negatively impacted in that she becomes angry trying to be a conversation partner, yet guilty if she ignores her spouse.

The group initially asked Mary questions and offered explanations. Doris said of John's low voice, "With the Parkinson's, that's part of his condition." Doris' husband also has Parkinson's; she told Mary that he speaks very low and that she cannot hear him either. Joe asked Mary if John speaks up when asked

to do so. Mary said, "Sometimes he will get angry and his voice booms forth." Rose pointed out that by asking John to repeat himself he will get irritated. Rose said, "At this point, what you're trying to do is have him as comfortable as possible and I'm sure he's irritated enough, you know, knowing."

The group's explanations and questions confirm Mary's positioning of John as a duality. He is positioned objectively as a person with Parkinson's and dementia like any other. At the same time, John is positioned as having the ongoing subjective capacity for self-reflection. Rose suggests that John can see himself becoming more symptomatic and he can be irritated by it. In fact, Rose positions Mary as possibly hurting John by trying to maintain their relationship as it was. Trying to enable conversation draws attention to John's decline, which is irritating and uncomfortable for him.

The group went on to offer Mary advice for managing her problem. Sy said, "Just say 'Yes' or somethin' like that. . . . Just acknowledge the fact that he said somethin'." Michelle, an intern with the group, said that at the adult day care part of the center they respond in these situations, "Yeah, that's exactly right." Mary said, "Just forget the content, I guess. There isn't much there anyway." The group's advice and Mary's response to that advice position John objectively. Sy and Michelle model how one objectively approaches talking with a person with dementia. Mary positions John as an objective "person with dementia" when she says the content of his speech is lacking.

Though this conversation positions John objectively, it does not strip him of all subjectivity. People do not like to be ignored; they desire acknowledgment. John would especially want acknowledgment from his wife of 50 years. John is positioned as having the subjective need for acknowledgment, but the objective "person with dementia" side of him alters how that need can/should be met. One responds differently to a duality, a person becoming more and more a collection of symptoms, than to a spouse.

The group's advice offers Mary a new position. Given that John is a duality, becoming more and more a collection of symptoms, Mary can be a duality. Mary can position herself objectively as a problem-solver—when a person with dementia's ability to produce content and volume wanes, conversation no longer works, so one takes an objective approach to the problem, responding to the act of speaking, rather than the content of speech. This response does not draw John's attention to his decline; hence, positioning herself objectively simultaneously positions Mary as a subjective (i.e., compassionate) spouse.

Group members positioning themselves as they always have in relation to their spouses no longer works; it creates negative impacts. What patterns of support group conversations offer members is new sense of self. They can position themselves as objective managers, which simultaneously positions them as deeply subjective spouses. In other words, they can care for (i.e., tend to physical, mental, and emotional needs) as a means of caring about (i.e., having feelings of affection) (Ward-Griffin, 2004).

Just as patterns of support group conversations regarding management position group members as objective/subjective dualities, patterns of conversations regarding caring for oneself contribute to this positioning. Patterns of support group conversations regarding caring for oneself suggest that group members must position themselves objectively; however, being objective is rooted in and fosters deep subjectivity.

One way to care for oneself is to get a break from caregiving. Faye, for example, told the group that she was "trying to get out more. And that has helped." How getting a break helps was elaborated in a conversation regarding Elizabeth having gone to an art museum. Elizabeth said that it was for her sanity. Rose agreed and turned the issue to the group as a whole, saying, ". . . It is always, for all of you, for your sanity. The more time that you take . . . for yourself . . . the better the caregiving goes on." Rose said that the alternative is feeling devastated. Abby chimed in that not getting a break leads to resentment. Other group members mentioned depression and exhaustion. Rose said, ". . . that's why it's always so important, we always talk about you taking care of yourself. Because if you don't, you're going to be miserable."

Patterns of conversations regarding caring for oneself collectively position group members as needing to become objective/subjective dualities. Group members do not easily engage in the types of activities Faye and Elizabeth describe. Sy told the group that he feels guilty being gone for even a little bit because Laura is happy going with him. Patterns of support group conversations regarding caring for oneself suggest, however, that group members must objectively assess their physical and emotional needs and take action accordingly. They must put aside their subjectivity to objectively do what needs to be done (Ward-Griffin, 2004).

Patterns of support group conversations regarding caring for oneself position group members objectively, but this objective position is simultaneously subjective. It is because one is so subjective, that one must be objective. Faye challenged Sy, for example, asking who would take care of Laura if he does not take care of himself. By objectively assessing and acting on their needs, group members are working to ensure they will be around for their spouses; hence, making objective assessments is a loving, subjective thing to do. When group members do not take up this position, challenges like the one Faye issued Sy occur.

Patterns of support group conversations regarding change and continuity do more than provide information; they create a new subject position for spouses—spouses are positioned as retaining some subjective capacities, but are largely positioned as objective collections of symptoms. Group members position themselves as negatively impacted by changes in their spouses and their relationships. Positioning their spouses as dualities allows group members to combat negative impacts on themselves by positioning themselves objectively. An objective subject position is created through patterns of conversations regarding management and caring for oneself. However, just as group members do not

dehumanize their spouses, they do not dehumanize themselves. Positioning themselves objectively simultaneously positions group members as deeply subjective.

DISCUSSION

Past caregiver support group research emphasizes outcomes and those outcomes are reflected in this research. For example, improved self-efficacy is a potential outcome reflected in patterns of conversations regarding caring for oneself. Practical knowledge is reflected in patterns of conversations regarding management. This research differs from past literature, however, by emphasizing a support group's communicative processes and the implications for caregivers' senses of themselves.

Patterns of support group conversations position group members as objective/ subjective dualities. This positioning is a layer of protection for the caregivers. Members come to the group with subjectivity. The group positions spouses and group members objectively so that they can do what needs to be done without destroying themselves. Subjectivity does not vanish; however, it is part of objectivity. The caregiver identity created within the group is a coping strategy that allows simultaneous objective/subjective positions to exist within single behavior sets (e.g., problem solving). Group members can respond to their situations objectively, but maintain subjectivity as spouses. For 90 minutes every week, the group re/constructs a way of thinking of oneself as a caregiver that potentially impacts well-being because it enables self-protection and coping.

Focusing on patterns of support group conversations enables us to see how group members communicatively create possible new ways of positioning their spouses and themselves. These new ways of looking are valuable because being flexible enough to adopt a more objective view of one's spouse and oneself can increase the accuracy of assessments and recognition of possible solutions because of the greater distance from the overwhelming emotional nature of relational change. Enabling objectivity can also facilitate openness to advice from the group and leader, thereby maximizing the mutual and reciprocal benefits of support groups. Without some degree of objectivity, the subjective can easily dominate and reduce the chances of discovering creative solutions to emerging troubles.

The objective/subjective positioning identified in this study can be translated into the practices of support group leaders. Within a group, a leader can explicitly distinguish between more objective and subjective ways of talking to spouses. Group leaders can also point to acceptance of an objective view of one's spouse as an appropriate struggle facing group members. If group members continue to position their spouses as they always have, the result is frustration; confusion; and, as we saw in Mary's case, anger. Group leaders can offer members the language of objectivity—at times one must learn to look at one's spouse objectively in terms of symptoms and disabilities. This will enable group members to position themselves objectively in relation, combating negative impacts.

Group leaders can also help members apply objective positionings to situations they face. A caregiver, for example, might subjectively express feelings of guilt regarding placement. A group leader can encourage a group member to back up and take an objective view of the situation: the spouse has conditions and symptoms that the caregiver can no longer manage, a care facility can manage those needs. A group leader can also encourage group members to see that objectification is not cold; objectivity is deeply subjective. By being able to objectify a spouse in terms of symptoms and needs and objectify oneself as a decision-maker for a person with dementia, a member can be a loving spouse because he or she is able to ensure the best possible care.

Group members may particularly struggle with focusing on themselves. For example, one of the most needed and desired types of assistance for informal caregivers is respite (Caserta, Lund, Wright, & Redburn, 1987; Feinberg & Whitlatch, 1998; National Alliance for Caregiving & AARP, 2004; Shope, Holmes, Sharpe, Goodman, & Izenson, 1993); however, even when caregivers have opportunities to have time away from the constant demands of their daily responsibilities, they often delay, underutilize, or avoid the services (FACCT—The Foundation for Accountability & Robert Wood Johnson Foundation, 2001; Lund, Wright, Caserta, 2005). One of the primary explanations is that they are unable to objectively assess their own needs and the impact that caregiving has on their well-being (Cottrell, 1996; Cox, 1997, 1998). Increased objectivity can stimulate their ability to get a bigger picture view of their situations and, hopefully, influence their decision-making.

Support group leaders and other group members can enhance the objectivity that each caregiver requires in order to recognize his or her needs and the merits of taking care of themselves. Group members can be explicitly urged to see that taking care of themselves constitutes taking care of their loved one. By objectively assessing one's own needs and finding ways to meet those needs, one is subjectively being a good spouse. It may take time for group members to take up this objective/subjective positioning, but group leaders can make explicit that it is a more objective position that group members must work to cultivate and that by doing so they are being deeply subjective.

Though a rich account, this case study is not the endpoint in understanding positioning in patterns of caregiver support group conversations. The results of this study were based on the conversations of an urban, white, middle-class support group composed of spouse caregivers. Far more needs to be known about the potential differences in support group experiences of adult children, grandchildren, and siblings who are racially, ethnically, and socioeconomically diverse, live in rural, suburban, and urban areas, and participate in diverse types of groups (e.g., Internet, open structure). Adult children caring for a parent, for example, may face different issues than spouses if they are also managing their own families. Given different issues, support groups for adult children may involve different patterns of conversations, meaning that adult children could

similarly or differently position their parents and themselves. Research indicates that minority caregivers are reluctant to attend support groups because they rightly assume the majority of members will be White and reflect White attitudes toward illness and caregiving (Henderson, Gutierrez-Mayka, Garcia, & Boyd, 1993). Future research should focus on ethnic minority caregivers in order to describe non-White attitudes toward caregiving, which likely reflect very different subject positions. Understanding broad identities being created within groups can help leaders further support diverse caregivers.

We hope, in the future, that we can provide leaders of support groups with more knowledge about the ways in which they can facilitate group conversations that allow caregivers to form identities that lead to optimal coping. Each of the five patterns of conversations that we identified warrant further attention so that we may learn more about their relationships to specific mental and physical health outcomes and/or if they relate to caregiver satisfaction with support group experiences. To do this, we cannot exclusively study the outcomes of support group meetings without examining the details of group processes.

Dementia is hard; it takes a physical, emotional, and relational toll on its sufferers and their loved ones. Support can impact well-being. This research focuses on patterns of conversations in a support group for spouses of persons with dementia; patterns of conversations within the group position members as objective/subjective dualities. The group's discourse is ultimately about coping and surviving. Dementia pushes people to the brink of sanity and survival; this group's discourse pushes back.

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