Marital Aggrandizement as a Mediator of Burden Among Spouses of Suspected Dementia Patients*

Norm O'Rourke, *University of Ottawa* and Cameron A. Wenaus, *University of British Columbia*

RÉSUMÉ
Les recherches récentes révèlent que l'idéalisation conjugale (mesurée par l'échelle de conventionalisation conjugale) est le principal déterminant du fardeau que peuvent ressentir les aidants naturels de personnes atteintes de démence. La présente étude corrobore l'existence d'une relation inversement proportionnelle entre ces deux phénomènes. De plus, il semble y avoir peu de relation entre le type de réponses au questionnaire d'enquête et les mesures typiques de désirabilité sociale (aveuglement et gestion des impressions). En outre, la tendance à écarter les expériences négatives de sa vie conjugale semble avoir peu de liens avec la stratégie d'adaptation axée sur les émotions et la résolution de problèmes, tel que cela a été défini dans le modèle phénoménologique cognitif de Lazarus et Folkman. La propension à idéaliser son conjoint et son mariage est étudiée par rapport à la théorie reconstructionniste de la mémoire et de la théorie des échanges sociaux.

ABSTRACT
Recent research suggests that the single strongest predictor of burden among dementia caregivers is a measure of marital aggrandizement (Marital Conventionalization Scale). The current study corroborates the significant inverse relation between these constructs. In addition, there appears to be little association between this response style and more standard social desirability constructs (i.e. self-deception, impression management). Furthermore, the tendency to discount negative experience in one’s marital history appears distinct from emotion- and problem-focussed coping as defined within Lazarus and Folkman’s cognitive

* This article was written with the support of a Social Sciences and Humanities Research Council of Canada (SSHRC) Doctoral Fellowship awarded to the first author (NO’R). Completion of this study was further supported by the Donald Menzies - Canadian Association on Gerontology Bursary. In addition, we wish to express our appreciation to Dr. Thomas Hadjistavropoulos for his contribution to an earlier draft.

Key Words: Appraisal, Burden, Caregivers, Dementia.
Mots clés: Évaluation, fardeau, aidants, démence.

Manuscript received May 22, 1997; manuscrit reçu le 22 mai 1997.
Manuscript accepted June 1, 1998; manuscrit accepté le 1 juin 1998.

Requests for offprints should be sent to: Les demandes de tirés-à-part doivent être adressées à:
Norm O’Rourke
School of Psychology
University of Ottawa
Rm. # 615 - 120 University
Ottawa, ON K1N 6N5

Canadian Journal on Aging / La Revue canadienne du vieillissement / Vol. 17 no. 4 1998, 384-400
phenomenological model. The propensity to idealize one’s spouse and marriage is discussed relative to the reconstructionist theory of memory and social exchange theory.

A preliminary study by O’Rourke, Haverkamp, Rae et al. (1996) challenges traditional understanding of burden among spouses of dementia patients. In this study, marital aggrandizement (as measured by the Marital Conventionalization Scale [MCS]; Edmonds, 1967) emerged as the single strongest (inverse) predictor of expressed burden among spousal caregivers. This construct was more strongly predictive of burden than patient impairment, duration of care, and hopelessness among caregivers. In other words, a significant proportion of caregivers indicated that their relationship was ideal prior to the onset of their spouse’s illness and that the premorbid personality of their spouse was devoid of character flaws (O’Rourke, Haverkamp, Rae et al., 1996).

This finding is also notable given the marginal relationship between expressed burden and a second, individual social desirability measure (r[64] = .26, p < .05). We conclude from this study that the MCS taps a separate and distinct construct as compared to traditional social desirability scales (O’Rourke, Haverkamp, Rae et al., 1996).

From this finding and related research (cf. Fowers & Applegate, 1995), marital aggrandizement is defined as a distinct response style by which respondents convey an inordinately positive appraisal of their spouse and marriage. In effect, this entails the propensity to discount negative perceptions of one’s marital history. This construct is deemed distinct from individually-mediated response biases; marital aggrandizement is thus a dyadic construct (i.e. occurring exclusively within relationships).

According to Paulhus (1991), standard measures of socially desirable responding are composed of two distinct factors. Instruments such as the Marlowe-Crowne Social Desirability Scale (MC-SDS) are believed to measure distinct tendencies to purposefully distort one’s presentation of self (i.e. impression management) as well as self-deception (i.e. an honest, yet overly positive self-presentation). Although preliminary research suggests that the MCS is composed of a single construct (Wenaus, O’Rourke, & MacLennan, 1997), it remains unclear if this dyadic response style reflects a need to deceive self or others. In the initial O’Rourke, Haverkamp, Rae et al. (1996) study, the MCS and the burden measure were verbally administered to participants, thus self-deception and impression management may both have been elicited.

Uncertainty has surrounded the precise function of the MCS from the outset. As stated by Edmonds (1967), there exists the need for valid measures of biased responding vis-à-vis marital instruments; however, research has consistently shown a weak correlation between the MCS and more standard measures of socially desirable responding (e.g., MC-SDS). Fowers, Applegate, Olson and Pomerantz (1994), in fact, suggest that the
MCS does not measure a response bias but *marital hypersatisfaction*. This would seem a logical assertion given the relationship between the MCS and expressed burden. In other words, it would be reasonable to suggest that caregivers who are perfectly satisfied with their spouse and marriage would be less burdened in this role. Marital hypersatisfaction, in effect, may mediate the demands of caregiving.

Examination of the item content of the MCS, however, would suggest otherwise. This scale does not measure satisfaction per se, but the absence of expressed negative beliefs and experience in one’s marital history (e.g., “My spouse understands and completely sympathizes with my every mood”; “I have never regretted my marriage, not even for a moment”). In the initial O’Rourke, Haverkamp, Rae et al. (1996) study, caregivers on average endorsed seven of 15 such statements from the MCS irrespective of illness severity and years married ($M = 36.7$ years married, $SD = 14.7$).

The suggestion that the MCS measures marital hypersatisfaction is also untenable from the perspective of dialectical materialism. This philosophical paradigm states that it is infeasible that one would arrive at the belief one’s marriage and spouse are ideal without the experience of dissatisfaction. Reality evolves continually and rational awareness can only be perceived in context to its opposite (Shirokov, 1978). With regard to enduring relationships, satisfaction exists along a continuum perceived only in relation to contrasting experience. Therefore, satisfaction cannot exist in isolation but is defined in context of one’s overall relational history.

We contend that marital aggrandizement reflects a distinct response style. Specific to dementia caregivers, it is hypothesized that the tendency to discount negative relational beliefs reflects a means to counter the emotional strain of this role. A primary objective of the current study was to replicate findings from the O’Rourke, Haverkamp, Rae et al. (1996) study which demonstrated a significant association between expressed burden and marital aggrandizement. The current study, however, provided respondents with greater anonymity. As opposed to presenting measures in a structured interview, spouses completed these instruments themselves (i.e. paper and pencil format). This methodology was selected to assess the degree to which the negative association between the MCS and expressed burden may be attributed to the demand conditions of structured, face to face interviews. It was assumed that greater anonymity would reduce the likelihood of purposeful distortion (i.e. impression management).

A related objective of the current study was to assess the construct measured by the MCS vis-à-vis more traditional social desirability constructs. As it is assumed that marital aggrandizement is distinct from self-deception and impression management, covariation among the MCS and these latter constructs should be minimal. This result would provide greater understanding of marital aggrandizement in relation to caregiver burden.
A further objective was to determine if integration of marital aggrandizement with the stress and coping paradigm might improve the conceptual clarity of this nebulous construct. A comprehensive body of research documents the utility of the cognitive phenomenological model among caregivers (DeLongis & O'Brien, 1990). Within this paradigm, coping is defined as variable cognitive and behavioural efforts to manage demands which tax or exceed one’s perceived resources (Lazarus & Folkman, 1984). Faced with stressful demands, one may take direct action, plan problem-solving strategies, and seek information. These examples of problem-focussed coping entail proactive management of stressful circumstances. The corollary is emotion-focussed coping in which caregivers regulate their affective awareness with tactics such as denial, wishful thinking, and avoidance (see Kramer & Vitaliano, 1994). It has been suggested that problem-focussed coping is more adaptive and predictive of positive outcomes. For instance, research suggests that caregivers who rely upon emotion-focussed coping are more prone to depression and lower life satisfaction (Seltzer, Greenberg, & Krauss, 1995; Wright, Lund, Caserta, & Pratt, 1991).

It is yet unclear how marital aggrandizement may relate to coping among caregivers. We hypothesized that elevated MCS scores represent a propensity to discount negative relational experience, in effect, reconstructing one’s marital history. Although this might appear to represent a means to affectively manage role demands, this falls outside the traditional definition of emotion-focussed coping. Marital aggrandizement would appear to be a distinct and separate means to contend with the demands of informal care.

Method

Participants
Fifty-six spouses were recruited for this study over a one-year period (24 men, 32 women). This sample was recruited at the Clinic for Alzheimer Disease and Related Disorders, Vancouver Hospital and Health Sciences Centre - UBC Site. Physician referrals to this tertiary diagnostic facility are received from all regions of British Columbia. As part of a structured two-day assessment, patients and collateral informants (e.g., caregivers) meet with health care professionals from various disciplines (i.e. neuropsychology, geriatric medicine, neurology, speech pathology, psychiatry, social work).

Caregivers were asked to complete a series of measures at the time their spouse underwent neuropsychological testing. These measures were randomly counter-balanced to ensure that the order of presentation did not impact responding (Forms A & B). For instance, responses to the MCS did not differ between forms ($t[56] = 1.20, ns$). Participants entered an office to individually complete the set of questionnaires. Each was provided with the telephone extension of the first
author (NOR) should s/he have any questions. During data collection, only three respondents sought clarification in this manner.

Upon completion, participants were requested to place questionnaires within the envelope provided, seal it, and deposit the package within a strongbox located in the room. This methodology was chosen to minimize the likelihood of biased responding due to impression management (Paulhus, 1991). Each set of questionnaires was coded so that responses could be matched with corresponding patient data.

**Measures**

The Burden Interview (BI; Zarit, Orr, & Zarit, 1985) was specifically developed for family caregivers of dementia patients. This instrument presents respondents with a series of 22 items. The degree to which caregivers endorse each item is rated along 5-point Likert-type scales. Although two subscales exist (personal strain and role strain), BI scores are most often reported as a combined total because of the significant correlation between subscales (e.g., r = .75, p < .001; Hadjistavropoulos, Taylor, Tuokko, & Beattie, 1994).

Internal reliability as measured by Cronbach's alpha (α) has been reported as ranging from α = .88 (Hassinger, 1986) to α = .94 (O'Rourke, 1995). Zarit and Zarit (1990) reported test-retest reliability as r = .71 (no time interval specified). These authors also stated that concurrent validity has been established for the BI vis-à-vis the Brief Symptom Inventory (r = .41; Zarit & Zarit, 1990).

The Marital Conventionalization Scale (MCS; Edmonds, 1967) was designed to assess overly positive appraisals of one's marriage. Items were selected from an initial set of 50 statements, each suggesting an idealized depiction of one's spouse and marriage (Edmonds, 1967). The items for this measure were purposely written in extreme terms such that they cannot be endorsed without conveying an inordinately positive depiction of the relationship.

Respondents are asked to indicate whether 15 statements are true or false (e.g., "We are as well adjusted as any two people in the world can be"; "If my spouse has any faults, I am not aware of them"). For this study, four additional items from the Marital Status Inventory (MSI; Weiss & Cerreto, 1980) were interspersed within the MCS to obfuscate its intent. It was assumed that this would lead participants to believe that the scale was intended to gauge stability of the marriage. Although the measure used for the current study was composed of 19 items, those from the MSI were not scored.

Internal consistency for the MCS appears to vary across populations. For instance, Grigg (1994) reported α = .75 among alcohol dependent men and their wives. Cronbach's alpha as measured among spouses recruited for the current study is more acceptable (α = .90). Convergent validity for the MCS has been established relative to the Locke-Wallace Scale of
Marital Adjustment (Edmonds, Withers, & DiBatista, 1972) and the Relationship Inventory (Schumm, Bollman, & Jurich, 1980).

In the initial validation study, Edmonds (1967) calculated relative weights for each item ranging from 5 to 10 ($M = 6.47$). It appears these weights were based upon item-scale correlations. Given the homogeneity of the sample from which these weights were derived (i.e. married students from one north-eastern U.S. university), item weights were not applied here nor in the previous O'Rourke, Haverkamp, Rae et al. (1996) study. Instead, one point was assigned for each MCS statement endorsed (range 0 to 15).

Scores range from 0 to 97 as per the scoring scheme proposed by Edmonds (1967). It was suggested that participants scoring above 20 be identified and purged from data sets as responses to other dyadic measures are largely distorted (as cited by Grigg, 1994). It is unclear, however, how this cut-off point was derived and few have heeded this recommendation (e.g., Hansen, 1981). Given this criterion, 66 per cent of participants (i.e. 37 of 56 caregivers) would have been excluded from the current study.

Given a mean item value of 6.47, young married persons on average endorsed 5.26 items in Edmonds’ (1967) initial validation study. More recent research, however, has reported significantly lower levels; for instance, husbands and wives endorsed 2.3 and 1.03 items respectively as reported by Grigg (1994). These response levels stand in marked contrast to an average of seven of 15 items endorsed by spouses of suspected dementia patients (O’Rourke, Haverkamp, Rae et al., 1996).

The Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1994) is a 40-item self-report measure. This scale was developed subsequent to empirical research delineating self-deception (SD) from impression management (IM) response biases (Paulhus, 1991). The BIDR is composed of two 20-item subscales. Respondents rate their degree of agreement to each statement along 7-point Likert-type scales (e.g., “I don’t care to know what other people really think of me”; “I don’t gossip about other people’s business”). One point is assigned for each 6- or 7-point response (subsequent to reversal of negatively-keyed items).

Among university undergraduates, Paulhus (1994) reported similar mean levels between male ($n = 197$) and female ($n = 265$) students. For both groups, self-deception ($M = 6.0, SD = 3.2$ male; $M = 5.6, SD = 3.1$ female) totals were marginally higher as compared to impression management ($M = 4.2, SD = 3.1$ male; $M = 5.4, SD = 3.2$ female).

Reported correlation coefficients between subscales ranged from $r = .05$ to $r = .40$ (Paulhus, 1991). Internal consistency, as measured by Cronbach’s alpha ($\alpha$), ranged from $\alpha = .65$ to $\alpha = .75$ for the SD subscale and $\alpha = .75$ to $\alpha = .80$ for the IM subscale (Paulhus, 1994). Among undergraduates ($N = 83$), test-retest reliability over a five-week period has been reported as $r =$
.69 and r = .77 for SD and IM subscales respectively (Paulhus, 1994). This suggests adequate stability of constructs over time.

The 40-item BIDR has been shown to correlate significantly with the Marlowe-Crowne Social Desirability Scale (r = .73; Paulhus, 1994) and the Multidimensional Social Desirability Inventory (r = .80; Paulhus, 1991). Convergent validity for the IM subscale has been established vis-à-vis the Lie Scale of the Minnesota Multiphasic Personality Inventory (Paulhus, 1994). Response levels to the IM subscale also show marked increase in mean levels from private to public response conditions; as expected, no such variability is noted for the SD subscale (Lautenschlager & Flaherty, 1990). These findings differentiate response sets and support the construct validity of subscales.

The Coping Responses Inventory from the Health and Daily Living Form (CRI; Moos, Cronkite, & Finney, 1990) was adapted for the current study. This scale was developed to assess generalized coping across situations; however, the instructions were adjusted in this instance to prime participants to consider the most stressful aspect of their marriage over the past year. Respondents were next asked to indicate how often they made use of 40 separate means of coping with the interpersonal stressor specified. Four separate response alternatives were provided ranging from no (0) to yes, fairly often (3).

This measure was initially validated among a sample of more than 1,800 late-middle-aged and older adults (Moos & Schaefer, 1993). According to Kramer and Vitaliano (1994), the CRI possesses adequate validity as compared to measures of depressive affect, life satisfaction, and health. Internal consistency for separate coping constructs has been reported as ranging from $\alpha = .60$ to $\alpha = .83$ among a randomly derived sample of 405 adults ($M = 39.4$ years; Holahan & Moos, 1990). Emotional discharge and affective regulation were collapsed into a single emotion-based subscale for this study, and problem solving and information seeking were combined to measure problem-focussed coping.

The Beck Hopelessness Scale (BHS; Beck & Steer, 1988) was developed as a circumscribed measure of hopeless ideation. As compared to generalized measures of depressive affect, hopelessness appears more strongly related to caregiver burden (O'Rourke, Havercamp, Tuokko, Hayden, & Beattie, 1996). The BHS asks whether 20 statements pertaining to self and one's future are true or false. This measure consists of 11 positively- and nine negatively-keyed items. Psychometric research suggests that scores of 9 or greater (of a possible 20 point total) provide a reliable distinction between asymptomatic and moderately hopeless persons (Beck & Steer, 1988).

Among elderly subjects, Abraham (1991) reported Kuder-Richarson coefficients across 18 points in time on average as KR-20 = .80 ($SD = .04$). Cronbach's alpha as measured among depressed older adults has been reported as $\alpha = .84$ (Hill, Gallagher, Thompson, & Ishida, 1988). Beck and
Steer (1988) stated that the BHS is appropriate for use with adults 17 to 80 years of age.

The Functional Rating Scale (FRS; Tuokko, Crockett, Beattie, Horton, & Wong, 1986) was developed to quantify patient impairment across various cognitive and functional domains (i.e. memory, social/occupational, home and hobbies, problem solving, personal care, affect, language, orientation). This measure provides a cumulative rating of dementia severity while recognizing uneven rates of decline among neurodegenerative disorders (i.e. global versus circumscribed deficits). Tuokko et al. (1986) reported inter-rater reliability coefficients ranging from $r = .63$ to $r = .93$ and 94.2 per cent correct classification as compared to standard neuropsychological measures.

Results
The majority of spouses recruited for the current study were wives (57%). This result corresponds to epidemiological research as caregivers of dementia patients most often are female (e.g., Canadian Study of Health and Aging Working Group, 1994). In contrast to existing research (Miller & Cafasso, 1992; Pruchno & Resch, 1989), few differences between genders were apparent. For instance, response levels to the MCS were similar for men and women ($t[56] = .58, ns$). In addition, burden scores did not differ ($t[56] = .43, ns$), nor was there a difference in terms of the hopelessness measure ($t[56] = .58, ns$). However, gender differences relative to coping were evident as wives presented with elevated scores in terms of both emotion- ($t[56] = 2.41, p < .05$) and problem-focused coping ($t[56] = 3.08, p < .01$). Further descriptive data for the current sample are presented in Table 1.

Hypothesis One
One intent of this study was to further define the function of the marital aggrandizement. In relation to more standard social desirability constructs, the MCS was analysed relative to self-deception, impression management as well as patient impairment and caregiver hopelessness. Multiple regression was performed to assess the predictive strength of each of these constructs (Cohen & Cohen, 1983). With MCS scores as the dependent variable, a significant regression equation emerged ($R^2 = .17, p < .05$); however, the BHS was the only variable to achieve singular significance ($F[4,51] = 4.47, p < .05$). Those who presented as more hopeless were less likely to endorse MCS items (see Table 2). This finding is consistent with the operational definition of marital aggrandizement as an inordinately positive depiction of one’s past should serve a protective function relative to despair in the present.

It is noteworthy that the only other independent variable to approach significance relative to MCS scores was impression management ($F[4,51] = 3.73, p = .06$). This finding was unexpected considering that spouses were not interviewed for this follow-up study. It was hypothesized that self-de-
Table 1
Descriptive features of patients and caregivers (N = 56)

<table>
<thead>
<tr>
<th>Feature</th>
<th>Mean</th>
<th>(SD)</th>
<th>Alpha (α)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Age</td>
<td>70.7</td>
<td>(9.87)</td>
<td>-</td>
</tr>
<tr>
<td>Duration (Months) of Symptoms</td>
<td>65.1</td>
<td>(41.8)</td>
<td>-</td>
</tr>
<tr>
<td>Functional Rating Scale</td>
<td>22.3</td>
<td>(6.42)</td>
<td>0.93</td>
</tr>
<tr>
<td>Years Married</td>
<td>41.0</td>
<td>(11.9)</td>
<td>-</td>
</tr>
<tr>
<td>Total Family Income</td>
<td>$38,800</td>
<td>(23,200)</td>
<td>-</td>
</tr>
<tr>
<td>Caregiver Age</td>
<td>69.2</td>
<td>(9.55)</td>
<td>-</td>
</tr>
<tr>
<td>Beck Hopelessness Scale</td>
<td>5.46</td>
<td>(3.82)</td>
<td>0.80</td>
</tr>
<tr>
<td>Zarit Burden Interview</td>
<td>23.6</td>
<td>(15.5)</td>
<td>0.94</td>
</tr>
<tr>
<td>MCS Total</td>
<td>5.89</td>
<td>(4.53)</td>
<td>0.90</td>
</tr>
<tr>
<td>BIDR Self-Deception</td>
<td>5.93</td>
<td>(2.69)</td>
<td>0.49</td>
</tr>
<tr>
<td>BIDR Impression Management</td>
<td>9.41</td>
<td>(3.45)</td>
<td>0.56</td>
</tr>
<tr>
<td>BIDR (Full Scale)</td>
<td>15.3</td>
<td>(4.76)</td>
<td>0.68</td>
</tr>
<tr>
<td>CRI Emotion-Focussed Coping</td>
<td>24.3</td>
<td>(4.67)</td>
<td>0.56</td>
</tr>
<tr>
<td>CRI Problem-Focussed Coping</td>
<td>31.4</td>
<td>(6.47)</td>
<td>0.73</td>
</tr>
</tbody>
</table>

Note:
Functional Rating Scale = dementia severity, MCS = Marital Conventionalization Scale, BIDR = Balanced Inventory of Desirable Responding, CRI = Coping Responses Inventory.

Table 2
Correlation coefficients and regression analysis with marital aggrandizement as the dependent variable (N = 56)

<table>
<thead>
<tr>
<th>Variables</th>
<th>MCS (DV)</th>
<th>FRS</th>
<th>BHS</th>
<th>SELFDEC</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRS</td>
<td>-0.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHS</td>
<td></td>
<td>-0.29*</td>
<td>0.19</td>
<td>-0.20</td>
<td>0.06</td>
<td>0.22</td>
<td>-0.28*</td>
</tr>
<tr>
<td>SELFDEC</td>
<td>0.13</td>
<td>0.04</td>
<td>-0.20</td>
<td></td>
<td>0.33</td>
<td>0.17</td>
<td>0.25</td>
</tr>
<tr>
<td>IMPRGMGT</td>
<td>0.24</td>
<td>0.00</td>
<td>0.07</td>
<td>0.19</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
* p < .05

$R^2 = .17 (p < .05)$. DV = dependent variable, MCS = Marital Conventionalization Scale, FRS = Functional Rating Scale, BHS = Beck Hopelessness Scale, SELFDEC = self-deception subscale of the Balanced Inventory of Desirable Responding, and IMPRGMGT = impression management subscale of the Balanced Inventory of Desirable Responding.

decision was more likely to be elevated considering that the identity of caregivers was masked. It should be noted, however, that neither self-deception nor impression management correlated significantly with MCS scores. This supports the hypothesis that the MCS taps a construct distinct from unitary socially desirable responding.

Hypothesis Two
A second regression equation was computed to examine caregiver burden (i.e. the BI served as the dependent variable). Subsequent to removal of two multivariate outliers, a strongly significant regression equation
Table 3
Correlation coefficients and hierarchical regression analysis of caregiver burden (n = 54)

<table>
<thead>
<tr>
<th>Variables</th>
<th>BURDEN (DV)</th>
<th>FRS</th>
<th>DURSx</th>
<th>MCS</th>
<th>EMOTION</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRS</td>
<td>0.45&lt;sup&gt;3&lt;/sup&gt;</td>
<td>0.23</td>
<td>-0.48&lt;sup&gt;3&lt;/sup&gt;</td>
<td>0.46&lt;sup&gt;3&lt;/sup&gt;</td>
<td>0.30&lt;sup&gt;1&lt;/sup&gt;</td>
<td>0.68</td>
<td>0.34</td>
<td>0.26&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>DURSx</td>
<td>0.23</td>
<td>0.05</td>
<td>-0.17</td>
<td>-0.07</td>
<td>0.20</td>
<td>-0.02</td>
<td>0.06</td>
<td>-0.04</td>
</tr>
<tr>
<td>MCS</td>
<td>-0.48&lt;sup&gt;3&lt;/sup&gt;</td>
<td>-0.17</td>
<td>-0.07</td>
<td>-1.33</td>
<td>0.39&lt;sup&gt;2&lt;/sup&gt;</td>
<td>-1.33</td>
<td>0.50</td>
<td>-0.36&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>EMOTION</td>
<td>0.46&lt;sup&gt;3&lt;/sup&gt;</td>
<td>0.20</td>
<td>0.39&lt;sup&gt;2&lt;/sup&gt;</td>
<td>-0.22</td>
<td>-0.22</td>
<td>1.26</td>
<td>0.63</td>
<td>0.36&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>PROBLEM</td>
<td>0.30&lt;sup&gt;1&lt;/sup&gt;</td>
<td>0.30&lt;sup&gt;1&lt;/sup&gt;</td>
<td>0.03</td>
<td>-0.23</td>
<td>-0.57&lt;sup&gt;3&lt;/sup&gt;</td>
<td>-0.20</td>
<td>0.45</td>
<td>-0.08</td>
</tr>
</tbody>
</table>

Notes:
1. <sup></sup><i>p < .05</i>
2. <sup></sup><i>p < .01</i>
3. <sup></sup><i>p < .001</i>

<sup>R</sup><sup>2</sup> = .22 for FRS and DURSx (<i>p < .005</i>); <sup>Δ</sup><sup>R</sup><sup>2</sup> = .14 subsequent to entry of the MCS (<i>p < .001</i>); <sup>Δ</sup><sup>R</sup><sup>2</sup> = .08 subsequent to entry of EMOTION and PROBLEM (<i>p < .001</i>). DV = dependent variable, FRS = Functional Rating Scale, DURSx = duration (months) of symptoms, MCS = Marital Conventionalization Scale, EMOTION = emotion-focused coping, PROBLEM = problem-focused coping.
emerged ($R^2 = .44, p < .001$). Dementia severity and duration of symptoms were entered as a first step in this hierarchical regression equation (see Table 3). This was performed to enable analysis of caregiver features subsequent to covariation for patient variables. Although significant, it is noteworthy that illness variables accounted for less than one-quarter of observed variance in expressed burden ($R^2 = .22, p < .005$). This finding is consistent with previous research suggesting that burden occurs largely as a function of caregiver characteristics (O’Rourke, Haerkamp, Tuokko et al., 1996).

MCS scores were next entered as a separate step. Although participants completed questionnaires privately, marital aggrandizement emerged as a significant predictor of caregiver burden ($\Delta R^2 = .14, p < .001$). The standardized beta coefficient obtained here ($\beta = -.36, p < .01$) was identical to that reported in the initial O’Rourke, Haerkamp, Rae et al. (1996) study in which the MCS was verbally administered. This suggests that method of data collection does not significantly affect MCS response levels.

Coping responses were entered as a final step within this regression equation. Emotion- and problem-focused coping contributed significantly to prediction of burden scores ($\Delta R^2 = .08, p < .001$); only emotion-focused coping, however, provided unique significance ($F[5,48] = 4.01, p < .05$). In contrast, problem-focused coping appeared unrelated to expressed burden among caregivers ($F[5,48] = .19, ns$).

Hypothesis Three
Also evident, MCS scores correlated significantly with neither problem- ($r[54] = -.23, ns$) nor emotion-focused coping ($r[54] = -.22, ns$). Although marital aggrandizement and emotion-focused coping each contributed significantly to prediction of burden scores, the lack of association between these constructs suggests that both share a distinct association with expressed burden. In other words, marital aggrandizement does not appear to be related to coping as currently defined (Lazarus & Folkman, 1984). Caregivers who aggrandize their relational history did not present as burdened, whereas reliance upon emotion-focused coping was significantly correlated with expressed burden.

Because of the relatively small ratio of subjects to variables, cross-validation shrinkage was calculated for this second regression equation (Wilson & Reynolds, 1982). With five dependent variables and a sample size of 54 participants, $R^2_{\text{pred}} = .42$. This squared multiple correlation remained significant, suggesting that the significance of the regression equation was not due to large, chance correlations ($t[54] = 3.14, p < .001$).

Discussion
A notable outcome of the present study was that the MCS remained significantly associated with expressed burden although responses were obtained anonymously. This suggests that elevated MCS scores do not
result as a deliberate attempt to present one's marriage as devoid of
difficulties (e.g., conscious dissembling due to interview format).

This finding was supported by the nonsignificant correlation between
the MCS and the impression management subscale of the BIDR; nor was
marital aggrandizement related to the self-deception. Together, these
results corroborate the contention that this response style is distinct from
more standard modes of socially desirable responding.

Caution is warranted, however, given the elevated mean levels of
impression management as compared to BIDR norms. In contrast to levels
reported by Paulhus (1994), participants recruited for the present study
provided markedly higher response levels on this BIDR subscale. Despite
a methodology chosen to minimize impression management (Paulhus,
1991), demand characteristics of this clinical setting may not allow for the
perception of full anonymity.

A related observation pertains to reliability of the BIDR. In contrast to
estimates of internal consistency recorded among university undergraduates,
coefficient alphas for both impression management and self-deception
suggest that the BIDR may be less reliable among older adults. This
underscores a pervasive difficulty with many measures; instruments
developed with convenience samples (e.g., undergraduates) may not be valid
for older adults.

According to the stress and coping paradigm (Lazarus & Folkman,
1984), distress occurs when coping responses are seen as insufficient to
meet perceived stressors. This model has been instrumental in providing
broader understanding of burden among dementia caregivers (e.g., Kra-
mer, 1992). Although the present study suggests that the MCS is distinct
from coping responses, the MCS and emotion-focused coping both contri-
buted significantly to prediction of burden scores. This suggests distinct
pathways by which burden occurs; spouses may aggrandize their relational
history or attempt to regulate affective experience. The former was in-
versely associated with the experience of burden, whereas emotion-
focused coping was predictive of caregiver burden.

These findings further suggest that relative to caregiver burden marital
aggrandizement is distinct from coping. As coping responses are elicited
only when stressors are deemed sufficiently severe (Lazarus & Folkman,
1984), marital aggrandizement may function to reduce perceived strain.
More precisely, marital aggrandizement may mediate appraisal such that
stressors are deemed less severe. Idealized perceptions of one's spouse and
marriage may thus reduce the degree to which neurodegenerative illness
is perceived as taxing one's resources.

The question remains as to how some caregivers come to recall strictly
positive aspects of their marital history. Is this a function of caring for a
spouse with dementia, and is this strategy adaptive over time?

This tendency may be best understood within social exchange theory
(Thibaut & Kelley, 1959). According to Buunk and Hoorens (1992), nega-
tive affect commonly occurs when persons do not derive benefit from their relationships with others. Dementing disorders insidiously rob spouses of their life partner as the person they once knew slowly slips away; over time, the marriage becomes progressively less reciprocal and the likelihood of burden and depression increases (Baumgarten, 1989). As the demands of care escalate, this relationship no longer resembles a marriage and benefits become less apparent for the spouse providing care (e.g., loss of companionship and emotional intimacy; Fitting, Rabins, Lucas, & Eastham, 1986).

The spouse may reconstruct his or her relational history in order to contend with this imbalance. In other words, s/he may reconcile the current context with the recollection of a marriage that was ideal before her or his spouse became ill. As the disease progresses, memories may become increasingly skewed to balance current demands vis-à-vis years of marital bliss. In this way, caregivers contend with current circumstance, believing that they were privileged to have had many years with their spouse as the net beneficiary of their marriage. Provision of care thus serves as perceived payment or appreciation for the privilege of sharing their lives in better times.

These assertions are consistent with the reconstructionist theory of memory (Neisser & Winograd, 1988). In contrast to the view that recollections are retrieved largely as first encoded, this perspective contends that memory functions as a malleable and adaptive process (Holmberg & Holmes, 1994). Events are recalled in context of current awareness in order to maintain the continuity of meaning and experience. This has been documented most consistently in terms of autobiographical memory (i.e. personal life events).

When dissonance between past and present occurs, memories can be recast to reconcile one’s past with existing beliefs and behaviours. This need not entail outright confabulation, but subtle reconstruction or selective recall of specific details (McFarland, Ross, & Giltrow, 1992). This process has been documented in longitudinal research with married persons. Men who perceive their relationships as deficient at present appear inclined to rate their marital histories negatively in contrast to favourable reports provided years before (Holmberg & Holmes, 1994). In other words, present circumstance appears to affect the continuity of perceptions, such that relational memories are modified in relation to current beliefs and perceptions. This finding may facilitate interpretation of the results of the current study.

More research is required, however, to ascertain the precise function of the MCS. For instance, marital aggrandizement should be assessed among spouses of other patient populations to more fully assess the adaptive value of this construct. Although this follow-up study replicates the principal findings of previous research, it remains unclear if this propensity to reconstruct one’s relational history is idiosyncratic to spouses of dementia
patients or may emerge universally among persons within enduring relationships. In order to maintain contentment within any relationship over time, there may exist the tendency to favour recollections of positive features of the couple's shared history.

Marital aggrandizement must also be assessed over time to more fully determine the function of this construct. The current study provides some consistency in terms of previous research, but more questions than answers remain. Therefore, interpretation of results warrants due caution. For instance, it cannot necessarily be assumed that elevated MCS scores occur as a result of providing care to a spouse with dementia. Although mean levels within the current sample and the previous O'Rourke, Haverkamp, Rae et al. (1996) study were notably elevated as compared to other research (e.g., Grigg, 1994), it cannot be assumed that this phenomenon is directly attributable to the spouse's illness. Older couples may be more prone to marital aggrandizement and therefore, these perceptions may predate the onset of illness.

Although the content of the MCS indicates that few could endorse these items without distorting presentation of their marriage, the mindset of these caregivers is not well understood. Longitudinal study is required with larger, more heterogeneous samples in which to determine the etiology and function of marital aggrandizement among married persons.

References


