Chapter 8. Discussion

This chapter examines the hypotheses put forward in earlier sections of the manuscript in light of the empirical results obtained. The first section, **Hypotheses Regarding Individual Differences and Outcome,** discusses the role of personality in predicting social dependency and morale, the major aim and undertaking of this project. The second section, **Hypotheses Regarding Adult Development,** addresses questions of whether age-related disability produces personality change, and whether there are indications of personality differences between older and younger cohorts. Finally, the third section, **Questions with Relevance for Applied Research,** translates the results into practical recommendations for the further care and treatment of the elderly individual. In conclusion, the limitations of the present study are examined.

1. Hypotheses Regarding Individual Differences and Outcome

The main goal of this study was to test three explanations for social dependency among elderly care recipients. Each explanation was based upon a personality construct: dependency, affiliation, or authority. We are now in position to address the fundamental question posed by this piece of research: *Did these personality constructs, in fact, explain why some elderly exhibit more social dependency than others?*

1.1 Predicting Social Dependency

Personality Correlates

In the final analysis, personality variables were weak predictors of social dependency. Judging from the zero-order correlations, authority constructs appeared to be the most promising influences on social dependency. A more differentiated analysis of the social dependency construct in terms of its subdimensions seemed to indicate that dependency constructs also play a minor role. Affiliation constructs showed no significant association with social dependency whatsoever.

These results must be accorded some weight, especially considering the multimethod assessment procedure employed: Personality forms were completed by care recipients,

behavior ratings forms were completed by two staff members working independently. Furthermore, the consistency of the results is also striking. There seems to be a rank order of importance implied; each authority construct was superior to each dependency construct, and each dependency construct was superior to each affiliation construct in its association with social dependency.

Nonetheless, the crucial finding came to light in the regression analysis, which sought to explain social dependency using the widest possible array of predictors. In the final regression equation, none of the personality terms contributed uniquely to the amount of variance explained.

Let us begin our analysis with a review of the bivariate correlations. Here, the relationship between respect for authority and social dependency was clear: individuals who respect authority, especially medical authority, were rated by their caregivers as being significantly more dependent. A frequent complaint about measures of authoritarianism is that they do not correlate with relevant behaviors (Ray, 1984; Rigby, 1987), and in this respect, the clearly significant relation observed was very gratifying.

A review of the *Respect for Medical Authority* scale shows a number of items related to passivity in the patient role. One can easily imagine that persons who concur with these items were also passive in regulating their health, which is the first major component of social dependency. For instance, such persons might be expected to spend correspondingly less effort in maintaining self-care activities, in monitoring their health and staying alert, and in finding constructive ways of passing the time of day. Instead, they allow the staff to do such things for them. Subdimensional analysis also showed that persons with high respect for medical authority turn to their caregivers for companionship, emotional support, and guidance, which is precisely what one would expect from an individual with an affinity for authority figures.

My failure to demonstrate a stronger relationship between trait dependency and social dependency is somewhat disappointing, however. It is hard to conceive of a better or more relevant construct than trait dependency for predicting dependent social behavior. The hallmark of trait dependency is the tendency to "seek help or advice [from others]" (Stumpf et al., 1985; p. 46). Furthermore, the construct has been repeatedly linked to compliant and

yielding behavior (Bornstein, 1993). Dependent individuals should therefore behave much in the same way as those who strongly respect authority. However, the correlational results were only significant with regards to certain subdimensions of social dependency (self-care maintenance and emotional support). Hence, the present findings only weakly support this notion.

As argued elsewhere, affiliation, particularly caregiver affiliation, was also expected to influence social dependency, and the failure to demonstrate any significant relationship whatsoever warrants some kind of explanation. One reason, not entertained heretofore, might be that the authority hypothesis excludes the affiliation hypothesis. If care personnel are first and foremost authority figures, then bonding, in the sense of friendships between caregiver and care recipient, may become more difficult. One must recognize the fact that caregivers are chiefly employed to supervise and instruct, and thus may wish to preserve a certain professional distance to their clients in an effort to preserve their authority.

The foregoing interpretations are based upon simple bivariate correlations between personality scores and ratings of socially dependent behavior. However, the regression analysis revealed personality factors to have little or no unique effect on the outcome. Given the arguments above, why didn't personality variables contribute more unique variance to the regression equation? Is personality irrelevant in this behavioral setting?

Aside from formal considerations concerning the quality of the measurement instruments employed and sample size (see **4. Limitations of the Present Study,** below), three credible arguments might be made:

a) *Slightly different constructs are needed.* The present study didn't attempt a comprehensive assessment of personality. Instead, it focused on three specific personality-based explanations of social dependency. Constructs with slightly different shades of meaning (e.g., loneliness instead of affiliation, dominance instead of authority) might have proved themselves to be better predictors of the outcome variable.

b) *Important mediating variables were not accounted for.* In particular, the size and density of social network, as well as the caregiver's personality and work

constraints (i.e., lack of time), can mediate the impact of personality on social dependency.

c) *Dispositional explanations of social dependency are simply wrong.* Variance in the dependent variable might truly be largely due to physical limitations. Subsequently, there is little room for personality to play a significant role. Certainly, this is an acceptable reason why personality was not found to impact on social dependency, and only dogma would prevent one from considering it.

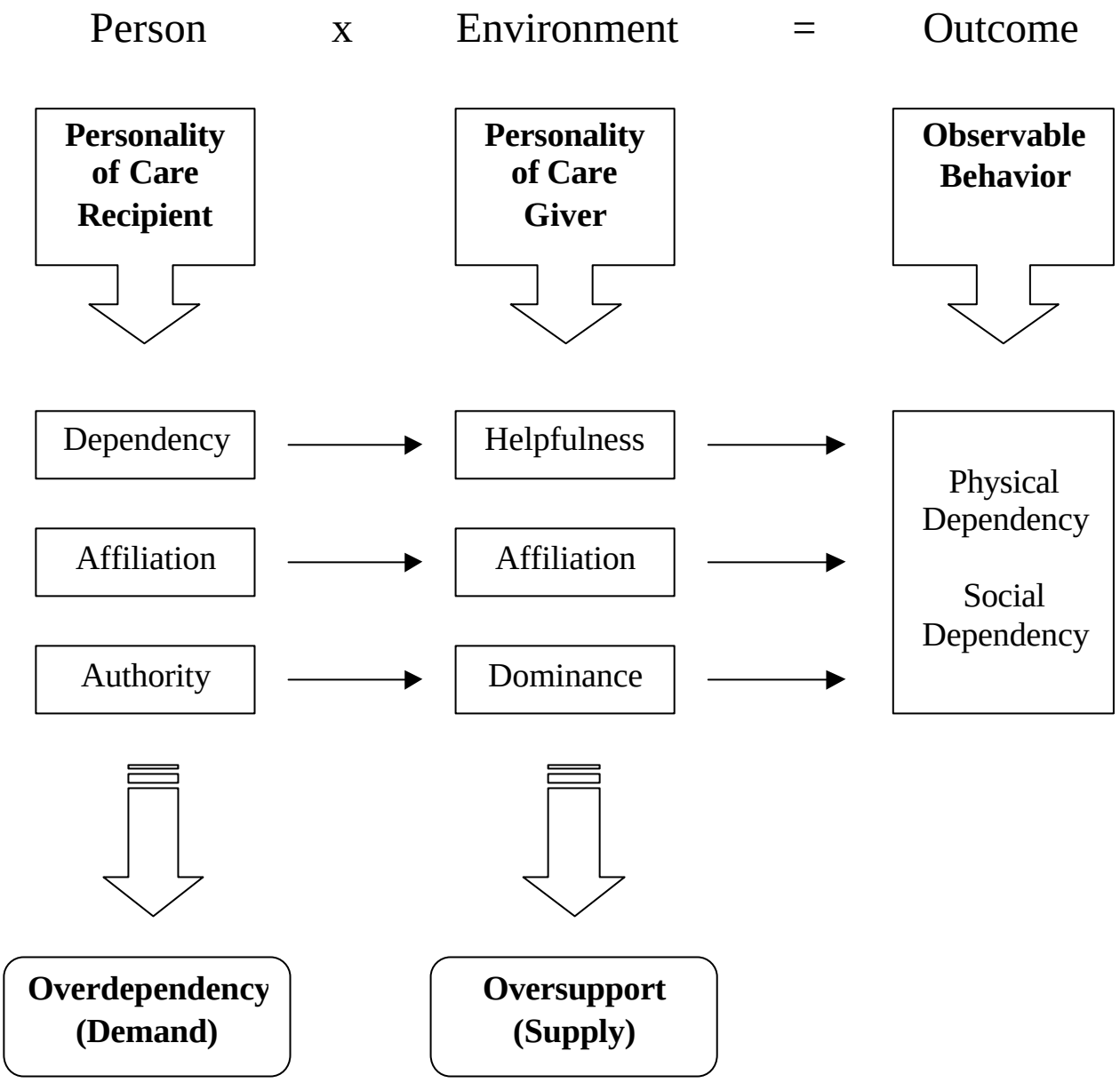
Although all of these arguments have some merit, the second appears to be the most profound. The social network of the care recipient was not systematically examined in this study, and it is an important mediating variable. A person who has a large circle of family and friends need not turn to a caregiver for companionship, emotional support, and guidance. The social support network can take over running small errands (that the elderly person might well be capable of doing alone). In fact, family members often monitor the care recipient's diet and motivate them to stay physically active and mentally alert. They might also assist in finding meaningful activities (even if this only entails inquiring what the care recipient has done today). In sum, all of these social dependency needs can (and perhaps should) be met by persons external to the healthcare system.

Secondly, caregivers who cannot or will not engage with their charges could be another reason social dependency needs are not met. The fact that caregivers feel the time crunch keenly has been well-documented. A consequence might be the wish to maintain superficial relationships, which might reduce stress and burnout. Emotional exhaustion, a classic feature of the burnout syndrome, may arise when caregivers cannot provide the high level of emotional support that care recipients generally need (Weyerer & Zimber, 2000).

Other caregivers may feel that it is inappropriate to befriend clients (Eustics & Fischer, 1991), or simply have no interest in forming a deeper relationship. Over the course of the hundred or so interviews conducted, many of the respondents complained that the staff had little desire to become better acquainted. Staff were perfunctory in their duties, taking little time to even exchange a few words. This would seem to indicate either extreme time pressure and/or an unwillingness on the part of staff to bond with the care recipient.

Finally, the personality of the staff member might also mediate the expression of dependency in the caregiving relationship (see **Figure 24**).

Figure 24. Personality Factors in the Caregiving Dyad



The message is that these factors may effectively negate any variance explained by personality factors. A wide social network will reduce the amount of social dependency exhibited in the caregiving context, whereas staff attitudes and task demands can effectively block it altogether. In my opinion, both are sufficient to explain why personality variables failed to contribute significant variance in the regression analysis.

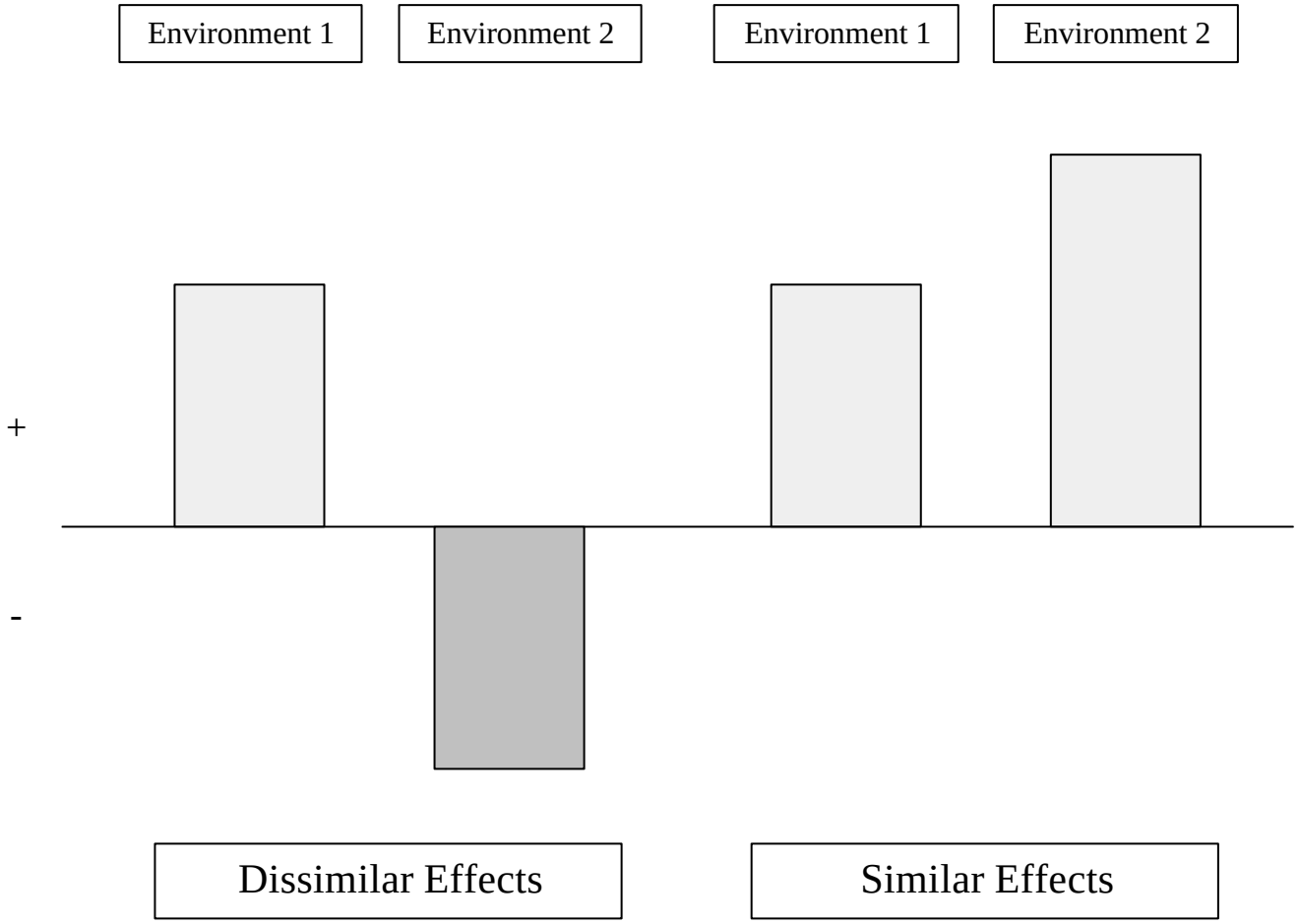
Person-Environment Interactions

There was also a pronounced lack of person-environment interactions in the data obtained. Six personality traits and two caregiving environments yielded 12 interaction terms. The analysis thus examined the whole gamut of person-interactions, without producing a single significant result. Do these results suggest that P-E fit doesn't explain dependent behavior in the caregiving environment? Is the concept of P-E fit unimportant in this particular field of inquiry?

In order to answer these questions, one must understand precisely what an interaction is. An interaction effect is most likely to be found when a given trait or ability has positive effects in one environment, and negative effects in another. For example, being rich or attractive is generally advantageous, but under circumstances (in war-time, in a crime-ridden environment), they can threaten one's chances of survival. A classic example of P-E interactions in a developmental context is offered by Kahana, Liang and Felton (1980). Elders who required impulse control were better adjusted in institutions that were controlling, and less happy in institutions that were not. Here, the desire for the social regulation of behavior, a relatively neutral characteristic, can become adaptive or maladaptive, depending upon the circumstances of one's living arrangement.

What if the direction of an effect is hypothesized to be the *same* in two different environments? Obviously, an interaction then becomes much harder to find. After reviewing the hypotheses put forward earlier to explain social dependency, it becomes evident that trait dependency, trait affiliation, and respect for authority were all postulated to have *similar* or *main* effects on social dependency, regardless of the caregiving context. To wit: High scores on any of these traits should result in higher social dependency. **Figure 25** illustrates these two scenarios.

Figure 25. Dissimilar vs. Similar Interaction Effects.



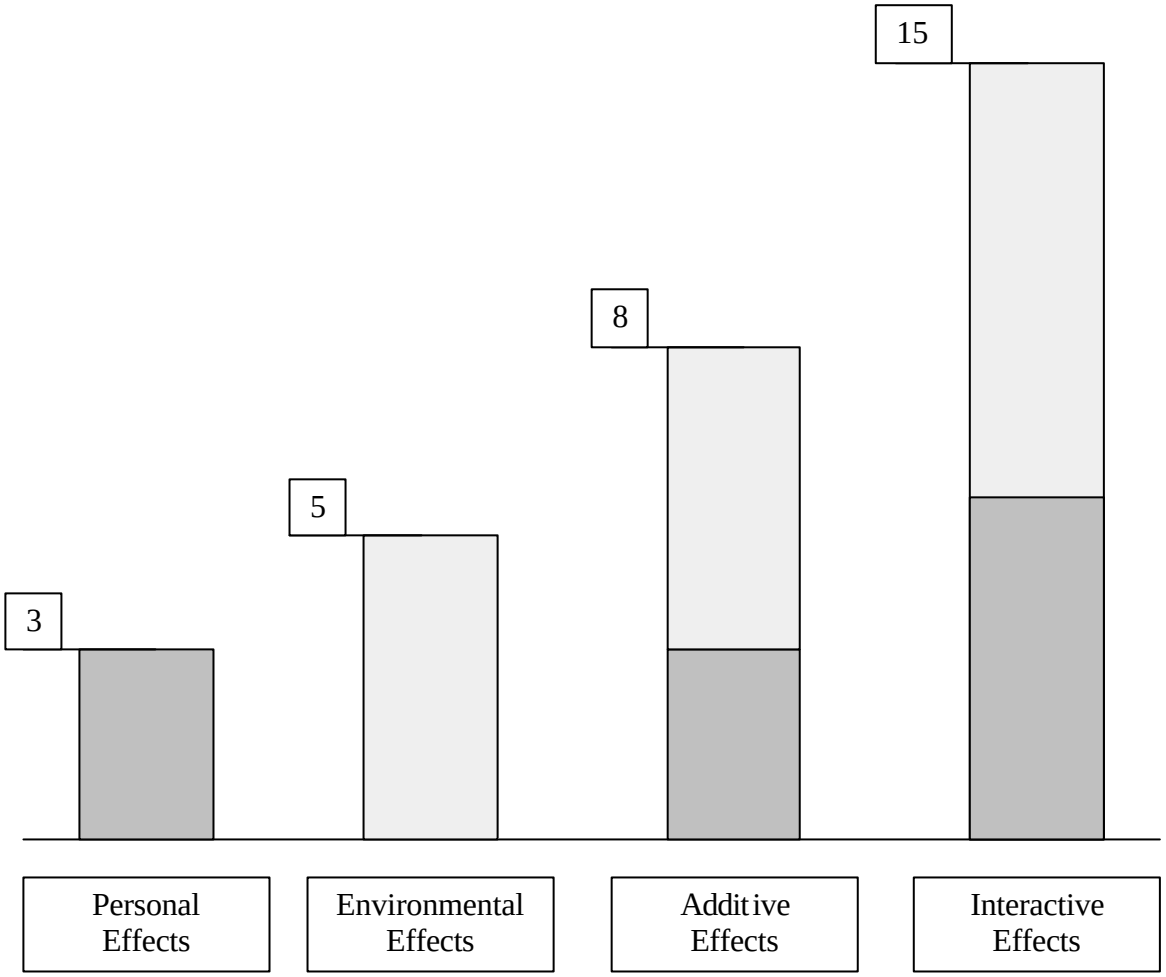
If a trait or ability has the same effect in both environments, finding an interaction doesn't become impossible, just much more difficult. Here, an interaction would have to entail *multiplicative* (and not merely additive) effects. In this case, an interaction will only occur when the environmental context somehow magnifies the salience of the person-related variable or vice versa.

In order to illustrate the point, consider the level of aggression exhibited by spectators at a soccer game. Being among rowdies (an environmental factor) might increase the amount of aggression exhibited. Likewise, consuming alcohol (personal factor) might also increase one's level of aggressive behavior. Combining both factors might lead to *additive* effects. More likely, however, they will lead to *interactive* effects. A person who is intoxicated is more susceptible to peer pressure (i.e., to engage in aggression). A person who is susceptible

to peer pressure is also more likely to consume alcohol (when that is expected in a given context). When personal and environmental forces are *mutually reinforcing,* as this example shows, an interaction is expected.

Figure 26 provides an illustration of additive and interactive effects.

Figure 26. Additive vs. Interactive Effects



What reasons might there be to assume a person-environment interaction of the kind described above? Upon reflection, there are a few. The home environment is more conducive to certain kinds of social exchange (e.g., intimacy), and certainly offers less social regulation of behavior (i.e., the amount of "impulse control" alluded to by Kahana et al., 1980). These environmental factors might indeed foster, to a very slight degree, the expression of affiliation and authoritarian attitudes. But it is not altogether clear how these personality characteristics could, in turn, fundamentally alter the physical environment, especially the institutional

environment. Interaction between person and environment, it would appear, cannot proceed unhindered to produce social dependency. Thus, at this level of analysis, and with regards to the present outcome, person and environment are probably best construed as factors which are simply *additive* in nature.

In sum, it is difficult to see how person and environment would mutually reinforce each other to produce social dependency. Therefore, interaction terms are not likely to be salient predictors of this outcome. Again, this does not exclude person and environmental variables from having compound or additive effects on social dependency.

Demographic and Environmental Variables

If neither personality nor person-environment fit influences social dependency, what does? Physical dependency, or functional health, plays a key role, explaining 16% of the variance in the outcome variable. This is only natural, since an individual's physical resources will determine how well he or she can regulate health-related activities and obtain social capital. A person who is very, very weak, for example, can't make much of an effort to stay active and alert, maintain a healthy diet, and find constructive activities. He or she must invest considerable resources just to remain alive and responsive. Similarly, the need for companionship, emotional support and guidance increases because the person does not have the energy or mobility resources to seek out others for these purposes.

Another interesting predictor of social dependency was the caregiving environment. Quite contrary to expectations, social dependency was higher in homecare settings. Not only was the total dependency score significantly higher, but in fact, each and every one of the subdimensions was significantly higher in home vs. institutional environments. More importantly, in the final regression equation, the caregiving environment contributed an equal (16%) share of unique variance, over and beyond other variables.

This finding was unexpected for a number of reasons. To be frank, the institutional setting is a last resort for most of today's elderly, not a place where they ideally would like to be. They are often expensive, unattractive, and do not offer the comfort, privacy or spaciousness that one has grown accustomed to. But aside from these concerns, transition to a nursing home is most often due to chronic illness which cannot be compensated for by one's informal support

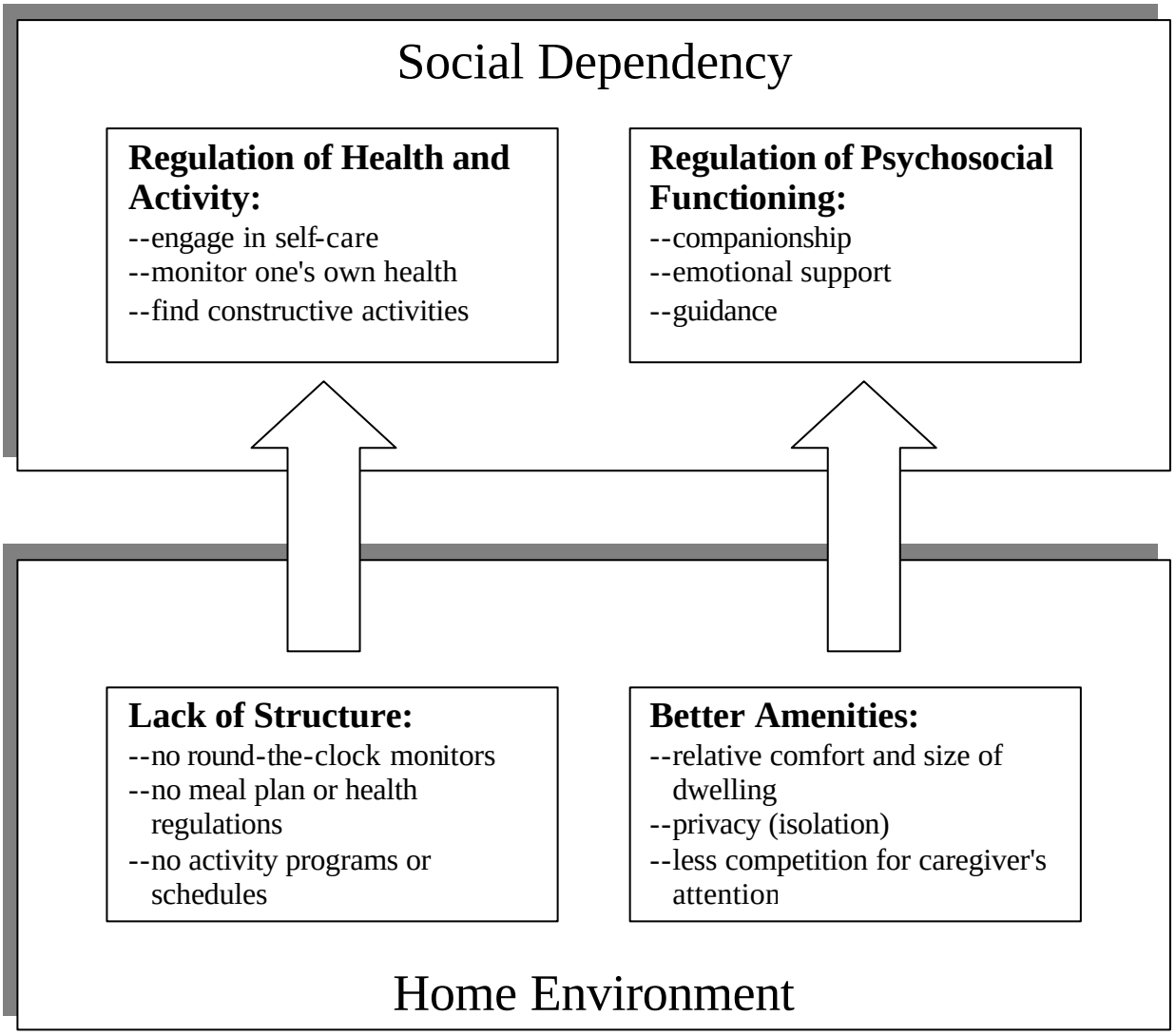
network. Although it would be unfair to characterize nursing homes as gulags for the old, the stereotype of the older resident who feels her family doesn't visit her enough is certainly no myth. Because such persons feel uprooted, with no external contacts to speak of, it is actually quite plausible to think that they would be inclined to rely upon staff for warmth and human contact.

The corollary to this argument is that people in the community are connected to others. They derive a sense of wellness from their surroundings, their friends and neighbors, and the multitude of pleasurable activities that one can pursue at home. For this reason, it could be conjectured that homecare recipients do not need staff to provide anything more than hands-on care with daily activities.

This argument looks fine on paper, but experience in the field teaches otherwise. If an elderly individual needs help with ADLs, chances are they have mobility problems which prevent them from coming together with others. These very same health problems have led them to abandon their more ambitious leisure pursuits. The general lack of social partners makes their interaction with the caregiver a special and very pleasurable event. It often represents the only social contact the elderly care recipient will have all day. They may thus be even more inclined to seek warmth and human contact from their caregivers.

In order to fully understand this result, one must elaborate a few of the very important differences between home and institutionalized care. I have already touched upon the most common misconception concerning *social integration*, and argued that both homebound and institutionalized care recipients seem to desire more of it. However, the home environment appears to offer particularly fertile ground for the seeds of dependency. First, the home environment lacks the structure so common to institutions, including health regulations, a meal plan, an activity program, etc... which can foster dependency upon staff to monitor and manage these aspects of the individual's care program. Second, the home environment offers many amenities, such as comfort and privacy, which can promote affiliative exchanges and social bonding. A more detailed description of these differences, as well as their impact on social dependency, is depicted in **Figure 27** (below).

Figure 27. Influence of the Homecare Context on Social Dependency



As **Figure 27** indicates, one of the reasons that social bonds are more likely to develop in the home environment is because of the one-to-one nature of the interaction. Although homecare providers must also adhere to a time schedule, they are relatively free from distractions while providing care to one individual. I consider this to be a critical difference between the caregiving contexts. The hectic and often chaotic nature of institutional care, in which one sometimes must care for several persons simultaneously, might effectively prevent relationships from forming. Much like children who learn not to bother mother when she is trying to do several things at once, the elderly care recipient might give up trying to cultivate any sort of friendship or seek emotional support from their already harried caregivers.

In conclusion, one can state that the home environment offers distinct advantages and disadvantages to the institutional environment. On the one hand, the home lacks the structure of the institution, which has been put into place in order to guarantee the health and safety of its residents. On the other, the home affords more privacy, comfort, and intimacy. Yet regardless of how one classifies these differences, it must be recognized that both factors have the same end-effect: they promote social dependency.

Nonpredictors of Social Dependency

Age was not a significant predictor of social dependency, despite demonstrating a very significant negative correlation with social dependency ($p < .01$). Older individuals, accordingly, were rated by their caregivers as being less socially dependent. As mentioned earlier, nursing home residents were somewhat older than homecare residents, so the effects of age and environment were confounded. This is most probably the reason why age, in the final regression, did not explain a significant amount of unique variance in social dependency.

Familiarity with one's caregiver also did not predict social dependency. Its zero-order correlation to social dependency was weak, of course, failing conventional levels of significance ($p < .10$). Nonetheless, it was assumed that long-term relationships would lead to more social bonding and a greater likelihood of bringing about companionship and emotional support in the caregiving context. One might speculate that because social dependency comprises other forms of assistance (notably, the regulation of health and activity), it may not have varied strongly with the length of the relationship.

1.2 Predicting Well-Being

Well-being, or more precisely morale, was the second major outcome of the present study. Again, the essential question concerns the role of personality on this measure of psychological adjustment. *Did the personality constructs under investigation explain differences in well-being in elderly care recipients?*

Personality Correlates

Zero order correlations revealed that dependency constructs had strong and significant relationships to well-being. Succorance had the best association with well-being by far. Affiliation constructs seemed to be somewhat less important, showing weaker and nonsignificant associations (generally at the $p < .10$ level). Conversely, attitudes toward authority did not seem to be related to well-being at all.

Much like the results reported for social dependency, the personality correlates of morale showed a very consistent pattern. Both succorance and stoicism exhibited the highest correlations with well-being, followed by affiliation and caregiver affiliation, and finally the respect for unspecific and medical authority. Thus, the constructs can be distinctly ordered -- dependency, affiliation, authority -- in terms of their relationship to the outcome.

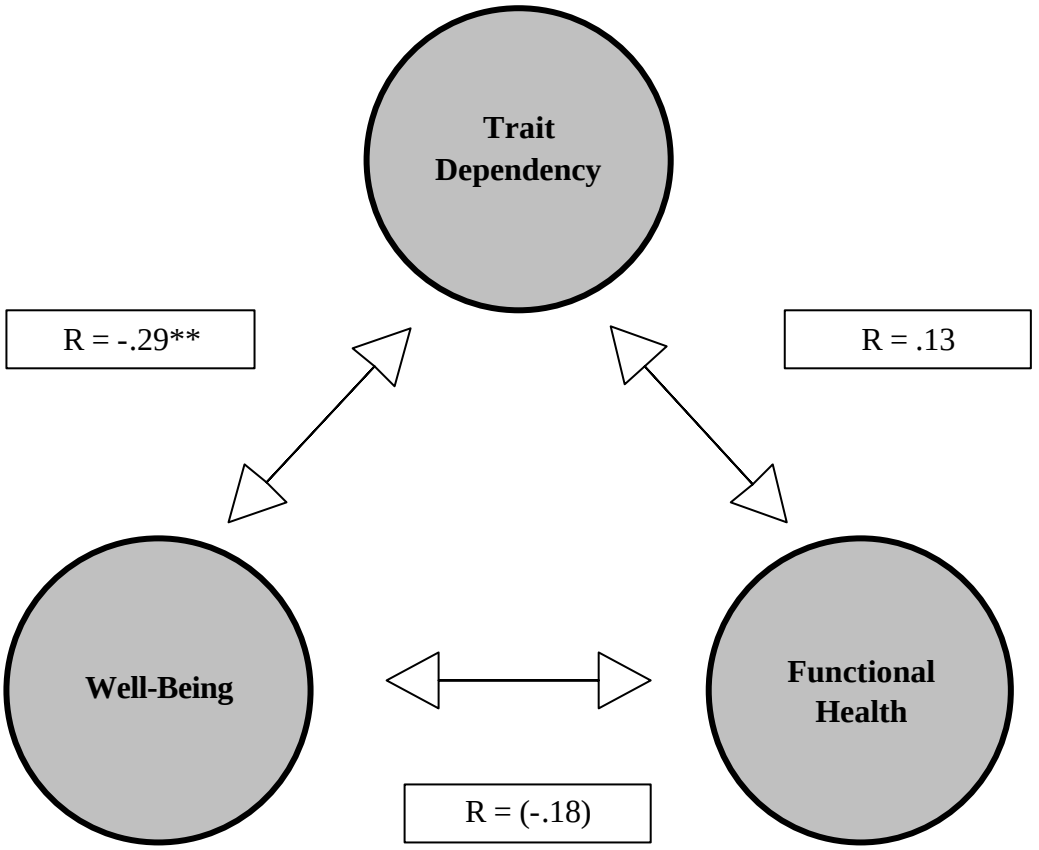
In the final regression, succorance and affiliation were the best predictors of well-being, accounting for 23% and six percent of the variance, even after controlling for demographic variables. Male gender was also able to add another significant amount of variance explained (9%). Note that compared to social dependency, less variance in morale could be accounted for by the predictor set. Whereas 53% of the variance in social dependency could be accounted for, only 45% of the variance in morale could be explained in the final regression equation.

The main reason for examining the impact of personality on well-being was to identify which factors appear particularly adaptive among older, physically disabled adults. Clearly, low trait dependency seems to be a defining characteristic. This interpretation, however, must be qualified in at least one respect. Western society, it must be noted, places great value on being self-reliant. Remaining independent is a primary goal for every elderly person who is confronted with chronic illness. In fact, both independence and well-being are socially desirable characteristics, and because of this, the tendency to answer in a favorable way could very well explain some of the association between these two variables.

One explanation for the observed correlation between trait dependency and morale, given the nature of the study participants, is that trait dependency reflects functional health. Persons with poor health or chronic infirmity must often seek help from others, which should lead to

inflated scores on the *Succorance* scale. However, two very important results make the situation more complicated. Succorance was not related to functional health, and functional health was only weakly related to morale. **Figure 28** depicts the observed relationships between functional health, trait dependency, and well-being.

Figure 28. Statistical Relationships Between Trait Dependency, Functional Health and Well-Being



**p < .01

( ) p < .10

If one construes ADL scores as an objective measure of dependency, and succorance scores as a subjective one, a pattern seems to emerge. Perhaps it is not the actual or observed level of dependency, but its *subjective appraisal*, that is the influential determinant of well-being. This would accord well with a great deal of literature on coping with age-related disability. The relationship between functional health and trait dependency deserves much closer

scrutiny, and I will address the developmental aspects of this issue in **Section 2, The Developmental Perspective** (below).

Affiliation was also a strong predictor of morale. The manner in which the construct was operationalized, however, did not account for the shrinking of social networks that so often accompanies old age. Accordingly, high scorers on this dimension may not have had *more desire to affiliate* with others, but simply *better social networks.* Larger social networks generally (but not always) entail more support. Therefore, a significant relationship between affiliation and morale confirms most expectations.

The results regarding caregiver affiliation support this notion. Caregiver affiliation, it will be recalled, is operationalized solely in terms of *desire or preference* to associate with others. This factor was not a significant predictor of morale; hence, it is likely that it is only the presence of a social network, not necessarily the desire to socialize with others, that is associated with well-being.

In conclusion, it would appear that personality has obvious relevance in determining well-being. This was a pleasant surprise after discovering that personality factors were relatively weak predictors of dependent behaviors. In hindsight, this particular pattern of results is unsurprising. Personality, it has been argued, has at best tenuous relationships to actual behavior (Mischel, 1968). Its impact on well-being may be more direct, through psychological mechanisms. Hence, the influence of personality on psychological adaptation to age-related disability (morale) can be easily demonstrated, whereas its effect on dependent behavior, which is shaped by contextual circumstances, is more difficult.

Our general pattern of results has shown that it is not *autonomy* per se, but rather *a healthy sense of autonomy* that is vital to one's well-being. This might be especially true of older individuals, who see dependency and infirmity encroaching from all sides. A strong social support network -- and perhaps the desire to affiliate with others -- also appear to be sound predictors as well.

Person-Environment Interactions

One of the more interesting results observed in this study were interactions between personality and environment on morale. Namely, affiliation and respect for medical authority interacted with caregiving context: those with low scores on these personality dimensions tended to be happier at home, less happy in institutions. Conversely, those with high scores were happier in institutions, less happy at home. Granted, the interactions were weak, failing to reach conventional levels of significance with regards to respect for medical authority (results significant only at $p<.10$). Still, given the nature of such constructs and the features of different caregiving environments, such interactions might be expected.

As previously stated, interactions are most likely to occur when a given trait or ability has dissimilar effects in two different environments. The desire to affiliate with others is presumably beneficial when there are, in fact, others to affiliate with. Certainly, nursing home residents have ample opportunity to socialize with others. In fact, the argument could be made that nursing home residents have *too much* contact to one another. Ensuring each individual's right to privacy, for example, has long been an issue in the design of residential facilities (e.g., Moos & Lemke, 1996). Conversely, elderly persons living at home often have few contacts to the outside world. Although they are still integrated into the community in the sense of living in a neighborhood, mobility and other health-related impairments prevent them from coming together with family and friends as often as they'd like. Due to the relative isolation, then, a person who enjoys being alone will be better able to adapt.

The findings regarding respect for medical authority can be interpreted in precisely the same manner. Persons scoring high on this trait tended to have higher morale in the institutional environment. Nursing homes today are full of medical personnel, and it makes sense to think that a resident who respects their authority might be better adjusted to that environment. The fact that persons with high respect for medical authority are comparatively worse off in the home environment is quite simple: the scale is designed to measure dysfunctional attitudes and behaviors in the doctor-patient relationship. Patients who hold medical misconceptions and do not take an active role in their care will, under normal circumstances, suffer the consequences of their actions. Those in medical institutions, on the other hand, can afford to take a more passive role, abdicating responsibility to the omnipresent nursing personnel.

An older study of the "good hospitalized patient" underscores this point (Vernier et al., 1961 cited by Greenberg & Fisher, 1977). Patients who were passive and conforming in the ward had difficulty functioning adequately in the community after discharge. Greenberg and Fisher conclude that "Apparently, traits such as passivity and submissiveness are not as adaptive outside of the hospital setting (p. 31)."

What is even more remarkable, in my estimation, is that a scale of dysfunctional attitudes can actually be associated with improved well-being *within* the hospital setting. But this is precisely what the interaction shows. What conclusion can be drawn by this strange set of facts? Is the environment itself, in some sense, dysfunctional? Certainly, this notion might be entertained, especially in light of the fact that some institutions are run like prison wards (Esser, 1997). Nevertheless, a large amount of trust placed in the health care system might not be unwarranted, especially if one has been able to build upon that trust over a lengthy period of institutionalization.

In conclusion, one must again stress the weak associations upon which these interpretations rest. The interaction between respect for medical authority and caregiving environment did not formally achieve significance in a two-tailed test. Still, it would appear that sociable persons who comply readily with medical authority are relatively happier in nursing homes. Conversely, those who prefer to be on their own and take a more active and discerning role in their ongoing care are better suited to the homecare environment.

Nonpredictors of Morale

Most demographic and environmental factors did little to explain variance in morale. One notable exception was functional health. Functional health was the only demographic factor to have a substantial zero-order correlation with well-being. The impact of health on well-being has been well documented, and one might generally have expected a significantly higher amount of variance to be explained by this variable in the final regression equation.

1.3 Summary

This section of the discussion set out to examine the role of personality in predicting two major outcomes: *social dependency* and *morale*. Zero-order correlations indicated that social

dependency is chiefly related to authority constructs, whereas morale is chiefly related to dependency constructs.

In regression analysis, however, personality variables did virtually nothing to explain social dependency. Instead, physical dependency and caregiving environment were the major predictors. In terms of morale, personality variables were clearly the most substantial predictors, with trait dependency and affiliation assuming critical roles. The differential relevance of personality, then, can be clearly discerned with regard to well-being (which is essentially a psychological construct) and less to observable behavior.

2. Hypotheses Regarding Adult Development

The goal of the following section is to examine likely influences on personality over the life course. In order to do so, it will be helpful to distinguish between *age-graded* and *history-graded* influences on development (Baltes, 1987) or between *aging* and *the aged* (Birren, 1996). The study of *aging* requires an understanding of maturational processes that are part of growing older. Conversely, the study of the *aged* requires an appreciation for the historical forces that have shaped one's development.

Obviously, this is an ambitious task, and ideally, the development of personality over the life course should be studied in a cross-sequential design, with a sample of elderly balanced in terms of control variables, such as age, gender, health, and education. To focus solely on differential aspects of personality in the present study, however, would be to miss a fundamental opportunity to understand how dependency-related constructs have been shaped over the life course.

The discussion and interpretation of data presented below is restricted to a select number of constructs which might very plausibly have been influenced by specific maturational and historical factors.

2.1 The Relation of Physical Dependency to Trait Dependency: Evidence of Resilience Over the Life Course?

The Goal and Rationale for the Present Analysis

The principle question addressed in this analysis is whether age-related decline in functional health is associated with trait dependency. As argued earlier in **Chapter 3** (**Excurs: A Lifespan Perspective on Personality Development**), there is every reason to postulate a link between physical dependency and psychological dependency. A differential analysis (presented in **Section 1,** above) examines whether the predisposition to solicit or require help leads to increases in physical dependency. Conversely, the developmental analysis presented in this section reverses the causal relationship between these two constructs, examining whether physical dependency leads to increased acceptance or acknowledgement of dependency.

There is an additional rationale for conducting this analysis. Much of the present study has involved experimenting with new concepts and ideas. It is perhaps a natural proclivity of younger scientists to come up with fresh approaches to old problems. In the present case, these efforts have resulted in the creation of several new personality scales (the *Stoicism, Caregiver Affiliation,* and *Respect for Medical Authority* scales). Although these procedures show promising evidence of psychometric quality, it must be conceded that they have not yet survived the rigors of extensive testing and usage. It might be prudent therefore, to analyze data from two or three scales that have been tried and found true. The standard personality measures employed in this study have, without exception, excellent construction and proven validity. I therefore restrict the following analysis to the German versions of the *Activity of Daily Living* scales (Lawton et al., 1982), the *Philadelphia Geriatric Morale* scale (Lawton, 1975) and the *Succorance* scale (Jackson, 1984).

The Dependency Paradox

Overall, the results presented in **Chapter 6** of this work offer little evidence that age-related disability brings about higher trait dependency. The correlation between physical dependency (ADL score) and trait dependency (succorance score) was in the expected direction (.13), but clearly insignificant. Residents in the skilled geriatric nursing facility had by far the most

disability and, on average, somewhat higher trait dependency than the other study participants. However, this difference was not statistically significant. Even a paramedian split of the sample into high and low competence groups produced no significant differences in trait dependency score.

To form some idea of how minimal these group differences were, consider the following: On average, residents in skilled nursing facilities scored one point higher on the *Succorance* scale than the rest of the study participants. This is the equivalent of assenting to one additional item on a 16-item scale. By the same token, the ADL score for these residents was *twice* as high as the score for the comparison group (14.8 compared to 7.2).

Upon careful reflection, these findings are little short of astounding. Why are the elderly so loathe to acknowledge their dependency upon others? Given the circumstances of their disability, it is perfectly natural and adaptive for the frail or disabled individual to seek and accept help from others in their environment. Indeed, that is what the caregivers are there for! To some extent, the respondents must be aware of their obvious dependency since every person in this study has engaged an institutional or homecare provider. Nonetheless, they seem to have made little, if any, psychological shift towards dependency, at least as measured by this particular personality scale.

Could the failure to demonstrate a significant effect lie in the operationalization of the dependency construct? Is the *Succorance* scale somehow not applicable in the present context? Consider the following seven questionnaire items:

1. I usually feel insecure without someone nearby to whom I can turn for help.
2. I enjoy being around people who protect me.
3. I'd rather be dependent upon no one. (negative item)
4. The thought of being alone in the world frightens me.
5. I prefer dealing with problems myself. (negative item)
6. Whenever I feel that I may be in danger, I look for help from others.
7. I am normally very independent. (negative item)

These items constitute a significant portion of the *Succorance* scale, the measure of trait dependency used in this study. There is every reason in the world to think that a sick or disabled person would answer these items differently than a healthy one. For example, it is easy to imagine that a person with disability might be more inclined to feel insecure without a helper nearby, might be more accepting of protective individuals, or acknowledge the fact that he or she is dependent in some fundamental ways. Naturally, not all disabled persons will feel this way, but certainly, one would expect them, as a group, to be *more inclined* to endorse such items *than their better-abled counterparts.* And this is precisely the test which failed significance.

There are a number of reasons why this argument is especially true of those coping with age-related disability. First, many of these persons have been living with functional impairments for years upon years. Over time, acceptance of one's dependent state should set in. Initial feelings of autonomy should erode over time, and the individual should come to identify him- or herself as relatively dependent. Second, dependency in old age -- if not the norm -- is still normal, which should lessen the social stigma of being dependent. And third, the future holds little prospect of recovery from age-related loss in functioning. Chances are that further irreversible, uncontrollable decline will occur and even more dependency will result. In essence, the future self is predetermined by a pathological process, which would be expected to profoundly shape one's concept of self. For these reasons, one would expect the group of disabled elderly to concede a larger measure of dependency than a healthy comparison group. Obviously, this was not observed here.

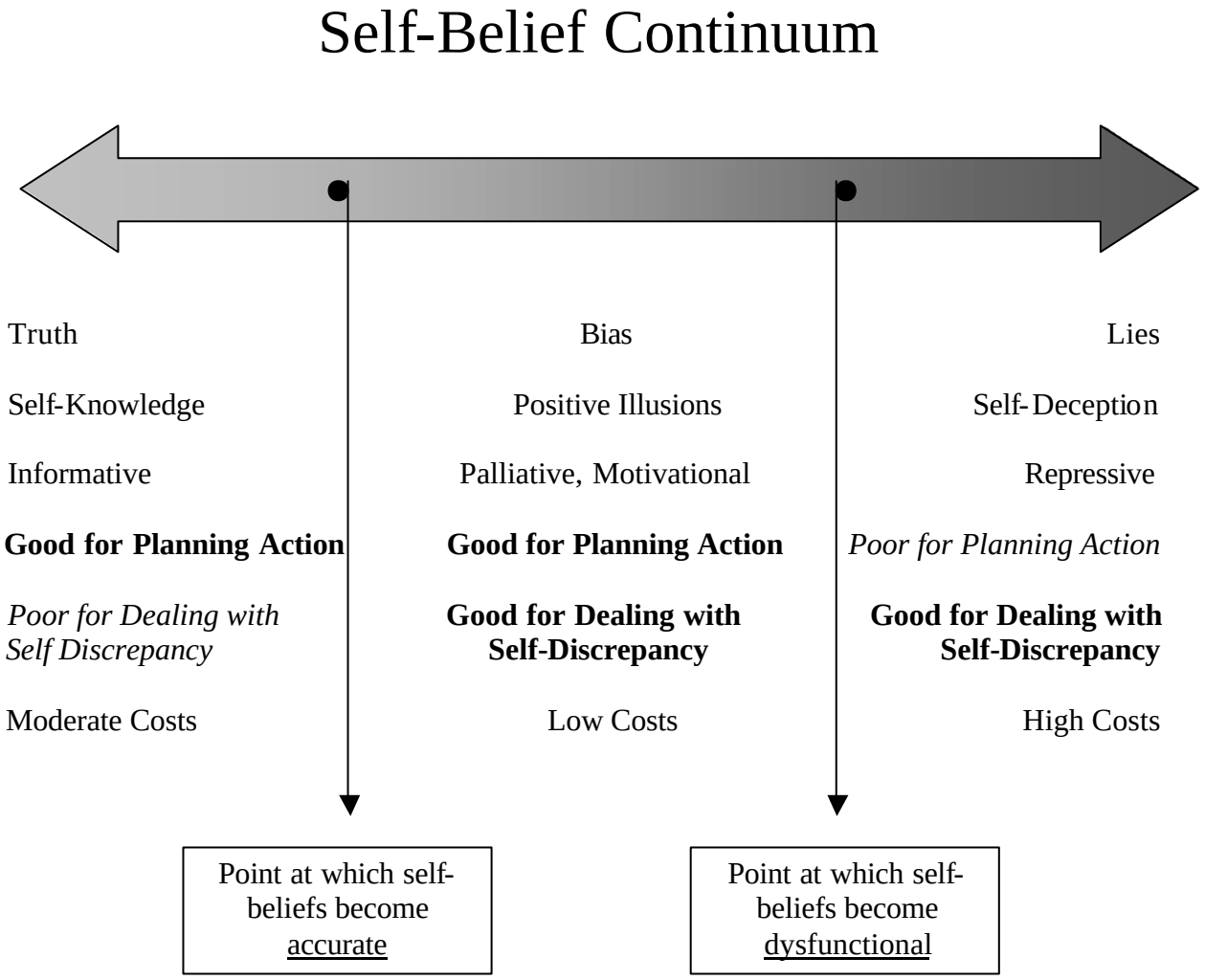
The Self-Belief Continuum

This response pattern can be essentially interpreted as a form of *psychological adaptation.* Some might see evidence of *resilience* here; others might assert that the elderly are in *denial.* Generally, processes of psychological adaptation are framed in terms of the self and self-concept (and not personality), and it would be a mistake to blur the underlying distinctions between these three constructs. However, when personality questionnaires employ transparent methodology, as is true in the present case, they can be assumed to assess the self-concept. One implication of this insight is that the mechanisms used to defend the self-concept can lend stability to personality. This might be one factor that can account for the

great deal of stability observed in personality across the lifespan (**Excurs: A Lifespan Perspective of Personality Development**).

What are the differences between resilience and denial? The basic differentiation made here lies along a truth continuum (see **Figure 29**).

Figure 29. The Self-Belief Continuum



Self -beliefs have different truth values and different functionality. As the figure shows, when a belief stops being true and when it stops being functional are two different things. Accurate self-knowledge is usually viewed as being advantageous. Knowing one's limitations can be helpful in planning and executing action. The drawback of being absolutely candid with oneself, obviously, is having to face painful realities. Another disadvantage, frequently

overlooked in the literature, is that self-scrutiny requires effort. (Were the admonition to "Know Thyself" easy to do, the builders of the temple at Delphi would hardly have gone to the trouble of inscribing it over the entrance!)

Gross self-deception, on the other hand, is clearly dysfunctional. It can be detrimental, even dangerous, to planning action. Although somewhat effective in reducing the pain of self-discrepancy, it is generally regarded as a somewhat primitive and easily assailable psychological defense mechanism, and thus costly to maintain (Greve, 1990).

The most functional alternative appears to be the middle way. Compared to self-knowledge, positive illusions (Taylor and Brown, 1988; 1994) are less accurate in planning successful action, but this is offset by their motivational advantages. The story of the little engine that could illustrates how positive illusions can be a useful tool for dispelling doubt and enhancing performance. This form of psychological coping also reduces the pain of self-discrepancy, and is arguably the most effective solution of the three. Finally, positive illusions can be generated without the constant scrutiny required to achieve self-knowledge nor the elaborate rationalizations required by self-deception. Hence, this form of defense can be maintained at relatively low costs.

The Kinds and Limits of Resilience

Let us now apply this model of self-related beliefs to our sample of elderly care recipients. Suppose we have an individual with pronounced care need, who nonetheless exhibits low trait dependency. His image of himself is one characterized by marked self-reliance. If these self-related beliefs are indeed accurate, then he might be said to be demonstrating *first-order resilience,* i.e., the beliefs reflect the fact that this individual has truly found ways to preserve an autonomous lifestyle (through selection, optimization, compensation, or whatever mechanism has corrected actual functional deficits). When self-beliefs diverge from the truth, they result in *second-order resilience,* which connotes exaggerated, yet highly functional beliefs that serve to support actual autonomy and reduce self-discrepancy. However, when the beliefs only serve as a means of repression, are blatant distortions of the truth that can, in all likelihood, lead to dysfunctional action planning, then they might be termed *third-order resilience.* (Given that some authors view resilience as essentially positive, they might hesitate to classify denial as a form of resilience at all.)

What kinds of resilience were observed in the present sample? It's hard to say without exploring the reasons behind individual answers. Much of the resilience shown by the elderly does indeed appear to be first- or second-order resilience. For example, not feeling insecure or afraid when alone or in danger, feeling capable of making decisions by oneself, or eschewing excessive attention and coddling are all rather mature characteristics. If the responses given by the subjects were truthful (and not defensive posturing), then the elderly have proven themselves to be quite adept at maintaining these aspects of autonomy despite chronic illness and infirmity.

As the self-belief continuum has shown, definitions of dependency can be stretched to a person's whim, often with palliative effects. However, there is evidence that these definitions, at least in the present sample, have been stretched too far. At this point, resilience becomes dysfunctional.

For example, there are grounds for saying that persons with an ADL score greater than 8 should not describe themselves as being "very independent." By definition, a person with this level of impairment is unable to perform two or more basic activities of daily living (e.g., washing, dressing) without considerable assistance. In light of this fact, it is interesting to note that 14 of the 15 care recipients who had this level of disability characterized themselves in these very terms. Denial, or third-order resilience, would seem to be a fairly common response to disability among this sample of elderly. This rather extreme degree of illusion is perhaps tolerated and even fostered by their present social environment, i.e., the nursing staff (Taylor and Brown, 1994).

A few pieces of evidence indicate that respondents do become psychologically dependent when functional impairment becomes overwhelming. An examination of the norms for the *Succorance* scale is particularly instructive in this regard. As **Figures 7a** and **7b** (see **Chapter 7**) illustrate, succorance clearly decreases among older men and women alike. One's sense of autonomy, it would seem, increases with age. Mature individuals are often more capable and have access to more resources than their younger counterparts, and perhaps the steady decline in succorance across the lifespan reflects this fact.

Now compare the responses from the present sample to these norms. Recall that the study participants were not only much older than the persons assessed in the normative samples, they also had chronic, age-related disability. The results of the comparison are clear: women showed resilience, men did not. But before we attribute this difference to gender, the reader is reminded of the obvious bias in the study sample. That is, the women in this study were far older and stronger than the men. As such, they did not suffer loss to the same degree, and thus may have been able to maintain an image of themselves as relatively independent. The men, on the other hand, showed precisely the pattern of psychological dependency one might expect. In the face of insurmountable difficulty, they conceded or acknowledged their dependency upon others, which is reflected in significantly higher succorance scores.

A second line of evidence concerns the stoicism concept. Stoicism represents the polar opposite of trait dependency, and correlations between stoicism and physical dependency were quite strong and negative. That is, the elderly individual with functional impairment did not adhere to the stoic philosophy. The most obvious explanation is that stoicism is not adaptive in these circumstances. Individuals who need assistance can no longer afford to embrace a life philosophy that calls upon them to be tough and self-reliant. Another plausible explanation is that stoic individuals, by definition, ask for less help.

As mentioned earlier, longitudinal studies are needed in order to test these hypotheses properly. In particular, the length of time the individual has been physically dependent is equally, if not more, relevant for the formation of a dependent character trait than his or her absolute level of physical dependency. A shortcoming of the present study is that no attempt was made to assess this variable, e.g., "How long have you required the services of a caregiver?". However, even this assessment would only give us a rough idea of the when the interpersonal dependency relationship began. A precise trajectory of increasing physical dependency can only be calculated over a longitudinal observation interval, which, in some cases could conceivably stretch over a period of 30 years or more.

2.2 Stoicism and Respect for Medical Authority: Remnants of an Earlier Era

In order to understand dependency among the elderly, the topic must be approached from different angles. I have already reviewed how the process of aging, and the experience of age-related disability, might affect trait dependency. But of course, this is only one half of the picture. Older individuals are the product of a specific social and cultural era. In the following, I wish to examine how *historical influences* might plausibly have shaped different facets of psychological dependency. The focus of this section will be placed upon two of the newly developed constructs, stoicism and respect for medical authority, which were specially designed to highlight differences between younger and older cohorts.

Again, any comprehensive analysis of developmental phenomena must have a cross-sequential design. In order to do justice to the issue of cohort differences in personality, one would have to employ a much larger, representative sample of persons both young and old, and monitor their change scores over a longitudinal interval. As such, the present analysis is kept purposefully short and is only meant to serve as an impetus to further research efforts.

Evidence of Cohort Differences

In order to demonstrate cohort differences in the variables of interest, responses to the *Stoicism* and *Respect for Medical Authority* scales were obtained from older and younger age groups. The 114 elderly individuals from the main study were between 65 and 98 years of age. The 72 university students (nonpsychology majors) who served as the comparison sample were between 19 and 25 years of age. As we have seen, the results showed significant differences between younger and older cohorts on measures of stoicism and respect for medical authority (both p's $< .0001$). These differences are exceptionally robust, especially considering the small sample sizes.

In the sample of elderly care recipients, stoicism and respect for medical authority were also significantly correlated with certain sociodemographic variables. Stoicism was correlated with functional health and age, whereas respect for medical authority was correlated with education. Regarding outcome, Stoicism was correlated with morale, and respect for medical authority was correlated with social dependency.

Stoicism

I am inclined to interpret higher stoicism among the elderly as a *cohort effect*. The hardship experienced by the German survivors of World War II has already been illustrated in earlier sections of this manuscript. The holocaust had a profound impact on most of the elderly individuals interviewed for this study. And stoicism appeared to be an adaptive and culturally sanctioned means of dealing with hardship.

For example, a frequent response to various items in the *Stoicism* scale, particularly Item #3 ("When times are hard, one must learn to make do with less.") was, "Oh yes, we learned that in the War." Without prompting, one man described his imprisonment in a Russian labor camp, even holding up a rectangular magnifying glass to illustrate the size of his daily bread ration. In this particular case, the horrors of war brought about a fundamental change in perspective, one characterized by a stoic life philosophy.

Of course, the War ended more than 50 years ago. And certainly, not everyone was devastated by it. However, it was perhaps not war-time experiences themselves, but rather the long period of reconstruction afterward, which strongly fomented stoicism in Germans. This period of poverty and hardship, by most estimates, stretched for 15-20 years, during which time basic essentials (such as food, clothing, and shelter) were, by today's standards, hard to come by. The elderly respondents often referred to the diligence and self-sacrifice required of them in postwar Germany. On the other hand, their travails also seemed to breed an appreciation for the simple pleasures of life. Thus, it is natural to think that the reconstruction of Germany may have instilled a sense of stoicism in those who lived through it.

Intermeshed with the socioeconomic conditions of the last century are religious ideologies, such as the Protestant work ethic, which shape one's character. Humility, abstinence, and earthly toil, it will be noted, are part and parcel of the Christian doctrine. Jesus was essentially a poor man who suffered greatly for the sake of others. Almost all of the seven deadly sins (greed, envy, and sloth in particular) have strong conceptual associations with the stoicism construct. Because elders, compared to the youth of today, are far more religious, their high stoicism scores might be traced back to their religious upbringing. What is

particularly intriguing about this argument is that it applies to much of the Western world, not just Germany in particular.

There are two lines of argumentation, however, that trace high stoicism among the elderly to *maturational effects*, and it would be remiss not to mention them here.

The first argument is premised on the fact that hardships are part of life. The laws of chance dictate that the older a person becomes, the more likely he or she is to have experienced many different kinds of hardship (such as the death of a loved one, a period of unemployment, a natural disaster). Such hardship can be character-building. If this is true, then one would expect stoicism to increase linearly with chronological age. If the respondents from the main study can be taken to represent one cohort (most of the subjects were between 65 and 95 years old), then the correlation between stoicism and age reported for this group provides empirical evidence in support of the hypothesis.

The second argument is based upon the mechanism of selective mortality. Assume for the moment that stoicism is an adaptive trait which heightens one's ability to deal with adversity. (stoicism was significantly correlated with well-being, in fact.) According to the mechanism of selective mortality, weaker (i.e., less stoic) individuals tend to die out, leaving the stronger (i.e., more stoic) individuals in the pool of survivors. When viewed from this perspective, the stoicism that is so prevalent among the elderly is not bred into them as part of their socialization, i.e., not a cohort effect at all, but results from the natural culling of the weak that occurs across time.

Respect for Medical Authority

Respect for medical authority among the elderly is best understood as a cohort effect. The conservative political and cultural landscape in the early part of the century undoubtedly contributed to authoritarian behavior. It has been difficult to separate the concept of authoritarianism, as a personality construct, from political ideology. Lederer (1995) provides an interesting discourse on how difficult it was to place a name to the construct (Fascism vs. Authoritarianism) in the classical research of Adorno et al. (1950). In a later chapter, she presents correlations between respect for unspecific authority, the concept of authority employed in the present study, with political and ethnocentric attitudes. Clearly then, there is

conceptual and empirical evidence that suggests political ideology can influence one's respect for authority.

This interpretation is strengthened by the significant relationship observed between respect for medical authority and education in the present study. In Germany, educational opportunities in the earlier and middle part of the last century were dismal. A sizable minority of those interviewed (42%) had little more than an elementary education. Since the *Respect for Medical Authority* scale assesses basic knowledge concerning the medical system and enlightened attitudes towards the patient role, education might well be expected to influence scores.

Education is also likely to have complex and subtle effects on patient-doctor interaction. The unquestioning obedience exhibited by most elderly persons might be traced back, at least in part, to differences between doctor and patient in terms of social and educational status. As we have seen, the elderly individuals in the present sample were rather poorly educated. By contrast, a general practitioner has many years of education, as well as a university degree, and perhaps many other professional qualifications. To a person who hasn't finished grade school, a doctor might therefore be a somewhat imposing figure. The elderly individual might thus feel that it is inappropriate to second-guess a person with years of medical expertise and knowledge at his or her disposal, and unquestioningly comply with whatever treatment regimen is prescribed.

Add to this a patronizing medical system, and the recipe for conformity in the caregiving relationship is complete. The present definition of respect for medical authority encompasses the aspect of passivity. According to the medical model of illness, the patient should, in fact, play a relatively passive role. It is only with the advent of the social model that health is conceived of as a multidimensional (social) process. Wellness is something that must be actively preserved and maintained, and obviously, individuals must be prepared to bear the brunt of responsibility for it.

Finally, on a positive note, a number of retired healthcare professionals (e.g., doctors, nurses, pharmacists) were included in the sample. As a rule, their scores on the *Respect for Medical Authority* scale were near perfect, i.e., they made few errors regarding proper patient attitudes

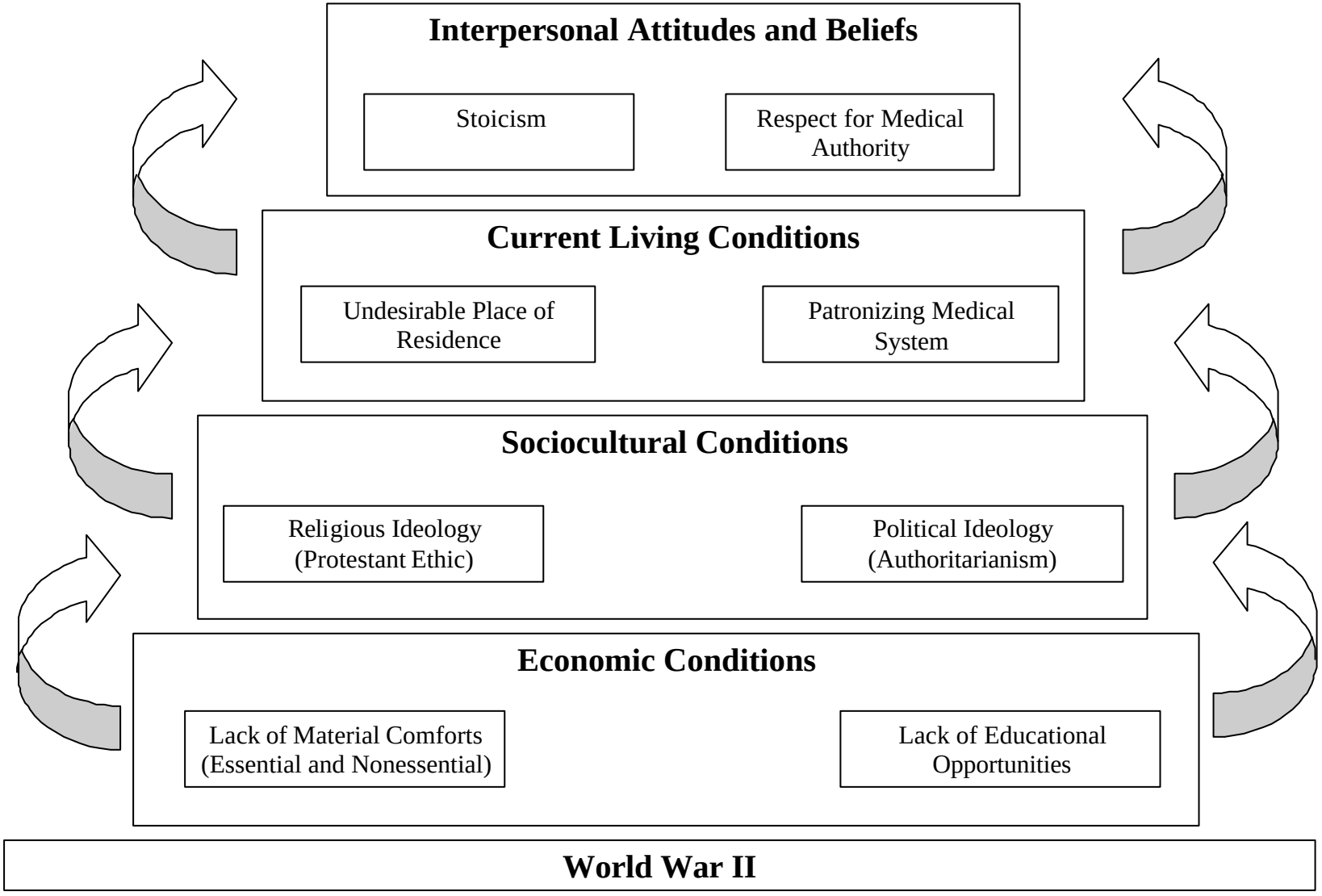
and behavior. This suggests that the tendency to respect authority can be overwritten by a correct understanding of how doctors and patients should constructively interact.

2.3 Summary

This section of the discussion has attempted to understand personality among elderly care recipients from a developmental perspective. Evidence of *age-related changes* in personality was first examined. Contrary to expectations, disability did not seem to produce much personality change in the present sample of elderly care recipients. Trait dependency was only weakly (and not significantly) correlated with physical dependency. These results, however, must be qualified in two respects. First, the male respondents in this sample did in fact exhibit significantly higher scores on trait dependency compared to the norms that have been established for persons aged 50 years or older. Second, an analysis of individual items reveals that many of the subjects may have answered the questions in a defensive or biased manner. Thus, stability in trait dependency may, in part, reflect psychological resilience to age-related loss.

This discussion has also examined evidence of *age-related differences* in personality. As expected, large differences in stoicism and respect for medical authority were observed between older and younger comparison groups. **Figure 30** summarizes our conjectures regarding how these specific historical conditions may have influenced interpersonal attitudes among today's cohort of elderly.

Figure 30: The Influence of Social History on Elders' Attitudes and Beliefs



The cohort explanations for stoicism and respect for medical authority presented above do not exclude each other. The purpose of the diagram is to illustrate how these various social, economic, and political contexts build upon one another, culminating in certain attitudes.

The present findings support the notion that aspects of personality fostered by the early sociocultural context can lead to insights into later developmental issues. In support of this notion, scores on both the *Stoicism* and *Respect for Medical Authority* scales, which were designed to measure cohort effects, were better predictors of outcome than their standardized counterparts. If personality measures were created with the elderly in mind, they might reveal generational differences that explain patterns of development (see **Chapter 9**).

Does any of this have relevance for future cohorts of elderly? The arguments presented in this section are premised upon a certain constellation of social, economic, and political contexts which will never repeat itself. In time, there will no longer be anyone who witnessed the horrors of World War II, nor the painful reconstruction of postwar Germany. Indeed, this may be why some researchers in the field of aging have developed a distaste for the systematic investigation of cohort effects: history changes, and by the time its impact on development is understood, the cohort has reached a very advanced age. I take issue with this view for two reasons:

1. *It is too cynical.* In order to design care for today's elderly, we must understand their history. The present cohort of elderly individuals deserve our understanding, as well as our best efforts to provide the care and assistance they need.

2. *It is too short-sighted.* There is much to be said for the belief that those who ignore history are doomed to repeat it. If the historical trends of the late 20th century continue into the 21st century, then we already have a blueprint for understanding the elderly of tomorrow. The further *liberalization* of politics and society may make today's generation appear quite authoritarian (less tolerant, more conservative) years from now. Similarly, the *modernization* of society may make them appear more stoic.

A thought experiment might illustrate the latter point. Consider that as time marches on, advances in healthcare provision, medical technology, human rights, wealth distribution -- progress in a hundred different spheres -- are bound to occur. If infectious disease is

eradicated from the face of the earth, what will future generations think of those of us who lost a loved one to AIDS? What will they think of persons who, instead of foregoing corrective lens surgery, opt to wear glasses instead? Or who prefer to watch TV instead of climbing into a virtual simulator?

One need not be well-versed in history to understand the arguments presented here. That elderly individuals have not had the same economic and educational opportunities as younger persons today is widely accepted as fact. The liberalization of politics and modernization of society in the last half of the 20th century are also not obscure developments. But precisely how these variable influences the psychology of the older adult, as well as late life development, has been left unexplored. Hopefully, this short foray into the sociocultural determinants of personality will encourage further study into how such developments can impact on the elderly individual's attitudes and beliefs towards being helped, and illuminate our understanding of today's cohort of elderly.

3. Questions with Relevance for Applied Research

So far, the discussion of findings have been concerned with the theoretical issues concerning the role of personality in determining social behavior and well-being as well as the possible origins of personality. *But how can these results be applied to the care of elderly persons?* Three of the constructs employed in this study were specially designed to offer insights that could be of practical utility to caregiving professionals: *caregiver affiliation, respect for medical authority,* and *social dependency*. Each is treated separately below.

3.1 Caregiver Affiliation

The most significant findings concerning caregiver affiliation were null results. Caregiver affiliation did not vary between home and institutional contexts, nor did it vary as a function of competence. It was unrelated to age and gender, and had no significant association with social dependency. Its relationship to morale missed conventional levels of significance ($p < .10$).

A differential analysis of the *Caregiver Affiliation* scale shows the highest endorsement for items that assess desire for casual contact (see **Chapter 7**). More intimate forms of contact,

including nonprocedural touch and the exchange of personal information, were less frequently desired. Reciprocity, e.g., anxiety regarding taking up a disproportionate share of the staff's resources or the desire to compensate staff for their assistance, was not a concern for most of the respondents.

Taken together, these results demonstrate two things. First, the findings can be generalized across the sample. That is, elderly care recipients, regardless of age, gender, or level of functioning, seem to share the same views about their caregivers. Second, care recipients generally prefer casual contact, not intimacy, in the caregiving relationship. They are somewhat split, however, on becoming more friendly and intimate with their caregivers over time. Most of the respondents had rather firm opinions on this matter, with 62% of the sample clearly agreeing, and 23% clearly disagreeing.

Finally, the elderly care recipient expressed relatively little desire to engage in reciprocal relations with caregivers. Overall, balance motivations indicated that the respondents had little fear of becoming a burden to the staff, and generally did not experience shame or guilt, even when they required extensive assistance from staff. Given the professional nature of the help provided, this is clearly the correct attitude to have. In asides, however, female respondents sometimes expressed a preference for having a female staff member assist them with intimate care activities, such as washing and dressing.

The *practical implications* of these findings are straight-forward. Whether at home or in the institution, staff should not feel obliged to befriend every person in their care. A significant minority of residents apparently prefers distance in the caregiving relationship. This finding accords well with a study by Heiselman and Noelker (1991), who found that roughly half of the care recipients they investigated preferred social distance from staff, i.e., the clients receiving care wanted service, not a personal relationship, from staff. Furthermore, it would seem wise for caregivers to use touch, as a demonstration of affection, very selectively, since a full quarter of respondents felt such behavior to be unpleasant (at best) or inappropriate (at worst). Because caregiver affiliation does not seem to impact on social dependency, indulging the social needs of the care recipient isn't likely to increase dysfunctional social or emotional behavior. To be frank, the needs expressed by the present sample were quite minimal -- polite conversation was the chief desire -- and complying with such requests

should be possible for even the most overtaxed caregiver. It might further have a slight effect on well-being.

Of course, further refinement of the scale is needed. To be sure, we don't know whether the generally low caregiver affiliation exhibited in this sample is truly indicative of the respondent's desire to affiliate, or are perhaps a sign of resignation to the fact that most of their caregivers are too stressed to pursue friendly relationships with them. In other words, the staff's desire to affiliate might directly influence the care recipient's desire to do so.

3.2 Respect for Medical Authority

The respect for medical authority construct has already figured prominently in this discussion. In order to understand the psychological dynamic of the caregiving context, two essential premises must be acknowledged. First, the elderly are likely to have pronounced respect for authority, and second, the healthcare system has long been overly authoritarian and paternalistic. If these premises are true, then it stands to reason that the elderly may be in danger of becoming cogs in the machinery of the system. They may quickly submit to the authority of the person or institution that is responsible for their care. Therefore, an excess of respect for medical authority, which entails an improper understanding of the patient role, might explain the elderly individual's dependency in interactions with medical personnel, including professional caregivers.

I have already reviewed how various sociocultural and political influences may have helped shape the elderly individual's attitudes toward authority. But, in order to arrive at the *practical implications* of these results for caregiving, perhaps a more differentiated analysis of the respect for medical authority construct must be made.

If one deconstructs the *Respect for Medical Authority* scale, three essential components can be found. Generally, the scale can be divided into questions that reflect trust in one's doctor (4 items), passivity in the patient role (5 items), and an understanding of the patient's rights (3 items). Because the present sample of elderly performed so poorly on many of the items in this test (see **Chapter 7, Table 17**), the obvious recommendation would be to make the older care recipient:

1. more objective in evaluating their doctors;
2. more active in their role as patient; and
3. more informed of their rights as a patient.

The question is: how? I would favor a three-pronged approach targeting *the care recipient, the caregiver,* and *the service provider*.

Care recipients can be taught to take a more critical, yet constructive stance in the doctor-patient relationship. Asking questions of their doctor, reflecting upon their medical condition, and deciding between treatment modalities are certainly acceptable and adaptive responses to chronic illness. Furthermore, care recipients should be informed of their legal rights as a patient, particularly their right to refuse treatment. Finally, assertiveness training might be the intervention of choice for nursing home residents who seem to have difficulty challenging authority.

Caregivers of all kinds, including untrained aides, should be made aware of the fact that the elderly, as a group, tend to place to much trust in authority figures, especially medical personnel. The problem seems to be particularly acute among those elderly with poor education. Moreover, professional caregivers must themselves be fully informed about their obligations, under law, to protect patient rights, including ethical standards regarding the right to die and pain relief (e.g., Solomon et al., 1993). Reinforcing these notions fosters an environment where the care recipient's wishes are respected. It places power in the hands of elderly individuals, and encourages them to assume responsibility for critical treatment decisions.

Doctors and medical nurses in particular should take the time to improve communication with such patients, encourage them to contribute to the dialogue by asking questions and allowing them to give a full account of their symptoms. Since many elderly do not feel it is proper to "complain" about the side effects of medication, and furthermore, seem to be under the misapprehension that medication prescribed by a doctor always helps, it is essential to monitor their response to treatment regimens all the more closely (Beers, 1992). Finally, medical professionals should note that some measure of passivity -- or even failure to acknowledge patient rights -- might result from age-related cognitive impairment. In these

cases, when making medical decisions becomes an overwhelming experience, an excessive amount of trust might be construed as an adaptive response.

Finally, the architecture of the health care system itself can be changed to ensure that patient's rights are not abused. For example, each and every care recipient should be informed of their rights as a patient as a necessary prerequisite to admission to a nursing home or the provision of homecare services. When serious abuse occurs, there should be clear channels for filing an official complaint. Care recipients should be informed about how to seek redress when they feel that the service they have received is substandard or that they have been treated unfairly. Ideally, the care recipient would meet with a case worker or advocate on a regular basis to discuss continuing issues in their care. Cognitively impaired individuals should meet with and be monitored by the caseworker even more frequently. A large proportion of elderly care recipients may be unable to give informed consent, and the regular nursing staff is not always adept at identifying such cases (Barton, Mallik, Orr & Janofsky, 1996). When this happens, the proper legal procedures for appointing a surrogate decision-maker (e.g., a close family member) should be instituted.

In conclusion, these recommendations must be qualified in one very important respect. A certain degree of trust is necessary to every relationship. The purpose of these kinds of interventions is not to make elderly persons overtly critical of the medical establishment, but rather, to underscore the contribution they can and should be making to the caregiving dialogue.

3.3 Social Dependency

The present study has reported findings regarding social dependency, without, however, elucidating how they might be applied to the practical care of the elderly individual. Social dependency, it will be recalled, was chiefly associated with physical dependency, or declines in functional health. It was also consistently higher in the homecare as opposed to the institutional environment. As illustrated in **Figure 27** (above), higher social dependency was traced back to the characteristics of the home environment, including its lack of institutional structure and relative comfort in terms of space and amenities. Physical dependency and caregiving environment, it will be noted, accounted for virtually all of the variance in social

dependency. Interindividual differences in age, gender, and education, as well as the personality measures employed, contributed little to the regression analysis.

The *practical implications* of these findings are far-reaching. First, professional caregivers should be aware that social dependency seems to be an unavoidable consequence of physical dependency. If this is true, then it really does not matter what the person's attitudes or preferences are. It does not matter, for example, whether the person is inclined to ask for help, whether or not he or she enjoys social contact, or has pronounced respect for authority. Social dependency is only associated with real decline in functional health. It would appear then, that the psychosocial care of the elderly individual is an essential component of the caregiver's job. This is probably especially true of those elderly who are too cognitively impaired to regulate their health, or too weak and isolated to procure the social capital they deserve.

Further recommendations regarding the design of home- and institutional care might be ventured.

Recommendations regarding homecare: Homecare providers should be aware that the institution offers a much wider range of "hidden" support to their residents. For example, nursing homes have a larger number of staff to check in on their residents at different hours of the day. They also provide a housecleaning service, a meal program, an exercise program, social activities, and plentiful contact with peers. Homecare providers should thus try to complement their healthcare delivery with a wide range of other supportive measures. Cooperation with family members living in the vicinity is likely to play a more important role.

Recommendations regarding institutional care: This study has shown that a homelike environment has a definite impact on certain kinds of social behavior. I speculate that this effect can be traced back to the space, privacy, and freedom from distraction afforded by the home environment. This context is more conducive to social exchange. On several occasions, personal communication with caregiving professionals revealed that the home environment makes them feel more at ease with their tasks and more sociable in their interactions with the elderly. The stress and chaos associated with the institutional environment (especially poor organization of duties and time constraints) appears to make the

staff less receptive to overtures made by residents. Hence, nursing homes might experiment with one-to-one care of the elderly, which seems to be preferred by staff and residents alike.

In sum, institutions are to be commended for addressing health-related dependency needs with health regulations, meal plans, and activity programs. Homecare providers, however, are to be lauded for providing care that can more easily be translated into social capital for their clients.

3.4 Summary

This final section of the discussion reviewed findings with implications for elder care. The findings indicate that not all care recipients wish to pursue friendly relations with their caregivers. In fact, most seem to require little more than casual conversation, which is a reasonable demand to make upon a healthcare provider.

Conversely, attitudes toward medical authority seem to warrant some kind of intervention. If the present sample is any indication, respect for medical authority is far too high among the elderly. Fortunately, many steps might be taken to address this issue.

Finally, the findings show that personality did not greatly influence social dependency. Instead, social dependency seems to be largely determined by the respondent's general level of functioning and the context of care. Although most elderly appreciate the greater freedom and comfort afforded by the homecare, these very features of the home environment appear to promote social dependency upon one's caregiver.

4. Limitations of the Present Study

This discussion of findings would not be complete without a review of the limitations of the present study. Six of these warrant particular attention:

a) *The sample of elderly was rather small.* Only 86 out of the 114 persons received hands-on care from trained professionals. This could be a reason why stronger effects were not observed generally and in the regression analysis in particular.

b) *The sample of elderly was not representative.* No attempt was made to stratify the sample in terms of demographic variables (e.g., age, gender, health, and caregiving environment). The women in the sample, as mentioned earlier, were both older and stronger than the men, leading to interpretational difficulties.

c) *The study's design was cross-sectional.* Cross-sectional designs have certain limitations. The discrepancies observed between older and younger age groups in this study represent age differences, not true change. Further studies are required to determine whether such differences are attributable to maturational or cohort effects.

d) *Comparison groups were selected for convenience.* The extremely large age differences in personality observed were partly due to the fact that adults from extreme ends of the age spectrum were sampled. Better comparisons might be made with more carefully selected cohorts (e.g., baby boomers).

e) *Mediating variables were not accounted for.* The failure to assess the social network of the care recipient, in particular, was a serious oversight. From a developmental perspective, it would also have been interesting to know when functional decline first began. Individuals who have lived with their disability for some time might be more amenable to receiving help, i.e., exhibit higher trait dependency.

f) *The measurement instruments employed require further validation.* Three of the personality scales, as well as the major outcome index, were new and require further revision and refinement.

The last point, in particular, requires further elucidation. Although the design and testing of the newly developed scales was largely a success, psychological measures, as well as the constructs which serves as their foundation, must be continually refined and improved. All of the scales employed in this study could be made better by making them longer and integrating difficulty criteria into the process of psychometric testing. Further analysis of reliability (especially retest reliability) is necessary as well. Specific areas of improvement would also include the following:

Stoicism: The *Stoicism* scale, at present, is rather short and doesn't do justice to the concept it is intended to measure. The scale might be expanded to include more items that assess humility and modesty, as well as industriousness, willingness to toil, and the perception of life as a never-ending struggle, all of which seem consistent with the stoic philosophy. Additional items would also improve the reliability of the scale, of course.

Caregiver Affiliation: The *Caregiver Affiliation* scale was created in a largely intuitive manner, based upon the different forms of social capital that one can obtain through relationships. A more valid and thorough approach to scale construction would rely upon interviews with elderly care recipients regarding the "ideal" caregiver. The sample for this pilot study would have to be sufficiently large and varied. By better delineation of the construct, however, the reliability and validity of the scale might be improved.

Respect for Medical Authority: The *Respect for Medical Authority* scale should undergo continued testing and refinement. Additional items with special relevance for geriatric patients, such as knowledge regarding surrogate decision-makers, advance directives (e.g., "do not sustain" orders) and specific uses of force (e.g., use of physical restraints, forced intravenous feeding of patients), might prove interesting points for assessment and perhaps intervention.

Social Dependency: The arguments regarding the further refinement of psychological measures is doubly true for the *Social Dependency* rating scale. A bit of error in measuring independent variables can be excused; if the effect is random, then the worst that can happen is a null effect. Conversely, pains must be taken to measure the dependent variable with utmost precision. The social dependency concept is still in its infancy and attempts could be made to better define and measure it. Because environment seems to have a very basic effect on patterns of social interaction, interviews with caregivers might be a good way to understand the different task demands associated with different caregiving environments. This, coupled with surveys of caregivers' attitudes towards bonding with their clients, might provide the elaboration needed to improve the definition and measurement of the social dependency construct.

Despite the limitations described here, it is hoped that this exploratory analysis of different kinds of age-related dependency, as well as their personality correlates, will contribute to the current understanding of older adults and the aging process.