From Caregiving to Bereavement: Trajectories of Depressive Symptoms Among Wife and Daughter Caregivers

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This study examined the trajectory of depressive symptoms for wife and daughter caregivers during the transition from caregiving to bereavement, and it investigated whether the trajectory varies by caregivers’ caregiving stress, social support, and background characteristics. Hierarchical linear modeling was used to analyze four-wave longitudinal data collected from 157 wife and daughter caregivers who lost elderly relatives to death. Results show that, on average, caregivers experience increasing depressive symptoms as their care recipients approach death, and they experience decreasing symptoms after. Care recipients’ problematic behavior and caregivers’ kinship, income, and feelings of overload moderate the change in depressive symptoms during the transition. Services to support caregivers should target specific groups of caregivers, based on caregiving experience and background characteristics, at times when they are most in need.

Caregiving and bereavement are often interrelated, as most deaths of older persons in America occur after a period of chronic illness, disability, and family caregiving (Bass, Bowman, & Noellker, 1991; Schulz, Newsom, Fleissner, Decamp, & Nieboer, 1997). The literature, however, tends to treat these events separately. Studies of family caregiving have largely focused on the time when caregiving is active, whereas studies of bereavement usually focus on adjustment after the death (Schulz et al., 2001). Rarely is the same sample of individuals followed from caregiving through bereavement. In this study, I view caregiving and bereavement as an ongoing process that exists in a chronic context (Pearlin, 1989). The study has two aims: to examine how depressive symptoms of wife and daughter caregivers change in the transition from caregiving to bereavement, and to investigate whether the depressive symptom trajectories of caregivers during this transition vary by their predeath caregiving stress and social support, and their kinship relationship with care recipients and income.

Bereavement Models

The death of a close relative is one of the most stressful life events (Holmes & Rahe, 1967). Studies of the general bereaved population, however, tend to concur that the mental health effect of bereavement attenuates over time; few bereaved persons experience prolonged adverse effects (Norris & Murrell, 1990). For those who have cared for people before their death, two models regarding the adjustment process have been proposed, both based on the stress and coping paradigm (Bass & Bowman, 1990; Schulz et al., 1997). The depletion model suggests that caregiving is a chronic stressor that depletes personal and social resources. Therefore, in facing another stressor (bereavement), caregivers are not equipped to cope and are vulnerable to negative consequences. The relief model also asserts that caregiving is stressful; however, it proposes that the death of care recipients provides stress relief to caregivers and allows them to reengage in other roles and activities, which ease their adjustment to bereavement.

Empirical studies on caregivers’ change in mental health following their care recipients’ death have been inconclusive. Some found that caregivers do not become less depressed after bereavement; rather, their predeath levels of depression continue well into the postloss period, with a trajectory similar to that of continuing caregivers (Bodnar & Kiecolt-Glaser, 1994). Others found that caregivers’ depressive symptoms increase in the months immediately after the death and then decline at varying rates over time (Chentsova-Dutton et al., 2002; Mullan, 1992; Schulz et al., 2003).

The different trajectories of depressive symptoms found in caregivers after the death of their care recipients might in part be due to study differences in timing, interval, duration, and number of observations. Caregivers’ experience of distress is likely to vary during the time before and after care recipients die. The direction and extent of change may therefore depend on when preloss and postloss assessments are conducted. The interval between assessments and the duration of observation matter, because too long an interval may cause the observer to miss changes that are transient, whereas too short an observation period leaves the observer unable to detect long-term changes. Finally, using two time points to analyze change assumes linearity, which may not capture the dynamics of caregiver depression. Thus, my primary aim in this study is to examine changes in caregivers’ depressive symptoms during the bereavement transition by using a design and methodology that overcomes limitations of prior studies.

Diversity Within Caregivers

Caregivers’ response to bereavement is likely to vary, given their variation in responding to caregiving (Pinquart & Sorensen, 2003). On the basis of the caregiving stress process model proposed by Pearlin, Mullan, Semple, and Skaff (1990), in this study I examine the effects of three sets of factors—caregiving...
Caregiving Stress

The term caregiving stress refers to conditions, experiences, and activities arising from caregiving that are problematic (Pearlin et al., 1990). According to the model by Pearlin and colleagues, caregiving stress has both objective and subjective aspects. Objective caregiving stress refers to stressors that stem from care recipients’ needs and the associated care demand, such as care recipients’ problematic behavior and limitations in basic and instrumental activities of daily living (ADLs and IADLs, respectively; these include, e.g., bathing, dressing, and housekeeping). Subjective caregiving stress refers to caregivers’ subjective experience of hardships in the caregiving role, such as feelings of overload and burden.

From the perspective of the aforementioned relief model, caregivers who experience high stress during caregiving should feel great relief when they exit the caregiving role; hence, their mental health recovery should be faster than low-stress caregivers. In contrast, the depletion model suggests that more intense stress during caregiving depletes more coping resources, so caregivers have more difficulties adapting to bereavement. Neither model specifies whether subjective and objective stress operate the same way.

Previous studies investigating the effects of caregiving stress on caregivers’ bereavement adjustment have mostly focused on subjective stress, and the results are mixed. Schulz and colleagues (2001), for example, found that spouse caregivers reporting more strain associated with caregiving are more likely to improve in health risk behaviors and have no further increase of depressive symptoms following their spouse’s death, compared with spouse caregivers with low strain and with spouse noncaregivers. Skaff, Pearlin, and Mullan (1996) found that bereaved caregivers with higher levels of role captivity during caregiving have greater increase of mastery after their spouse’s death, compared with spouse caregivers with low strain and with spouse noncaregivers. Skaff, Pearlin, and Mullan (1996) found that bereaved caregivers with higher levels of role captivity during caregiving have greater increase of mastery after their spouse’s death, compared with spouse caregivers with low strain and with spouse noncaregivers.

Research Questions and Hypotheses

I ask two questions in this study.

First, how do depressive symptoms of wife and daughter caregivers change during the course of the transition from caregiving to bereavement? The relief and depletion models predict different patterns of change in the depression of caregivers following their care recipients’ death, with the former suggesting a decline from high levels of depressive symptoms and the latter a continuation or elevation of previous levels. Overall, the literature provides more support for the relief hypothesis (e.g., Mullan, 1992; Schulz et al., 2003). Changes in caregiver depression before the death are less clear (George, 2002). An increase in caregivers’ depressive symptoms from about 4 months before to the time of the care recipients’ death has been reported (Schulz et al.). Hence, I expect the trajectory of caregivers’ depressive symptoms during the course of caregiving and bereavement to be curvilinear, with symptoms increasing as care recipients are closer to death and decreasing thereafter.

Second, how do objective and subjective caregiving stress, social support, kinship, and caregiver income affect caregivers’ trajectories of depressive symptoms? On the basis of the relief model and prior work (Schulz et al., 2001; Skaff et al., 1996), I hypothesize that caregivers who experience high levels of subjective caregiving stress have a greater sense of relief on exiting the caregiving role, which leads to faster recovery, indicated by steeper decline in depressive symptoms. The literature does not provide enough information to specify a hypothesis regarding the effects of objective caregiving stress on caregivers’ bereavement adjustment; therefore, this issue is an exploratory one in this study.

Social Support

Social support has been conceptualized as a resource that has direct and indirect benefits to caregivers (Pearlin et al., 1990). Various dimensions of social support have been used to predict bereavement outcomes and well-being in the literature. Research consistently shows that perceived support, such as satisfaction with support, is the strongest predictor (Bass & Bowman, 1990; Krause, 2001). A prior study found that more satisfaction with the support received during caregiving predicts less difficulty experienced in bereavement by caregivers, and that satisfaction with caregiving support is a better predictor than satisfaction with bereavement support for caregivers’ bereavement adaptation (Bass et al., 1991).
following the care recipient’s death. Wife caregivers are expected to experience more difficulties adjusting to bereavement (i.e., slower decline in depressive symptoms after the death) than daughter caregivers, because of the greater impact of bereavement on the identity and structure of life for wives. On the basis of previous research findings (Arbuckle & de Vries, 1995; Skaff et al., 1996), I also expect low-income caregivers to have more difficulties in this transition.

**METHODS**

**Participants**

As shown in Figure 1, the caregivers included in this study were recruited for the Well-Being of Women (WBW), which was a longitudinal study of women and caregiving. The WBW sample was a subset of a larger probability sample drawn by random-digit dialing for the State of Wisconsin Bureau on Aging in 1991. The larger sample consisted of 2,250 persons aged 60 or older and 500 persons younger than age 60 who provided care to a relative aged 60 or older. In 1993, the WBW project staff telephoned all these persons to determine their current caregiving status. To ensure a sufficiently large pool of caregivers, members of the staff also contacted an additional 1,000 households by means of random-digit dialing. If, in the screening call, a wife or daughter was found to be providing care to a husband or parent as a result of his or her aging, illness, or disability, with at least one ADL or IADL, she was identified as a caregiver (for details about the sample, see Seltzer & Li, 1996).

At baseline (Wave 1), WBW staff members recruited 129 wife and 207 daughter caregivers to participate in the WBW study, representing 73.8% of the eligible women from the telephone screening. In addition, as comparison groups, the staff recruited a sample of wife (n = 119) and daughter (n = 86) noncaregivers whose elderly relatives did not need care. The staff collected four waves of data, with each wave about 18 months apart. In the first three waves, the staff collected data by interviewing the respondents in their homes and using self-administered questionnaires completed by respondents. At Wave 4, as a result of budget constraints, the staff used mail questionnaires. At each wave of data collection, staff assessed the care recipient’s condition. If the care recipient was deceased, date of death was recorded and a modified set of data collection procedures was used. Data collection continued regardless of the status of the care recipient.

Among the 336 caregivers at Wave 1, 149 lost their care recipients as a result of death by Wave 4 and 60 were lost to follow-up (Figure 1). In addition, 8 noncaregivers at Wave 1 became caregivers at a later wave, prior to being bereaved. Hence, a total of 157 women experienced the transition from caregiving to bereavement during the four-wave study period. These women constituted the sample for the present analysis.

The sample of individuals consisted of 53 wife and 104 daughter caregivers. Virtually all were White (96.2%). At baseline (Wave 1), they averaged 63.6 years old (SD = 9.0). Most had a high school or more education (83.4%). Their care recipients averaged 83.1 years old (SD = 8.7) at baseline; the recipients were quite diverse in their reason for needing care, including dementia (n = 31), arthritis (n = 21), heart trouble (n = 17), asthma or emphysema (n = 16), stroke (n = 15), diabetes (n = 7), cancer (n = 6), blindness (n = 6), and other disease categories (n < 6 for each). Approximately 20.2% of the

![Figure 1. Transition from caregiving to bereavement of the Well-Being of Women study sample; each wave is approximately 18 months apart. (Open ovals denote noncaregivers at baseline, Wave 1, who became caregivers prior to being bereaved. WC = wife caregivers; DC = daughter caregivers.)](https://academic.oup.com/psychsocgerontology/article-abstract/60/4/P190/545287/16-March-2019)
daughter caregivers cared for their fathers. The bereaved caregivers were comparable with the continuing caregivers and those who were lost to follow-up (no difference in Wave 1 measures of depressive symptoms, kinship, income, education, satisfaction with support, overload, burden, dementia diagnosis, and problematic behavior of care recipients). However, relative to continuing caregivers and those lost to follow-up, the bereaved caregivers cared for elders with more functional limitations and who were older.

**Measures**

**Outcome variable.**—The outcome variable was depressive symptoms, which I measured by use of the 20-item Center for Epidemiological Studies–Depression scale (CES-D; Radloff, 1977). The CES-D asks respondents to report symptoms of depression in the previous week on a 4-point scale ranging from rarely to most of the time. I computed a scale score, with higher scores indicating more depressive symptoms. Cronbach’s alpha reliabilities of CES-D ranged from \( \alpha = .85 \) to \( \alpha = .88 \) throughout the four waves. Because of a skewed distribution, I transformed the variable (natural log of 1 + raw CES-D score; I added 1 because some respondents scored 0 on CES-D).

**Predictor variables.**—The predictor variables included three sets—caregiving stress, social support, and caregiver background characteristics. I measured most predictors (except kinship) at the wave before and closest to the death, which occurred .82 years (SD = .42) before the care recipients died, on average. As I subsequently explain in the Data Analysis section, the sample varied in the number of measurement points before and after the death. Each respondent, however, had at least one assessment before the death, which made it possible for me to examine the effects of predeath measures on changes in caregiver depression during the bereavement transition. Table 1 displays the ranges, means, standard deviations, Cronbach’s alpha reliabilities, and correlations of all predictor variables.

**Caregiving stress.**—Caregiving stress included both objective and subjective stress. The former was indicated by four variables: care recipient’s problematic behavior, functional limitations, dementia diagnosis, and duration of care. I measured problematic behavior by use of a 14-item scale (e.g., trying to dress the wrong way, swearing or using foul language; see Pearlin et al., 1990). Caregivers rated each item from 0 (never) to 2 (usually). I measured functional limitations by use of a modification of the Barthel Index (Mahoney & Barthel, 1965), which assesses care recipients’ performance in ADL and IADL areas. Caregivers rated each from 0 (independent) to 2 (not at all). The scale scores of depressive behavior and functional limitations were the sum of their respective items. Dementia diagnosis referred to whether the care recipient had Alzheimer’s disease or other types of dementia (coded 1). Research shows that caring for older adults with dementia is more challenging than caring for those without it (Ory, Hoffman, Yee, Tenenstedt, & Schulz, 1999). Duration of care indicates the length of exposure to care-related stressors, measured by number of years that the caregiver had provided care to her care recipient before his or her death.

Subjective stress was indicated by role overload and burden. I assessed overload by use of a four-item scale that asks about the caregivers’ experience of being overwhelmed by care-related responsibilities, such as feeling exhausted at the end of the day and having more things to do than one can handle (Pearlin et al., 1990). Each item was rated from 1 (not at all) to 4 (completely). I measured burden by use of the Zarit Burden Interview (Zarit, Reever, & Bach-Peterson, 1980), which assesses problems frequently faced by caregivers, including health, finances, and social life. I computed scale scores for overload and burden, with higher scores indicating higher stress levels.

**Social support.**—Support was indicated by caregivers’ satisfaction with the support received from their personal networks, assessed by a single item with four response categories (0 = completely dissatisfied to 3 = completely satisfied).

**Caregiver background characteristics.**—Background characteristics included kinship and income. Kinship was a dummy coded variable (wife = 1, daughter = 0). Income referred to total household income of the caregiver, measured in dollars. I transformed the income variable by using the natural log to reduce skew.

**Data Analysis**

I conducted hierarchical linear modeling (HLM) based on maximum likelihood estimation, using the software developed by Raudenbush, Bryk, Cheong, and Congdon (2000). The repeated measures of depressive symptoms were conceived as being nested within individuals; thus the analysis of change had two levels: within persons (Level 1) and between persons (Level 2).

### Table 1. Information Regarding Predictor Variables (N = 157)

<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Range</th>
<th>M (SD)</th>
<th>Cronbach’s ( \alpha )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problematic behavior</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0–23</td>
<td>7.69 (4.54)</td>
<td>.80</td>
</tr>
<tr>
<td>2. Functional limitations</td>
<td>(-.04)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0–28</td>
<td>15.18 (7.36)</td>
<td>.87</td>
</tr>
<tr>
<td>3. Dementia</td>
<td>.27**</td>
<td>.19*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0–1</td>
<td>0.22 (.42)</td>
<td>.20*</td>
</tr>
<tr>
<td>4. Duration of care</td>
<td>.18*</td>
<td>.04</td>
<td>-.01</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.67–35.61</td>
<td>8.31 (5.85)</td>
<td>.17*</td>
</tr>
<tr>
<td>5. Overload</td>
<td>.10</td>
<td>.18*</td>
<td>-.02</td>
<td>-.04</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>4–16</td>
<td>8.05 (3.17)</td>
<td>.12*</td>
</tr>
<tr>
<td>6. Burden</td>
<td>.41**</td>
<td>.07</td>
<td>-.12</td>
<td>.08</td>
<td>.46**</td>
<td>1</td>
<td></td>
<td></td>
<td>16–55</td>
<td>31.87 (7.21)</td>
<td>.81</td>
</tr>
<tr>
<td>7. Satisfaction with support</td>
<td>.06</td>
<td>-.06</td>
<td>.10</td>
<td>.06</td>
<td>-.14</td>
<td>-.17*</td>
<td>1</td>
<td></td>
<td>0–3</td>
<td>2.57 (.62)</td>
<td>.29**</td>
</tr>
<tr>
<td>8. Kinship</td>
<td>-.18*</td>
<td>-.08</td>
<td>-.06</td>
<td>-.20*</td>
<td>.12</td>
<td>-.09</td>
<td>.02</td>
<td>1</td>
<td>0–1</td>
<td>0.34 (.47)</td>
<td>.10</td>
</tr>
<tr>
<td>9. Income (natural log)</td>
<td>-.13</td>
<td>-.04</td>
<td>.01</td>
<td>.01</td>
<td>-.09</td>
<td>-.10</td>
<td>.06</td>
<td>-.29**</td>
<td>8.44–11.46</td>
<td>10.27 (.75)</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05; **p < .01.
The HLM analysis proceeded in two stages. First, I examined the intraindividual variability in depressive symptoms over time. In this study, time refers to the length of time before and since the death of the care recipient. I created this by subtracting the date of interview from the date of death, and I measured it in years. Hence, a minus sign of time indicated time before the death, a zero indicated the time at death, and a plus sign indicated time since the death.

In the data set, each caregiver had four measurement points covering about 4.5 years (Waves 1 to 4), from before to after the care recipient’s death. However, because care recipients died at different times during the study, the period of time covered by the sample can be 9 years, ranging from −4.5 years (care recipients died right before Wave 4) to +4.5 years (care recipients died right after Wave 1).

At the first stage of the analysis, I compared three Level 1 models, which represented that caregivers’ depressive symptoms (a) do not change over time (no time effect), (b) change at a constant rate (linear time effect), and (c) change at a rate that accelerates (or decelerates) over time (quadratic time effect); I constrained the Level 2 model to be unconditional (i.e., no predictors). I used likelihood ratio tests to determine the best model. This analysis would answer the first research question and identify the change parameters that best describe individual change in depressive symptoms over time.

Then, I examined interindividual differences in the trajectory of depressive symptoms by modeling the individual change parameters as a function of the proposed predictors at Level 2. To improve estimation efficiency and construct a model that was parsimonious, I first examined each predictor variable separately; I dropped those with no significant correlation with any change parameters. I then simultaneously entered all significant predictors from the separate analyses to predict each individual change parameter; I retained only significant predictors in the final model.

Except kinship, all other study variables had missing data, with burden having the highest proportion (12.7% missing). I used multiple imputation that involved a regression approach and data-augmentation algorithm to impute these missing values, using the software developed by Schafer (1999). I analyzed three imputed data sets. I obtained a single point estimate by averaging across the estimates from the three imputed data sets, and I used a formula to calculate the standard errors (Schafer & Olsen, 1998). I used a level of α < .05 for all statistical tests in this study.

**RESULTS**

**Descriptive Findings**

Table 2 displays the means and standard deviations of depressive symptoms at the four measurement points for all bereaved caregivers and for subgroups of caregivers who lost their care recipients at different waves, by kinship. Three observations are noted. First, the depression level of the bereaved sample of individuals was the lowest at Wave 4, when all had lost their care recipients. Their average depressive symptoms at Wave 4 were less than those that occurred when they all were providing care (Wave 1). Second, caregivers’ depression levels were the highest at the wave right after the care recipients’ death (e.g., at Wave 2 for caregivers who lost their care recipients between Waves 1 and 2), and they had a declining trend after the death. Third, wives had higher and more fluctuating depression levels across waves than daughters.

For comparison, the bottom three rows of Table 2 present depressive symptoms of continuing caregivers (the WBW sample of individuals who continued to provide care throughout Waves 1 to 4). Note that the depression levels of the continuing caregivers were relatively stable from Waves 1 to 4.

**Individual and Mean Change of Depressive Symptoms**

The first HLM analysis examined how the depressive symptoms of the individuals in the study sample changed during the course of caregiving and bereavement. Using likelihood ratio tests to compare three nested models (no time effect, and linear and quadratic effects of time, respectively), the analysis suggests that quadratic change functions best describe intraindividual variation in depressive symptoms over time.

**Variation in Caregivers’ Trajectories of Depressive Symptoms**

The mean trajectory does not necessarily represent the trajectory of individual caregivers. Next, I examined the...
variation in the trajectory of depressive symptoms by caregivers’ predeath caregiving stress, social support, and background characteristics. When I analyzed each predictor variable separately, I found that functional limitations and dementia had no significant correlation with any individual change parameters; thus, I omitted them from subsequent analyses. I then entered the remaining variables simultaneously as predictors; duration of care became statistically insignificant and so I dropped it. Model B in Table 3 presents the final model.

Model B shows that, at the time of the care recipients’ death, caregivers who felt overloaded, burdened, dissatisfied with support received, and were wives of the care recipients had higher levels of depression. In addition, changes in depressive symptoms during the transition from caregiving to bereavement varied by care recipients’ problematic behavior and by caregivers’ overload, kinship, and income. To illustrate their effects on caregivers’ trajectories of depressive symptoms, Figures 2 and 3 display the adjusted change curves of depressive symptoms according to differences in problematic behavior, overload, kinship, and income.

Figure 2 shows that caregivers of recipients with more problematic behaviors had higher depression levels than caregivers who had cared for elders with fewer problematic behaviors during caregiving, which continued into bereavement. Additionally, the change curves show that the former were less likely than the latter to decline in depressive symptoms after their care recipients died. Such findings suggest that caregivers who care for older persons with more problematic behaviors are slower in mental health recovery during bereavement.

Caregivers who experienced high overload had a steeper increase of depressive symptoms before their care recipients died, and a more rapid decline of symptoms following the death, compared with caregivers with low overload (Figure 2). This change pattern suggests that caregivers who feel overloaded during caregiving are more likely to improve in mental health following their care recipients’ death.

Wife and daughter caregivers had very different trajectories of depressive symptoms (Figure 3). The depressive symptoms of wife caregivers accelerated as their husbands were closer to death, and they decelerated after the death. Daughters had lower levels of depression at all times and were relatively stable in depressive symptoms during the course of caregiving and bereavement. I explored the interaction effects of kinship and other predictor variables and found them to be statistically insignificant.

Caregivers with high income were more likely to have a downward trajectory of depressive symptoms that began before their care recipients died and extended to after the death, whereas low-income caregivers were likely to experience depressive symptoms during caregiving and their high levels of depression continued into bereavement (Figure 3). The longer the time since bereavement, the bigger the depression gap was between high- and low-income caregivers.

### DISCUSSION

This study shows that, on average, wife and daughter caregivers experience increasing depressive symptoms as their care recipients are closer to death, and decreasing symptoms after their care recipients die. Such findings are consistent with that of Schulz and colleagues (2003) and suggest that the transition from caregiving to bereavement provides relief rather than poses mental health risks for caregivers.

Deviation from the average trajectory is evident, however. I found care recipients’ problematic behavior and caregivers’ feeling of overload, kinship, and income to moderate caregivers’ change of depressive symptoms during the bereavement transition. The finding related to problematic behavior seems to support the depletion hypothesis. Prior research has shown that problematic behaviors of care recipients have adverse effects on caregiver mental health, in part because they lead to an erosion of psychological and social resources (e.g., mastery, self-concept, and social support; see Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch., 1995; Li, Seltzer, & Greenberg, 1999; Skaff & Pearlin, 1992). The diminishment of these resources may be the reason for the finding that caregivers of elders with more problematic behaviors recover slower during bereavement. Such findings suggest that caregiving to elders with problematic behaviors might have long-term negative effects on caregivers’ psychological well-being.

The finding related to overload, however, supports the relief model. Although overload has been found to predict caregiver depression during active caregiving (Alspaugh, Stephens, Townsend, Zarit, & Greene, 1999); its adverse effects may be more role specific and limited to the time when one is an occupant of that role. Research shows that overload remains stable during caregiving but decreases dramatically following care recipients’ death (Aneshensel et al., 1995). The relief felt

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Table 3. Hierarchical Linear Modeling Estimation of Fixed Effects

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model A (Mean Trajectory)</th>
<th>Model B (Final Model)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>2.178 (.065)**</td>
<td>1.970 (.070)**</td>
</tr>
<tr>
<td>Problematic behavior</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Overload</td>
<td>0.011 (.014)</td>
<td>—</td>
</tr>
<tr>
<td>Burden</td>
<td>0.065 (.019)**</td>
<td>—</td>
</tr>
<tr>
<td>Satisfaction with support</td>
<td>—</td>
<td>0.021 (.010)*</td>
</tr>
<tr>
<td>Kinship</td>
<td>0.609 (.108)**</td>
<td>—</td>
</tr>
<tr>
<td>Income</td>
<td>—</td>
<td>—0.128 (.069)</td>
</tr>
<tr>
<td>Deviance (no. of estimated parameters)</td>
<td>1330 (5)</td>
<td>1218 (18)</td>
</tr>
<tr>
<td>Likelihood ratio test $\chi^2(\ell)$</td>
<td>—</td>
<td>112 (13)**</td>
</tr>
</tbody>
</table>

Notes: Unstandardized regression coefficients are presented; standard errors are given in parentheses. Problematic behavior, overload, burden, satisfaction with support, and income were centered around the sample mean. The log transformation of depressive symptoms, measured by the Center for Epidemiologic Studies–Depression scale was the outcome variable.

*p < .05; **p < .01; ***p < .001.
by caregivers might have therapeutic effects; for instance, it might evoke a new sense of control over their lives (Skaff et al., 1996). Caregivers who have felt more overloaded during caregiving may free up more time and energy to attend to neglected needs and roles after caregiving ends, which facilitates adaptation.

Following the death of their care recipients, wife caregivers had a steeper decline of depressive symptoms than did daughters. Although this finding is unexpected, it is understandable considering the high depression level of wives before the death. Relief, however, does not mean freedom from grief (Skaff et al., 1996). When their husbands die, wife caregivers may experience competing feelings of grief and relief. Low-income caregivers are more likely than high-income caregivers to endure high levels of depressive symptoms from before to after the loss of their care recipients. The vulnerability of low-income caregivers may be related to the fact that poverty itself is a chronic stressor that takes a toll on mental health, in addition to diminishing caregivers’ coping capacity.

This study contributes to the literature in four significant ways. First, in this study I conceptualized caregiving and bereavement as an ongoing process and examined changes in caregivers’ depressive symptoms in this process. I utilized multiple measurement points spanning caregiving to bereavement, and the analytic approach incorporated their information simultaneously in the same model rather than simply capturing changes between pairs of preloss and postloss measurements.

Second, using the HLM approach, I maximized the use of available data and examined the patterns of change in caregivers’ depressive symptoms over a relatively long period of time. To my knowledge, this is the first study that has taken such a long view to understand the dynamics of caregivers’ depressive symptoms during the bereavement transition. Third, the findings regarding problematic behavior and role overload have not been reported before. Although future studies are needed to validate whether and understand why problematic behavior and overload have differential effects on caregivers’ bereavement adjustment, research in this direction may shed light on our understanding of the long-term consequences of objective and subjective stress. Fourth, this study shows that the social standing of the caregiver, including income and kinship, is relevant to the caregiver’s emotional adaptation during the bereavement transition. These findings illustrate the importance of social structural factors in psychological processes.

The findings have practice implications. First, bereavement support services to caregivers should target vulnerable groups, including those with low incomes and those who have cared for recipients with high levels of problematic behavior. Second, the year before care recipients die seems to be particularly distressing for caregivers. Services to help caregivers cope with the dying process may be needed. Third, some caregivers, including wife caregivers and caregivers who feel overloaded, have a great need for supportive services when they are active caregivers.

Figure 2. Caregivers’ trajectories of depressive symptoms: Mean, by problematic behavior and overload (CES-D = Center for Epidemiological Studies–Depression scale).
Limitations of this study include a virtually all-White sample of individuals, a relatively small sample size, and the lack of a comparison group. The sample composition limits generalization of the findings to non-White populations. The limited sample size, coupled with the approach used to select predictors into the final model, warrants caution when the findings are interpreted. Cross-validation of the findings on independent samples is needed. The lack of a comparison group makes it less clear whether the patterns and predictors of change found in this study are unique to caregivers and the bereavement transition (Amirkhanyan & Wolf, 2003). Also note that the care recipients in this sample had diverse diseases, which could affect caregivers’ depression trajectory. The small number of care recipients in each disease category made it difficult for me to examine the effects of disease type in this study.

To conclude, a particularly important contribution of this study is that it describes a relatively long-term trajectory of caregivers’ depressive symptoms during the transition from caregiving to bereavement, using prospective data and multiple measurement points. It shows that caregivers respond differently during the final stage of caregiving. Further research on individual differences in responding to the bereavement transition may illuminate the stress process and help in the design of interventions to support caregivers.

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