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ORIGINAL ARTICLE

Emotionality and the assessment of memory performance (one's own and that of other people)

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BACKGROUND
In clinical practice, the assessments provided by relatives are treated as a source of information about the emotional-cognitive difficulties manifested by a customer. Usually, those opinions are treated as objective data, i.e. data that indicate the real possibilities of the evaluated person.
Data suggest that personality and affective factors of the assessing individual may modify the manner of describing an individual person in one's care, regardless of the actual difficulties experienced by that individual.

PARTICIPANTS AND PROCEDURE
In the study, the scale of the Memory Functioning Questionnaire (MFQ) was used in the version investigating oneself, a peer and an elderly individual in relation to whom the assessing individual undertakes care and support activities. The MFQ is relevant to different aspects of memory. The MFQ is composed of 64 questions grouped in scales composed of different numbers of items. Low results on the scales and a low general result illustrate the feeling that one experiences memory difficulties, whereas higher results illustrate the feeling that one's memory is highly efficient.
The participants (N = 65 individuals; 61% female and 29% male) were between 40 and 76 years old (M = 51.50 and SD = 7.25). In the analyses, the intensity of depression (GDS) and of positive and negative emotionality – state and trait (SUPIN) – of the assessing individual were taken into consideration, assuming that their intensity would correlate with opinions relevant to mnemonic capacities (one's own and those of other people).

RESULTS
On average, the participants assess their mnemonic competence as higher than that of their peers and of the elderly. The higher the level of abilities which the former ascribe to themselves, the better are those which are ascribed by them to a peer and an elderly individual. Negative affectivity shapes the conviction that one's own mnemonic competence is deteriorating, and that the same thing is happening to that of a peer/an elderly individual as well.

CONCLUSIONS
Evaluation of the psychological functioning of a customer prepared by relatives/a caregiver can indicate symptoms of subclinical severity.
There exists a connection between the affective-personality traits of a caregiver and the manner of the assessment of mnemonic competence (one's own and that of near relations). The direction of those connections is not clear. The negative affectivity of a near relation/caregiver may result in formulating negative opinions about oneself, and about those in their care. Conversely, typical developmental memory changes in oneself and others can cause anxiety and depressive mood.

KEY WORDS
memory self-efficacy; memory efficacy in others; negative and positive state-trait affect

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BACKGROUND

Complaints about one's own memory constitute one of the problems more frequently reported in the course of a psychological (clinical) interview; the deterioration of memory and the different manifestations of that problem are also frequently emphasized by the caregivers/near relations of those in their care. Those complaints are formulated principally by individuals who have experienced brain dysfunctions, for example, by individuals who have undergone cerebrovascular accidents, cranial-cerebral injuries, by individuals in whose case dementia syndrome is diagnosed, suffering from Parkinson disease without dementia, suffering from multiple sclerosis, who have undergone carbon oxide poisoning, and numerous other people (Fritsch, McClendon, Wallendal, Hyde, & Larsen, 2014; van Rijsbergen, Mark, de Kort, & Sitskoorn, 2013), but also by healthy individuals (Lima-Silva & Yassuda, 2009). Complaints and/or the observations of near relations commence the process of clinical diagnosis. The reason for that fact is that complaints may be the manifestation of, observed in oneself, the deterioration of capacity, whereas the observations of near relations are treated as a reliable, i.e. objective, source confirming the presence of deficits. However, people with brain pathology and clinical symptoms experience some difficulties in formulating complaints about their own memory deficits and abilities (in connection with language deficits, executive dysfunctions, anosognosia, which may have an isolated or generalized character, emotional disorders – elevated – decreased level of affect, dysphoria) (Roessler-Górecka, Iwański, & Seniów, 2013).

It is also a caregiver who is one's near relative who may, depending on the influence exerted by different factors, provide information which will direct the attention of a diagnostician in the incorrect direction. That aspect, namely, whether opinions formulated by near relations (and, if yes, to what degree) may be determined by the traits of them, is not the subject matter of a large number of analyses.

In connection with the presumption that a caregiver will provide clinically significant information, numerous diagnostic methods encompass two parallel versions: one for a customer/patient/an afflicted individual, and also one for a caregiver/a near relation. One of the restrictions relevant to the frequent application of the techniques of that type is the fact that they are not available in Poland, in which country the foundation is usually constituted by data obtained by means of a free interview with a member of the family/a caregiver. Nevertheless, the literature offers different examples of such methods, directed towards, in a broader view, different aspects of cognitive functioning, or, studying the matter less broadly, certain aspects of them. A significant number of them refer to memory; one example is the Memory Functioning Questionnaire (MFQ) (Zelinski & Gilewski, 2004) or modifications of it, or the Metamemory in Adulthood Questionnaire (MIA) (Dixon, Hultsch, & Hertzog, 1988). Other methods involve different spheres of functioning. For example, the Patient-Reported Outcomes in Cognitive Impairment (PROCOG) encompasses 2 parallel versions; one is intended to be applied by a customer, the other one by a caregiver (Frank, Lenderking, Howard, & Cantillon, 2006). The items are grouped in scales encompassing different numbers of them (plus the total/general result): affect, decreasing the level of hitherto possessed abilities, semantic memory, episodic memory, other traits of cognitive functioning, long-term memory, the influence exerted by deficits upon social functioning. The Cognitive Failures Questionnaire (CFQ) is a list of symptoms, which may be the consequence of a cerebrovascular accident – the Checklist for Cognitive and Emotional consequences following stroke (CLCE24) (van Rijsbergen et al., 2013).

There are numerous factors shaping the degree of compatibility between the opinions of the individual who is being assessed and the one who is assessing. The degree of compatibility of assessment depends on the level of the insight gained by the afflicted individual into their own problems (when it is maintained, the afflicted individual ascribes to themselves much greater restrictions than those which are ascribed to them by their near relations), but also on the time that has passed since the occurrence of a brain pathology (a longer time is conducive to greater compatibility of those assessments) (Hart et al., 2003; Holm, Schönberger, Poulsen, & Caetano, 2009; Vanderploeg, Brlanger, Duchnick, & Curtiss, 2007).

Reports from examining individuals suffering from a brain pathology and their relatives fail to provide results. The lack of compatibility was, among others, proved taking into consideration the intensity of executive disorders resulting from head injury (self-assessment, and also the assessment conducted by near relations 10 years after the injury); it is interesting that these were near relations who noticed the current difficulties of the afflicted individuals as less intensive than they did themselves (Barrett, McLellan, & McKinley, 2013).

A greater level of compatibility occurs in the situation in which the afflicted individual and the caregiver assess the degree of motor dysfunctions and the somatic, rather than the cognitive ones. Complaints may as well have a different structure – some of them are complaints relevant to determined difficulties (for example, memory, attention) (SCCc – subjective cognitive complaints – concept), while others reveal anxieties, fear, decreased mood in connection with difficulties being experienced or predicted (SCCw –

worry) (van Rijsbergen, Mark, de Kort, & Sitskoom, 2015; van Heugten, Rasquin, Winkens, Beusmans, & Verhey, 2007).

Other, non-clinical factors also shape the degree of the compatibility of assessment. Among others, those encompass, on the one hand, the cultural and environmental background, because, in certain cultures, there is a propensity for complaining about one's capacities in the case of the lack of actual cognitive deficits (Eriksen & Ihlebaek, 2002), followed by emotional-personality traits, in the case of which decreased mood, the feeling of being alone, and/or burnout, intensify the feeling of deteriorated functioning. On the other hand, those are traits of a caregiver/a near relation, and also the character of the relationships connecting them with the individual being described. The manner of assessing an individual in one's care may be determined the character of the items which somehow activate social stereotypes. So as to provide an example, Cherry, Brigman, Hawley and Reese (2003) report that in the case of the scale encompassing the answers 'yes'/'no', the Knowledge of Memory Aging Questionnaire (KMAQ) was applied, and the describing individuals have a propensity for ascribing greater, i.e. pathological, intensity of mnemonic difficulties to those being assessed. Introducing additional options eliminates mistakes of that kind.

Taking into consideration the data referred to hereinabove, it is interesting to undertake analyses relevant to the manner in which people assess their own memory, the memory of partners at the same age, and elderly individuals, and also whether there exist correlations between emotional traits and memory self-efficacy, and the memory-efficacy of others.

PARTICIPANTS AND PROCEDURE

PARTICIPANTS

The research was approved by the Committee of Ethics (decision no. 2/2015) of the Faculty of Pedagogy and Psychology of Maria Skłodowska-Curie University in Lublin. Data were obtained from 65 individuals (61% female, 29% male) aged between 40 and 76 years (M = 51.50, SD = 7.25). The criterion of inclusion was having expressed one's consent to participate in the research, having a partner at the same age, and undertaking in relation to them different supporting activities in daily life, and also having the experience of looking after a parent or another elderly member of the family. All the participants declared a lack of mental and neurological burdens, either current or in the past.

A similar number (expressed as a percentage) of participants had received secondary or higher education (44.60% in each group), whereas the remainder had received primary or vocational education. The majority of the studied individuals are employed as white-collars employees (69.20%), some of them as blue-collar ones (18.50%), and some are unemployed (4.60%). The remaining ones are pensioners or retired (7.70%).

PROCEDURE

In the research, the MFQ (in the experimental version) (Gilewski & Zelinski, 1986; Gilewski, Zelinski, & Schaie, 1990) was applied. The MFQ has not been adapted to Polish conditions. The original text had been translated from the English language into the Polish one, and also retranslated into the English language by a qualified translator. The MFQ is composed of 64 questions grouped in scales, each of which consists of a different number of items, and the studied individual expresses their opinion about them, selecting one of the answers provided on the Likert scale (between 1 point and 7 points). Low results on the scales and a low general result illustrate the feeling of mnemonic difficulties, whereas higher scores indicate the feeling of a high capacity of one's own memory. The scales are as follows:

1. The general/total result. This is the sum of those referred to below, and it may amount to between 64 and 448 points. A low result indicates the feeling that memory is deteriorated, whereas a higher one indicates the feeling that one's capacity in those terms is good.
2. The general assessment of one's own memory, taking into consideration the existing changes or difficulties (1 – an enormous problem, 7 – a lack of problems).
3. Assessment of one's own memory in comparison with own earlier capacities – in comparison with the situation a year before, until the time when one was young (1 – ever worse, 7 – no changes, or even ever better): the results are within the limits between 5 points, meaning the feeling of deterioration, weakening, connected with age, up to 35 points – the sense of stability, or even improvement, connected with age.
4. Assessment of the frequency of mnemonic difficulties (1 – always, 7 – never). A result of 18 points means a high level of the sense of difficulty in memorizing surnames, faces, appointments, telephone numbers, dates, course of the conversation, during the conversation, etc., whereas the result amounting to 126 points indicates the sense of a lack of such difficulties.
5. Assessment of the degree of difficulty in memorizing articles which one has read in newspapers and parts of books. Ten points means the conviction that there occur difficulties in memorizing smaller or larger fragments of such passages; 70 points

expresses the conviction that there are no such difficulties.

6. Assessment of the degree of difficulty in memorizing/recalling episodes from recent years – 4 points indicates the conviction that there occur difficulties of that type; 28 points expresses the conviction that there are no such difficulties.
7. Assessment of the severity of the mnemonic difficulties being noticed. Eighteen points indicates the feeling that the deficits of that type are very serious, whereas 126 points indicates that the studied individual is convinced that even if they do occur, they are of no importance.
8. Assessment of the frequency of the application of mnemonic techniques. Eight points indicates the frequent use of mnemonic techniques in connection with the feeling that it is necessary to compensate for difficulties, whereas 56 points indicates not taking advantage of the assistance of that kind.

The MFQ was applied in 3 variants: in reference to oneself (similarly to the original version), in reference to peers, and in reference to elderly individuals. In the latter two categories, it was the task of the participant to underline such values on the Likert scale which were the response to the question about the manner in which the participant assesses the memory of their partner (their peer), and also the memory of elderly individuals (an elderly individual). The analyses also took into consideration the intensity of depression (Geriatric Depression Scale [GDS], version 30; Yesavage et al., 1983), and the intensity of negative and positive affectivity – as a state and as a trait (SUPIN, versions C30 and S30 in the adaptation of Brzozowski, 2010).

RESULTS

In Table 1, the following data were included: means (*M*) and standard deviations (*SD*) of assessment ob-

Table 1

Means (M), standard deviations (SD), and the comparisons of the results of the MFQ (one-way univariate repeated measures ANOVA and post-hoc comparisons)

Scales	MFQ – me (*M*, *SD*)	MFQ – peer (*M*, *SD*)	MFQ – an elderly individual (*M*, *SD*)	*F* (*p*)	*Post-hoc*
MFQ – general result/sum	319.89 (55.18)	303.90 (49.45)	229.70 (57.54)	74.59 (.001)	1-2 (.030) 1-3 (.001) 2-3 (.001)
MFQ – general assessment	4.69 (1.52)	4.68 (1.09)	3.11 (1.25)	37.43 (.001)	1-2 (1.000) SI 1-3 (.001) 2-3 (.001)
MFQ – comparison with the past	16.83 (6.59)	17.30 (6.10)	12.65 (5.64)	17.03 (.001)	1-2 (1.000) SI 1-3 (.001) 2-3 (.001)
MFQ – frequency of deficits	89.13 (18.41)	84.30 (18.30)	63.88 (17.97)	49.17 (.001)	1-2 (.150) SI 1-3 (.001) 2-3 (.001)
MFQ – reading	56.40 (16.30)	54.40 (14.50)	42.90 (15.63)	26.33 (.001)	1-2 (.840) SI 1-3 (.001) 2-3 (.001)
MFQ – episodes	18.88 (5.09)	17.30 (4.35)	14.90 (5.41)	14.61 (.001)	1-2 (.050) 1-3 (.001) 2-3 (.005)
MFQ – importance of deficits	99.88 (20.26)	91.80 (19.87)	71.54 (22.42)	47.85 (.001)	1-2 (.013) 1-3 (.001) 2-3 (.001)
MFQ – mnemonic techniques	33.80 (11.51)	30.50 (19.87)	25.20 (9.85)	18.15 (.001)	1-2 (.040) 1-3 (.001) 2-3 (.001)

Note. 1 – MFQ-me, 2 – MFQ-peer, 3 – MFQ-elderly; SI – statistically insignificant.

tained in the 3 variants of the MFQ, and also the results of the parametric comparisons of dependent data (one-way univariate repeated measures ANOVA and *post-hoc* comparisons). The means indicate that the studied individuals assess their competence on average higher than the competence of their peers, and of elderly individuals. The differences between the competence ascribed to oneself and that ascribed to a peer are sometimes without statistical significance; however, they find their general capacities (MFQ – the general/total result/sum) and ability to recall episodes (MFQ-episodes) to be higher, treating possible troubles as insignificant for daily functioning (MFQ-importance), and declaring that they take advantage of mnemonic techniques (MFQ – mnemonic techniques) less frequently.

Mnemonic difficulties having an intensity higher than their own and those of their peers are ascribed to elderly individuals. That attitude is relevant to all the subscales of the MFQ.

Afterwards, the correlation coefficients (*r*-Pearson) between the intensity of the assessments ascribed to oneself, to a peer and to an elderly individual on all the scales of the MFQ (Table 2), and also the intensity of emotional traits and the age of the assessing individual and the results of the MFQ for 3 variants (Table 3) were calculated.

It was found that the assessing individuals describe the capacities of their peers and elderly in accordance with the manner in which they assess themselves: the higher the level of abilities they ascribe to themselves, the higher also is the one ascribed to their peer, and also an elderly individual. That propensity is relevant to all the aspects of the MFQ.

The emotional traits of the participants clearly shape the opinion concerning their memory capacities of them, of their peers, and also, selectively, of elderly individuals (Table 3). Simultaneously, with the increase in depressive mood (GDS), one observes stronger conviction that their memory is deteriorating (concerning different aspects of it, but also the increased necessity of taking advantage of mnemonic techniques), and – what is interesting – the conviction that different aspects of memory are deteriorating becomes stronger in the case of individuals at the same age. Similarly, negative affectivity, understood as personality predisposition (SUPIN C30 NU) and the current state (SUPIN S30 NU) shape convictions that mnemonic competence, both one's own and that of a peer, is deteriorating. There exists one exception in that area – simultaneously with the intensity of negative emotionality (state and trait), the belief that the memory of a relative is getting better increases.

Similarly, in the case of self-assessment, the current negative state shapes the conviction that, in comparison with the earlier years of life, memory capacity is not deteriorated, but instead becomes stable. Simultaneously, a higher level of positive emotionality (trait and state) of the assessing individual correlates with more positive assessments of certain aspects of memory – one's own and that of a peer. Those correlations are slightly different in reference to the group of elderly individuals.

Assessing individuals whose emotional predisposition is negative, and whose current state is negative as well, ascribe to elderly individuals solely ever more severe mnemonic deficits.

As one grows older, the propensity for ascribing to their peers generally decreased levels of mnemonic competence increases, and so does the conviction that possible deficits may exert an influence on the entire scope of their functioning.

DISCUSSION

Clinical papers from recent years have placed particularly strong emphasis on the need to increase the diagnostic value of cognitive complaints. That is connected with the predictive character, which means that complaints may suggest the presence of a brain pathology in spite of the lack of difficulties in performing diagnostic tasks (Kalpouzos & Eriksson, 2013). The information obtained from caregivers/near relations determines the direction of diagnosis, constituting the point of reference (comparison) for the self-descriptions of a customer. However, numerous factors modify the manner in which an assessing individual perceives cognitive capacities/hindering factors of other people. One of those factors is constituted by the fact that the scales of the MFQ type refer to the sense of self-efficacy, and, therefore, they fail to indicate the actual own competence, or the competence of the individuals being assessed (others' efficacy) (Zelinski & Gilewski, 2004). For that very reason, the methods consisting in a (self)description ought to be supplemented by the diagnosis of cognitive functions (so-called objective data). Those data, usually taken into consideration in the process of diagnosis, fail to reveal numerous problems in daily functioning, which may be discovered through the techniques of (self)assessment.

In the situation in which a diagnostician takes advantage of data obtained from self-description and from other people, one also ought to take into consideration the factors characterizing caregivers. The present results and the results of other research proved that the convictions concerning the functioning of one's own memory are influenced by emotional-personality factors, i.e. neuroticism, depression, and a decreasing sense of self-efficacy.

A trait of individuals having elevated indices of negative affectivity is a propensity for noticing in the case of other people as well a decreased level of competence, formulating critical judgements, which are not usually identical with the actual (objective) indi-

Table 2

Correlations: MFQ-me and MFQ-peer and MFQ elderly

Scale	Me: MFQ – general result/ sum	Me: MFQ – general assess-ment	Me: MFQ – com-parison with the past	Me: MFQ – fre-quency of defi-cits	Me: MFQ – reading	Me: MFQ – epi-sodes	Me: MFQ impor-tance of defi-cits	Me: MFQ – mne-monic tech-niques
P: MFQ – general result/sum	.55 (.001)	.39 (.001)	CSI	.49 (.001)	.44 (.001)	CSI	.57 (.001)	.29 (.008)
P: MFQ – general assessment	.29 (.010)	.32 (.005)	CSI	.33 (.004)	.22 (.040)	.24 (.030)	.27 (.014)	CSI
P: MFQ – comparison with the past	CSI	CSI	.49 (.001)	CSI	CSI	CSI	CSI	CSI
P: MFQ – frequency of deficits	.32 (.005)	.43 (.001)	CSI	.43 (.001)	CSI	CSI	.23 (.030)	CSI
P: MFQ – reading	.39 (.001)	.25 (.020)	CSI	.39 (.001)	.56 (.001)	CSI	.39 (.001)	CSI
P: MFQ – episodes	.35 (.002)	.28 (.010)	CSI	.43 (.001)	CSI	.39 (.001)	.23 (.030)	.25 (.020)
P: MFQ – importance of deficits	.34 (.003)	CSI	CSI	.32 (.005)	.24 (.030)	CSI	.41 (.001)	.23 (.030)
P: MFQ – mnemonic techniques	.22 (.040)	CSI	CSI	CSI	CSI	CSI	CSI	.45 (.001)
E: MFQ – general result/sum	.24 (.030)	.23 (.040)	CSI	.24 (.030)	CSI	CSI	CSI	CSI
E: MFQ – general assessment	CSI	CSI	CSI	.22 (.040)	CSI	CSI	CSI	CSI
E: MFQ – comparison with the past	CSI	CSI	CSI	CSI	CSI	CSI	CSI	CSI
E: MFQ – frequency of deficits	.31 (.006)	.33 (.004)	CSI	.26 (.016)	CSI	.24 (.030)	.33 (.004)	CSI
E: MFQ – reading	.38 (.001)	.36 (.001)	CSI	.27 (.015)	.36 (.002)	CSI	.39 (.001)	CSI
E: MFQ – episodes	.29 (.009)	CSI	CSI	.27 (.014)	CSI	CSI	.25 (.020)	CSI
E: MFQ – importance of deficits	.22 (.040)	CSI	CSI	CSI	CSI	CSI	.29 (.010)	CSI
E: MFQ – mnemonic techniques	CSI	CSI	CSI	CSI	CSI	CSI	CSI	.24 (.030)

Note. P – peer; E – elderly; CSI – statistically insignificant correlation; $p \leq .05$; $p \leq .01$; $p \leq .001$.

Table 3

Correlations: assessment of mnemonic competence (one's own and that of other people) and age, intensity of depressive mood and positive/negative emotionality – state and trait

Scale	GDS	Age	SUPIN S30 PU	SUPIN S30 NU	SUPIN C30 PU	SUPIN S30 NU
Me: MFQ – general result/sum	–.38 (.001)	CSI	.30 (.007)	–.33 (.003)	.35 (.002)	–.36 (.001)
Me: MFQ – general assessment	–.36 (.001)	CSI	CSI	CSI	.21 (.050)	CSI
Me: MFQ – comparison with the past	–.27 (.013)	CSI	CSI	.23 (.003)	CSI	CSI
Me: MFQ – frequency of deficits	–37 (.001)	CSI	.33 (.003)	–.34 (.003)	.41 (.001)	–.35 (.002)
Me: MFQ – reading	CSI	CSI	.27 (0.02)	–.27 (.020)	.28 (.010)	CSI
Me: MFQ – episodes	CSI	CSI	.38 (.001)	CSI	.38 (.002)	CSI
Me: MFQ – importance of deficits	CSI	CSI	CSI	–.39 (.001)	.23 (.030)	–.43 (.001)
Me: MFQ – mnemonic techniques	–.33 (.001)	CSI	CSI	CSI	CSI	CSI
P: MFQ – general result/sum	–.38 (.001)	–.23 (.030)	.22 (.030)	–.26 (.020)	.27 (.030)	–.34 (.003)
P: MFQ – general assessment	–.27 (.013)	–.21 (.040)*	CSI	–.25 (.020)	.31 (.006)	–.25 (.020)
P: MFQ – comparison with the past	CSI	CSI	CSI	.40 (.001)	CSI	.23 (.030)
P: MFQ – frequency of deficits	–.43 (.001)	CSI	CSI	–.35 (.002)	CSI	–.33 (.003)
P: MFQ – reading	CSI	CSI	CSI	CSI	CSI	CSI
P: MFQ – episodes	CSI	CSI	.23 (.030)	CSI	.34 (.030)	–.21 (.040)
P: MFQ – importance of deficits	–.21 (.040)	CSI	CSI	CSI	CSI	–.37 .001)
P: MFQ – mnemonic techniques	–.21 (.040)	CSI	CSI	CSI	CSI	–.23 (.030)

(Table 3 continues)

Table 3

(Table 3 continued)

Scale	GDS	Age	SUPIN S30 PU	SUPIN S30 NU	SUPIN C30 PU	SUPIN S30 NU
E: MFQ – general result/sum	CSI	CSI	CSI	CSI	CSI	CSI
E: MFQ – general assessment	CSI	CSI	CSI	CSI	CSI	CSI
E: MFQ – comparison with the past	CSI	CSI	CSI	CSI	CSI	CSI
E: MFQ – frequency of deficits	CSI	CSI	CSI	CSI	CSI	CSI
E: MFQ – reading	CSI	CSI	CSI	CSI	CSI	CSI
E: MFQ – episodes	CSI	CSI	CSI	CSI	CSI	CSI
E: MFQ – importance of deficits	CSI	CSI	CSI	−.29 (.009)	CSI	−.22 (.040)
E: MFQ – mnemonic techniques	CSI	CSI	CSI	CSI	CSI	CSI

Note. P – peer; E – elderly; CSI – statistically insignificant correlation.

ces of memory capacities (Bandura, 1989; Kavanagh & Bower, 1985). The competence of other people (for example, of a partner) is assessed by individuals having negative emotionality as low as well, although more positively than their own (Forgas, Bower, & Krantz, 1984). That is the effect of the attributive style of thinking (Bandura, 1989; Blazer, 2002). A similar tendency is described in the case of caregivers of individuals with behavioural disorders, for example, with dementia (Sink, Covinsky, Barnes, Newcomer, & Yaffe, 2006); a higher level of depression of a caregiver was conducive to exaggeration, which means to ascribing to the afflicted individuals a higher level of behavioural disorders. Spruytte, Audenhove, Lammertyn and Storms (2002) stated that the assessment conducted by an individual in their care is, to a large extent, determined both by the earlier type of mutual relationships and by the character of current deficits, and also the traits of a caregiver – individuals with a hostile attitude towards an individual in their care may ascribe to them a higher level of intensity of symptoms, and also their internal (not connected with the medical condition) origins.

Therefore, caregivers conclude that the behavioural disorders of an individual in their care are the result of low motivation rather than the result of a pathological process. Needless to say, the relationships of that type may also be explained by the fact that the exacerbated clinical symptoms (for example, losing one's way, forgetting) result in the increased burnout of a caregiver, and that encompasses the level of hostility and negative attitude towards an individual in the need of assistance. Positive affectivity, in turn, results in a more positive assessment of different mnemonic competence in the case of other people.

The correlation between the emotional traits of the assessing individuals and the assessments of memory does not refer to all its aspects, and that means that is principally relevant to oneself, and also to individuals at a similar age, but not to elderly ones. It seems that the emotional factor loses some of its importance whereas what becomes more significant is knowledge relevant to memory in the case of elderly individuals having the character of stereotypes, and also resulting from experience (for example, the observations of changes within the scope of memory, or listening to the complaints made by elderly individuals) (West, Dennehy-Basile, & Norris, 1996).

The stereotypes presume an increase in mnemonic difficulties as one grows older (Zanardo, De Beni, & Moè, 2006), but – what is interesting – those

stereotypes may be triggered by the contents of the questions, for example of those in the MFQ (Eich, Murayama, Castel, & Knowlton, 2014). Another explanation of the results, even though the MFQ is clearly relevant to memory, may indicate mistaking the natural/developmental traits of memory, or cognitive slowing down in the case of elderly individuals suffering from deficits. That is relevant not only to physiologically aging individuals, but also to the individuals from clinical groups. Cahn-Weiner, Ready and Malloy (2003) observed among the caregivers of people suffering from Alzheimer's disease (AD) a propensity for explaining difficulties of the afflicted individuals within the scope of a single, namely mnemonic, cognitive domain, not encompassing the linguistic aspects, or the emotional ones. Changes in one's memory competence and/or observing them in others can lead to beliefs about the inevitability of memory deficits in old age. It is also possible that memory errors, typical for age but often observed in themselves or relatives, including the elderly, may increase anxiety or depression by increasing confidence in the seriousness of the memory problems.

The indicated relationships between the affective traits of the assessing individuals and the manner in which they perceive their own competence, that of a peer and of elderly individuals, are restricted. The study is relevant to participants from the general population, and therefore it requires continuation with the participation of individuals having experience within the scope of looking after individuals suffering from a brain pathology. Gender should also be taken into account as a variable that affects self-esteem.

CONCLUSIONS

1. Evaluation of the psychological functioning of a customer prepared by relatives can indicate symptoms of subclinical severity.
2. There exists a connection between the emotionality of a caregiver and the manner of the assessment of the mnemonic competence of oneself and of near relations. The direction of those relationships is not clear. The negative affectivity of a near relation/a caregiver may result in formulating negative opinions about oneself and about the individuals in one's care. Conversely, typical developmental memory changes in oneself and others can cause anxiety and depressive mood.

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