Chapter 3. An Alternative Psychological Approach to Dependency Among the Elderly

In this chapter, an alternative approach to understanding dependency in caregiving contexts is presented. The starting point of the theoretical inquiry is the simple question: *Why do some older care recipients become more dependent upon their caregivers than others?* The lion's share of this chapter attempts to answer this question. Accordingly, three plausible explanations for dependency behavior, based upon *the dependent personality, trait affiliation,* and *attitudes toward authority,* are presented.

Each of the following sections (**Sections 1-3**) is dedicated to one of these personality constructs. The sections contain an introduction, which first describes the construct and the instruments commonly used to measure it. Empirical findings are used to explore: 1) whether or not the personality dimension is elevated among elderly, and 2) whether it has been linked to dependent behavior, such as compliance, yielding, or help-seeking. Finally, these personality concepts are extended to address issues in the lives of older adults. Three new variations of the standard concepts -- *stoicism, caregiver affiliation,* and *respect for medical authority* -- are presented.

The final section of this chapter (**Section 4**), builds upon existing notions of caregiving. Traditionally, psychological studies of caregiving have restricted their investigation to the assistance received with daily activities, such as bathing and dressing. Elder care, of course, comprises much more, including *monitoring the patient's health and activity,* as well as *providing emotional support and guidance*. Based upon theoretical considerations, I attempt to define and catalogue these forms of assistance and exchange under the rubric of *social dependency.*

1. The Dependent Personality

The dependent personality offers us the first, and perhaps most plausible explanation of why some older care recipients become overly dependent upon their caregivers. The individual with a dependent personality, by definition, exhibits a proclivity to solicit help and reassurance from others.

1.1 Introduction

Dependency, from the eyes of a personality theorist, is a trait or personality type that is acquired early in life and demonstrates relative stability throughout the lifespan. In his seminal book on the subject, *the Dependent Personality*, Robert Bornstein (1993) defines dependency in terms of its motivational, cognitive, affective, and behavioral sequelae. The dependent behaviors he describes best illustrate what is meant by the concept and include the tendency to seek help, support, approval, guidance, and reassurance from others. Trait dependency has been furthermore linked to passivity, conformity, and the tendency to yield to others, especially authority figures, in interpersonal transactions.

The notion of dependency as an individual characteristic may seem strange to advocates of social reinforcement theory, but one should note that excessive dependency has long earned the distinction of being identified as a personality disorder in the Diagnostic and Statistical Manual of Mental Disorders. According to the most recent manual (DSM-IV), the essential feature of dependent personality disorder is: "a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation ... The dependent and submissive behaviors are designed to elicit caregiving and arise from a self-perception of being unable to function adequately without the help of others (p. 665)." The authors note that the disorder may occur in an individual who has a serious medical condition or disability, which makes differential diagnosis difficult. They furthermore assert that dependent personality disorder is one of the most frequently reported personality disorders in mental health clinics.[i]

The psychometric literature affords the interested reader a broad palette of instruments that measure various forms of psychological dependency. Bornstein (1993) alone lists a dozen or so, ranging from projective tests (*Rorschach Oral Dependency Scale*; Masling et al., 1967) to multidimensional objective tests (*Measure of Interpersonal Dependency*; Hirschfield et al., 1977). Many of the standard personality inventories, it will be noted, also contain dimensions that assess trait dependency. For example, Greene (1980) describes a *Dependency Scale (Dy)* comprising 57 items from the Minnesota Multiphasic Inventory. High scorers on the scale are described as being "dependent, submissive and passive (p. 191)." The *16 Personality Factors Questionnaire* (Cattel & Eber, 1962) contains no less than four factors that bear some resemblance to the dependency construct, including *humility* ("mild, accommodating,

conforming...docile...dependent; p. 14"), *tender-mindedness* ("dependent, overprotected...demanding of attention or and help; p. 15"), *group-dependent* ("...likes and depends on social approval...tends to go along...needs group support; p. 17"), and *subduedness* ("...group-dependent, chastened, passive personality...likely to desire and need support from other persons and likely to orient his behavior toward persons who give such support; p. 22"). Dependency needs also figure prominently in the writings of Murray (1938) and the personality measures that evolved from them, such as the *Thematic Apperception Test* (Kagan & Mussen, 1956) and the *Personality Research Form* (Jackson, 1970).

1.2 Empirical Studies on the Dependent Personality

There is quite a vast and rich literature on the dependent personality. The number of psychometric and projective instruments developed to assess this feature of one's personality, as well as the identification of severe dependency as a standard clinical disorder, attests to this fact. Not very much of the research, however, has dealt specifically with older individuals. Still, there is no reason why the theoretical concepts and empirical findings would not apply to older individuals. As one might guess, the dependent personality has been strongly linked to dependent behavior.

1.2.1 The Dependent Personality and Compliance

As mentioned earlier, the dependent personality has been associated with behavioral compliance and help-seeking, especially in conjunction with authority figures. Unfortunately, Bornstein's (1993) review comprises a rather large number of old, obscure references regarding compliance in experimental situations (e.g., complying with impossible task demands, yielding to group opinion). In a later study, however, Bornstein and Masling (1985) demonstrated that dependent individuals are more likely to promptly comply with a research participation requirement in a sample of college freshman. Other recent research has also shown that dependent individuals are more likely to seek help from the experimenter in tightly controlled laboratory tasks (e.g., Shilkret & Masling, 1981; Sroufe, Fox & Pancake, 1983).

Nonetheless, much of the empirical work linking dependency to compliance appeared in the 50s and 60s. An additional drawback is that much of the research employs artificial

laboratory tasks as the measure of behavioral dependency. Finally, one must concede that virtually all of these studies have focused exclusively on children and young adults. Clearly, the existing literature might benefit from *newer* research that focuses on *elderly* subjects in a *natural* setting. Studies involving elderly care recipients, which observe dependency in real-life care interactions (e.g., dressing oneself, pursuing meaningful leisure activities with a professional caregiver), provide a golden opportunity for demonstrating the ecological validity of the dependency construct.

1.2.2 The Dependent Personality and Help Seeking

Patients are prone to develop psychological dependency upon their helpers, and the elderly care recipient is no exception. After an illuminating review of the literature on dependency and patienthood, Bornstein (1993) concludes that "...the onset of an episode of illness tends to produce increases in dependent behavior even in persons who do not ordinarily show exaggerated dependency needs (p. 145)." Thus, elderly care recipients might be expected to demonstrate elevated levels of trait dependency.

A sizable body of literature has examined individual differences in dependency and how they affect various kinds of patient behavior. For example, studies have convincingly demonstrated that the dependent personality seeks prompt treatment for physical illness (Greenberg & Fisher, 1977). One reason may be that the dependent personality is more willing to enter into a doctor-patient relationship and has a more positive attitude towards physicians and inpatient treatment in general (Greenberg & Fisher, 1977; Zeldow & Greenberg, 1980). Dependent individuals have also been found to remain in treatment for longer intervals than their nondependent counterparts (Greenberg & Bornstein, 1989). The latter study, based on a sample of 75 psychiatric patients, found that women who received high scores on a projective test of oral dependency remained hospitalized for almost twice as long as those who received low scores.

Clear evidence that trait dependency is associated with help-seeking in a therapeutic context is provided by Lorr and McNair (1964). In their study, 150 male patients being treated for psychological disorders were rated by their therapists regarding dependent behavior. Of the ten behaviors most strongly correlated with dependency scores, the top three were:

1. relies on the therapist for support or reassurance
2. seeks or requests direct advice and guidance
3. submissively and passively solicits help

This does not imply that dependency is an undesirable characteristic or hampers the therapist-client relationship. To the contrary, dependency in therapeutic contexts quite often has beneficial effects. For example, dependent persons in drug rehabilitation are more willing to comply with lengthy treatment regimens and remain abstinent than their nondependent counterparts (Poldrugo & Forti, 1988 cited by Bornstein & Bowen, 1995).

It stands to reason that if the dependent individual is inclined to seek excessive help and guidance from a therapist, then he or she will do the same with a geriatric nurse. Overall, the studies reviewed here clearly underscore the importance of trait dependency for understanding patient behavior. Results from medical contexts indicate that dependent individuals are hard pressed to relinquish the patient role, with obvious social and financial implications for health care delivery among the elderly.

1.3 New Directions: Stoicism

As a rule, elderly individuals do not enjoy being dependent upon others. In contemporary society, one tends to associate dependency with incompetence or worse, with terminal decline. It is therefore natural for the elderly individual, despite encroaching limitations, to focus on his or her *autonomy.* Many elderly take pride in having lived so long and having been able to weather the adversities that life has dealt them. Thus, the older individual today often appears to be tough and independent-minded: features that are diametrically opposed to the dependent personality.

My observations in a nursing home context support these notions. For instance, it is commonplace for residents of nursing homes -- even those with weighty functional limitations -- to attest that they are self-reliant. Moreover, most state that they are well-satisfied with their present accommodations, however modest they may be. Another striking feature of many nursing home residents is their ability to endure the innumerable aches and pains that accompany aging with relatively little complaint. The older individual's tenacity in the face

of challenging circumstances is praiseworthy to be sure, but more to the point: is there a coherent way to describe these attitudes?

Indeed, the attitudes observed seemed to represent a life philosophy, one that was decidedly stoic in nature. *Stoicism* is described in the Encyclopedia of Philosophy as a Hellenistic philosophy in which things such as health, property, and honor are viewed as advantages, not needs (Hallie, 1972). The definition of a stoic individual, offered by the Random House dictionary, is one who is "free from passion, unmoved by joy or grief, and able to submit without complaint to unavoidable necessity." These values appear to be engrained in the character of older Germans.

Origins of Stoicism Among the Elderly

But where did these values come from? Without doubt, the origins of the stoic character lie in the historical events that shaped the early parts of the 20th century. As Elder (1981) noted, "The imprint of history is one of the most neglected facts in [human] development. Lives are shaped by the settings in which they are lived and by the time of encounters with historical forces (p. 3)." I see the simplicity of life at the turn of the century, the suffering experienced during two World Wars, especially the relative hardship and adversity that ensued in the period of reconstruction, as well as traditional religious and ideological beliefs comingling in the formation of the stoic character.

Technological advances have brought such comfort to modern living that it is sometimes hard to appreciate the harshness of growing up in yesteryear. Johnson (1995), for instance, reports that Black Americans express contentment despite having experienced incredible hardship, such as lifelong poverty and racism. She poignantly describes the lives of these persons, most of whom "grew up as the children or grandchildren of slaves [and] defined a good childhood as never going to bed hungry (p. 23)." The persons in these studies were likely to compare their past life, rather than more objective standards, as a reference point. This aura of survivorship, of having been beaten down and overcome great odds, she argues, gives sustained meaning to their lives, even unto old age.

Recession and war are world events that profoundly influence human development. Surviving a social crisis, like the Great Depression, can sometimes foster growth and wisdom

(Ardelt, 1998). However, the challenges imposed by such calamities can seriously threaten one's very existence, not to mention chances for personal fulfillment in life. Although the United States was never invaded in World War II, Tuttle (1993) speculates on how the war affected the lives of American boys and girls. The fear and uncertainty experienced by these youngsters might be expected to diminish their future prospects for happiness. War-time migration, the separation of the father from the family, and the engagement of the mother in bread-earning activities are only some of the disruptions in family structure that surely changed the lives of those growing up in the 40s. If these phenomena is worthy of research in young Americans, how much more so is this true of young Germans!

Wartime experiences may have played a particularly prominent role in making the older generation of Germans a tough and resilient group of individuals. Because of the collective guilt shared by the German people for their complicity in the Holocaust, it is easily forgotten that they too suffered atrocities during the war and a very painful period of recovery afterwards. Like most other older Europeans today, the older German is very much a survivor.

Few have illustrated this fact more eloquently than Meyer and Schulze (1985), who recount the stories of five Berlin families during and after the second World War. It would be quite difficult, in the space of a paragraph, to capture the despair and devastation that each family endured. The men were generally absent from 1942 to 1948, and some returned home many years later. Life was characterized by a never-ending struggle to obtain material wants -- food, warmth, shelter -- and gnawing fears about air raids and invasion. The family awaited news from their husbands and fathers with equal portions of hope and dread. The exhausting task of raising children in a war-torn environment naturally took its toll on the young mothers left behind. That their burden only became heavier when the men finally returned is just one of the cruel ironies of the war. Years of fighting and imprisonment left most men with grievous injuries and emotional problems, rendering them incapable of returning to the supportive and pivotal position they had once enjoyed. Not only did marriages suffer, but in many of the accounts, the distance between father and child often proved to be wholly unbridgeable.

Yet even under these horrific circumstances some gains were to be had. Meyer and Schulze speak with particular praise for the women of the era, whose "autonomy and self-confidence

[thus gained] had far-reaching consequences. Women learned to cope with the most difficult of life circumstance without the support of their husbands (p. 215; author's translation)." There is no doubt in my mind that the strengths acquired in this manner would be adaptive in dealing with most any developmental challenge in later life.

Of course, hunger and poverty were not wiped out with the signing of the armistice. Much of Germany lay in ruins. Although the German Economic Miracle (or "Wirtschaftswunder") was touted as a remarkable achievement, it could first be felt by the end of the 50s, and then, only in modest terms. Meyer and Schulze note that by the time the standard of living improved to normal, the respondents were already between 40 and 60 years of age. Perhaps due to this fact, they argue, many of the older persons interviewed still lived in very modest accommodations: the economic and employment markets were so catastrophic that their impact was felt for many years afterwards.

Housing was particularly scarce after the war, and extreme crowding became a necessity (Pallowski, 1985). Children and adolescents were often crammed in twos, threes, and fours to a room until the late 1950s. Further data from 1955 cited in this source shows that only circa 10% of all households had refrigerators, washing machines, and/or hotwater boilers. Only six percent of the populace had automobiles. Even by 1960, a significant minority could still not afford major appliances, such as washing machines and televisions. Thus, although some may have escaped the ravages of war, few had access to the material comforts that we today take for granted. The relative hardship that ensued may have gone a long way to fomenting a stoic life philosophy among the people who lived through the lengthy reconstruction of postwar Germany.

The foundations of stoicism, especially in German elders, might also be traced back to social ideologies that were prevalent in the 19th and early 20th centuries, namely the Protestant Ethic. In his book, *Conceptualizing Philosophies of Human Nature*, Lawrence Wrightsman presents an apt description of the Protestant Ethic taken from the famous German philosopher, Max Weber:

> "Human nature was seen as independent and self-reliant. People were strongly motivated and responsible for their own welfare. They possessed the vibrant feeling of control over their own welfare and the belief that, through thrift, hard work, and competitive struggle, they could raise their position in life. The Protestant Ethic was a variation of the Spartan view of a durable mankind ... It

> was the dominant philosophy of human nature in that 'Century of Hope,' the 19th century, that seems so far away from our own time (p. 57)."

Many features of stoic philosophy are clearly illustrated here: self-reliance, thrift, and hard work. Although many of these virtues are still alive today, contemporary society places more emphasis upon mutual cooperation and acceptance (Wrightsman, 1992). The outlines of the dependency vs. autonomy dialectic discussed earlier are faintly visible in this description of changing cultural values. Society may be learning to embrace the concept of dependency.

1.4 Summary

The concept of (trait) dependency offers a plausible explanation of dependency in older care recipients. Both experimental and natural field studies have convincingly demonstrated that trait dependency is associated with help-seeking behaviors. (Even more weight must be accorded these findings, given the wide array of subjects and measures employed.) There is every reason to believe that the elderly care recipients with a dependent personality structure would readily solicit and accept more help from their caregiver.

Stoicism is offered as a construct that places value on self-reliance and toughness; hence, in many ways, it represents the antithesis of the dependent personality. Unlike trait dependency, stoicism represents a life philosophy, i.e., it is framed in terms of moral prescriptions, or how one *ought* to act. A stoic life philosophy might be particularly prevalent among today's elders, especially those who are old enough to have witnessed the cataclysmic events that have indelibly shaped the first half of the 20th century.

Excurs: On the Relation between Attachment and Emotional Dependency

Attachment and the emotional dependency are similar concepts, yet strikingly different in certain respects. In the literature on attachment, some interesting theoretical parallels have been put forward comparing human development in early and later stages of life. Empirical research has only begun to delve into the evolution of attachment in late-life relationships.

Conceptual Differences between Attachment and Emotional Dependency

Attachment, in its classical sense, is reserved for *early* developmental contexts. Although Bowlby (1969) alluded to the fact that attachment has an impact on development from the cradle to the grave, the lion's share of attachment research focuses on the process by which the child bonds to a special person, usually the mother. Attachment is an affectional tie whose existence can be inferred by proximity-seeking and anxious behaviors. It is thus a concept which ultimately characterizes a single, unique, and most often reciprocal relationship. Later research has expanded the notion of attachment into other developmental contexts (e.g., romantic attachment).

The development of the dependent personality in childhood has also been the subject of extensive investigation. However, the hallmark of the dependent personality appears to be help-seeking, and this tendency can be generalized to others (not just one person) and can manifest itself in many different life contexts (not just early developmental ones). A corollary of this insight, of course, is that dependency is commonly understood in terms of social interactions (and not relationships).

Because the present study focuses on the elderly, and their dependency upon a team of caregivers, the construct of trait dependency seems more suitable to the present point of inquiry. Nonetheless, attachment theorists have ventured a few interesting ideas about social relationships in later life. Kalish and Knudtson (1976) see a direct parallel between the conditions which foster attachment behavior in children and the elderly. According to their argument, attachment allows children to compensate for the fact that they are weak and vulnerable. Similarly, as older individuals begin to lose mastery and control, they too may revert to attachment behavior. However, by old age, the early objects of attachment have disappeared, so elders turn to younger members of the family (preferably, the sons and daughters who care for them). The authors go on to claim that other health care personnel, such as doctors, nurses, welfare workers, might also become attachment figures, though this form of affectional bond is generally weaker and rarely mutual. Similar propositions have been put forward by Hansburg (1980) and Main (1999).

Empirical Research on Attachment in the Elderly

Empirical studies on attachment in the elderly are few and far between. Hansburg (1972) has investigated attachment during childhood and adolescent development. By means of the *Separation Anxiety Test* (SAT), a projective technique for eliciting emotional responses to separation, the author has attempted to describe and catalogue how young boys and girls react to significant change experiences (such as moving to a different home, losing one's mother). Many of these responses, depending upon how one groups them, can be understood as forms of hostility, anxiety, and withdrawal. More importantly, Hansburg (1972) examines the balance of *attachment* vs. *individuation* responses to the SAT. Depending upon context, both attachment and individuation (a response characterized by self-reliance) are interpreted as adaptive forms of coping.

In a later paper, Hansburg (1986) describes the application of the SAT to a sample of 100 elderly individuals. The sample was divided into five different groups in light of their level of activity and functioning, contrasting those living an active and healthy life at home with those living in nursing homes and medical facilities. Although the analysis was somewhat rudimentary, relying upon descriptive statistics (mean scores of different groups) not subject to significance testing, the results are still interesting: elders living a dependent lifestyle displayed more vulnerability to separation distress. In 11 out of 16 factors, the emotional responses to separation were higher among the functionally disabled groups. A subsequent analysis of the sample, divided this time according to age group, suggested that age per se did not have an impact on the insecure attachment exhibited. Hansburg (1980) interprets these findings in terms of age-related disability, suggesting that the physical dependency that results from poor health can easily lead to feelings of insecure attachment among the elderly.

In a similar study, Park and Vanderberg (1994) examined the impact of attachment on life satisfaction in the elderly. Using an index of attachment-individuation balance (AIB) developed by Hansburg (1986), the authors divided their sample of elderly subjects into those who were overly dependent and those who were overly self-sufficient. One of the major hypotheses in this study was that overly dependent individuals, due to their personality structure, would be better able to cope with age-related losses to autonomy (worsening health, loss in social activity, physical decline in the last five years). Surprisingly, the results were precisely the opposite: when confronted with a loss of autonomy, overly dependent elders

reported a more pronounced and highly significant drop in life satisfaction scores compared to the study's other subjects.

This study can be critiqued regarding the methods used to measure attachment: like Hansburg (1986), the authors employed a test with elderly subjects that was originally designed for adolescents. Conversely, West and Sheldon (1988) developed an instrument for assessing four kinds of pathological attachment in adults. Based largely upon Bowlby's theoretical framework, West and Sheldon describe *compulsive self-reliance, compulsive care giving, compulsive care seeking,* and *angry withdrawal.*

Compulsive care seeking, which arises from doubts regarding the attachment figure's availability and responsiveness, is particularly interesting in the present context. A person exhibiting this form of pathological attachment "...defines life in terms of problems that require assistance ... defines the attachment relationship in terms of receiving care ... [and] ... expects the attachment figure to assume responsibility for major areas of one's life (p. 155)." West and Sheldon go on to draw a parallel between dependent personality disorder and compulsive care seeking. While one cannot deny that dependent individuals engage in compulsive care seeking, the comparison fails to recognize that individuals with dependent personality disorder seek help from many different figures, not just one.

Conclusions

Research on attachment in later life is still in its early stages. Some interesting, yet very tentative theoretical parallels between early (adolescent) and late human development have been put forward. Very few studies have empirically investigated attachment among the elderly in need of care, however.

2. Trait Affiliation

In the previous section, I argued that that dependency in the caregiving context might be associated with dependent personality traits. Of course, this is only one explanation why some elderly care recipients become overly dependent upon their caregivers. There are other personality constructs that might also influence dependency in the caregiving context, and *trait affiliation* is one of them.

To understand the argument, one must acknowledge that caregiving isn't only about receiving physical assistance. In the caregiving context, every interaction offers the elderly individual a chance to obtain social contact, to exchange a few words or thoughts with a fellow human-being. Individuals who enjoy social contact thus have a motive to seek out or prolong interactions with their caregivers: they might be inclined to ask for help when in reality, no help is needed. For these reasons, trait affiliation might be associated with higher dependency.

2.1 Introduction

The affiliation construct requires little introduction. It is a standard part of almost every major personality inventory used today (e.g., similar constructs are to be found in the MMPI, 16-PF, and PRF). Affiliation tendency is expressed in social behaviors; the individual with this tendency prefers to work and socialize with others, and will avoid being alone. The desire to affiliate with others can be linked to social competence and extraversion (which encompasses the tendency to be outgoing, among others).

2.2 Empirical Studies on Trait Affiliation

Trait affiliation, understood strictly as a personality construct, has not figured prominently in aging research. However, *social engagement* might be thought of as an expression of one's desire to affiliate. Similarly, *loneliness* also has conceptual links to trait affiliation, and these issues have long been areas of interest in gerontology. In general, the literature shows that affiliation needs of the elderly -- especially the disabled elderly individual -- may be frustrated, giving the older individual a strong motive for seeking out the help and companionship of a caregiver.

2.2.1 Social Engagement in the Elderly

Research on *social engagement* in the elderly can offer us precious insights into personality because social behavior can be construed as an expression of affiliation tendency. The decline of social activity in later life is a well-established fact (e.g., Carstensen, 1987). Theoretical explanations for the decline, however, diverge greatly. *Disengagement theory*

(Cumming & Henry, 1961) suggests that older individuals naturally lose interest and thus decrease investment in social activities. Conversely, *activity theory* suggests that decline in social activity is due to age-related barriers, such as health restrictions and stereotypes. In other words, the desire to affiliate with others remains strong, but is frustrated by external circumstances surrounding growing old. A third explanation for age-related decline in social activity is *selectivity theory* (Carstensen, 1989). According to this theoretical account, affiliation does not decrease, but is rather focused on a select number of persons as a means of affect regulation.

The current perspective on social engagement is that it is essential to healthy aging. For example, the assessment of social engagement has been federally mandated in the Resident Assessment Instrument for nursing home populations (Mor et al., 1995). And a number of intervention studies, now considered classics in the field, have been designed to promote social interaction among the elderly (for a review, see Carstensen, 1987). The interventions range from visiting programs, reinforcement of prosocial behavior, modifying the environment to encourage socializing

However, Laura Carstensen, one of the preeminent researchers in the field, has repeatedly pointed to the fact that programs designed to promote social contacts with peers seldom have lasting, beneficial effects (for a pithy critique, see Carstensen, 1986). She concludes that "few studies have reported generalization of effects outside of the experimental setting ... and none have obtained changes ins self-reported well-being (p. 230; Carstensen, 1987)." Moreover, higher rates are not maintained after external contingencies for interaction are removed (p. 230; Carstensen, 1987). In a later article, the author goes so far to suggest that social interactions in nursing homes -- mainly due to health conditions that impede communication between residents -- are fraught with peril (Carstensen, 1991), an insightful observation that has since been supported empirically (Resnick et al., 1997).

Overall, Carstensen's arguments are sound and should lead us to reconsider the many well-intentioned efforts to improve the social environment of nursing homes. Instead of trying to increase the *frequency* of *interactions* in these environments, perhaps it would be better to focus on improving the *quality* of *relationships* with others, especially with one's family and one's caregivers.

An interesting analysis of such relationships was conducted by Powers (1992). Essentially, the study describes the different kinds of social networks found among elderly care recipients. A fundamental premise of the study is that the size and function of the network varies according to the individual's need for attachment vs. autonomy.

40% of the networks examined were *institution-centered*, characterized by casual relationships (minimal emotional involvement) used to procure material goods and services. The individuals were highly self-reliant. *Kin-centered* networks (26%), as the name implies, were not focused on staff, but on members of the immediate or extended family; these persons had perfunctory relations with their caregivers. *Balanced* networks (28%) were generally the largest in terms of number of persons in the network. The residents in balanced networks had the tendency to transform formal relations with staff into relationships that might be called friendships. The relations were also viewed as useful in obtaining an advocate who would protect the individual. Finally, *small cluster* networks (7%) were tightly knit, exclusive groups, sometimes including staff as a member.

In most of the social networks described above, staff played a minor or perfunctory role. However, a significant minority, involving over a quarter of the residents, formed closer attachments (balanced networks). Interestingly, these networks almost always included a staff member of some authority. Furthermore "...[the] loss of primary attachments in kin-centered networks sometimes prompted residents to turn to intra-institutional resources, such as staff (p. 1341)." Thus, the author argues that kin-centered networks may be transitory, evolving into other kinds (usually balanced) networks.

In conclusion, the author underscores the role of affiliation in the shaping of one's support networks, stating that "personalities ... influenced the structure and function of their networks ... there were differences in willingness to seek and accept help (p. 1341)." This study thus affords tantalizing evidence that affiliation motives influence help-seeking among elderly care recipients.

2.2.2 Loneliness in the Elderly

A person's desire to affiliate with others is reflected in the concept of loneliness. Does loneliness increase with age? What percentage of elderly are lonely? Reviews of the

loneliness literature sometimes omit firm answers to these questions (e.g., Rook, 1988). In Germany, one-third of those over 60 report being lonely at least sometimes (Statistisches Bundesamt, 1997 quoted by C. Tesch-Römer, 2000). A meta-analysis of 44 studies by Pinquart (1996), however, concluded that loneliness is not significantly correlated with age. Moreover, after compiling the results of these studies, only 5-10% of the elderly reported suffering from loneliness often. Pinquart (1996) rightly underscores the limitations of loneliness research: because the subjects who volunteer to participate in a psychological study are more open and engaging, for example, they may tend to underestimate the actual prevalence of loneliness in the population. Similarly, one must consider the special case of the older, disabled person: there are good reasons to believe that loneliness might be a particular problem for elderly care recipients.

First, health-related problems are likely to hinder social interactions. Mobility impairment obviously diminishes the individual's ability to physically meet with family and friends in the community. Vision impairment also reduces one's action radius (Wahl, Oswald & Zimprich, 1999), much to the same effect, and hearing impairment impedes verbal communication, reducing the quality of social interactions. It is therefore unsurprising that age-related loss has been found to be a major predictor of loneliness (Walton et al., 1991).

The living arrangements of older individuals are also likely to have some influence on how lonely they become. Care recipients typically live in relative isolation (the very fact that a person requires physical assistance from a professional is often due to the fact that there is no one in the immediate vicinity who can care for them). This form of social isolation can be attributed to the shrinking of the social network in advanced age; such is the case when the loved ones of the very old are deceased. In a similar vein, a feeling of isolation often accompanies recent transitions to supportive living environments. Having to live in strange surroundings naturally produces homesickness and a longing for familiar faces.

Ironically, nursing home residents -- who are embedded in densely packed networks -- appear to be at particular risk for living isolated lives. Hyer and Hyer (1984) found loneliness to be widespread in samples of both poor and well-functioning nursing home residents. One reason may have been limited social contact with the outside world; nursing home residents typically have fewer visits, telephone calls, and letters than adults living independently (Gueldner et al., 1992). Even within the institution, residents may find it difficult to form friendships with

peers, many of whom may be cognitively impaired. Relocation also frequently disrupts friendships between nursing home residents (Wells & MacDonald, 1981). Thus, it appears that the old maxim may be true: One *can* be lonely in a crowd.

Finally, gender may have an influence on loneliness. When asked whether they are lonely, women typically report more loneliness than men (Borys & Perlman, 1985). In explaining their finding, Borys and Perlman speculate that women, compared to men, consider interpersonal relations to be more important, and may be more likely to view current problems and difficulties in terms of loneliness. Using a social perception task, the authors demonstrated that lonely men are viewed more negatively than lonely women, which may make a male individual less likely to concede loneliness -- to himself or to others.

In sum, because care recipients are usually older, health impaired, and female, loneliness is more likely to be prevalent in this population. Accordingly, Cohen (2000) stresses that loneliness is an important mental health issue that requires the attention of specialists in the field, including caregivers.

Interestingly, this notion is supported by a study that links loneliness with health care utilization (Kempen & Suurmeijer, 1991). Employing a model originally put forward by Anderson and Newman (1973), the study sought to predict the utilization of homecare based upon *need* (ADL / IADL, loneliness, depression, satisfaction with health), *enabling* (informal home care, social / emotional support, income level), and *predisposing* (sociodemographic and proximity of helpers) variables. Overall, need variables were found to be the best predictors of home care utilization. However, a more differentiated analysis, separating ADL from IADL, showed loneliness to be a significant predictor of health care utilization (i.e., assistance with IADLs).

More recently, Russel, Cutrona, de la Mora and Wallace (1997) examined the relation between loneliness and subsequent admission to a nursing home in a large sample (N=3000) of rural elderly. Lonely elders were more likely to enter a nursing home, and to do so sooner, than their nonlonely counterparts. In fact, loneliness remained a significant predictor of nursing home admission after other variables (e.g., age, physical health, social contact) were controlled for.

The findings reported in these two studies on loneliness in elderly care recipients raises the question of whether lonely elders are more likely to employ health care services as a means of obtaining social contact.

2.3 New Directions: Caregiver Affiliation

Previous approaches to caregiving focus on *interactions* and pay little attention to the *relationships* that form in the caregiving context. The amount of affiliation expressed by the elderly care recipient is constrained by the nature of the caregiving relationship, including *reciprocity, power,* and *commitment* issues. Affiliation can express itself in terms of need for *casual contact, physical contact,* and *intimacy*. It would be interesting to explore what kinds of social capital older individuals desire from their caregivers. Such motives, because they pertain directly to the current caregiving relationship, might be a better predictor of behavioral dependency than general affiliation tendency.

The Nature of the Caregiving Relationship

One of the defining features of social research on the caregiving context is that it commonly focuses on the *caregiving interaction*. There are a number of arguments, however, which support employing the *caregiving relationship* as the unit of analysis. On average, care recipients receive assistance over the course of several years. Nursing home residents in Germany, for example, typically reside in their supportive environment for four years or more (Dritter Altenbericht, 2001). Furthermore, elderly care recipients often prefer to interact with the same caregiver, an observation from the field that coincides with empirical findings on older adults preferences for familiar partners (e.g., Fredrickson & Carstensen, 1990). Finally, individualized care has been touted as a more humane approach to long-term care, one that has been proven to reduce physical dependency and mortality (Miller, 1985).

Perhaps for these reasons, there seems to be a growing emphasis on *primary vs. team models* of health care delivery in geriatric units. Fulmer, Ashley and Reilly (1986) contrasts team nursing, implemented since the early 50s, with primary nursing, which came about in the early 80s.

> "The role of the primary nurse, which is analogous to that of the primary physician, requires the ability to form therapeutic relationships with individual

> persons, to make decisions, and to assume accountability for these decisions. Professional nursing allows for comprehensive, coordinated patient-centered care. It encourages the nurse to use all intellectual and creative resources and skill to formulate and implement the most appropriate and personalized nursing care plan for a particular patient (p. 36; taken from Clifford, 1982)."

Primary nursing is no more costly than team nursing, provides for a continuity of care, and gives the elderly care recipient an advocate who can speak on his or her behalf. It is also beneficial to the socially isolated, lonely or depressed patient. These considerations suggest that insight into the caregiving context might well begin with an understanding of the *relationship* that develops between caregiver and care recipient.

What, in fact, are the defining characteristics of the caregiving relationship? Hinde (1993) presents a theoretical framework for describing social relationships. *Reciprocity, power,* and *commitment* are among the essential features he describes.

Social exchange theorists state that *reciprocity* is a key element to any relationship. Without an equitable "give and take" in a relationship, discord is bound to occur. Of course, reciprocity does not necessarily entail symmetry: Quite often, different commodities are exchanged between the individuals in a relationship, and the caregiving relationship is highly asymmetrical in this regard. In return for the services they provide, professional caregivers receive financial reimbursement, and in this sense, the relationship is reciprocal. To the casual observer, however, the relationship *appears* quite different. For the duration of the relationship, the caregiver provides a tremendous amount of physical assistance, as well as emotional support and guidance, to the elderly individual. This is the defining feature of the relationship. As the name implies, the caregiver "gives" -- the care recipient "takes." Add to this is the fact that much of the caregiver's work is physically and emotionally draining (not to mention poorly compensated), and the notion of reciprocity in the caregiving relationship seems to evaporate rather quickly.

Moreover, the *power* distribution in the caregiving relationship is highly asymmetrical. The caregivers' most obvious source of power is the simple fact that the care recipient is dependent upon them. However, there are other, rather subtle advantages enjoyed by caregivers that grant them even more power in the relationship. For example, caregivers are more mobile than care recipients, and can more easily engage or disengage from social contact. Caregivers, especially those in institutions, commonly have the authority to withhold

certain privileges. Finally, caregivers can rely upon their colleagues (as well as others higher up in the institutional hierarchy) to assist with "patient management." The caregiving relationship then, is clearly marked by a power imbalance, one that strongly favors the caregiver.

Finally, the *commitment* given to the caregiving relationship may be wanting. As mentioned earlier, elderly individuals often spend years of their lives in a state of relative dependency. However, they may go through a number of different caregivers in the process. The profession is a stressful one (Weyerer & Zimber, 2000), and the serial replacement of caregivers is a simple necessity in health care administration. High staff turnover rate can render efforts to form a relationship futile. Focus on primary care, in which one nurse attends to all of the needs and case management of one elderly individual, can strengthen commitment, of course.

The Expression of Affiliation in the Caregiving Context

This brief analysis of the caregiving relationship serves to delineate the context in which affiliation needs can be expressed. As alluded to above, the particular nature of the caregiving relationship might impede the formation of a lasting relationship. *Likewise, these circumstances might also help or hinder the expression of affiliation in the caregiving context.*

The first and perhaps most important obstacle, in my estimation, is overcoming the lack of reciprocity in the caregiving relationship. The older care recipient must be able to accept help without feeling guilty. For instance, when a problem arises, he or she must be able to ring the nurse without trepidation. He or she must also learn to receive assistance with the intimate activities of washing or dressing without feeling ashamed. In short, in order to develop a relationship with one's caregiver, the care recipient must not *fear being a burden.* If this criteria is fulfilled, then a closer relationship might form. As mentioned earlier, imbalance in power and lack of commitment may pose further obstacles to social bonding.

Beyond these concerns lie the elderly individual's *disposition* to form a friendship with the caregiver, as well as attitudes regarding whether friendship is appropriate in this relationship. These questions must be pursued further. What exactly does the elderly person desire or expect from their caregivers? Just small talk? Interesting conversation, perhaps? Do care

recipients, as a group, wish to confide in their caregivers? Should partners in the relationship become closer to one another over time?

What an individual wants out of a relationship can thought of as different forms of *social capital.* Three important ones are *casual contact, physical contact,* and *intimacy.*

Casual contact consists of everyday verbal exchanges or conversation. Although most every care interaction is marked by some kind of casual contact, one should not belittle its importance. Many relations to others never go further than casual contact, but the lack of pleasant and stimulating interaction with another, such as conversing with one's neighbor, can go a long way to reducing loneliness (Bondevik & Skogstad, 1996) and improving morale (Wenger, Davies & Shahtahmasebi, 1995).

Physical contact is also a commonplace and at times, necessary part of caregiving. Hollinger and Buschmann (1993) present a thorough examination of how elderly care recipients feel about being touched. Touch is differentiated in terms of whether it is *procedural* or *nonprocedural.* Nonprocedural touch, research shows, is used most often with younger and able elders, whereas depressed elders are less likely to be touched. In their study of 100 nursing home residents, respondents found touch to be more pleasant when the recipient was independent and touch was nonprocedural, above the waist, and administered by a nurse's aid. However, these findings are of a general nature, and the authors caution that people differ in their need for touch. More importantly, the study recommends that touch be used selectively because it robs the resident of control and can promote dependency. For example, the authors argue that "touch that facilitates dependent behaviors by the resident may lead to helplessness ... (p. 458)." Likewise, the acceptance of touch can signal the resident's willingness to be dependent.

In ideal circumstances, the older individual can achieve a sense of *intimacy* in the caregiving relationship and begin to regard the caregiver as a friend. Hays (1988) emphasizes the voluntary and unscripted nature of *friendship* -- friendships are not task-related, they result simply from taking enjoyment in another person's company, and the only requirements are circumstances conducive to personal interaction and emotional bonding. Of course, some factors can facilitate the formation of friendships. For instance, mutual liking (which requires congruent ways of looking at the world), and authenticity (or the ability to be open, honest,

and unguarded with another) are important to starting a genuine friendship. More importantly, friendships require motivation on the part of the individual -- poor social skills and shyness can hinder a friendship from forming, for example.

Very old individuals -- because they have resolved major life tasks such as raising children and engaging in a meaningful profession -- certainly appear to have more time for cultivating friendships, and one might conjecture that close relationships would bring them a good deal of joy. However, there may be a disparity between caregivers and care recipients regarding expectations for closeness. In a study of mutual respect in the caregiving relationship, 95% of the nursing assistants expected to become like family to the care recipient, whereas only 50% of the care recipients shared this sentiment (Heiselman & Noelker, 1991). Whether or not there is ample room in the caregiving context for caregivers and care recipients to become friends remains an unsolved issue.

As friendships develop, mutual helping and *self-disclosure*, or the sharing of confidences with another, gain importance (Hays, 1988). The desire to confide in another seems to be a natural impulse. In fact, the presence of a confidante has been shown to lead to less loneliness and higher well-being in older individuals (Wenger, Davies & Shahtahmasebi, 1995; Wenger, 1984). A recent study on confidant relationships in old age showed that the elderly are at risk for losing confidants (Wenger and Jerrome, 1999). Interestingly, when dependency, disability or death severed old ties, the respondents appeared remarkably adept at finding someone else to confide in. To be perfectly fair, elders generally preferred to confide in older friends and family members, a finding confirmed by Powers (1992), who found only a tiny percentage of nursing home residents (ca. 5%) were willing to confide in the nursing staff. Nonetheless, because *proximity* and *frequency of contact* are of paragon importance to the development of a confidante relationship, Wenger and Jerrome (1999) underscore the role of the professional caregiver in this regard. In fact, the authors go so far as to say that their findings have "crucial implications for the organization and delivery of domiciliary and residential services. It is clearly advantageous for the psychosocial well-being of many older people that they can develop confidant friendships with individuals whose job it is to care for them (p. 292)."

In general, motivations to obtain social capital can be construed as affiliation tendencies. Thus, if a person enjoys conversation with a caregiver, or a well-intentioned pat on the arm now and then, or is willing to confide in a caregiver, one might venture that affiliation is high.

When applied to the caregiving context, however, it seems proper to refer to *caregiver affiliation.* Even more so than general affiliation tendency, caregiver affiliation is likely to be associated with efforts to solicit care.

2.4 Summary

Accepted theoretical accounts of social engagement among the elderly (such as activity theory) stress the fact that people maintain their desire to affiliate with others into old age. When disability sets in, caregivers are likely to become important social partners for a significant number of elderly individuals. The loneliness that arises from age-related disability and social isolation can strengthen the affiliation motive and the tendency to seek or accept help. Research on caregiving would do well to recognize the fact that relationships form between caregivers and care recipients. A fundamental question that arises from this insight is: what does the older individual want from the caregiving relationship? Social capital motivations -- or the desire for casual contact, physical contact, and intimacy with one's caregiver -- might be better predictors of behavioral dependency than general affiliation tendency.

3. Attitudes toward Authority

So far, I have reviewed evidence, both theoretical and empirical, which supports the notion that trait dependency and trait affiliation influence the amount of dependency exhibited in the caregiving context. Both of these explanations have been based upon individual differences. There is one final, person-oriented explanation for why some individuals become overly dependent upon their caregivers, one based upon the elderly individual's *attitudes toward authority.*

Pronounced respect for authority is likely to lead to dependency in elderly care recipients through the mechanism of compliance. This argument is based on the premise that caregivers, especially those who have received professional training, are authority figures. Caregivers, it will be noted, belong to a well-defined power hierarchy, and their main function is to regulate the behavior of their charges. Normally, patient compliance is a desirable commodity. However, because caregivers often provide an excessive amount of help (as described in **Chapter 2**), the elderly individual with pronounced respect for authority

becomes endangered. They readily comply with the caregivers' wishes and learn to adopt a passive and dependent role in the care interaction.

3.1 Introduction

Attitudes toward authority are not a typical component of standard personality inventories. Nonetheless, the seminal work by Adorno et al. (1950) on the authoritarian personality gave rise to rich traditions in personality research in both Germany and America. An older review of the literature identified no less than 37 measures related to authoritarianism (Ray, 1984), and another contends that authoritarianism is a historic landmark in the social sciences that has produced hundreds of studies over the last 40 years (Christie, 1997).

Lederer (1995) traces the history of research on authoritarianism, placing equal emphasis on the writings of Theodor Adorno, Robert Altemeyer, and Detlef Oesterreich. Although each of these authors had distinct notions regarding the precise nature of the authoritarian personality and its genesis, a common thread is quite evident in their work. *Aggression, submissiveness,* and *conventionality* are the three most prominent components of the authoritarian personality (Adorno et al., 1950; Altemeyer, 1981). Oesterreich (1974) defines the authoritarian personality solely in terms of dogmatic conformity, which might be construed as a subtle shift of emphasis to the latter component. In contrast, the hallmark of the authoritarian personality for Adorno et al. (1950) is "... the tendency to submit to others of higher authority ... (p. 228)." What I wish to emphasize here is that the behavioral predispositions toward *obedience* and *conformity* are inextricably tied to the authoritarian construct. Notably, Lederer herself developed a scale to measure this very aspect of the authoritarian personality (*Respect for Unspecific Authority*; Seipel, Rippl and Lederer, 1995).

All three authors discussed by Lederer view the genesis of the authoritarian personality in early socialization experiences. Interestingly, each views the *family* context -- and not the *political* context -- in which one is raised as the critical factor. Adorno et al. (1950) trace the authoritarian personality back to its psychodynamic roots, to the hierarchical structure of the family, with an all-powerful, cold-hearted father and a hapless, self-sacrificing mother. Altemeyer (1981), employing a social learning paradigm, argues that authoritarianism is simply handed down from parents to children. Similarly, Oesterreich (1973) sees the origins of authoritarianism in parental overprotection. These differences are more than nuances to be

sure, but what is striking about these explanations is that they do not view authoritarianism in terms of the repression or violence sanctioned by the larger social or political context.

3.2 Empirical Studies on Attitudes toward Authority

Empirical research on attitudes toward authority offer a truly fascinating perspective to the study of adult development. The study of authoritarianism was a major avenue of research in social psychology in the 1950s, especially in Germany, though interest appears to have dwindled considerably since. Whether or not this research has included the elderly is an interesting point of discussion, since many of the individuals who participated in earlier research (if still alive) must now be quite old.

3.2.1 Authoritarianism

Is there evidence that authoritarianism is higher among the elderly? Using the California F Scale, a well-established questionnaire measure, parents were found to be significantly more authoritarian than their adult children (Bush, Gallagher & Weiner, 1982). Pratt, Hunsberger, Pancer and Roth (1992), as well as Heaven (1985), investigated age differences using Altemeyer's authoritarianism inventory (*Right Wing Authoritarianism* scale, RWA). Both studies found authoritarianism to be significantly higher in older subjects, but the samples were rather small (a total of 60 and 121 subjects were employed in each study, respectively). To be fair, it should be added that Heaven failed to find age differences in authoritarian attitudes using two additional standardized measures. However, two larger studies, one comparing 500 adults under 20 years to 500 adults over 50 years (Reddy, 1983), and another, comparing 364 adults under 30 years to 441 adults over 60 years (Youmans, 1973), reported clearly higher authoritarianism in older groups. The current state of knowledge thus suggests that elderly individuals, in most respects, are significantly more authoritarian than their younger counterparts.

Pratt and Norris (1994) argue that age trends and cohort effects are equally plausible explanations for the differences in authoritarianism observed between older and younger generations. Most authors, however, emphasize the different value orientations that were prevalent in earlier historical eras (e.g., Youmans, 1973). In line with the latter assumption, authoritarianism has been characterized as an "old-fashioned" social orientation (Ray, 1990).

Moreover, authoritarian attitudes seem to have been more prevalent among the adolescents of yesterday than those of today. Lederer and Kindervater (1995) report a clear decrease in authoritarianism among American teenagers between 1945 and 1978, which leveled off thereafter. In West Germany, the contrast was even more extreme. Baseline levels of authoritarianism were even higher, but the drop was sharper over the same time period (Rippl, Seipel & Lederer, 1995). As a consequence, younger and older Germans are likely to hold vastly different views about authority.

To my mind, higher authoritarianism among today's elderly, especially among older Germans, would hardly be surprising. It is no coincidence that the authoritarian personality became a burning issue of interest shortly after World War II. The considerable efforts devoted to this topic were no doubt guided by the need to come to terms with the atrocities of that era. The distinctly German sense of propriety and order served as immediate and plausible sociocultural explanations for the deeply entrenched anti-semitism demonstrated by the public at large, as well as the mechanical obedience exhibited by Hitler's executioners. There is some evidence that economic threat may have also greatly contributed to the authoritarianism of the times (Sales, 1972). However, more likely explanations include poor educational opportunities, authoritarian family structures, and lower class attitudes, all of which appear to be intricately woven together (Rippl, Seipel & Lederer, 1995).

Assuredly, the Germans do not have a monopoly on authoritarianism. A common refrain among the elderly on both sides of the Atlantic is that the youth of today have no respect for authority. The liberalization of Western society can hardly be contested and it certainly must contribute in good measure to the disparity in authoritarianism between older and younger generations the world over. In this vein, Alwin (1988) describes a seachange in the desired traits in children, from obedience to autonomy, between 1924 and 1978. The shift in cultural values appears to reflect the freedom that has been granted to women and children in modern society, advances in technology and the organization of work that makes greater autonomy a necessity, as well as the social empowerment afforded by increased educational opportunities.

Further research on authoritarianism as a function of age or time period, let alone its impact on social interactions in later life, appear to be wanting (Wilderom & Cryns, 1985). There are two major reasons for this unhappy state of affairs. First, as we have seen, authoritarianism can be construed in various terms. Aggression and attitudes toward coercion/punishment,

dogmatic, rigid, or conventional thinking, political conservatism, and ethnocentricity are just a few of these. The voting behavior of authoritarians, or their attitudes toward homosexuality, however, are of little interest to the present point of inquiry. Rather, for the present study, the notion of *authoritarian submissiveness* plays a central role. For example, do attitudes toward authority influence patient behavior, such as compliance with a treatment regimen? Are persons with authoritarian tendencies, in fact, more obedient when given orders from an authority figure? Because the authoritarianism construct carries so many different shades of meaning, research is fairly distributed among different tracks.

Second, much of the research on authoritarianism has been largely restricted to studies of adolescent development. For example, a number of scales have been developed to measure authoritarian tendencies in juveniles (Fend & Prester, 1986; Viehofer, 1980; Oesterreich, 1974). These instruments typically focus on aggression or the condoning of violence in school and family settings. Most do not appear to have been subject to much rigorous testing. The rationale for examining authoritarian tendencies in children and parents is perhaps the intent to prevent the proliferation of extremists and racially motivated violence. While these are laudable goals, the focus neglects the fact that older adults experience many of the same social forces, such as peer pressure. Moreover, attitudes toward authority are certain to influence nonaggressive behavior (e.g., complying with tax regulations) and rational decision-making (e.g., reaching a fair verdict in a jury).

Some authors have turned away from the classic concept of the authoritarian personality to examine *general attitudes toward authority* (Rigby & Rump, 1982). What is particularly interesting about this trend is its focus on a wider range of different social partners and more subtle problem behaviors. The lion's share of the literature still treats issues in child and adolescent development (e.g., Juang & Silbereisen, 1999); however, behavior problems are more likely to be excessive obedience and compliance rather than delinquency and antisocial behavior. In samples of adolescents and young adults, attitudes toward authority have been found to correlate with self-reported adherence to rules and regulations (Emler & Reicher, 1987), observable obedient or respectful behavior (Rigby, 1987), and compliance with a morally questionable directive (Petersen & Dietz, 2000). In a series of seven studies, Shively and Larsen (1990) extended previous research by examining attitudes toward specific figures and institutions, such as respect for the law, the police and physicians. Other research has even examined submissive attitudes toward one's superiors in the work environment (DeZoort

& Roskos-Ewoldsen, 1997; Rahim & Afza, 1993). Although all of these efforts demonstrate welcome advancement and differentiation in the field, there has been little attention given to attitudes toward authority among older adults, and to my knowledge, virtually none which examines whether respect for authority leads to submissiveness or compliance in caregiving contexts.

Thus, despite the large amount of research on the authoritarian personality, this review of the literature has only been able to uncover a handful of studies that are relevant to the present point of inquiry. The richness of the construct has led to the investigation of other facets of the authoritarian personality, such as ethnocentrism and political extremism, that are of little interest here. Much of the research focuses on developmental processes in childhood and adolescence, with a view to understanding delinquency and aggression. The few studies on attitudes toward authority that have, in fact, addressed authoritarian submissiveness in adults target young (college-aged) subjects.

3.2.2 Power and Authority in Medical Settings

The considerable literature on authoritarianism and the individual's attitude toward authority is complemented by extensive research on power and authority in medical settings. Whereas research on authoritarianism has not followed the singular aim of showing that attitudes toward authority lead to compliant and submissive behavior, studies from the field of health psychology have recognized that the medical model of illness breed submissiveness and powerlessness in patients.

Nursing homes are first and foremost healthcare or medical facilities. Lidz and Arnold (1995) illustrate how some geriatric facilities adopt many of the routines found in hospital settings. For example, staff may refer to residents as "patients" or simply by their medical condition. Long-term care often focuses on custodial issues, such as maintaining good hygiene and compliance with medication schedules at the expense of psychosocial care. In addition, the social environment exerts strong pressure on the residents to adhere to routine and defer to the staff's authority. They describe this system quite aptly as *the medical model.*

Karuza, Rabinowitz & Zevon (1986) also discuss the prevalence of the medical model as a mode of helping among both older and younger individuals. In contrast to other models of

care, the medical model states that individual is responsible for neither the cause or the solution to the problem at hand. The self is viewed as being weak, experts are relied upon to fix the problem, and dependency results.

Francke (1994) differentiates between two basic models of medical care: The *paternalistic* and the *cooperative*. Benevolent paternalism assumes the doctor knows better than any other what is in the patient's best interest, and should prescribe treatments accordingly. The cooperative model, on the other hand, requires a mutual agreement regarding the illness and its treatment; in short, the patient should have some say in the diagnosis and therapy of his or her condition. A similar argument was put forward by Hasselkus (1994), who emphasizes collaboration, as well as the sharing of control and responsibility, with the family caregivers of geriatric patients. As individuals move from the hospital setting to the home setting, power is handed from the doctor or occupational therapist to the elderly person and the family members caring for them, who then must assume responsibility for defining problems and finding solutions. Both authors clearly favor a cooperative model, which not only enhances compliance, but minimizes the dangers of infringing patient's rights.

Not everyone, and certainly not every elderly individual, is aware of their rights as a patient. *The Patient's Bill of Rights*, published by the American Hospital Association (1980), delineates what every patient is entitled to, including the right to decent care, the right to be informed of diagnosis, treatment, and prognosis, the right to refuse treatment, the right to patient confidentiality, and the right to be informed of hospital costs and regulations. Likewise, *The Patient Self Determination Act* requires medical facilities to inform patients of their rights under state law to execute advance medical directives (Glick, Cowart, and Smith; 1996). The creation of such legislation is an important step in reversing the paternalism of an outdated medical system. But for some of the older members of society, who may have been 60 when *The Patient Bill of Rights* was first published, it seems to have come rather late!

Therefore, in order for patients to be able to assert themselves in medical settings, clear communication between doctor and patient is crucial (Haug, 1996; Adler, McGraw and McKinlay, 1998). Systematic attempts to improve communication were first made in the late 70s and 80s (Kaupen-Haas, Mischo-Kelling & Reiter; 1993). It would be a mistake, however, to lay all of the blame on medical professionals: the patient must have a proper understanding of his or her role in the doctor-patient relationship. This requires knowledge of both one's

rights and responsibilities, with a view toward ensuring bodily health and a constructive dialogue with health professionals.

3.3 New Directions: Respect for Medical Authority

As we have seen, research on the authoritarian personality has tended to concentrate on adolescent development. More recently, research has begun examining the attitudes of adults toward different sources of authority. This development is a promising one, for it is precisely the older generation, especially in Germany, that is likely to harbor distinctly authoritarian attitudes. However, even if one were to prove that older individuals are more authoritarian, one must identify the practical implications of this finding. To wit: What impact does pronounced respect for authority have in the context of later life development?

One of the most important challenges facing the older person is coping with age-related health problems. The older individual, for better or worse, must interact with medical professionals more and more frequently. And because doctors and nurses are authority figures, the older individual's attitude toward authority will mark those social interactions. Although the medical system has long been paternalistic, efforts have been made to make it a more egalitarian system of care. This raises an interesting question: Have the patients produced by that era changed as well, or are they still playing by the old rules? Do they have a thorough understanding of their rights? Of the proper patient role? Do they place too much faith in their doctors and the efficacy of modern medicine?

In fact, there are clear indications that today's elderly do *not* have a proper understanding of the doctor-patient relationship. In a review of the older person's behavior in medical encounters, Beisecker (1996) contends that older adults are more passive than younger ones, noting that they "ask fewer questions, verbally disagree less often with physicians, and seem more content to let physicians make decisions for them (p. 18)." Other studies have shown that older patients failed to raise important medical problems (Blanchard et al., 1988; Rost & Frankel, 1993). They also tend to give more socially desirable responses, show more gratitude, and are more fearful of expressing complaints than younger patients (Breemhaar, Visser & Kleijnen, 1990).

In a review of authority and health behavior, Haug (1988) shows that older patients are more accepting of physician advice and less likely to challenge their professional authority. She essentially sees such compliant behavior arising from two factors. First, older persons are less likely to be well-educated and hence, willing to acquiesce to the physician's authority by virtue of his or her superior medical knowledge. Second, older individuals are somewhat distanced from the "new consumerism," which espouses a more egalitarian conception of the doctor-patient relationship. Elders may also have misconceptions about what constitutes a good working relationship with their doctor (Adler, McGraw & McKinlay, 1998). In these cases, being compliant and nonconfrontational appears to be an intentional strategy for winning the doctor's goodwill and continued attention.

In light of these findings, four components appear to be essential to constructive social interactions with medical personnel.

1) *active stance in the patient role.* Patients must take an active role in caring for their health instead of abdicating responsibility for their condition. Much chronic illness, especially cardiovascular disease, can be prevented and even treated through proper diet and exercise. But also, patients ought to try to understand their illness, to note when symptoms first appeared and what might possibly be responsible for them. Such information makes a valuable contribution to the initial consultation. Furthermore, patients should feel free to ask their doctor questions without prompting, and finally, be prepared to decide between various treatment alternatives, instead of automatically ceding that responsibility to the doctor.

2) *knowledge of patient rights.* Uninformed patients cannot possibly defend themselves from infringements. The right to medical confidentiality, as well as the right to refuse medical treatment (including the daily administration of medications), are among the most fundamental patient rights. Among geriatric patients, issues regarding advance medical directives (Barton et al., 1996), as well as surrogate decision-making and the use of physical restraints in cases of dementia must be given special emphasis.

3) *well-placed trust in medical personnel.* This component is perhaps the most difficult to define, for trust characterizes most relationships, and is an essential for

effective medical intervention (Francke, 1994). Although patients must trust their doctor, however, they should also be able to take a critical, reflective stance. They must realize that doctor's can and do make mistakes. Switching doctors, or merely seeking a second opinion, are not acts of disloyalty; in a market economy, they are necessary steps in securing the best medical services available.

4) *proper understanding of medication.* A proper understanding of medication goes beyond knowing what drugs one takes, what problems the drugs target, and what effects they have. More generally, the patient must understand that medications sometimes do not work. (Indeed, this is the reason why many different medications are on the market; a medication's efficacy can differ between individuals.) Furthermore, patients must understand the significance of side-effects. This information is vital to determining the proper dosage, which can be particularly difficult among older persons.

The person who fails to adhere to these rules of conduct embraces a medical model of care, and has an excess of *respect for medical authority.* The patient adopts a passive and uncritical role; instead of trying to understand health problems, he or she lets the doctor diagnose and cure them. Consequently, persons who adopt this attitude cannot possibly contribute to the ongoing dialogue in a constructive fashion. They are not only likely to be ignorant of their rights as a patient, but equally likely to have an exaggerated notion of their doctor's competence and the efficacy of medication. Surely, such faith is misplaced: one out of five older patients are prescribed medication that, in general, should not be administered to the elderly, and one out of seven are prescribed a medication that is not indicated or in fact contraindicated (Steinhagen-Thiessen & Borchelt, 1996).

What place does respect for medical authority assume in the caregiving context? To understand the importance of the concept, one must first acknowledge the fact that professional caregivers are first and foremost medical personnel. Many are qualified nurses, and even when this is not the case, the personnel don the mantle of authority as soon as they put on their uniforms. Regardless of their actual training, most caregivers dispense medication and monitor many aspects of the individual's health. While they may not command the respect that a fully credentialed doctor does, the caregiving staff still possess considerable expertise and hence, carry some measure of medical authority. If the foregoing

is true, then one would expect care recipients with pronounced respect for medical authority to exhibit compliant and submissive behavior with their caregivers, too. And because caregivers, for various reasons, are inclined to reinforce dependency behavior, the person who respects their authority will tend to acquiesce to their demands.

3.4 Summary

Authoritarianism is a concept with rich research traditions in Germany and elsewhere. A principal component of the authoritarian personality is submissiveness or acquiescence to authority figures. Because the construct possesses so many different facets, however, empirical research on authoritarian submissiveness among the elderly is scarce. Nonetheless, there are plausible reasons to believe that the elderly, due to their socialization, are in fact authoritarian in their world views.

Respect for authority would seem to have far-ranging consequences for social interactions. Because medical institutions are power structures, and because the elderly are often forced, due to age-related declines in health, to obtain care from them, respect for (medical) authority fundamentally influences their interchange with medical professionals and thus has an impact on maintaining important aspects of autonomy in later life.

4. Behavioral Dependency

This chapter has offered three, person-based explanations for why some elderly persons become too dependent upon their caregivers, each based upon various personality traits, beliefs and attitudes. What this chapter has so far neglected is a detailed description of the specific dependent behaviors that might result from such individual differences. What kind of dependent behaviors can result in the caregiving context? When does an elderly individual, in fact, become "too dependent?"

In the final section of this chapter, I describe the various kinds of assistance that care recipients require. This comprises not only assistance with the fundamental activities necessary for one's survival (such as eating), but many other kinds of monitoring, encouragement, and emotional support which promote self-maintenance and well-being.

4.1 Assistance with Activities of Daily Living

Care of the older individual involves a wide array of physical assistance with various tasks. Perhaps the most common form of currency when speaking of dependency is the activity of daily living (or ADL; Lawton et al., 1982). Activities of daily living comprise those tasks that are essential to our daily existence, such as eating, washing, and dressing. The inability to perform one or more ADLs is the principal reason for the elderly individual to seek the assistance of a residential or homecare service (e.g., Wolinsky, Stump & Callahan, 1997).

Incidentally, Kovar and Lawton (1994) state that there is no universally accepted list of activities that must be included in an assessment of physical dependency. There is more latitude in selecting IADLs, or Instrumental Activities of Daily Living, in particular. The latter typically comprise such things as cooking, using the telephone, shopping, or running errands. Moreover, ADLs identify the most disabled members of society (i.e., community-dwelling persons often have perfect scores). Frames of reference for scoring include task-descriptive (e.g., "Are you always neatly dressed?"), assistance from others ("Do you receive help with dressing?"), latent ability ("Can you do dress yourself?"), difficulty ("Do you have difficulty with dressing?"), and performance estimates. Much research employs proxy reports (a third person rates the individual regarding the ADL) instead of self-reports.

4.2 The Regulation of Health and Activity

Traditionally, psychological studies of dependency in caregiving situations have restricted their analysis to the physical assistance given with everyday tasks. However, one should note that gerontological nursing goes far beyond assistance with ADLs. First, it includes the management of health, nutrition, elimination, activity and exercise, sleep and rest, as well as cognitive and perceptual impairment (Fulmer, Ashley & Reilly, 1986). The precise description of what such management entails is enough to fill volumes (e.g., Ebersole & Hess, 1994), and it is little wonder that nurses spend years learning how to monitor and provide physical care to their patients.

Second, gerontological nursing involves helping patients to help themselves. Though the phrase has often been reiterated in the past, the contention requires a crucial conceptual switch: the caregiver is no longer a *doer*, but a *motivator*. This step forward doesn't eliminate

dependency, however; rather, it creates a completely different kind of dependency. The fundamental question regarding a patient thus changes from "Can the patient wash himself / herself?" to "Can the patient *be motivated* to wash himself / herself?" Not all patients are equally motivated to engage in self-care. Some will readily comply with social reinforcement, whereas others will not. Some will allow themselves to be reactivated, perhaps even taking pleasure in regaining basic living skills, while others will remain passive, stubbornly insisting that the staff take a hands-on approach to their care. Essentially, the provision of care moves from being a *physical* problem to being a *motivational* problem.

The identification of motivational problems among care recipients has not been the focus of a substantial body of research. Instead, the notion of "problematic behaviors" in older adults has been understood in more obvious terms. For example, Burgio and Stevens (1998) place emphasis on physical aggression and disruptive vocalizations, with very little mention of dependent behaviors. Other behaviors that are difficult for the nursing staff to manage include depression (Burrows et al., 2000) and restless, inappropriate, or dangerous behavior (Ray et al., 1992). In a fairly recent review of measures of behavioral disturbance, Teri and Logsdon (1994) identify no less than 28 instruments. Though many of these are multidimensional, assessing a wide range of problematic behaviors, all but six explicitly assess symptoms arising from mental illness or were tested on samples of dementia patients. Clearly, the definition of problem behaviors has been largely limited to manifestations of psychopathology, not overdependency.

It is important to understand that there are other dysfunctional behaviors that occur in older adults, and not all of these problems are due to mental illness. Passivity and lack of meaningful activity are perhaps two of the most typical problems that occur in nursing homes, but among the least likely to be identified as being problematic. The care recipient who is meek and submissive goes unnoticed, whereas the aggressive or hallucinatory individual creates quite a stir. Instruments designed to identify problematic behaviors in the elderly are quite deficient in this regard: they do not identify individuals who must be continually reanimated and reactivated by staff.

Perhaps the only exception to this rule is the Multidimensional Observation Scale for Elderly Subjects (MOSES; Helmes, Csapo & Short, 1987). Here, the resident's ability and / or inclination to demonstrate interest in outside events and keep occupied are viewed as

important elements of health-related functioning. Interestingly, the instrument does not acknowledge that excessive compliance or dependency can also be problematic. Instead, cooperation with nursing care and compliance with staff instructions are viewed as desirable behaviors, to be contrasted with resistance, rebellious, or aggressive behaviors.

4.3 The Regulation of Psychosocial Functioning

So far, the role of the professional caregiver in treating the body has been discussed. What has not been addressed is the psychological and social well-being of the care recipient. As Greene and Adelman (1996) put it, "to provide effective and human care to elderly patients, physicians must attend to both the physical aspects of disease and the psychosocial concerns of their patients (p. 84)." This statement was made in the context of medical care provided by a family physician. What would it entail in terms of professional caregiving?

Psychosocial care is a popular term for describing the fact that elderly care recipients often require more than physical and medical assistance. It is a frequent complaint among relatives visiting an elder in the nursing home: Grandmother is clean and fed, but few seem to *care* for her in a personal way. What are these persons trying to say? Three practical issues seem to be behind these kinds of complaints:

1) *Is the resident socially integrated?* Staff have an important liaison function. They can strengthen bonds between the patient and others on the ward. Emotional bonding between staff and patient is also a welcome event.

2) *Is the resident activated?* Staff can interact with the patient and provide mental stimulation. If necessary, staff can offer their own companionship to the socially withdrawn resident. Finally, they can encourage participation in the activity program or other meaningful pursuits alone.

3) *Does the resident have a primary counselor?* In other words, does the resident have someone they can share their troubles with, someone who can provide guidance, or who can act as their advocate? Staff can and should take over these social functions as well.

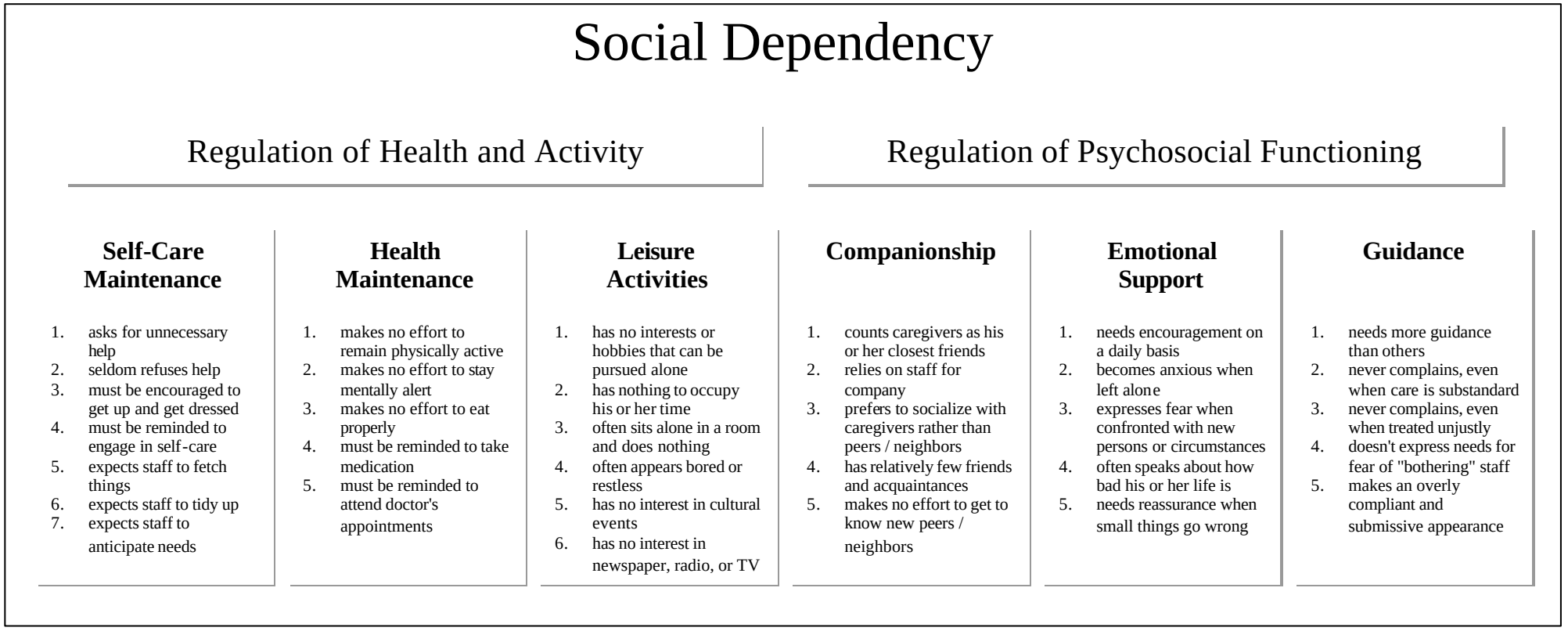
Social integration and activation, listed as points 1) and 2) above, seem to touch upon the need for *companionship.* In discussing social relationships among the elderly, Rook (1990) argues that support and companionship serve distinct functions. Whereas support seeks to solve problems and reduce negative emotional states (fear, frustration), companionship is pursued for its own sake and enhances positive emotional states (joy, a sense of belonging). In this context, it is interesting to note that in at least half and perhaps more of all dyads, the elderly regard their caregivers as friends rather than professional helpers (Heiselman & Noelker, 1991; Eustis & Fischer, 1991).

Having a primary counselor, listed as point 3) above, seems highly desirable because care recipients need *emotional support* and *guidance.* These forms of psychosocial support are absolutely essential for the humane treatment of elderly care recipients, most of whom have no one else they can turn to. Facing chronic illness and infirmity is often a frightening experience, even when one is surrounded by friends and family. If an elderly patient does seek emotional support and reassurance from a strong helper, then it would be uncaring of the nurse, as a fellow human-being, to deny it to the patient.

4.4 New Directions: Social Dependency

As we have seen, elderly care recipients require more than physical assistance with the daily routine. The caregiver must encourage the care recipient to care for themselves and thus maintain autonomy. Furthermore, a humane approach to geriatric care means that the caregiver is prepared to offer companionship, emotional support, and guidance to the care recipient. Both of these commodities, *the regulation of health and psychosocial functioning,* can be integrated into the more elaborate concept of *social dependency* (see **Figure 4,** below).

Figure 4. The Social Dependency Construct



The model of social dependency presented in **Figure 4** was based on constructive dialogues with caregivers and observations of actual caregiving interactions. However, similar conceptions of social support could be found in the literature. In an essay on the supportive functions of interpersonal relationships, for example, Wills (1985) describes many different kinds of support. Perhaps the most obvious is *instrumental* and *informational support,* which, in the caregiving context, can be construed as assistance with ADLs and the application of the nurse's medical knowledge to the patient's ongoing care.

The other forms of social support described by Wills can be discerned in the model of social dependency presented above. For example, *motivational support* entails:

> "... encouraging persons to persist in their efforts at problem solution, reassuring them that their efforts will ultimately be successful and that better things will come, helping them to endure frustration, and communicating their belief that 'we can ride it through' (p. 74)."

Motivational support is precisely what caregivers must provide the older individual with functional health problems. Encouragement can be applied to three different areas, to efforts to engage in self-care, to monitor health, and to engage in constructive (not necessarily social) activity. Again, the literature supports this differentiation; Ebersole and Hess (1994) differentiate between various forms of wellness, including *self-responsibility, nutritional awareness,* and *physical fitness* or *activity,* which correspond roughly to the first, second, and third dimensions of social dependency depicted in **Figure 4**.

Finally, Wills describes two further kinds of support, *social companionship* and *emotional support.* As previously argued, these supportive functions are part and parcel of psychosocial care and comprise the fourth and fifth dimensions of social dependency in **Figure 4.** To this I would add guidance and direction, which is a further valuable commodity to be obtained in social relationships, if taken in appropriate measure.

4.5 Summary

Comprehensive elder care goes far beyond treating the body. Providing assistance with selfcare activities is perhaps the most obvious form of caregiving, but the elderly care recipient also needs much encouragement and frequent monitoring, especially in terms of health-related activity, such as adhering to a proper dietary and exercise regimen.

Psychosocial care provides the elder with companionship, emotional support and guidance, which are highly desirable commodities. These forms of social dependency serve to complement forms of physical dependency that are commonly employed as intervention targets in elder care.

Footnotes:

[i] Advocates of the social reinforcement explanation for dependency might contend that the framers of the DSM-IV have made *a fundamental attribution error* (Ross et al., 1977), i.e., have ascribed behavior to features of the individual rather than the behavioral context. But although clinicians have been wrong before (most notably, the diagnosis of homosexuality as a form of mental disorder in earlier versions of the DSM), the argument that some persons are more prone to be dependent upon others is compelling.