Motivations for Caregiving in Adult Intimate Relationships: Influences on Caregiving Behavior and Relationship Functioning

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Motivations for Caregiving in Adult Intimate Relationships: Influences on Caregiving Behavior and Relationship Functioning

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*This study identified and examined the correlates of specific motivations for caregiving in romantic couples (*N = *194 couples). At Time 1, couple members completed measures assessing motivations for caregiving, the quality of caregiving that occurs in the relationship, and personal and relationship characteristics that might influence caregiving motivations. Relationship functioning was then assessed 2 to 3 months later. Results revealed that (a) there are a number of distinct motivations for providing and for* not *providing care to one's partner, (b) the motivations are associated with various personal features of the caregiver and the recipient, (c) the caregiver's perceptions of the relationship influence his or her caregiving motives, (d) different motivations for caregiving predict different patterns of caregiving behavior, and (e) responsive caregiving predicts the recipient's perceptions of healthy relationship functioning both immediately and over time. Implications of identifying the motivations that promote or inhibit the provision of responsive support in intimate relationships are discussed.*

Keywords*: motivation; caregiving; social support; couples*

A large body of literature indicates that receiving social support helps people cope more effectively with stressful life events and may have long-term benefits for psychological and physical well-being (e.g., Cohen & Syme, 1985). However, we still know surprisingly little about the specific personal and interpersonal mechanisms that determine the quality of care that relationship partners provide to one another. One reason for this gap is that prior research on social support has tended to focus on the support recipient and much less attention has been paid to the support provider. As a result, we know very little about the specific, underlying motivations that lead individuals to be responsive or unresponsive support providers or about the ways in which these motives shape the quality of care that partners provide to one another. To address these gaps, the current investigation provides a first, in-depth examination of caregiving motivations in adult relationships. The primary goal of this investigation is to identify the specific types of motivations that adults have for providing (and for not providing) support/care to their partners. Additional goals are to examine (a) individual difference factors that are associated with, and likely to be important predictors of, these different motivations, (b) the degree to which different motivations are associated with different patterns of caregiving behavior, and (c) the influence of caregiving behavior on relationship functioning over time.

Why Study Caregiving Motivations?

The caregiving role is a complex one that requires individuals to respond flexibly to a wide range of needs as they arise. Because caregiving often involves a good deal of responsibility, as well as cognitive, emotional, and sometimes tangible resources, caregivers must be motivated to accept that responsibility and expend the time and effort required to provide effective support. If care-

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givers are not sufficiently motivated, then it is likely that they will provide either low levels of support or ineffective forms of support that are out of synch with their partner's needs. However, there currently exists no research in the relationships literature that has examined the specific motivations that underlie the provision of care/support. Research in the helping literature has examined motivations for helping strangers (generally as a bystander in an emergency); however, no comparable work has been done with regard to helping close relationship partners. Because caregiving motivations are likely to play an important role in determining the quality of caregiving that is given in a relationship, it is important to first identify the specific types of motives that relationship partners have for providing (and not providing) care to one another and then to examine the influence of these motivations on patterns of caregiving behavior. Romantic relationships were targeted for this investigation because many adults come to rely heavily on their romantic partner as an important source of support and care and because motivations for providing care/support have not been examined in this context (see Feeney & Collins, 2001, for an exception, which provides a preliminary examination of the degree to which a global assessment of altruistic versus egoistic caregiving motivation, among a variety of other personal and relationship factors, predicts caregiving quality; the current investigation extends this prior work by identifying and examining the predictors and influence of specific types of caregiving motivations).

What Motivates Individuals to Provide (or to Not Provide) Support/Care to Intimate Partners?

The first goal of this investigation was to identify the specific motivations that individuals have for providing support/care to their relationship partners. In doing so, we drew from several relevant theoretical perspectives.

Helping literature. We began by turning to the social psychological literature on helping, which has examined motivations for helping strangers. Attempts to understand what motivates people to help strangers have focused on three general explanations (see Schroeder, Penner, Dovidio, & Piliavin, 1995, for a review). First, according to the *learning* approach, people are motivated to help others because they have been reinforced for helping in the past. Conversely, people may *not* help others because they have learned that helping leads to negative consequences. People may learn about these consequences either through direct experience or through social learning (observing others' behavior and consequences).

A second explanation focuses on social *norms* and argues that people are motivated to follow rules for accepted and expected behavior (Schroeder et al., 1995). For example, people may follow the norm of reciprocity (helping to reciprocate help that one has received in the past), an equity norm (helping to maintain a fair proportion of inputs and outputs), and/or a norm of social responsibility (helping because social norms dictate that one should).

A third explanation focuses on the influences of *arousal and emotion.* According to this perspective, specific emotions may motivate people to help others. For example, feelings of sympathy may increase helping, whereas feelings of anger may inhibit helping. Researchers also have shown that guilt (for a previous transgression) and other negative motivations (e.g., sadness) may be powerful motivators of helping (Regan, Williams, & Sparling, 1972; Salovey, Mayer, & Rosenhan, 1991). Negative moods are thought to promote helping because helping behavior can attenuate negative moods (see Cialdini et al., 1987, for a description of the negative-state relief model; Piliavin, Dovidio, Gaertner, & Clark, 1981, for a description of the arousal cost-reward model).

All of these motivations for helping are thought to be hedonistic in that people are helping others to benefit themselves. However, according to Batson's empathy-altruism hypothesis (Batson, 1991), empathic concern produces an altruistic motivation to reduce the other person's distress and improve the other person's welfare. Batson argues that there are egoistic motives for helping (helping to gain rewards or avoid punishment, helping to reduce one's own arousal) and altruistic motives for helping (helping to reduce the other person's need/arousal). Egoistic motivations involve benefiting another as a means to self-benefit. Some egoistic motives include helping because the individual has an interest in the activity, to obtain a feeling of power, as a result of feelings of obligation, to obtain a reward, and out of a desire for social contact (Reddy, 1980; Schroeder et al., 1995). In contrast, altruistic motivations for helping involve benefiting another as an end in itself, that is, benefiting others is an ultimate goal in its own right and any associated self-benefits are unintended consequences. The existence of altruistic versus egoistic motivations for helping has been a major source of controversy in the helping literature. However, proponents of each position have provided evidence indicating that both egoistic motivation (e.g., Cialdini et al., 1987) and altruistic motivation (e.g., Batson et al., 1991) may underlie helping behaviors.

Motivational systems. Other perspectives that are useful for identifying motivations for caregiving within the context of close relationships involve theories of motivational processes (e.g., Carver, 1996; Carver & White, 1994; Diener & Emmons, 1984; Gray, 1987; Higgins, 1998) that postulate the existence of distinct appetitive

and aversive motivational systems. According to Gray's (1987) neuropsychological model of motivation, the behavioral approach system (BAS) and the behavioral inhibition system (BIS) underlie most behavioral and emotional responses to environmental stimuli. Specifically, the BAS is an appetitive system that motivates behavior in response to signals indicating that acting to gain a reward or to avoid something unpleasant would be associated with the most desirable outcomes (Gray, 1972, 1994). Thus, the BAS activates behavior in response to signals of reward and nonpunishment (incentives) and is associated with approach behaviors. The BIS, on the other hand, is an aversive motivational system that prevents, inhibits, or restricts behavior in response to signals indicating that *not* acting to avoid punishment, or *not* acting because no rewards can be obtained, would be associated with the most desirable outcomes. Thus, the BIS inhibits behavior in response to signals of punishment, threat, and nonreward and is associated with avoidance behaviors (Gray, 1972, 1994). BIS and BAS are thought to be two independent systems, each of which becomes activated (through separate neural mechanisms) in response to specific environmental stimuli, resulting in distinct behavioral outcomes. Thus, in identifying different motives for caregiving in close relationships, it will be important to explore not only the factors that promote caregiving behavior (appetitive motives) but also those that inhibit such behavior (aversive motives). Although the BIS/BAS model has not been applied to social support behavior, Gable, Reis, and Elliot (2000) provide initial evidence for the importance of distinguishing appetitive and aversive motivational systems in the context of close relationships.

Attachment theory provides another theoretical perspective for understanding motivations to provide support. Attachment theory postulates the existence of a caregiving system, which is thought to be a behavioral safety-regulating system that becomes activated in response to a significant other's distress (Bowlby, 1982). This system motivates people to provide comfort and support to significant others, which serves to reduce the risk of close others coming to harm (Bowlby, 1982). Although the goal of this system is to motivate caregiving behavior, there are likely to be individual differences in the strength of eliciting events that activate the system. For example, avoidant caregivers may avoid activation of the caregiving system (perhaps by strategically being inattentive to environmental cues that signal a need for caregiving), whereas anxious caregivers may attempt to override its activation because their own attachment needs are viewed as more pressing. In addition, there are likely to be individual differences in the ways in which different caregivers seek to deactivate the system once it has been activated. For example, avoidant caregivers may be motivated to deactivate the system quickly by whatever means possible (resulting in less responsive and effective caregiving), whereas secure caregivers may be motivated to respond in a way that will be most helpful to the recipient.

Hypotheses. Theories of helping, motivation, and attachment allow us to identify the types of motives that are likely to underlie the provision of support/care in intimate relationships. First, it is likely that motivations for caregiving can be either egoistically or altruistically motivated. Second, it is likely that some caregiving motives are appetitively based (*promoting* the provision of support/care) and some are aversively based (*inhibiting* the provision of support/care). Based on these assumptions, we developed a preliminary measure designed to assess distinct motivations that underlie caregiving in intimate relationships. This measure was divided into two sections, one that assessed motives for helping (the appetitive system) and one that assessed motives for *not* helping (the aversive system).

First, we reasoned that individuals have a variety of motivations for helping their relationship partners, which reflect the functioning of the behavioral approach system. Furthermore, we expected that some of these motives are relatively altruistic and some relatively egoistic. For example, consistent with the empathy-altruism link identified in the helping literature, we expected that some caregivers may be altruistically motivated to help their relationship partners because they feel love, concern, and responsibility for them and truly wish to reduce their partners' need/distress. Nevertheless, we expected that even close relationship partners may sometimes provide care/support to get some type of reward (e.g., to be praised, to receive help in return, to feel in control, to reduce one's own anxiety) or to fulfill obligations and avoid unpleasant consequences for not helping (e.g., to avoid feelings of guilt, to avoid the wrath of a displeased partner, to avoid making a bad impression, to make up for a past transgression). Other egoistic motivations that individuals may report for helping relationship partners include helping for strategic relationship purposes (e.g., to keep the partner in the relationship) and helping because the caregiver perceives his or her partner to be incapable of handling problems on his or her own, a motive that may appear to be altruistic but may instead be perceived as burdensome and obligatory for the caregiver.

Second, we reasoned that caregivers would have a variety of motivations for *not* helping their relationship partners, which reflect the functioning of the behavioral inhibition system. For example, some individuals may have learned that helping leads to negative (or at least unrewarding) consequences, perhaps because one's partner is difficult to help and unappreciative of one's

support efforts, because one's partner is too dependent and expects too much, or because distress is perceived as aversive. Additional reasons for not providing care/support to relationship partners may involve a lack of resources (e.g., time and energy), a perceived lack of skill with regard to helping others, a lack of concern and responsibility for one's partner, and perceptions that the partner is capable of handling problems on his or her own.

From Where Do These Motives Come?

Another goal of this investigation was to examine features of the caregiver, the recipient, and the relationship that may be associated with caregivers' motives for helping and for not helping their partners. According to the principles of learning theory, people can learn about the consequences of helping and thus develop particular motivations for helping significant others, either through direct experience or through social learning. Therefore, we hypothesized that caregivers who report a supportive relationship history with their own caregivers (parents) will report more altruistic motivations (feelings of love, concern, and responsibility) and less egoistic motivations (e.g., reward seeking, obligation) for caring for their relationship partners. We further anticipated that an unsupportive relationship history would be associated with specific motives for not caregiving, including a perceived lack of skills, a dislike of distress, and a lack of concern/responsibility for one's partner.

We also expected that chronic personality characteristics of both the caregiver and the recipient would be associated with caregiving motivations. First, we previously reported that insecure caregiver attachment is associated with an overall index of egoistic motivations for providing care (Feeney & Collins, 2001). In the current investigation, we expected that different types of insecurity would be associated with different types of egoistic motives. Specifically, because individuals with an avoidant attachment style tend to emphasize self-reliance (Hazan & Shaver, 1987), we expected these caregivers' support efforts to be motivated primarily by opportunities for reward and feelings of obligation. We also expected avoidant caregivers to report not helping their partners because they dislike distress, lack feelings of responsibility, and feel their partner is too dependent. Because anxious individuals tend to be dependent on others' acceptance of them for a sense of personal well-being (Hazan & Shaver, 1987), we expected these caregivers' support efforts to be motivated primarily by a desire to meet strategic relationship goals (e.g., closeness, control) and an obligatory desire to avoid negative consequences (e.g., rejection).

Other characteristics of the caregiver and the support-recipient, including self-esteem and depression, were expected to influence caregiving motivations. For example, we expected that caregivers who have partners who are depressed and have low self-esteem would report that they help their partners primarily because they perceive their partners as being needy and incapable of handling problems on their own and because they feel obligated to help. Furthermore, we expected that caregivers of depressed and low self-esteem partners would report not helping because their partner is difficult to help, is perceived to be too dependent, and because the caregiver feels that he or she lacks knowledge regarding how to help the partner.

Finally, we expected that the caregiver's reports of the quality of his or her relationship would influence caregiver motivation. Specifically, we predicted that people who are involved in happy, satisfying, and trusting relationships would be more likely to endorse altruistic motives for helping their partners (feelings of love, concern, and responsibility for one's partner) and less likely to endorse egoistic or hedonistic reasons for helping (feeling obligated to help, hoping to be rewarded for helping). Finally, we expected that caregiver reports of poor relationship functioning (i.e., high levels of conflict) would be associated with the aversive motivations for not caring for one's partner (e.g., not helping because the partner is difficult to help, because the caregiver lacks feelings of responsibility, because the caregiver dislikes expressions of distress). No specific hypotheses were advanced regarding gender differences in caregiving motives.

What Implications Do These Motives Have for Caregiving Behavior?

An important reason for identifying caregiving motives is that they should play a central role in determining the quality of care that individuals actually provide. In a previous report, we showed that a general index of egoistic motivations for caring was associated with ineffective forms of support (Feeney & Collins, 2001). The current investigation takes a more in-depth look at the influence of specific types of caregiving motives (both for providing and for not providing support) on caregiving outcomes.

In general, we hypothesized that individuals who are egoistically motivated to care for their partners are likely to provide poor, unresponsive caregiving, mainly because they are likely to provide the type of caregiving that is more beneficial to *themselves* than to the partner (e.g., convincing a partner that his or her problem is unimportant to alleviate one's *own* distress or time commitment). Moreover, we anticipated that different types of egoistic motives would be associated with different

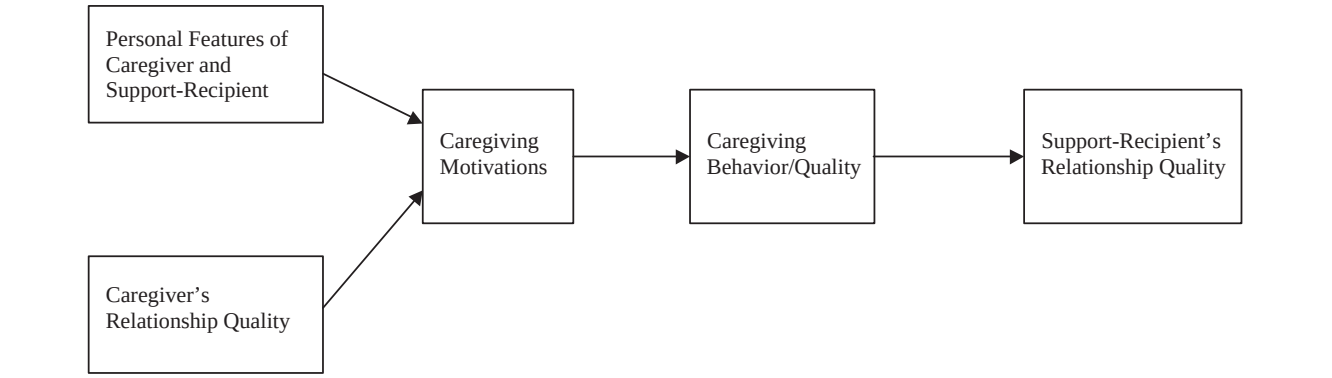

Figure 1 General conceptual model depicting hypothesized relations among variables.

types of ineffective caregiving. Specifically, individuals who care for their partner to gain strategic relationship rewards (e.g., helping to make their partner dependent) are likely to be compulsive (overinvolved) caregivers, whereas individuals who report obligation motives (e.g., helping to avoid negative consequences) are likely to be the more controlling caregivers. In contrast, individuals who are relatively altruistically motivated to care for their partners (e.g., out of a genuine concern for the partner's well-being) are likely to provide more responsive caregiving mainly because they are likely to provide the type of support that is dictated by the *partner's* needs.

How Does Caregiving Behavior Influence the Quality of Relationships Over Time?

A final goal of this investigation was to examine the degree to which caregiving quality predicts the support-recipient's reports of relationship quality over time. This was important to examine because warm and responsive caregiving should be central to the development of secure, well-functioning relationships in adulthood, just as it is in childhood with parent/child dyads (Collins & Feeney, 2000). Thus, the hypotheses revolve around dyadic effects in which one partner's caregiving behavior predicts the other partner's relationship outcomes. Specifically, we expected that higher levels of responsive caregiving (and lower levels of controlling and compulsive caregiving) provided by the caregiver at Time 1 would be associated with high levels of relationship satisfaction and trust, and with low levels of relationship conflict, reported by the support recipient 2 to 3 months later (at Time 2).

Summary

In summary, the goals of this investigation are to identify the specific motives that individuals have for providing and for not providing care to their romantic partners and to identify some potential correlates (predictors and outcomes) of these motives. A general conceptual model depicting the proposed pattern of relationships among variables is presented in Figure 1. It is expected that characteristics of the caregiver, recipient, and relationship will predict caregiving motives, which should, in turn, predict caregiving quality. Caregiving quality is expected to predict relationship functioning over time. This article will provide an in-depth examination of the links depicted in the model.

METHOD

Participants

Time 1. Participants were 202 couples from the State University of New York at Buffalo and the University of California, Santa Barbara, who participated in a larger investigation of caregiving processes in adulthood.[1] Couple members participated at three time points as part of the larger investigation; however, only two phases are relevant for the current article.[2] For each phase of the study, one member of the couple was designated as the "support recipient" and his or her romantic partner was designated as the "caregiver." The mean age of support recipients was 19.1 (range = 17-33) and the mean age of caregivers was 19.5 (range = 17-28). Couples had been romantically involved for an average of 14.4 months (range = 1-95) and all were heterosexual. The majority of couples were involved in dating relationships (93%) and a small percentage were either married or engaged to be married (7%). Of the 202 original couples, 8 couples were excluded from data analyses, either because they were not proficient in English or because their involvement in an established romantic relationship was questionable. Of the remaining 194 couples, 111 men and 83 women were assigned to the caregiver role.[3]

Materials and Procedure

Time 1. Couple members completed questionnaires in separate, private rooms. These questionnaires

included a measure of motivations for caring for one's partner and a measure of motivations for *not* providing support/care to one's partner. Both measures, each consisting of 40 items, were designed specifically for use in this study. For the *Motivations for Caregiving* measure, participants were presented with the phrase, "On occasions when I help my partner, I generally do so because . . . " and then were asked to rate a series of motivations on a scale from 1 (*strongly disagree*) to 6 (*strongly agree*). Sample items include, "I love my partner and am concerned about my partner's well-being" and "I want to avoid negative consequences from my partner (e.g., my partner would get angry)." This measure was designed to assess a variety of egoistic motives (e.g., feeling obligated, wanting to benefit the self) and relatively altruistic motives (e.g., love and concern for partner motives) for helping one's partner. For the *Motivations for Not Caregiving* measure, participants were presented with the phrase, "On occasions when I *don't* help my partner, I generally don't do it because . . . " and then were asked to rate a series of motivations on the same 6-point scale (e.g., "My partner doesn't appreciate my helping efforts"; "I don't like to hear about problems"). This scale was developed to identify various motives for *not* helping one's partner (e.g., dislike of distress, lack of concern and responsibility, lack of skills). Both measures were designed to identify and examine the full range of motivations that individuals are likely to have for providing and for not providing care to a romantic partner. Detailed analyses regarding the identification and reliability of specific subscales, as well as the predictive validity of these subscales, are presented below.

Participants also completed measures of various individual difference factors that might be associated with caregiving motivations. These included measures of attachment style, self-esteem, depression, and history of support/nurturance from parents. Attachment style was measured using Brennan, Clark, and Shaver's (1998) 36-item measure, which contains two subscales: The *Avoidance* subscale (α = .92) measures the extent to which a person is comfortable with closeness and intimacy as well as the degree to which a person feels that others can be relied on to be available when needed. The *Anxiety* subscale (α = .92) measures the extent to which a person is worried about being rejected, abandoned, or unloved. The avoidance and anxiety dimensions were not significantly correlated with each other (r = .12, *ns*). *Self-esteem* was assessed with Rosenberg's (1965) 10-item scale (α = .86). *Depression* was assessed with an abbreviated (16-item) version of the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977) (α = .81). To assess history of support/nurturance from parents, participants rated 29 adjectives describing their relationship with their mother (or primary female guardian) while growing up and the same 29 adjectives describing their relationship with their father (or primary male guardian). Thirteen adjectives assessed warmth and acceptance (e.g., supportive, nurturing) and 16 items assessed coldness and rejection (e.g., neglecting, angry). An index of warm/accepting history with each parent was computed by reverse-scoring responses to the negative adjectives and then averaging all 29 items (α = .96 for mother, α = .96 for father). Finally, a composite index of *supportive history with parents* was computed by averaging the subscales for mother and father (α = .96).

Participants also completed measures of relationship factors that were expected to be associated with caregiving motivation. These included measures of satisfaction, conflict, and trust. *Relationship satisfaction* (α = .91) was measured using the four items employed by Van Lange et al. (1997) and two additional items from Collins and Read (1990). These items assessed the degree to which respondents felt happy and satisfied with their current relationship. *Relationship conflict* (α = .90) was measured using six items (Collins & Read, 1990) assessing the degree to which respondents argue with their partners and get on each other's nerves. *Relationship trust* (α = .88) was measured with a modified eight-item version of Rempel, Holmes, and Zanna's (1985) Trust Scale, which assesses the respondent's confidence in the degree of caring, responsiveness, and availability expected from the partner in the face of an uncertain future. There was moderate correspondence between caregiver and recipient reports of satisfaction (r = .43, p < .001) and conflict (r = .50, p < .001) and low correspondence between partner reports of relationship trust (r = .11, *ns*).

Couple members completed a variety of caregiving measures designed to assess their own and their partner's caregiving behavior. These measures included existing scales as well as additional items developed specifically for this investigation. Based on a principal components analysis, composite indexes were computed to represent three patterns of caregiving: (a) responsive, (b) compulsive, and (c) controlling.[4] The *responsive caregiving* composite (α = .96) included items from several scales that were highly intercorrelated and loaded on a single factor. This index included (a) 12 items from the Proximity and Sensitivity subscales of the Kunce and Shaver (1994) Caregiving Questionnaire, (b) 12 items assessing the provision of instrumental and emotional forms of support within the relationship (Feeney & Collins, 2001), (c) 12 items, reverse-scored, assessing negative and neglecting forms of caregiving (Feeney & Collins, 2001), and (d) 10 items assessing global support/caregiving quality, 6 items adapted from the Quality of Relationships Inventory (Pierce, Sarason, & Sarason, 1991) and 4 additional items (Feeney & Collins, 2001).

The *compulsive caregiving* composite (Kunce & Shaver, 1994; 6 items, α = .59) measured the extent to which caregivers get overinvolved in their partner's problems and the *controlling caregiving* composite (Kunce & Shaver, 1994; 6 items, α = .81) measured the degree to which caregivers are controlling in their attempts to help their partners solve problems. For the current investigation, the caregiver's reports of his or her own caregiving behavior, and the recipient's reports of his or her partner's caregiving behavior, were examined. As reported in a previous investigation (Feeney & Collins, 2001), caregiver and recipient reports of caregiving quality are moderately correlated ($r = .32$, $p < .001$, for responsive caregiving; $r = .28$, $p < .001$, for compulsive caregiving; and $r = .28$, $p < .001$, for controlling caregiving).

Time 2. Approximately 2 to 3 months after participating in the first phase of the investigation, both members of each couple were sent, by mail, a follow-up questionnaire. First, participants were asked if they were still romantically involved with their partner. If either member of the couple indicated that they were no longer dating their partner, the couple was coded as "broken up," otherwise they were coded as "still together." If participants indicated that they were still together, they were asked questions regarding their current relationship quality, which included the same relationship satisfaction (α = .92), conflict (α = .92), and trust (α = .84) scales that they had completed at Time 1.

Of the original 194 couples who participated at Time 1, 177 couples (91%) were mailed follow-up questionnaires. Seventeen couples (9%) could not be located for various reasons (e.g., change of address). Of the 177 couples who were mailed the follow-ups, 128 (72%) support-recipients and 115 (65%) caregivers completed and returned their questionnaires.[5] Of these, 100 couples were still involved in relationships, completed the follow-up measures, and are included in data analyses.

RESULTS

Motivations for Caregiving

In the first set analyses, our goal was to identify specific motivations for caregiving that were empirically and conceptually distinct. The results of a principal components analysis, as well as a conceptual analysis of the items, revealed that the 40 Motivations for Caregiving items could be formed into seven distinct dimensions.[6] The classification of items on each of the seven dimensions was determined by consideration of both the factor loadings and the theoretical cohesiveness of the items. Thus, a few items that did not load highly on a particular factor were retained if they contributed to the breadth and theoretical depth of the construct. Table 1 provides the scale items and reliabilities for each dimension.

TABLE 1: Scales Representing Specific Motivations for Caregiving

Scale/Items
Feels love, concern, and interdependence (α = .85)
I want my partner to be happy.
I can't stand to see my partner hurting.
I love my partner and am concerned about my partner's well-being.
I feel bad when my partner feels bad; his or her problem is my problem.
I feel responsible for my partner's well-being.
I get a great deal of happiness and pleasure from making my partner happy.
He or she also helps and cares for me.
Enjoys helping (α = .89)
I enjoy helping people solve their problems.
Just knowing that I've done a good thing makes me feel good.
I can easily empathize with other people and identify with their problems.
It makes me feel good about myself to know that I've helped my partner.
I truly enjoy helping my partner.
It makes me feel good about myself when I help my partner.
Self-benefit (α = .82)
My partner can be very annoying when he or she is stressed, so I help so that I can get some peace.
I want to reduce my own anxiety and escape a distressing situation.
I don't want my partner to reflect negatively on me, so I help him or her so that he or she doesn't make me look bad.
It makes me feel in control when I help my partner.
I expect some form of payment in return later.
It makes me look good to others when I help my partner.
My partner will be more likely to help me if I help him or her.
I will be rewarded (e.g., praised, thanked, honored, etc.) for helping my partner.
Relationship purposes (α = .67)
I want to develop a closer relationship with my partner.
I want my partner to need me and to depend on me.
I sometimes feel that I don't deserve my partner (e.g., because he or she is more intelligent, attractive, etc., than me), so I try to make our relationship more equitable or balanced by helping my partner.
My partner will be more likely to remain in the relationship if I provide care for him or her.
Feels obligated (α = .81)
I feel guilty if I don't help my partner.
I feel obligated to help my partner; it's expected of me.
I want to avoid negative consequences from my partner (e.g., my partner would get angry).
I have to help in order for my partner to accept and love me.
My partner is very bossy and demanding; he or she makes me help.
I'm trying to make up for a past transgression or offense.
Needy (incapable) partner (α = .85)
My partner really needs my help.
My partner sometimes finds it difficult to handle things on his or her own.
My partner might not handle the situation correctly without me.
Capable caregiver (α = .81)
I'm pretty good at handling distress.
I'm very good at figuring out what people want/need.
I'm very good at solving problems.

The first factor contains *love and concern motivations*, which appear to reflect relatively altruistic motivates for helping one's partner (helping to promote the partner's happiness and well-being). The second factor contains motivations involving *caregiver enjoyment of helping*, which may reflect a mixture of both altruistic and egoistic motivation (feeling good as a result of helping one's partner). The remaining five factors reflect various egoistic or hedonistic reasons for helping: The third factor reflects selfish motivations in which the caregiver *expects to receive some self-benefit* for his or her help and the fourth factor reflects egoistic *relationship motives* for helping, involving the use of caregiving as a way of obtaining partner commitment and relationship stability. The fifth factor reflects *feelings of obligation* involving a desire to avoid negative consequences of not helping. The sixth factor reflects motives involving a *perception of the partner as being needy and incapable* of handling problems on his or her own. The final factor reflects motivations involving the *caregiver feeling capable* of helping or possessing the relevant skills needed to provide care to one's partner. On the basis of this analysis, we computed composite indexes for each dimension by averaging the items that loaded on, or conceptually fit with the description of, each factor. Three of the original 40 items that did not load on any of these factors, or that did not make theoretical sense to place on any of these factors, were excluded from further analyses. Correlations among the seven motivations for caregiving indexes are shown in the appendix.

Motivations for Not Providing Care

A similar procedure was used to identify specific motivations for *not* providing care/support to one's partner. The results of a principal components analysis, as well as a conceptual analysis of the items, revealed that the 40 Motivations for Not Caregiving items also could be formed into seven distinct dimensions. Again, the classification of items on each of the seven dimensions was determined by a joint consideration of the factor loadings and the degree to which it made theoretical sense for the item to be represented on a particular factor. Subscale items, and reliability estimates, are shown in Table 2.

The first three factors reflect features of the caregiver that tend to inhibit caregiving behavior. The first factor reflects *perceived lack of skills*, the second factor reflects *dislike of distress* involving a feeling of discomfort being in the presence of distressed individuals, and the third factor reflects *perceived lack of resources (time)*. The remaining four factors reflect features of the relationship and features of one's partner that tend to inhibit caregiving: The fourth factor reflects a *lack of concern and responsibility* for helping one's partner, the fifth factor reflects the feeling that one's partner is *difficult to help and unappreciative of helping efforts*, the sixth factor reflects feelings that the *partner is too dependent* and expects too much of the caregiver, and the final factor reflects a perception of the *partner as being capable* of handling the situation on his or her own. Again, we computed composite indexes for each of these motives by averaging the items that loaded on, or conceptually fit with the description of, each fac-

TABLE 2: Scales Representing Specific Motivations For Not Caregiving

Scale/Items
Caregiver lacks skills (α = .83)
I'm not good at figuring out what kind of help people want or need.
I don't know how to help my partner.
I never know what kind of help my partner really wants.
I typically don't respond well to stress—mine or anyone else's.
I don't have any expertise in that particular problem area.
Caregiver dislikes distress (α = .88)
I prefer to maintain some distance; I'd rather not get involved.
I don't like to be around people who are distressed.
It's too distressing to get involved in other people's problems.
It's too stressful for me to try to help people with their problems.
I don't like to hear about problems.
Caregiver lacks resources—time (α = .79)
I don't have the time.
I'm too busy with my own problems.
Caregiver lacks concern/responsibility (α = .79)
I don't feel concerned about my partner's well-being.
I don't feel sympathetic toward my partner; he or she typically deserves what he or she gets.
My partner is often the cause of the problem.
It's not really my responsibility to help him or her.
My partner gets too emotional about things that aren't important.
The problem is not very important.
Partner is difficult and unappreciative (α = .90)
My partner never takes my advice anyway.
My partner doesn't like my help.
My partner doesn't really want my help.
My partner doesn't appreciate my helping efforts.
My helping efforts never work, so there's no point in trying.
We always get in a fight when I try to help him or her.
My partner is too bossy and demanding, so I don't like (or want) to help.
My partner is impossible to help; I can never please him or her.
Partner is too dependent (α = .69)
I think my partner should try to handle his or her own problems.
My partner expects me to do everything and doesn't do enough for himself or herself.
My partner is too dependent on me.
My partner *always* has a problem, so I get tired of helping.
Partner is capable (α = .82)
My partner is good at handling problems on his or her own.
My partner is able to effectively handle problem situations as they arise.
My partner is better at solving his or her own problems.
My partner doesn't really need my help.
My partner prefers to handle problems on his or her own.

TABLE 3: Correlation and Regression Analyses Predicting Caregiver's Motives for Helping From Caregiver and Recipient Personal Features

	Feels Love and Concern		*Enjoys Helping*		*Self-Benefit*		*Relationship Purposes*		*Feels Obligated*		*Needy Partner*		*Capable (Good at It)*	
	r	β	r	β	r	β	r	β	r	β	r	β	r	β
Caregiver														
Avoidance	–.42***	–.44***	–.35***	–.35***	.26***	.15*	–.03	–.18*	.18**	.06	.04	–.05	–.11	–.11
Anxiety	.23**	.30***	.20**	.29***	.24***	.07	.54***	.41***	.30***	.12	.22**	.10	.09	.15
Self-esteem	.11	.11	.05	.11	–.14	.09	–.31***	–.10	–.19**	–.03	–.06	.04	.20**	.27**
Depression	–.03	–.01	.02	.03	.36***	.29***	.38***	.15*	.34***	.26***	.19**	.15	–.04	.00
Gender	.12	.10	–.11	–.13	.21**	.15*	.20**	.14*	.34***	.31***	.29***	.26***	.11	.04
Supportive history	.04	–.02	.07	.00	–.29***	–.14*	–.28**	–.14*	–.22**	–.04	–.19**	–.10	–.09	–.15
R^2		.28***		.20***		.22***		.38***		.26***		.14***		.10**
Recipient														
Avoidance	–.18*	–.16*	–.17*	–.15*	.10	.08	.03	.02	.03	–.01	–.05	–.11	–.15*	–.16*
Anxiety	.00	.06	–.10	–.07	.05	.04	.05	.01	.05	–.01	.15*	.05	.00	–.02
Self-esteem	.08	.04	.09	.01	.03	.11	–.09	–.07	–.02	.05	–.12	–.03	.03	.03
Depression	–.12	–.10	–.14	–.06	.11	.12	.07	.04	.14*	.17*	.21**	.20*	.03	.09
R^2		.05		.04		.03		.01		.02		.06*		.03

NOTE: $N = 194$. For gender, 1 = female, 2 = male.
*$p < .05$. **$p < .01$. ***$p < .001$.

tor. Five of the original 40 items loaded separately on independent factors and were thus excluded from the composites and from subsequent data analyses. Correlations among the seven motivations for not caregiving indexes are shown in the appendix.

Data Analytic Strategy for Examining Predictors and Influences of Caregiving Motives

After identifying specific motivations for providing and for not providing care to one's partner, we tested hypotheses regarding predictors and influences of caregiving motives (summarized in Figure 1) using both correlation and regression analyses. For each research question, we first examined the zero-order associations among the motivations and the hypothesized predictors/outcomes. Next, because many of the hypothesized predictor variables are intercorrelated to varying degrees, we conducted regression analyses to explore the unique predictive ability of each variable. For instances in which two or more predictor variables are very highly intercorrelated ($r > .60$), composite variables were formed. Because our goal was to identify the unique predictors and influences of the specific motivations for providing and for not providing care to one's partner outlined above, we avoided the composition of composite or latent variables except when high intercorrelations existed among predictor variables. For all analyses, the couple (not the individual) is the unit of analysis.

What Features of the Caregiver and Recipient Are Associated With the Caregiving Motives?

Caregiver features. As shown in Tables 3 and 4, correlational analyses revealed that caregivers who are higher in attachment-related avoidance reported more egoistic motives for helping their partner, including helping because they feel obligated (and want to avoid negative consequences) and because they hope to get something in return (self-benefit). Avoidant caregivers were less likely to report helping out of genuine concern for their partner's well-being or because they enjoy helping. Finally, avoidant caregivers reported that they do not help their partners because they dislike distress, feel that their partner is too dependent and difficult, and lack concern, resources, and skills.

Caregivers who are higher in attachment-related anxiety report some similar motivations; however, they also report that they help their partner to gain love and acceptance and to keep their partner in the relationship and because they perceive that their partner is needy. When anxious individuals do not help their partners, they report that it is because they lack skills and because the partner is difficult to help.

Analyses also revealed that caregivers who are higher in self-esteem report helping their partners because they are good at it, not because they are egoistically motivated. Caregiver self-esteem was negatively associated with lack of skills and having a difficult partner. In contrast, caregiver depression was positively associated with egoistic motives for helping, including perceiving that one's partner is needy, feeling obligated (and wanting to avoid negative consequences of not helping), and hoping to gain relationship and other rewards in return for helping. Moreover, depressed caregivers were more likely to report that they do not help their partners because the partner is too dependent and too difficult to

TABLE 4: Correlation and Regression Analyses Predicting Caregiver's Motives for Not Helping From Caregiver and Recipient Personal Features

	Lack of Skills		*Dislike of Distress*		*Lack of Resources*		*Lack of Concern*		*Difficult Partner*		*Partner Too Dependent*		*Capable Partner*	
	r	β	r	β	r	β	r	β	r	β	r	β	r	β
Caregiver														
Avoidance	.19**	.12	.31***	.26***	.22**	.23**	.34***	.26***	.33***	.21**	.29***	.23***	.04	.04
Anxiety	.15*	.00	.01	–.10	.08	.09	.00	–.18*	.17*	–.05	.01	–.11	.07	.09
Self-esteem	–.29***	–.22**	–.05	.02	.00	.04	–.11	–.06	–.25***	–.10	–.01	.09	–.05	–.07
Depression	.24***	.11	.13	.10	.00	–.07	.18*	.13	.33***	.21**	.16*	.15	–.05	–.14
Gender	.04	.06	.24***	.23**	.10	.06	.35***	.34***	.25***	.23***	.27***	.24***	.03	.01
Supportive history	–.12	.01	–.18*	–.07	–.06	.00	–.29***	–.15*	–.31***	–.14*	–.25***	–.16*	–.03	–.03
R^2		.12***		.16***		.06*		.28***		.25***		.19***		.02
Recipient														
Avoidance	.18**	.14	.17*	.13	.10	.10	.16*	.09	.19**	.13	.01	–.06	.25***	.25***
Anxiety	–.03	–.13	.13	.03	.05	.06	.22**	.08	.12	.00	.20**	.05	–.04	–.03
Self-esteem	–.10	–.07	–.14	–.01	.00	.06	–.19**	–.01	–.12	–.03	–.16*	–.01	.02	.06
Depression	.16*	.16	.27***	.23**	.06	.04	.37***	.32***	.33***	.31***	.33***	.32***	.06	.05
R^2		.06*		.09***		.02		.15***		.12***		.12***		.07**

NOTE: $N = 194$. For gender, 1 = female, 2 = male.
*$p < .05$. **$p < .01$. ***$p < .001$.

help and because the caregiver lacks appropriate skills and a sense of responsibility.

As predicted, caregivers who reported a supportive relationship history were less likely to be negatively or selfishly motivated in their caregiving behavior. Caregivers who reported an *un*supportive relationship history were more likely to report that they do not help their partners because the partner is too dependent and too difficult to help and because the caregiver dislikes distress and lacks feelings of concern and responsibility.

Finally, although we made no specific predictions about gender differences in caregiving motivation, some differences did emerge. Male caregivers were more likely to report helping because they feel obligated, hope to get something in return (self-benefit), have a needy partner, and want to meet other relationship goals. In addition, male caregivers were more likely to report that they do *not* help because the partner is too dependent, the partner is difficult to help, and the caregiver lacks concern and dislikes distress.

Follow-up regression analyses in which all caregiver features (avoidance, anxiety, self-esteem, depression, gender, supportive history) were simultaneously entered as predictors of each caregiving motive revealed that each feature accounted for unique variance in the prediction of one or more of the caregiving motives. For example, caregiver avoidance and anxiety emerged as unique predictors of the *feels love and concern* and *enjoys helping* motives for helping, accounting for 28% and 20% of the variance in each motive, respectively. In addition, nearly all caregiver features (avoidance, anxiety, depression, gender, supportive history) emerged as unique predictors of the relationship motive for helping, accounting for 38% of the variance in this motive. Of interest, caregiver avoidance and gender emerged as unique predictors of the dislike of distress motive for not helping one's partner. (See the top panels of Tables 3 and 4 for additional details regarding the regression analyses.)

Recipient features. The correlations presented in Tables 3 and 4 also show that the recipient's attachment style, self-esteem, and depression were associated with his or her partner's caregiving motives (a dyadic effect). Specifically, recipient avoidance was negatively associated with caregiver reports of feeling capable, love and concern, and enjoyment motives for helping the partner. Caregivers who have more avoidant partners are also more likely to report that they do *not* help the partner because the partner is capable of handling the problem on his or her own, because the partner is difficult to help, and because the caregiver dislikes distress, lacks skills, and lacks concern.

Recipient anxiety was associated only with caregiver reports of needy partner motives for helping and with partner too dependent and lack of concern motives for *not* helping. Moreover, recipient self-esteem was negatively associated with partner too dependent and lack of concern motives for not helping the partner. Finally, recipient depression was positively associated with caregiver reports of needy partner motives and obligation motives for helping, and with partner too dependent, dislike of distress, lack of skills, difficult partner, and lack of concern motives for *not* helping. Of interest, partners of anxious and depressed individuals reported helping

TABLE 5: Correlation and Regression Analyses Predicting Caregiver's Motives for Helping From Caregiver's Perceptions of the Relationship

	Feels Love and Concern		*Enjoys Helping*		*Self-Benefit*		*Relationship Purposes*		*Feels Obligated*		*Needy Partner*		*Capable (Good at It)*	
Caregiver	r	β	r	β	r	β	r	β	r	β	r	β	r	β
Satisfaction	.53***	.65***	.36***	.39***	–.19**	–.07	.03	.28***	–.15*	.05	.02	.24**	.14*	.15
Conflict	.01	.31***	–.08	.11	.26***	.20*	.36***	.42***	.36***	.33***	.34***	.41***	.02	.12
Trust	.17*	.03	.18*	.07	–.16*	–.06	–.20**	–.15*	–.24***	–.14	–.18*	–.13	.11	.10
R^2		.35***		.15***		.07**		.19***		.14***		.17***		.03

NOTE: $N = 194$.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 6: Correlation and Regression Analyses Predicting Caregiver's Motives for Not Helping From Caregiver's Perceptions of the Relationship

	Lack of Skills		*Dislike of Distress*		*Lack of Resources*		*Lack of Concern*		*Difficult Partner*		*Partner Too Dependent*		*Capable Partner*	
Caregiver	r	β	r	β	r	β	r	β	r	β	r	β	r	β
Satisfaction	–.28***	–.18*	–.27***	–.24**	–.22**	–.21**	–.35***	–.26***	–.47***	–.31***	–.26***	–.16*	–.15*	–.20*
Conflict	.24***	.11	.14	.00	.11	.00	.27***	.13	.41***	.21**	.30***	.23**	–.04	–.13
Trust	–.25***	–.15*	–.19**	–.10	–.11	–.04	–.22**	–.08	–.37***	–.18**	–.15*	–.01	–.04	–.01
R^2		.11***		.08***		.05*		.15***		.30***		.11***		.04

NOTE: $N = 194$.
*$p < .05$. **$p < .01$. ***$p < .001$.

because the partner is needy and incapable of handling the problem on his or her own.

Regression analyses in which all recipient features (avoidance, anxiety, self-esteem, depression) were simultaneously entered as predictors of each caregiving motive largely supported the correlational analyses. However, only recipient depression emerged as a unique predictor of the needy partner motive for helping and of the dislike of distress, lack of concern, difficult partner, and partner too dependent motives for not helping one's partner. (See Tables 3 and 4 for additional information.)

Are Caregivers' Reports of Relationship Quality Associated With Caregiving Motives?

As shown by the correlations in Tables 5 and 6, caregivers who report being more satisfied with their relationships and more trusting of their partners reported more concern and enjoyment (and less obligation and less self-benefit) motives for helping their partners. Of interest, relationship satisfaction was positively associated with feeling capable motives and relationship trust was negatively associated with needy partner and strategic relationship motives. Caregiver reports of relationship satisfaction were also negatively associated with all motivations for not helping one's partner. In addition, higher levels of relationship conflict were associated with more selfish motives for helping one's partner (i.e., obligation, self-benefit, and strategic relationship purposes) and with a variety of negative motives for not helping one's partner (e.g., difficult partner, lack of concern, dependent partner). Caregivers who reported higher levels of relationship conflict were also more likely to report lack of skills and needy partner motives.

Follow-up regression analyses in which all caregiver relationship variables (satisfaction, conflict, trust) were simultaneously entered as predictors of each caregiving motive indicated that each relationship variable accounted for unique variance in the prediction of the caregiving motives. For example, caregiver perceptions of relationship satisfaction, conflict, and trust emerged as unique predictors of relationship motives for helping one's partner (accounting for 19% of the variance) and of difficult partner motives for not helping one's partner (accounting for 30% of the variance). (See Tables 5 and 6 for additional details regarding the regression analyses.)

Are Caregiving Motives Associated With Caregiving Behavior?

Correlation and regression analyses examining the links between caregiving motives and caregiving behavior are presented in Tables 7 and 8. Because high intercorrelations among predictor variables pose problems for multivariate data analyses, composite variables were formed of highly correlated motivation variables (*r*

TABLE 7: Correlation and Regression Analyses Predicting Caregiver's Reports of Caregiving/Helping Behavior From Caregiver's Motives for Helping

	Caregiver Report						*Recipient Report*					
	Responsive		*Compulsive*		*Controlling*		*Responsive*		*Compulsive*		*Controlling*	
	r	β	r	β	r	β	r	β	r	β	r	β
Feels love and concern/enjoys helping	.73***	.66***	.12	.05	–.22**	–.23**	.26***	.25**	.07	.01	–.06	–.08
Self-benefit/feels obligated	–.38***	–.32***	.28***	.08	.36***	.23**	–.01	.07	.07	–.04	.09	.02
Relationship purposes	.09	.01	.32***	.17*	.12	–.01	.09	.02	.14	.11	.03	–.01
Needy partner	–.15*	–.15**	.33***	.24**	.35***	.29***	–.08	–.18*	.12	.10	.14*	.15
Capable (good at it)	.37***	.20***	.10	–.05	.00	–.04	.11	.07	.06	.00	.02	.00
R^2		.70***		.16***		.23***		.09**		.03		.03

NOTE: $N = 194$.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 8: Correlation and Regression Analyses Predicting Reports of Caregiver's Caregiving/Helping Behavior From Caregiver's Motives for Not Helping

	Caregiver Report						*Recipient Report*					
	Responsive		*Compulsive*		*Controlling*		*Responsive*		*Compulsive*		*Controlling*	
	r	β	r	β	r	β	r	β	r	β	r	β
Lack of skills	–.51***	–.28***	.12	.07	.21**	.05	–.17*	.00	.03	.05	.01	–.14
Lack of resources	–.22**	.08	.12	.06	.19**	.04	–.17*	–.06	.07	–.01	.16*	.12
Lack of motivation (lack of concern/helping is aversive)	–.66***	–.57***	.22**	.19*	.45***	.45***	–.25***	–.20*	.08	.07	.18*	.19*
Capable partner	–.09	.08	–.12	–.18*	–.12	–.21**	–.18**	–.14	–.03	–.05	.04	.03
R^2		.49***		.08**		.25***		.09**		.01		.05*

NOTE: $N = 194$.
*$p < .05$. **$p < .01$. ***$p < .001$.

> .60) for purposes of the regression analyses in which they are being examined as predictors of caregiving outcomes. As shown in the appendix, the enjoys helping and feels love and concern motives for helping ($r = .69$), as well as the self-benefit and feels obligated motives for helping ($r = .69$), were highly intercorrelated. Therefore, these variables were standardized and two composite variables were formed. With regard to the motivations for not helping one's partner, the difficult partner, lack of concern, dislike of distress, and partner too dependent variables were highly intercorrelated (mean $r = .66$). Thus, these variables were standardized and averaged into a variable representing a lack of motivation to help because the caregiver lacks concern and perceives helping to be aversive.

As shown in Table 7, correlational analyses revealed that the caregiver's motivations for providing care were associated with patterns of caregiving behavior. As predicted, caregivers who reported a more responsive (and less compulsive and controlling) caregiving style were more likely to endorse altruistic motives and less likely to endorse egoistic motives for helping their partner, and some of these associations were corroborated by support-recipient reports. Specifically, responsive caregivers report that they help their partners because they feel love and concern for them and enjoy making them happy, because they feel capable of helping, and not because they hope to gain a self-benefit or feel obligated or because they perceive the partner to be needy. In contrast, compulsive (overinvolved) caregivers were motivated primarily by self-benefit/feelings of obligation, strategic relationship goals, and perceptions that the partner is needy and incapable. Finally, controlling caregivers report helping because of obligation/self-benefit motives and because they perceive that their partner is incapable of handling problems. Controlling caregivers also were less likely to be motivated by love, concern, and enjoyment motives.

Follow-up regression analyses in which all motivation for helping variables were simultaneously entered as predictors of each caregiving variable revealed that four of the five motivation variables emerged as unique predictors of caregiver reports of responsive caregiving, accounting for 70% of the variance. The relationship

TABLE 9: Correlation and Regression Analyses Predicting the Support Recipient's Perceptions of the Relationship and Changes in Support Recipient Perceptions of the Relationship at Time 2 From Caregiving at Time 1

	Time 1 (n = 194)						*Time 2 (n = 100)*					
	Satisfaction		*Conflict*		*Trust*		*Satisfaction*		*Conflict*		*Trust*	
	r	β	*r*	β	*r*	β	*r*	β	*r*	β	*r*	β
Time 1 caregiver report												
Responsive	.16*	.22**	−.16*	−.05	.22**	.22**	.04	−.09	−.05	.00	.18	.10
Compulsive	−.10	−.16	.22**	.11	−.06	−.04	−.20*	−.06	.23*	.06	−.23*	−.17
Controlling	−.03	.16	.29**	.20*	−.12	.02	−.14	−.12	.19	−.03	−.18	−.02
R^2		.05*		.09***		.05*						
Time 1 recipient report												
Responsive	.52***	.45***	−.40***	−.27***	.44***	.42***	.21*	.05	−.20*	.11	.33***	.20
Compulsive	−.17*	−.05	.19**	.05	−.01	.08	−.27**	−.31**	.24*	.07	−.14	−.09
Controlling	−.39***	−.12	.39***	.21*	−.26***	−.06	−.15	−.14	.33***	.04	−.31**	−.16
R^2		.29***		.20***		.20***						

*$p < .05$. **$p < .01$. ***$p < .001$.

and needy partner motives emerged as unique predictors of caregiver reports of compulsive caregiving (accounting for 16% of the variance), and the love/concern/enjoyment, self-benefit/obligation, and needy partner motives uniquely predicted caregiver reports of controlling caregiving (accounting for 23% of the variance). With regard to recipient reports of the partner's caregiving behavior, only the love/concern/enjoyment and needy partner motives emerged as unique predictors of responsive caregiving, accounting for 9% of the variance (see Table 7).

As shown in Table 8, correlational analyses revealed that caregivers' motivations for *not* providing care were associated with their reports of caregiving behavior, and several of these associations were corroborated by partner reports. Specifically, higher levels of unresponsive and controlling caregiving were strongly associated with a variety of motives for not providing care to one's partner, including a lack of skills, lack of resources, and a lack of motivation stemming from perceptions of the partner as being difficult and unappreciative, perceptions of the partner as being too dependent, a dislike of distress, and feeling a lack of concern and responsibility for one's partner. Finally, compulsive caregivers tend to report that they do not help their partners because they lack the motivation to help (because the partner is unappreciative or too dependent and because the caregiver lacks concern).

Follow-up regression analyses in which all motives for not helping were simultaneously entered as predictors of each caregiving variable revealed that the lack of skills and lack of motivation variables uniquely predicted unresponsive caregiving (accounting for 49% of the variance) and the lack of motivation and capable partner motives predicted compulsive and controlling caregiving (accounting for 8% and 25% of the variance, respectively). The few effects that emerged for the recipient's report of the partner's caregiving were consistent with those for the caregiver's report (see Table 8).

Does Caregiving Quality Predict the Support Recipient's Reports of Relationship Quality Immediately and Over Time?

Time 1 reports of relationship quality. We first examined the degree to which Time 1 reports of caregiving quality predicted the support recipient's concurrent reports of relationship quality. As shown in Table 9, correlational analyses revealed that both recipient and caregiver reports of responsive caregiving were positively associated with the recipients' relationship satisfaction and trust and negatively associated with the recipients' reports of relationship conflict. Moreover, both recipient and caregiver reports of compulsive and controlling caregiving were associated with recipient reports of greater relationship conflict. Recipient reports of compulsive and controlling caregiving also were negatively associated with recipient reports of relationship satisfaction.

Follow-up regression analyses in which the caregiving variables were simultaneously entered as predictors of each relationship variable revealed that (a) the recipient's report of responsive caregiving emerged as a unique predictor of recipient relationship satisfaction and trust, accounting for 29% and 20% of the variance, respectively, and (b) the recipient's reports of responsive and controlling caregiving uniquely predicted the recipient's report of relationship conflict, accounting for 20% of the variance. Similar results were obtained using the caregiver's reports of his or her own caregiving behavior (see Table 9).

Time 2 reports of relationship quality. We next examined the degree to which Time 1 reports of caregiving quality predicted the support recipient's Time 2 reports of

relationship quality and changes in reports of relationship quality over time. As shown in Table 9, the support recipients' reports of relationship quality at Time 2 were significantly associated with both caregiver and recipient reports of the caregiver's behavior at Time 1. Specifically, the support recipients' relationship satisfaction at Time 2 was positively associated with the partner's responsive caregiving (as reported by the recipient) and negatively associated with the partner's compulsive caregiving (as reported by caregivers and recipients). Similarly, relationship trust at Time 2 was positively associated with responsive caregiving (as reported by recipients), negatively associated with controlling caregiving (as reported by recipients), and negatively associated with compulsive caregiving (as reported by caregivers). In contrast, relationship conflict was associated with high levels of compulsive caregiving (as reported by both partners), low levels of responsive caregiving (as reported by the recipient), and high levels of controlling caregiving (as reported by the recipient).

The final series of analyses examined whether the caregiving patterns reported at Time 1 predict *changes* in the support recipients' reports of relationship quality at Time 2. A series of regression analyses was conducted in which the caregiving variables were simultaneously entered as predictors of the support recipients' Time 2 reports of relationship quality, controlling for their reports of relationship quality at Time 1. As shown in Table 9, the support recipients' report of their partners' compulsive caregiving at Time 1 predicted a deterioration in the support recipients' relationship satisfaction. However, none of the other caregiving variables (based on reports from either the support recipient or the caregiver) predicted changes in the recipients' reports of relationship quality over time.

DISCUSSION

The results of this study contribute to the social support and relationships literatures by identifying motivations that underlie effective and ineffective caregiving behavior. In a previous investigation of caregiving processes in adulthood (Feeney & Collins, 2001), we found empirical evidence for our proposal that skills, resources, and motivations are important mechanisms that explain individual differences in caregiving patterns. The current investigation extends this prior work by focusing in greater depth on the specific types of motivations that lead individuals to provide and to not provide care to their relationship partners. Taken together, the results provide strong evidence that specific motivations are associated with specific features of the caregiver, recipient, and relationship and with specific caregiving patterns. This investigation also provides support for the hypothesis that specific caregiving patterns (which are presumably influenced by the caregiver's underlying motives) predict the quality and functioning of relationships over time. Results are discussed in more detail below.

Motivations for Providing and Not Providing Care/Support

This study is the first to investigate specific motives that promote or inhibit the provision of social support in intimate relationships. Based on a review of the helping, motivation, and relationships literatures, we developed a preliminary measure that identified seven specific motivations for caregiving in adult close relationships and seven specific reasons why individuals do *not* provide care to their close relationship partners. At a general level, these different motivations are consistent with Gray's theory of motivational processes, which postulates the existence of distinct appetitive and aversive motivational systems. Also, consistent with the helping literature, the caregiving motives identified here may be conceptualized into relatively altruistic versus relatively egoistic motives. For example, love and concern motives represent relatively altruistic motives, whereas self-benefit, obligation, and strategic relationship motives represent relatively egoistic motives. However, enjoyment motives, capable caregiver motives, and needy/incapable partner motives are somewhat more difficult to categorize as clearly egoistic or altruistic. For example, although enjoyment motives seem egoistic in nature, individuals who report relatively altruistic love and concern motives for helping their partners also report that they derive some degree of pleasure from helping their partner (see the appendix, section A). Likewise, the needy partner motives seem to be relatively altruistic on the surface; however, the items on this scale, which reflect perceptions that one's partner is incapable of handling problems on his or her own, seem to include a burdensome, obligatory undertone and were correlated with other selfish motives (see the appendix, section B).

It is important to note that although the factor analyses guided our clustering of items, we also made decisions about scale content based on a conceptual analysis of the items. For example, the item "I will be rewarded (e.g., praised, thanked, honored, etc.) for helping my partner" had a lower-than-desirable factor loading on the Self-Benefit scale but it was retained on that scale because it made conceptual sense to do so. It is important to keep in mind that although people may be motivated to help a partner to gain something in return, not everyone will seek or desire the same reward. For example, a caregiver who helps to feel "in control" may not also help to get some peace from an annoying partner. Nonetheless, both of these motives are driven by the desire to gain something in return for helping. Although

the reliability estimates for all of the motivations scales were respectable, an important goal for future research will be to further develop these scales in light of the results reported here. For example, items could be added to the Caregiver Lacks Resources subscale to assess other types of resources, such as lacking the cognitive capacity and emotional energy to help one's partner. Also, there are likely to be other motivations that were not included in our scales (e.g., not helping to punish one's partner for a perceived transgression).

Caregiver, Recipient, and Relationship Features Associated With Caregiving Motives

After identifying specific motivations for helping and not helping relationship partners, we next attempted to address the question, "From where do these motives come?" Given the cross-sectional nature of this component of the study, causal statements regarding precipitating factors cannot be made. Our goal was to identify some correlates of specific caregiving motivations that might point to precipitating features of the caregiver, the support recipient, and the relationship to spotlight in future longitudinal and experimental research. With regard to features of the caregiver, results revealed that an insecure attachment style, low self-esteem, depression, and an unsupportive relationship history were associated with relatively egoistic motives (obligation, reward, and strategic relationship motives), which were later shown to be linked to ineffective caregiving. Thus, as predicted, individuals who have a general tendency to view themselves and/or others negatively, to be uncomfortable with intimacy, to be hypersensitive to the approval of others, and/or to have had a cold/rejecting history with one's parents appear to be most likely to provide care to their partners when there will be a clear personal benefit in doing so. It makes good sense that the support provided by these individuals would be egoistically motivated. For example, individuals who report an uninvolved and unsupportive history with childhood caregivers may have learned to withhold support in the absence of strong external pressures to do otherwise. Likewise, individuals who are uncomfortable with intimacy (i.e., individuals with an avoidant attachment style) are unlikely to provide care/support to their partners (which often involves some degree of emotional intimacy) unless they feel obligated to provide support or unless they hope to gain a personal reward for doing so. Consistent with this speculation, our results revealed that when avoidant individuals *do* help their partners, it is not because they enjoy helping or because they feel concern and responsibility for them; instead, they are motivated by obligation and self-benefit. In fact, these individuals report that they do *not* help their partners because they dislike exposure to distress and because they perceive their partner to be too dependent—both of which reflect their discomfort with intimacy and preference for independence and self-reliance (Bartholomew & Horowitz, 1991).

Of interest, features of the support recipient also appear to influence caregiving motivations. Caregivers who have avoidant partners reported that they do *not* help their partners because they perceive the partner to be both difficult to help and capable of handling problems on his or her own and because the caregiver lacks the skills needed to help. In contrast, caregivers of partners who are anxious, depressed, and/or have low self-esteem report that they do *not* help their partners because they perceive the partners to be too dependent and because they lack feelings of concern and responsibility for them. When these caregivers *do* help, they report that it is because the partner is needy and incapable of handling problems on his or her own. These results suggest that the neediness of anxious, depressed, and low-self-esteem individuals may frustrate those who attempt to care for them. Perhaps individuals who have chronically negative perceptions of themselves exhaust the resources of those who care for them such that caregiving becomes burdensome. It is noteworthy that depressed support recipients, in particular, are perceived by caregivers as being especially difficult to help.

With regard to features of the relationship that might influence caregiving motivations, results revealed that caregivers who report high levels of relationship satisfaction and trust endorse more altruistic and less egoistic motivations for helping their partners. It makes intuitive sense that the support efforts of individuals who are involved in satisfying relationships would be motivated by a genuine concern for the welfare of their partners and that they would derive a sense of personal enjoyment from caring for their partners (Rusbult & Buunk, 1993). Of interest, caregivers who report low levels of relationship trust report helping their partners for relationship purposes. These individuals appear to be using social support as a strategy for keeping their partners dependent on them and involved in the relationship. As expected, caregiver reports of poor relationship quality also were strongly associated with a variety of motivations for *not* providing care/support to one's partner, including a dislike of distress, perceptions that the partner is too dependent and difficult to help, and a lack of concern/responsibility for one's partner.

It is noteworthy that caregiver personal features are more predictive of caregiver motives than recipient personal features. Although there is no way in the current investigation to definitively address whether this reflects a case of common method variance inflating correlations, we believe that the stronger correlations between caregiver motives and caregiver personal features reflect

the stronger influence that caregiver features should have on his or her own motives; we would not expect recipient features to play as strong a role in determining caregiver motives. For example, a caregiver who is uncomfortable with intimacy should report less enjoyment motives for caring for his or her partner regardless of the partner's characteristics. An important avenue for future research will be to investigate the influence on caregiving motives of other caregiver and recipient features (e.g., perceived self-competency) and of their interaction with specific situational factors (e.g., the nature of the problem requiring assistance).

Taken together, these findings are consistent with our broader theoretical model (Collins & Feeney, 2000; Feeney & Collins, 2001), which postulates that social support is part of a dynamic, interpersonal process that is shaped by individual difference factors that each partner brings with him or her into the interaction, as well as by features of the relationship. Although we are examining one component of the larger social support process in this investigation, it is important to remember the larger, dyadic context in which caregiving motives exert their influence.

Caregiving Behaviors Associated With Caregiving Motives

One reason to identify specific motivations for caregiving is that they should play an important role in determining the quality of care that is provided. Consistent with our predictions, caregiving motivations were differentially associated with three different types of caregiving behavior: responsive, overinvolved (compulsive), and controlling caregiving. Specifically, more responsive caregivers were those who reported helping their partners for relatively altruistic reasons (because they feel love and concern for them), whereas less responsive and more overinvolved and controlling caregivers were those who reported helping for relatively egoistic reasons (obligation, self-benefit). It is noteworthy that caregivers who report strategic relationship motives for helping also tend to be the more overinvolved caregivers. Thus, caregivers who provide support primarily when they see a clear personal benefit in doing so appear to provide either low levels of support or else ineffective forms of support that are out of sync with their partners' needs. These results support the argument that a focus on the "other," rather than "self," is necessary for the provision of responsive care.

With regard to motivations for not helping one's partner, results revealed that the less responsive and controlling caregivers were those who reported not helping their partners because they lack the motivation (because the partner is too dependent, the partner is difficult and unappreciative of support attempts, the caregiver lacks feelings of concern and responsibility for the partner, and the caregiver dislikes distress) and because they lack the skills and the time (resources) needed to help. The major differences between compulsive and controlling caregivers in their underlying motivations are (a) compulsive (but not controlling) caregivers report helping for strategic relationship reasons and (b) controlling (but not compulsive) caregivers report *not* helping because they lack skills and resources, and they report that when they *do* help, it is not because they enjoy helping or because they feel love and concern for their partner.

Taken together, these results support the proposition advanced in this article that being a good, responsive caregiver requires the caregiver to be appropriately motivated. Moreover, caregiving effectiveness was just as strongly linked to behavioral inhibition as behavioral activation. Finally, it is noteworthy that these results were obtained from the perspectives of both couple members, albeit the associations were substantially stronger for the caregiver's self-report. Although there is moderate agreement between caregiver and recipient reports of caregiving, we suspect that the stronger associations between caregiver motives and caregiver reports of his or her own caregiving behavior reflect the greater insight and access that the caregivers have into their own caregiving behavior rather than simply being a function of shared method variance. We suspect that support-recipients in the early stages of their relationships may overlook or may be reluctant to report negative features of the caregivers' behavior, reporting more positive and less negative caregiving behavior than the caregiver might report himself or herself. Additional factors that may contribute to the differing strength of associations between caregiver motives and the two reports of caregiving include (a) personality characteristics biasing recipients' and caregivers' reports of caregiving, (b) the fact that partners in dating relationships are unlikely to depend on one another as their sole source of support and thus may be willing to give their partner the benefit of the doubt when making caregiving ratings, and (c) the fact that participants made summary ratings of general caregiving characteristics, which may be more open to bias than ratings of specific support/caregiving events. We are unable to tease apart these various explanations in the current investigation.

Our goal for including partner reports of caregiving was not only to provide another valid and important perspective regarding the caregiving that occurs in the relationship but also to obtain the methodological benefit of providing some corroborative evidence for the associations between caregiver motives and caregiving behavior. Although the associations were weaker with the recipients' reports of caregiving, the major patterns were

corroborated in the dyadic analyses, indicating that there is some shared social reality among couple members. Our view is that multiple perspectives are needed to gain a complete understanding of the caregiving that takes place in a relationship. Although any perspective is fallible, both caregiver and recipient perspectives are important and provide meaningful reports of the caregiving that occurs in the relationship. An important avenue for future research will be to obtain an additional, independent perspective by examining the links between caregiving motives and actual caregiving behavior as observed in the laboratory.

Although no hypotheses were advanced regarding gender differences in caregiving motives, men were more likely than women to report helping their partners for relatively egoistic reasons (e.g., obligation, self-benefit, strategic relationship reasons). Men were also more likely to report that they do *not* help their partners because they perceive the partner to be too dependent and difficult to help, they dislike distress, and they lack feelings of responsibility. These gender differences are important to the extent that they are reflected in corresponding gender differences in caregiving behavior. As noted in a previous report, male caregivers did indeed report less responsive and more controlling caregiving behavior than female caregivers (Feeney & Collins, 2001). Nevertheless, because research on gender differences in social support has been inconsistent, and because gender differences may be more apparent on self-report than observational measures (e.g., Barbee et al., 1993; Goldsmith & Dun, 1997; Mickelson, Helgeson, & Weiner, 1995), an important goal for future research will be to replicate the current results and identify the particular contexts in which gender differences are most likely to emerge.

Caregiving Predicting Relationship Functioning

The results of the second phase of the investigation provide evidence that effective and ineffective caregiving behaviors are linked to the support recipients' reports of the quality and functioning of the relationship over time. In general, support recipients were happier and more trusting at Time 2 when they perceived their partners to have been more responsive, less compulsive, and less controlling at Time 1. Moreover, support recipients' reports that their partners were compulsive caregivers at Time 1 predicted decreases in their relationship satisfaction over time. The fact that caregiver reports of his or her own caregiving predicted recipient reports of relationship quality are especially noteworthy. Although it makes sense that the recipients' reports of the partners' caregiving were stronger predictors of the recipients' reports of relationship quality over time, the general pattern of results was similar for both couple members' ratings. As described above, the fact that these dyadic effects corroborate the effects involving the recipients' reports of caregiving is a methodological strength of the current investigation.

Because it is difficult to predict outcomes over time, the fact that effective caregiving at Time 1 predicted relationship functioning at Time 2 is encouraging. Caregiving is likely to be important because it leads to beneficial short-term outcomes (e.g., improved mood, problem resolution), which in turn, should have a cumulative impact on longer-term outcomes (Collins & Feeney, 2000). This process is likely to be complex and should be addressed on a more detailed level in future longitudinal research. For example, as described by Cutrona (1996), social support may prevent the emergence of destructive relationship forces by providing a positive emotional tone in the relationship and by engendering a sense of closeness and trust that strengthens commitment between partners. Expressions of care and support also may promote the recipient's self-esteem by providing encouragement or a secure base from which to perform challenging behaviors. All of these factors, in combination, should enhance the couple's prospects for healthy relationship functioning as well as the recipient's sense of personal well-being.

Conclusions and Caveats

This study was intended to provide a first, in-depth examination of specific motivations for caregiving (and for not caregiving) in adult close relationships and to provide an important point of departure for future research examining the microdynamics of caregiving. The results of this study shed some light on some motives that might lead people to be good, responsive caregivers, as well as some motives that may impede the provision of responsive caregiving. The longitudinal follow-up added another important dimension to this investigation by establishing that caregiving predicts the quality and functioning of romantic relationships over time.

As is the case with many research investigations, this study raises as many questions as it answers. For example, what happens when people have multiple motives, some of which may be conflicting? It is likely that caregiving behavior may depend on the particular motivating force that takes precedence in a given situation. An important goal for future research will be to identify the particular situational constraints that may make one motive more salient than another.

With regard to study limitations, it is important to keep in mind that this study is correlational. Although results were consistent with our theoretical model, we cannot establish the direction of causality and observed relationships between variables could stem from other, unmeasured variables. Also, when interpreting the

results, it is important to keep in mind that some of the motivations were intercorrelated, indicating that they were not empirically independent constructs. Although it makes theoretical sense that many of these motivations would be intercorrelated to some degree, an important goal of future research will be to manipulate and examine the independent effects of particular motives.

It is also important to keep in mind that people may not always fully understand what motivates them (Ross & Nisbett, 1991). The reasons people give for helping, although they may actually believe them, may not always accurately reflect the true causes of their behavior. In this study, we attempted to avoid this pitfall by generating a list of positive and negative motives for respondents to rate rather than allowing respondents to produce their own motives in an open-ended fashion. Nevertheless, experimental studies that manipulate various motivations to examine their effects on behavior will also assist in this regard.

In conclusion, the purpose of this investigation was to lay a foundation for the examination of caregiving motivations within the context of adult close relationships. Caregiving reflects a complex set of interacting events and processes that include motivational, cognitive, emotional, and behavioral components. Although we are off to a great start, the factors that influence caregiving behaviors, as well as the short-term and long-term consequences of specific caregiving patterns, will still require a great deal of unraveling in future research.

APPENDIX

A: Intercorrelations Among Caregivers' Motives for Helping

	Capable (Good at it)	*Needy Partner*	*Relationship Purposes*	*Feels Love and Concern*	*Enjoys Helping*	*Feels Obligated*	*Self-Benefit*
Capable (Good at it)	—						
Needy partner	.37***	—					
Relationship purposes	.20**	.39***	—				
Feels love and concern	.30***	.14	.37***	—			
Enjoys helping	.42***	.09	.34***	.69***	—		
Feels obligated	.12	.47***	.51***	.05	.06	—	
Self-benefit	.10	.42***	.40***	–.08	–.10	.65***	—

B: Intercorrelations Among Caregivers' Motives For Not Helping

	Capable Partner	*Partner Too Dependent*	*Dislike of Distress*	*Lack of Skills*	*Difficult Partner*	*Lack of Concern*	*Lack of Resources*
Capable partner	—						
Partner too dependent	.01	—					
Dislike of distress	.19**	.51***	—				
Lack of skills	.34***	.28***	.54***	—			
Difficult partner	.20**	.65***	.62***	.51***	—		
Lack of concern	.14	.62***	.67***	.40***	.74***	—	
Lack of resources	.21**	.39***	.37***	.30***	.32***	.33***	—

NOTE: $N = 194$.
**$p < .01$. ***$p < .001$.

NOTES

1. Participants for this study were part of a larger investigation of caregiving processes in adulthood (see Feeney & Collins, 2001). However, the research questions and variables examined in the two investigations do not overlap.

2. An additional, intermediate wave of data collection involved an experimental laboratory session, the results of which are reported in Feeney and Collins (2001).

3. Role assignment was determined by a component of the larger investigation in which the couples participated.

4. To integrate this work with prior research on caregiving processes, the caregiving composites were computed in the same way that we previously established as appropriate based on both conceptual and empirical analyses of the caregiving items (see Feeney & Collins, 2001).

5. Analyses revealed that there were no significant differences between support recipients who sent back their questionnaires and those who did not in dating length, age, or relationship quality. However, female support recipients were more likely to return their questionnaires than male support recipients, $\chi^2 = 6.10$, $p < .05$, and support-recipients who returned the follow-up questionnaire rated their partner's Time 1 caregiving behavior as being more responsive, $t(192) = 2.44$, $p < .05$, and less controlling, $t(192) = -2.27$, $p < .05$. Additional analyses revealed no significant differences between caregivers who returned their questionnaires and those who did not in dating length, age, or gender. However, caregivers who returned the follow-up were

rated by their partners as less controlling at Time 1, $t(192) = -2.17$, $p < .05$, and had partners who reported less relationship conflict, $t(192) = -2.18$, $p < .05$. Thus, individuals who participated in the follow-up were somewhat better caregivers (or had partners who were somewhat better caregivers) than those who did not participate.

6. To retain a sample size appropriate for conducting a principal components analysis of a 40-item scale, we used the responses of both members of the couple ($N = 388$) in this analysis.

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