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Memory, Mood, and Marriage: Examining the interplay in older adults

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“My every molecule seems to scream out that I do, indeed, exist, and that existence must be valued by someone! Without someone to walk this labyrinth by my side, without the touch of a fellow traveler who understands my need of self-worth, how can I endure the rest of this uncharted journey?”

Diana McGowin, 1993

In her book “Living with the Labyrinth”, Diana McGowin’s words not only reflect her subjective experience of a recent dementia diagnosis, but also poignantly highlight the expectations from a fellow traveler, who, in most instances, is the spouse (1, 2). The spouse is expected to navigate the tasks of providing instrumental assistance, honoring the autonomy of the affected individual, while making meaning of the relationship and its changing dynamics. Historically the focus had been on spousal caregivers’ emotional and physical health (3), with interest in the interplay of cognitive changes between spouses in the last fifteen years. In the Cache County study, Norton *et al.* reported a six-fold increase in the risk for dementia among spouses of individuals with dementia compared to spouses of those who did not have dementia, controlling for several risk factors (4). Furthermore, an individual’s emotional health (i.e., depression) can also affect their spouse’s emotional health (5). Shared environmental exposures, similar appraisal of situations as stressful, assortative mating, similarly evolved patterns of problem-solving, and caregiving burden have been discussed as possible contributors to the dyadic associations (4, 5).

The current issue of the journal features a timely addition to the literature by Joan Monin *et al.* (6). Using data from the Cardiovascular Health Study (CHS), the authors conducted an elegant and multi-layered analysis of depression, cognition, and their longitudinal inter-relationship among couples in a multi-centric sample of over 1,000 community-dwelling adults over age 65. They examined the progression of depression and cognition within individuals over seven years and how each factor influenced one another. They also explored how an individual’s depression and cognition influenced their spouse’s symptoms. Last, they examined gender-differences in the association for each symptom, i.e., if wives influenced husbands more than vice versa. The study measured cognition using the modified mini-

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mental examination, depression using the Center for Epidemiologic Studies Depression scale and controlled for age, education, activities of daily living and instrumental activities of daily living. The authors observed that cognitive decline predicted greater decline, depressive symptoms predicted further worsening of depression, and this was observed within each individual. Within an individual, cognitive decline predicted depression over time but not vice versa. In the between-spouses analysis, depression in an individual predicted depression in their spouse. Interestingly, depression in an individual, but not cognitive decline, predicted cognitive decline in their spouse. The authors did not find gender differences, contrary to their hypothesis that husbands' symptoms would influence their wife's symptoms more than vice versa. Despite limitations such as the lack of information on psychiatric history, the length and quality of relationships, medical illnesses, and caregiving burden, this and similar studies mark a watershed not only in the cultural and environmental context of our patients, but also the boundaries of our roles as clinicians working with older adults.

Moreover, the Monin study highlights unique questions regarding the evolving aging demographic, institution of marriage as well as the role of positive traits and potential interventions. First, the study by Monin *et al.* and others like it are heteronormative. Following the 2015 U.S. Supreme Court ruling, 24% of LGBT adults over the age of 50 were reported to have legally married (7). The interplay of depression and cognition among older LGBT adults is yet to be understood and not generalizable, as they may have dissimilar gender roles, different caregiving patterns, and shorter durations of marriages. Moreover the institution of marriage has evolved since the Baby Boomer generation. Divorces, re-marriages, non-marital cohabitation, and complex intergenerational family structures have all increased with ensuing impact on longevity, functional decline, healthcare utilization, and time to institutionalization (8). This calls for greater nuance in exploring the marital and social context in the care of an individual and the inclusion of these dimensions in future research.

While a number of studies have focused on depression and dementia, there are important roles for positive psychological traits such as resilience, optimism and spirituality. Higher caregiver resilience was associated with participation in support groups; higher self-efficacy, resourcefulness, positive thinking, greater family empathy and spirituality; fewer family problems; and less caregiver abuse (9–12). Older adults with optimistic spouses had fewer depressive symptoms and chronic illnesses, better physical functioning and marital quality than those with less optimistic spouses (13, 14). Likewise, caregivers with high religiosity and spirituality were more likely to use effective dementia management strategies and had better quality of life (15). Within infertile couples, an individual's spirituality improved their partner's infertility-related stress and quality of life (16). Adopting positive psychiatric approaches to bolster psychological traits in patient populations may improve outcomes for couples (17).

Research findings on the interplay of symptoms among older adult spouses belies long held beliefs in mental health that a clinician should not treat members of the same family, but call for dyadic interventions and greater emphasis on the family as the unit of treatment. Interventions that “enhancing couplehood” can bolster their ability to face the challenges of

an illness like dementia (18). “Couples Life Story Approach” or a 5-week life review-type therapy for couples bolsters couple resilience and identity (19). Community occupational therapy trains patients in using aids and caregivers in coping strategies (20). Similarly, enhancement of family resilience – through education, self-help groups, and communication strategies may bolster the family’s ability to adapt to the demands of dementia (21). Couples-oriented treatments for depression have been reported to enhance dyadic communication and social support for the patient (22), with improved outcomes for both the patient and spouse.

The Monin *et al.* paper showcases important clinical considerations for geriatric mental health providers. The influence of a spouse’s cognition and emotional well-being on a patient, and vice versa, cannot be ignored. Inclusion of spouses and key family members in the treatment of older individuals with dementia or depression may greatly improve outcomes for the entire family unit. Future work and interventions must consider the growing number of non-heteronormative and multicultural relationships in the older population as well as consider the role of positive psychological traits.

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