Published in final edited form as:

Clin Gerontol. 2011 April ; 34(3): 173–189. doi:10.1080/07317115.2011.554627.

Ethnic Minority Status, Depression, and Cognitive Failures in Relation to Marital Adjustment in Ethnically Diverse Older Women

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Abstract

The authors investigated the relationship between marital adjustment and ethnic minority status, depressive symptomatology, and cognitive failures among 78 married, community-dwelling, and predominantly non-European-American older women (ages 57–89). Respondents were screened to rule out dementia. Level of depressive symptoms, self-report of cognitive failures, and marital adjustment were obtained. As hypothesized, higher depressive symptomatology and cognitive failures were associated with worse marital adjustment ($p < .05$ for both). The same was true for membership in a non-dominant ethnic group, albeit only when ethnic status was considered outside the context of the other two independent variables. These results have clinical implications and fit within the theoretical framework of the socioemotional selectivity theory (Carstensen, 1992) applied to marriage in older age, a conceptualization formulated by Bookwala and Jacobs in 2004.

Keywords

Relationship satisfaction; race; mood symptomatology; cognitive complaints

Marital adjustment is the perceived degree of agreement between spouses on issues such as conflict resolution, finances, sexuality, relationships with in-laws, philosophy of life, and recreation; it also refers to the subjective amount of happiness or regret experienced in a marriage (Locke & Wallace, 1959). Because of its association with physical health factors in adulthood as well as in later life (cf. Baker, Paquette, Szalai, et al., 2000; Melton, Hersen, Van Sickle, & Van Hasselt, 1995), marital adjustment has become a construct of interest to researchers in the field of aging. However, the traditional focus of studies of marital adjustment in older age has been the Caucasian population in this country (e.g. Bookwala & Jacobs, 2004; Davila, Karney, Hall, & Bradbury, 2003). Little empirical evidence is available about the relationship of marital adjustment to demographic and psychological factors among older adults, particularly ethnically diverse older women, and available findings on marital adjustment may not be generalizable to this population.

To focus on ethnicity and marital adjustment in older age would rightfully extend the study of older adults' marriage into larger societal contexts. The cultural landscape of the United States is one of ever-changing diversity due to previous and continued immigration (Schildkraut, 2007). Thus it is overly simplistic to assume that the stresses of acculturation and discrimination do not affect marriage in later life to a significant degree. Nevertheless, only a few researchers have targeted the relationship of ethnicity/race to marital adjustment and have done so in somewhat dated investigations on non-geriatric samples. Tucker, James and Turner (1985) reported that Whites had higher average scores on marital adjustment than Blacks. Negy and Snyder (1997) obtained similar findings when comparing Mexican-American couples to Euro-American couples. Research on this topic is definitely lacking in regard to community-dwelling older women with ethnic minority backgrounds, in spite of the fact that older women are more prone to depression and more likely to remain depressed than older men (Barry, Allore, Guo, Bruce, & Gill, 2008). Cross-culturally, high depression rates are common within this population. They range from 14.5% in China (Chi et al., 2005) to as high as 58% in Italy (Minicuci, Maggi, Pavan, Enzi, & Crepaldi, 2002). These figures underscore the significance of studying the link between older women's depressive symptomatology and important variables such as marital adjustment.

Numerous studies (mainly on younger samples) have consistently confirmed the significance of the relationship between depression and marital adjustment, which appears bidirectional to some researchers (e.g., Davila et al., 2003), yet unidirectional to others. The empirical evidence for the latter case is mixed. Some scholars have found that depression is caused by marital dissatisfaction in non-geriatric samples of women (e.g., Hollist, Miller, Falceto, & Fernandes, 2007). Conversely, Gagnon, Hersen, Kabacoff, and Van Hasselt (1999) noted that depression often causes marital dissatisfaction in late life. The differential impact of depression on marital adjustment as a function of age could explain, at least partially, the discrepant findings across studies. Research indicates that, in late life, the association between depression and marital satisfaction becomes stronger (e.g., Whisman, 2007), with depressive symptomatology affecting marital adjustment adversely (e.g., Bookwala & Jacobs, 2004). However, scholars have yet to examine the relationship between these two variables among ethnically diverse older women.

A neglected yet promising potential predictor of marital adjustment in older age is the report of cognitive failures/complaints, which can be common at all ages. The construct of cognitive failure reflects minor cognitive lapses associated with perception, memory, and motor function; it has been widely assessed through a self-report tool, the Cognitive Failure Questionnaire (CFQ; Broadbent, Cooper, FitzGerald, & Parkes, 1982), and is unrelated to age in many studies (e.g., Knight, McMahon, Green, & Skeaff, 2004). To our knowledge, thus far scholars have not yet targeted the relationship between cognitive failures and marital adjustment in older, community-dwelling married women without dementia. There is empirical evidence suggesting that this relationship is significant in couples in which one spouse has a formal diagnosis of either dementia (e.g., de Vugt et al., 2003) or dementia precursor syndrome (Garand et al., 2007). The aforementioned researchers noted that deterioration in marriage quality often occurs as a function of dementia-related behaviors that cause stress in spousal caregivers (e.g., asking the same question multiple times).

Assessing cognitive failures is pertinent to the theoretical foundation of the present study. The CFQ assesses problems individuals report while processing information and, thus, it is often viewed as an index of the level of complaints about one's self-assessed ability to function cognitively (e.g., Hohman, Beason-Held, Lamar, & Resnick, 2010). Additionally, several studies have shown that higher CFQ scores are suggestive of enhanced vulnerability to stress, in that they are highly related to several psychiatric symptoms associated with stress as reported by Broadbent et al. (1982). Consequently, CFQ scores could also be used as an index of stress vulnerability, a variable seldom targeted in ethnogeriatric research on marital adjustment in samples without dementia. It is important to test whether older women with higher CFQ scores can handle the everyday, commonly experienced marital stress and minimize conflicts associated with it versus scoring high on marital maladjustment. In light of this study's theoretical conceptualization of marriage in older age described next, the latter scenario is more likely to be true. It should be noted that, to reduce redundancy, we refer to cognitive *failures* and *complaints* interchangeably, as done by other researchers (e.g., Knight et al., 2004).

As a first step, we began to investigate potential risk factors for marital maladjustment in older women without dementia. The theoretical foundation for this work rests in the conceptual framework proposed by Bookwala and Jacobs (2004) on how to apply Carstensen's (1992) socioemotional selectivity theory to marital relations in older age. According to Carstensen's theory, in later life people attribute significantly more importance to increasing emotional closeness in intimate relationships, focusing also on minimizing undesired personal contacts that offer no emotional rewards. However, as pointed out by Bookwala and Jacobs, minimizing contact with one's spouse is not usually feasible for married older adults. Thus, the emotional regulation conceptualized by Carstensen might take a different form within the context of marriage in older age, yet still achieve the same emotional benefits. Namely, older adults are often adaptively able to find ways to minimize—thus attribute less weight to—marital conflicts. Most important for the purpose of this discussion, such adaptive abilities could result in higher levels of perceived marital adjustment.

A potential corollary to the above is that older adults might be less able to minimize marital conflicts if they are experiencing depression or they are self-reporting high levels of cognitive failures, which could be indicative of higher vulnerability to stress, as conceptualized in the above-mentioned studies, as well as of a tendency to complain about one's cognitive function. This corollary is also in line with Beck's (1970) depression theory, which asserts that people with mood disorders possess a negative cognitive triad characterized by pessimistic views of self, the world, and the future. As shown by Smith and Peterson's (2008) research on dysphoric adults, holding this pessimistic viewpoint within a marriage could lead to automatically interpreting situations negatively, considering spouses' neutral statements as insults, and over-perceiving criticism in their comments. If we add to this clinical picture self-reporting cognitive failures and belonging to an ethnic minority group, the cumulative potential burden of these factors could attenuate older women's energy needed to deal with (or overlook) marital conflict. Thus, it is reasonable to foresee that this scenario could result in worse marital adjustment.

The following hypotheses were tested: Reporting higher levels of a) depressive symptomatology and b) complaints about one's cognitive functioning would be associated with worse marital adjustment in community-dwelling older women. We also hypothesized that ethnic minority status would be a significant risk factor by itself, as well as when considered within the context of the aforementioned two variables.

It is worth noting that, in 1987, Fincham and Bradbury raised a valid methodological point, which is still relevant over 20 years later, regarding research on variables related to marital adjustment. Many of such factors (e.g., communication) are often covered, at least partially, by the tools typically used to measure marital adjustment. The ensuing overlapping of content introduces circularity and transforms research into a tautology. We minimized this problem by making sure that none of the variables used in model tested overlapped with the construct of marital adjustment or with the measure used to quantify it.

Methods

Participants

Initial respondents for this investigation comprised a subgroup of 80 currently married older women (ages 57–89) residing in a major metropolitan area, who were also participating in a larger federally-funded study examining cultural factors in psychological adjustment and quality of life. Inclusion criteria for this study were: at least 55 years old, currently married, and fluent in English. Women were excluded from this study if they did not pass a dementia screening test. Another exclusion criterion, i.e., residing in an assisted care facility, was set in order to minimize approaching women with significant cognitive impairments.

Table 1 illustrates the demographic characteristics of the sample and the descriptive statistics for the dependent and independent variables. Over two-thirds of the sample self-identified as an ethnic minority. Participants reported a variety of educational backgrounds; age was distributed in a normal fashion; over 80% of the sample was 65 years of age or older. Education was negatively skewed, with the majority of respondents having attended only high school and more than one third of the sample not having graduated. Many participants' marital adjustment scores fell within the maladjustment range (40%) and the mean score of marital adjustment was in the same range. Almost a quarter (24.4%) of the sample was clinically depressed, as indicated by elevated scores (i.e., 6 or higher) on the SELFCARE (D) measure.

Procedure

Participants were recruited via purposive sampling with the intent to maximize ethnic minority inclusion. The research team posted advertisements in newspapers, on websites, and in different ethnic communities at places including churches, stores, and senior centers. Additionally, fliers were posted at locations such as apartment complexes for seniors. Interviewers respectfully approached older women at the end of church services and at stores to optimize the inclusion of participants who are otherwise isolated and unlikely to volunteer in research. Interviewers, ethnically-matched to respondents, were trained in

theory and research methods applied to geriatric psychology. They also received training in clinical interviewing and cultural competence skills.

All the women interested in participating in this study were assigned a code number that was placed on their assessment battery (for confidentiality reasons, research assistants did not record any name). This was followed by the cognitive screening procedure to rule out dementia. Interviewers administered the assessment protocol in a one-on-one format at locations geographically convenient to the women recruited, such as libraries and senior centers. Eligible participants completed the assessment section in approximately 45 minutes to an hour and a half. Interviewers administered the assessment packet by reading each question to the respondents, with a break at midpoint to minimize fatigue.

Measures

Screening Tool—We screened potential participants for dementia by using the Mini-Cog (which was not used in the main data analyses; Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000). Borson, Scanlan, Chen, and Ganguli (2003) successfully validated this 3-item measure on ethnically diverse older adults. According to these authors, the Mini-Cog is not influenced by education or language; its use was ideal for this study because it can rapidly screen out participants with dementia.

Demographic Variables—Sociodemographic data were collected from all participants on marital status, age, ethnicity, and education.

Marital Adjustment—The Marital Adjustment Test (MAT; Locke & Wallace, 1959) is a 15-item measure of people's subjective degree of adjustment in their marital relations; it has high internal consistency (Cronbach's $\alpha = .90$). Scores lower than 100 indicate marital maladjustment. We optimized the MAT's original scoring system by applying two modifications recommended by Freeston and Plechaty (1997). The use of this measure was particularly suitable for this study, since the MAT quantifies both the degree of adjustment made to minimize conflicts and the subjective happiness experienced within one's marriage, which supports our interchangeable use of the terms marital *adjustment* and *satisfaction*.

Cognitive Failures/Complaints—The Cognitive Failures Questionnaire (CFQ; Broadbent et al., 1982) is a 25-item tool used to assess how frequently respondents qualifying for our study—although free from dementia—experienced minor failures in motor function, perception, and memory within the past 6 months. The items of the CFQ are negatively phrased and rated on a frequency scale ranging from 0 to 4, with 0 = never and 4 = very often. The maximum CFQ score is 100. According to Broadbent et al., the internal consistency of this measure is high, and factor analytic procedures have shown good evidence for a single general factor. Although Rabbitt and Abson (1991) found CFQ scores to be unaffected by age and not indicative of early stages of more severe cognitive impairment, recent longitudinal research provided support for the validity of CFQ scores as markers of age-related changes in older adults' memory and brain activity (Hohman et al., 2010).

Depressive Symptomatology—This variable was measured by using the SELFCARE (D) depression scale (Bird, MacDonald, Mann, & Philpot, 1987). This 12-item tool was developed specifically for the purpose of measuring level of depressive symptoms in community-dwelling older adults. Scores range from 0 to 12, with scores between 6 and 12 indicating the presence of significant clinical depression. Psychometric research by Bird et al. showed a Kappa reliability score of .77, indicating that the SELFCARE (D) is a reliable measure. This tool has been validated with good results in general practice (Upadhyaya & Stanley, 1997) and in home care (Banerjee, Shamash, MacDonald, & Mann, 1998), with sensitivities for detecting depression in the 90% range.

Data Analyses

First, we calculated Mini-Cog scores to eliminate participants with dementia; two of the women recruited were eliminated, reducing the sample size to 78. The descriptive statistics reported herein include mean values or percentages (depending upon the nature of each variable), with standard deviations and range scores provided whenever applicable. We conducted zero-order correlational analyses (i.e., Pearson's) to examine the bivariate relationship between the variables, then performed a hierarchical multiple regression analysis with marital adjustment as the dependent variable. Ethnicity, depressive symptomatology, and cognitive failures were entered in the model as independent variables. Before conducting the regression analyses, following the guidelines provided by Cohen, Cohen, West, and Aiken (2003), a dummy variable was created to assign a numeric value to ethnic background. We entered ethnic status (dummy coded with 0 = *belonging to an ethnic minority group* and 1 = *being European-American*) in the first block to test whether ethnicity was uniquely related to MAT scores by itself. The second block contained depression and cognitive complaints in order to quantify these factors' contribution to variance in the dependent variable while accounting for ethnicity.

Results

Given the wide range of age and education level of the sample, we treated age and education as possible control variables. However, age was unrelated to any of the other variables, regardless of whether we examined it as a continuous variable or recoded it into a dichotomous one, with 0 = 71 (non-normative age for women to be married) and 1 = 70 (normative age for women to be married). Similarly, education level was not significantly correlated with any of the variables in the study. Based on those failed significance tests, age and education levels were not included in subsequent data analyses. As displayed in Table 2, correlational analyses showed a moderate yet significant relationship between ethnicity and MAT scores, with European-American older women reporting better marital adjustment than their ethnic minority counterpart. Depression and cognitive failures were also negatively associated to marital adjustment at a significant level.

As illustrated in Table 3, ethnicity was significantly associated with marital adjustment in Model 1 of the hierarchical multiple regression analysis, $p = .03$. However, when we entered ethnicity in Model 2 simultaneously with depression and cognitive complaints, ethnic status was no longer significant, but depressive symptomatology and cognitive failures were

correlated negatively with marital adjustment ($p = .04$ and $p = .02$ respectively). The overall regression model was statistically significant, $p = .001$, with the three factors in question accounting for more than 21% of the total variance in MAT scores.

Discussion

The above findings offer clinically-relevant insights into older women's marital adjustment in relation to depression, cognitive failures, and ethnicity. Those three variables, considered simultaneously in Model 2, accounted for over one-fifth of the variance in MAT scores. Ethnicity was significantly related to marital adjustment; however, once we took depression and cognitive failures into account, ethnic status receded into the background.

As previously noted, 40% of MAT scores fell within the maladjustment range and about one respondent in four was clinically depressed. These figures highlight the importance of studying both marital adjustment and depression in older women. The depression finding is suggestive of depression being under-diagnosed and/or under-treated in this population, in line with results of other researchers (e.g., Pfaff & Almeida, 2005). Moreover, most of our research participants had limited education: considering that 70% of the sample self-identified as an ethnic minority, this finding corroborates Bryant, Taylor, Lincoln, Chatters, and Jackson's (2008) report of lower educational achievements in ethnic minorities compared to Caucasians.

There was also a moderate (yet significant) relationship between cognitive failures and depression scores. Different—and possibly interrelated—interpretations of this outcome are possible. One is that higher CFQ scores could be indicative of difficulties concentrating, reflecting other psychiatric symptomatology (such as depression in this case). An alternative explanation derives from considering that this finding corroborates prior empirical evidence on healthy older individuals, as reported for instance by Knight et al. (2004), who reasoned that older adults with depressive symptoms might confer a more negative meaning to their cognitive failures than their non-depressed counterpart. Similarly, upon discovering that CFQ and depression scores were significantly correlated in a sample aged 50–85, Rabbit and Abson (1990) stated that such findings are indicative of a common loading for low self-regard. Thus, higher CFQ scores among older women with higher depression scores in our sample may reflect these respondents' negative appraisal of ordinary cognitive failures (common at all ages), i.e., a pessimistic interpretation that was absent in non-depressed respondents. However, if CFQ scores are indeed markers of objective problems in cognitive functions, as recently reported by Hohman et al. (2010), then higher depressive symptomatology in older women with higher CFQ scores could reflect the negative affect that accompanies the accurate realization of having cognitive difficulties.

Concerning the results of the multiple regression analyses, as expected, older women with higher scores on depression had lower MAT scores. This is in line with the application of Beck's (1970) depression theory to marriage. As previously mentioned, older women with higher depressive symptomatology are likely to view their marital lives more pessimistically, owing to their negative cognitive triad. In turn, this could be reflected in lower MAT scores. Prior research on ethnic minorities corroborates this result, such as a

non-geriatric study on 99 Brazilian women in which Hollist et al. (2007) found that marital distress is a predictor of subsequent depressive symptomatology two years later. Another significant result is that higher levels of cognitive complaints were negatively associated with marital adjustment, corroborating available empirical findings on couples in which one spouse had significant cognitive impairment (e.g., de Vugt et al., 2003; Garand et al., 2007). The present result extends such prior evidence to older women with cognitive complaints and is also in line with Bookwala and Jacobs' (2004) conceptualization of marital adjustment in older age. In this regard, it is possible that respondents with higher CFQ scores might have been less able to minimize marital conflicts, potentially corroborating Broadbent et al.'s (1982) aforementioned assertion that higher scores on higher CFQ scores indicate increased vulnerability to stress.

Contrary to expectations, although significant by itself, ethnicity failed the significance test in the final regression model. There was a significant association between ethnicity and depression, with non-European-Americans being significantly more depressed; this may partially explain why ethnicity was no longer significant once we included depression in the data analyses. Nonetheless, when considered outside the context of clinical variables, ethnic minority status was a significant risk factor for marital maladjustment. This may be due to the fact that non-European-American cultures often adhere to more traditional gender roles that are likely to be in conflict with current gender role expectations in the U.S. (not assessed in this study). To offer a potential interpretation of this finding, perhaps non-European-American respondents, living in the progressive urban area of Los Angeles County, had internalized the more egalitarian gender roles common in this part of the U.S. In turn, this affected their MAT scores negatively, because a significant portion of such scores is based on the self-reported degree of compromise made to minimize marital conflicts. This potential explanation is in line with prior research findings. Among them are the results of a study on Chinese married couples in Hong Kong—in which the women (ages 35–60) had breast cancer—indicating that wives' marital adjustment was not related to their own psychological distress, but to how well they adopted their husbands' perspective (Wai-Ming, 2002). Back in 1985, Casas and Ortiz obtained findings pointing to willingness to compromise and minimize conflict as critical factors in this discussion. Those authors, upon comparing Mexican-American couples born in the U.S. with those born in Mexico, found that higher levels of acculturation were related to increased marital distress. They attributed such findings to the stress of having to redefine the traditional roles of husband and wife when living in the U.S. Concerning gender role conflicts for women in particular, Negy and Snyder (1997) discovered that, among Mexican-American couples, wives in more acculturated couples reported higher marital distress than their husbands. It is interesting that Negy and Snyder's result was no longer significant once other variables entered the picture. In a similar fashion, introducing older women's depressive symptomatology and cognitive failures in the model tested herein obscured the relationship of ethnicity to marital adjustment.

Limitations, Recommendations for Future Research, and Clinical Implications

Several limitations of this study must be acknowledged. Among them, this investigation was cross-sectional, thus its findings do not imply causation. Also, the task of recruiting ethnically diverse older women who were currently married proved to be particularly challenging. Consequently, the sample size was modest; as a result, it was not methodologically feasible to run data analyses on each ethnic group. Additionally, it could be argued that the present findings represent only one side of the marital coin. Yet, in view of the difficulties already encountered when collecting the data, the recruitment of respondents' spouses would have made gathering this sample even harder. Furthermore, we were unable to establish clear distinction between objective and self-reported changes in cognitive function as we did not employ a clinician-administered test of cognitive functioning, nor did we assess other factors potentially related to marital adjustment, e.g., acculturation, gender roles, duration of current marriage, physical health, or use of anti-depressants.

Future investigations could target a variety of research questions that remain unanswered. For instance, more detailed analyses with larger samples viewed longitudinally might yield additional information about causal features, including whether depression and cognitive failures at time 1 predict marital maladjustment at time 2. Also, the nature of the self-report cognitive measure used herein justifies why talking about CFQ scores from the perspective of level of cognitive complaining is most appropriate in the present study. However, interested researchers could add a clinician-administered test of cognitive function to the assessment battery to correlate marital maladjustment with specific cognitive deficits. It would be interesting to investigate mechanism(s) by which cognitive failures impact marital satisfaction, e.g., testing whether the relationship in question is mediated by specific behavioral manifestations of cognitive problems, as already discovered among samples in which one spouse had significant cognitive impairment (e.g., de Vugt et al., 2003; Garand et al., 2007). Furthermore, although the present findings suggest that depression and cognitive failures may play a mediating role in the relationship between ethnicity and marital adjustment, this should be verified in research with larger samples. In addition, because we collapsed all ethnic minorities together, research is needed to examine intra-group differences. For example, in a study conducted in Finland, depression was independently related to poor marital relations in older men, but not in older women (Kivelä, Luukinen, Viramo, & Koski, 1998); thus, our study should be replicated with ethnically diverse older men to test whether the present findings extend to this population.

Prospective studies on intimate partnerships in older age should target other neglected minority populations of older adults such as lesbian and gay older couples. Even though some researchers have discovered more similarities than differences in heterosexual versus homosexual relationships (e.g., Simons, 2008), Schumm, Akagi, and Bosch (2008) found that intimate partner satisfaction was higher for lesbian women in a relationship than for their heterosexual counterpart. In view of this conflicting empirical evidence, research efforts should elucidate whether findings on relationship satisfaction among heterosexual

populations translate to gay and lesbian individuals. Special attention must be paid to recruiting individuals in later stages of life and with diverse ethnic status, given their underrepresentation in research. If models of gay and lesbian intimate partnerships in older age differ from heterosexual ones, this valuable information could be used to develop clinical interventions aimed at increasing couple satisfaction among homosexual older men and women.

The present findings have clinical implications, alerting practitioners aiming at enhancing older women's marital adjustment to the need to take into account their patients' depressive symptomatology, cognitive complaints, and ethnic status. Concerning depression, it is significant to note that our correlational findings do not necessarily prove that treatment of older women's depression would improve marital adjustment. However, in therapy with older women who are dissatisfied with the quality of their marriage, depressive symptomatology should certainly be assessed and, given the high rate of clinical depression in this study, assessment should occur regularly with all older women patients. The "complaint factor" assessed herein, in its potential negative relation to marital adjustment, was specific to cognitive function. However, depressed individuals who complain about their functioning—not about cognition but about physical pain, which is common in older age—exhibit lower MAT scores than depressed people without pain, as reported by Mohamed, Weisz, and Waring (1978) in an dated study that is nonetheless relevant to this discussion. Thus, the assessment and subsequent treatment of a variety of reasons for complaining (e.g., depression, pain, both, or other factors) should be carefully conducted by clinicians working with older adults who are experiencing marital maladjustment. Furthermore, given that low MAT scores might predate, be concomitant with, or a consequence of depression (Prince & Jacobson, 1995), mental health professionals should investigate the causality of the marital maladjustment-depression link. To provide an example, a clinician working with an older couple in which the woman has low MAT scores may determine that the marriage is causing depression in an otherwise psychologically healthy individual. In this scenario, struggling to preserve the marriage can aggravate the woman's psychological symptomatology, while abandoning such a relationship may be a healthier choice. However, the woman in question could be opposed to considering marital dissolution, e.g., for cultural reasons. These sensitive and often intertwined issues could require consultation and/or referral of one of the members of the older couple to another clinician (e.g., when the husband is also a client who is significantly distressed by his wife's marital dissatisfaction).

With regard to cognitive failures, if an older woman with low MAT scores obtained a high CFQ score (which, as already pointed out, is a potential marker of decreased cognitive functioning), it would be wise for her clinician, if the latter is not trained in cognitive assessment, to refer her to a neuropsychologist (or related professional) to comprehensively assess her cognitive functioning. Once the nature and magnitude of the cognitive problems experienced are clarified, they should be addressed in cognitive rehabilitation training (as well as through other therapeutic means such as medications), in an effort to minimize their deleterious impact on marital satisfaction. It would also be appropriate to evaluate whether an older woman with cognitive difficulties is less able to minimize marital conflicts. If this is indeed the case, the issue may be addressed in therapy by imparting conflict resolution

skills and, if depression is also an issue, by targeting its amelioration while accounting for the patients' cognitive deficits.

Clinicians should also consider ethnic minority status as a potential risk factor for marital maladjustment. Also, because respondents from ethnic minorities were more depressed than their European-American counterpart, clinicians need to focus on accurately diagnosing depression in older women with an ethnic minority status. For instance, immigrant older women could experience increased negative stresses that are reflected in less satisfying marriages due, at least partially, to the stress of becoming acculturated. Their marital problems might have developed a long time ago, or might have started in older age. Clinicians working with this population should carefully assess all these issues, including whether marital dissatisfaction started or escalated after moving to the U.S. and, if needed, assist older women in their acculturation process. Similarly, women from historically oppressed ethnic groups may experience the additional stress related to discrimination and/or institutional racism, which could moderate the relationship between depression, cognitive failure, and marital maladjustment.

Conclusion

In spite of the limitations of this research, its findings highlight the role of depressive symptomatology, cognitive failures, and ethnic minority status (only if considered outside the context of the other two variables) as significant risk factors for marital maladjustment within our target population. No other published study has tested the model of older women's marital adjustment adopted herein, thus the present findings, albeit in need of corroboration in future studies, offer a unique contribution to this area of ethnogeriatric research. They suggest that depression and cognitive failures contribute significantly to variance in marital adjustment among primarily non-European-American older women who do not have dementia, and both do so in a negative way. Moreover, from a theoretical perspective, they are congruent with Bookwala and Jacobs's (2004) model of marital adjustment in older age.

Acknowledgments

This research was supported by two National Institute of Health grants, SCORE S06 GM048680 - 12A1 and NIGMS MARC 2T34 GM008395, Luciana Laganá, Principal Investigator. We thank Dr. Scott Plunkett, the study's statistical consultant, as well as the first author's students (from her gerontology classes and the Adult Behavioral Medicine Laboratory at CSUN) for their involvement in data collection.

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Table 1

Characteristics of the Sample

Variable	M	SD	Range	%
Age (N=78)	70.19			
Ethnicity				
European-American				32.1
Mexican-American				12.8
Asian-American				7.7
Other Hispanic-American				7.7
Native-American				6.4
African-American				1.3
Mixed				32.1
Education				
Less than High School				35.9
Graduated from High School				17.9
Completed Trade School				7.7
Some College				15.4
Bachelor's Degree				12.8
Master's Degree				5.1
Ph.D., M.D., and/or J.D.				2.6
Refused to Answer				2.6
Marital Adjustment	96.94	34.66	6–142	
Depressive Symptoms	3.50	2.86	0–11	
Cognitive Failures	33.27	13.92	3–67	

Table 2

Zero-order Correlations between the Independent and Dependent Variables

Variable	1	2	3	4	5	6
1. Marital Adjustment	–					
2. Ethnicity	.27*	–				
3. Depressive Symptomatology	–.36***	–.35***	–			
4. Cognitive Failures	–.35***	–.11	.28**	–		
5. Age	–.02	–.03	–.11	.09	–	
6. Education	.09	.18	.30**	–.05	–.09	–

*
 $p < .05$
**
 $p < .01$

 $p < .001$.

Table 3
Summary of Hierarchical Regression Analyses for Variables Related to Marital Adjustment

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Ethnicity	17.77	8.05	.25*	9.73	7.98	.13
Depressive Symptomatology				-2.83	1.38	-.23*
Cognitive Failures				-.67	.27	-.27*
<i>R</i> ² change		.06			.15	
<i>F</i> for change in <i>R</i> ²		4.87*			6.99**	

* *p* < .05
** *p* < .01.