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The Other Side of Support

Emotional Overinvolvement and Miscarried Helping

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> Too long a sacrifice
> Can make a stone of the heart
> —William Butler Yeats

The social support literature is generally optimistic about people's willingness and ability to respond positively to someone in distress (e.g., Lin, Simeone, Ensel, & Kuo, 1979; see Cohen & Syme, 1985, for reviews). Much less attention has been given to the negative impact that others may have on people in stressful circumstances (Coyne & DeLongis, 1986; Dunkel-Schetter & Wortman, 1982; Fiore, Becker, & Coppel, 1983; Rook, 1984) and how well-intentioned support attempts may fail because they are excessive, untimely, or inappropriate (Maddison & Walker, 1967; Wortman & Lehman, 1985). Whereas the social support literature tends to emphasize the benefits that may accrue from helpful involvement of others, this small but growing number of studies suggests that even when would-be helpers know what to do, they may often be unable to carry it out effectively (Lehman, Ellard, & Wortman, 1986).

Relationships with family members and particularly the spouse may largely account for the association between social support and adapta-

tional outcomes (House, 1981). Moreover, there is evidence that support from other sources does not entirely compensate for what is lacking in close relationships (Brown & Harris, 1978; Coyne & DeLongis, 1986). Yet, studies of families attempting to help a member who is facing a crisis document the fallibility of family relationships as sources of support, as well as their vulnerability to deterioration under such circumstances (Wishnie, Hackett, & Cassem, 1971). There is evidence that when trying to help a partner in crisis, family members often become involved in ways that are constraining and debilitating (Speeding, 1982).

In contrast to the dominant themes of the social support literature, the family therapy literature has contributed an understanding of how people involved with a person in distress—particularly those closest to that person—may become emotionally overinvolved, critical and hostile to the stressed person, and become psychologically distressed themselves. The family therapy literature suggests that both under-involvement (which can be seen as a lack of support) and overinvolve-ment of family members (Hoffman, 1975; Minuchin, 1974; Olson, Sprenkle, & Russell, 1979) can lead to negative adaptational outcomes. For instance, it has been found that for both schizophrenics and depressives, the level of emotional overinvolvement of the patient's closest relative is the best predictor of relapse after return from the hospital (Hooley, Orley, & Teasdale, 1986; Vaughn & Leff, 1976). Apparently contradicting the social support literature's assumption that the distressed person will benefit from greater involvement with others, family therapists often seek to disengage or individuate the distressed person from a destructive overinvolvement in close relationships (Haley, 1980).

Various aspects of a possible miscarried helping process have been discussed in the context of graduate student comprehensive examina-tions (Mechanic, 1962), chronic pain (Maruta, Osbourne, Swanson, & Hallnig, 1981), disability (Fengler & Goodrich, 1979), and illness, such as Alzheimer's disease (Ware & Carper, 1982), renal failure (Malmquist & Hagberg, 1974) and stroke (Watzlawick & Coyne, 1980). The specific issues, stakes, coping tasks, and appropriateness of various forms of involvement vary across these situations, but there is nonetheless a basis for postulating a general underlying process.

Our goal is to reconcile these divergent assumptions about the benefits and drawbacks of family involvement by offering an interac-tional perspective on how efforts to be helpful to persons under stress can become miscarried, particularly in close relationships. Overinvolve-ment on the part of would-be helpers is the key variable in the process we

wish to describe. Without denying the benefits of positive involvement, we point to some potential pitfalls. We attempt to illustrate how a support provider's investment in being helpful and achieving a positive outcome may ironically lead to behavioral transactions that are detrimental to the recipient's well-being and successful adaptation.

There are a number of ways in which family members' emotional overinvolvement in being helpful can prove self-defeating (DeLongis & Coyne, 1986). First, it may simply interfere with their problem solving or performance of instrumental tasks. For instance, physicians tend to believe that family members are less effective in providing cardiopul-monary resuscitation than are persons who are more emotionally detached (St. Louis, Carter, & Eisenberg, 1982).

Second, emotionally overinvolved family members may become too focused on the instrumental outcomes of their helping efforts or demonstrations of their helpfulness to be aware of what they are communicating to the recipient. In attempting to be helpful, family members are also providing a commentary about their competencies, feelings, and relationships—and those of the help recipient. These expressive aspects of their behavior can provide as much impact as do their instrumental accomplishments. Inadvertently, family members' efforts may leave the recipient feeling guilty, incompetent, resentful, lacking in autonomy, or coerced. Family members' protests of "But I am only doing it for your own good" are frequently indications of such a miscarriage of the helping process.

A third way in which family members' overinvolvement may prove self-defeating is that over time the helper and recipient may accumulate issues about their relationship that take precedence over other concerns. For instance, demands and intrusiveness on the part of the overinvolved support provider may confront the recipient with an unfortunate choice between preserving autonomy by resisting these efforts or doing what is adaptive. If someone is too insistent in offering their suggestions that a person not eat between meals, then "refusing to be pushed around" may take precedence over "cheating on my diet" as a label for snacking, and snacking becomes more justifiable. Over time, the initial dilemma of whether or not to snack can be suppressed by the more general disagreements over the support provider's right or need to make such suggestions and the recipient's commitment to the diet plan and ability to comply with it.

The paradigmatic situation that gives rise to the process we wish to describe, therefore, involves at least two persons who are in a close relationship, one of whom faces a major life change entailing distress, uncertainty, and the need to make a sustained effort at readjustment

under threat of failure. The life change might be a physical illness, such as heart disease, stroke, or cancer; an injury, such as spinal cord injury; or a loss, such as bereavement or unemployment. Alternatively, the life change may be a decision to make a beneficial modification in longstanding behavior, such as to lose weight or abstain from alcohol. The close relationship allows at least one other person (i.e., the helper) who has some investment in the well-being of the stressed individual to observe and comment. However, in this situation the burden of effort for the solution falls upon the stressed person, presenting some key tasks that only this person can accomplish. Although the helper can offer support and advice, there is a limit to what this person can do directly, even though his or her emotional or material well-being is at stake. The process of becoming overinvolved is also more likely to occur when there is at least some ambiguity about the reasons for any setbacks or lack of progress, so that the helper can at least entertain the possibility that a lack of motivation or other characterological defect of the stressed person is responsible.

A key feature of our overinvolvement model borrows from social psychology the notion of situational versus dispositional attributions for behavior. By describing ongoing dynamics, both within the distressed individual and the helper *and* between the two parties, our goal is to offer a situational perspective on miscarried helping rather than one that blames the helper, the recipient, or both parties.

We begin by noting two examples of the fallibility and vulnerability of close relationships when one of the parties in the relationship faces a life change. We then illustrate how an interactional perspective can be applied to such relationships, summarizing some of its major assumptions. Next, we present an analysis of the process through which support attempts can become miscarried in such relationships, and identify some common variables that influence this process. Finally, we discuss the implications for interventions arising from this model of emotional overinvolvement.

Illustrations

Anecdotal and case reports have emphasized the importance of marital support in functional recovery from a myocardial infarction, but have also suggested that impediments to recovery result from marital overprotectiveness, pessimism about the outcome, and marital conflict (Bellak & Haselkorn, 1956; Davidson, 1979). For instance, Wishnie, Hackett, and Cassem (1971) studied 18 families post-MI and

found that there was a "steady, eroding conflict over the implications of the illness in all of them" (p. 1294). Although longstanding marital problems tended to become aggravated, such conflicts occurred even when the marriage and premorbid home life had been quite stable (see also Christ, 1983). Wishnie et al. (1971) noted:

> The wives in particular tended to overprotect their husbands in an aggressive way. They felt guilty at having somehow been instrumental in the genesis of the heart attack and were frustrated at being unable to express grievances and anger lest such action bring on another MI. Their solicitousness often took on a punitive quality which was thought to represent an indirect expression of suppressed anger. (p. 1294)

Numerous studies suggest that spouses of persons who have recently had a myocardial infarction are themselves distressed (compare Kline & Warren, 1983; Skelton & Dominian, 1973), and some studies have found that they are actually more distressed than the heart attack victims (Gillis, 1984). In an effort to cope with his or her own distress, the helper may engage in counterproductive behavior to assist the post-MI patient. For instance, spouses may become overprotective in a way that counteracts the positive results of the patients' strivings to resume normal activity (Kline & Warren, 1983; see also Wishner & O'Brien's 1978 discussion of overprotectiveness with diabetes). Taylor, Bandura, Ewart, Miller, and DeBusk (1985) studied men who were recovering from an uncomplicated myocardial infarction and found that, contrary to the husbands' own assessments of themselves as moderately hardy, wives judged their husbands' cardiac capacity as severely debilitated and incapable of withstanding physical and emotional strain. Whereas treadmill exercises increased the patients' perceptions of their physical and cardiac efficacy, wives continued to perceive their husbands' cardiovascular capacity as impaired, even after receiving informative counseling to the contrary.

The life-threatening nature of a myocardial infarction poses special challenges to a spouse, but issues of inappropriate involvement similarly arise in the context of more mundane coping tasks, such as a decision to reduce weight. The general conclusion of literature concerning the role of the spouse in weight-reduction programs is that spouses generally voice support for their partners' decision to lose weight, yet may get involved in unhelpful ways (Brownell, 1982). For instance, Stuart and Davis (1972) found that 91% of husbands reported supporting their obese wives' intentions to lose weight. Yet, when Stuart and Davis recorded mealtime conversations, they found that, compared to their

wives, husbands were four times more likely to offer food, seven times more likely to talk about food, and their ratio of criticism to praise was 12 to 1.

Consistent with suggestions in the social support literature, Pearce, LeBow, and Orchard (1981) found that actively involving the spouse produced more weight loss than a conventional behavioral program. Yet a similar increment in weight loss resulted from instructing the spouse not to get involved in any way in his wife's efforts to lose weight. It appears that instructing husbands to refrain from attempting to be helpful may be as effective for long-term maintenance as training them to be actively supportive.

Thinking Interactionally About Support

Before proceeding to a discussion of our model of miscarried helping, it is useful to note some of the assumptions of an interactional perspective. When persons are facing serious difficulties, it is unlikely that any single supportive exchange will prove decisive. Rather, there will be repeated exchanges between the persons involved in which each person's behavior may be seen as both a response to the other's behavior and an occasion or impetus for the other's next response. Typically, the social support literature has not dealt with the patterning of such extended interactions. Most studies of social support have examined the relationship between social involvement or global perceptions of support and subsequent mental or physical health; little attention has been paid to how supportive responses are interwoven or concatenated over time. Communication theorists (Watzlawick, Jackson, & Beavin, 1967) have noted that interactional patterns have emergent properties, such that they can take a turn contrary to the initial goals and commitments of participants. Consistent with this, we have previously explored how depressed persons and those in their immediate social environment may unwittingly become involved in a pattern that perpetuates the depressed persons' distress, as a result of their attempts to control and reduce it (Coates & Wortman, 1980; Coyne, 1976a, 1976b; Watzlawick & Coyne, 1980)

The notion that behavior has both a content- and a context-defining aspect is central to an interactional perspective (Ruesch & Bateson, 1951; Watzlawick et al., 1967). That is, a given response has both content and a tendency to define a situation in a way that constrains the interpretations that can be made and the responses that follow. For instance, consider the statement, "I want you to do it for yourself, and not for me." The speaker is masking the fact that he or she wants the recipient to take a certain course of action, and yet in this context, even if the recipient already intended to take the action, it would now be done with a diminished sense of self-initiative. The recipient may now be saddled with a choice between adaptive behavior and autonomy: "Do I take this action or do I refuse to be told what to do?" Sensitized to this, the would-be helper is constrained by what has been said and has limited options. One can concede one's stake in the matter ("O.K., I do want you to do it. Do it for me.") or escalate the denial and even communicate rejection ("I really don't care what you do.").

Dealing with extended sequences, one must come to terms with their circularity and punctuation. An observer can isolate Person A's encouragement and view Person B's performance as a response to this. Yet this is somewhat arbitrary, for one could also have viewed Person A's behavior as a response to Person B's previous performance. Thinking interactionally, the isolation of simple temporal sequences is seen merely as a provisional punctuation. Firm notions of simple linear causality are abandoned, and the existence of reciprocal influence or feedback loops is highlighted (Coyne & Holroyd, 1982). Nonetheless, how respondents punctuate their exchanges and whether or not they agree can dramatically influence their subsequent interactions. For instance, a depressed stroke victim may see his inertia and reluctance to resume previous activities as a response to his family's coercion and criticism, whereas his family sees their behavior as an attempt to rouse him from his abulia, and they may take satisfaction in what little he does as a measure of the success of their efforts. Sadly, both the stroke victim and family can find validation for their point of view in the behavior of the other.

A Model of Miscarried Helping

We will use this interactional perspective to explore a process of miscarried helping, which may arise among those facing significant life changes and their intimates. We begin by describing the initial situation encountered by partners when one of them is facing a significant life change, and examine how optimism and hope give way to disillusionment as the situation fails to improve. We illustrate how support providers begin to doubt the motivations of their partners, and consequently, respond with new demands and stronger exhortations for improvement. Finally, we describe how exchanges between the provider and recipient can gradually become locked into a destructive pattern characterized by hostility and criticism on the part of the support

provider and repeated displays of distress and dysfunction on the part of the recipient.

We maintain that although this pattern is neither inevitable nor even modal, it occurs more often among those facing serious life changes than has generally been acknowledged. After presenting the model, we attempt to identify certain aspects of the crisis, as well as particular characteristics of the relationship that increase the likelihood of miscarried helping. Finally, we discuss the implications of our analysis for subsequent research and for interventions with individuals facing major life changes.

The Initial Construction
of the Situation

The process with which we are concerned starts with a change in routine, whether it is a stressful event that threatens the well-being of one of the family members or a decision to undertake a difficult change in behavior. During this period, positive morale and optimism may be voiced in an effort to make the stressed person feel supported. These supportive efforts are likely to take the form of encouragement and expressions of empathy and affection. Often, the change may initially produce identifiably positive effects on the quality of interaction. A "honeymoon" period may occur: There may be a break-up of the daily routine; caring between the parties involved may be made more apparent than normally is the case; and bonds may be temporarily strengthened.

The family may develop an initial construction of the crisis (Reiss, 1981), or definition of their situation, that includes a shared sense of how these circumstances came about and what needs to be done. This construction may require everyone to put other issues and concerns aside, to accept otherwise intolerable behavior, reduce demands (Parsons & Fox, 1952), and generally be more patient and charitable. Family members' awareness of a clear superordinate goal (compare Sherif, Harvey, White, Hood, & Sherif, 1961) may lead them to pull together to deal with the crisis (compare Aronson & Osherow, 1980). Expressions of support and grateful acknowledgment of its receipt may allow the parties to feel better about their relationships, and there may be a sense of renewal or rediscovery of the strength of these relationships.

At this time, however, the seeds for potential overinvolvement may be planted by the implicit understanding that this is a family problem, and that the family shares responsibility for resolving it successfully. For

example, one stroke victim's wife described her behavior during the early stages of recovery in the following way, "I gave him repeated pep talks and assured him we were going to lick this awful thing that had ruined *our* lives." (Fisch, Weakland, & Segal, 1983, p. 259, emphasis added). Similarly, in describing couples in which one member is undergoing maintenance hemodialysis for kidney disease, Shambaugh, Hampers, Bailey, Snyder and Merril (1967) have noted that some spouses typically use "we" when discussing the impaired partner's situation (see also Hoebel, 1976; Palmer, Canzona, & Wai, 1982).

The Costs of Care Giving

Over time, the support provider may become more aware of the costs of dealing with the crisis. In addition to experiencing general anxiety and concern over the partner's plight (Farkas, 1980), the support provider may be faced with significant role strains (Piening, 1984). Often, distressed individuals are not able to fully carry out their normal responsibilities (Gutman, Stead, & Robinson, 1981; Hill, 1958; Litman, 1974; Parsons & Fox, 1960), forcing the support provider to perform multiple roles (D'Elia et al., 1981; Markson, 1971).

Additionally, studies of myocardial infarction, head trauma, and Alzheimer's disease suggest that helpers may relinquish much of their social life and outside activities in order to cope with their partner's problems, and these changes tend to be long-term (Aronson, Levin, & Lipkowitz, 1984; Packwood, 1980). Support providers may become burdened by their perception of the partner's increasing dependence (Teusink & Mahler, 1984). In a study of the stress of living with Alzheimer's disease, for example, it was not uncommon for the patients to follow their spouses from room to room, never allowing him or her out of sight (Ware & Carper, 1982; see Mayou, Foster, & Williamson, 1978, for a discussion of dependence among heart patients). If the life change requires that the partner stop working or curtail social activities, prior friendships may wane because the individuals no longer share the same social worlds.

In addition to introducing a variety of stressful changes in the support provider's life, the crisis may also undermine many of the positive features that previously characterized the relationship. In the past, the support provider may have turned to the marital relationship for solace in times of stress. In the present situation, however, the stressed person's preoccupation with his or her own coping tasks may preclude the provision of support to the helping partner (Piening, 1984). People's

illnesses, for example, often become the focus of their lives as treatment regimens, periods of discomfort, medical appointments, and the logistics of accomplishing mundane activities structure and fill their days (Charmaz, 1983). Given the pressing needs of the stressed person, the support provider may feel it is crass or selfish to request support, or to even mention his or her own investments or needs.

The Costs of Receiving Care

As support continues to flow from the provider to the recipient, the recipient may become increasingly uncomfortable in the role of the helpee. The recipient may become concerned about increasing dependency, and about the lack of reciprocity that characterizes his or her present relationship with the partner (Palmer et al., 1982; Williamson, 1985). As the ill person observes increasing signs of strain in the caregiver, feelings of guilt and shame may arise (Charmaz, 1983). Particularly in cases in which partners are dependent on the spouse for physical care, they may feel demeaned by having little control over whether or when certain things are done for them.

Even in those cases in which the recipient is able to perform many functions for him- or herself, there may be tensions around the issue of receiving help. As Brickman and his associates (1982) have emphasized, help often carries with it the implicit assumption that people are incapable of solving their own problems. Support from the spouse can therefore undermine the distressed person's self-esteem if it implies that he or she is an "impaired person" (DiMatteo & Hays, 1981). In a study of cancer patients by Peters-Golden (1982), many patients reported that they were made to feel incapable of performing ordinary tasks by the oversolicitous attitudes of others. Patients reported that others often attempted to "foist incapacitation upon them" by preventing them from carrying out their usual chores, and they resented "being babied" in this way (see Wishnie et al., 1971, for a similar phenomena among heart patients).

Flagging Morale and Redefinition of the Problem

If the situation persists, and family members try to cope with the demands and burdens of their loved one's problems, they may begin to feel emotionally drained, trapped, and resentful (Thompson & Doll, 1982; Dunkel-Schetter & Wortman, 1982). Family members' attempts

to provide reassurance and encouragement may acquire a hollow ring because they are contradicted both by the unchanged situation and by signs of impatience, frustration, or doubt on the helper's part. The support provider may begin to show signs of strain, and expressions of worry and concern may become more frequent and intense.

Moreover, becoming increasingly aware of all that the helper is doing, the recipient may feel pressured to respond with signs of improvement. However, if the situation does not improve, the support recipient may feel trapped between a felt sense of responsibility to the partner to show signs or recovery and the harsh, unyielding reality of his or her situation. The power that the stressed person has over the well-being of the helper can be an awesome burden. Thus a disabled man stated, "I want to get better and relieve the strain on my wife. . . . I really get upset when I feel I've let her down. . . . I feel so helpless and need so much help that it's very discouraging" (Fengler & Goodrich, 1979).

As the distressed person becomes increasingly aware that his or her problems are causing others anxiety, he or she may feel forced to adopt a more stoic self-presentation for the benefit of those others (compare Swanson & Maruta, 1980). Yet, to the extent that this self-presentation is convincing, it sets up the helper for unrealistic assessments of the stressed person's condition and may raise doubts about the authenticity of any difficulties that the stressed person subsequently displays. Hilbert (1984) has described the insoluble dilemma of concealment versus disclosure that this poses for sufferers of chronic pain. One subject in this study noted:

I know that in the long run I'd be caught at something. . . . They'd say "Well, why didn't you tell?" . . . If you go into a situation straightforward saying this is what my problem is then somewhere along the line if you have it, they won't think you've invented it. (p. 371)

Yet almost all the subjects in the study indicated pressures not to complain or bring up depressing topics, and they expressed concerns about being seen as a burden or as soliciting sympathy. When they do complain about pain or fatigue, they may be confronted with blaming statements, such as "You are not doing enough," "You don't try to push yourself," or "You are using it as an excuse" (Charmaz, 1983).

Reconstruction of the Situation

Even if not obvious from the start, it becomes apparent that the distressed person's plight is not going to yield immediately, and that a

positive outcome cannot be assured. This absence of positive change may call into question the existing construction of the crisis and perhaps even the intentions and motivations of everyone involved. A common reinterpretation is that the task is indeed easy, but that the distressed person does not have the right attitude—a lack of improvement implies a lack of effort. The support provider may emphasize to the recipient that things are not as bleak as they appear, and that progress is a matter of hard work. As one stroke victim was told by his adult son, "You look at television and you see people [without arms] who are painting oil paintings with the paintbrush held in their teeth . . . I really think that if you wanted to, you could do a heck of a lot of things right now. I think it's a matter of saying, "Damn it, I'm going to do this for myself because I want to do it" (Fisch et al., 1983, p. 257).

Advice is often accompanied by frequent monitoring of the target person's progress. In one study of recovery from myocardial infarction (Bilodeau & Hackett, 1971), patients described being closely supervised by their families with respect to activities, diet, smoking, medication, and naps. Patients frequently expressed frustration, humiliation, and anger in response to this surveillance. These behaviors of the would-be helper may maintain a negative self-focus on the part of the stressed individual, which in turn disrupts adaptive behavior, and increases self-criticism and negative affect. Literature from a wide variety of sources suggests that focusing attention on the target person's performance may undermine that performance (Strack, Blaney, Ganellen, & Coyne, 1985; see Dweck & Wortman, 1982, for a review). This research implies that well-intentioned behaviors, such as voicing explicit expectations about what the target person needs to do in order to improve, providing advice about how to proceed, and monitoring the target person's performance for signs of improvement, may prove self-defeating (Wishner & O'Brien, 1978).

Another reason why explicit expectations, advice, and demands for improvement may fail to have the desired effect is because such behaviors can undermine the distressed person's intrinsic motivation, or initiative, to engage in productive, adaptive behaviors (Palmer et al., 1982). By offering the distressed individual help and advice, the support provider can turn an internal attribution ("I am doing things to get better because I want to and I am capable of doing it") into an external attribution ("I am doing these things because of my partner"). This has been referred to as the "overjustification effect" (Bem, 1967; Deci, 1975). The major premise is that when external reasons for performing a particular behavior are made salient, the distressed individual may cease to believe that the activity is being performed because of intrinsic interest or motivation.

Although the support provider may come to feel that the problem hinges primarily upon the distressed person's pessimism and negative attitude, the recipient may become increasingly convinced that the barriers to improvement are real and that there is little he or she can do that will make any difference. The recipient may point attention to physical constraints or even exaggerate setbacks in order to justify this view. This may prove persuasive, but such a strategy may backfire, convincing the helper that the stressed person's performance is not an accurate indicator of his or her capabilities and raising the possibility of malingering.

Becoming Overinvolved and Taking Responsibility for the Partner's Well-Being

The natural course of the coping task or recovery process may limit the negativity of ensuing interactions. The stressful situation may resolve itself, or at least there may be concrete indications of improvement that restore hope and allay fears. Moreover, at any point in the process, the parties may receive new information validating the seriousness of the partner's problem and the fact that it is impervious to ameliorative efforts. For instance, there is some evidence that when the disabled partner's medical status is clarified, family bonds are strengthened (Zahn, 1973). If the situation continues unabated, however, support providers may redouble their efforts, becoming more involved and even more demanding.

Given the support provider's investment in the outcome, the recipient's continued displays of distress can come to be viewed by the helper as an accusation that the proffered support is inadequate (Bullock, Siegal, Weissman, & Paykel, 1972). Thus in failing to heed or benefit from the support provider's advice, the distressed partner is offering what may be interpreted as rejection. With each exchange, the helper has invested more and more of his or her own esteem and well-being and interprets the partner's lack of progress in a highly personalized way. Having become involved, the helper has accepted some of the responsibility for a positive outcome and part of the blame if it is not achieved.

By this point, the helper has suffered repeated failure experiences at the hands of the distressed partner. The helper may come to believe that the ill person purposely undermines him or her by performing poorly or functioning inadequately. The most pressing problem for the helper may be that his or her well-being comes to depend on the ill person, who is denying the helper the opportunity to feel good. In this sense, the

helper has lost control over his or her well-being. Yet, the self-interests of the helper may remain a taboo topic, and the helper may deny any agenda other than being of assistance. As the wife of a stroke victim explained to her husband:

> When I tell you to lift your leg and stop dragging it, I am only doing it for your own benefit, because I think that if you concentrate hard enough on lifting that leg then you are able physically to do it. (Fisch et al., 1983, p. 259)

At this point, the distressed partner may feel that the only way to cope with the situation is to exhibit more distress and dysfunction. There are several reasons why it may be advantageous for the ill partner to exhibit increasing levels of distress. First, the partner may reason that appearing distressed will provide sufficient evidence of genuine incapacity to get the support provider to lower expectations and reduce demands. Second, by demonstrating weakness and by failing to try harder, the distressed person can structure the situation so that he or she has a relatively nonthreatening explanation for failing to get better. According to the self-handicapping theory (Jones & Berglas, 1978; Snyder & Smith, 1982), individuals may display symptoms, perform ineptly, and even create impediments to successful performance, in order to establish a ready excuse for potential failure. Setting up the situation in this way enables individuals to avoid the threatening attributions that might otherwise arise from the failure to improve (see also Norem & Cantor, in press).

Finally, the would-be helper's intrusive efforts, combined with the unyielding nature of the problem, may infuse the distressed person with feelings of failure and helplessness. A modicum of self-respect and some sense of control may be found in frustrating the helper's intrusive and coercive efforts. Saying "no" to the helper and rejecting opportunities for positive change may be the most self-affirming accomplishment within reach. In a study of 74 men with multiple sclerosis, and their families, Power (1979) reported that failure to function "was a strong manipulative device . . . a weapon for gaining attention and exerting control over the family" (p. 619).

Stalemate: Characterological Attack and Rejection

At this point, the helper has assumed a major share of the responsibility for an outcome that cannot be directly controlled. The helper may shift to seeing the stressed person as spiteful, uncooperative, and ungrateful. By attributing the problem to the distressed person's character, the helper may feel absolved of any responsibility for the distressed person's failure to improve.

Of course, this construction of the situation can also provide justification for behaviors that are not only nonsupportive, but that border on cruelty (Williamson, 1985). The distinction between ostensibly supportive efforts and aggression may become blurred. Efforts aimed at encouragement may give way to infantilizing advice, coercion, and characterological attack (Aronson et al., 1984; Piening, 1984; Teusink & Mahler, 1984). The support provider may verbally attack the distressed person, or may become abusive in forcing the distressed person to comply with demands. The two partners are likely to punctuate these behavioral sequences differently. The support provider is likely to view his or her aggressive, unpleasant behavior toward the partner as necessitated by the partner's behavior. Further, the support provider is likely to view any subsequent constructive behaviors of the partner as evidence that his or her former demands and exhortations are having a beneficial effect. On the other hand, the distressed partner may come to view the support provider as a hostile and destructive person who is relentlessly harassing him or her. Neither party may be able to understand the situational forces that have altered their relationship and contributed to their growing estrangement.

In some cases, what Patterson and Reid (1970) have termed "coercive control" may come to dominate the couple's exchanges. The helper and distressed person have repeatedly failed in trying to influence each other, and the frequency of positive exchanges has been greatly reduced. They may well have discovered that the principal remaining tactic now available to them is to be aversive—the helper with demands and criticism and the stressed person with a spiteful ineptness or lack of progress. Coercive control involves being aversive until another person makes some desired change in behavior. Though in that respect successful, such a strategy may reduce the probability that the other person will feel favorably inclined to do what is wanted in future exchanges, and thus calls for a repetition of the aversiveness. Although neither person would prefer such means of interpersonal influence, these strategies may become dominant as everything else seems to fail. Once established, such a pattern can be self-maintaining, and the original goals and commitments of the participants become lost. Biglan and Thorensen (1987) have described such a pattern in the marital interactions of chronic pain patients.

Influencing or Risk Factors

In a given case, what factors determine whether the support provider is likely to become overinvolved in the recipient's recovery, and thus ineffective as a helper? Below, we provide a summary of some factors that may influence the likelihood of a miscarried helping process.

Characteristics of the stressor are all important factors, with greater effort and sacrifice of the stressor are all important factors. The severity, duration, and trajectory required for more catastrophic, longer-term, and downhill trajectory illnesses or life changes (Litman, 1974; Van Uitert, Eberly, & Engdahl, 1985). However, the uncertainty or variability of the course of the stressor will also be an influencing factor: miscarried helping processes are more likely when there is a lack of clarity as to what can be reasonably expected in terms of outcome, as well as the extent to which it can be influenced by the efforts of the support provider or recipient. Situations in which symptoms and barriers to recovery are present at some times and absent at others may lead the support provider to assume that the distressed partner has more control over the symptoms and barriers than is really the case (Piening, 1984). Also, symptoms such as pain or depression, which are hard to validate externally, may be especially likely to engender suspicion on the part of the support provider that the partner is exaggerating the problem. Unfortunately, much of the subjective experiences of discomfort and dysfunction associated with various life stressors have an uncertain relationship to objectively defined disease (Eisenberg, 1980; Sternbach, 1968).

Orientations to the situation. A second set of factors that may influence the likelihood of miscarried helping is each partner's orientation to the crisis or life change (Piening, 1984). For instance, the extent to which the helper's investment in the coping process is an extension of the helper's commitment to the stressed person, rather than a matter of felt guilt or obligation, may be important. The potential for intrusiveness and overinvolvement may be enhanced by family members' sense of responsibility for the occurrence of the stress, or—in the case of a catastrophic event such as a stroke that has an irreversible negative impact—regrets that they did not behave more positively before the event. Such a sense of guilt is not uncommon. In a fifth of couples in which one partner had a myocardial infarction, either the patient, the spouse, or both believed that the spouse was responsible for the heart attack (Davidson, 1979; see also Kline & Warren, 1983).

The distressed individual's apparent responsibility for the onset of the crisis may also importantly affect the helping and coping process. The helping context, for instance, may be quite different for two men with

lung cancer if one had smoked two packs of cigarettes a day against his doctor's and wife's requests, and the other had never smoked. The former type of situation may increase the likelihood that the partner will become overinvolved, in a sense taking the stance, "Because you have handled things badly, you leave me no choice but to take over." Such a stance may be taken not only in cases in which the partner's lifestyle has contributed to the problem, but in cases in which the partner is unwilling to seek help or to follow the prescribed treatment regimen (Charmaz, 1983).

A related factor that may influence the likelihood of miscarried helping concerns the support provider's feelings of perceived choice about providing aid or the extent to which he or she anticipated that such help might be necessary. An older woman who married a man whom she knew was chronically ill may react quite differently to the burdens of care than a young wife whose spouse unexpectedly becomes quadriplegic. In one study of the wives of disabled men, several younger women made reference to the unexpectedness of their situation. As one wife expressed it, "I didn't expect this—mopping up the bathroom, changing him" (Fengler & Goodrich, 1979).

Tasks faced by the helper. An additional influencing factor is the kinds of tasks faced by the helper. Here, too, ambiguity is more conducive to miscarried helping. Some crises or life changes require particular types of help, and as a result there are clearly defined ways in which the support provider can be helpful without being overbearing or intrusive. There are thus opportunities for the support provider to manage his or her own distress with constructive action, but without the risk of usurping or challenging the autonomy of the recipient. The greatest difficulties are posed when the support provider has good cause to feel concerned or responsible, but no clear way of identifying how a satisfactory contribution to the distressed person's efforts can be made. A miscarried helping process is also more likely when the nature of the coping task is such that the support provider has little alternative but to passively endure prolonged awkwardness and repeated setbacks on the part of his or her distressed partner, even when aware that he or she could readily perform the task for the partner.

Network factors. A fourth factor concerns the wider network, or context, of the distressed individual and support provider. The availability of other family members or friends who can help shoulder the burden or provide understanding to the primary support provider may be especially important (Van Uitert et al., 1985). Evidence suggests that the likelihood of miscarried helping is reduced if the helper has other sources of esteem or involvement, such as work or leisure activities, in

addition to his or her relationship to the partner. These kinds of interactions may be useful to the helper for purposes of ventilation and validation (Bond, 1982a). Unfortunately this is often not the case in helping situations (Aronson et al., 1984; Mayou et al., 1978; Sands & Suzuki, 1983). Another important network factor is contact with health care providers. By informing both the patient and helper about what lies ahead, the health care provider may facilitate the coping process (Corbin & Strauss, 1984; Williamson, 1985). Again however, there is considerable evidence to suggest that family members often have little contact with such professionals and thus have little basis on which to develop a construction of the crisis that is based on accurate information (Bond, 1982b).

Relationship factors. Finally, the nature of the relationship between the support provider and the distressed partner is likely to play an important role during the coping process (Piening, 1984; Wishner & O'Brien, 1978). Several studies suggest that individuals in marriages judged to be unhappy before the crisis experience more stress and conflict following the event (e.g., Croog & Fitzgerald, 1978; Skelton & Dominian, 1973; Mayou et al., 1978). If the couple has a history of conflicted or inhibited communication, they may be unable to share feelings and reactions to the crisis that would facilitate subsequent exchanges between them. For example, a wife may be unable to share her feelings of vulnerability and impending loss triggered by her husband's heart attack. His awareness of these feelings, however, might have led him to avoid exerting himself in her presence, and thus led to less overprotectiveness on her part. Couples with a history of communication problems may also have difficulty sharing and negotiating tasks so that both parties are comfortable (Aronson et al., 1984). The wife may assume that she is "helping" her husband to do as much as possible for him; she may be unaware of the feelings of impotence that accompany myocardial infarctions, and his need to be able to do things for himself. Couples who communicate effectively are much more likely to develop a shared construction of the crisis, and of what needs to be done during the recovery period (Evans & Miller, 1984; Hill, 1970; Palmer et al., 1982; Swanson & Maruta, 1980). Later on in the recovery process, inhibited communication may make it difficult for the sensitive issue of the helper's needs and investments to be raised. In addition, the extent to which the distressed person can communicate appreciation for the sacrifice made by the helper may determine whether the help is a source of satisfaction or resentment.

As inevitable frustrations and setbacks occur, how the helper and stressed person handle hostility can take on critical importance. Kahn,

Coyne, and Margolin (1985) have suggested that distressed couples' inhibitions of the expression of negative feelings and their avoidance of conflict often coincide with chronic tension and a tendency to vent hostilities noncontingently (see also Palmer et al., 1982). Inhibition and avoidance allow the accumulation of unresolved issues, resentment, and guilt, so that when an overt disagreement does occur, it becomes the occasion for an intense and hurtful exchange with little opportunity for constructive problem solving. The futility and aversiveness of such exchanges encourages more inhibition and avoidance, which allows tension to build until another noxious exchange is precipitated. Researchers studying how families cope with chronic illness frequently comment on the tendency for family members to get caught in similar cycles of hostility, inhibition, and more hostility. In home hemodialysis, it has been emphasized that such patterns may interfere with spouse's needed participation in treatment:

Our impression has been ... that the "ideal" families for home dialysis are not the dedicated ones in whom dedication is often a reaction formation to aggression and guilt, but those with little tendency to guilt and high verbal aggression. Or, in other words, we prefer the husband who can quarrel with his wife and then connect her to the machine. (Kaplan-DeNour & Czackes, 1970, p. 218)

If inhibition of the expression of negative feelings has previously characterized the relationship, the frustrations that the partner and stressed person cause each other may aggravate the problem. However, the threat that overt conflict may adversely affect the stressed person may produce a communication problem where one did not exist. Among spouses of heart attack patients, for example, fear that a "wrong word" might kill their mate often results in decreased communication and marital estrangement. As one spouse put it, the situation "is like sitting on a keg of dynamite ... ready to ignite" (Stern & Pascale, 1978, p. 85).

In sum, these five sets of risk factors discussed above may influence whether the family's concern and caring will be channeled into constructive help, or whether it will give way to intrusiveness and to behaviors that undermine the distressed individual's own initiatives.

Implications for Interventions

In response to the growing concern about the psychological and economic costs of hospitalization, increasing pressure is being brought

to bear on families to provide care for a chronically ill or disabled family member. The present analysis suggests that such a situation has its own unique risks. Marital and family relationships may be the most important sources of support that a person can have, yet given the interdependencies they entail, they may have a particular vulnerability: namely, one person's emotional and material investments in the outcome of another's coping efforts can lead to a miscarried helping process. We have attempted to describe how this may unfold and how the concern and investment characterizing close relationships can, paradoxically, be a disadvantage.

The present analysis suggests a number of specific steps that can be taken by health care providers to minimize the likelihood that miscarried helping will occur. Professionals can improve the situation by helping the stressed person and family members to develop realistic expectations about the problem and about what lies ahead (Wishner & O'Brien, 1978). The present analysis suggests that it would be highly desirable to provide information to the stressed person and the support provider at the same time, as this may enhance the likelihood that they develop a shared construction of the situation. Ideally such information should be highly specific; general statements, such as "avoid overexertion" may be interpreted differently by the stressed person and the spouse (Bilodeau & Hackett, 1971). Health care professionals can also ameliorate the situation by providing guidance to family members about specific ways in which they can be helpful to the stressed person. In cases in which communication appears to be inhibited, the health care provider may be able to help the parties negotiate a division of labor and responsibilities with which both parties are comfortable.

As the situation continues, health care professionals can help by providing as much information as is available to validate the stressed person's symptoms. If the illness or problem has a variable course, it would also be desirable to explain this to both parties. Provision of such information should reduce the likelihood that the spouse will attribute problems and setbacks to the stressed person's lack of motivation.

A professional helper may be able to intervene in the process by describing the miscarried helping process, and by pointing out the dangers of overinvolvement on the part of the helper. Both parties can be helped to understand the importance of the support provider remaining involved in other activities, and in maintaining a support network outside of the marital relationship (Farkas, 1980; Fengler & Goodrich, 1979; Piening, 1984). Emphasizing this to the stressed person may make him or her feel less abandoned, as well as making the support provider feel less guilty, when he or she becomes involved in other

activities. The tendency of those who become ill to become self-focused and preoccupied with their situation might also be mentioned to both parties. Such a discussion may enhance the likelihood that the stressed person will make the effort to show appreciation for the sacrifices that are being made.

At the same time, the support provider's tendency to force the stressed individual to focus on the stressor might also be discussed. Similarly, information regarding care givers' needs to direct their stressed partners, to voice explicit expectations, or to monitor their progress closely may be helpful.

Discussions of how people may feel and act during the helping process may also be worthwhile. In an earlier study of support attempts tendered to the bereaved (Lehman et al., 1986), evidence suggested that although most individuals are able to identify the responses that would be most helpful to people in distress (such as allowing them to express their feelings), they often appear not to be able to execute these helpful support strategies in face-to-face interactions. Support providers often experience intense anxiety in their interactions with distressed individuals. There are many reasons why displays of distress from *intimates* may provoke the greatest amount of anxiety in helpers, as compared to displays of distress from strangers, casual acquaintances, and friends. Namely, close support providers: (1) may feel more responsible for alleviating their partner's distress; (2) may have a greater need and desire to see their partner get better because of both altruistic and selfish reasons; and (3) may become more frustrated by a lack of improvement by their partner over time.

The anxiety caused by these and other mechanisms may lead well-intentioned support providers to do and say things to their distressed partners that are, in fact, unhelpful. With proper intervention, it may be possible to teach people how to manage and control the anxieties inherent in their interactions with close associates.

Conclusion

The optimism of the social support literature concerning the benefits of social relationships may be well founded. As noted earlier, however, the social support literature includes very few studies that have focused on supportive exchanges and how they change over time, when a person is undergoing a significant life change. The present analysis suggests that it would be instructive to examine how the support provider and the distressed person's perceptions of the problem, and one another's

intentions, motivations, and behaviors change as the crisis unfolds. It would also be worthwhile to document the helping strategies that are employed as the situation evolves, and each party's judgments regarding the appropriateness of these strategies (compare Wortman & Lehman, 1985). With greater recognition of the pitfalls of emotional overinvolvement, we can develop more realistic expectations about helping relationships.

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About the Editor

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