Section 1: Theoretical Explanations of Dependency in Later Life

Chapter 1. Understanding Dependency Among the Elderly

1. The Etiology of Dependency in Later Life

John Donne, the 16th century poet, once declared, "No man is an island." From our very first heartbeat, we are dependent upon another, and we remain dependent to our dying breath. To elucidate the myriad ways people are dependent upon each other would be an enormous task, quite beyond the scope of this manuscript. Thus, before advancing any further, it would seem prudent to address an essential question: What kind of dependency is of present interest? Dependency upon whom and for what? When one speaks of human development, the dependency that quite typically first comes to mind is *interpersonal,* or dependency upon another human-being. And this is precisely the form of dependency I wish to address, one based upon *caregiving,* or receiving help with fundamental, life-sustaining activities.

Caregiving, which is only one unique form of dependency, is a domain with a foot firmly entrenched in the beginning and the end of life. Before children have learned to master their environments, they are the focus of much caregiving. Likewise, after adults have lost the ability to care for themselves, caregiving again becomes an issue. This great branch of scientific inquiry then, must be whittled down to *elder care.* To be perfectly precise, the kind of dependency under examination involves the *formal* or *professional care for the elderly*.

In a very general sense, professional care addresses the needs of a person who has experienced loss. Therefore, the next section of this manuscript very briefly reviews findings on developmental losses in advanced age. Coping with age-related loss is discussed using models of successful aging that have become dominant in various scientific circles over the last decade. I hope to show that interpersonal dependency among the elderly is a common, functional, and appropriate response to age-related infirmity. My goal is to present a balanced view of interpersonal dependency in later life and to integrate the construct into existing notions of successful aging.

1.1 Developmental Losses in Old Age

There is no question that aging is marked by progressive deterioration of the body. Many different physiological parameters, such as nerve conduction velocity, maximal heart rate, and muscle strength all drop linearly over the adult lifespan. As the integrity of the body dissipates, the aging adult grows physically weaker, becomes more vulnerable to infectious disease, and falls prey to innumerable chronic illnesses affecting the cardiovascular and skeletal system. On average, select components of memory begin to fade and certain cognitive processes grow sluggish, even in the absence of degenerative brain diseases, such as Alzheimer's dementia.

An exhaustive review of the decrements that accompany old age is both unwieldy and unnecessary. To reiterate: Our point of departure is *professional caregiving* of the elderly. Though every aging individual experiences some loss, not all loss leads to a state in which the individual is dependent upon another for basic care. What kinds of losses then, precipitate professional caregiving? Essentially, two kinds: loss of *functional health* and loss of *social support.*

Loss of functional health is commonly defined as the inability to carry out one or more activities of daily living, such as bathing or dressing. The percentage of elderly with functional health decline appears at first to be quite modest. For example, just 1.5% of all Germans between the ages of 60 and 65 years require care (Dritter Altenbericht, 2001). However, this percentage nearly doubles every five years. Thus, almost 20% of those aged 80-84 years, 34% of those aged 85-89 years, and 55% of those aged 90 years or more require care. Contrary to popular belief, 70% of those who require care live in private households. Nonetheless, these kinds of decline in functional health are critical determinants of nursing home admission (Wolinsky et al., 1992).

Functional decline is the natural product of three age-related changes in health. First, *physical frailty,* or general deterioration in strength, balance, and endurance that accompanies aging, can prevent or impede the ability of elders to care for themselves. To be sure, deterioration of the individual's biological performance capacity is gradual, and most indices do not show substantial decline until late adulthood. Frailty is thus more commonly a concern among those of very advanced age, when poor strength or balance might easily result in mishap,

making close monitoring advisable. A second age-related change concerns the growing incidence of c*hronic physical illness* with age. The elderly individual typically suffers from a number of illnesses and complaints. The most prevalent happen to be cardiovascular disease, osteoporosis, and arthritis, all of which impair the mobility and agility of the older adult and are prerequisites for being able to pursue one's normal routine, e.g., bathe and dress independently. Finally, *mental illness* can have a devastating effect on everyday competence. Although dementia and depression are less common concomitants of the aging process, they have perhaps the strongest and wide-ranging impact on functional health and self-maintenance.

Loss in everyday competence, however, is not sufficient reason to seek out the services of a professional caregiver. A *lack of social support* must also accompany functional health decline. Bereavement is the most typical example of a crisis which can strip a person of their most cherished support person. With advancing age, the elder begins to outlive trusted friends, neighbors, and even younger members of the family, which further diminishes the social network. 93% of the care received by the elderly comes from members of the extended family (Dritter Altenbericht, 2001). Thus, it unsurprising that elders without a spouse, or without younger family members who can care for them, are at risk for institutionalization (Wingard et al., 1987; Wan and Weissert, 1981). Naturally, the family's perception of the situation (e.g., whether or not the elder is viewed as a family burden, attitudes toward professional caregivers) also plays a role.

To sum up, a person who is dependent upon others for professional care has almost always suffered functional health decline coupled with a lack of social support. Despite the relatively high prevalence rates of illness and institutionalization among the very old, however, the deficit view of aging has been strongly contested and rightly so (e.g., Wahl, 1991a). A number of arguments have been put forward, chief among them, the great *interindividual variation in aging* and the remarkable *ability of older individuals to cope with adversity.*

Simply put, interindividual variation means that though some persons experience loss, many others do not. The truth of this assertion rests upon how loss is defined. The facts have already been illustrated: while it is indeed true that the great majority of elders over 65 years of age do not require care, it is equally true that many aspects of biological functioning decline steadily with age. However, even loss that appears to be unavoidable can, in many

instances, be remedied. Indeed, few would argue that the elderly are helpless when confronted with age-related decline and loss. To the contrary, there are effective coping mechanisms that buffer the individual from experiencing functional loss and, hence, becoming dependent upon a professional caregiver. In the early 90s, theoretical research into adult development synthesized these forms of coping into *models of successful aging.*

Models of successful aging propose to offer a broad roadmap for understanding the multitude of different ways that individuals -- and not merely only older ones -- cope with loss. Interpersonal dependency can be understood as a fundamental way of dealing with the foibles of the aging process. Thus, it is crucial to review how theorists have viewed interpersonal dependency, to identify whether or not they have attempted to integrate the concept into developmental models, and how successful their efforts have been.

2. Models of Successful Aging

Models of successful aging attempt to explain how aging individuals, despite the kinds of losses described above, manage to maintain their everyday competence and well-being. Over the last 20 years or so, there has been remarkable convergence in various theoretical models (Heckhausen & Schulz, 1995; Brandtstädter & Greve, 1994; Baltes & Baltes, 1990; Whitbourne, 1987; Lazarus & Folkman, 1984; Rothbaum, Weisz & Snyder, 1982). In the following, I will limit the discussion to two exemplary models of successful aging that have left an indelible mark on the study of aging: *the model of selective optimization with compensation* (Baltes & Baltes, 1990) and *the dual process model* (Brandtstädter, Wentura & Greve, 1993).

2.1 Selective Optimization with Compensation

The model of selective optimization with compensation is based upon two observations about human development. First, aging involves both gains and losses, but losses begin to outweigh the gains in advanced age (Heckhausen, Dixon & Baltes, 1989). Despite these losses, the elderly exhibit remarkable stability in their physical and emotional functioning. For example, the elderly generally evince a very low prevalence rate of depression (Blazer, 1989). In short, everyday competence and well-being do not decline to the extent one might expect given the culmination of age-related losses.

According to the model of selective optimization with compensation, the aging individual's performance in a variety of life domains is improved by three fundamental mechanisms.

Selection entails reducing one's sphere of activity in order to focus one's resources on more essential or important pursuits. With age, some activities -- horseback riding for example, or perhaps the physical toil of maintaining a house -- may become too strenuous. By reducing or eliminating such activities from one's weekly routine, one can avoid experiencing loss of control and failure. Time and effort can be invested in other life domains, enabling the aging individual to excel in other, perhaps more age-appropriate pursuits.

Optimization entails enhancing one's performance abilities through conditioning, practice or new learning. There is *plasticity* in human development, i.e., the older individual has considerable *latent reserve capacity* (Baltes, 1987). Many older adults thus have the potential to function at levels that are comparable to much younger ones. Of course, some loss, such as decline in sensory functioning, cannot be ameliorated through practice. Nonetheless, many individual resources can be optimized through regular exercise (strength and flexibility, for example). Likewise, deterioration in intellectual functioning, such as the ubiquitous memory problems in old age, can be prevented or even reversed through the continued engagement of mental abilities (Schaie & Wills, 1986).

Compensation is defined as an effort to overcome a specific loss or improve inadequate performance. Baltes and Baltes offer the example of a hearing aid, a common prosthetic device, as a form of compensation, but any means of external aid would qualify. The environmental support afforded by nursing homes, for example, with barrier free bathrooms and handrails, can compensate for mobility problems. Interestingly, Baltes and Baltes contend that some abilities can compensate for others, such as when increases in crystallized intelligence offset declines in fluid intelligence. In line with this argument, Bäckman and Dixon (1992), employing a much broader definition of compensation, state that much compensation may not be deliberate, and hence, not employed in a strategic fashion.

The model of selective optimization with compensation provides a nicely differentiated view of how a person -- *any* person, not just the aging individual -- can improve functioning in a variety of life domains. It can well be regarded as a cornerstone in gerontological literature,

having inspired countless inquiries into the nature of successful aging. One could argue, however, that their model isn't truly *psychological* in nature (see, e.g., Whitbourne, 1987 for a contrasting approach). Certainly, the propositions made by Baltes and Baltes cogently describe an integrative theoretical framework for understanding human adaptation to loss, especially in later life, yet the process of *psychological adjustment* -- how the individual construes the changes in his or her adaptive potential -- seems to be relegated to the sidelines. Denial, resignation, and acceptance of loss are classical themes in psychology. What import do these processes have for successful aging? As we shall see, the dual process model addresses this very question.

2.2 The Dual Process Model

Perhaps the most fundamental premise of the dual process model is an insight made over a century ago by James (1890). The individual can be divided into the *actual* and *ideal self,* and discrepancies between the two are the source of psychological distress.

Naturally, there are two fundamental ways of remediating discrepancies between actual and ideal selves. Either the actual self can be improved to meet one's ideal, or the ideal can be lowered to conform with the actual self. For example, a golfer, dissatisfied with his game, has essentially two options. He can work hard on his game until it exceeds an accepted performance standard (e.g., until he shoots under par), or he can lower the performance standard he has set for himself. The first option targets the actual self, or the subject's current golfing ability. The second focuses on the ideal self, or the desired goal in this context.

Baltes and Baltes (1990) have argued that age-related losses are largely *irreversible* and *uncontrollable*. If this is truly the case, then active, strategic attempts to improve performance cannot hope to counter some forms of age-related loss. Despite the number of good older golfers, hand-eye coordination and strength inevitably fail with advanced age. Better clubs and increased practice on the driving range can help only so much. Ultimately, it would be reasonable for the subject to reappraise the goal he has set for himself.

To sum up, the essential premise of the dual process model is that *self-discrepancy* is the engine that drives the process of adaptation. A further tenet is that there are *two* fundamentally different yet perfectly complementary ways of resolving such discrepancy.

Assimilation has been defined as "instrumental or compensatory activities that aim at preventing or alleviating losses in domains which are relevant to self-esteem and identity (Brandtstädter & Greve, 1994; p. 52)." The processes of selection, optimization, and compensation already alluded to above serve these functions as well and can thus be categorized as forms of assimilation. Active attempts to create a social reality that is congruent with one's self image, a process that has been termed "self-verification" (Swann, 1983), are also assimilative in nature. A teenager who selectively affiliates with those who are less popular, for example, is likely to solicit positive feedback. It is easy to solicit responses or expectations from the social environment simply through one's style of dress: Just wearing running shoes might lead others to believe a middle-aged adult is somewhat younger and athletic.

Accommodation has been defined as "readjustments of personal goals and aspirations which dampen or neutralize negative self-evaluations (Brandtstädter & Greve, 1994; p. 52)." Accommodative processes include a host of tricks that can ameliorate the impact of loss. *Disengagement from blocked goals* involves relinquishing a goal completely or finding a substitute to take its place, such as when an older man begins to feel less comfortable with his role as a businessman and more with his role as a grandfather. The *adjustment of aspirations* is reflected in declines in the perceived importance of certain personal goals. Placing less emphasis on one's personal appearance, on impressing others through one's style of dress, might reflect this process of adjustment. Finally, losses typically bring about different changes in life circumstance, and *palliative interpretations* serve to accentuate the positive. For example, having to rely on another person for help may make one feel incompetent; however, it can result in new friendships, and underscoring such developments softens the blow to one's self-esteem.

As mentioned earlier, the dual process model states that self-discrepancy drives the process of adaptation. If self-discrepancy can be effectively prevented, then there is no need to employ any sort of self-regulation strategy. Further development of the dual process model thus led to the identification of *immunization* processes (Greve, 1990). Greve differentiates between *data-driven* and *concept-driven* forms of defense. Data-driven forms of immunization entail a bias in the processing of negative self-perceptions; a person who denies making a mistake, forgets or disregards the fact that a mistake was made, or blames external circumstances for

its occurrence, indulges in data-driven immunization. Conversely, concept-driven forms of immunization involve redefining or reconceptualizing a descriptive attribute in terms of the individual's own strengths. Thus, an older person might come to redefine his notion of intelligence, emphasizing aspects that improve with age (such as factual knowledge, wisdom) rather than those that deteriorate (perceptual speed, rote memory).

The dual process model represents a significant step forward in our understanding of successful aging. It builds upon the model of selective optimization with compensation, acknowledging these very important mechanisms for improving performance, especially when confronted with loss. However, based upon the insight that age-related loss implies self-discrepancy, it goes on to present a finely differentiated picture of the many ways that aging individuals can resolve such discrepancies through psychological restructuring. The legacy of the dual process model is that reflection, reappraisal, and reinterpretation are fundamental mechanisms which curtail self-discrepancy and thus, promote psychological well-being.

The dual process model is also more nuanced than certain other models of successful aging (e.g., problem- vs. emotion-focused coping; Lazarus & Folkman, 1984). Brandtstädter and colleagues have often stressed the importance of differentiating between intentional and nonintentional processes of self-regulation. Assimilative processes are intentional strategies that are employed to counteract perceived losses. Accommodative processes, on the other hand, cannot be employed willfully or voluntarily. One cannot change one's preferences because it would be wise to do so. Hence, the processes that might promote accommodation are likely to be very different from those that promote assimilation.

A further advantage to the dual process model is that it conjoins these two distinct processes into a mechanized whole, complete with mediating factors (Brandtstädter, Wentura and Rothermund, 1999). Immunization processes involve the defensive negotiation of self-discrepant evidence and can thus be construed as an important first step in the psychological adjustment process. Once the individual acknowledges loss, however, further correctives are required. The ensuing processes of assimilation and accommodation are intertwined in a series of feedback loops. Assimilative strategies are employed when personal control can be increased (e.g., through practice) or external aids can be readily employed. If this fails,

accommodative processes aid the restructuring and/or rescaling of developmental goals so that assimilation can continue.

These assumptions can be directly tested. For example, according to the model, assimilation is functional when goals are realistic. Accommodation becomes functional when developmental potentials can no longer be realized. Yet accommodation should serve to adjust goals to future developmental potentials with a view to supporting further assimilative striving. Therefore, the model goes beyond a mere description of coping forms: it provides us with a model of how these processes interact and hence, affords us with a number of testable hypotheses which can be used to explore the nature of successful aging.

2.3 Critique

Having reviewed two models of successful aging, we are now able to turn to the question that prompted this line of inquiry: *What role does interpersonal dependency play in aging successfully?*

From the foregoing, it is quite evident that current models of successful aging focus on maintaining functional autonomy (or maintaining one's *sense* of autonomy) despite loss. The notions of successful aging are focused on the *self*. Moreover, they elevate *autonomy* or personal agency to the highest goal. Assimilation, much like compensation, can boost one's actual autonomy (or actual control of a situation) through intentional efforts to improve personal capability. Accommodation, much like selection, can boost one's sense of autonomy (or perceptions of control) through processes of disengagement, reappraisal and interpretation.

One salient feature of these models, then, is the lack of stature accorded to *interpersonal dependency*. Interpersonal dependency is either disregarded entirely (as is the case in the dual process model), or interpreted to be something of a failure, a view shared by much of Western society. Yet human development has long been understood in terms of *both* fundamental modalities, autonomy and dependency. Franz and White (1985) contend that "theories and methodologies emphasizing 'agentic' values such as autonomy ... [are] neglectful of half of human experience -- that is the communal, interpersonally connected part that is essential to the well-being of both males and females (p. 225)." Similarly, Lykes (1985) suggests that a notion of self rooted in assumptions of autonomy, independence, and separation is

predominant in mainstream Western culture. She argues that individuality must be contrasted with sociality. Women, as well as members of minority groups and the underprivileged, are more likely to adhere to a notion of self that is interdependent upon others. In contrast to the values embraced by the establishment, affiliation is experienced as a fundamental strength and a source of empowerment. This sentiment is echoed in the concept of *social coping* (Greenglass, 1993), which has been advanced as a third mechanism of adaptation, in addition to problem-focused and emotion-focused coping (Lazarus & Folkman, 1984).

When applied to the *caregiving context*, one must concede that models of successful aging do an admirable job of illustrating how the older individual might adapt to certain kinds of personal losses. Most of the examples of selection, optimization and compensation, for example, have been skillfully applied to all kinds of performance deficits that arise from health-related losses. However, there is a definite limit to the plasticity of behavior. Although the elderly have considerable untapped reserves, their potential to develop new sources of strength and resistance diminishes with age. It is also rather evident that the accommodative mechanisms cannot easily neutralize threats to essential domains of functioning, i.e., those which define the need for care. For example, how does one put a positive spin on the fact that one can no longer feed oneself? These observations illustrate two important facts: 1) assimilation and accommodation have limitations in explaining successful aging in long-term care; and 2) dependency upon others may, at least to some extent, be an unavoidable consequence of aging.

Moreover, as argued earlier, professional caregiving is not merely the result of functional health decline; rather, it is also precipitated by deficiencies in one's social support network. Preventing or coping with such deficiencies are issues that current models of successful aging may not be able to adequately address. Many of the older individuals encountered in caregiving settings resemble nothing so much as orphans, bereft of the social contact and support that most of us take for granted. Contact to family and friends is a priority to virtually all, but many do not seem unable to cultivate and maintain such ties to their satisfaction. Sustaining relationships in later life, especially maintaining one's support system in the face of expectable change, may be the key to unlocking the puzzle (Rosowsky, 1995).

The adroit management of social relationships is likely to require a host of strategies that are quite different from the mechanisms of assimilation or accommodation. Likewise, selective

optimization with compensation might not be the key to understanding how support is acquired and managed. Rather, it might be better to draw upon the vast literature on *interpersonal processes,* including theories and concepts which treat the formation of relationships, compatibility between partners, social exchange and reciprocity, social scripts, and especially, individual differences, such as sociability.

Present conceptions of successful aging then, must go beyond mechanisms of *self-regulation* to include processes of *social regulation.* A fundamental proposition of this view is that successful aging requires the individual to cultivate interpersonal dependency with others.

Previous Attempts to Integrate the Dependency Construct Into Notions of Successful Aging

Any discussion about what interpersonal dependency is would be quite remiss not to pay proper tribute to the seminal work of M. Baltes. Implicit to her earlier research is that dependency is to be avoided. For example, dependency is described as "an overwhelming negative phenomenon (p. 301; Baltes, 1988)." Even if it can sometimes serve to procure attention, dependency is viewed as a poor means of control, one that might legitimately be considered manipulative. The author stresses, nonetheless, that dependency might be the only available means of procuring attention from others; hence, her early writing betrays a certain ambivalence toward the construct.

Later conceptualizations of dependency are much more positive. In a major article on successful aging in long-term care institutions, Baltes, Wahl and Reichert (1991) discuss dependency upon others as one form of compensation. Elderly care recipients, they write, rely upon nursing staff, just as they rely on other environmental supports, such as grab-bars and wheelchairs. Similar arguments have been put forward in other models of successful aging (primary compensation; Heckhausen & Schulz, 1995). The Baltes group maintains that while dependency itself is not to be avoided, an excess of dependency ("overcompensation") certainly is. Blame for overcompensation is placed squarely upon the shoulders of the nursing staff. Thus, in this review, the natural expression of dependency among older individuals appears to have lost its negative connotations.

A later theoretical development elevated dependency from being a form of compensation to a third means of coping with loss, on equal footing with selection and compensation (Horgas,

Wahl & Baltes, 1996). Here, dependency is viewed as an act of delegation which frees up the older individual's resources for other pursuits. Time and energy can be saved by having another person's assistance. Of crucial importance here is that dependency is viewed as an *intentional strategy* that serves the greater goal of *autonomy*. The term *proxy control* was later given to describe such acts of delegation (Baltes, 1996). The concept of dependency as a strategic form of coping, one which complements the processes of selection, optimization, and compensation, has continued to this day (Gignac, Cott & Badley, 2000).

The latest theoretical advance was put forward by M. Baltes in *The Many Faces of Dependency in Old Age* (1996), which stresses that dependency is necessary and appropriate in certain relationships. For example, most therapists, especially psychoanalytically oriented ones, maintain that a successful therapeutic relationship requires dependency from the client. Second, cultural mores dictate that dependency is necessary and appropriate at certain times (e.g., during mourning) or at certain developmental stages (e.g., in early childhood, in forming intimate relationships). The challenge, she argues, is not to eliminate dependency, but to find a *balance* between dependent and autonomous functioning. *Interdependence* is a term she uses to describe the need for both agency and attachment in adulthood (Baltes & Silverberg, 1994).

It was perhaps inevitable for theorists to acknowledge that dependency is necessary and appropriate in *all* of life's developmental stages. Such thinking reflects the social nature of human-beings, our natural desire to commune with one another, to seek bonds of trust and mutual obligation. Dependency, including dependency in caregiving contexts, thus goes far beyond the desire for social control, and in retrospect, the integration of dependency into the model of selective optimization through compensation may have been misguided. To state that interpersonal dependency is simply a form of "environmental compensation" is consumerist and ultimately, dehumanizing. Interpersonal dependency must be accorded a much larger role in human development.

The reconceptualization of dependency as an essential feature of successful aging may be gaining momentum. A spate of theoretical articles have been published in recent years, emphasizing the functional nature of dependency. Most recently, Pincus and Wilson (2001) differentiate between love dependence ("the need to obtain and maintain proximal relationships with nurturing others; p. 242"), exploitable dependence ("the need to obtain and

maintain acceptance and appreciation from others and avoid conflicts; p. 243") and submissive dependence ("the need to obtain and maintain instrumental support from others; p. 243"). The results clearly indicate that love dependence is related to adaptive functioning, whereas exploitable and submissive dependence are not. Even though few of these results touch upon later life development, it is quite plausible to conclude that some forms of dependency might facilitate successful aging.

This assumption is supported by the notion of social or relational competence (Hansson & Carpenter, 1994). Hansson and Carpenter introduce their model of relational competence by tentatively dividing dependency into seven stages and illustrating the tasks associated with each stage. With the advent of caregiving, for example, the elder must clarify and assert his or her needs, as well as lay down the ground rules for receiving help. As dependency increases, sustaining family contact and easing collective burden become new challenges. By framing dependency in terms of relational competence, the authors implicitly view the construction, utilization, and maintenance of dependency relationships as being generally functional and adaptive. They furthermore contend that relational competence may be particularly useful in addressing the consequences of age-related dependency.

Finally, Bornstein (1998) traces the development of the dependency construct to its earliest roots. Psychoanalytic, social learning, and interpersonal views of dependency presume that the dependent individual is immature, feminine, or weak. Bornstein feels that it is high time to "depathologize" dependency. The empirical findings he reviews convincingly demonstrate that dependency is not a flaw or deficit in functioning, but can be an active, adaptive, and mature style of human interaction. Moreover, the author contends that "life-span developmental models have the potential to play a key role in depathologizing dependency...dependency in late adulthood can, if conceptualized accurately and responded to appropriately, be an important part of successful aging (p. 72)."

To sum up: Any model of successful aging that disregards interpersonal dependency, or frames it merely in terms of control, neglects the *social nature of human-beings*. Every individual is embedded in a supportive milieu, and interpersonal dependency is a natural part of human interaction. We are all dependent, in some ways, upon others. In fact, complete autonomy would be torturous. Perhaps the desire to feel needed, loved, and worthy are not goals in the strict sense of the word, and, therefore, classic models of successful aging have

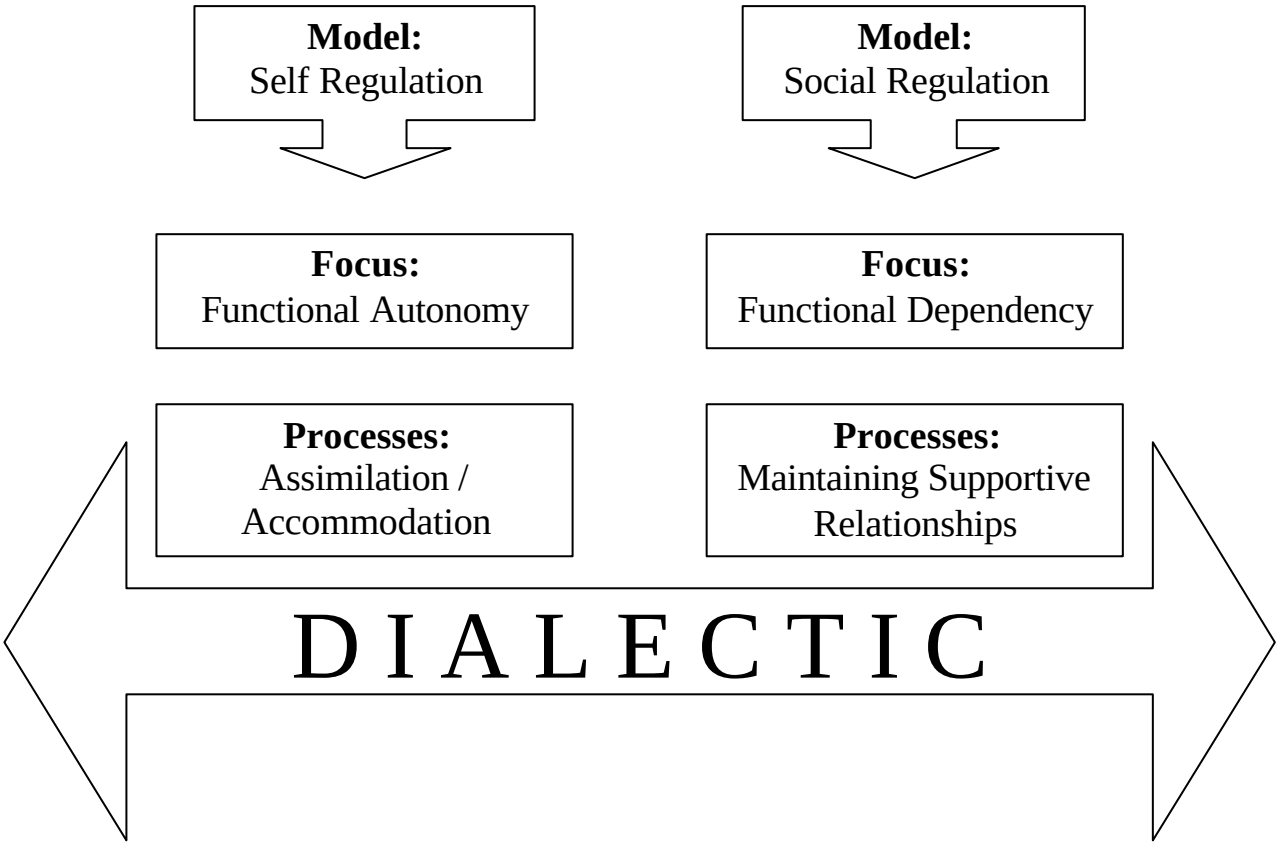
not addressed them. Yet certainly, satisfying these needs is essential to successful aging -- indeed to all human existence.

Interpersonal dependency is anything but a failure. It is how many cope with age-related loss. It can be highly functional, a deeply satisfying and self-affirming way of coping in its highest form, a rational form of delegation that frees up resources for other pursuits, in its lowest.

3. The Autonomy-Dependency Dialectic

Dependency and autonomy, it has been argued, are not polar opposites (Baltes & Silverberg, 1994). This is a rather peculiar contention given the etymological roots of the words "dependent" and "independent," but it is actually not an uncommon assertion. What theorists are trying to reconcile by making this claim, perhaps, is the fact that dependency and autonomy are both part of life. The relation between autonomy and dependency can be better viewed as a *dialectic* (see **Figure 1**).

Figure 1. Dialectical Approach to Understanding Autonomy-Dependency



What is a dialectic? A dialectic, as defined here, is not simply a dimension which can be used to discriminate different states of being, such as happy vs. sad or young vs. old. Rather, it is a dimension which necessarily implies maintaining a *balance* (Wrightsman, 1992) or *tension* (Carlson, 1972) between opposite poles. The "dialectics" that define Erikson's developmental stages, such as trust vs. mistrust, are not true dialectics under such a definition. A dialectic often provides a more nuanced understanding of a given phenomenon than a dimension and subsequently, offers a better theoretical heuristic. In line with this argument, Carlson (1972) levels an incisive critique against the simplistic application of dimensions in personality psychology, stating that "psychologists have tended to bypass the troublesome and challenging issues posed by polarity constructs by collapsing intrinsically qualitative dichotomies into endpoints of bipolar unidimensional scales (p. 22)."

A *dialectic approach to development* might be understood as the necessity to strive toward two developmental goals, each of which competes with the other. What is essential to the

notion of a dialectic in a developmental context is that both of the goals or tasks are desirable. For example, autonomy, it has been argued, can only be purchased at the price of security (Parmalee and Lawton, 1990). Nonetheless, it is quite obvious that one should seek to enhance both autonomy and security whenever possible. Other examples of dialectics that operate in developmental contexts include individuation vs. attachment (Hansburg, 1986), individuality vs. sociality (Lykes, 1985) and solitude vs. companionship (Rook, 1990).

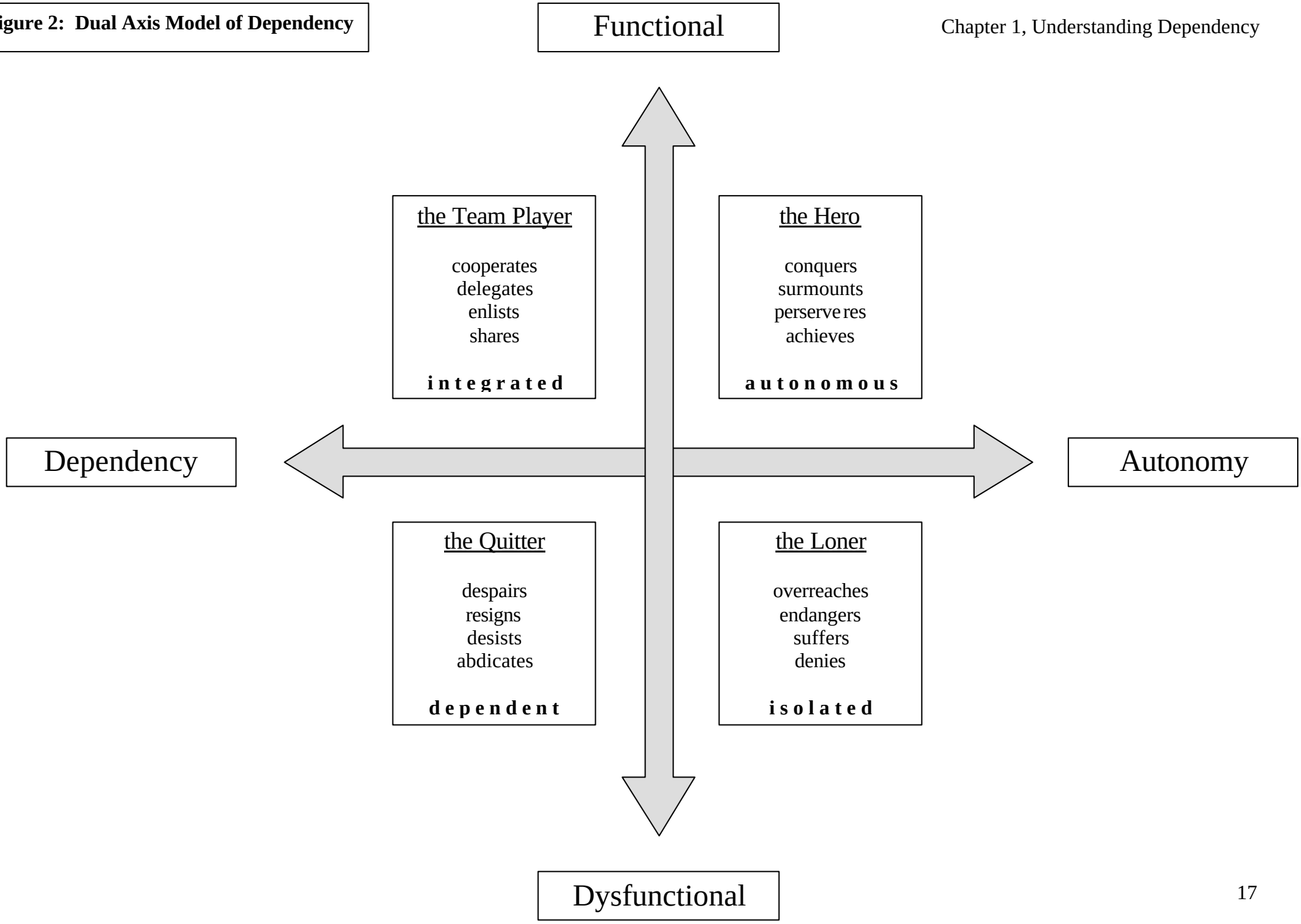
The logical consequence of viewing the relation between autonomy and dependency as a dialectic, of course, is that both autonomy and dependency become goals worth pursuing. Although it may sound counterintuitive, this means that one should encourage interpersonal dependency as well as personal autonomy. The key to understanding this paradox is the realization that autonomy and dependency, depending upon circumstances, can be functional or dysfunctional.

A similar idea was recently advanced by Nadler (1997). The author writes of *autonomous help-seeking* (which results in future independence) as opposed to *dependent help-seeking* (which results in *overutilization of help*), and *underutilization of help* (which results in prolongation of hardship or suffering). Bornstein and Bowen (1995) make the same conceptual differentiation in therapy with dependent clients. Accordingly:

> "... a central goal of psychotherapy with dependent patients need not be a wholesale reduction in dependency-related motivations. Rather, successful psychotherapy with the dependent patient should focus on helping the patient achieve a healthy balance between his/her strivings for dependency and connectedness on the one hand, and for autonomy and independence on the other (p. 530)."

The autonomy vs. dependency dialectic, then, can perhaps best be viewed from a functionalist perspective (see **Figure 2**).

Figure 2: Dual Axis Model of Dependency



My definition of *functional autonomy* can be taken directly from the dual process model outlined above. Individuals should strive to the best of their ability to correct self-discrepancies, as long as the means to do so are available and the chances of success appear reasonable. When goals become frustrated, reappraisal of one's performance standards or accommodative shifts in preferences serve to preserve a sense of functional autonomy.

Dysfunctional autonomy occurs when the individual seeks to master situations that cannot be mastered, or to be more precise, cannot be mastered alone. Strong control beliefs can help produce an adaptive response, but there are certain situations over which the individual has little or no control. The belief that one can control the uncontrollable is unrealistic at best, and might produce irrational guilt or pathology at worst if the individual stubbornly refuses to accept help in order to achieve desired goals or alleviate suffering (Janoff-Bulman & Brickman, 1982; Thompson, Cheek & Graham, 1988). Dysfunctional autonomy can lead to serious injury and even death, such as when individuals, despite age-related decrement in strength, coordination, or vision, persist in strenuous lifting, making major household repairs, or driving an automobile long after they should have given up such endeavors.

Functional dependency would entail acknowledging when one needs help, accepting and actively seeking out help when necessary, cooperating with one's helper in a constructive fashion, as well as developing and deepening the dependency relationship, if appropriate. Sensitivity to the needs of one's helper is always a priority for the functionally dependent individual. Given time and mutual compatibility, emotional bonding with such partners may occur. Functional dependency, in a larger sense, entails not only accessing the social support network, but also constructing and maintaining it over one's lifetime.

Dysfunctional dependency results from not living up to one's potential due to fear, ignorance, helplessness or sheer laziness. I would also define the use of dependency as a strategic means of leverage as dysfunctional (e.g., feigning dependency or malingering in order to procure social contact or sympathy). Contingent reinforcement of dependent behavior is an example of dysfunctional dependency that is instigated by the social environment. Socially reinforced dependency is the form most often discussed in the caregiving literature and has been variously termed "excess disability" (Kahn, 1975), "nurse-induced dependency" (Miller, 1985), and "learned dependency" (Baltes, 1996).

By this point, I hope to have provided the reader with a balanced view of autonomy and dependency. Dependency, it has been argued, is an essential part of human existence. Maintaining the equilibrium of the autonomy vs. dependency dialectic is a developmental challenge for all ages, but it takes on special meaning for the disabled elderly individual, whose social resources may be extremely limited and therefore require careful conservation and management. Indeed, the individual with a dependent nature, who is adept at soliciting help and sensitive to the needs of helpers, and who enjoys being cared for when the situation demands such attention, is likely to deal well with age-related challenges.

Having posited that successful aging goes beyond functional autonomy to include functional dependency, we are now in a position to examine empirical research on interpersonal dependency among the elderly.