

Negative Reactions to Received Spousal Care: Predictors and Consequences of Miscarried Support

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This study focused on the negative reactions of older women with osteoarthritis to the receipt of instrumental support (i.e., physical assistance) from their husbands and the effects of such negative reactions on the women's psychological well-being and self-care. Applying a person–environment fit model, the authors predicted that women's negative reactions to spousal support would be determined by the fit between this support and the personal centrality (importance) of being functionally independent. Consistent with this prediction, women who received high levels of support from the husband and for whom being functionally independent was not highly central reacted less negatively to this support. More negative reactions to spousal support were related to greater concurrent depressive symptomatology and fewer self-care behaviors. In addition, negative reactions were predictive of the women's increased depressive symptomatology and decreased life satisfaction. Findings illustrate a useful theoretical approach to the examination of support from family caregivers.

Key words: spousal support, person–environment fit, negative reactions, osteoarthritis

The vast majority of community-residing older adults who need assistance with personal or instrumental activities of daily living (IADLs) receive this care from family members (Boaz & Hu, 1997; National Alliance for Caregiving and the American Association of Retired Persons, 1997). For older adults who are married, the spouse is usually the primary caregiver (Marks, 1996). Despite spouses' best intentions, however, their assistance is not always perceived as helpful by recipients (e.g., Clark & Stephens, 1996; Thompson, Sobolew-Shubin, Graham, & Janigian, 1989). Moreover, assistance that is perceived as unhelpful by care recipients is related to their poorer emotional and physical well-being (see reviews by Burg & Seeman, 1994; Martire & Schulz, 2001).

Findings from studies on chronically ill adults suggest that instrumental support from family members (e.g., assistance with IADLs) is not always well received, especially when there is a lack of fit between this support and personal characteristics of the recipient (e.g., Reich & Zautra, 1991; Schiaffino & Revenson, 1995). One recipient characteristic that may be relevant in this regard is the personal importance or centrality of being functionally independent. That is, the benefit of receiving instrumental support may depend on whether this support fits with the recipient's preference to complete activities on his or her own (e.g., Nadler & Fisher, 1986). The present study examined two research questions. First, is receiving higher levels of instrumental support associated with more negative reactions of the recipient when this support is incongruent with the centrality of being functionally independent? Second, what emotional and physical health consequences may occur as a result of recipients' negative reactions to the support they receive? To examine these questions, the study focused on older women who were experiencing pain and disability associated with osteoarthritis (OA) and were receiving instrumental support from their husbands.

The powerful negative effects on older adults of family members' hostile or critical actions are well known (e.g., Krause, 1995; Rook, 1984; Stephens, Kinney, Norris, & Ritchie, 1987). However, even actions that are intended by family members to be supportive may not be viewed as such by older adults who are coping with chronic illness. One action that may not be viewed as helpful is the provision of more assistance with IADLs (i.e., instrumental support) than is needed or wanted. Stroke patients have reported that one of the most common unhelpful actions by the spouse is the underestimation of the patient's ability to com-

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plete tasks on his or her own (Clark & Stephens, 1996). Many disabled older adults report receiving help with activities for which they do not need it from their spouses (Newsom & Schulz, 1998).

Studies have demonstrated negative consequences of receiving high levels of assistance from family members, including poorer emotional well-being (Silverstein, Chen, & Heller, 1996) and greater emotional strain (Newsom & Schulz, 1998). It has been proposed that high levels of assistance also may harm the recipient's self-evaluations, including perceived competence and perceived control. First, assistance from others may somehow erode the recipient's confidence and sense of competence in performing activities (e.g., Baltes, 1988; Seeman, Bruce, & McAvay, 1996). Indirect evidence for this type of negative reaction to support is found in the increased inactivity of older adults who receive family assistance in a manner that fosters dependency (Baltes & Wahl, 1992) and in the increased risk for onset of disability among older adults who receive instrumental support from family and friends (Seeman et al., 1996).

A second type of self-evaluation that is likely to be affected by high levels of received support is perceived powerlessness or lack of control over this support. If the amount of assistance received is more than is needed or desired, the recipient may feel that the provider is insensitive to his or her needs and that he or she has no choice or power over assistance that is provided (Ryan & Solky, 1996; Shumaker & Brownell, 1984). Relatedly, an accumulating literature shows that social support can influence the recipient's perceptions of control in the domain in which support is given (e.g., Bandura, 1997; Krause, 1994; Martire, Stephens, & Townsend, 1998).

The concept of person-environment fit may be useful in identifying the conditions under which negative reactions to instrumental support are likely to occur. According to this theoretical framework, psychological adjustment is a function of the degree of fit between aspects of the social or physical environment and an individual's characteristics (e.g., French, Rodgers, & Cobb, 1974; Parmelee & Lawton, 1990). Thus, reactions to instrumental support may in part be determined by the fit between the amount of support received and the recipient's personal characteristics.

Findings from studies on chronic illness are consistent with theories of person-environment fit. Reich and Zautra (1991) have shown that older patients who have an internal locus of control experience poorer mental health when their family or friends encourage them to be reliant on others for assistance, whereas patients with an external locus of control experience better mental health when receiving this same type of support. Other research has shown that rheumatoid arthritis patients who receive high levels of spousal support but who appraise their illness as a challenge (rather than as a threat) have poorer mental health, suggesting that this level of support does not fit with the patients' need for support (Schiaffino & Revenson, 1995). Moreover, nursing home residents who have a self-determined motivational orientation (i.e., those whose behaviors are intrinsically driven) experience better mental health in settings where they have greater choice over personal care and other daily activities. In contrast, residents who have a less self-determined orientation are better adjusted in settings that are more highly constrained (O'Connor & Vallerand, 1994).

The personal importance or centrality of functioning independently is another characteristic that may be influential in determin-

ing negative reactions to assistance with daily activities. Individuals who receive assistance in a domain that is highly central to them have a more negative affective response and feel more negatively about the provider of assistance than those for whom the task is not highly central (Daubman, 1995; DePaulo, Brittingham, & Kaiser, 1983). This centrality of life domains also has been labeled in the social and gerontological literatures as *salience* (Hoelter, 1985; Krause, 1999), *importance* (Brandstatter & Rothermund, 1994), or *ego relevance* (Fisher, Nadler, & Whitcher-Alagna, 1982).

Although research has focused on the personal importance of maintaining independence in middle and late adulthood (Brandstatter & Rothermund, 1994), this recipient characteristic has not been examined for its role in determining negative reactions to assistance with daily activities. It is possible that the degree of fit between the amount of assistance received with daily activities and the centrality of being independent in this domain determines the recipient's reactions to support. That is, higher levels of assistance may be associated with greater negative reactions (i.e., perceived incompetence and powerlessness) in individuals for whom it is very important to be independent.

There is evidence that negative reactions to assistance have affective and behavioral consequences for older adults that extend beyond the effects of illness severity on these outcomes. Feeling strained or overprotected (e.g., not being allowed to do things that could be done independently, having responsibilities taken over unnecessarily) has been shown to be related to increased depressive symptomatology for the recipient, even after controlling for disability level or illness severity (Newsom & Schulz, 1998; Thompson & Sobolew-Shubin, 1993). In addition, perceptions of unhelpful personal assistance are related to less life satisfaction for the care recipient beyond the effects of disability level (Nosek, Fuhrer, & Potter, 1995).

Negative reactions to assistance may also undermine patients' motivation to engage in self-care behaviors that could promote their health. Specifically, self-care behaviors such as exercise, use of assistive devices, and avoidance of harmful activities are relatively proximal health indicators that are likely to be affected by assistance from others. Research has shown that individuals recovering from a myocardial infarction make less effort toward rehabilitation when their spouses are overprotective (Coyne & Smith, 1991). In addition, studies on chronic pain patients have shown that family members may unintentionally reinforce inactivity in patients by providing assistance when it is not needed (e.g., Romano et al., 1992; Turk, Kerns, & Rosenberg, 1992). These findings suggest that an individual's motivation to engage in self-care behaviors may be undermined as a result of assistance.

The present study focused on older women with OA who were receiving assistance from their husbands with IADLs. OA is the most common chronic illness of women over the age of 65 and a significant source of pain and disability (i.e., difficulty with daily activities) in this population. Because older married individuals with OA often depend on their spouses for assistance with daily activities, OA provides a rich context in which to examine negative reactions to spousal assistance and the psychological and behavioral consequences of such miscarried support.

The first aim of this study was to test the hypothesis that higher levels of instrumental support from the husband would be related to greater negative reactions (perceived incompetence, powerless-

ness) to this support only among those women who placed greater importance on being functionally independent. Conversely, it was expected that higher levels of support would be related to less negative reactions to this support among those women who placed less importance on being functionally independent. This hypothesis was based on the concept of person–environment fit, in that negative reactions were predicted to result from the incongruence between the social environment (amount of help received) and a characteristic of the individual (importance of being independent). The focus on perceived incompetence and powerlessness was based on evidence that these may be two of the more common negative self-evaluative reactions to spousal assistance. The second aim of this study was to examine the effects of negative reactions to support (incompetence and powerlessness) on patients' concurrent and prospective psychological well-being and arthritis self-care behaviors. It was predicted that higher levels of negative reactions to support would be related to more depressive symptoms, less life satisfaction, and fewer self-care behaviors, both concurrently and 6 months later. On the basis of previous research findings, we predicted that these effects of perceived incompetence and powerlessness on recipients' well-being and self-care would be independent of the effects of their disability level and the amount of support they received.

Method

Participants

Participants were 101 older women with a primary diagnosis of OA who were identified through medical records at a rheumatology clinic in Akron, Ohio. All clinic patients who were female, married, diagnosed with OA, and 60 years of age or older served as the population from which this sample was obtained. Letters were sent to these patients, and they were then contacted and screened for additional inclusionary criteria. The additional criteria were that the patient had experienced pain in the past month as well as difficulty in carrying out either personal care or IADLs, that she received assistance from her husband with at least one activity, and that the husband was the individual who had provided the most assistance with daily activities. In addition, participants had to meet a conservative standard criterion for cognitive functioning as measured by the Short Portable Mental Status Questionnaire (SPMSQ; Pfeiffer, 1975). No participants had more than three errors on this 10-item measure, and most had no errors.

A total of 283 women were screened for eligibility. Of the 283 women, 148 (52%) were screened and found to be ineligible to participate in the study. The most common reasons for ineligibility were that the woman experienced no limitations from her arthritis (40% of ineligibles), did not receive help from her husband with daily activities (14%), or did not have a primary diagnosis of OA (14%). Of the 135 women who were eligible to participate at Time 1 (48% of 283), 115 were willing to participate, yielding a participation rate of 85%. Time 2 questionnaires were mailed to participants 6 months after their Time 1 interview. Of the 115 women interviewed at Time 1, 7 women did not complete the Time 2 questionnaires, and 7 women had surgery during the 6-month interim, leaving a final sample of 101 women (an attrition rate of 6%). Reasons for attrition were that questionnaires were not returned (4 women), hospitalization (2 women), and 1 woman declined further participation.

Measures

Received Instrumental Support

Participants were asked to indicate how often their husbands helped them with six activities during the past month (e.g., household tasks, opening things) because of limitations due to arthritis. Response categories were 1 (*never*) to 6 (*several times a day*), and thus scores could range from 6 to 36. The average level of instrumental support was 17.7 ($SD = 6.1$, range = 7–31). Cronbach's alpha for this measure was .74.

Centrality of Independence

The centrality of independence in carrying out IADLs was assessed with items created for this study and based on theoretical and empirical work on social support and identity (e.g., Nadler, 1997; Ryan & Solky, 1996). Much of the existing literature points to three dimensions of this construct: the personal value of various domains to an individual's identity or sense of self, support-seeking behaviors in regard to highly central tasks, and the affective component of receiving help with highly central tasks. Participants were asked to indicate the extent to which they agreed with eight statements that addressed these three dimensions of the personal centrality of completing activities with minimum assistance from others. One negatively worded item was dropped from the measure on the basis of evidence that it may have been misunderstood by participants (see Table 1 for the final set of items). Response options ranged from 1 (*strongly disagree*) to 4 (*strongly agree*), and thus scores could range from 7 to 28. The average score for this scale was 20.7 ($SD = 2.9$, range = 12–28), and Cronbach's

Table 1
Endorsement of Items Assessing Centrality of Independence

Item	Percentage endorsing	
	Agree	Strongly agree
1. Being able to do these activities on your own is very important to you.	56.4	38.6
2. Having to rely on others for help with these activities does <i>not</i> bother you. ^a	19.8	2.0
3. Being in need of assistance with these activities is irritating to you.	62.3	11.9
4. For you, not being able to do these activities on your own is one of the most frustrating things about having arthritis.	60.4	24.8
5. It does <i>not</i> upset you to need help from others with these activities. ^a	42.6	3.0
6. Sometimes you won't even ask for help with these activities, even if doing these activities by yourself is difficult or painful.	70.3	11.9
7. You think of yourself as a person who <i>should</i> be able to do these activities on her own.	72.3	17.8

Note. Activities refers to instrumental activities of daily living.

^a These items were reverse coded.

alpha was .78. A principal-components factor analysis determined that all items loaded on one factor (eigenvalue = 3.12, 45% variance).

Participants were also asked whether any specific IADL was particularly important for them to do on their own. Over half of the participants ($n = 58$, or 57%) reported that one of the six activities referenced was particularly important for them to do on their own. For these 58 women, the most frequently reported activity was household tasks ($n = 25$, or 43%), the second most frequently mentioned activity was shopping or running errands ($n = 12$, or 21%), and the third most frequently mentioned activity was getting and reaching for things ($n = 10$, or 17%).

Negative Reactions to Spousal Support

Participants were asked to indicate the extent to which they agreed with seven statements regarding their reactions to instrumental support from their husbands, using a scale from 1 (*strongly disagree*) to 4 (*strongly agree*). These items were derived from the literature on reactions to received support (e.g., Nadler & Fisher, 1986; Shumaker & Brownell, 1984) and are described below. A principal-components factor analysis using varimax rotation determined that these items in fact assessed two separate constructs (see Appendix).

Perceived incompetence. Three items assessed participants' perceived incompetence in carrying out IADLs as a result of assistance received from their husband ("You felt that you could no longer do these activities well"; "You felt that there was no point in trying to do these activities on your own"; "You felt inadequate because you needed help with these activities"). Scores for this scale could range from 3 to 12, and the average score was 7.3 ($SD = 1.6$, range = 4–12). Cronbach's alpha for this measure was .63.

Perceived powerlessness. Four items assessed participants' perceptions that they had little choice or control over the assistance received from their husbands ("You felt that you had little say concerning the help you received from him"; "You felt that he was sensitive to whether you wanted help or not" [reverse scored]; "You felt that you had choices over the help that you got from him, such as how much he gave, when he gave it to you, and how it was given" [reverse scored]; "You wanted to continue doing as much as you could on your own"). Scores on this measure could range from 4 to 16, and the average score for this scale was 7.6 ($SD = 1.2$, range = 4–11). Cronbach's alpha for this measure was .54. Recomputed alphas indicated that the low reliability of the negative reactions measures is mainly due to the number of items and not their internal consistency. Using the Spearman-Brown prophecy formula (Nunnally & Bernstein, 1994) and assuming the same average interitem correlations, we determined that the Cronbach's alpha value for the three-item incompetence measure would have been .70 with four items and the alpha value for the four-item powerlessness measure would have been .70 with eight items.

Psychological Well-Being

Depressive symptoms. The Center for Epidemiologic Studies—Depression scale (CES-D; Radloff, 1977) was used to assess depressive symptomatology. The CES-D is a 20-item scale that asks participants to indicate how frequently they experienced certain symptoms or feelings during the past week. Scores can range from 0 to 60, with higher scores reflecting greater symptomatology. The average level of depressive symptomatology at Time 1 was 12.9 ($SD = 9.0$, range = 0–43), and at Time 2 it was 15.0 ($SD = 9.8$, range = 0–50). A cutoff score of 16 on the CES-D has been suggested as a way of identifying individuals who are at risk for clinical depression. In this sample, 34% of the participants scored at or above this cutoff at Time 1 and 39% scored at or above this cutoff at Time 2. Cronbach's alpha for this measure was .87 at Time 1 and .89 at Time 2.

Life satisfaction. Life satisfaction was assessed with five items from the Americans' Changing Lives study (House, 1986; Neugarten, Havig-

hurst, & Tobin, 1961). Four of these items were rated with response options of 1 (*strongly disagree*) to 5 (*strongly agree*) (e.g., "These are the best years of my life"), and one item ("How satisfied are you with your life as a whole?") was rated using a scale from 1 (*not at all satisfied*) to 5 (*very satisfied*). Scores could range from 5 to 25, with higher scores reflecting greater life satisfaction. The average level of life satisfaction at Time 1 was 14.5 ($SD = 2.6$, range = 9–21), and at Time 2 it was 14.3 ($SD = 3.0$, range = 6–20). The alpha for this measure was .70 at Time 1 and .79 at Time 2.

Arthritis Self-Care

A self-care scale was created for the present study by assessing the practice of 10 health behaviors that are commonly recommended for self-management of arthritis (e.g., exercise, maintaining or losing weight, maintaining an optimal balance between rest and activity, avoiding activities that would damage joints; Hochberg et al., 1995). A two-step procedure was used to assess arthritis self-care. First, participants were asked to indicate to what extent they agreed or disagreed that they had practiced each of these 10 self-care behaviors over the past month, using a scale from 1 (*strongly disagree*) to 4 (*strongly agree*). Next, participants were asked whether each behavior had been recommended to them by a health care provider. Questions were asked in this sequence for the purpose of assessing only self-care behaviors of which participants were aware and to assess self-care in a way that was less likely to be affected by the participants' wish to appear compliant with health care recommendations. A self-care score was calculated for each participant by summing the responses for only those behaviors that had been recommended. Arthritis self-care scores could range from 10 to 40, and the average score was 23.4 at Time 1 ($SD = 6.2$, range = 13–40) and 23.8 at Time 2 ($SD = 6.6$, range = 12–39). Cronbach's alphas at Times 1 and 2 were .78.

Control Variables

Disability. Physical disability was assessed with items from the Health Assessment Questionnaire, a measure designed for arthritis populations (HAQ; Fries, Spitz, & Young, 1982). Participants were asked to indicate the level of difficulty they had with four IADLs in the past month (e.g., shopping, driving) on a scale from 0 (*without any difficulty*) to 3 (*unable to do*). The average level of disability was 3.3 at Time 1 ($SD = 2.6$, range = 0–12) and 3.7 at Time 2 ($SD = 2.7$, range = 0–11). Cronbach's alpha for this measure was .79 at Time 1 and .84 at Time 2.

Pain severity. Pain severity over the past month was assessed with the five-item Pain subscale of the Arthritis Impact and Measurement Scales (AIMS2; Meenan, Mason, Anderson, Guccione, & Kazis, 1992). Items are rated on a scale from 1 (*no days*) to 5 (*all days*), and thus scores can range from 5 to 25. The average level of pain was 17.0 ($SD = 4.3$, range = 7–25), and Cronbach's alpha for this measure was .78.

Marital satisfaction. The participant's marital satisfaction was assessed with the five-item Quality of Marriage Index (QMI; Norton, 1983). Items are rated on a scale from 1 (*strongly disagree*) to 4 (*strongly agree*), and thus scores can range from 5 to 20. The average level of marital satisfaction was 17.5 ($SD = 3.0$, range = 6–20), and Cronbach's alpha for this measure was .95.

Analysis Plan

The first hypothesis, that centrality of independence would moderate the relationship between instrumental support from the husband and negative reactions to this support, was tested using hierarchical moderated regression analyses and data from the first time point. Separate regression analyses were conducted for each of the two negative reaction outcomes (perceived incompetence, powerlessness), and each analysis controlled for the nonfocal negative reaction outcome. In these analyses, instrumental

support from the spouse was entered into the regression equation first, followed by centrality of independence, and, finally, the product of Support \times Centrality of Independence. Before creating the product term for support and centrality of independence, these variables were centered by subtracting the mean value for each predictor from individual scores. This centering procedure was used to decrease the likelihood of multicollinearity between the interaction term and its components (Aiken & West, 1991; Jaccard, Turrisi, & Wan, 1990). A significant R^2 change ($p \leq .05$) for the interaction term was considered indicative of a moderating effect of independence centrality, and this effect was further examined through a decomposition analysis (Aiken & West, 1991; Jaccard et al., 1990). That is, the slope of received support on negative reactions at high and low levels of centrality of independence (1 SD above and below the mean, respectively) was examined using unstandardized regression coefficients to determine whether the significant interaction reflected the hypothesized moderation effect of centrality on the relationship between support and negative reactions.

To identify additional control variables to be included in regression analyses testing the first hypothesis, we examined partial correlation coefficients between each negative reactions outcome and a set of background and health-related variables, controlling for the other negative reactions outcome. This set of variables included age, race, education, income, pain severity, disability, and marital satisfaction. A partial correlation of $pr \geq .30$ was selected as the cutoff for inclusion as a control variable (Reichardt, 1979). The patient's IADL disability level was correlated with perceived incompetence ($pr = .44$) and thus was included as a control variable in the regression analysis for that outcome. The patient's marital satisfaction was correlated with perceived powerlessness ($pr = -.37$) and thus was included as a control variable in the regression analysis for that outcome.

The second hypothesis, that negative reactions would be related to poorer well-being and less self-care, also was tested with hierarchical regression analyses. First, concurrent relationships between each of the negative reactions measures and the well-being and self-care measures were examined, controlling for disability and amount of received support. Second, prospective relationships between negative reactions and the outcome measures were examined, controlling for change in disability, amount of received support at Time 1, and the relevant outcome measure at Time 1.

To identify additional control variables to be included in the regression analyses testing the second hypothesis, we examined partial correlation coefficients between the outcomes and the set of background and health-related variables. The partial coefficients examined for the cross-sectional analyses controlled for disability and amount of received support at Time 1, whereas the partial coefficients examined for the longitudinal analyses controlled for change in disability, amount of received support, and the relevant outcome measure at Time 1. The patient's marital satisfaction was correlated with depressive symptoms and life satisfaction above $pr = .30$ at Time 1 ($prs = -.39$ and $.55$, respectively) and thus was included as an additional control variable in the cross-sectional analyses testing the second hypothesis for those outcomes. The patient's race was correlated with arthritis self-care at Time 2 ($pr = .33$) and thus was included as an additional control variable in the longitudinal analyses testing the second hypothesis for that outcome.

Results

The average age of patients was 69.1 years ($SD = 5.7$, range = 61–86), and the average age of husbands was 71.0 years ($SD = 6.4$, range = 52–92). Most of the sample was Caucasian (97%), and the remainder was African American. Both patients and husbands reported receiving 13.3 years of education, on average. Approximately one fourth of the husbands were employed, and 14% of the patients were employed. Couples had been married

for 42.0 years on average ($SD = 12.9$, range = 2–62). Average yearly household income was between \$25,000 and \$30,000. Patients reported having arthritis for 19.7 years on average ($SD = 15.3$, range = 1–66) and typically reported having arthritis in five joints or sets of joints (e.g., knees). The most common sites of arthritis were the knees (70% of participants), back (69%), and hands (67%). Using a visual analogue scale that ranged from 0 to 200 mm, participants indicated that their current level of pain was 88.5 mm, on average ($SD = 45.3$, range = 12–190).

Table 1 presents the seven items that assessed the centrality of being functionally independent, and the percentage of participants endorsing each item with *agree* or *strongly agree*. These items measure three dimensions of centrality by assessing the extent to which functional independence is important to one's identity (Items 1 and 7), the tendency to not seek help when it is needed (Item 6), and the extent to which the need for assistance is distressing (Items 2, 3, 4, and 5). At least three fourths of the women agreed or strongly agreed with each of the positively worded items.

Table 2 presents the zero-order correlations between all study measures. Not unexpectedly, a higher level of disability was strongly related to receiving higher levels of instrumental support from the husband. Centrality of independence, which was examined as a potential moderator of received support in this study, was not significantly related to instrumental support. This lack of association provides a more interpretable interaction term (Baron & Kenny, 1986). Perceived incompetence and powerlessness also were not significantly correlated, indicating that these are two distinct indicators of negative reactions to spousal instrumental support.

Moderating Effects of Centrality of Independence on Instrumental Support

Table 3 displays findings for analyses examining the potential moderating effects of centrality of independence for each of the two negative reactions. This table displays unstandardized regression coefficients (B) and their standard errors (SE), standardized regression coefficients (β), the variance accounted for by each predictor (ΔR^2), and the total variance accounted for in these analyses. The coefficients in this table represent the effects of the predictors on each negative reaction at the last step of each analysis.

Contrary to prediction, centrality of independence did not emerge as a moderator of the effects of support on perceived incompetence. However, as hypothesized, the interaction of received support and centrality of independence accounted for a significant amount of variance in perceived powerlessness beyond the effects of support, centrality of independence, and the control variables (perceived incompetence and marital satisfaction). This effect accounted for 4% of the variance in powerlessness, a relatively strong moderation effect in field research studies (McClelland & Judd, 1993). A decomposition analysis for this interaction indicated that the slope of powerlessness on support was significantly different from zero at low centrality of independence ($B = -.07$, $p < .01$) but not at high centrality of independence ($B = .02$). Figure 1 depicts these slopes.

As can be seen in Figure 1, higher levels of support from the husband were associated with less perceived powerlessness for

Table 2
Zero-Order Correlations Between Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12		
1. Disability	—													
2. Marital satisfaction		-.12												
3. Received instrumental support			-.10											
4. Centrality of independence				-.03										
5. Perceived incompetence					.11									
6. Perceived powerlessness						.06								
7. Time 1 depressive symptoms							.20*							
8. Time 2 depressive symptoms								.70***						
9. Time 1 life satisfaction									-.45***					
10. Time 2 life satisfaction										-.51***				
11. Time 1 arthritis self-care											.14			
12. Time 2 arthritis self-care												.13		
													.23*	
														.21*
														.05
														.26**
														-.02
														.11
														.12
														-.19
														-.23*
														.08
														.01
														.14
														.16
														.91***

Note. $N = 101$.
* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

participants with low centrality of independence. This finding is consistent with the first hypothesis, in that greater levels of spousal support were related to fewer negative reactions for recipients who placed less importance on being functionally independent. In addition, receiving higher levels of support was associated with more perceived powerlessness for those participants for whom it was highly important to be independent; however, this relationship was not statistically significant.

Negative Reactions to Spousal Support and Changes in Well-Being and Self-Care

The results of the regression analyses examining perceived incompetence and powerlessness as predictors of concurrent well-being and arthritis self-care are presented in the top half of Table 4. As shown in this table, greater perceived incompetence as a result of the husband's instrumental support was related to more concurrent depressive symptomatology for wives, after controlling for disability, amount of received support, and marital satisfaction. Perceived incompetence also accounted for significant additional variance in depressive symptoms (3%, $p < .05$). Greater perceived powerlessness was associated with fewer concurrent self-care behaviors, after controlling for disability and amount of received support, and accounted for significant additional variance in self-care (4%, $p < .05$). Neither type of negative reaction was predictive of concurrent life satisfaction.

The results of the longitudinal analyses examining negative reactions as predictors of change in well-being and self-care are presented in the bottom half of Table 4. As shown, greater perceptions of incompetence stemming from the husband's support were related to decreased life satisfaction for wives over time and accounted for an additional 5% of the variance ($p = .01$). In addition, more powerlessness was related to increased depressive symptomatology for wives over time and accounted for an additional 2% of the variance in this outcome ($p = .05$). These effects were observed after controlling for Time 1 outcome status, change in disability, and amount of received support at Time 1. Neither perceived incompetence nor powerlessness was related to change in arthritis self-care behaviors.

Discussion

Consistent with the concept of person-environment fit, the present study showed that fewer negative reactions to the receipt of spousal instrumental support occur when there is a fit between the amount of support received and the recipient's need for independence. Older women perceived themselves as less powerless as a result of high levels of instrumental support from their husband if it was not highly important to them to perform tasks independently. The present study also showed that negative reactions to instrumental support have significant consequences for care recipients. Women who felt less competent or more powerless as a result of their husbands' assistance engaged in fewer concurrent self-care behaviors and experienced poorer psychological well-being over time.

As predicted by our first hypothesis, women who received more instrumental support from their husbands were less likely to feel powerless over this assistance if it was not highly important to them that they do these tasks on their own. Previous studies have

Table 3
Moderation Analyses for Negative Reactions to Spousal Support

Predictor	Perceived incompetence ^a				Perceived powerlessness ^b			
	<i>B</i>	<i>SE</i>	β	ΔR^2	<i>B</i>	<i>SE</i>	β	ΔR^2
Received instrumental support	-.03	0.03	-.10	.01	-.03	0.02	-.14	.02
Centrality of independence	.05	0.05	.10	.01	-.11	0.04	-.26**	.07**
Support \times Independence Centrality	-.00	0.01	-.00	.00	.02	0.01	.20*	.04*

Note. $N = 101$.

^a This analysis controls for perceived powerlessness and instrumental activities of daily living disability. Total $R^2 = .22, p < .001$. ^b This analysis controls for perceived incompetence and marital satisfaction. Total $R^2 = .27, p < .001$.

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

demonstrated that receiving high levels of support from family members can be upsetting (Newsom & Schulz, 1998; Silverstein et al., 1996). The findings of the present study suggest that negative reactions are not as likely to occur for older adults who value independence less highly. Our findings complement those of other studies that have shown that effects of received support may depend on the recipient's personal characteristics (e.g., Reich & Zautra, 1991; Schiaffino & Revenson, 1995). In addition, these findings extend previous research that has focused on negative reactions in terms of perceived unhelpfulness or decreased well-being by focusing more specifically on recipients' self-evaluations of competence and control. Theorists have speculated that social support has the potential to either enhance or erode an older adult's sense of control or competence (Antonucci & Jackson, 1987; Krause, 1995), but little empirical attention has been given to examining these relationships.

Although we found that women with low independence centrality felt less powerless as a result of high levels of support (as predicted from the concept of person-environment fit), we did not find that women with high independence centrality felt more powerless as a result of receiving high levels of instrumental support. It is possible that different findings in regard to high centrality may have been observed with nonmarital caregiving

dyads. Because of the interdependent and peer nature of the marital relationship, receiving high levels of support from a spouse when it is highly important to do things on one's own may be less upsetting or threatening than receiving high levels of support from another family member such as an adult child. Several recent studies have shown that support received from adult children has the potential to negatively impact older adults' mental health, especially when more support is received than is given by the older adult to the child (e.g., Davey & Eggebeen, 1998; Lee, Netzer, & Coward, 1995). Thus, examining the effects of support from different sources may be important in future research on older adults' negative reactions to the receipt of care.

The notion that older adults differ in terms of their need for independence is not new in the gerontological literature (e.g., Cohler, 1983; Troll & Smith, 1976). However, the personal centrality of being independent has received little empirical attention as a factor that may be important in understanding the consequences for older adults of receiving care from others. Our findings suggest that centrality of independence is a construct that deserves further empirical research in this context. In addition, it would be useful to determine in future research if the centrality of functional independence changes over time as a result of increasing dependence on others. Theory and empirical work indicate that individuals downgrade the importance of domains such as physical health and personal independence over time as a means of protecting themselves from the negative effects of a loss of perceived control in these domains (e.g., Brandstadter & Rothermund, 1994; Schulz, Heckhausen, & O'Brien, 1993). This compensatory mechanism of downgrading the personal centrality of being functionally independent may be adaptive in the face of dependence on others for physical assistance.

The second aim of our study was to examine the effects of negative reactions to spousal support on wives' psychological well-being and arthritis self-care behaviors. We found that women who felt that they were less competent in carrying out daily activities as a result of their husbands' instrumental support also reported more concurrent depressive symptoms and were less satisfied with their lives over time, and women who felt more powerless over support received from their husbands experienced more depressive symptoms over time. Notably, these effects on psychological well-being were observed even after controlling for the patient's level of physical disability, the amount of support received from the spouse, and well-being status at baseline.

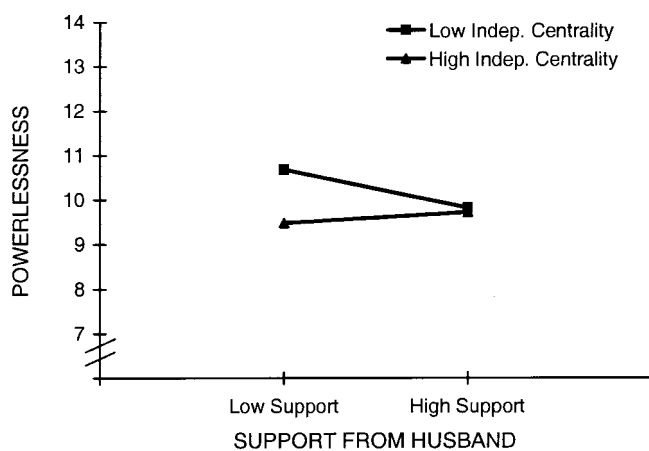


Figure 1. Interaction of spousal instrumental support with centrality of independence for the outcome of perceived powerlessness. Indep. = independence.

Table 4
Effects of Negative Reactions on Concurrent and Prospective Well-Being and Self-Care

Predictor	Depressive symptoms		Life satisfaction		Arthritis self-care	
	β	SE	β	SE	β	SE
Concurrent analyses						
Control variables						
Disability	.27*	.12	-.05	.13	.05	.15
Received instrumental support	.15	.11	-.11	.12	.18	.14
Perceived incompetence	.17*	.09	.02	.09	.06	.11
Perceived powerlessness	.11	.09	-.01	.09	-.21*	.10
Total R^2	.39***		.35***		.11*	
Prospective analyses: T2						
Control variables						
T1 outcome	.66***	.08	.64***	.08	.90***	.05
Change in disability	.20**	.07	-.13	.08	-.03	.04
T1 received instrumental support	.04	.08	.09	.08	.04	.05
T1 perceived incompetence	-.05	.08	-.19**	.08	-.01	.05
T1 perceived powerlessness	.14*	.07	-.05	.08	.02	.05
Total R^2	.56***		.49***		.83***	

Note. Concurrent analyses of depressive symptoms and life satisfaction also controlled for marital satisfaction. Prospective analyses of T2 arthritis self-care also controlled for race. $N = 101$; T1 = Time 1; T2 = Time 2. * $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

These findings extend the literature documenting that satisfaction with support received from the spouse has a significant impact on the adjustment of individuals coping with a chronic illness (e.g., Cutrona, 1996; Thompson & Sobolew-Shubin, 1993). Our findings suggest that social support that detracts from a recipient's self-evaluations of competence and control may contribute to a feeling of being less able to manage one's illness, and thus to diminished emotional health. These effects on well-being of negative reactions to support are consistent with an investigation of nursing home residents, which examined the extent to which formal and family caregivers provided *autonomy support*, defined as being able to take the recipient's perspective and to encourage him or her to be more self-directed. In that study, autonomy support from family members and nursing home staff was related to greater life satisfaction for the care recipient (Kasser & Ryan, 1999).

The present study showed that negative reactions to instrumental support not only may have consequences for psychological well-being but also may interfere with health-related behaviors. Women who felt more powerless over received physical assistance engaged in fewer concurrent health behaviors that are essential for the successful management of OA, such as physical exercise and joint protection strategies. These findings suggest that a lack of control over the ability to regulate help that is received from others may contribute to the sense that one has little control over the trajectory of an illness and a subsequent tendency to take less self-regulatory action. Our findings complement research on diabetic and post-myocardial infarction patients showing that unsupportive attitudes and behaviors of spouses are related to lower adherence to diet, medication, and exercise regimens (see review by Burg & Seeman, 1994).

It should be acknowledged that we did not find support for our hypothesis that negative reactions to spousal assistance are related

to change in OA self-care behaviors over time. We believe that these null findings are due in large part to the lack of change in self-care behaviors over the 6-month follow-up, which may reflect that health behaviors are less likely than emotional well-being to change over a short time interval. However, our findings are also limited by the negative reaction measures that were used in tests of both study hypotheses. Our negative reaction measures were not highly internally consistent, which may have led to an underestimation of the links among support, negative reactions, and well-being, and also may have limited our ability to find stronger effects.

Several limitations to the generalizability of our findings should also be noted. First, our hypotheses focused on IADLs, and thus our findings may not apply to assistance with personal care activities such as bathing and dressing. In addition, it is not known whether our findings would have differed with a sample of older male patients and their caregiving wives. Future research should focus not only on how the centrality of independence affects the receipt of support for older men coping with chronic illness but also on the extent to which there are gender differences in independence centrality and which tasks are important for men as compared with women to complete on their own.

Our findings extend the caregiving literature by demonstrating the value of using a theoretical model to identify conditions under which support to older adults from family caregivers is likely to miscarry and also by demonstrating that miscarried support has psychological and behavioral consequences for the recipient. As others have noted, knowledge of older adults' preferences in regard to receipt of care is useful in the design of psychosocial interventions (e.g., Carpenter, Van Haitsma, Ruckdeschel, & Lawton, 2000). One promising avenue is to work with both members of caregiving dyads to identify the tasks that the care recipient perceives as the most important to do independently or with

minimal help from the caregiver. Furthermore, for tasks the care recipient perceives are important to do alone but for which some type of assistance is necessary, it may be useful to identify assistive devices or techniques that facilitate independent functioning.

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Appendix

Exploratory Factor Analysis Results for Negative Reaction Measures

Item	Factor loadings after rotation	
	Factor 1: Perceived Incompetence	Factor 2: Perceived Powerlessness
You felt that you could no longer do these activities well.	.84	.06
You felt that there was no point in trying to do these activities on your own.	.73	-.11
You felt inadequate because you needed help with these activities.	.74	.06
You felt that you had little say concerning the help you received from him.	.27	.59
You felt that he was sensitive to whether you wanted help or not.	-.18	.61
You felt that you had choices over the help that you got from him, such as how much he gave, when he gave it to you, and how it was given.	.08	.71
You wanted to continue doing as much as you could on your own.	-.07	.61