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# Do Spousal Discrepancies in Marital Quality Assessments Affect Psychological Adjustment to Widowhood?

*We use prospective couple-level data from the Changing Lives of Older Couples to assess the extent to which spouses concur in their assessments of marital quality (N = 844) and whether discrepancies in spouses' marital assessments affect the bereaved spouse's psychological adjustment 6 months after loss (n = 105). Spouses' assessments of marital quality are correlated modestly ( $r = .45$ ), with women offering less positive assessments. Bereaved persons who had rated their marriages more positively than their spouse at the preloss interview reported higher levels of anger 6 months postloss. We conclude that persons who offer more positive appraisals of their marriages than their spouse may view spousal loss as a particularly unjust event. We discuss implications for understanding late life marriage and spousal bereavement.*

Spousal loss is one of the most distressing transitions experienced by older adults, yet its psychological consequences vary widely on the

basis of characteristics of the decedent, the bereaved, and the marital relationship (Carr et al., 2000). Recent studies reveal that older adults who rated their marriages very favorably experience elevated levels of yearning following spousal loss, compared to persons who had less satisfying marriages (Carr et al.; Wheaton, 1990). Husbands and wives, however, may experience marriage very differently and may not necessarily concur when assessing the emotional climate of their relationship. Discrepancies in spouses' marital quality assessments are associated with high distress and low satisfaction among married couples (Liang, Krause, & Bennett, 2001), yet we know of no studies that explore whether these consequences persist after the marriage ends and affect the adjustment of bereaved spouses.

Our study aims to address this gap. We (a) assess the prevalence and nature of discrepant marital quality assessments among older married men and women, (b) identify the psychosocial correlates of such discrepant assessments, and (c) examine whether discrepant marital quality assessments affect grief symptoms among recently bereaved spouses. We use data from the Changing Lives of Older Couples (CLOC) study, which obtained marital quality assessments from husbands and wives and tracked the bereavement experience of those spouses who became widowed. The CLOC study's prospective design and measures of both spouses' perspectives

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provide us with a unique opportunity to explore whether and how imbalances in spouses' marital appraisals affect the well-being of older adults when the marriage ends.

#### BACKGROUND

The physical and mental health benefits of marriage are documented persuasively (Mancini & Bonanno, 2006). The protective effects of marriage are due, in part, to the exchange of instrumental support and emotional intimacy. Core components of emotional intimacy include mutuality (Kenny & Acitelli, 1994), reciprocity of understanding, and similarity of spouses' experiences, values, and attitudes (Byrne & Blaylock, 1963). Similarity is particularly important in long-term marriages; changes that create new dissimilarities between partners can cause unexpected negative emotional responses (Heller & Wood, 1998).

The assumption that similarity in spouses' perceptions is a prerequisite for a successful marriage has its roots in the symbolic interactionist paradigm. This sociological perspective is based on the assumption that rewarding social interactions can develop only if both parties adhere to (or, at the very least, do not contest) a shared system of language and understanding (Blumer, 1969). Social constructionist perspectives emphasize that "consensus" and "shared meaning" are defining features of high-quality relationships (Berger & Kellner, 1964).

Empirical studies concur that similarity in spousal perceptions is critical for effective family functioning. Discrepancies in spouses' self-reported attitudes, values, and appraisals are associated with compromised marital functioning and psychological well-being (Deal, Wampler, & Halverson, 1992; Heller & Wood, 1998; Liang et al., 2001). We know of no studies, however, that have extended this line of inquiry to bereavement research. Do the psychologically distressing consequences of dissimilar spousal perceptions persist after the marriage ends and affect the psychological adjustment of recently bereaved spouses? We propose that persons whose preloss marital appraisals diverge from those of their spouse will grieve differently than bereaved persons whose marital assessments were similar to their spouse. Further, we propose that the psychological consequences of discrepant assessments are contingent on

whether one offers a more or less positive marital appraisal than their spouse. We next review research documenting the linkages between one's own marital quality assessments and spousal bereavement and suggest reasons why prior studies using the bereaved spouse's marital assessments only provide an incomplete portrayal of one's late marriage.

#### *Marital Quality and Spousal Bereavement*

When close emotional bonds are severed through death, individuals respond with intense emotional reactions, including depressive symptoms, anxiety (or "active distress"), yearning, and anger (Bowlby, 1980). Grief symptoms vary in intensity, however; attachment theories propose that the dissolution of emotionally significant ties elicit the strongest psychological reactions. Psychoanalytic theorists concur with this claim yet argue that the loss of a conflicted relationship—rather than a warm and loving relationship—would lead to more intense or "pathological" grief (Freud, 1917/1959). Survivors who had an ambivalent relationship with their late spouse are believed to have difficulty letting go, yet they also are angry at the deceased for abandoning them. Parkes and Weiss (1983) found that widow(er)s who reported retrospectively high levels of marital conflict evidenced higher levels of anxiety, guilt, and depressive symptoms 24 to 48 months postloss, compared to those in less conflicted marriages.

Two important methodological issues undermine Parkes and Weiss's (1983) conclusion, however. First, the bereaved provided retrospective assessments of marital quality after their spouse died, so their reports may be biased by their current mood (Futterman, Gallagher, Thompson, Lovett, & Gilewski, 1990; Hirschfield et al., 1989). Second, marital quality was assessed by the bereaved spouse only and provide only a partial assessment of the marriage.

Widowed persons may "sanctify" or offer unrealistically positive assessments of their late spouse as a way to honor the deceased (Lopata, 1981). Conversely, those who are most depressed postloss may offer the most negative or ambivalent retrospective accounts of their marriage because depressed mood affects one's cognitions and appraisals (Beck, 1967). The CLOC obtained marital quality measures prior

to spousal loss, so we can examine prospectively the effects of marital quality and spousal discrepancies on the survivor's adjustment to loss.

We know of only three studies that explore linkages between preloss marital quality assessments and widow(er)s' adjustment. Persons with better marriages were found to suffer more yearning and depressive symptoms, whereas those in conflicted marriages experience less distress postloss (Bonanno et al., 2002; Carr et al., 2000; Wheaton, 1990). These findings are consistent with propositions of attachment theory, where the loss of close relationships is distressing (Bowlby, 1980). Yet these studies share an important limitation: They focus solely on marital appraisals offered by the spouse who becomes bereaved (Bonanno et al.; Carr et al.). They did not consider whether the other spouse shared these assessments nor whether discrepancies in the spouses' perceptions shape psychological adjustment to loss.

#### *The Impact of Discrepant Marital Assessments on Spousal Bereavement*

Given the persuasive literature showing that lack of consensus in marriage is associated with poorer relationship quality and psychological well-being (Deal et al., 1992; Heller & Wood, 1998), we expect that individuals who offer marital assessments that diverge from those of their spouse will differ from those offering concordant assessments with respect to symptoms of depression, anxiety, anger, and yearning 6 months after loss. We propose further that the psychological consequences of discrepant assessments will vary on the basis of whether one offers a more or less positive assessment than one's spouse.

First, we expect that those who rate their marriage more positively than their spouse does will report fewer grief symptoms. Persons who see their relationship and loved one in an overly positive light report greater satisfaction with both their marriages and their lives (Gagne & Lydon, 2004). Highly positive assessments, referred to as "optimistic illusions" (Taylor & Brown, 1994) or "distortions," provide a feeling of emotional security that serves as a coping resource in the face of a stressor, such as widowhood. Our study, like prior studies of "distortions" in marital assessments, relies on a subjective indicator of discrepancy. We cannot

ascertain the veridical quality of one's marriage, as the CLOC did not obtain marital assessments from an unbiased observer. Rather, we rely on the "constructivist approach" (Kruglanski, 1989), where an appraisal is considered accurate if the spouses concur (Murray & Holmes, 1997).

We also expect that persons who rate the marriage more positively than their spouse will report lower levels of yearning, relative to persons offering concordant assessments. Yearning reflects a desire to recover the deceased person; a highly positive view of one's marriage may diminish the unsettling desire to reconnect with one's late spouse or to "undo" any of the wrongs or hurtful exchanges that are an inevitable aspect of long-term marriages. Those who offered more favorable marital assessments than their spouse may be particularly adept at "continuing bonds" with the deceased—a bereavement strategy associated with positive psychological adjustment (Boelen, Stroebe, Henk, & Zjierveld, 2006).

Second, we propose that persons who evaluate their marriage less positively than their spouse will report more severe grief symptoms, particularly anger and depression, relative to persons offering concordant assessments. Anger is an emotional response to experiences that violate or challenge one's values (de Rivera & Grinkis, 1986; Frijda, 1993). A widely held value among married couples—particularly those in long marriages—is that both partners should love and care for each other more or less equally and spouses share a consistent view of the marriage (Berger & Kellner, 1970). When this edict is violated yet cannot be remedied because one's spouse has died, the survivor may experience frustration and anger. Such imbalances also may lead to depression, because of an implied lack of control in one's relationship.

#### *Other Influences on Marital Quality Discrepancies and Psychological Adjustment to Loss*

Spouses' assessments of marital quality and the surviving spouse's adjustment to loss may reflect characteristics of each individual prior to the loss. Thus, we adjust our analyses for baseline health and demographic and socioeconomic characteristics in order to account for a potentially spurious relationship between our purported predictor and outcome variables.

First, we control preloss depressive symptoms of both spouses because one's emotional state may shape both marital appraisals and the well-being of the survivor. Depression may create stressful marital interactions, which in turn could lead to further depressive symptoms (Davila, Bradbury, Cohan, & Tochluk, 1997)—perhaps persisting throughout the bereavement process. Controlling for baseline mental health also helps distinguish between one's affective state before the death and change that occurred following the death (Jacobs, 1993).

Second, marital quality and psychological adjustment to spousal loss are linked to one's social resources and vulnerabilities. We control for socioeconomic status (education, income, home ownership) and demographic characteristics (age, race, gender) at baseline. Low socioeconomic status (SES) elevates one's risk of both mortality and spousal loss (Feinglass et al., 2007). Persons with fewer economic resources also are susceptible to more marital strain (Conger et al., 1990) and psychological distress (Miech, Power, & Eaton, 2007). Blacks report consistently more marital discord than Whites (Goodwin, 2003) and, consequently, less distress in the face of spousal loss (Carr, 2004). Women report poorer marital quality over the life course (Umberson, Chen, House, Hopkins, & Slaten, 1996) than men and also adjust better to spousal loss (Lee, DeMaris, Bavin, & Sullivan, 2001).

Finally, we control for both spouses' physical health and caregiving status at baseline. Marital quality and psychological well-being suffer when one spouse is in poor health and the other has to act as caregiver (Booth & Johnson, 1994). Both the person with the disabling condition and the healthier caregiving spouse must readjust established roles and expectations (Schumacher, 1995). The onset of health problems and caregiving duties may affect both the unhealthy and healthier spouses' perceptions of the marriage (Gordon & Perrone, 2004). Caregiving prior to spousal loss also affects the psychological adjustment of bereaved spouses. Although studies are inconclusive, some find that caregivers are relieved following spousal loss, whereas others find the "wear and tear" of caregiving makes one particularly vulnerable to the strains of bereavement (for a review, see Schulz, Boerner, & Hebert, 2008).

In sum, we evaluate (a) the extent to which spouses converge in their marital quality

assessments, (b) the correlates of spouses' discrepant versus convergent marital appraisals, and (c) the impact of discrepant appraisals on the psychological adjustment of the bereaved spouse 6 months after loss. Specifically, we hypothesize that (H1) discrepant marital quality assessments significantly affect the psychological well-being of bereaved spouses, net of both partners' individual appraisals; (H2) persons whose marital assessments are more positive than their spouse's will report fewer grief symptoms; and (H3) persons whose marital assessments are less positive than their spouse's will report more grief symptoms 6 months postloss.

## METHOD

### *Sample*

The CLOC study is a prospective study of a two-stage area probability sample of 1,532 married individuals from the Detroit standard metropolitan statistical area. To be eligible for the study, respondents had to be English-speaking members of a married couple where the husband was age 65 or older. All sample members were noninstitutionalized and capable of participating in a 2-hour interview. Approximately 65% of persons contacted for the initial baseline interview participated, which is consistent with the response rate from other Detroit-area studies.

The baseline face-to-face interviews were conducted from June 1987 through April 1988. For 846 of the 1,532 persons interviewed at baseline, parallel data were collected for both self and spouse. Thus, the CLOC has self-reported data for both husband and wife for 423 marital dyads. The original CLOC investigators randomly selected a subset of individuals for whom both spouses would be interviewed; thus, persons for whom we have dyadic data do not differ significantly from other participants in the baseline interview.

Following the baseline interview, study investigators continuously monitored spousal loss among the CLOC participants by reading daily obituaries in three Detroit-area newspapers and by using monthly death record tapes provided by the State of Michigan. The National Death Index (NDI) was used to confirm deaths. Of the 319 (21% of the 1,532 baseline respondents) who lost a spouse during the study period, 276 (86%) participated in at least one

of the three follow-up interviews that were conducted 6 (Wave 1), 18 (Wave 2), and 48 months (Wave 3) after the death. The primary reasons for nonresponse among the remaining 43 bereaved persons (14%) were refusals (38%) and ill health or death at follow-up (42%).

We used two analytic samples. First, to assess the frequency and correlates of spousal discrepancies in marital quality assessments, we focused on the 844 individuals for whom the CLOC obtained both husband's and wife's baseline data. We omitted the two persons (i.e., one couple) for whom one spouse did not complete the marital assessments. Second, to assess prospectively the effects of such discrepant evaluations on the psychological adjustment of bereaved spouses, we tracked the subsample of study participants who became bereaved as of the 6-month follow-up interview and for whom both spouses' data were obtained at baseline. At the 6-month follow-up, 250 bereaved persons (35 men and 215 women) completed interviews. Of those 250, the CLOC had obtained baseline information for self and spouse on 105 bereaved older adults (29 men and 76 women). The 105 bereaved persons for whom couple data are available are a random subset of all bereaved persons; thus, this analytic subsample does not differ significantly from the overall bereaved sample.

### Measures

*Marital quality assessments and discrepancy indicators.* Discrepancies in spouses' marital quality assessments are considered as both an outcome and a predictor of adjustment to loss. We focus on marital quality assessed at baseline. Factor analyses of nine positively and negatively worded items yielded one factor. We also constructed two subscales comprising positive and negative dimensions of marital quality, yet the scale alphas and factor loadings were superior in the single-factor model. Scale alphas for the single marital quality scale were .86 and .87 for the primary respondent and spouse, respectively.

Respondents and spouses were each asked (a) how much does your spouse make you feel loved and cared for; (b) how much is your spouse willing to listen when you need to talk about your worries and problems; (c) there are some serious difficulties in our marriage (reverse-coded); (d) thinking about your marriage as a whole, how often do you feel happy about it; (e) taking all

things together, how satisfied are you with your marriage; (f) how often do you feel bothered or upset by your marriage (reverse-coded); (g) my spouse doesn't treat me as well as I deserve to be treated (reverse-coded); (h) how often would you say you and your spouse typically have unpleasant disagreements and conflict (reverse-coded); and (i) in some marriages there are times when you feel very close, but other times when you can get more upset with that person than with anyone else. How much does this sound like the relationship you have with your spouse? (reverse-coded). Respondents were asked to assess how frequent (i.e., *almost always*, *often*, *sometimes*, *rarely*, and *never*) or how true (i.e., *very true*, *somewhat true*, *a little true*, and *not at all true*) each statement was in characterizing their marriage. Items are drawn from the Dyadic Adjustment Scale (Spanier, 1976). Total scores equal the average response across items; scale scores are standardized, and higher scores reflect better marital quality.

We constructed a trichotomous indicator of discrepancy between the two spouses' appraisals. After calculating the difference between the respondent's and spouse's scores (i.e., marital quality<sub>R</sub>—marital quality<sub>SP</sub>), we constructed three dichotomous measures indicating whether their scores were the same (reference category); respondent (i.e., spouse who eventually becomes bereaved) offered a more positive evaluation than spouse; or respondent offered a less positive evaluation than spouse. The cut-points were roughly one half of one standard deviation above or below the mean discrepancy value.

We also considered alternative cut points (one-third and two-thirds standard deviations), yet results were consistent across models assessing the effects of discrepancies on psychological distress among the bereaved. A more fine-grained measure of both direction and size of discrepancy would offer a more informative portrayal of marital quality discrepancies and spousal adjustment to loss, yet the subsample of bereaved persons for whom we have both spouses' marital assessments ( $n = 105$ ) is too small to subdivide further.

In our multivariate analyses, we adjust for the main effects of each partner's marital quality assessment as well as the categorical indicators of the discrepancy. We use the categorical measures rather than a continuous measure representing the absolute difference between



partners' scores because such a model would be underidentified (see Hendrickx, de Graaf, Lammers, & Ultee, 1993, for a review of modeling discrepancy effects).

### *Psychological Adjustment Outcomes*

We examine four outcomes: two general mental health indicators (depressive symptoms and anxiety) and two loss-related symptoms (yearning and anger). Depressive symptoms ( $\alpha = .83$ ) were assessed with a subset of 9 negative items (e.g., felt depressed, felt sad) from the 20-item Center for Epidemiologic Studies depression (CES-D) scale (Radloff, 1977). Respondents indicated how often they experienced each symptom in the week prior to interview. Response categories were *hardly ever*, *some of the time*, or *most of the time*. Anxiety ( $\alpha = .86$ ) was assessed with 10 items from the Symptom Checklist 90 Revised (Derogatis & Cleary, 1977). Respondents were asked to indicate how often they experienced each symptom (e.g., nervousness, feeling fearful) in the week prior to interview. Response categories are *not at all*, *a little bit*, *moderately*, *quite a bit*, and *extremely*.

Yearning ( $\alpha = .75$ ) encompasses four symptoms experienced in the past month: longing for one's spouse, painful waves of missing spouse, feelings of intense pain or grief, and feelings of loneliness and missing spouse. Anger ( $\alpha = .68$ ) taps three feelings experienced in the month prior to the interview: resentful or bitter about the death, the death was unfair, and anger toward God. Response categories are *no*, *never*; *yes*, *but rarely*; *yes*, *sometimes*; and *yes*, *often*. Items were drawn from widely used grief scales including the Bereavement Index (Jacobs, Kasl, & Ostfeld, 1986), Present Feelings About Loss (Singh & Raphael, 1981), and Texas Revised Inventory of Grief (Zisook, Devaul & Click, 1982). Scores are standardized for ease of comparison.

### *Potential Confounding Factors*

Spouse and respondent health at baseline each were assessed with the question, "How would you rate your health at the present time? Would you say it is excellent, very good, good, fair, or poor?" Responses of *fair* or *poor* are coded as 1. Both spouses' depressive symptoms and anxiety at baseline were measured the same way as respondents' symptoms at the 6-month follow-up, described above (Derogatis & Cleary,

1977; Radloff, 1977). Both spouses' caregiving duties are indicated with a dummy variable set equal to 1 for those who provided care to their spouse "because of a health problem." We also considered alternative cut points, such as more than 10 hours per week. The direction and significance of effects were similar, so we used the less restrictive measure, given the low proportion of persons providing spousal care at baseline.

### *Control Variables*

Control variables include age (in years), gender (1 = *female*), race (1 = *Black*), home ownership at baseline (1 = *owns home*), total household income at baseline (natural log of income), and education (a continuous measure ranging from 3 to 17 years of completed schooling). Each of these measures refers to the demographic characteristics of the primary respondent (i.e., bereaved spouse). We did not separately consider both spouses' socioeconomic characteristics because household income and home ownership reflect resources of the couple rather than an individual. Spouses also shared demographic characteristics, reflecting assortative mating processes where individuals marry persons of similar ages, ethnic backgrounds, and educational levels (Kalmijn, 1998). Correlations between spouses' ages and education level were .55 and .60, respectively. Nearly all CLOC participants were in racially homogamous marriages.

Finally, we control for the number of months elapsed between the baseline and Wave 1 interviews in all models predicting psychological adjustment. Although Wave 1 interviews occurred exactly 6 months following spousal loss, variation in the timing of spousal death means that the time between the baseline and Wave 1 interviews could range from 6 months to 6 years, with an average duration of 38 months ( $SD = 18$  months).

## RESULTS

### *Bivariate Analyses*

Table 1 displays means (for continuous measures) or proportions (for categorical measures) for all variables used in the analysis. The left panel describes the large baseline sample for whom both spouses' assessments were obtained ( $N = 844$ ). The right panel describes the subset of individuals for whom couple-level data were

obtained and who went on to become bereaved and participated in the 6-month follow-up interview ( $n = 105$ ). Within each subsample, we conducted two-tailed  $t$  tests to assess significant gender differences (denoted by asterisks). We also conducted  $t$  tests to evaluate whether the bereaved subsample ( $n = 105$ ) differs significantly from the nonbereaved persons ( $n = 739$ ) who make up the majority of the baseline married sample ( $n = 844$ ). Significant mean differences are denoted with the superscript  $a$ .

Spouses offered discrepant assessments of their marriages, with women offering significantly more critical evaluations. Correlational analyses (not shown) conducted among the sample of 844 married persons revealed a zero-order correlation of just .45 between partners' marital quality reports. This modest correlation is surprising, given that the average marital duration among CLOC participants is 43 years. Women reported marital quality scores that were roughly 0.333  $SD$

Table 1. Descriptive Statistics for All Variables Used in Analysis

	Baseline Sample of Married Persons ( $N = 844$ )			Bereaved Spouses at 6-Month Follow-Up ( $n = 105$ )		
	Total	Men	Women	Total	Men	Women
Dependent variables						
Depressive symptoms (CES-D) at 6-month follow-up (standardized)	.26 (1.24)	.37 (1.34)	.22 (1.21)	.38 (1.24)	.48 (1.26)	.34 (1.24)
Anxiety symptoms (standardized)	.05 (1.07)	.12 (1.12)	.021 (1.04)	.07 (1.08)	.18 (1.27)	.026 (1.00)
Yearning (standardized)	–	–	–	.02 (1.03)	.15 (.99)	–.024 (1.04)
Anger (standardized)	–	–	–	–.03 (.94)	.33 (1.06)	–.17* (.86)
Marital quality assessments at baseline						
Marital quality, own report (standardized)	0 (1.0)	.16 (.91)	–.16*** (1.06)	–.16 (1.01)	.026 (.96)	–.175 (1.03)
Marital quality, spouse report (standardized)	0 (1.0)	–.16 (1.06)	.16*** (.92)	–.03 (1.01)	–.173 (.977)	.017 (1.03)
Indicators of discrepancy in spousal assessments						
Respondent higher than spouse	.34	.47	.19***	.29	.45	.22***
Respondent and spouse: same	.26	.26	.26	.27	.31	.25
Respondent lower than spouse	.34	.19	.47***	.38	.17	.46***
Potential confounds						
Respondent: Depressive symptoms (CESD) at baseline (standardized)	–.01 (.99)	–.09 (.98)	.07** (.99)	–.03 (.87)	–.22 (.61)	.04 (.94)
Respondent: Anxiety at baseline (standardized)	–.07 (.89)	–.10 (1.07)	–.04 (.66)	–.10 (.59)	–.26 (.47)	–.03+ (.61)
Spouse: Depressive symptoms (CESD) at baseline (standardized) <sup>a</sup>	0 (1.00)	.088 (1.00)	–.088* (.99)	.20 (1.03)	.29 (1.04)	.16 (1.03)
Own health at baseline (1 = poor)	.24	.25	.23		.31	.24
Spouse's health at baseline (1 = poor) <sup>a</sup>	.30	.28	.32		.48	.55
Respondent provided care to spouse in 6 months prior to baseline interview <sup>a</sup>	.07	.06	.08		.28	.19
Spouse provided care to respondent in 6 months prior to baseline interview	.07	.08	.06		.03	.01
Respondent became bereaved after baseline interview <sup>a</sup>	.16	.10	.22***			

Table 1. *Continued*

	Baseline Sample of Married Persons ( <i>N</i> = 844)			Bereaved Spouses at 6-Month Follow-Up ( <i>n</i> = 105)		
	Total	Men	Women	Total	Men	Women
Control variables						
Age (in years)	69.96 (6.09)	72.01 (5.32)	67.89*** (6.13)	74.72 (7.26)	68.51*** (6.20)	
Gender (1 = female) <sup>a</sup>	.50	–	–			
Race (1 = Black) <sup>a</sup>	.12	.12	.12	.17	.21	
Education (in years)	11.70 (2.86)	11.63 (3.13)	11.76 (2.56)	11.35 (3.47)	11.41 (2.71)	
Income (natural log)	1.52 (.48)	1.53 (.50)	1.50 (.49)	1.44 (.50)	1.29 (.48)	
Home ownership (1 = owns home)	.90	.90	.90	.97	.87	
Months between baseline and 6-month follow-up interview	–	–	–	38.45 (18.95)	37.53 (18.31)	
<i>N</i>	844	422	422	29	76	

Notes: Data are from the Changing Lives of Older Couples Study, 1988–1994. Data presented are unweighted.

<sup>a</sup>The 105 persons in the baseline sample who became bereaved differ significantly from the 739 who did not lose a spouse.

Two-tailed *t* tests were conducted to assess significant gender differences, where  $+p < .10$ . \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ .

lower than those reported by men ( $p < .001$ ) in the baseline sample ( $N = 844$ ). A similar pattern emerged in the bereaved subsample, where women reported marital quality scores roughly 0.2 *SD* lower than men, yet the gender difference was not significant, perhaps because of the reduced sample size and statistical power.

Persons in the baseline sample who went on to become bereaved during the study period differ significantly from their nonbereaved counterparts with respect to caregiving and both own and spousal well-being at baseline. Persons who became bereaved during the follow-up period reported higher levels of depressive symptoms at baseline, were more likely to describe their spouse as in poor health, were more likely to be a spousal caregiver, and were less likely to be a spousal care recipient compared to those who were not bereaved at the 6-month follow-up. These significant differences reflect the fact that older bereaved persons typically lose their spouses to long-term chronic illness and thus may experience spousal caregiving and emotional distress even in the months prior to loss (Carr et al., 2001).

### Multivariate Analyses

*Correlates of discrepant evaluations.* We use multinomial logistic regression models to investigate the correlates of discrepancy in spouses' marital assessments in the baseline sample. Odds ratios (OR) (and confidence intervals) are presented in Table 2. Discrepant marital quality assessments are related to gender, race, depressive symptoms, and preloss caregiving. Women are more likely than men to offer marital quality assessments that are less positive than their spouse's (OR = 2.15,  $p < .001$ ). Compared to Whites, Blacks are less likely to offer marital assessments that are concordant with their spouse's; they offer marital assessments that are either less favorable (OR = 2.01,  $p < .05$ ) or more favorable (OR = 1.94,  $p < .05$ ) than their spouse's.

Depressed individuals and caregivers evaluate their marriages more negatively than their spouses do. With each 1 *SD* increase in one's own depressive symptoms, the odds that a primary respondent rates his or her marriage more poorly than one's spouse increase by 39%, and the odds that a spouse rates his or her marriage more poorly than the partner increases by 46%. Primary respondents who were spousal caregivers at baseline are roughly half as likely



Table 2. Multinomial Logistic Regression Predicting Whether Primary Respondent Assesses Marital Quality as Higher, Lower, or Same as Spouse

	Marital Quality	
	Respondent Lower Than Spouse	Respondent Higher Than Spouse
Demographic characteristics		
Age (in years)	.976 (.93 – 1.02)	.995 (.95 – 1.04)
Spouse's age (in years)	.993 (.95 – 1.04)	.974 (.93 – 1.02)
Gender (1 = female)	2.15** (1.31 – 3.53)	.476** (.29 – .78)
Race (1 = Black)	2.01* (1.07 – 3.77)	1.94* (1.03 – 3.65)
Education (in years)	1.01 (.94 – 1.09)	1.03 (.95 – 1.10)
Owns home (1 = home owner)	.730 (.40 – 1.35)	.753 (.41 – 1.39)
Income (natural log)	1.48† (.95 – 2.29)	1.30 (.84 – 2.03)
Well-being		
Respondent health (1 = fair/poor)	.996 (.62 – 1.59)	1.15 (.71 – 1.85)
Spouse health (1 = fair/poor)	.991 (.65 – 1.53)	.635* (.41 – .99)
Respondent depressive symptoms (CES-D)	1.39** (1.14 – 1.71)	.973 (.79 – 1.21)
Spouse depressive symptoms (CES-D)	.975 (.79 – 1.21)	1.46*** (1.19 – 1.78)
Respondent provided care to spouse in 6 months prior to interview	.690 (.34 – 1.42)	.481* (.22 – 1.07)
Spouse provided care to respondent in 6 months prior to interview	.454* (.21 – .99)	.662 (.33 – 1.34)
Respondent became bereaved after baseline interview	1.07 (.62 – 1.84)	1.27 (.73 – 2.22)
Chi-square; <i>df</i>		155.91; 28
Pseudo $-R^2$ (Nagelkerke)		.203

Notes. Data are from the Changing Lives of Older Couples Study, 1988–1994. Odds ratios and 95% confidence intervals are presented. The omitted category is respondent and spouse offer “same” assessment of marital quality.

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

as noncaregivers to rate their marriages more positively than their spouse. Similarly, spouses who were providing direct care to the primary respondent at baseline are 45% as likely as noncaregivers to rate their marriage better than their spouse. In sum, depressed persons and caregivers offer more negative marital appraisals than their partners, with similar patterns evidenced among both primary respondents and spouses.

In preliminary analyses, we estimated parallel ordinary least squares (OLS) regression models, where the outcome was a continuous measure

of respondent's marital quality assessment. We found that marital quality discrepancies are predicted by slightly different factors than are individual assessments. Gender, race, and both own and spouse's depressive symptoms were significant correlates of respondent's marital quality assessments, yet preloss caregiving was significantly associated with discrepant marital assessments only.

*Effect of discrepant marital assessments on bereaved spouses' psychological adjustment.* We estimated OLS regression to evaluate the

effects of both spouses' marital quality assessments and discrepancies therein on the bereaved spouse's psychological adjustment 6 months after loss. We focused on four dimensions of adjustment: depressive symptoms, anxiety, yearning, and anger. We found statistically significant ( $p < .05$ ) effects for anger only and discuss only those results here. Results are presented in Table 3; Model 1 includes indicators of both partners' marital quality assessments and discrepancy indicators, Model 2 incorporates all demographic and socioeconomic variables, and Model 3 includes baseline well-being measures. We estimated a fourth model, which adjusted for both respondent and spousal caregiving. Neither measure was a significant predictor, nor did they attenuate (or suppress) the effect of the marital quality and discrepancy variables, so we omitted these measures from the final analysis.

For all four outcomes, we also evaluated models that adjusted for respondent and spouse marital assessments and controls only (i.e., discrepancy measures were omitted). The model fit was poorer than for models including the discrepancy measures, evidenced by adjusted  $R^2$  values of .095 versus .141, in the anger symptoms model. These results suggest that the discrepancy measure is not capturing the main effect of either partner's marital assessment (Hendrickx et al., 1993). Rather, the discrepancy indicators affect survivor well-being above and beyond the main effect of each partner's assessment. We also evaluated two-way interaction terms between gender and each of the discrepancy measures; none was statistically significant ( $p < .05$ ).

Model 1 reveals that both spouses' marital quality evaluations and the discrepancy therein affects bereaved spouses' anger levels 6 months postloss. Bereaved persons who rated their marriages more positively than their spouse (at baseline) have significantly higher levels of anger 6 months postloss ( $b = .84$ ,  $p < .01$ ) compared to those who offered marital assessments similar to those of their spouse. This effect remains large and statistically significant ( $b = .72$ ,  $p < .05$ ) even when baseline characteristics are controlled (see Model 3).

Respondents' own marital quality assessments also affect their anger symptoms following loss. Net of all controls, Model 3 shows that the more positively one appraises his or her marriage at baseline, the lower one's anger levels following loss ( $b = -.30$ ,  $p < .10$ ).

Table 3. OLS Regression Models Estimating the Effect of Discrepant Marital Quality Assessments on Anger Symptoms Among Older Bereaved Spouses 6 Months After Loss

	Model 1	Model 2	Model 3
Marital quality			
Marital quality, own assessment	-.44* (.18)	-.36* (.18)	-.30† (.18)
Marital quality, spouse assessment	.39* (.18)	.29 (.18)	.24 (.19)
Marital quality, own score higher than spouse score	.84** (.32)	.82** (.32)	.72* (.33)
Marital quality, own score lower than spouse score	-.50† (.30)	-.39 (.32)	-.36 (.32)
Demographic characteristics			
Age		-.02 (.02)	-.02 (.02)
Gender (1 = female)		-.29 (.24)	-.31 (.24)
Race (1 = Black)		-.59* (.26)	-.54* (.26)
Education (in years)		.007 (.04)	.02 (.04)
Owns home (1 = home owner)		.30 (.31)	.34 (.31)
Income (natural log)		.04 (.23)	.06 (.24)
Baseline well-being			
Own health (1 = fair/poor)			.28 (.23)
Spouse health (1 = fair/poor)			-.19 (.21)
Own depressive symptoms (CES-D)			.23* (.12)
Spouse's depressive symptoms (CES-D)			.001 (.11)
Months between baseline and Wave 1 interview			-.001 (.006)
Intercept	-.108 (.19)	1.14 (1.37)	.81 (1.49)
Adjusted $R^2$	.065	.117	.141
N		105	

Notes: Unstandardized regression coefficients (and standard errors) are presented. Data are from the Changing Lives of Older Couples Study, 1988–1994. The omitted category of the discrepancy measure is "concordant assessment," which includes persons whose spouse's score was within 0.50 SD of their own.

†  $p < .10$ . \*  $p < .05$ . \*\*  $p < .01$ .

These results suggest that the loss of a high-quality marriage is associated with lower levels of postloss anger; if one's marital assessment departed substantially from their spouse's, however, anger levels are highly elevated. We found

few other statistically significant predictors of anger. Blacks report less anger than Whites, and persons with more depressive symptoms at baseline report higher levels of anger symptoms 6 months following loss.

#### DISCUSSION

Our study expands upon prior research in five ways. First, we used prospective data to examine the effects of spouses' discrepant marital quality assessments on the psychological adjustment of bereaved spouses 6 months after loss. These baseline marital assessments were neither biased positively by retrospective "sanctification" of the late spouse (Lopata, 1981) nor biased negatively by depressed affect experienced by the recently bereaved (Parkes & Weiss, 1983). Second, we used self-reported marital quality measures from both partners and evaluated the unique effects of discrepant assessments on the surviving spouse's adjustment to loss after adjusting the absolute level of each partner's own assessment.

Third, because the CLOC obtained measures of preloss depressive symptoms, physical health, and caregiving from both spouses, we could effectively control for potentially spurious influences that may affect both the spouses' marital appraisals and the surviving spouse's psychological adjustment 6 months postloss. Fourth, we focused on four distinctive psychological symptoms following loss, so we were able to identify specific effects that might not have been detected in an overarching composite scale. Fifth, we explored whether the effects of spousal discrepancies in marital quality affect grief symptoms differently for men and women.

We found older husbands and wives offer discrepant assessments of their marriages and that these discrepancies have psychological consequences for the survivor when one's spouse dies. Moreover, discrepancies in spouses' marital assessments are related to the psychological state of the persons making the assessments. We elaborate on these findings and discuss their implications for understanding late-life bereavement and marital quality assessments.

#### *Health Problems and Spouses' Discrepant Marital Appraisals*

Discrepancies in spouses' marital assessments are strongly related to the partners' caregiving responsibilities and emotional state at the time of assessment. Persons providing care to an ailing spouse are less likely than noncaregivers to offer a superior assessment of their marriage. Prior studies have established that both the ill and the caregiving spouse must readjust their established roles and interactions within the marriage (Schumacher, 1995) and these changes, in turn, affect marital appraisals (Gordon & Perrone, 2004). Our results suggest further that if spouses' marital assessments change with the onset of caregiving duties, they may not necessarily change in the same direction. A divergence in marital appraisals may be a unique source of distress for older married couples as they grapple with changes in daily life, including health changes and shifts in caregiving responsibilities.

We also found that the more intense one's depressive symptoms, the more likely one is to appraise his or her marriage more negatively than one's spouse. This finding is consistent with studies demonstrating that depressed mood may negatively bias one's subjective assessments of his or her relationships and experiences (Futterman et al., 1990; Hirschfield et al., 1989). Our results suggest further that depressive symptoms among married elders can negatively affect spousal relations through increased imbalances in marital perceptions because such imbalances can undermine the otherwise protective function of marriage in old age.

Our findings have potentially important implications for understanding strains and rewards particular to long-term marriages. Social constructionist views on marriage presume that spouses develop a shared understanding and knowledge of their relationship, particularly over long periods of time (Berger & Kellner, 1964). Our analysis, however, reveals that older spouses may offer divergent appraisals, particularly during periods of stress or compromised health. Physical and cognitive declines may create new and unanticipated challenges for married couples and may alter long-established patterns of communication, support, and give-and-take interactions. The erosion of marital

“consensus” or “shared meaning” may compromise the quality of the marital relationship and partners’ individual well-being (Berger & Kellner).

Scholars and practitioners should attend not only to the individual physical and mental health needs of older married persons but also to interactions between spouses and each partner’s perceptions of and reactions to such interactions. Although the treatment of geriatric depression, for example, is critical for ensuring a high quality of life of depressed older adults, our results suggest that such treatments also may help to preserve the quality of the marriage and may help to ensure that both partners adhere to an agreed-upon view of the union. We caution, however, that our results do not show definitively whether depressive symptoms lead to discrepant marital assessments or whether these discrepancies affect the partners’ depressive symptoms. Our findings do suggest that practitioners should not treat marital quality and each partner’s mood as isolated attributes but rather as mutually influential factors that carry implications for both partners’ well-being.

#### *Discrepancies and Psychological Adjustment of Bereaved Spouses*

We hypothesized that discrepant marital quality assessments would affect psychological adjustment to loss (H1). We expected that persons who appraised their marriage more positively than their spouse would go on to experience less severe grief symptoms (H2), whereas those offering more negative appraisals would have more severe grief symptoms (H3). We found only modest support for H1 and no support for H2 and H3. To the contrary, we found that persons offering more positive marital appraisals than their spouse experienced elevated grief symptoms.

Regarding H1, we found that discrepant assessments do not uniformly affect adjustment to loss. Neither depressive symptoms, anxiety, nor yearning are affected by discrepant marital quality assessments. Anger is the only one of the four outcomes affected. Regarding our second two hypotheses, we found that bereaved persons who had rated their marriage more positively than their spouse reported anger levels that were nearly 0.75 *SD* higher than those whose marital quality assessments converged with their spouses. This effect remained large

and significant even after the main effect of both respondent’s and spouse’s marital quality assessments were controlled. This finding is surprising and contrary to our initial expectation. We suspect that one of two processes may explain the counterintuitive finding.

First, the discrepancy could indicate an imbalance in the love and support exchanged in the marriage, which violates married persons’ taken-for-granted assumptions about consensus in marriage. Second, the discrepancy could reflect the surviving spouse’s tendency to “idealistically distort” the positive attributes of the late spouse and late marriage (Fowers, Lyons, & Montel, 1996). Although we cannot evaluate directly either explanation, our interpretations are guided by two conceptual literatures: the interpersonal and social sources of anger and the tendency to offer positively biased assessments of one’s romantic relationships.

Anger is conceptualized as an emotional response to actions or events that violate or challenge one’s values (de Rivera & Grinkis, 1986; Frijda, 1993). Widely held values among married couples—particularly those in long-term marriages—are that both partners should love and care for each other and the partners should adopt a similar, shared view of the marriage. When these edicts are violated and cannot be “undone” or repaired because one’s spouse has died, the survivor may experience frustration and elevated anger symptoms.

We had expected that the persons who held a more critical view of the marriage would feel frustration at their inability to undo the unhappiness that they might have inflicted on their spouse. One possible explanation for our counterintuitive finding is that the partners who viewed the marriage more positively may feel frustrated that they could not sustain their loved one’s life. They may view protecting and sustaining their spouse’s life as an integral part of the marital bargain. Moreover, they may feel “cheated” for having a greater emotional investment in their marriage and for reporting more intense love or attachment than the now deceased spouse.

An alternative, although complementary, interpretation is that an overly positive marital assessment offered by the respondent, relative to his or her spouse, could reflect “idealistic distortions” about one’s marriage (Fowers et al., 1996). Multiple studies document that married persons tend to endorse unrealistically positive

descriptions of their romantic relationship and partner (Fowers et al.; Gagne & Lydon, 2004). In general, these upwardly biased assessments are associated with a range of positive psychological attributes, including a tendency to attribute positive events and outcomes to one's spouse (Fincham & Bradburn, 1987) and lower levels of conflict in one's relationship (Murray & Holmes, 1997).

Our study suggests, however, that such idealistic distortions may take a psychological toll after the marriage ends. Taylor and Brown (1994) observed that persons who hold unrealistically positive assessments of one's self and one's relationship (i.e., optimistic illusions) also tend to overestimate their ability to control most personal situations and underestimate the likelihood that a negative event will befall them. They may be blindsided and overwhelmed by the death of their spouse and the loss of a relationship that they idealized (Martz et al., 1998). The loss may seem particularly unfair and thus may elicit anger—rather than sadness—among the bereaved. Consistent with this interpretation, a longitudinal study of college students found that the more idealist their beliefs about their romantic relationship, the greater difficulty they had in adjusting to relationship dissolution because their sense of security was undermined (Helgeson, 1994).

In sum, social constructionist perspectives emphasize that a shared definition of the situation is critical for the effective functioning of a dyadic relationship (Berger & Kellner, 1964). We found that when spouses hold divergent perspectives on their relationship, the consequences transcend the boundaries of the dyad and affect the well-being of the bereaved spouse, even after the dyadic relationship has been dissolved by widowhood.

#### *Limitations and Future Directions*

Our study has several limitations. First, because of the relatively small number of bereaved spouses at the 6-month follow-up, we could not explore subgroup differences in adjustment to loss. Although we investigated gender differences in the effects of marital quality discrepancies on survivor well-being, we did not detect any statistically significant patterns, perhaps because of our small sample size and limited statistical power. Future studies should consider a broader array of contextual and

individual characteristics that may condition the effects of discrepancies on the well-being of both married and bereaved spouses. For example, are the psychological consequences of discrepancies contingent upon the health of both partners prior to loss? Such investigations will help researchers to identify those persons for whom marital quality discrepancies may be associated with particularly distressing bereavement outcomes.

Second, we considered only the short-term consequences of discrepancies on bereaved spouses. Future analyses should explore whether the effects documented here persist in the longer term and whether effects for the outcomes of anxiety, depressive symptoms, or yearning are “delayed” (Freud, 1917/1959) and emerge only as more time has elapsed since the loss.

Third, we assessed only a limited set of potential correlates of discrepant spousal assessments. Future studies should consider a fuller set of individual- and couple-level characteristics and should do a more rigorous assessment of the ways that measurement error might contribute to such discrepancies. Finally, our analyses of the correlates of discrepancy relied on a single wave of data; thus, we cannot draw causal inferences about the relationship between depressive symptoms of respondents and spouses and discrepancies in their marital perceptions. Future studies using multiple waves of dyadic data and multiple indicators of marital quality could investigate whether being married to a depressed person indeed deprives one of mutuality in the relationship and whether spouses' mental health contributes to discrepant views of marriage among older couples.

Despite these limitations, our findings have implications for studying marriage and spousal loss in later life. Persons who rate their marriage more positively than their spouse went on to have significantly elevated anger symptoms. Anger is considered among the most problematic grief symptoms because it is linked to social isolation and rejection of social support among the bereaved (Parkes & Weiss, 1983). Although social gerontologists conceptualize widowhood as an acute crisis and propose interventions to help the newly bereaved to adjust to the loss (Wortman & Silver, 2001), our results suggest that attention also should be paid to older married persons who are in relationships marked by low levels of consensus.

Our findings also have broad implications for family scholars, who typically rely on just



one partner's assessment of marital quality. Our results reveal that spouses—even those in long-term marriages—may offer divergent appraisals of a single dyadic relationship, and those discrepancies are most acute when one partner is experiencing a major stressor, such as caregiving demands, illness, or depressive symptoms. Studies linking marital quality to a broad array of life course outcomes—including risk of divorce, partner's physical and mental health, and children's outcomes—may reveal very different patterns if the marital assessments considered capture both spouses' views, as well as discrepancies therein.

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