

Does Duration of Spousal Caregiving Affect Risk of Depression Onset? Evidence from the Health and Retirement Study

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Objectives: *To assess the association of current and long-term spousal caregiving with risk of depression in a nationally (U.S.) representative sample of older adults.*

Methods: *We studied married and depression-free Health and Retirement Study respondents aged 50 years and older ($n = 9,420$) at baseline from 2000 to 2010. Current (≥ 14 hours per week of help with instrumental/activities of daily living for a spouse in the most recent biennial survey) and long-term caregiving (care at two consecutive surveys) were used to predict onset of elevated depressive symptoms (≥ 3 on a modified Centers for Epidemiologic Studies Depression scale) with discrete-time hazards models and time-updated exposure and covariate information. **Results:** *Current caregiving was associated with significant elevations in risk of depression onset (hazard ratio: 1.64; Wald χ^2 , 1 df: 28.34; $p < 0.0001$). Effect estimates for long-term caregiving were similar (hazard ratio: 1.52, Wald χ^2 , 1 df: 3.63; $p = 0.06$). **Conclusions:** *Current spousal caregiving significantly predicted onset of depression; the association was not exacerbated by longer duration of caregiving. (Am J Geriatr Psychiatry 2013; ■:■–■)***

Key Words: Caregiving, depression, depressive symptoms, older adults, spouses

Caregiving is common among older age spouses and has long been associated with increased depressive symptoms for the caregiver. A recent meta-analysis of articles on caregivers and depression¹ found that spousal status and number of months as a caregiver were significantly associated with caregiver depression. However, the evidence is actually mixed,² and many of the articles comprising the literature base have methodologic limitations, including small convenience samples and cross-sectional designs. We used the U.S. Health and Retirement Study (HRS) to examine whether current or longer term caregiving for a spouse predicted onset of depression in a nationally representative sample of older adults. We posited that both current and long-term caregiving would be positively associated with risk of incidence of elevated depression symptoms and that long-term caregiving would pose higher risk of incidence of elevated depressive symptoms than current caregiving.

METHODS

The HRS is a longitudinal survey of a national sample of US adults aged 50 years and older and their spouses. Details of the study are provided elsewhere.³ Enrollments occurred in 1992, 1993, or 1998 with biennial interviews through 2010. The most current follow-up information shows retention $>80\%$ through 2008. The HRS was approved by the University of Michigan Health Sciences Human Subjects Committee, and these analyses were determined exempt by the Harvard School of Public Health Office of Human Research Administration.

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Spousal Caregiving Duration and Depression

The study was restricted to married HRS participants born 1900 to 1947 and interviewed in 2000, which was the earliest year when caregiving assessments were consistently worded and asked with respect to spouses. The HRS sample included 11,476 age-eligible, married respondents interviewed in 2000. We excluded 1,885 (16.4%) who reported previous elevated symptoms of depression in 2000 and 171 (1.5%) who were missing key covariate information; thus, 9,420 individuals contributed person-time to the primary analyses.

Spousal caregiving demand was calculated in each biennial interview wave (2000–2008) based on the care recipient's report regarding assistance with activities of daily living and instrumental activities of daily living. HRS respondents with care needs were asked to list the people who most provided assistance in the last month and, for each person, the estimated time spent on caregiving each day. An indicator variable was generated for whether a spouse was a listed caregiver, and we calculated amount of care provided per week for these analyses. To be consistent with other studies of caregiving using these data,⁴ the primary exposure classification was a dichotomized variable of <14 and ≥ 14 hours of care per week. Long-term caregiving was defined as providing ≥ 14 hours of care per week during two consecutive biennial survey assessments; this exposure was calculated between 2002 and 2008.

Depressive symptoms were self-reported by the caregiver by using a modified, 8-item version of the Centers for Epidemiologic Studies-Depression (CES-D) scale. Our outcome variable was a dichotomized indicator for whether the respondent reported ≥ 3 depressive symptoms in the past 2 weeks. This threshold was previously found to provide high sensitivity and specificity for depression per the Composite International Diagnostic Interview–Short Form.⁵

The HRS survey design includes both individuals in a couple (e.g., both husband and wife) as survey respondents. There are a number of possibilities of combinations of caregiver/care recipient relationships within one couple; both, only one, or neither respondents in the household could be caregivers and care recipients. Because not everyone in the sample is a caregiver or care recipient, we also refer throughout to the unit of analysis as “respondents”; we refer to their spouse as “spouse” where necessary. In the main analyses, for both current and long-term caregivers,

we compared respondents who are caregivers with a reference group of all other respondents; for simplicity, the covariates in these analyses are referred to as “caregiver,” and “care recipient” characteristics refer to respondent and spouse's characteristics, respectively. In the sensitivity analysis, we reasoned that because one provides care only when your spouse needs care, the “potential caregivers” should be restricted to individuals whose spouses had care needs. The sample was therefore restricted to respondents whose spouses have care needs (e.g., a wife is included as a respondent only if her husband has a care need); thus, this analysis compares caregiver respondents with “potential” caregiver respondents, rather than with all respondents, adjusting for the caregiver/“potential” caregiver's and the “potential” care recipient's characteristics, respectively.

Covariate information was self-reported; caregiver demographic, socioeconomic status, and health information was reported by the caregiver, and care recipient health information was reported directly by the care recipient. Variables defined at baseline included caregiver's demographic characteristics: age and age-squared, race, Hispanic ethnicity, gender, length of marriage, and socioeconomic position (years of education [0–17], father's education [categorical, $<8/\geq 8$ years], a missing indicator for father's education, and logged per-capita household income [baseline]). Time-varying covariates were lagged one wave behind exposure assessment and included: caregiver health status (current drinking [any/none in past 2 weeks], current smoking status [yes/no], a summary of total number of self-reported conditions [high blood pressure, diabetes, cancer, lung disease, heart disease, stroke, psychiatric problems, and arthritis] calculated in the RAND version of the HRS dataset, and self-rated health [excellent/very good/good versus fair/poor]) and care recipient health status (summary score of chronic conditions, care recipient self-rated health, and care recipient self-report of physician's diagnosis of a memory illness). For observations with missing values, we set continuous variables to the mean and categorical variables to the referent group, and we included missing indicator variables in the analytic models.

Discrete-time hazard models were used to test our three hypotheses. Analyses were conducted by using SAS version 9.2 with PROC GENMOD using a logit link (SAS Institute, Inc., Cary, NC) and robust variance

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