Late-Midlife and Older Couples’ Shared Possible Selves and Psychological Well-being During Times of Illness: The Role of Collaborative Problem Solving

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We investigated associations between spouses’ shared possible selves and well-being as a function of their perceptions of collaboration in 61 late-midlife (M = 60 years) and older (M = 72 years) couples dealing with prostate cancer. Spouses completed assessments of possible selves (with shared selves defined as possible selves portraying a similar goal across spouses), psychological well-being, and enjoyment and frequency of collaboration. Associations between shared selves and better well-being occurred through better enjoyment of collaboration regardless of age (after controlling for marital quality and subjective health). An interaction revealing that shared selves were associated with better well-being only with frequent collaboration was obtained with older couples but was not found in late-midlife couples.

Key Words: Collaborative problem solving—Late-midlife and older married couples—Prostate cancer—Psychological well-being—Shared possible selves.

POSSIBLE selves or personal goals of close relationship partners are often intertwined, such that partners can facilitate, hinder, or share each other’s pursuits (e.g., Meegan & Berg, 2001; Ruehlman & Wolchik, 1988; Salmela-Aro & Little, 2007). Especially during late adulthood when people experience losses in resources required for goal pursuit (e.g., health, income, cognitive abilities; Freund & Riediger, 2001; Jopp & Smith, 2006), couples may benefit from sharing possible selves, that is, from both spouses hoping to bring about or seeking to prevent similar future events or outcomes. This benefit of shared possible selves to levels of well-being or adjustment, however, may depend on couples’ enjoyment of working together and frequently collaborating to accomplish goals.

The present study examined the association between shared hoped-for and feared possible selves (Markus & Nurius, 1986) and psychological well-being (Ryff, 1989) in late-midlife and older married couples dealing with the husband’s prostate cancer. Prostate cancer is an illness that is impactful for both husbands and wives due to the potential consequences of the illness and its treatment for the relationship (e.g., impotence, incontinence). The experience of prostate cancer may alter husbands’ and wives’ goal system—focusing it more on health-related, social, and transcendental goals and making goals more difficult to achieve (cf. Pinquart, Nixdorf-Hänchen, & Silbereisen, 2005). Prostate cancer is an illness largely of late adulthood when numerous resources may be more limited (increased incidence of illness for both husband and wife, reduced income due to retirement, and declines in cognitive function; see Berg & Upchurch, 2007). We compared late-midlife and older couples to determine whether benefits associated with sharing possible selves varied with age (and presumed resources).

Consistent with theoretical views that coping with chronic illness is a dyadic process in which goals, appraisals, and coping of patient and spouse should be examined in relation to one another (Berg & Upchurch, 2007; Revenson, Kayser, & Bodenmann, 2005), we developed a dyadic measure of couples’ shared goals. Previous work on couples’ goals focused on one person’s perception of how the spouse supported or hindered the pursuit of one’s goals (e.g., Brandstätter, Baltes-Götz, & Heil, 1990; Brunststein, Dangelmayer, & Schultheiss, 1996; Feeney, 2004) or the extent to which individuals perceived goals as shared (i.e., “our”; Hwang, 2004; Kaplan & Maddux, 2002; Meegan & Berg, 2001; Meegan & Goedereis, 2006). With one exception (Meegan & Goedereis), this research did not consider the perspective of both partners when determining whether goals were shared. We extended the measurement of couples’ goals by employing a measure that does not rely on subjective perceptions of sharedness. Possible selves of each spouse were gathered independently and independent coders, rather than the spouses, identified shared goals. Shared possible selves were those where achievement of one spouse’s goal implied the achievement of the other spouse’s goal. For example, a husband’s goal to “regain good health” was interdependent with his wife’s goal to “have a healthy husband” in that if his goal were accomplished, her goal would as well. This measure should be less affected by appraisal processes that are activated when individuals explicitly assess their spouse’s involvement in goal pursuits and, thus, be less colored by overall marital quality.
Shared possible selves were expected to relate to well-being in couples coping with prostate cancer, consistent with findings from the few studies on perceptions of shared goals and well-being in healthy couples. Shared goals (Hwang, 2004; Kaplan & Maddux, 2002), as well as spousal support for individual goals (Brandstädter et al., 1990; Brunstein et al., 1996; Feeney, 2004), were associated with higher subjective well-being, self-esteem, perceived likelihood of achieving goals, and actual goal enactment. Shared goals further predicted greater spousal involvement in an individual’s daily goal pursuit activities, and this involvement was related to greater positive affect (Meegan & Goedereis, 2006).

The developmental-contextual model of couples coping with illness (Berg & Upchurch, 2007) predicts that shared possible selves (as an indicator of dyadic appraisals) facilitate well-being as they reflect the couples’ marital satisfaction (Hagedoorn et al., 2000) and the enjoyment the couple experiences in collaborative settings. Previous work lends support to several links in this hypothesized mediational process, although the entire pathway has not been examined. First, daily collaborative coping (an indicator of shared problem solving) was associated with better daily mood as couples dealt with stressful events surrounding prostate cancer (Berg, Wiebe, et al., 2008). Second, a link between interpersonal engagement of collaboration and adjustment was found in our study of adolescents with type 1 diabetes collaborating with their mothers (Berg, Schindler, & Maharajh, 2008). Conversely, difficulties in communicating with one’s spouse surrounding prostate cancer were associated with poorer adjustment (Helgeson & Lepore, 1997). Thus, shared selves may relate to well-being through greater collaborative involvement in dealing with problems (Meegan & Goedereis, 2006) and greater enjoyment of collaboration.

However, shared selves may relate to psychological well-being predominately when they occur in the context of frequent collaboration. The developmental-contextual model (Berg & Upchurch, 2007) highlights the importance of the fit between spouses’ appraisals and their dyadic problem solving for their well-being and adjustment. That is, in order for couples’ shared selves to be most effective, they must be matched with a consistent collaborative approach toward working together. In our work with adolescents with type 1 diabetes, collaborative coping with the mother was associated with greater perceived coping effectiveness when it was matched to the appraisal of the stressor (i.e., collaborative coping in conjunction with viewing the stressor as shared; Berg, Skinner, et al., 2009). Thus, shared possible selves may carry with them the expectation that pursuit of those goals will be carried out together (Meegan & Goedereis, 2006), and therefore, shared selves may show the strongest associations with well-being when they occur together with frequent collaboration.

As both shared possible selves and engagement in collaborative problem solving can be expected to reflect the dyad’s positive relationship quality (Bodenmann, Pihet, & Kayser, 2006; Hagedoorn et al., 2000), we included marital quality as a rival predictor in our analyses to identify the unique contribution of shared selves. Two prior studies found a positive association between self-reported shared goals in couples and marital satisfaction (Hwang, 2004; Kaplan & Maddux, 2002). As another control variable, we added subjective health, which is a known covariate of subjective well-being (Okun, Stock, Haring, & Witter, 1984) and may simultaneously limit collaboration. Thus, we tested whether our results for shared selves were robust when considering relational quality or health status as alternative explanations.

In sum, the goal of our study was to examine the pathways between the couple’s shared possible selves and the psychological well-being of husbands with a recent prostate cancer diagnosis and their wives. We predicted that a greater percentage of shared selves would be associated with greater well-being through the frequency and enjoyment of collaboration surrounding everyday problems while dealing with prostate cancer. Therefore, both frequency and enjoyment of collaboration were included as potential mediators in our path model. Our second hypothesis concerned the match between the percentage of shared selves and the frequency of collaboration. We expected collaboration frequency to moderate the relationship between shared selves and psychological well-being, such that a stronger positive association between shared selves and well-being would occur when the couple collaborated frequently. When running this model, we further included marital quality and subjective health as rival predictors, expecting that the hypothesized mediated and moderated associations between shared selves and well-being would be robust with these controls. Finally, we tested whether the predicted associations differed between couples in late-midlife and old age. As older couples experience more resource limitations than late-midlife couples, being able to pool resources in striving for shared possible selves may be particularly beneficial to the former.

**Methods**

**Participants**

Sixty-one men diagnosed with localized prostate cancer (Stage I) and their wives were recruited from oncology, radiation therapy, and surgical clinics (93%) and advertisements in prostate cancer support groups (7%) while in the process of treatment decision making. Twenty men had undergone some treatment for prostate cancer by the time they completed the possible selves interview (i.e., hormone therapy, radiation, surgery, seed implants). Individuals were excluded if they had a history of cancer other than skin cancer (given its high incidence in the area), did not speak English, or did not have a significant other (see Berg, Wiebe, et al., 2008, for details regarding this sample).
Husbands were 40–84 years old (M = 67.5, SD = 9.0), and wives were between 38 and 80 years (M = 64.6, SD = 9.2). Spouses were largely in long-term marriages (M = 38.7, SD = 14.0, range 1–60 years). As marriage length was highly correlated with age (husbands: r = .51, p < .001; wives: r = .57, p < .001) and unrelated to perceptions of collaboration and well-being when rival predictors were considered, we did not include this variable in our analyses. Participants were mostly Caucasian (95.1% of both spouses), were retired (65.6% men, 75.4% women), and had some education beyond high school (76.7% men, 62.3% women). The majority of participants (75.4% of both spouses) were from the dominant religion in the Salt Lake City area (Latter-day Saints).

Procedure

Each spouse received a take-home packet of questionnaires, including demographics and perceptions of collaboration, psychological well-being, marital quality, and subjective health. Approximately 1–2 weeks later, a 1-hr home interview occurred where participants listed their possible selves. Couples received $38 for completing these parts of the study.

Measures

*Shared possible selves.*—Based on Hooker’s (1992) protocol, participants listed up to 28 possible selves (14 hoped-for and 14 feared selves). Shared possible selves were examined for both spouses’ hoped-for and feared selves because both motivate future-oriented behavior in healthy and ill people (Frazier, Cotrell, & Hooker, 2003). Respondents were asked “what you would like to become or what you would like to happen in the future” and to write a word or phrase that described each of their up to 14 hoped-for selves. For feared selves, participants were asked about “what you would not like to become or what you fear could happen in the future.” Participants were given example selves that a young adult might generate, such as “becoming a homeowner” (hope) or becoming a “homeless person” (fear).

Participants reported possible selves in several life domains, with the greatest percentage related to health or independence (husbands: M = 37.06%; wives: M = 35.26%), family (husbands: M = 11.54%; wives: M = 14.37%), leisure or lifestyle (husbands: M = 12.87%; wives: M = 12.38%), and material concerns (husbands: M = 12.82%; wives: M = 10.20%). On average, less than 10% of spouses’ possible selves pertained to the domains achievement, other relationships, and own death or bereavement. Prostate cancer explicitly was not prominent among couples’ possible selves (14 husbands and 3 wives reported at least one self concerning cancer). However, possible selves related to prostate cancer were typically reported on a more implicit level, for instance, hopes for good health or fears concerning dependency.

Based on a newly developed coding scheme (which can be obtained from the first author), husbands’ and wives’ hoped-for and feared selves were categorized into two mutually exclusive categories: “shared and nonshared.” Hoped-for selves for husbands and wives were compared first, with separate codes applied for feared selves. “Shared selves” were those where both spouses named a similar possible self that needed to be accomplished interdependently, that is, if one spouse’s goal was accomplished, then the other spouse’s goal was accomplished. Shared selves included both implied interdependence of outcomes where the wife’s goal-striving outcomes would influence the husband’s goal-striving outcomes (e.g., both spouses mentioned becoming “financially secure”) and explicit interdependence (e.g., a wife’s goal of “healthy husband” shared her husband’s goal “to pull through operation”).

“Nonshared selves” occurred when a spouse’s reported self was different from all of the other spouses’ selves (e.g., the wife’s possible self to “make several quilts” was not a possible self mentioned by her husband). Possible selves that contained a similar content but could be realized independently of one’s spouse were coded as nonshared. For instance, a husband’s self to “continue in my education” and the wife’s self to “increase my education/knowledge” could be accomplished independently. The first four authors served as coders, training together until agreement reached more than 80%. Kappas for the final coding were .70 for husbands’ hopes, .70 for fears, .74 for wives’ hopes, and .65 for fears. One couple’s possible selves data were dropped from analyses because the wife had trouble understanding the instructions, providing responses that were uninterpretable.

We computed the percentage of shared possible selves (hoped-for and feared selves together) relative to the total number of possible selves (between 2–14 hopes and 1–14 fears). Hopes and fears were combined as shared hopes and fears related to outcomes in similar ways. Shared selves occurred across all life domains listed earlier. Analyses conducted to test whether associations of shared selves with other study variables varied depending on the content of the shared selves did not yield any systematic differences by domain.

As the percentage of shared possible selves was highly correlated between husbands and wives, r = .77, p < .001, we created a dyadic variable by averaging scores for husband and wife to reflect the “couple’s percentage of shared selves,” ranging from 0% to 53%, M = 18.76, SD = 14.64. As scales of proportions tend to be bunched up at the extremes, the arcsine transformation (Cohen, Cohen, West, & Aiken, 2003) was applied to the shared selves score, which was subsequently retransformed to a percentage score (via a linear transformation that did not alter the new distributional properties) to enhance interpretability (for descriptive statistics for the transformed score and intercorrelations, see Table 1).
Table 1. Means and Intercorrelations of Study Variables for Husbands and Wives

<table>
<thead>
<tr>
<th></th>
<th>M (SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of couple’s shared selves (after arcsine transformation)</td>
<td>24.86 (15.53)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>24.86 (15.53)</td>
</tr>
<tr>
<td>2. Frequency of collaboration (PCQ)</td>
<td>4.31 (0.66)</td>
<td>0.18</td>
<td>0.50**</td>
<td>0.78**</td>
<td>0.55**</td>
<td>0.73**</td>
<td>0.41**</td>
<td>0.13</td>
<td>4.15 (0.77)</td>
</tr>
<tr>
<td>3. Enjoyment of collaboration (PCQ)</td>
<td>4.52 (0.58)</td>
<td>0.28*</td>
<td>0.62**</td>
<td>0.38**</td>
<td>0.57**</td>
<td>0.69**</td>
<td>0.32*</td>
<td>0.10</td>
<td>4.32 (0.64)</td>
</tr>
<tr>
<td>4. Psychological well-being (Ryff)</td>
<td>43.31 (4.83)</td>
<td>0.30*</td>
<td>0.43**</td>
<td>0.69**</td>
<td>0.55**</td>
<td>0.57**</td>
<td>0.41**</td>
<td>0.16</td>
<td>42.15 (5.94)</td>
</tr>
<tr>
<td>5. Marital quality (DAS)</td>
<td>120.30 (15.53)</td>
<td>0.21</td>
<td>0.57**</td>
<td>0.64**</td>
<td>0.49**</td>
<td>0.71**</td>
<td>0.26*</td>
<td>0.05</td>
<td>118.72 (17.24)</td>
</tr>
<tr>
<td>6. Subjective health</td>
<td>3.56 (0.90)</td>
<td>0.23*</td>
<td>0.18</td>
<td>0.24*</td>
<td>0.25*</td>
<td>0.11</td>
<td>0.34**</td>
<td>-0.49**</td>
<td>3.28 (0.90)</td>
</tr>
<tr>
<td>7. Age group for couple (0 = husband &lt;70 years; 1 = husband ≥70 years)</td>
<td>0.49 (0.50)</td>
<td></td>
<td></td>
<td>0.29*</td>
<td></td>
<td></td>
<td>0.10</td>
<td></td>
<td>0.11</td>
</tr>
</tbody>
</table>

Notes: Means and correlations for husbands are reported below the diagonal, and means and correlations for wives are reported above the diagonal. Correlations for the same measure between husbands and wives are reported in the diagonal (gray; _—_ indicates that no correlation can be computed as this is a couple variable). *p < .10; **p < .05; ***p < .01.

Perceptions of collaboration.—The nine-item Perceptions of Collaboration Questionnaire (PCQ) assessed spouses’ perceptions of collaboration when solving everyday problems on 5-point scales (1 = strongly disagree to 5 = strongly agree). The PCQ includes three dimensions of collaboration (frequency, interpersonal enjoyment, and cognitive compensation) assessed with three-item scales, established through confirmatory factor analysis in our prior research (Berg, Schindler, Smith, Skinner, & Beveridge, 2009; Berg, Schindler, et al., 2008). We used two of these subscales (the third was unrelated to shared selves). “Frequency” assessed how often the spouses perceived to work together (e.g., “Nearly every day my spouse and I work together to make everyday decisions.”). “Interpersonal enjoyment” measured the extent to which collaboration was enjoyed (e.g., “I enjoy the support and encouragement I receive when I work together with my spouse.”). Scores for frequency (husbands: $\alpha = .74$; wives: $\alpha = .71$) and interpersonal enjoyment (husbands: $\alpha = .80$; wives: $\alpha = .58$) were computed by averaging across the three items per scale.

Psychological well-being.—Participants completed the 54-item Psychological Well-Being Scales (Ryff, 1989), including autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. Items were rated from 1 = strongly disagree to 6 = strongly agree. Before computing the subscale scores (sum across nine items; theoretical range 4–54), missing values (one to eight missing item responses for 30 participants) were substituted by this participant’s mean across the nonmissing items of the respective subscale (four subscales were summed for a measure of overall well-being).

Marital quality.—The 32-item Dyadic Adjustment Scale (Spanier, 1976) measured marital quality, with varying response scales (e.g., 6-point scales of frequency all the time to never and frequency of agreement always agree to always disagree). A summary score can theoretically range from 0 to 151 (husbands: $\alpha = .94$; wives: $\alpha = .95$). Before computing the scales, missing values (1–11 missing responses of 30 participants) were substituted by this participant’s mean across the nonmissing items of the respective subscale. We averaged across the six subscales (husbands: $\alpha = .93$; wives: $\alpha = .95$) as we were not interested in specific facets of well-being, and factor-analytic findings (Ryff & Keyes, 1995) demonstrated that the six scales form a single second-order factor of well-being.

Statistical Analyses

As our variables came from couples, we used structural equation modeling and included husbands’ and wives’ data in one analysis akin to the actor–partner interdependence model (Kenny, Kashy, & Cook, 2006). Thus, these analyses accounted for the statistical interdependence between spouses, tested for differences in path coefficients between husbands and wives, and included participants with incomplete data in the analyses. Mplus (version 5.1; Muthén & Muthén, 1998–2008) handles incomplete data by utilizing all available observations to compute full information maximum likelihood parameter estimates and also estimates indirect effects in a mediation model.

A multigroup path model tested for age group differences. Two groups were demarcated: late-middlelife couples ($n = 31$) included husbands younger than 70 years (age range 40–69, $M = 50.8, SD = 7.0$) and their wives (age range 38–79, $M = 59.0, SD = 8.4$) and older couples ($n = 30$) included husbands who were aged 70 years and older (age range 70–84, $M = 74.4, SD = 4.3$) and their wives (age range 58–80, $M = 70.5, SD = 5.6$). The cutoff at age 70 was primarily based on practicality of obtaining age groups of equal size. Age was not analyzed as a continuous variable in...
our path model as the vast majority of our participants were in their 50s and 60s (56%) or 70s (34%) and, therefore, did not well represent the entire age range included in the sample (5% of the sample was younger than 50 years and 5% of the sample was 80 years or older). However, we conducted several analyses testing for main and interactive effects of age as a continuous variable for comparison, which replicated the results to be reported for the two age groups.

When running the path model, we centered all variables in the model apart from psychological well-being (percent of shared selves and marital quality were further divided by 10 such that the unstandardized path coefficients represented the increase in well-being for a 10% increase in shared selves and a 10-point increase in marital quality). In addition to the model paths, we estimated the residual covariances between the variables for each spouse as well as between husband and wife. We initially constrained corresponding path coefficients, intercepts, and covariances to be equal for age groups and for husbands and wives and then tested whether releasing these constraints (one parameter at a time) improved model fit. With one exception, we did not obtain significant differences between age groups in our multigroup path model, $\Delta \chi^2(1) = 0.00$ and 2.82, ns, when the equality constraint was lifted. The exception was the interaction between the percentage of the couple’s shared selves and frequency of collaboration in predicting well-being, which differed between late-midlife and older couples, $\Delta \chi^2(1) = 5.51, p < .05$. We thus released the constraint on this path and continued testing for differences between husbands and wives but did not find any, $\Delta \chi^2(1)$ between 0.00 and 2.43, ns, thus retaining equality constraints for husbands and wives.

**Results**

Variable intercorrelations (Table 1) show the hypothesized association between the percentage of couples’ shared selves and husbands’ well-being, $r = .30, p < .05$, and a trend for wives’ well-being, $r = .24, p < .10$. To examine mechanisms accounting for these relationships, we ran a path model including the expected mediation and moderation effects of frequency and enjoyment of collaboration on the relationship between couple’s percentage of shared selves and well-being. We tested associations of marital quality and subjective health with our central variables, including them as rival predictors of those variables in which they explained independent portions of variance (Figure 1).

First, we ran the hypothesized model ($\chi^2 = 133.03, df = 110, p = .07, \text{RMSEA} = .08$, CFI = .92, TLI = .92) are presented in Table 2 and Figure 1.

We tested for the indirect effect of shared selves via enjoyment of collaboration on well-being and obtained a significant indirect effect of $0.18, p < .05$ (Table 2). As our sample was comparably small, we corroborated this finding by obtaining bootstrap estimates of the indirect effect based on 5,000 bootstrap samples of $n = 61$ couples drawn with replacement from our original sample. We report the bias-corrected bootstrap 95% confidence intervals for our estimates, recommended as the single best method to test for indirect effects (MacKinnon, Lockwood, & Williams, 2004). The bootstrap analysis largely confirmed our results (Table 2; significant estimates are indicated by zero not being included in the confidence interval). The reported indirect effect remained significant, providing support for the mediational role of enjoyment of collaboration in the relationship between shared selves and well-being.

Although the percentage of shared selves was unrelated to collaboration frequency, we obtained the hypothesized interaction between shared selves and frequency in predicting well-being in older, but not in late-midlife, couples (Table 2). To further probe this interaction, we employed an online tool to follow up interactions (Preacher, Curran, & Bauer, 2006). As expected, a greater percentage of shared selves was related to greater well-being when older couples reported collaborating frequently ($M + 1 SD), t(54) = 3.48, p < .01. This association was marginally significant when collaboration frequency was average, $t(54) = 1.91, p < .10$. In couples who collaborated infrequently ($M - 1 SD), percentage of shared selves tended to be negatively related to well-being, $t(54) = -1.73, p < .10$ (Figure 2).

When probing the region of significance for the simple slopes, the percentage of shared selves was significantly positively related to well-being with frequency scores above 4.25 and significantly negatively related to well-being with frequency scores below 3.25. The findings reported earlier held with marital quality and subjective health included in the model.

**Discussion**

Consistent with the developmental-contextual model of couples coping with illness (Berg & Upchurch, 2007), we found that shared possible selves among late-midlife and...
older couples dealing with prostate cancer were associated with greater psychological well-being. As expected, this association was mediated by enjoyment of collaboration regardless of couples’ age, such that a greater percentage of shared selves for the couple was related to greater enjoyment, which was in turn related to better well-being. This finding is in line with our earlier research showing that enjoyment of collaboration is associated with better adjustment when adolescents and their mothers cope with illness (Berg, Schindler, et al., 2008) and extends this to couples in mid- to late life.

Contrary to our prediction, frequency of collaboration was unrelated to the percentage of the couple’s shared selves and, thus, did not function as a mediator of the relationship between shared selves and well-being. This contrasts with Meegan and Goedereis (2006) who found that shared goals predicted greater spousal involvement in goal pursuit. The nature of our assessment of shared selves, which does not rely on self-reports of sharedness, may account for these diverging findings. Prior research relied on perceptions of one’s spouse as sharing important goals;
Table 2. Parameter Estimates for Path Model of Indirect and Moderated Associations Between Couple’s Shared Selves and Psychological Well-being

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Unstandardized estimate</th>
<th>Late-midlife couples</th>
<th>Older couples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept PWB</td>
<td>42.52**</td>
<td>41.553</td>
<td>43.356</td>
</tr>
</tbody>
</table>

Direct effects (paths)

| Percentage of couple’s shared selves → enjoyment of collaboration | 0.06* | 0.002 | 0.119t | .15* | .14* | .12* | .12* |
| Marital quality → frequency of collaboration | 0.29** | 0.193 | 0.385 | .61** | .75** | .65** | .62** |
| Marital quality → enjoyment of collaboration | 0.25** | 0.191 | 0.308 | .62** | .72** | .61** | .62** |
| Subjective health → frequency of collaboration | 0.09* | 0.003 | 0.196 | .10* | .10* | .12* | .10* |
| Frequency of collaboration → PWB | 1.09 | −0.824 | 2.490 | .16 | .14 | .16 | .13 |
| Enjoyment of collaboration → PWB | 3.24** | 1.229 | 5.743 | .41** | .35** | .44** | .33** |
| Percentage of couple’s shared selves → PWB | 0.50* | −0.089 | 0.951 | .17† | .14† | .14† | .11† |

Residual covariances

| Frequency–enjoyment of collaboration | 0.11** | 0.058 | 0.165 | .46** | .62** | .41** | .41** |
| Husband’s frequency–wife’s frequency | 0.08* | 0.009 | 0.079 | .36** | .28* | .09 |
| Husband’s enjoyment–wife’s enjoyment | 0.02 | −0.030 | 0.116 | .23* | .26* | .19* | .18* |
| Own frequency–spouse’s enjoyment | 0.05* | −0.003 | 0.116 | .32* | .21† |
| Husband’s PWB–wife’s PWB | 3.47† | −0.245 | 8.117 | .06† | .05† | .05† | .04† |

Indirect effect

| Shared selves → enjoyment → PWB | 0.18* | 0.015 | 0.518 | .06† | .05† | .05† | .04† |

Explained variance

| R² frequency of collaboration | .43** | .64** | .43** | .42** |
| R² enjoyment of collaboration | .45** | .58** | .42** | .42** |
| R² PWB | .64** | .55** | .49** | .35** |

Notes: All corresponding model paths were constrained equal for age groups (except for the Shared Selves × Frequency interaction) and for husbands and wives.

BC 95% CI = bias-corrected 95% confidence interval based on 5,000 bootstrap samples; LL = lower limit of BC 95% CI; UL = upper limit of BC 95% CI; : 0 = parameter constrained to zero; PWB = psychological well-being; H = husbands; W = wives.

*p < .10; **p < .05; ***p < .01.

in our coding, couples had to nominate the same possible selves independently, making our measure of shared goals fairly conservative. Consistent with this explanation, spouses in our study, on average, shared 19% of their possible selves, a much lower estimate than observed when people appraised shared goals (more than 60% shared goals reported by Meegan & Goedereis). Self-reports of shared goals may be colored by the actual frequency of collaboration, such that couples who are interdependent may both collaborate frequently and perceive many goals as “our” goal. Furthermore, the illness context may account for the differences between our results and those of Meegan and Goedereis with healthy adults. That is, prostate cancer has been described as a cancer where couples move in (information gathering) and out (final treatment decision is individual) of collaboration (Maliski, Heilemann, & McCorkel, 2002), such that shared goals may not have such a tight connection with collaboration.

Although collaboration frequency did not mediate the relationship between shared selves and well-being, the hypothesized interaction between shared selves and collaboration frequency predicting well-being occurred in older but not in late-midlife couples. When husbands aged 70 years and older or their wives reported to collaborate frequently during everyday problem solving, a greater percentage of possible selves shared by the couple was associated with better psychological

Figure 2. Interaction between older couples’ shared selves and frequency of collaboration in predicting well-being (unstandardized simple slopes are reported).
well-being. However, when older couples collaborated very infrequently, the couple’s percentage of shared selves was negatively related to well-being. No comparable interaction occurred with husbands younger than 70 years and their wives. This finding may be attributable to older couples having fewer resources for goal pursuit, as indicated, for instance, by their poorer subjective health compared with late-midlife couples (see Table 1). Similar to prior research underscoring the need to optimally use individual (Jopp & Smith, 2006) or dyadic (Hagedoorn et al., 2000) resources when resource status is poor (as may occur for older adults experiencing illness), this finding underscores the necessity of pooling resources to pursue common goals when the resources of each spouse alone may not suffice to make progress toward a hoped-for outcome or to avoid a feared outcome. In contrast, late-midlife couples may have sufficient resources such that collaborative involvement is not needed to bring about desired outcomes. This age-differential interaction suggests the importance of considering the match between the dyadic organization of goals, collaboration, and the resource status of couples experiencing chronic illness (see Berg, Skinner, et al., 2009, for similar findings with adolescents with type 1 diabetes and mothers).

The mediated and moderated effects of collaboration on the relation between shared selves and well-being were robust when marital quality and subjective health were included as rival predictors. In spite of the high zero-order correlations of marital quality with frequency and enjoyment of collaboration and psychological well-being, shared selves played an additional role in predicting perceptions of collaboration and well-being. In contrast to earlier reports of positive associations between shared goals and marital satisfaction (Hwang, 2004; Kaplan & Maddux, 2002), our measure of shared selves was not significantly related to marital quality, which may be because our measure is less influenced by perceptions of relationship quality.

We also need to acknowledge some limitations of this study. First, the cross-sectional study limits conclusions regarding causal relations between shared possible selves and well-being. Second, the findings have been obtained with a sample of late-midlife and older couples dealing with prostate cancer, chosen because we assumed that the effects of shared selves would be pronounced in the presence of this illness that affects both husbands and wives (Couper et al., 2006). As this is a very specific context, we do not know whether these results could be replicated with healthier and/or younger couples, although we would expect so. The age sample distribution and our parsing it into discrete groups may limit our understanding of age differences. However, the late-life nature of prostate cancer and practicalities of gathering a sample distributed by age provide challenges for research in this area. Third, the sample was small. However, we were able to corroborate our significant findings through bootstrap analyses. We cannot rule out that additional significant associations of shared selves with collaboration frequency or marital quality would be obtained in a larger sample. Fourth, we developed an alternative measure of shared selves for this study that did not rely on spouses’ appraisals of shared possible selves. We do not know whether our findings could be replicated with other measures of couples’ shared selves or goals (Hwang, 2004; Meegan & Goedereis, 2006) or how our measure relates to these alternative measures. Finally, our measures assessed collaboration in everyday situations that went beyond problems regarding prostate cancer, with the possibility that more explicit measurement of collaboration for prostate cancer problems may have demonstrated stronger effects.

In spite of some limitations, the study developed a promising method for examining couples’ shared possible selves that are associated with better well-being through increased enjoyment of collaboration. In the illness context, shared possible selves are an asset especially in older couples who collaborate frequently. As infrequent collaboration was associated with poor marital quality but unrelated to the percentage of the couple’s shared selves, interventions aimed at improving the marital relationship for those experiencing illness (Martire, Lustig, Schulz, Miller, & Helgeson, 2004) should be especially beneficial in distressed couples with many shared selves. Their well-being could benefit not only from their improved marital quality but also from the positive effects of shared selves and more frequent collaboration. In addition to facilitating collaboration, shared selves may trigger other positive relationship dynamics, such as more harmonious interactions that are facilitated by a shared frame of reference. Enhancing well-being through better marital interactions, shared selves, and collaboration is especially important for couples in mid- and late life as illness is a normative challenge (Berg & Upchurch, 2007).

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