Perceived Overprotection: Support Gone Bad?

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Objectives. This article focuses on the effects of perceived overprotection, a potentially problematic aspect of receiving support, on the ability to adjust to a chronic impairment, specifically, age-related vision loss. Perceived overprotection is an especially critical issue in this population of chronically ill older adults because of the safety issues associated with vision impairment and because perceptions on the part of the older adult that the support providers are overprotective may lead to excess disability.

Methods. Participants were 584 older men and women with age-related vision impairment who applied for services at a vision rehabilitation agency. Path analysis was used to examine the effects of perceived overprotection on two positive indicators of adjustment: vision-specific adaptation and environmental mastery. Moreover, antecedents of perceived overprotection were examined.

Results. Higher levels of perceived overprotection were associated with less optimal adjustment to age-related vision loss, with lower scores on measures of vision-specific adaptation and environmental mastery. Higher levels of functional disability and instrumental support received were associated with higher levels of perceived overprotection.

Discussion. Findings indicate that support providers of older adults with visual impairment as well as vision rehabilitation service providers need to be aware of the detrimental impact of perceived overprotection.

For many older adults, an age-related decline in the ability to perform activities of daily living often means that family and friends have to assist with certain tasks, especially at the onset of a disability. Unfortunately, receipt of instrumental support may actually set the stage for older adults to perceive their support providers as being overprotective, which has been considered a problematic aspect of receiving support (Diehl & Willis, 2003; Thompson, Galbraith, Thomas, Swan, & Vrungos, 2002). Perceived overprotection is defined as “a perception on part of the ill adults that he/she is overhelped, induced to be dependent, shielded from stress, and generally not treated as an adult” (Thompson & Sobolew-Shubin, 1993a, p. 87). Individuals who perceive the care that they receive as overprotective have the feeling of being unnecessarily helped or overly restricted by support providers (Thompson & Sobolew-Shubin, 1993b).

Studies that have conceptualized perceived overprotection as such have found a relationship between perceived overprotection and the occurrence of depressive symptoms among stroke patients (Evans & Miller, 1984; Mulhall, 1978; Newman, 1984; Thompson & Sobolew-Shubin, 1993b; Thompson, Sobolew-Shubin, Graham, & Janigian, 1989), cancer patients (Kuijer et al., 2000; Thompson, 1992), and healthy, community-dwelling older adults (Thompson & Sobolew-Shubin, 1993a). The theory of learned helplessness (Seligman, 1992) has been used to explain the link between perceived overprotection and depression. Feelings of overprotection can lead to a sense of loss of control (Thompson & Pitts, 1992), and consequent helplessness can lead to depression (Avorn & Langer, 1982; Hyman, 1971; Thompson & Sobolew-Shubin, 1993a; Thompson & Spacapan, 1991).

Besides demonstrating the detrimental impact of perceived overprotection on depression, prior research has also documented its negative impact on rehabilitation outcomes. For instance, perceived overprotection among stroke patients led to the patients’ decreased motivation to work in physical therapy programs (Evans & Miller, 1984; Mulhall, 1978; Newman, 1984; Thompson, Sobolew-Shubin, Graham, & Janigian, 1989).

Studying overprotection in a functionally disabled population is particularly relevant, not only because experiencing a disability entails the reliance on help from others, but also because the negative effects of perceived overprotection may further exacerbate the impact of the disability already decreasing the older person’s sense of personal autonomy (Brandstädter & Rothermund, 1994; Nadien & Denmark, 1999; Schulz, Heckhausen, & O’Brien, 1994), and may, therefore, lead to excess disability. A common chronic health condition found among older adults is age-related vision loss, with 20% of Americans 65 years old and older reporting some type of vision problem even when using corrective lenses (Lighthouse Inc., 1995). Research has demonstrated that vision loss significantly predicts functional disability in older adults after controlling for age, gender, and comorbidity (Burmedi, 2003; Horowitz, 1994; Rubin, Roche, Prasada-Rao, & Fried, 1994) and, in fact, has been found to be the second most frequent chronic illness causing disability in elderly persons (Ford et al., 1998).

In a visually impaired population, overprotection can be viewed as an especially salient issue, not only because age-related vision loss represents a chronic disabling condition, but also because vision loss is often associated with falls and injuries (Tideiksaar, 1997). Therefore, the perception of older adults with visual impairments that their support network is overprotective might be especially likely among older adults with vision impairment because of the safety issues involved. But the role that is played by perceived overprotection in adaptation to a prototypical, age-related chronic impairment (vision loss) rather than an acute impairment (stroke) or potentially life-threatening illness (cancer), however, has not yet been explored in a systematic manner. Plus, the effects of perceived overprotection on positive aspects of psychological...
This research aims to determine if functional disability as well as the receipt of instrumental support function as predictors of perceived overprotection. Finally, it aims to determine if perceptions of overprotection mediate the effects of instrumental support received on the outcomes. Therefore, this research seeks to contribute to the conceptual knowledge about problematic aspects of support receipt that may hinder the psychosocial adjustment to chronic disabling conditions.

**Hypotheses**

Figure 1 depicts the conceptual model of the study. It is noted that, on the basis of prior work on perceived overprotection, demographic variables were not expected to play a role in the relationships among variables and thus were not included as predictor variables. According to the proposed conceptual model, we first hypothesized (in line with the first aim of the study) that increased levels of perceived overprotection will be associated with less optimal psychosocial adjustment to vision loss, specifically with decreased levels of environmental mastery as well as vision-specific adaptation. In line with the second aim of the study, it was hypothesized that increased levels of functional disability as well as instrumental support received would be associated with increased levels of perceived overprotection. Moreover, in line with the third aim of the study we hypothesized that perceived overprotection would mediate the effect of instrumental support on the outcomes with higher levels of instrumental support having a negative impact on outcomes through perceived overprotection. The predictions regarding the remaining pathways in the conceptual model were based on prior research. Prior research has shown that older adults with vision impairment activate instrumental support at the onset of a disability (e.g., Reinhardt, 2001). We, therefore, hypothesized that higher levels of functional disability will be associated with higher levels of instrumental support. Moreover, on the basis of prior research that has shown that having a disability impacts an older person’s sense of mastery (Brandstaedter & Rothermund, 1994) as well as adaptation (Reinhardt, 2001) independently of other factors, we hypothesized that functional disability would have an independent, negative effect on mastery and adaptation to vision loss.

**Methods**

**Participants and Procedures**

New applicants to a vision rehabilitation agency who were 65 years old or older were contacted by telephone. Study eligibility criteria (determined over the telephone) included: having a relatively recent vision impairment (onset of vision impairment within the past five years), being community-dwelling, having no prior use of vision rehabilitation services, being English-speaking, being free of cognitive impairments (assessed by the Mental Status Questionnaire; Pfeiffer, 1975), and being hearing intact for participation in an in-person interview. Of 1,052 eligible respondents, 55.5% (N = 584) participated. Study participants were compared with refusals on sociodemographic variables (gender, race, age, and marital status). Information on refusals was available from the consumer information system of the agency. Results showed that study participants were significantly more likely than refusals to be Caucasian, significantly younger than refusals, significantly more likely to have a vision impairment in the right eye than refusals, significantly more likely to have participated in a vision-related consumer information system of the agency. Results showed that study participants were significantly more likely than refusals to be Caucasian, significantly younger than refusals, significantly more likely to have a vision impairment in the right eye than refusals, significantly more likely to have participated in a vision-related consumer information system of the agency.
and more likely to be married than refusals. Trained, master’s level interviewers conducted in-home interviews prior to the participant receiving any vision rehabilitation services. Instruments were administered as part of a 90-min, comprehensive interview. Older adults were paid $25 for their participation.

Fifty-three percent of study participants were women, as a function of oversampling older males. The average age of participants was 80.4 years (SD = 7.6) with ages ranging between 65 and 100 years. The vast majority of participants were Caucasian (83.7%), 12.2% were African American, 3.6% were Hispanic, and 0.5% were from other races (e.g., Asian). Forty-one percent of participants reported that they were married, 43% were widowed, 9% were never married, and 7% were divorced or separated. Twenty-nine percent had less than a high school education, 25% were high-school graduates, 20% completed some college, 12% were college graduates, and another 13% went to graduate school. Regarding income adequacy, 4% indicated that they “can’t make ends meet,” 40% of participants indicated that they “just manage to get by,” 34% said that “money is not a problem” for them, and 22% had “enough money with a little extra.”

Measures

Functional disability.—Functional disability was assessed with a modified version of the Older Americans Resources and Services (OARS) Multidimensional Functional Assessment Questionnaire (Center for the Study of Aging and Human Development, 1975). The modified version, which has 4 additional items assessing functional tasks that may be affected by vision loss (difficulty identifying bills and coins, difficulty identifying one’s clothing, difficulty identifying food on one’s plate, and difficulty getting around in unfamiliar places), consists of 7 items assessing personal activities of daily living and 11 items assessing instrumental activities daily living. Respondents are asked how much difficulty they have performing these 18 activities of daily living by rating them on a 4-point scale (1 = no difficulty; 4 = can’t do without help). The point ratings of the 18 items were summed to create a total functional disability score ranging between 18 and 72, and $\alpha = .89$ for this sample.

Social support.—Received instrumental support was assessed for family and friends/neighbors separately. Each of these scales had 5 items which asked how often over the past month participants received help with shopping, housekeeping, transportation, mail, and finances (measured on a 6-point scale; 1 = not at all, 6 = every day). The content of the first 3 items was taken from the Arizona Social Support Interview (Barrera, Sandler, & Ramsay, 1981), and the other two were added as they pertain to types of help persons with vision impairment report receiving. For this analysis, scores from the family and friends/neighbors scales were combined to obtain a global indicator of received instrumental support. Reliability analyses of the present data produced $\alpha = .84$ for the Family Instrumental Support Scale and $\alpha = .77$ for the Friend Instrumental Support Scale. It is noted that received support (not perceived support) was studied, so that respondents would have something on which to base their judgment of overprotection.

Perceived overprotection from family and friends was measured using the 8-item short version of the Overprotection Scale for Adults (OPSA; Thompson & Sobolew-Shubin, 1993a). Respondents are asked to rate their degree of agreement or disagreement with statements regarding overprotection on a 4-point Likert scale (1 = strongly disagree; 4 = strongly agree). Sample items include: The people around me don’t let me do the things I could do myself,” “Sometimes those around me treat me like a small child,” “People do not think that I can take care of myself,” and “I feel comfortable asking my family and friends for help with things I can no longer do, because of my vision loss.” Reliability analyses of the present data showed $\alpha = .85$ for this sample.

Adjustment to vision loss.—Adjustment to vision loss was measured using an indicator of psychosocial well-being (environmental mastery) and an indicator of vision-specific adaptation (adaptation to vision loss). Environmental mastery was assessed using the Ryff and Keyes (1995) 9-item scale. Respondents are asked to rate (on a 4-point Likert scale) their degree of agreement or disagreement with statements regarding how much control they have over their surroundings (1 = strongly disagree; 4 = strongly agree). Sample items include: “In general, I feel I am in charge of the situation in which I live,” “The demands of everyday life often get me down,” “I do not fit very well with the people and the community around me,” and “I often feel overwhelmed by my responsibilities.” Scores can range between 9 and 36, and $\alpha = .78$ in the present sample.

Adaptation to vision loss was measured using the 14-item version of the Adaptation to Vision Loss (AVL) scale (Horowitz & Reinhart, 1998, 2005). Factor analysis of the scale indicates that although different aspects of psychosocial adaptation are reflected in the items (i.e., realistic acceptance of limitations associated with vision loss while concurrently recognizing continuing capabilities; openness of learning new ways of doing things through rehabilitation; and appropriate use of help from family members and friends), the scale is more consistent with a unidimensional measure (Horowitz & Reinhart, 2005). Using a 4-point Likert scale (1 = strongly agree; 4 = strongly disagree), participants were asked to respond to statements encompassing the above domains. Sample items are: “Visual impairment is the cause of all my problems,” “As a person with vision loss, I can become more independent by learning new ways of doing things,” and “I feel comfortable asking my family and friends for help with things I can no longer do, because of my vision loss.” Reliability analyses of the present data showed $\alpha = .85$ for the 14-item AVL scale.

RESULTS

Table 1 reports sample size, means, standard deviations, possible and actual ranges, skew, and kurtosis for all study variables. Bivariate correlations for all study variables are listed in Table 2. Both higher environmental mastery and higher scores on the AVL scale were significantly associated with lower functional disability, lower amount of instrumental support received, and lower perceived overprotection. Perceived overprotection was significantly, positively associated with both functional disability and instrumental support. The two outcome measures were significantly positively (but...
moderately) correlated. In addition, to ensure that perceived overprotection was not related to demographic characteristics, bivariate correlation analyses were conducted between perceived overprotection and the major demographic variables, i.e., age, gender, race, and marital status. These bivariate correlations did not show any significant relationships with levels of perceived overprotection. Therefore, demographic variables were not included in the analytic model.

Path analysis as suggested by Raykov and Marcoulides (2000) using LISREL (Joreskog & Soerbom, 1999) was used to test the proposed conceptual model allowing for examination of both direct and indirect effects of independent and mediating variables on outcome variables. The current data (listwise n = 569) met assumptions of multivariate normality with a relative multivariate kurtosis of 1.10. The type of estimation used was maximum likelihood. When the proposed conceptual model was fit to the data it yielded a satisfactory fit ($\chi^2$[2, N = 569] = 1.62; $p = .45$; Adjusted Goodness of Fit Index [AGFI] = .99; Normed Fit Index [NFI] = 1.00; Root Mean Square Error Approximation [RMSEA] = .00; Comparative Fit Index [CFI] = 1.00). Models with an AGFI, NFI, and CFI in the mid-90s or above represent a reasonably good fit to the data (Hu & Bentler, 1999). Moreover, Browne and Cudeck (1993) have suggested that an RMSEA should be below .08 for models that fit the data well.

Table 3 contains direct and indirect parameter estimates for all variables. To test the first study hypothesis, the direct paths between perceived overprotection and the outcome variables were examined. Results show that there was a significant direct, negative effect of overprotection on environmental mastery ($\beta = -.21$) as well as on adaptation to vision loss ($\beta = -.23$). Results also confirm the second hypothesis with regard to antecedents of perceived overprotection in that both functional disability and instrumental support had a significant direct, positive effect on perceived overprotection ($\beta = .29$ and $\beta = .18$, respectively). The third study hypothesis was also confirmed: Instrumental support had a significant, indirect negative effect on environmental mastery ($\beta = -.04$) and adaptation to vision loss ($\beta = -.04$) through perceived overprotection. Finally, functional disability as predicted based on prior research not only had a significant direct, positive effect on instrumental support ($\beta = .28$), but also had a significant direct, negative effect on environmental mastery ($\beta = -.37$) and adaptation to vision loss ($\beta = -.41$), the two indicators of adjustment.

**DISCUSSION**

The primary goal of this research was to investigate the impact of perceived overprotection, a problematic aspect of support receipt, on adjustment to age-related vision loss, a chronic and disabling condition. The research was intended to broaden prior work on the role of problematic types of support receipt in adjusting to late life disability. As hypothesized, findings demonstrated that perceived overprotection was associated with less optimal adjustment, manifested in lower levels of mastery and lower levels of adaptation to vision loss. This finding adds to previous research conducted with stroke patients (Evans & Miller, 1984; Mulhall, 1978; Newman, 1984; Thompson & Sobolew-Shubin, 1993b; Thompson et al., 1989), cancer patients (Thompson, 1992), and healthy, community-dwelling older adults (Thompson & Sobolew-Shubin, 1993a) for whom perceived overprotection has been found to be associated with significant depressive symptoms. The current research used positive outcomes, environmental mastery, an indicator of well-being, and a vision-specific adaptational measure. It appears that in addition to perceived overprotection being related to negative outcomes (depression), it also influences positive outcomes such as one’s sense of mastery and the ability to cope with an age-related stressor, such as a decline in vision.

Findings also demonstrated that functional disability resulted in increased feelings of perceived overprotection from family, friends, and neighbors in this sample of visually impaired older adults. This may be due to association of vision impairment with increased risk of falls and injuries (Tideiksaar, 1997), which in turn results in relatives and friends being concerned about and involved in the safety and well-being of the older adult. This concern and involvement may result in the perception of one’s support providers as overprotective.

In addition, the finding that higher levels of instrumental support resulted in higher levels of perceived overprotection...
with their family members and sometimes friends, can address work very closely with the visually impaired persons, but also loss. Moreover, the research has implications for raising the awareness that perceptions of overprotective care have detrimental risks surrounding this problematic aspect of receiving support. Consequently, having support groups for family members and friends (as part of the rehabilitation process) could raise awareness of overprotection represents an initial reaction to the support that older adults receive at the onset of a disability. Subsequently, feelings of overprotection may subside after the receipt of vision rehabilitation services, which focus on teaching independent living skills. Future research may also focus on the study of additional social support predictors of perceived overprotection, such as negative interactions, and perceived adequacy of both instrumental and emotional supports. Moreover, the inclusion of support providers in addition to support recipients in future research will further the identification of the antecedents and dynamics of perceived overprotection.

Despite its limitations, this study has practical implications for the development and design of vision rehabilitation services which aim to teach visually impaired individuals to maximize their functional ability and to enable them to lead more independent lives despite having a disability. Findings point toward programs, such as support groups, that include support providers of visually impaired older adults and that address issues around perceived overprotection as well as the potential risks surrounding this problematic aspect of receiving support. Consequently, having support groups for family members and friends (as part of the rehabilitation process) could raise awareness that perceptions of overprotective care have detrimental effects on the older adult’s ability to adjust to age-related vision loss. Moreover, the research has implications for raising the awareness about perceived overprotection among vision rehabilitation providers working with elderly persons and their families. These service providers, who in many cases not only work very closely with the visually impaired persons, but also with their family members and sometimes friends, can address issues around perceptions of overprotection in the course of service provision and help to promote optimal adjustment to age-related vision loss.

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