Dementia caregiving in spousal relationships: a dyadic perspective

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Abstract

Objectives: The number of couples facing a dementia diagnosis for one partner of the spousal dyad increases. Spousal caregiving can be a highly stressful experience associated with negative caregiver outcomes such as depression and poorer immune function. However, surprisingly little is known about how the illness and the required care effects patient's well-being and relational changes experienced by afflicted couples. The aim of this study was to provide a literature review on how the dyadic perspective is taken into account and on how dementia effects both parts of the dyad. Methods: In order to outline findings about individual and dyadic well-being of affected couples, we conducted a literature search to review the three types of studies. First, studies focusing on one partner's perspective, usually the perspective of the caregiver; second, studies including the caregiver's and partially the care receiver's view; third, studies directly referring to both partners' perspectives. Results: The majority of studies neglect the individual with dementia by exclusively assessing caregiver variables or only indirectly including patients' characteristics. Very few studies embrace dyadic and relational variables to execute how both partners experience the illness, spousal caregiving, and changes in the relationship. Despite the arguable validity of self reports of individuals with dementia, some studies demonstrated the usefulness of including both partners' perspectives. Discussion: Results indicate the urgent need of integrating the perspective of the individual with dementia to improve the understanding of the effects of dementia caregiving.
Dementia caregiving in spousal relationships: a dyadic perspective

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Dementia caregiving in spousal relationships: A dyadic perspective

Abstract

In the next few years, an increasing number of older couples will have to face a dementia diagnosis for one partner of the spousal dyad. Caring for a spouse with dementia can be a highly stressful experience associated with negative caregiver outcomes such as depression, anxiety, and poorer immune function. In general, dementia illness and providing care have a lasting effect on both the caregiving and the care receiving partner. However, surprisingly little is known about the effects of the illness on the dynamics of spousal interactions.

Therefore, we review current evidence from three types of studies including data of afflicted dyads: First, data collection focusing on one partner’s perspective, usually the perspective of the caregiver; second, data collection including the caregiver’s and partially the care receiver’s view; third, data collection directly referring to both partners’ perspectives.

This review finds widely differing methodological approaches with respect to sampling procedures, study designs, and measurement of dyadic perspectives; thus making a comparison of findings difficult. We illustrate shortcomings of this research area, such as the lack of studies directly including the perspective of the demented individual. On the basis of current theories of dyadic exchange, we conclude with guidelines and recommendations for future research.

Keywords: dementia care, spousal caregiving, dyadic perspective

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Dementia caregiving in spousal relationships: A dyadic perspective

Due to increased life expectancy, a growing number of older couples have to face the transition to a caregiving relationship when one spouse becomes physically ill, frail, or develops dementia. Following this societal development, scientific dementia literature reveals growing interest in afflicted partners in both the caregiver’s and the care receiver’s position. Thus, we consider it timely and necessary to review the existing caregiving literature with regard to what can currently be said about the impact of dementia on the relationship dynamics of afflicted couples.

The prevalence of dementia in individuals older than 65 years is about 7% and increases in people over 80 years (Bickel, 2001). Dementia is a syndrome indicating brain and cognitive dysfunction causing significant impairment in social functioning (Bondi & Lange, 1998). It is a progressive degenerative brain disorder leading most importantly to severe amnesia, deficits in language, executive functions, and attention. Alzheimer disease (AD) is the most common form of dementia in older people, followed by vascular dementia (Lobo et al., 2000). Since this paper concentrates on the impact of dementia on dyadic processes, we do not discriminate in the following between different dementia forms when using the term AD or dementia.

Due to growing impairments in the course of the illness, personal relationships of people who suffer from dementia, such as the relationship between the caregiver and the care recipient, may be negatively impacted. The provision of care for a demented person can be physically and mentally demanding and stressful. Consequently, many studies have demonstrated increased stress levels and other negative consequences for spousal and familial caregivers’ health and quality of life (e.g., Pinquart & Soerensen, 2003; Vitaliano, Zhang, & Scanlan, 2003). There are, however, also contrary results indicating differences between caregivers with respect to their adaptability to the caregiving situation (Alspaugh, Stephens, Townsend, Zarit, & Greene, 1999; Danhauer et al., 2004; Gaugler, Davey, Pearlin, & Zarit,
2000; Schulz & Williamson, 1991). Nonetheless, the overall knowledge on the caregiver’s mental and physical well-being is broad. In contrast, relatively little is known about how caregiver and care receiver variables interact. Taking both perspectives into account might not only help to solve some of the ambiguous findings on the caregiver side but also to get a better understanding of the changes and processes taking place within the dyad as dementia progresses.

**Aim of the review**

This paper concentrates on the impact of dementia on the afflicted spousal dyad. It has the aim to review existing studies with regard to the amount of the integrated dyadic perspective. Thereby, we will illustrate methodological and theoretical discrepancies in dementia caregiver literature and offer suggestions for future dyadic dementia research that may overcome existing methodological problems.

**Categorization of caregiving research from a dyadic perspective**

Focussing on a dyadic perspective, studies on dementia caregiving can be categorized by the amount to which they take dyadic processes into account. Here, three data collection methods can be distinguished: First, data about the caregiving situation are gathered from one person only, usually from the caregiver. This type of study design focuses only on variables from one individual indicating no dyadic perspective per se. The only data concerning the partner are typically the diagnosis, age, and gender. Although these factors are relevant, they do not include aspects of dyadic interactions. Second, data are collected from both partners of the caregiving dyad, whereas one individual’s perspective is directly and the partner’s perspective is indirectly measured (e.g., by using caregiver information to assess care receiver variables or dyadic constructs). Third, some studies include directly measured data from both partners of the dyad. In this case, the dyadic perspective is adequately integrated in the analyses. Each of these data collection designs offers its advantages and disadvantages which we will describe in the following sections.
Studies focusing on the caregiver’s perspective

Studies solely referring to caregiver features provide information on the impact of caregiving on the dementia caregiver’s health and well-being. Negative outcomes associated with familial, as well as spousal caregiving are well documented in the research literature (Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991; Pinquart & Sörensen, 2003; Schulz, O’Brien, Bookwala, & Fleissner, 1995). There is empirical evidence that supports the negative influence of AD on the partners of afflicted individuals. Gallagher-Thompson et al. (2001) found that spousal carers showed higher levels of depression and stress, less reciprocity and fewer shared pleasures than noncaring wives of healthy partners. Although carers averagely report high burden and low well-being, some caregivers manage to remain high in levels of satisfaction, mental and physical health (e.g., Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995; Kramer, 2000; Townsend et al., 1989), and even report positive implications and gains (Kramer, 1997). Similarly, Heru, Ryan, and Iqbal (2004) examined familial caregivers of moderately disabled subjects with dementia and found that caregivers perceived more reward than burden and their quality of life was similar to a control sample. These findings indicate that caregiving can also be personally rewarding for caregivers.

Variables that potentially moderate the relationship between caregiving and caregiver well-being have been considered in several studies. One important moderator is gender of the caregiver. Research here shows that men seem to adapt better than women to the caregiving situation (Gilhooly, Sweeting, Whittick, & McKee, 1994). In fact, Thompson et al. (2004) demonstrated key differences in biological and emotional responses in spousal dementia caregivers: Male caregivers had significantly lower levels of stress, depression, anxiety, subjective caregiver burden, anger-hostility, and somatic symptoms as well as higher levels of social and physical functioning, mental health, and sense of coherence compared with female caregivers. No gender differences were found in social support and coping resources. That male advantage was confirmed in a meta-analysis which included indirect patient’s
measurements (Pinquart & Sörensen, 2006). However, the differences were small to very small. Nevertheless, the question how these biological and emotional responses of the caregivers are influenced or possibly mediated by care receiver or dyadic features (e.g., relationship quality, social exchange within the dyad) remains unanswered.

Research on marital relationships has identified communication skills as main predictors of marital satisfaction and relationship quality (Weiss & Heyman, 1997). It has been demonstrated in several studies that interaction and communication patterns, as well as satisfaction with the sexual relationship are clearly related to marital happiness (Litzinger & Gordon, 2005). It is plausible to assume that marital satisfaction and communication in caregiving dyads are similarly related. Polk (2005) conducted interviews with spousal and familial caregivers to describe the role of communication in dementia caregiving. Results showed that caregivers are often confronted with uncertainty and ambiguity about the causes of the patients’ behaviors. Since the interviews only included the caregivers’ perspectives, it is possible that the care receivers may not agree with the caregiver. Furthermore, possible dyadic moderators are not considered in detail. Thus, the informative value of these interviews is limited to one half of the dyad.

Studies focusing on caregiver measurements are economical and frugal to accomplish, but they contribute very little information on dyadic interactions. Nevertheless, even from a dyadic perspective, these studies can provide relevant information because caregiver well-being could affect the care receiver. It is plausible to suggest that caregivers with poorer mental and physical health may have less effective coping strategies which in turn affect the care receiver (Hooker et al., 2002). In sum, study designs only including the carer’s perspective may, from a dyadic perspective, at least give hints on relevant caregiver aspects which might influence the caregiving dyad. However, possible interactions between caregiver and care receiver features require more detailed dyadic information.
Indirect measurement of care receiver characteristics

The majority of dementia caregiver studies examined the perspectives of subjects with AD either by analyzing data of caregivers, or by observational methods of the demented individual (e.g., observation of behavioral disturbances) to investigate dyadic variables influencing the caregiving situation. Dementia severity and level of dementia symptoms are commonly assessed care recipient features. Although discrepancies between self-reports of individuals with dementia and proxy ratings of clinicians and caregivers are well documented (Gibbons, Teri, Logsdon, & McCurry, 2006; Teri & Wagner, 1991), these data are usually gained by proxy ratings. As an example, DeVugt et al. (2003) indirectly included dyadic information by investigating the association between particular dementia symptoms and changes in the marital relationship. Both variables were assessed by caregiver-based measures. The results indicated that passive and apathic behavior of the care receiver had most impact on the deterioration of the marital relationship.

The identification of factors that increase the risk of developing negative caregiver outcomes is generally useful in detecting particularly vulnerable caregivers. A review of studies on family care of relatives with dementia reported aspects that are most problematic for caregivers. “Acts of commission” by the care recipient, such as wandering, incontinence, aggression, or fecal smearing, were frequently cited as problematic and extremely stressful; “acts of omission”, such as inability to prepare a meal or to get dressed, were described as being less negative (Gilhooly et al., 1994). It is plausible that dementia severity is associated with caregiver well-being indicating that higher dementia severity correlates with lower well-being; but this association could not unequivocally be demonstrated (Gilhooly et al., 1994). Indeed, the relation between dementia symptoms and caregiver well-being seems to be more complex. A study of Majerovitz (1995) examined dementia spousal caregivers and showed that greater memory and behavioral problems were related to higher levels of caregiver burden and depression. An extensive longitudinal intervention study with mainly spousal
caregivers by Perren, Schmid, and Wettstein (2006) explored associations between the caregivers’ well-being and the course of the demented persons’ impairment. Results showed that level and increase in problematic behaviors (aggression, apathy, disinhibition, etc.) and increases in functional and cognitive deterioration of the care receiver negatively affected caregiver well-being. Thus, not only the severity of current problems and the stress the caregiver experiences, but also the rate of change is substantial for caregiver well-being.

Another association between caregiver characteristics and care receiver symptoms has been demonstrated by Sink, Covinsky, Barnes, Newcomer, and Yaffe (2006). The authors showed that caregiver characteristics (e.g., age, level of education, caregiver burden) are correlated with neuropsychiatric symptoms of the demented care recipient, independent of other patient characteristics. In their study, familial and spousal caregivers who were younger, more depressed, less educated, more burdened or spent more hours caring reported more neuropsychiatric symptoms of the care receiver. On the one hand, this study demonstrated the interrelation between care receiver and caregiver, on the other, it shows the utility for taking care receiver features into account when predicting the behaviors of individuals within a dyad.

Some studies indicated both negative and positive psychosocial changes for dementia caring spouses. Gallagher-Thompson et al. (2001) found that women caring for their demented husband not only reported a lower well-being (e.g., depression, stress) than noncaring wives of healthy partners, but also noticed similar closeness and shared values to their husbands compared to noncaring wives. Eloniemi-Sulkava et al. (2002) conducted semi-structured interviews with caregivers to examine the changes spousal carers of demented partners experience after illness onset. The participants reported a significant decline in happiness, equal relations, and in the care recipients’ expressions of sexual needs. On the one hand, participants reported that many dimensions of the marriage were negatively influenced by dementia (e.g., disturbing jealousy, improper sexual behaviors of the care recipient). On the other, AD did not significantly affect the general atmosphere of the relationship and a few
carers even report positive changes (e.g., increased tenderness). Using a qualitative approach, Narayan et al. (2001) confirmed the coexistence of negative and positive changes for caregiving spouses. For example, spouses reported experiencing caring as self-fulfilling and affirming while concurrently experiencing negative responses, such as relational deprivation with their partner. In terms of changes in the marital relationship, the majority of carers perceive a deterioration of their relationship, but at the same time, they report feeling closer to their spouses now than in the past (DeVugt et al., 2003). Going back to the dyadic perspective, it would be interesting to know how the relationship changes reported by the caregivers are experienced by the care receivers.

There are a number of influencing factors in the caregiving setting, such as relationship quality and affection, which can help to build or enhance caregiver resiliency. Horowitz and Shindelman (1983) demonstrated the relevance of affection between caregiver and care receiver. They presented a significant association between caregiver perceived affection and stress symptoms in a sample of spousal and familial carers: The more affection the caregiver felt for the care recipient, the less negatively caregiving demands were experienced. In this study, affective spousal relationships were negatively influenced by the need to provide care, indicating a decrease of affective feelings. Conversely, other familial carers participating in this study showed a trend toward a closer emotional bond to the care recipient now than in the past. Since marital relationships were most negatively affected, the authors conclude that spousal relationships suffer the greatest strain as a result of caring. However, this raises the question how caregiver and care receiver perceived affection is related and how amount of concordance or discordance may affect the dyad. Knop, Bergman-Evans, and McCabe (1998) examined the association between relationship quality, coping skills, and depression in spouses caring for their demented partners. The results showed that past and present relationship quality was inversely linked to depression scores. The authors concluded that carers with good past and present relationship quality are more
committed, less depressed, and more likely to find gratification in caring for their spouses. Nevertheless, the majority of participants rated the present relationship quality less favorably than past relationship quality. Similarly, Lawrence, Tennstedt, and Assmann (1998) found that higher relationship quality was associated with lower depression levels, even when controlled for disability and cognitive impairment of the care recipient. Another study focused on the caring spouse’s perspective of the caregiving situation (Lewis, Hepburn, Narayan, & Kirk, 2005). Higher well-being, lower burden, lower depression, and higher caregiver competence were found in spouses who described the caregiving relationship as being a continued spousal connection and integrate the caregiving role in the marital relationship. These spouses did not see caring as a separate occupation, but as part of the continued relationship with their partners. Taken together, it is plausible that good past and present relationship quality helps the spousal caregiver to adapt more effectively to the caregiving situation compared to spouses with lower relationship quality. Nevertheless, it remains unclear how the amount of agreement between both partners’ perceived relationship quality influences dyadic well-being.

The relevance of coping strategies is disclosed in a mediational model including escape-avoidance coping (e.g., to avoid people, to make efforts to escape from the stressor) and depressive symptoms of spousal caregivers, as well as problem behaviors of the demented partner (Mausbach et al., 2006). The authors demonstrated significant positive correlations between patient problem behaviors and escape-avoidance coping of the caregivers and between escape-avoidance coping strategies and depressive symptoms of the caregivers. Furthermore, this study showed that escape-avoidance coping mediated the association between problem behaviors of the care receiver and depression in spousal caregivers.

Within all these studies, patients’ variables were assessed by caregiver-based measures. Thus, dyadic changes were detected for only one part of the dyad. Indeed, studies have demonstrated the importance of protective factors and risk factors, either of the caregiver
or the care receiver (e.g., dementia symptoms, coping strategies of the caregiver), or the dyad (e.g., relationship quality) influencing caregiver adaptability. However, from a dyadic perspective, the current state of research is unsatisfying. Indirect measurements of the care receiver perspective provide only partial information about the dyad. No definite conclusions concerning the interaction between caregiver and care receiver factors can be drawn because the care receiver’s view of the dyadic situation remains unexplained. Many studies demonstrated only low correlations between self-reports of demented individuals and ratings from their caregivers (Gibbons et al., 2006; Naglie et al., 2006; Teri & Wagner, 1991) indicating that indirect measurements provide inaccurate information on the second part of the dyad. Thus, assessments using proxies should be used with caution (Novella et al., 2006). Self reports of the care receivers are hardly found in the literature (Cotrell & Schulz, 1993).

Hence, past research has not only neglected a resource for understanding some kind of inconsistency in the presentation and progression of the illness, but also personal and psychosocial needs, as well as experiences of demented individuals have long been put aside (Nygard, 2006). The lack of studies focusing on both partners of the caregiving dyad can be regarded a fundamental deficit in dementia research which might be associated with the relatively sparse knowledge about adaptive capacities and psychosocial factors influencing spousal well-being or relationship quality.

*Studies focusing on the care receiver*

There are only few research projects that have directly involved demented subjects in their examinations and thereby successfully demonstrated the usefulness of focusing on the care receiving partner. In a study by Clare (2002), individuals with early-stage AD were asked to describe their coping strategies and emotional responses following the growing dementia symptoms. Many participants were able to describe various ways in which they tried to adjust to arising memory deficits and other dementia symptoms (e.g., compensating strategies, developing a fighting spirit). Additionally, many participants reported to enjoy the feeling to
be an important source of information despite their illness. Cotrell and Schulz (1993) summarized other benefits for patients and their families, such as telling one’s unique and unheard story or experiencing catharsis, thus, participating in a study may contribute to the patients’ self-esteem. The usefulness of including individuals with AD in research studies can also be supported by a recent study in which dementia patients completed self reports describing their current personality on personality dimensions (e.g., dominance, cold heartedness, extraversion, and submission). For some dimensions, demented persons did not differ significantly from normal controls in their self awareness of personality. Patients exhibited proper insight into many dimensions of personality and into personality changes since the onset of disease (Rankin, Baldwin, Pace-Savitsky, Kramer, & Miller, 2005).

Although, these studies demonstrated the opportunity to directly include individuals with dementia in research studies, the dyadic perspective is not sufficiently considered when the second part of the couple, either the caregiving or the care receiving partner, does not partake in these investigations. Studies actually referring to both partners are indeed the only possibility to get insight into caregiving dyads.

*Studies including the dyad*

To evaluate relationship dynamics of afflicted couples, Reilly, Relkin, and Zbrozek (2006) developed a partner-patient questionnaire and successfully included a self-reported depression scale of the demented partner to test validity. Spousal interaction, a key component of marital satisfaction (Litzinger & Gordon, 2005), was assessed in an impressive study by Gallagher-Thompson et al. (2001). The authors used not only dementia caregiver ratings, but also observational methods to assess the interaction of both partners. Fundamental differences were found between caring and noncaring wives: First, noncaregiving couples were more interactive and expressed more support to each other compared with caring spouses. Second, husbands with dementia were highest in interactions which build rapport (e.g., smiling). Due to the fact that Gallagher-Thompson and colleagues used a cross-sectional study design,
future research is needed to detect the development of spousal communication of afflicted couples. Furthermore, possible influencing factors such as depression levels or perceived relationship quality of both partners should be included in further studies.

These studies actively involving demented persons and their partners demonstrate that interviewing demented participants and interpreting patients’ statements is certainly challenging but worth trying to improve our understanding of adaptive processes within spousal dyads affected by dementia. In addition, several studies suggest that feasible qualitative data from demented subjects may be obtained at least in mild dementia (e.g., Sands, Ferreira, Stewart, Brod, & Yaffe, 2004).

If both partners’ perspectives are usefully integrated in dementia caregiving studies, our knowledge about dyadic caregiving processes will increase. Several researchers have already mentioned the necessity of examining the dyadic perspective (Clare, 2002; Cotrell & Schulz, 1993; Franks, Wendorf, Gonzalez, & Ketterer, 2004; Gilhooly et al., 1994; Pearce, Clare, & Pistrang, 2002). Hellström, Nolan, and Lundh (2005) criticized the fact that very few studies have focused on the relationship between caregiver and the person with dementia as well as on the way both partners experience this relationship. The authors conclude that the consideration of the “couplehood” is essential to attain a better understanding of how spouses live with AD and how they respond to the impact of dementing illnesses. Lyons, Zarit, Sayer, and Whitlatch (2002) noted that “the caregiving relationship, by definition, is made up of two people”. This implies that the understanding of how the care receiver’s and caregiver’s perspectives diverge and converge is relevant for research questions and for practical interventions. The near absence of the patient’s perspective in dementia literature is probably due to ethical aspects, problems of studying the population, and the questionable accuracy of demented subjects’ statements (Cotrell & Schulz, 1993). As individuals with dementia may demonstrate distractibility, concentration difficulties, or misunderstanding during assessment, they are often seen as unreliable respondents (Cotrell & Schulz, 1993; Gilhooly et al., 1994).
However, a better insight into relationships of afflicted couples is unapproachable when one half of the dyad is neglected.

*Potential moderators of dyadic processes in the caregiving setting*

Dementia caregiver literature is a broad research area of particular importance. Studies on caregiving, however, differ not only in terms of the integrated dyadic perspective, but also in terms of using different samples, caregiver and care receiver variables, as well as measurements and study designs. This makes study comparisons problematic and partly explains ambiguous findings which are often found in dementia literature. In the following, we will discuss three problematic issues found in the literature possibly determining unsatisfying results.

Prevalence rates show that spouses are the predominant providers of long-term care for people suffering from dementia (e.g., Narayan, Lewis, Tornatore, Hepburn, & Corcoran-Perry, 2001). That raises the question whether familial caregiving dyads differ from spousal caregiving dyads. Indeed, the comparability of spousal and familial carers is problematic. Meuser and Marwitt (2001) demonstrated differences in the quality of emotions reported by adult child and spouse carers. First, child caregivers basically described feelings of grief, anger, and frustration. Conversely, sadness was the predominant emotion in spouses constantly increasing from early to severe dementia stages. Second, spousal caregivers reported more empathy and compassion. Furthermore, spouses have a higher risk of physical health problems, depression, and role overload than adult child caregivers (Barnes, Given, & Given, 1992). Pinquart and Sörensen’s study (2003) supports the diversity between caregiver groups: In their meta-analysis, spousal caregivers reported higher levels of stress and lower levels of physical health and self-efficacy than caregiving adult children. Due to the diversity, a discrete reflection of different caregiving dyads is essential to get a better understanding of caregiver burden and on the impact dementia has on the dyadic relationship. Despite these differences, many publications included spousal and familial caregivers in the same sample.
Thus, conclusions from these studies should be drawn with caution. More detailed studies which separate between different caregivers are needed to draw definite conclusions about dyadic processes in spousal dyads.

The progressive course of dementia from mild forgetfulness to severe loss of mental function is rarely found in individuals with other diseases. Nevertheless, another methodological issue in caregiver research is that many studies do not differentiate between different care recipients’ diagnoses suggesting that dementia caring can easily be compared with caring for individuals suffering from other chronic diseases. This, however, is problematic, as the demands in dementia care are usually different than in diseases without significant cognitive impairments and possibly affect the caregiving dyad differently. For example, Lee and Kolomer (2005) demonstrated that the severity of cognitive impairment correlates with the likelihood of severe problems within the dyad, such as abuse of a demented person by his familial caregiver. A recent study displayed that nondementia caregivers experience lower stress levels than dementia caregivers (Bertrand, Fredman, & Saczynski, 2006). However, since research findings are sparse, no solid answer can be given to the question whether dementia caregiving is generally more stressful and associated with qualitative different dyadic processes than caring for someone with another disorder (Gilhooly et al., 1994). Thus, we recommend that comparisons of dyadic processes between different caregiving groups should be done with appropriate caution.

The last problematic aspect we want to discuss is that only few studies tried to generate and test theoretical explications for the impact of caring on caregivers and marital relationships. Some research projects are based on variations of the theory of stress and coping from Lazarus and Folkman (1984; e.g., Lawton, Moss, Hoffman, & Perkinson, 2000). This theory proposes that adaptation to stress is mediated by two variables: appraisal of the particular stress and the coping strategies of the individual. Referring to the caregiving situation, the adaptation hypothesis suggests that caregiving demands are strongest when
caregiving begins. Due to the fact that the literature provides only partial support for this theory, the predictive usefulness of the adaptation hypothesis in dementia caregiving remains unclear (Kneebone & Martin, 2003; Powers, Gallagher-Thompson, & Kraemer, 2002). Moreover, here again, the focus lies exclusively on the caregiver but not on the afflicted dyad. In fact, this theory makes no predictions concerning the influences of social exchange and dyadic stress (Bodenmann, 2000). Only the integration of dyadic theories (e.g., Bodenmann’s concept of dyadic stress, 2000) in a model will allow to derive hypotheses concerning caregiver stress and changes of the caregiving relationship.

Another theoretical construct, called family adaptability, considers dyadic variables to comprehend the relationship between caregivers and demented partners (Majerovitz, 1995). Family adaptability is one of the three dimensions constituting Olsen’s Circumplex Model (Olsen, 1999) which describes differences between functional and less functional relationships. Family adaptability is defined as the amount of change in relationship leadership, role relationships, and relationship rules in response to situational needs. Based on the family adaptability approach, more adaptable couples are more likely to change their problem solving strategies in new situations and have less strict relationship rules than less adaptable couples (Olsen, 1999). Olsen suggested that couples with low levels of adaptability are less functional than couples with flexible and balanced family systems over time. Majerovitz (1995) examined the association between family adaptability and the impact of spousal dementia caring. Results indicated that the level of family adaptability moderates the relationship between caregiver stress and depressive symptoms: Among less adaptable caregivers, greater illness-related stress correlates with greater depression; whereas this association was not found among more adaptable spouses. Less adaptable participants might have more difficulties in adjusting their daily routines in response to changing demands of dementia care (Majerovitz, 1995). Taken together, the concept of family adaptability seems to
be a useful model concerning caregiver stress. However, empirical research that actually applied this model is rare.

From a theoretical perspective, two social psychological theories provide relevant information to conceptualize dyadic relationships and possibly caregiving relationships: Social Exchange Theory and Equity Theory (Walster, Walster, & Berscheid, 1978). These theories focus on dyadic relationship features by explaining how one feels about a relationship with another person depending on the balance of the relationship: As Baikie (2002) suggests these theories may also provide a theoretical framework to examine spousal dementia caregiving. The basic principles of Social Exchange Theory suggest that individuals try to achieve maximum rewards at minimum cost when they enter and remain in a relationship (Gergen & Gergen, 1986). One important difference between these theories is that Equity Theory focuses on contributions to and obtainments from relationships. This theory assumes that the balance between what is given and what is received in an exchange is essential for the well-being of individuals (Gergen & Gergen, 1986). Equity theorists believe that individuals who are confronted with inequity in their relationships will feel distress. Studies showed that equitable couples seem to be happier, more satisfied with their relationship, and more confident that the relationship will last than inequitable couples (Walster, Traupman, & Walster, 1978). However, rewards and costs may not always be balanced between two partners, but it is anticipated that equitable relationships may be balanced over time (Bierhoff & Grau, 1999). Due to the fact that equity theory considers possible relationship changes over time and provides a useful background to analyze changes and even longitudinal developments of spousal dyadic interactions, we propose that these theoretical approaches can be fruitfully applied to caregiving couples. First, we assume that if the marriage is experienced as equitable before illness onset, the caregiving partner will positively interpret the duties of care as a reflection of the further relationship (Baikie, 2002). Thus, social exchange theories may illuminate why spouses provide care in the first place and why some
caregivers even report positive aspects and personal gains of caring for the demented spouse. Second, we anticipate that not only high quality, but also high equality of the past relationship enable the couple to maintain the relationship in times of illness (e.g., Knop et al., 1998; Lewis et al., 2005). Nevertheless, systematic studies have to be conducted in the future to assess the predictive usefulness of social exchange theories in the spousal caregiving context.

In sum, the lack of theoretical framework in dementia research in general and in dyadic processes in dementia research in particular, causes uncertainty as research findings often cannot be explained properly. We believe that applying the existing theoretical models of the development of dyadic interactions will be an important step to expand our understanding of the diverse results in dementia research and to develop effective interventions for dementia caregivers and afflicted dyads.

**Discussion and Conclusions**

Taken together, this paper demonstrates that dementia literature provides ambiguous results concerning the impact of a dementing illness of one person within a dyad. Only a few studies actually refer to the spousal dyad indicating the integration of the caregiver’s and the care receiver’s view. Due to the fact that theory-based research is rather sparse, adequate theoretical explanations for the illustrated diversity in caregivers cannot be given. Finally, we want to give recommendations that should improve scientific knowledge of dyadic processes in couples afflicted by dementia.

First, dyadic data, such as spousal interaction and social exchange, may be assessed using observational methods and self-reported data of both partners. Observational methods overcome possible limitations due to the cognitive decline in the individuals with dementia, but do not provide sufficient information. Thus, a combination of qualitative observations and interviews may be an effective method for demented study participants (Nygard, 2006). Second, detailed studies separating between both different care receiver’s diagnoses and different caregiver groups or that focus explicitly on one diagnosis and one caregiver group
are needed to obtain better insight into dementia caregiving dyads. Furthermore, we recommend theory-based, longitudinal study designs to observe dyadic exchange processes and to investigate the development of potential adaptive resources during the illness progress. Third, the examination of caregiving dyads should be based on a theoretical framework to enable theory-based explanations of the results and provide a basis for intervention strategies improving adaptive abilities for afflicted couples. It is important, however, to choose theories that are appropriate for the investigation of dyadic processes, such as the concept of dyadic stress (Bodenmann, 2000) or Equity Theory (Walster et al., 1978). Due to the fact that first, spouses are the predominant care providers for individuals with AD and second, the caregiving situation constitutes of a dyadic relationship between caregiver and care receiver, getting a better knowledge of the dementia caregiving dyad should be of great relevance for future research. Furthermore, focusing on the dyadic relationship will not only lead to a better comprehension of caregiver stress, but also help developing effective therapeutic interventions to enhance dyadic well-being of afflicted couples. Although integrating demented individuals in psychological studies will remain a difficult task in psychological and psychiatric research, some studies undoubtedly demonstrated its usefulness (e.g., Gallagher-Thompson et al., 2001). We expect that the advantages of direct assessments of both caregiver’s and care receiver’s perspectives will far outweigh the risks and disadvantages.
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