Psychosocial outcomes in diabetes
Schokker, Marike Christina

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Chapter 2

The association between regulatory focus and distress in patients with a chronic disease: the moderating role of partner support

Marike C. Schokker, Thera P. Links, Marie Louise Luttik, Mariët Hagedoorn

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2.1 Introduction

A chronic illness can have quite an impact on a person's life. Many chronic illnesses require permanent life-style changes and self-management, for which the patient needs knowledge, skills, and discipline. Considering their difficult task, it is not surprising that a substantial minority of the patients develops psychosocial problems (for reviews, see Anderson, Freedland, Clouse, & Lustman, 2001; MacMahon & Lip, 2002; Schmier, Chan, & Leidy, 1998).

However, a large number of patients do not report elevated levels of distress, which raises the question what factors may protect patients from the experience of distress. Several studies demonstrated the importance of considering individual characteristics and coping skills of patients as influential factors (e.g., Bedi & Brown, 2005; Hesselink et al., 2004; Rose, Fliege, Hildebrandt, Schirop, & Klapp, 2002; Shnek, Irvine, Stewart, & Abbey, 2001; Skaff, Mulan, Fisher, & Chesla, 2003; Van Jaarsveld, Ranchor, Sanderman, Ormel, & Kempen, 2005).

In this study, we are interested in regulatory focus (Higgins, 1997, 1998; Lockwood, Jordan, & Kunda, 2002) as an individual characteristic that might predispose patients to experience either low or high levels of distress. Regulatory focus consists of two self-regulatory systems: self-regulation with a promotion focus and self-regulation with a prevention focus. A promotion focus refers to the extent to which one is focused on obtaining positive outcomes, whereas a prevention focus refers to the extent to which one is focused on avoiding negative outcomes. A person's regulatory focus is considered to be a stable individual difference variable which develops during interactions with caregivers in childhood. This notion is supported by studies that showed a relation between parenting styles and regulatory focus (Keller, 2008; Manian, Papadakis, Strauman, & Essex, 2006). Furthermore, persons can have either a strong promotion focus or a strong prevention focus, but it is also possible that a person has both a strong (or weak) prevention and promotion focus. This is also illustrated by the weak or nonsignificant associations that have been found between promotion and prevention focus in previous studies (Coolsen, 2004; Keller, 2006; Keller & Bless, 2006; Lockwood et al., 2002; Miller & Markman, 2007; Oyserman, Uskul, Yoder, Nesse, & Williams, 2007; Sullivan, Worth, Baldwin, & Rothman, 2006).

Some studies have put forward that overall, a strong promotion focus might be more adaptive than a weak promotion focus, while a weak prevention focus might be more adaptive than a strong prevention focus (Eiser, Eiser, & Greco, 2004; Miller & Markman, 2007). In a sample of students, a prevention focus was positively related to depressive symptoms ($r = .56$), whereas a promotion focus and depressive symptoms were negatively related ($r = -.50$; Miller & Markman, 2007). Another study of students found that a relatively
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strong prevention focus was associated with more depression, anxiety, and neuroticism, and less self-esteem, whereas a relatively strong promotion focus was associated with, for example, more self-esteem, agreeableness, and openness (Coolsen, 2004). Parents of survivors of childhood cancer who expressed a stronger prevention focus during an interview, reported less well-being than parents who expressed a weaker prevention focus (Eiser et al., 2004).

A related concept to regulatory focus is that of approach and avoidance goals. An approach goal is formulated in terms of trying to reach or achieve a positive outcome (cf. promotion focus) whereas an avoidance goal is formulated in terms of avoiding or preventing something (cf. prevention focus). A number of studies within this line of research deal with the question to what extent approach and avoidance goals are associated with well-being (for a review, see Elliot & Friedman, 2007). Within these studies people are asked to formulate their goals in their own words, after which each goal is coded by the researcher as either avoidance, or an approach goal. Numerous studies have demonstrated that a high proportion of avoidance goals relative to approach goals is associated with multiple negative consequences, like more physical symptoms (Elliot & Sheldon, 1998), lower perceived competence and autonomy (Elliot & Sheldon, 1998), and lower subjective well-being (Elliot & Church, 2002; Elliot & Sheldon, 1997; Elliot, Sheldon, & Church, 1997).

To conclude, research on regulatory focus and research on approach and avoidance goals suggests that persons with a relatively weak promotion focus and persons with a relatively strong prevention focus are more prone to experiencing negative psychological outcomes.

Regulatory focus has been mainly examined in student samples. However, it is not yet known how regulatory focus is related to psychological outcomes in older adults with a chronic disease. In our study, we selected patients with diabetes, asthma, or heart disease. These are all three chronic diseases in which the patient can exert control over the course of the disease by engaging in several self-management behaviors (see also Kuijer & De Ridder, 2003; Schreurs, Colland, Kuijer, De Ridder, & Van Elderen, 2003). In persons with a chronic disease imposing certain limitations and self-management tasks, it may be especially beneficial to focus on the positive outcomes that can be achieved, whereas a rather weak orientation towards positive outcomes will probably be maladaptive. Therefore, we expect that patients with a relatively weak promotion focus experience more distress than patients with a relatively strong promotion focus. Also, we expect that a relatively strong prevention focus is associated with more distress than a relatively weak prevention focus. Although the long-term goal within the context of chronic illness is often communicated to patients in terms of preventing the development of complications, we believe patients’ well-being is enhanced when they reframe this goal in terms of being
and staying fit and healthy. Put differently, patients will feel less distressed when they are less preoccupied with possible negative outcomes in the future (a weak prevention focus), and instead, are more focused on positive outcomes (a strong promotion focus).

Although a person's regulatory focus is considered to be a trait-like characteristic, one's current focus can also be situationally induced, for example by letting individuals describe personal experiences relevant either to achieving a positive or a negative outcome (Higgins, Roney, Crowe, & Hymes, 1994; Lockwood et al., 2002). Similarly, we posit that certain supportive behaviors of significant others may create either a promotion- or prevention-focused environment, directing patients to use either promotion- or prevention-focused strategies. Previous studies on chronic diseases demonstrating associations between support from the family and coping behaviors by the patient support this notion. For example, supportive behaviors that can be viewed as promotion-oriented, such as promoting self-care behaviors or stimulating a positive appraisal, were associated with adaptive coping behaviors, such as actively dealing with the disease by seeking information (cf. promotion-focused strategies). On the other hand, unsupportive behaviors that can be viewed as prevention-oriented, such as criticism or avoidance, were associated with maladaptive coping behaviors, such as avoiding thinking about the disease (cf. prevention-focused strategies). We argue that the promotion-focused environment a partner's supportive behavior is thought to create, may buffer patients with a weak promotion focus and/or a strong prevention focus against high distress. The prevention-focused environment that might be created by unsupportive behavior, may aggravate distress in patients with a weak promotion focus and/or a strong prevention focus.

Three Styles of Spousal Support

In this study, we assessed three support behaviors, namely, active engagement, protective buffering, and overprotection (Coyne, Ellard, & Smith, 1990; Coyne & Smith, 1991, 1994; Hagedoorn et al., 2000). Active engagement is a support behavior in which the partner uses constructive problem-solving methods, like involving the patient in discussions, inquiring how the patient feels and asking about the help and information needed. As this definition implies, active engagement is a support behavior in which the partner makes use of promotion-oriented support strategies. Protective buffering means hiding one's concerns, denying one's worries, concealing discouraging information, preventing the patient from thinking about the illness, and yielding in order to avoid disagreement. Overprotection means that the partner underestimates the patient's capabilities, resulting in unnecessary help, excessive praise for accomplishments, or attempts to restrict activities.
These latter-two support behaviors are more prevention-oriented in that partners who adopt these styles are focused on keeping the patient from being harmed.

Based on our theoretical outline, we derived the following hypotheses:

1. Patients' promotion focus will be negatively associated with distress.
2. Patients' prevention focus will be positively associated with distress.
3. Moreover, these associations will especially apply to patients who perceive their partner to be low in active engagement, to patients who perceive their partner to be high in protective buffering, and to patients who perceive their partner as highly overprotective. The highest levels of distress are expected in those patients with a weak promotion focus and/or a strong prevention focus combined with either low levels of active engagement, and/or high levels of protective buffering and overprotection.

### 2.2 Method

**Participants and Procedure**

The data used to test our hypotheses are part of a large national survey. Within this survey nine local district council offices from different areas in the Netherlands were asked for a random sample of addresses of 500-1000 persons of 55 years of age or older who were not living at the same address. In total 5500 individuals were invited to participate in the study. They received a questionnaire accompanied by an information letter by mail. Individuals who were willing to participate could return their completed questionnaire in a pre-stamped envelope. Anonymity and confidentiality was guaranteed. After three weeks a reminder letter was sent to everyone. In total, a number of 2497 respondents (45.4%) completed the questionnaire.

For the purposes of this study, we only used the data of respondents with an intimate partner and who reported having diabetes, asthma, or heart disease when presented a list with several health problems. There were 477 respondents (19.10%) with an intimate partner and who indicated having either one of the three chronic illnesses. This final subsample consisted of 356 men and 111 women, and 10 respondents for whom sex is unknown. The majority of the respondents (72.5%) reported having one or more other comorbidities besides diabetes, asthma, or heart disease, which may not be surprising because of the older age of the sample. The mean age was 67.76 years ($SD = 7.87$ years) and the mean duration of respondents' relationship was 40.19 years ($SD = 11.39$ years). The majority of the respondents (87.8%) were married.
Measures

Regulatory focus. Regulatory focus was assessed with the Regulatory Focus Questionnaire developed by Lockwood et al. (2002); Dutch translation by Van Stekelenburg and Klandermans (2003). It has been demonstrated that this questionnaire is related to the Behavioral Inhibition System/Behavioral Activation System (BIS/BAS) scales by Carver & White (1994), which measures approach and avoidance (Summerville & Roese, 2008). The Regulatory Focus Questionnaire consists of two subscales designed to measure promotion and prevention focus. Both subscales contain nine items and each item was rated on a seven-point scale ranging from 1 (totally disagree) to 7 (totally agree). A few adjustments were made, since some of the items of the original questionnaire focused on the academic domain, and therefore were not relevant to our sample. For example, in the items in which the original questionnaire referred to academic goals and ambitions, we removed the word 'academic'. Examples of promotion items are “I frequently imagine how I will achieve my hopes and aspirations”, and “In general, I am focused on achieving positive outcomes in my life” (M = 4.15, SD = 1.32, Cronbach’s α = .85). Examples of prevention items are “I am anxious that I will fall short of my responsibilities and obligations”, and “I often imagine myself experiencing bad things that I fear might happen to me” (M = 3.79, SD = 1.24, Cronbach’s α = .78).

Ways of giving support. We used a questionnaire developed by Buunk, Berkhuysen, Sanderman, and Nieuwland (1996) to assess three ways of partner support; active engagement, protective buffering, and overprotection. Respondents were asked to rate to what extent their partner adopted each support style in reaction to their illness. All items were measured on a five-point scale ranging from 1 (never) to 5 (very often). Buunk et al. (1996) reported adequate internal consistencies and test-retest reliabilities for the subscales regarding perceptions of patients who had suffered a myocardial infarction as well as their partners. Also, studies of persons coping with cancer found satisfactory internal consistencies (Hagedoorn et al., 2000; Hinnen, Hagedoorn, Sanderman, & Rancho, 2007; Kuijer et al., 2000). The subscale for active engagement consisted of five items. Examples are “My partner asks me how I feel”, and “When something bothers me, my partner tries to discuss the problem” (M = 3.90, SD = .78, Cronbach’s α = .88). The original subscale for protective buffering consisted of eight items. Examples are “My partner tries to hide his or her worries about me”, and “My partner gives in when I make an issue of something”. However, because the internal consistency was relatively low (Cronbach’s α = .61), three items were deleted, which increased the internal consistency (Cronbach’s α = .72, M = 2.39, SD = .74). Six items measured overprotection. Examples are “My partner treats me like a baby”, and “When it comes down to it, my partner seems to think that I don’t know what’s right for me” (M = 2.34, SD = .74, Cronbach’s α = .75).
Distress. Psychological distress was assessed with the 12-item version of the General Health Questionnaire (GHQ; Goldberg & Hillier, 1979; Werneke, Goldberg, Yalcin, & Ustun, 2000). The 12 items were summed into a total score, with a higher score indicating more psychological distress ($M = 10.28$, $SD = 4.95$, Cronbach’s $\alpha = .88$). An example item is “Lately, did you feel unhappy and low spirited/down?” ($0 = \text{not at all}, 3 = \text{much more than usual}$).

2.3 Results

Descriptives
Table 2.1 presents the correlations and means for the variables under study. Age was weakly positively associated with overprotection, and promotion and prevention focus. The three support styles were only weakly to moderately intercorrelated. Furthermore, overprotection showed a weak positive association with distress, whereas active engagement and distress showed a weak negative association. The associations between the support styles and the two regulatory foci were weak at most. The correlations between regulatory focus and distress were not entirely in line with our first two hypotheses. There was no significant association between promotion focus and distress and prevention focus was only weakly positively associated with distress. Further, the positive correlation between promotion and prevention focus was stronger than was expected in view of previous studies (Coolsen, 2004; Keller, 2006; Keller & Bless, 2006; Lockwood et al., 2002; Miller & Markman, 2007; Oyserman et al., 2007; Sullivan et al., 2006).

Table 2.1 Means, Standard Deviations, and Intercorrelations for the Variables under Study

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<td>.10*</td>
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<td>.01</td>
<td>.00</td>
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<td></td>
<td>10.28</td>
<td>4.95</td>
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Note. N varies as a result of missing values.
*p < .05, **p < .01.
We also tested whether gender and type of illness were associated with the variables under study. The only significant differences for gender were found on the three support styles. Men reported that their partner used more active engagement than women did ($M = 3.98$, $SD = .75$ vs. $M = 3.64$, $SD = .83$), $t = 3.84$, $p < .001$. Men also perceived their partner as more overprotective than women ($M = 2.44$, $SD = .71$ vs. $M = 1.95$, $SD = .69$), $t = 6.31$, $p < .001$. Women reported that their partner engaged more in protective buffering than men ($M = 2.33$, $SD = .72$ vs. $M = 2.56$, $SD = .79$), $t = -2.92$, $p < .01$. The only significant difference for type of illness was found on promotion focus $F(3,473) = 3.56$, $p = .03$. Post hoc tests indicated that patients with heart disease reported a significantly stronger promotion focus than patients with asthma ($M = 4.30$, $SD = 1.30$ vs. $M = 3.88$, $SD = 1.27$), $p = .02$.

Testing moderating effects
To test whether partner support (i.e., active engagement, protective buffering and overprotection) moderated the association between the patient’s regulatory focus and distress in patients, we conducted several hierarchical regression analyses. Number of comorbidities was associated with distress and was therefore included as a covariate in the analyses.

In consecutive steps, main effects (regulatory focus, either prevention or promotion focus, and support style, either active engagement, protective buffering, or overprotection) and interaction effects were examined. We avoided multicollinearity between the predictors and the interaction terms by computing the multiplicative functions as the products of the ‘centered’ scores on the component variables (Aiken & West, 1991). Distress was entered as the dependent variable. We calculated and plotted the regression slopes for patients high (+ 1 SD) and low (- 1 SD) on partner support, separately (Aiken & West, 1991).

Results of the regression analyses are depicted separately for promotion (Table 2.2) and prevention focus (Table 2.3). All the interactions between promotion focus and the three ways of support contributed significantly to psychological distress. These interaction effects were in line with hypothesis 3. Figure 2.1 depicts the results for promotion focus and active engagement. A promotion focus was negatively associated with psychological distress in patients. This effect was significant in patients who reported their partner showed relatively little active engagement ($B = -0.73$, $p < .01$), but not in patients who reported that their partner adopted this support style relatively often ($B = 0.31$, $p = .17$). Additional tests showed that, when promotion focus was weak, distress was significantly higher in patients who reported low levels of active engagement than patients who reported high levels of active engagement ($B = -1.87$, $p < .001$). In contrast, no significant difference between the two groups was observed in patients with a strong promotion focus ($B = -0.11$, $p = .79$).
Figure 2.2 presents the results for promotion focus and protective buffering. A promotion focus was negatively associated with psychological distress, but only in those patients who perceived their partner adopted the style of protective buffering relatively often ($B = -0.83, p < .001$). For patients who perceived their partner adopted this style seldom, the association was not significant ($B = 0.18, p = .42$). Further, the results showed that, when promotion focus was weak, distress was significantly higher in patients who reported high levels of protective buffering than patients who reported low levels of protective buffering ($B = 2.21, p < .001$). In contrast, no significant difference between the two groups was observed in patients with a strong promotion focus ($B = 0.41, p = .30$). Figure 2.3 presents the significant interaction of promotion focus and overprotection. Again as expected, a promotion focus was negatively associated with more psychological distress, but only in patients who perceived their partner as relatively overprotective ($B = -0.75, p < .01$). For patients who perceived their partner as less overprotective, this effect was not significant ($B = -0.03, p = .91$). Additional tests showed that, when promotion focus was weak, distress was significantly higher in patients who reported high levels of overprotection than patients who reported low levels of overprotection ($B = 1.85, p < .001$). In contrast, no significant difference between the two groups was observed in patients with a strong promotion focus ($B = 0.54, p = .19$).

For prevention focus we did find a main effect, but we did not find moderating effects of partner support, with the exception of overprotection (see Figure 2.4 for the depiction of this interaction effect). However, the shape of the interaction was different as expected. In contrast to hypothesis 3, a stronger prevention focus was associated with more distress in patients who perceived to be relatively little overprotected by their partner ($B = 0.75, p < .01$), but not in patients who perceived their partner as relatively overprotective ($B = 0.10, p = .70$). From Figure 2.4 it can be seen that patients who reported relatively low overprotection by their partner and who also reported a relatively weak prevention focus were relatively better off.
Table 2.2 Results of the Regression of Psychological Distress on Support Behavior and Promotion Focus

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Note. N varies as a result of missing values.
*p < .05; **p < .01.
Table 2.3 Results of the Regression of Psychological Distress on Support Behavior and Prevention Focus

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*Note. N varies as a result of missing values. *p < .05; **p < .01.
**Figure 2.1** The interactive effect of promotion focus and active engagement on psychological distress

![Graph showing the interactive effect of promotion focus and active engagement on psychological distress.](image)

**Figure 2.2** The interactive effect of promotion focus and protective buffering on psychological distress

![Graph showing the interactive effect of promotion focus and protective buffering on psychological distress.](image)
Figure 2.3 The interactive effect of promotion focus and overprotection on psychological distress

Figure 2.4 The interactive effect of prevention focus and overprotection on psychological distress
2.4 Discussion

Although the concept of regulatory focus has been extensively studied in student samples, this study is the first to investigate regulatory focus in a sample of older adults with a chronic disease requiring self-management behavior. In contrast with the study by Miller and Markman (2007), our study showed that promotion focus was not related to distress, and that prevention focus was only weakly related to distress. However, our results are in line with a recent study among women with breast cancer in which there was also no main effect of promotion focus on distress (Frieswijk & Hagedoorn, 2009).

Differences in findings may have to do with different types of samples (older age versus younger age, patient versus student). The weak positive correlation between prevention focus and distress, for example, might be explained by the older age of our sample. With increasing age, people may experience several losses, such as functional decline (Hebert, 1997) and a reduced capacity of working memory (Dobbs & Rule, 1989). Further, as shown in Table 2.1, the occurrence of a chronic illness and comorbidities become more prevalent with advancing age. This increasing salience of losses might lead older persons to become more focused on avoiding (further) losses, which would explain the correlation between age and prevention focus in our sample. In addition, under the circumstances of experiencing losses, a stronger prevention orientation would probably be less maladaptive than under the circumstances of being young and healthy. Although our sample of older adults scored lower on both prevention and promotion focus compared to the student samples in previous studies (all ts > 2.33, all ps < .05; Keller, 2008; Lockwood et al., 2002; Miller & Markman, 2007; Oyserman et al., 2007; Sullivan et al., 2006), the discrepancy between prevention and promotion was smaller compared to these student samples (all ts > 2.64, all ps < .01). Further, other studies did find that older adults reported a stronger goal orientation toward loss prevention (Ebner, Freund, & Baltes, 2006; Heckhausen, 1997). In addition, an orientation toward loss prevention was related to less well-being in younger adults, but no such negative association existed for older adults (Ebner et al., 2006).

The fact that our study on regulatory focus comprised a different type of sample might also explain the different associations between promotion and prevention focus that we found compared to other studies (Coolsen, 2004; Keller, 2006; Keller & Bless, 2006; Lockwood et al., 2002; Miller & Markman, 2007; Oyserman et al., 2007; Sullivan et al., 2006). While these other studies revealed rather weak correlations between the promotion and prevention subscales, (ranging from .05 to .27), our study showed a much stronger association between promotion and prevention focus (r = .57, p < .001), indicating that stronger prevention scores are associated with stronger promotion scores. The chronic diseases that were present in our sample, that is diabetes, asthma and heart disease,
require both promotion-focused and prevention-focused goals. Patients need to engage in short-term goals such as taking the right medication, keeping a healthy diet, exercising sufficiently, which indicates a need for a strong promotion focus. On the other hand, some of the long-term goals in the illness context are often communicated in prevention-focused terms, such as the prevention of complications. This means that patients (may feel the) need to focus on both positive outcomes as well as negative outcomes, which might explain the positive association between promotion and prevention focus. Another explanation for the rather strong association between promotion and prevention focus could be that our sample (older adults with a chronic illness) viewed the two subscales of prevention and promotion focus as one scale measuring goal-orientedness (see also Fellner, Holler, Kirchler, & Schabmann, 2007). Put differently, respondents in our sample may have looked upon prevention and promotion focus as two sides of the same coin.

Our hypothesis, that partner support would moderate the negative association between promotion focus and distress was confirmed. Although we could not detect a main effect of promotion focus on distress, our findings show that there is a negative association between promotion focus and distress in those patients who report to receive low levels of active engagement, and high levels of protective buffering and overprotection. The results are in line with the idea that promotion-oriented support (active engagement) encourages patients with a relatively weaker promotion focus to adopt promotion-oriented strategies and cognitions, leading to less distress. In contrast, behaviors like protective buffering and overprotection might induce a prevention-focused environment, which prevents patients with a relatively weak promotion focus further from adopting a more promotion-oriented mind set, thereby leading to more distress in these patients. To put it in other words, the results indicate that vulnerable patients, in terms of a relatively weak promotion focus, may benefit more, in terms of lower levels of distress, from supportive, promotion-oriented behaviors, whereas they may be harmed more by less supportive, prevention-oriented behaviors by the partner (cf. Hagedoorn et al., 2000).

Our results complement prior studies pointing out that social support might buffer or increase the negative impact of a vulnerable coping style or personality trait. For example, in patients with rheumatoid arthritis, it was found that unmitigated communion, an extreme focus on others to the exclusion of the self, was associated with distress, but only in those patients who reported high social constraints (Danoff-Burg, Revenson, Trudeau, & Paget, 2004). In cancer patients, high avoidance coping or behaviors in combination with low levels of social support predicted the highest levels of distress (Devine, Parker, Fouladi, & Cohen, 2003; Jacobsen et al., 2002).

Although we did find a main effect of prevention focus, in that a prevention focus was associated with more distress, this main effect was not moderated by partner support, except for overprotection. It was expected that a combination of a strong prevention focus
and a perception of high partner overprotectiveness would be problematic in terms of relatively high levels of distress. However, Figure 2.4 shows that either a strong prevention focus or high overprotectiveness is a sufficient prerequisite for experiencing relatively high levels of distress. Patients with a relatively weak prevention focus, who reported low levels of overprotectiveness, were found to show the lowest levels of distress. The fact that we could not find a moderating effect of active engagement and protective buffering suggests that unlike a lack of promotion focus, a relatively strong prevention focus cannot be compensated for by adequate partner support nor can its association with high distress be aggravated by inadequate partner support. It supports the idea that having a weak promotion focus is not the same as having a strong prevention focus. Future research may investigate under which circumstances a prevention focus is associated with distress.

The present study has a number of limitations that needs to be taken into account when interpreting the results. One limitation concerns our sample. We selected those respondents who reported having either diabetes, asthma, or heart disease when presented with a list of several health problems. However, we do not know for example the duration of their disease, or how well they were able to manage their disease, which might have an effect on regulatory focus and on partner support. Future studies should take into account such disease parameters.

A second limitation concerns our rather low response rate. Although this is what can be expected among elderly populations (Kaldenberg, Koenig, & Becker, 1994), we cannot exclude the possibility that any differences between responders and non-responders could have biased our results.

A third limitation is the cross-sectional design of our study which precludes us from drawing conclusions about causality. For example, there was a positive correlation between prevention focus and overprotection. This might indicate that a prevention focus in patients evokes overprotective behaviors from partners or that overprotection by partners leads to an adoption of a prevention focus in patients. However, it could also indicate that a prevention focus is associated with a negative outlook, and that this causes patients with a prevention focus to interpret partner behaviors negatively. Some studies provide preliminary evidence for this explanation. For example, one study showed that avoidance goals (cf. prevention focus) were associated with a more pessimistic evaluation of another person described in an essay (Strachman & Gable, 2006). It might therefore be interesting to include other measures of partner support, such as partners’ own perceptions of the support they provide, or observational measures.

Importantly, the third variable explanation is not very plausible with respect to the interaction effects, but we cannot conclude that a relatively weak promotion focus increases distress in patients who report to receive less active engagement, or more protective buffering or overprotection. Experimental studies are needed that establish
whether the manipulation of partner support styles that encourage either a promotion- or prevention-focused environment would lead to lower or higher levels of distress, especially in patients lacking a promotion focus.

More research is needed to draw final conclusions, but we can tentatively say that it appears that patients are psychologically better off when partner support stimulates a promotion focus in patients. Finally, our results do not necessarily have to represent a process only applicable to older persons with a chronic disease requiring self-management. It is quite possible that similar processes also apply to other stressful contexts besides having a chronic disease. Therefore, we would like to encourage future studies employing different samples to test the generalizability of our findings suggesting that supportive partner behavior weakens the negative link between promotion focus and distress in chronic diseases requiring self-management behaviors, while unsupportive partner behavior strengthens this link.

Footnotes

¹We also performed regression analyses with the original scale of protective buffering that consisted of eight items. The interaction effect between promotion focus and protective buffering remained significant, while the interaction effect between prevention focus and protective buffering remained nonsignificant.
References


Regulatory focus and partner support


