

2003

Individual differences in interpersonal dependency in older adults: Development of a measure and its evaluation in health care services

Deborah Gardner
Edith Cowan University

Follow this and additional works at: <https://ro.ecu.edu.au/theses>



Part of the [Developmental Psychology Commons](#)

Recommended Citation

Gardner, D. (2003). *Individual differences in interpersonal dependency in older adults: Development of a measure and its evaluation in health care services*. Edith Cowan University. Retrieved from <https://ro.ecu.edu.au/theses/1507>

This Thesis is posted at Research Online.
<https://ro.ecu.edu.au/theses/1507>

Edith Cowan University

Copyright Warning

You may print or download ONE copy of this document for the purpose of your own research or study.

The University does not authorize you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site.

You are reminded of the following:

- Copyright owners are entitled to take legal action against persons who infringe their copyright.
- A reproduction of material that is protected by copyright may be a copyright infringement. Where the reproduction of such material is done without attribution of authorship, with false attribution of authorship or the authorship is treated in a derogatory manner, this may be a breach of the author's moral rights contained in Part IX of the Copyright Act 1968 (Cth).
- Courts have the power to impose a wide range of civil and criminal sanctions for infringement of copyright, infringement of moral rights and other offences under the Copyright Act 1968 (Cth). Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

The Faculty of Community Services, Education and Social
Services.

School of Psychology



EDITH COWAN UNIVERSITY

Western Australia

**Individual Differences in Interpersonal
Dependency in Older Adults: Development of a
Measure and its Evaluation in Health Care
Services**

Deborah Gardner

This thesis is presented as part of the requirements for
the award of the Degree of Doctor of Philosophy (Clinical
Psychology) of Edith Cowan University.

September 2003

ABSTRACT

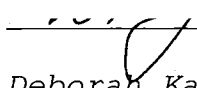
Increasing dependency in older age is conceptualised differently by various disciplines. Psychologists have contributed to the understanding of dependency in older age by describing and explaining the functionality of dependency across the life-span. Psychological research has also examined variables (such as the responses of carers to the dependent behaviours of older people) that exacerbate dependent feelings and behaviours (Baltes, 1996), but it has not included an individual difference measure of interpersonal dependency. According to Rosowsky, Dougherty, Johnson and Gurian (1997), an understanding of the ways that personality style affects older adults' engagement and reception of health services would assist providers in planning treatments and services that are more cost effective and attuned to individuals' needs. A review of the literature found that no scale for the measurement of interpersonal dependency of older adults had been developed. This research, therefore, developed a measure of interpersonal dependency for use with older adults and evaluated it in a home-care service setting. The following questions were addressed in the process: 1) Are older people who access home-care services higher in their levels of

interpersonal dependency than older people who do not access home-care services? 2) What is the relationship among interpersonal dependency, depression and physical dependency in an older home-care population? The scale was developed in four stages: 1) an item development stage that included the facilitation of focus groups followed by a scale pilot study; 2) an item reduction stage; 3) a stage that examined and summarised the components of the scale; and 4) a scale validation stage. The 15 participants for item selection focus group sessions and the scale pilot study included 14 women and 1 man aged over 65 years from Perth metropolitan day centres and also three allied health professionals. Participants for scale reliability and validity studies included 703 older adults (aged over 65 years). Two hundred and fifty-two were Silver Chain Nursing Association clients, 358 were Positive Ageing Foundation members and 93 were members of the Council on the Ageing. A reliable and valid 20-item interpersonal dependency measure for use with older adults resulted from the development process. In addition a comparative study utilising the new measure found that older adults in the home-care service population scored higher on the measure of interpersonal dependency than older adults sampled from the other populations. A hierarchical regression analysis found that both interpersonal dependency and

depression were significant positive predictors of mobility in older adults. These findings have important intervention and financial implications for service providers. Screening for interpersonal dependency in older adults could assist in designing interventions that are more attuned to individuals' needs and thus reduce reliance on services.

I certify that this thesis does not, to the best of my knowledge and belief:

- i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;
- ii) contain any material previously published or written by another person except where due reference is made in the text; or
- iii) contain any defamatory material


Deborah Karen Gardner

Date: 10 / 02 / 04

ACKNOWLEDGEMENTS

I would like to thank the many people who helped me complete this research. First I would like to thank the participants of the research for taking the time to talk to me and/or to complete and return questionnaires. Without them this research could not have been done.

Thanks also to Dr Gill Lewin, Research Manager, Silver Chain Nursing Association, for her inspiration and support throughout this research and to the Silver Chain research department staff for organising the despatch of the questionnaires to the Silver Chain participants. I would also like to thank Nigel Barker, Executive Director, Council on the Ageing and Marlene Robins, Positive Ageing Foundation for organising the despatch of the questionnaires to their organisations' members.

Next I would like to thank my supervisors, Associate Professor Edward Helmes, James Cook University and Dr Craig Speelman, Edith Cowan University for their helpful comments and suggestions and for their guidance and encouragement throughout this research. Thanks also go to Professor Alison Garton, Edith Cowan University for her editorial comments.

I would also like to thank Dr Eyal Gringart, Edith Cowan University, Pamela McNeill, PhD candidate, Edith Cowan University, Sharon Elsley, PhD candidate, Curtin University, Hillary O'Connell, Silver Chain, Bev Wheeler, Silver Chain and Kasia Harrison, Silver Chain for their insightful thoughts and for their assistance at various stages of the research.

I would also like to thank the Silver Chain Nursing Association (the industry partner), the Australian Association of Gerontology (R.M. Gibson Fund) and the Centre for Health and Ageing Research (Edith Cowan University) for their research grant assistance.

Thanks also to the university staff, especially Nicky Kemp, who provided practical assistance with the research.

Finally I would like to thank my husband, Geoff, who has supported, encouraged and assisted me throughout my years of study. Thank you for believing in me.

TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGEMENTS	vi
TABLE OF CONTENTS	viii
LIST OF TABLES	xi
LIST OF FIGURES	xiv
CHAPTER 1	1
Background	1
CHAPTER 2	6
Dependency Overview and Theoretical Basis for the Interpersonal Dependency Scale Development	6
The economics and social science perspective	8
The epidemiology perspective	11
The psychology perspective	12
The interactive model of dependency	22
Interpersonal dependency and older adults.	28
Interpersonal dependency and depression.	31
Interpersonal dependency and anxiety.	34
Interpersonal dependency and physical illness.	35
Measurement of interpersonal dependency.	36
Summary	40
Research Purpose	42
Subsidiary questions.	42
Hypotheses	43
Interpersonal Dependency Scale Construction	43
CHAPTER 3	46
Stage 1 - INTERPERSONAL DEPENDENCY SCALE ITEM DEVELOPMENT	46
Part 1: Focus Groups	46
Aim	46
Method	47
Participants	47
Instruments	48
Procedure	48
Results	53
Salient Themes	53
Discussion	65

Stage 1 - INTERPERSONAL DEPENDENCY SCALE ITEM DEVELOPMENT	68
Part-2: Initial Item Pool Selection Process	68
Method	68
Procedure	68
CHAPTER 4	77
Stage 2 - Scale Reduction: Initial Internal Consistency Reliability Analyses and Principal Components Analyses	77
Aims	77
Method	78
Participants	78
Instrument	79
Procedure	79
Scale reduction and reliability analyses	80
Principal components analyses	86
Interpretation	93
Interpretation	97
Interpersonal dependency comparison between samples	98
Interpersonal dependency comparison between gender	98
Relationship between age and interpersonal dependency scores	99
Discussion	99
CHAPTER 5	104
Stage 3 - Between Sample Dependency Scale Score Comparison and Component Examination	104
Aim	104
Method	107
Participants	107
Instrument	108
Procedure	108
Results	109
Gender x organisation interpersonal dependency score comparison	109
Relationship between age and interpersonal dependency scores	111
Interpersonal dependency scale internal consistency reliability analyses	111
Principal components analyses	112
Discussion	126
CHAPTER 6	130
Stage 4 - Interpersonal Dependency Scale Validation Study	130
Aim	130

Method	132
Participants	132
Instruments	132
Procedure	136
Results	136
Hierarchical Multiple Regression Analysis	140
Discussion	142
Conclusion	148
REFERENCES	152

LIST OF TABLES

Page

Table 1. Interpersonal Dependency Scale Items (85 items).....	72
Table 2. 20 Items with the Highest Item-total Correlations.....	83
Table 3. Final 20-Item Interpersonal Dependency Scale.....	85
Table 4. Oblimin Rotated Component Pattern Matrices for Interpersonal Dependency Variables (Initial and 2 Components Solutions)- SC Sample.....	88
Table 5. Component Correlation Matrix (Initial Solution)- SC Sample.....	89
Table 6. Oblimin Rotated Component Pattern Matrix for Interpersonal Dependency Variables (Initial Solution) and Unrotated Structure Matrix (1 Component Solution) - PAF Sample.....	91
Table 7. Component Correlation Matrix - PAF Sample....	92

Table 8. Oblimin Rotated Component Pattern Matrix for Interpersonal Dependency Variables (Initial and 2 Component Solutions)- SC Sample and PAF Sample Combined.....	96
---	----

Table 9. Component Correlation Matrix -(Initial Solution) SC and PAF Samples Combined.....	97
---	----

Table 10. Mean Interpersonal Dependency Scale Scores as a Function of Gender and Sample (Organisation).....	110
---	-----

Table 11. Oblimin Rotated Component Pattern Matrix for Interpersonal Dependency Variables (Initial and 2 Component Solutions) - SC Sample (Stage 3).....	113
--	-----

Table 12. Component Correlation Matrix (Initial Solution)- SC Sample.....	114
--	-----

Table 13. Oblimin Rotated Component Pattern Matrix for Interpersonal Dependency Variables (Initial and 2 Component Solutions)- PAF Sample (Stage 3).....	116
--	-----

Table 14. Component Correlation Matrix -(Initial Sololution) PAF Sample (Stage 3).....	117
Table 15. Interpersonal Dependency Variables (Initial and 2 Component Solutions)- COTA Sample (Stage 3).....	119
Table 16. Component Correlation Matrix (Initial Solution) - COTA Sample.....	120
Table 17. Oblimin Rotated Component Pattern Matrix for Interpersonal Dependency Variables (Initial and 2 Component Solutions) - Combined Samples (Stage 3)....	124
Table 18. Component Correlation Matrix (Initial Solution)- Combined Samples (Stage 3).....	125
Table 19. Intercorrelations for the Variables IDS-OA = Interpersonal Dependency Scale - Older Adults; DEQ = Depressive Experiences Questionnaire.	138
Table 20. Interpersonal Dependency Item and Social Desirability Score Correlations.....	139
Table 21. Results of the Hierarchical Multiple Regression Analysis on Mobility.....	141

LIST OF FIGURES

Page

Figure 1. An integrated model of dependency. From The
Dependent Personality (p. 162), by R.F. Bornstein, 1993,
New York: Guilford Press.....27

Figure 2. Distribution of interpersonal dependency scores
for the SC sample.....122

Figure 3. Distribution of interpersonal dependency scores
for the PAF sample.....122

Figure 4. Distribution of interpersonal dependency
scores for the COTA sample.....123

CHAPTER 1

Background

The immediate context for this program of research arose from observations within a local community service agency. The needs of the agency related to developments in applied research that suggested an empirical approach to the agency's problem. The background of the problem will be outlined initially prior to the major theoretical review.

Like home-care agencies worldwide, Silver Chain Nursing Association (the largest home-care agency in Western Australia) found in recent years that it was unable to meet the demand for its services. In February 1999, 724 people were listed as waiting for various types of home-care services and a further 143 people already in receipt of services from Silver Chain were listed as waiting for more hours of care (Lewin, 1999). This prompted Silver Chain to review its model of care delivery to determine cost effective ways of addressing the waiting list problem while improving (and not compromising) the quality of the services provided. The suggestion in the research literature that dependency of older people in

hospitals and nursing homes is brought about as much by a certain type of nursing care as it is by their physical and mental condition (Baltes, 1996; Baltes, Burgess & Stewart, 1980; Baltes, Honn, Barton, Orzech, & Largo, 1983; Baltes, Neuman, & Zank, 1994; Barton, Baltes, & Orzech, 1980; Bowsher, 1994; Grainger, 1993; Grainger, Atkinson & Coupland, 1996; Miller, 1984, 1985; Wahl, 1991) prompted an exploration of factors that might be contributing to the reliance on home-care services (domiciliary nursing, personal care and home help) of Silver Chain clients.

In order to explore such factors, the research department at Silver Chain conducted focus groups with direct care staff at five of its seven metropolitan bases (Gardner, 1999). The purpose of the focus groups was to identify groups of clients that might be at risk of becoming overly reliant on Silver Chain resources so that directions for intervention could be gauged. Those at risk of becoming "overly reliant" were defined as groups thought to be at risk of receiving more hours of care in the future or currently than their observed level of functional performance would seem to predict. Results of this investigation indicated that Silver Chain clients in general were likely to be at risk of becoming overly reliant on resources through the provision of over-care,

or services that appeared not to meet their immediate needs. Over-care and the provision of unneeded services to some clients was thought to result from direct care staff's perceived lack of time to rehabilitate clients, a lack of understanding of behavioural principles and ineffective initial and reassessment procedures. It was thought that assessment procedures failed to address social and mental health factors (depression, anxiety and excessive interpersonal dependency) that appeared to contribute to over- or mis-use of services.

While home-care agencies are concerned with supporting functional disability, the main factor that appeared to be contributing to over-reliance on Silver Chain's home-care services was over support of functional disability or of client perceived functional disability. It was suggested that many staff members were doing too many things for people that they were capable of doing for themselves. In addition many clients were receiving a fixed package of services related to their need even though they required only one or some of the services included in the package. Another factor suggested by Silver Chain staff to be contributing to over-reliance on services was the provision of services to those with dependent attitudes and behaviours or depression but no apparent physical disability.

Possibly, through the provision of over-care, unneeded services and misdirected services, Silver Chain was fostering rather than supporting the functional dependency of some clients. According to Baltes (1996), learned dependency (discussed in Chapter 2) can be a precursor to actual physical dependency if care is continued when the physical need for it is gone. Learned dependency maintains the need for functional support which, in turn, may contribute to further functional decline through lack of activity or lack of use of skills.

Results of the Silver Chain staff survey suggested that there were both "service" and "person" factors that were likely to interact to contribute to over- or mis-use of services. Following the staff survey, the Silver Chain research department has addressed some of the service factors by designing, trialling and implementing a new, voluntary interdisciplinary model of home-care delivery that aimed to rehabilitate clients with low levels of functional disability (or to maintain those levels) rather than support the disability. It also plans to develop a staff-training package that aims to educate staff on behavioural principles.

This thesis is concerned with interpersonal dependency as an individual difference variable in older people and its possible contribution to their over-reliance on home-care services. The thesis begins with a review of the general dependency literature. Then the interpersonal dependency literature is reviewed more specifically and this demonstrates the need for the development of a measure of interpersonal dependency for older adults.

CHAPTER 2

Dependency Overview and Theoretical Basis for the Interpersonal Dependency Scale Development

Increasing dependency in older age has interested gerontology researchers from various disciplines for many years. This interest has been at both the level of social policy and the level of the individual (Baltes, 1989; Baltes, 1996; Moane, 1993). Although the various disciplines conceptualise dependency differently, they all agree that dependency in older age can be a concern from the viewpoints of both older people and younger generations. For example, people in all generations stand to benefit either directly or indirectly, now or in the future, from policies directed to older people (Hendricks & Leedham, 1989). Furthermore, demographic trends indicate that the population of older adults is increasing while the numbers of families who are able to look after older family members at home is decreasing (Moane, 1993). This situation has resulted for a variety of reasons, such as the increase in the numbers of women in the work force, the changes in the structure of families and the geographic distance that separates

members of many families. The major focus of studies of dependency in older age, therefore, has been on the physical and cognitive limitations associated with ageing that require social support. Dependency, however, is multi-dimensional and multi-causal (Baltes, 1996). By limiting their focus to only the dependency needs of older people that result from physical and cognitive limitations, researchers limit their understanding of dependency in older people, and clinicians under-utilise significant components that might be useful in planning for the older person requiring health care services.

An understanding of dependency in older adults requires a differentiated view of the nature of dependency as well as an understanding of the implications of the dependency (Moane, 1993). But the multi-dimensional and multi-causal nature of dependency, and the failure of many researchers to define it adequately (Gibson, 1985) complicate analysis of the results of dependency studies. As pointed out by Baltes (1989), Baltes (1996) and Moane (1993) different disciplines are concerned with different kinds of dependency. These varying perspectives are reviewed below.

The economics and social science perspective

Economics and social science focuses on financial and social dependencies. Economists measure dependency in terms of the "dependency ratio", which refers to the proportion of people in the society who are in the labour force and financially supporting those who are not (due to retirement, disability, child rearing or childhood) (Johnson, 1990). In recent years social scientists have become interested in the possible social construction of dependency in older people. According to Johnson (1990) for example, an implicit devaluation of unpaid activities and the view that retired and/or disabled people are a "burden" underpins the dependency ratio calculation. These implied values are likely to reinforce older people's perception of their dependency as well as the perception of the general population regarding older people's dependency. Townsend (1981) discusses other social factors that similarly foster the psychological as well as the financial dependency of older adults such as the institutionalisation of retirement, pensionable status and institutional residence.

Nonetheless, the dependency ratio of particular groups informs social planning on a macro economic level. It

suggests which groups require funding for services but it provides no information about the actual specific needs of people within the groups (Baltes, 1996). In Western societies the dependency ratio is increasing at the rate of the increase in the older population (Baltes, 1994). Thus, there has been an emphasis on the service needs of older people in these countries. Due to political concerns about cost effectiveness and older people's expressed desire to remain in their own homes (Gibson, 1985; Oldman & Quilars, 1999; Townsend, 1981), social services now aim at maintaining the independence of the older people and at avoiding institutionalisation. The providers of services, however, have not considered that the services they offer might actually contribute to the dependency of older people instead of promoting autonomy (Baltes, 1996; Baltes, Wahl, & Reichert, 1991; Bruce, 2000; Dant, 1988; Gibson, 1985; Townsend, 1981).

Research suggests a shift from institutionalisation for older people to community care. But home-care staff (and staff of other health services) might still reinforce and create the dependency of older people by viewing them as "passive recipients" of the services, which are administered by people in positions of authority (Hendricks & Leedham, 1989; Townsend, 1981).

In addition to viewing older adults as recipients of government funded support, Baltes (1994) argues that many services designed for older adults do not consider the individual variation among elderly people who are now becoming highly dependent on the service system due to the fragmentation or oversupply of services. Care packages that cover the needs of many people are less expensive to provide than services tailored to meet the needs of individuals. In order to have a need met people must sometimes accept a fixed package of services even though they do not require all of the services it provides. At other times, according to the Silver Chain direct care staff (Gardner, 1999), individuals require a service that the agency does not offer so a service that is available is presented to them, even though it does not address the client's needs. Gibson (1985) and Oldman and Quilgars (1999) agree that the provision of a narrow range of services forces older people into over-utilisation of available services and thus into dependency. Gibson says this structured dependency could be overcome by the provision of a wider range of services that are designed to meet the individual needs of older people.

The epidemiology perspective

Epidemiological research generally equates dependency and disability. Results of this kind of research report the number of people who are physically or functionally dependent (Gallagher, Thompson, & Levy, 1980) on health services. This figure informs those who fund public health service and the service providers. Traditionally, the "burden" of supporting the physical and cognitive disabilities of older adults fell on both families and social institutions (Schwartz, 1979), but because of the increase in the population of older adults, the focus is now on maintaining the independence of older adults in their own homes (Baltes, 1996). It is also becoming recognised that while physical disabilities are more common in older adults than in younger adults, they are not the norm for the majority of the population of older adults (Bruce, 2000; Hendricks & Leedham, 1989; Stone, 2003). According to Baltes, however, accurate figures on people who are functionally dependent are difficult to ascertain. Functional dependency is defined in terms of the scores of individuals on measures designed to assess their ability to carry out activities of daily living (ADL) (such as showering or dressing) or instrumental activities of daily living (IADL) (such as shopping or

housekeeping) (Baltes, 1996). The proportion of people found to be dependent is a function of the measure used. As pointed out by Baltes (1996) and by Stone (2003), it is not surprising, therefore, that dependency prevalence rates across epidemiological studies vary drastically. For example, when the definition of dependency includes only people who need help in self-care, such as showering, percentages are low (Baltes, 1996). But when the definition includes people who need help in self-care and in instrumental daily activities, such as shopping, the percentages increase. Baltes cites research that demonstrates this. Wan, Odell and Lewis (1982), for example, found that 27% of people over 60 years of age require support with one or more IADL. On the other hand, Guralnick and Simonsick (1993) found between 5% and 8% of people aged over 65 years to be dependent using an ADL measure. As pointed out by Baltes (1996) much more work is needed in the area of defining and measuring physical or functional dependency (disability). Prevalence rates could then be more accurately determined along with disability needs.

The psychology perspective

Psychological research is usually designed to explain dependency. But even within the discipline of

psychology, three different types of dependency studied by psychologists belonging to different specialist streams emerge in the literature. Developmental psychologists focus on the functionality and intergenerational impact of dependency across the life-span, social psychologists are interested in environmentally induced dependencies such as learned dependency and clinical psychologists are concerned primarily with the etiology, correlates and sequelae of interpersonal dependency (dependent personality or disposition as opposed to dependent states in response to environmental or physical factors).

The developmental psychology perspective. Psychological research on dependency in old age has been largely influenced by life-span developmental theory (Baltes & Silverberg, 1994). It has focused on adaptive perceptions and behaviours associated with physical and cognitive limitations that are experienced by some older people. Developmental psychologists describe and contrast the dependency needs of people at different stages of their lives. Life-span developmental theory views dependency as a normal part of the developmental process for children and for older adults who are more likely to be dependent upon others due to physical and cognitive limitations. Dependency is also thought to be

functional and necessary during illness, thus people's degree of dependency varies across the life span according to their physical and cognitive needs. This view of dependency in old age is in line with that of epidemiologists and allied health professionals in that its focus is also on the functional and cognitive limitations of older age that require formal and/or informal support to compensate for the disability. But unlike epidemiologists and allied health service providers, who define dependency in terms of disability, developmental psychologists view increasing dependency in older age as a positive, adaptive developmental process that can facilitate connectedness, interdependence and autonomy (Baltes & Silverberg, 1994). According to Baltes and Silverberg, dependency assists all people in maintaining personal control by allowing them to compensate for a loss or lack of competency (see the discussion on Selective Optimisation with Compensation below). Dependency is viewed by developmental psychology as accommodating a "fit between competencies of the person and the demands of the environmental setting" (Baltes & Silverberg, 1994, p. 79).

The social psychology perspective. Baltes and her colleagues (Baltes, 1996) identified three models of behavioural dependency, which is usually the focus of

psychological studies of dependency in older adults. Each model is useful in explaining behavioural dependencies resulting from various sources. These are learned helplessness, learned dependency and selective optimisation with compensation. Both the learned helplessness and learned dependency models suggest that behavioural dependency is environmentally induced although they differ in terms of "their specification of the sources for dependency and their evaluation of the resulting outcome" (Baltes, 1996, p.25). They also differ in terms of implications for the nature of intervention. The selective optimisation with compensation model of successful ageing suggests that dependency is sometimes self-selected, rather than socially induced, as compensation for losses in reserve capacity associated with normal ageing.

Learned helplessness. According to the learned helplessness model of behavioural dependency, repeated experience with "noncontingency" results in negative outcomes such as lack of performance, cognitive deficits, or motivational deficits (Peterson, Maier & Seligman, 1993). Noncontingency refers to situations where there is no clear connection between behavioural and environmental events so people learn that their behaviour has no consequence on events affecting them (Peterson, 1993; Peterson, Maier & Seligman, 1993). For example, if

a people's attempts to resume normal activities after recovering from an illness are met with criticisms regardless of success or relative failure, they experience feelings of loss of control and become afraid to try anything else (Baltes, 1996). Interventions in cases of learned helplessness involve creating contingencies.

Learned dependency. Like the learned helplessness model, Baltes' research, which spanned 20 years, involved determining the environmental conditions involved in maintaining and developing dependent behaviours in older people (Baltes, 1996). Baltes postulated the learned dependency model as a result of her findings. It suggests that environmental contingencies differ for dependent behaviours as opposed to nondependent behaviours and outcomes for dependency also differ. Baltes was interested in whether the dependent behaviours of older people could be modified, changed or reversed. She found in institutions that specific behaviours generated specific responses (Baltes, Burgess, & Stewart, 1980; Baltes, Honn, Barton, Orzech, & Largo, 1983). Dependent self-care behaviours of residents led to "dependence-supportive" behaviours of staff (such as social actions), which in turn, led to dependent self-care behaviours of the residents. On the other hand, independent self-care behaviours of the residents led to

no response from staff. The staff rewarded the dependent behaviour of the older people even though these institutions aimed to maintain non-dependence as long as possible. Dependent behaviour was more likely to result in social contact and attention than any other behaviour of the older people. Findings were similar for a community setting (Baltes & Wahl, 1992). Social partners supported dependent self-care behaviours twice as often in the community setting as independent self-care behaviours. However, unlike those in the institutional setting, independent self-care behaviours were followed by social responses from social partners 28% of the time. According to Baltes (1996), interventions for learned dependency involve altering existing contingencies.

Selective optimisation with compensation. Selective optimisation with compensation (Baltes, 1995; Baltes & Baltes, 1990) refers to self-regulated dependency. The view here is that performance reduction in some areas can have "positive adaptive value". For example, losses in reserve capacity, such as endurance, due to normal ageing might lead a person to select dependency in terms of some of the instrumental activities of daily living so that he/she can continue performing a preferred activity such as playing golf. Thus, he/she is compensating for his/her loss of endurance by choosing to expend energy on things he/she wants to do, while leaving other things to

someone else. The selective optimisation view of dependency is perhaps more accurately a view of older adult autonomy since it implies adaptation to life circumstances through choice. Nonetheless, if one defines dependency in terms of the dependency ratio or in terms of reliance on health or home-care services then selective optimisation with compensation might indeed be one explanation of older adult dependency.

Clinical psychologists' perspective. Clinical psychologists are interested in the aetiology, correlates and sequelae of interpersonal dependency or dependent personality (Bornstein, 1995b). As mentioned previously, interpersonal dependency (or dependent personality - the two terms are commonly used interchangeably) is the primary concern of this project due to its possible contribution to older adults' use of health services.

The aetiology of interpersonal dependency is based on early psychoanalytic and social learning theories, which viewed dependency as a pathological personality characteristic having its roots in an overprotective parenting style and in the sex-role socialisation process in general (Birtchnell, 1988; Blum, 1949; Hirschfeld, Shea, & Weise, 1991). Much of the early research on interpersonal dependency was influenced by the

description of oral dependency as defined by psychoanalysis, which according to Masling, Rabie and Blondheim (1967), included the characteristics of immaturity, passivity and helplessness. As a result of this research, dependent personality disorder (DPD) was included in the second edition of the *Diagnostic and Statistical Manual* (DSM: American Psychiatric Association, 1952) as a subtype of passive-aggressive personality. The DSM characterised the passive-dependent person as helpless, indecisive and having a "tendency to cling to others as a dependent child to a supporting parent" (p. 37).

Later, object relations frameworks and social learning theories stressed the importance of social reinforcement in the development of dependent personality characteristics (Ainsworth, 1969; Maccoby, 1980). Then in 1980 DPD was coded in the DSM-III (American Psychiatric Association, 1980) into a category separate to passive aggressive personality, but the characteristics of the dependent person remained the same as in previous editions.

Influenced by social learning and object relations theories, Blatt and Shichman (1983) incorporated ideas from both theories as well as research findings on

cognitive development. They suggested that the development of interpersonal dependency resulted from a person's representations of him/herself as weak and ineffectual. These representations came about through interactions between family members.

Changes were made to the DPD symptom criteria in later editions of the DSM. For example, it was noted that some dysfunctional personality characteristics continue into older age. In addition "passive - dependent personality disorder" was labelled "dependent personality disorder" in DSM-IV-TR (American Psychiatric Association, 2000). Nonetheless, the description of DPD in DSM-IV-TR (2000) still implied that the person with DPD is pathologically passive.

According to the DSM-IV-TR (American Psychiatric Association, 2000), "A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has its onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 685). The person with DPD is characterised as demonstrating five of the following:

- difficulty making decisions without advice

- inability in assuming responsibility
- difficulty expressing disagreement
- difficulty initiating a project
- going to excessive lengths to seek help
- feeling helpless when alone
- replacing a close relationship as soon as it ends
- fearing of abandonment and disapproval

Bornstein (1993b) agrees that overprotective parenting and sex-role socialisation interact to create the levels of interpersonal dependency in people but he suggests that interpersonal dependency is not always pathological or a source of distress to the person labelled as dependent. Recent reviews of the results of years of interpersonal dependency studies indicate that the dependent personality is characterised by positive social adaptations as well as negative attributes (Bornstein, 1994a, 1998a, 1998b). For example, dependent people have been found to display higher levels of interpersonal sensitivity (Masling, O'Neill & Katkin, 1982; Whiffen, Aube, Thompson, & Campbell, 2000) and to have a greater desire to perform well academically than those who are not dependent (Bornstein, 1998b). Furthermore, passivity is no longer thought to be a trait belonging solely to the dependent personality profile (Bornstein, 1995a,

2000; Bornstein, Riggs, Hill, & Calabrese, 1996).

Passivity appears to be induced by the situation in which the passive behaviour occurs and by the dependent person's cognitions and motivation. This point is illustrated in the following discussion about Bornstein's (1993b) proposed interactive model of dependency.

The interactive model of dependency

Using Blatt and Shichman's (1983) integrated framework mentioned above, Bornstein (1993b, 1998a, 1998b, 1999a, 1999b, 2000) developed the interactive model of dependency that is summarised in Figure 1. Bornstein's model postulates that the aetiology of dependency lies in overprotective, authoritative parenting and sex role socialisation. According to the model an overprotective authoritarian parenting style deprives a child from the kind of learning experiences necessary for the development of a sense of mastery and autonomy. In addition, sex role socialisation often encourages the characteristics of dependency in girls more strongly than in boys.

The interactive model of dependency (Bornstein, 1993b, 1998a, 1998b, 1999a, 1999b, 2000) suggests that the dependent person's beliefs about him/herself are formed

in early childhood as a result of interactions with family members. If the person perceives him/herself to be powerless and ineffectual then the person will be motivated to seek guidance, help and support. The model suggests further that people who are motivated to seek guidance, help and support behave in ways that are likely to maximise their chances of obtaining the help that they believe they need. The interactive theory of dependency, therefore, can explain why passivity is not characteristic of only dependent people. For example, if passive behaviour increases a dependent person's likelihood of getting the help he/she desires, then he/she will behave passively. But if the situation calls for active assertive or aggressive behaviour, then the dependent person will behave accordingly. In addition:

... dependency-related affective responses (e.g., performance anxiety) strengthen and reinforce dependency-related motivations (e.g., need for support). Similarly, when a dependency-related affective response is stimulated, the person is more likely to exhibit dependent behaviour.

Most important, dependency-related affective responses strengthen the dependent person's belief in his or her own ineffectiveness.

Consequently, a feedback loop is formed, wherein affective responses that initially

resulted from particular beliefs about the self and other people ultimately come to reinforce those same beliefs. Similar feedback loops characterise the affect-motivation and affect-behaviour relationship (Bornstein, 2000, p.14).

Bornstein's interactive model of dependency (1993b) goes further to suggest that whether or not the dependent person is able to get his/her dependency needs met depends upon the quality of his/her social skills. The dependent person with good social skills is more likely to get the guidance, help and support that he/she desires than the dependent person with poor social skills. But success in doing so serves to reinforce the socially competent dependent person's perceptions of him/herself as being powerless and ineffectual. For the person with poor social skills, an inability to get dependency needs met might lead to anxiety and/or to depression and possibly to physical illness. This, in turn, reinforces the socially incompetent dependent person's beliefs about him/herself as being powerless and ineffectual. Thus, further feedback loops are formed.

Bornstein's (1993b) dependency model was developed following his review of dependency studies undertaken over the past 50 years. The findings of these studies

were considered and, as mentioned above, ideas from each of the psychoanalytic, social learning and cognitive models were incorporated. Bornstein's model appears to be the only existing model of dependent personality that deals with dependency across the life-span. Although no literature was uncovered that has found an association between parenting practices in early childhood and interpersonal dependency in older age, the components of dependency as defined by Bornstein appear to be unchallenged by other authors on the topic of interpersonal dependency.

Following the development of the interactive model of dependency Bornstein (1993b) proposed this working definition of dependency:

Dependency is a personality style (or "type") that is characterised by four primary components: (1) *motivational* (i.e., a marked need for guidance, approval, and support from others); (2) *cognitive* (i.e., a perception of self as relatively powerless and ineffectual, along with the belief that others are powerful and can control the outcome of situations); (3) *affective* (i.e., a tendency to become anxious and fearful when required to function independently, especially when the products of one's efforts are to be evaluated by others); and (4)

behavioral (i.e., a tendency to seek help, support, approval, guidance, and reassurance from others and to yield to others in interpersonal transactions) (p.19).

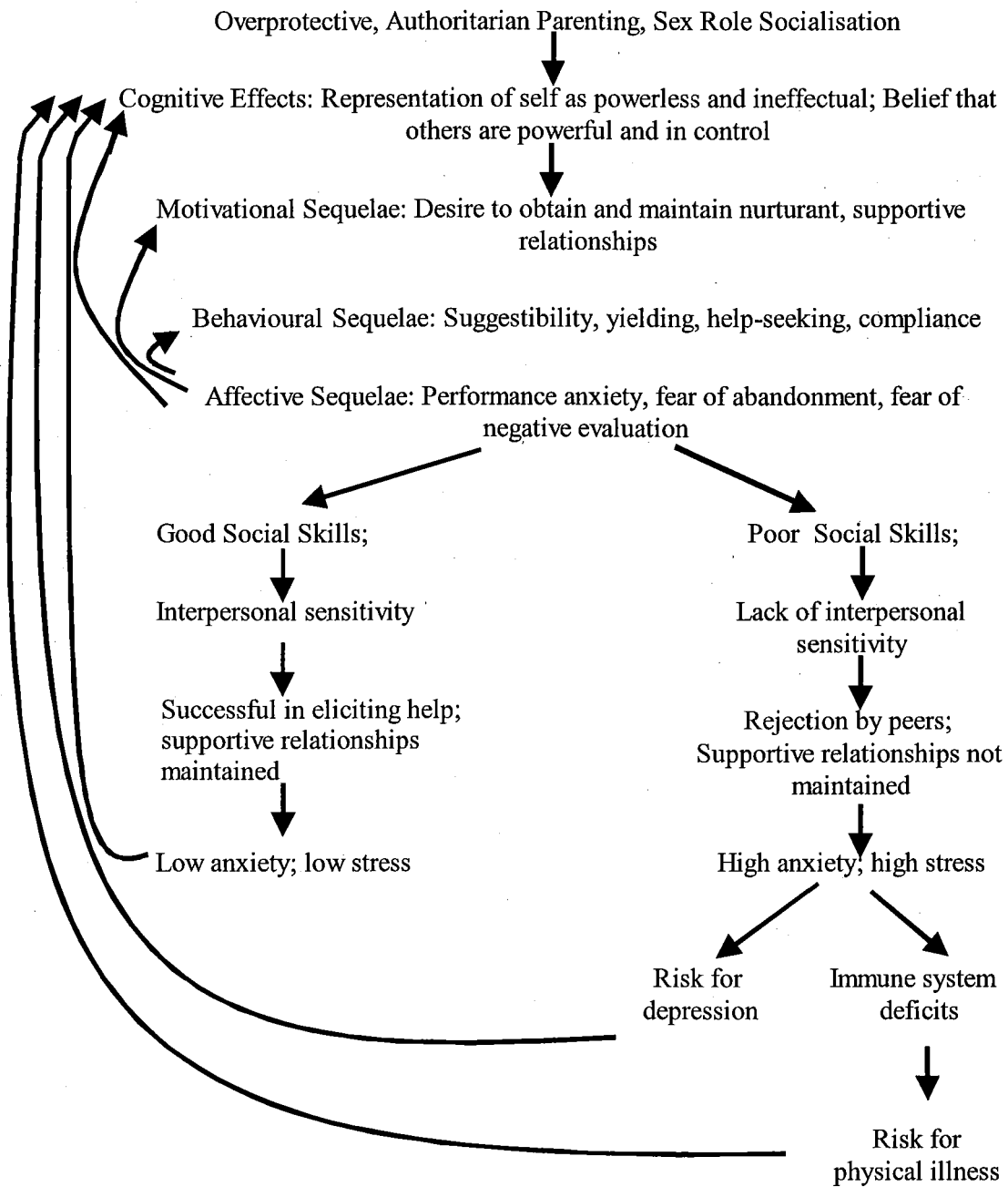


Figure 1. An integrated model of dependency. Redrawn from *The Dependent Personality* (p. 162), by R. F. Bornstein, 1993, New York: Guilford Press.

Interpersonal dependency and older adults.

While it is generally recognised that personality, by definition, endures across the life span, studies of interpersonal dependency have focused largely on young and middle-aged adults. This is possibly due to the stereotypical beliefs that dependency of any kind is normal in old age (Segal, Hersen, Van Hasselt, Silberman, & Roth, 1996) but pathological in young and middle-aged adults. It might also be due to the widely held belief that characteristics of personality disorders and styles do not present serious difficulty in older people. Such beliefs are challenged in recent work that suggests that the commonly used criteria for the diagnosis of personality disorders and styles have limited applicability to older adults (Rosowsky, & Dougherty, 1998; Rosowsky, Dougherty, Johnson, & Gurian, 1997; Segal et al., 1996). According to Rosowsky et al., personality disorders and styles do persist into older age and affect the way that older people engage help and receive health services. Rosowsky (2000) says that in the case of older people with a dependent personality style or disorder, it has been found that they fit very well into the routines of residential institutions but they also decline

functionally at a faster rate than people without a dependent personality. This is not surprising given Baltes' research discussed above that found dependent behaviours in health care settings are rewarded by the care-giving staff. Her model of learned dependency suggests that older people learn to be dependent on care if it is continued when the need no longer exists, or if more care is given than is required. Eventually, through lack of use of skills and possibly reduced self-efficacy, functional ability may decline. Given Rosowsky's suggestion, if dependency is already the personality style of the person receiving care, then it is likely that their dependent behaviours would be constantly reinforced and their functional decline exacerbated with no resistance.

Although the research of Bornstein and his colleagues was on dependency as a personality characteristic in younger adults, it supports Rosowsky's (2000) suggestion that a dependent personality style can affect the way that people engage and receive services. Bornstein (1993a) found dependent personality characteristics to be associated with inability or unwillingness to relinquish the patient role following treatment. Interpersonal dependency was also found to be associated with over-utilisation of health services (Bornstein, Krukonis,

Manning, Mastrosimone, & Rossner, 1993). If these findings could generalise to include older adults then dependent personality might explain, as suggested by the Silver Chain direct care staff (Gardner, 1999), the over-reliance on home-care services by some Silver Chain clients.

Life-span developmental models do play a key role in depathologising dependency and in using dependency on the caregiver in late adult life to foster healthy development. It is important to recognise that functional dependency is not the norm for the majority of older adults (Avlund, Davidsen, & Schultz-Larsen, 1995; Bruce, 2000; Stone, 2003) and that much of the dependency in older people is adaptive (Baltes, 1995) when physical disability does occur. But it is just as important to be able to recognise dependency in older adults that is pathological. As Baltes' (1996) research suggests, an expectation by health care staff of dependency in older age may reinforce the dependency of older people who are seeking health care services and possibly lead to functional decline. As discussed above, this appears to be especially likely for older people with dependent personality characteristics (Rosowsky, 2000).

Dependent personality in older adults, however, is a largely neglected area of research. This is surprising for four important reasons. First, a broad general interest in dependency as an individual difference variable is demonstrated by the proliferation of literature on the topic. Second, a broad interest in other types of dependency as they relate to older people (such as the previously discussed structured dependency, learned dependency, dependency due to disability and interdependency) is also demonstrated. Third, older people are heavy consumers of health services. Finally and most importantly, the possession of excessive dependent personality characteristics appears to predispose younger adults to the development of other mental health conditions such as depression and anxiety (Bornstein, 1995b, 1995c; Greenberg, & Bornstein, 1988b) and physical illness (Bornstein, 1998c; Greenberg, & Bornstein, 1988a). These conditions are all concerns for older adults as well.

Interpersonal dependency and depression.

According to a number of researchers, a link between depression and dependency is well established (Birtchnell, 1988; Bornstein, 1992; Emery & Leshner, 1982; Hirschfeld, Klerman, Chodoff, Korchin, & Barret, 1976;

Overholser, 1996). However, the data on both depression and interpersonal dependency in all studies reporting the link have been collected concurrently (Bornstein, 1992). Therefore, as pointed out by Bornstein, it remains unclear whether an interpersonally dependent disposition predisposes a person to depression or whether state dependency, which often coexists with depression (American Psychiatric Association, 2000) has influenced interpersonal dependency scores.

Nevertheless, recent research undertaken by Mazure, Bruce, Maciejewski and Jacobs (2000) does suggest that characteristics of interpersonal dependency appear to be risk factors for the onset of depression. They found that depression was three times more likely after a major adverse event if the person involved also reported personality characteristics that emphasised concern about disapproval. In addition, results of Overholser's (1996) research indicated that dependency and depression were linked via the maladaptive social functioning of people with high levels of interpersonal dependency and vulnerability for depression. According to Overholser, depression is likely if people high in dependency are unable to achieve their interpersonal goals. His findings support Bornstein's (1993b) theoretical interactive model of dependency suggesting that poor

social skills that result in an inability to elicit help can lead to the development of depression and/or anxiety. Other research suggests that social skills need not be particularly poor for dependent people to experience constant low mood. Zuroff, Stotland, Sweetman, Craig and Koestner (1995) found that dependency predicted high levels of dysphoria in college students even though it was also linked to more frequent and more intimate interactions than were experienced by a nondependent group. They suggested that highly interpersonally dependent people might have a need for intimacy that is so great that relatively intimate interactions are not sufficient to produce a sense of wellbeing.

Dependent personality in older adults has not been the focus in previous studies but depression has been associated with an increase in the utilisation of non-mental health services by older adults (Kempen & Stuurmeyer, 1991). For example, Banerjee and MacDonald (1998) found a high rate of depression among a British, elderly home-care population that could not be completely explained by functional disability. One possible explanation for this is that older people often present their psychiatric symptoms as somatic symptoms (Small, 1997). Nevertheless, given the findings on the links between interpersonal dependency and depression for

younger populations discussed here, some of this depression might have been explained by elevated interpersonal dependency.

Interpersonal dependency and anxiety.

Anxiety disorders have also been linked to interpersonal dependency in several studies. Davila and Beck (2002) found that young adults who reported high levels of social anxiety also reported high levels of interpersonal dependency. Agoraphobia has also been found to be associated with high levels of interpersonal dependency in young adults who attended a support group for people with agoraphobia (McCarthy & Shean, 1996). Furthermore studies that have examined the comorbidity of dependent personality disorder and anxiety disorders such as social phobia, panic disorder and generalised anxiety disorder, have consistently found links (Bornstein, 1992).

Overholser (1989) found that psychiatric inpatients with higher levels of dependency reported feeling more anxious than inpatients with lower levels of dependency. Like the studies of the relationship between depression and interpersonal dependency, however, it remains unclear whether interpersonal dependency scores are affected by dependent states that are the product of the anxiety.

Interpersonal dependency and physical illness.

Literature examining links between physical illness and dependent personality has found dependency to have both negative and positive health consequences (Bornstein, 1998c; Bornstein & Johnson, 1990). According to Bornstein, a dependent personality orientation increases a person's risk of developing a number of illnesses such as ulcers, heart disease, epilepsy and asthma.

Interpersonally dependent people who are experiencing stressful life events are at even greater risk (Bornstein, 1995b). But on the positive side, a dependent personality disposition is also associated with positive attitudes regarding physicians and hospitals (Parker & Lipscombe, 1980), seeking medical attention as soon as symptoms are noticed (Greenberg & Fisher, 1977) and with compliance with medical regimes (O'Neill & Bornstein, 2001; Overholser & Fine, 1994). However, once the dependent person has engaged a health service, he/she is reluctant to terminate it even when the service is no longer required (O'Neill & Bornstein, 2001).

Once again, if these findings can be generalised to the older population then there are important implications for providers of health care intervention services for older people. Important issues for consideration prior

to intervention would include assessment of interpersonal dependency, awareness of transference and counter-transference reactions that might impede therapeutic progress, awareness of various risk factors associated with dependency (such as those discussed above) as well as discharge planning and timely termination of services (Bornstein, 1994b; Bornstein & Bowan, 1995). This kind of informed planning and intervention would, in turn, have important personal implications for older people receiving the service (Dougherty, 2000; Rosowsky, 2000; Rosowsky, et al., 1997) as well as positive financial implications for the service provider.

Measurement of interpersonal dependency.

In order for research examining the correlates of interpersonal dependency in older adults to be undertaken, a measure that is reliable and valid for this population is necessary. Such a measure would also be useful in informing treatment intervention plans for older adults within both mental and physical health service settings and in evaluating the effectiveness of the interventions.

Due to the links between interpersonal dependency and a variety of health and mental health variables in young and middle-aged adults, many objective (self-report) and projective measures have been developed over the past 50 years for the measurement of interpersonal dependency (Bornstein, 1992, 1993b, Bornstein, Rossner, & Hill, 1994). The term "objective" has been used to describe pen and paper tests with standardised scoring procedures (Bornstein, 1999a). Projective tests, on the other hand, are those that require respondents to provide open-ended responses to stimuli that are ambiguous (such as inkblots).

Women have traditionally scored higher than men on objective measures of dependency (Birtchnell, 1988; Bornstein, 1992, 1993b) but there has been no significant difference found between the scores of women and men on projective measures (Bornstein, Bowers, & Bonner, 1996). Bornstein et al. (1996) suggest that this is possibly due to the face validity of most objective measures.

According to Bornstein et al., men are more likely than women to adopt a socially desirable response style when completing objective measures that are face valid because it is considered less socially acceptable for men to be dependent than it is for women.

Although reviews of the most commonly used measures of interpersonal dependency (Birtchnell, 1991; Pincus & Gurtman, 1995) have been critical (most are highly correlated with a social desirability response style), studies utilising a variety of objective and projective interpersonal dependency measures have produced consistent findings (Bornstein, 1992, 1993b, 1999a). However, neither projective nor objective dependency measures have been found to predict observable dependency-related behaviour (Bornstein, 1999a). This might be due to the failure of dispositional measures to consider situational factors that possibly affect behaviour in a variety of settings (Bornstein, 1999a; Mischel & Shoda, 1995). As pointed out by Bornstein, Riggs, Hill and Calabrese (1996), interpersonally dependent people do not behave passively in all situations. If items in dependency measures reflect the traditional view of passivity as being a characteristic of dependency, then the likelihood of the measure predicting true dependent behaviour is reduced.

The sequential process used in the development of the Attachment and Dependency scales (Livesley, Schroeder, & Jackson, 1990) of the Dimensional Assessment of Personality Pathology (DAPP, Livesley, Jang, & Vernon, 1998) ensured that the problems such as response style

were addressed. This approach was based on the four essential principles of personality test construction described by Jackson (1970). These are, "first the importance of psychological theory; second, the necessity for suppressing response style variance; third, the importance of scale homogeneity, as well as generalisability; and fourth, the importance of fostering convergent and discriminant validity..." (p. 63). In addition, items for the DAPP scales were "obtained from literature review, expert, and content analyses of interviews with patients with DPD [Dependent Personality Disorder] and/or attachment problems" (p.134). While the DAPP appears to offer a more comprehensive measure of dependency than previously developed measures, its applicability to older populations has not been demonstrated.

Some studies utilising global measures of personality have included older adults as participants, however measures specific to the assessment of personality styles and disorders in older adults are yet to be developed (Casey & Joyce, 1999). For example, the mean age of the sample used in the evaluation of the DAPP was 29.7 years. Therefore results might not generalise to samples of older adults. No studies were uncovered that have

utilised measures of interpersonal dependency with older adults.

Summary

As outlined above, four main kinds of dependency emerge in the literature: 1) structured dependency (an economic dependency of many people who are not in the workforce); 2) interpersonal dependency (a personality characteristic studied previously in young and middle-aged adults); 3) physical dependency (a disability that has resulted from physical and or cognitive limitations associated with ageing); and 4) learned dependency (a behavioural dependency learned through the reception of over-care).

None, one, or all of these types of dependency may affect older adults at any given time. Interventions designed to reduce the impact of dependencies on the lives of older adults will need to reflect the dependencies involved, and the interaction between the dependencies demonstrated or reported by individuals.

Much work continues to be conducted in the areas of supporting, reducing or maintaining the physical dependency levels of older adults in both residential and community settings and in the training of direct care

staff in behavioural principles. The possibility that older people who apply for community services might be fundamentally different, however, in terms of their levels of interpersonal dependency (as opposed to their physical dependencies) from people with similar disabilities who do not apply for the same services has been overlooked. This is surprising given the links between, interpersonal dependency and depression, anxiety, physical illness, compliance with medical regimes and attitudes to health professionals found for younger adults. An association between interpersonal dependency, psychopathology, physical illness and utilisation of health services for older adults would pose important implications for health service providers. As pointed out by Rosowsky et al. (1998), an older person's personality style does affect the way that he or she receives health care services. If an older person's perception of him/herself as being dependent is reinforced by the health care provider, then the likely product of this is reduced perceptions of autonomy and self-efficacy that become actualised over time (Rosowsky et al., 1998). This, in turn, could lead to additional psychopathology, physical ill health and increased service utilisation.

It is important therefore, to be able to measure interpersonal dependency in older people. Yet no measure of interpersonal dependency has been developed for use with older adults. Nor have any existing measures included samples of older adults in the validation process.

Research Purpose

The purpose of this research was to develop a reliable and valid objective measure of interpersonal dependency that reflects Bornstein's (1993b) interactive theory of the nature of interpersonal dependency in older adults.

Subsidiary questions.

In the process of evaluating the new measure, answers to the following subsidiary questions were sought:

- 1) Does an older home-care service population score higher on the measure of interpersonal dependency than other populations of older adults?
- 2) What is the relationship among interpersonal dependency, depression, anxiety and physical dependency in an older home-care population?

Hypotheses

Based on previous research that has found younger interpersonally dependent adults to utilise health services more frequently than younger non-interpersonally dependent adults, it was hypothesised that older people who access a home-care service would score significantly higher on the measure of interpersonal dependency than older people in non-health care populations. It was also hypothesised, based on the findings described by Baltes (1996), Bornstein (1993b) and Rosowsky et al. (1998) that interpersonal dependency, anxiety and depression would be significant predictors of a global measure of physical dependency in an older home-care population.

Interpersonal Dependency Scale Construction

The scale was developed using the systematic approach described by Jackson (1970). As mentioned above, Jackson proposed four essential elements of personality test construction. These included: 1) the importance of the test construction being grounded in psychological theory; 2) the need to suppress response style variance in the process of item selection; 3) the need to consider homogeneity and generalisability of the scale; and 4) the

need to consider the convergent and discriminant validity of the scale.

The study was divided into four stages. Stage 1 was further divided into two parts. In part 1 of Stage 1 (described in Chapter 3), the relevance of basing the development of items for an interpersonal dependency scale for older adults on Bornstein's (1993b) interactive theory of dependency was examined. Stage 1, part 2 (described in Chapter 3) involved the item development process which emphasised the selection of items that represent the components of dependency as defined by Bornstein and also the suppression of response style variation (such as a socially desirable responding style) (Jackson, 1970; Streiner & Norman, 1995). Chapter 4 focuses on the homogeneity and generalisability of the developed items by presenting the process used in Stage 2 of the study that reduced the number of items to those that appeared best to represent the construct for the study population. Chapter 5 describes Stage 3 of the study that re-examined the internal consistency reliability and construct validity of the final set of items selected in Stage 2 and also discovered and summarised the correlations of those variables by comparing the results of three different samples. Finally, Chapter 6 describes the testing of the

convergent and discriminant validity of the new interpersonal dependency scale for older adults that was undertaken in Stage 4 of the study. Interpretation and discussion of the results of each Stage of the study occur at each Stage.

Ethical approval to conduct the research was obtained from the Edith Cowan University Ethics Committee and from the organisations (Silver Chain Nursing Association, Positive Ageing Foundation and Council on the Ageing) involved in the research.

CHAPTER 3

Stage 1 - INTERPERSONAL DEPENDENCY SCALE ITEM

DEVELOPMENT

Part 1: Focus Groups

Aim

Prior to developing items for the interpersonal dependency measure for older people based on the integrated theory of dependency proposed by Bornstein (1993b), it was considered important to elicit the opinions and experiences in relation to interpersonal dependency of some people in the age group for whom the measure was intended. Analysis of the data collected during the focus group discussions was intended to assist in observations of Bornstein's theory of dependency in terms of its applicability to older people but was not intended to validate Bornstein's theory of interpersonal dependency empirically. In addition, results of the analysis were not intended to represent all older people's opinions about interpersonal dependency or their own experiences with dependency, nor were they intended to form the basis of the scale item development. Rather,

the integrative theory of dependency as proposed by Bornstein was to provide the framework for the analysis of the participants' responses. This, in turn, would inform decisions about the use of the theory in the selection of items for the interpersonal dependency scale. It was expected that the participants' responses would fit within the framework proposed by Bornstein, but because the theory was based largely on the results of interpersonal dependency research with younger populations, it was considered important to examine input from some older people and some allied health professionals who work with older people before using the framework.

Method

Participants

The participants included a sample of 15 volunteers (14 females and one male) aged between 73 and 91 years ($M = 83.0$). In addition, three female allied health professionals (a registered nurse, a physiotherapist and an occupational therapist aged 41 years, 28 years and 37 years respectively) took part in the focus group study.

Written informed consent was obtained from all participants.

Instruments

Focus questions (see below) were used to facilitate group discussions. These were based on the components of interpersonal dependency identified in the interactive theory of interpersonal dependency proposed by Bornstein (1993b).

Procedure

The item development process began with a review of the interpersonal dependency theory literature described in Chapter 2 (Bornstein, 1993b). In order to determine whether that theory matched interpersonal dependency as older people understand and experience it and to assist in the translation of the theory into scale items reflecting the interpersonal dependency needs of older people, focus group discussions regarding the components of interpersonal dependency were conducted with older adults and with a group of allied health workers.

Three separate focus group discussions were conducted with cognitively intact people aged over 70 years who attended day-centre facilities provided by a shire

council in a Perth metropolitan area. This convenience sample was selected because past research experience of Silver Chain (the project partner in the aged-care industry) had shown that few older clients attend group discussion sessions (due to physical limitations or transport difficulties). It was recognised that people attending the day-centres have similar physical dependency needs insofar as many experience one or more chronic illnesses (such as arthritis, minor to moderate respiratory or heart condition, sight impairment etc.) that are likely to interact with their interpersonal dependency needs. Nevertheless, there was no reason to believe that their individual interpersonal dependency needs would be the same. Despite physical dependency, some people are likely to retain a nondependent personality. Thus, input from people with varying interpersonal dependency needs was probable even though the sample was selected from one source (Morgan, 1988; Stewart & Shamdasani, 1990).

In the general population in Western Australia women in the age group of the older focus group participants outnumber men. According to Western Australian Census figures (Australian Bureau of Statistics, 2001) 35% of people in Western Australia aged 83 years are male. Therefore, the opinions and experiences of males in the

age group were under-represented in the focus group discussions. The one male in the group of 15 older people represented only 7% of the sample. Nonetheless, it was considered that this lack of male representation was unlikely to affect the outcome of the focus group discussions in terms of the aim of the discussions.

Permission from the council's day-centre facility co-ordinator was given to the researcher to approach two centres in the shire. The centre co-ordinators were telephoned and dates and times were set for the researcher to attend the centres. Day-centre members were informed face-to-face by the researcher of the aims of the focus group discussions and volunteers were sought for participation in the group discussions. Ten people from one centre and five from the other volunteered. Three groups of five were formed with the 15 volunteers. In order to reduce possible group dynamics effects (Morgan, 1988; Stewart & Shamdasani, 1990), focus group members were teamed with people who were not members of their usual social circle even though they attended the same day-centre. A focus group discussion took place with each group on different days in the same week.

Each focus group discussion began with group members being given a sheet containing information about the

focus groups as well as a follow-up pilot study (see Appendix A). Participants were informed that their responses to focus questions during the focus group session would be used to assist in the development of the interpersonal dependency scale items. The follow-up pilot study session would involve participants in completing and appraising the developed scale. Consent and commitment to participate in the two sessions was obtained (see Appendix A). The researcher then facilitated the 45-minute discussion using the following set of eight focus questions:

1. What characteristics would a person with a dependent personality have? (As opposed to dependent behaviour due to physical or mental ill-health.)
2. Are these characteristics the same for both dependent older adults and dependent younger adults? How are they different?
3. Why do you think some older people are dependent upon others even though they are not lonely and both their physical and mental health is good?
4. What do you think dependent older adults believe they need?
5. How do they go about getting those needs met?
6. What do you think a dependent older adult would worry about most?

7. What are the good things about being a dependent older adult?

8. What are the bad things about being a dependent older adult?

Another discussion was conducted with a small group of allied health professionals. This group consisted of a registered nurse, a physiotherapist and an occupational therapist. These professionals, who are employed by a home-care agency in Perth, Western Australia, are currently involved in designing and implementing a program to improve, or to maintain, the physical independence of older adults in the community. The discussion with this group followed the same procedure as the previous discussions; however, the group members were from an already formed group. Nevertheless, no group dynamic appeared to emerge that might have influenced anyone's responses or responding.

Each focus group discussion was tape-recorded. Taped recordings were later transcribed to assist analysis. Responses were categorised according to the components of Bornstein's (1993b) interactive theory of interpersonal dependency and other themes that emerged in the analysis.

Results

Salient Themes

The aetiology of interpersonal dependency in older people and the four components (i.e., the cognitive, motivational, affective and behavioural components) of interpersonal dependency as described by Bornstein (1993b) clearly emerged from the analyses of each of the focus group transcripts and notes. A brief discussion of each of the major themes follows. Other dependency related themes such as the social skills of interpersonally dependent people and adaptive versus maladaptive dependency also emerged. These will be discussed under the heading Social Skills. In addition, some focus group members raised perceived links between dependency and depression, between dependency and physical decline and between dependency and financial status. These links will be discussed in relation to the major dependency themes under the major theme headings.

The aetiology of interpersonal dependency. In support of Bornstein's proposed interactive theory of interpersonal dependency (1993b), all of the focus groups agreed that the aetiology of dependency could sometimes

be found in the parenting style experienced by the interpersonally dependent person. This was evidenced by a number of comments made by focus group members. For example, an older participant explained that the performance anxiety or "fear of failure" believed to be associated with the dependent personality comes from childhood. She said, "You can have a parent who says, 'You can't do this', or 'You're an idiot,' or 'You're ugly,' or 'You're too tall'. ... all that adds to the flatness of a child and the child can grow up with that on its back and carries it for the rest of its life" (focus group 2, Appendix A). When describing the character of an interpersonally dependent friend, another participant remarked, "Her family's done everything for her when she was a child, now she's just so selfish" (focus group 1, Appendix A). An allied health professional agreed that interpersonal dependency develops in childhood. She said, "You develop the pattern from a very early age". Another continued, "It could be they've had a parent who was very protective or um, made the child feel they were dependent when they were young so it's always carried on".

No-one suggested that sex-role socialisation played a part in shaping the dependent personality but comments did imply that the socialisation process in general might

have something to do with the development of dependency at later stages of life. For example many participants expressed an expectation of becoming increasingly dependent with age. They seemed to associate loss of physical strength (not just physical disability) with needing assistance with a variety of tasks that do not require physical strength such as most gardening tasks. A number of life experiences were also thought by older participants to be associated with the development of dependent personality traits throughout life. For example, it was suggested that socio-economic status might contribute to the development of dependent personality traits. It was suggested that a lack of money might lead to a loss of confidence, which, in turn, might lead to interpersonal (not just financial) dependency (focus group 2, Appendix A). Although another pointed out that the causal relationship might go in the other direction, people with dependent personality traits who are lacking in confidence might have difficulty securing employment, which, in turn, might lead to financial difficulties and perhaps financial dependency (focus group 2, Appendix A).

Life experience was also thought to suppress some dependent personality traits. Some older participants believed that previously dependent people could be

forced, by hardship, into situations that required them to learn to do things for themselves and thus they could develop some nondependent behaviours. For example, parents returning to the workforce and leaving older children who had been dependent previously to look after the house and younger children was an example given (focus group 3, Appendix A). The death of a spouse was another example of a situation that a participant thought might force a previously dependent person into developing some nondependent behaviours (focus group 3, Appendix A).

The cognitive component of dependency. Each group identified a cognitive component of interpersonal dependency that was in agreement with Bornstein's (1993b) description. When asked about dependent people's thoughts, responses from the three focus groups consisting of older people indicated that dependent people believe others are more powerful and in control of outcomes than they are. For example, responses included;

"They haven't got confidence in doing things for themselves and so they feel, you know, that they have to rely on someone else"(focus group 2, Appendix A).

"They don't seem to learn. They just think they can't"(focus group 2, Appendix A).

"[They believe they are] just not capable" (focus group 3, Appendix A).

"or, 'You can do it but I can't"(focus group 1, Appendix A).

Interestingly, responses from focus group participants suggested the belief that greater physical strength is associated with being more in control of outcomes. An older participant described a dependent person's cognitions by remarking, "They just think, 'Oh, I can't do it.' They think, 'You're stronger than me'" (focus group 1, Appendix A), even if the tasks being referred to did not necessarily require physical strength. Focus group participants could not identify specific tasks dependent people believe they require assistance with. They were thought to be, "just anything..." (focus group 1, Appendix A), but could include choosing clothes to wear or completing a form (focus group 2, Appendix A) both of which require minimal physical strength. In addition, an allied health professional (focus group 4, Appendix A) stated that, "...your natural response is to try and assist somebody who appears [because he/she is older] to have more need than you do.... The person may be strong, healthy and have what appears to be a very good social system behind them but they still have more need than you do". It appeared that having more "need" than the younger person meant that the older person was not seen to be as strong or as healthy as the younger person and

therefore was in more need of help and support than the younger person. It appeared also from the allied health professional's comment that she believed people generalise their belief that the older person is in need of help and support to include all of the activities that the older person needs or wants to perform, even if the activity does not require much physical strength. An older participant (focus group 2, Appendix A) who described herself as dependent supported this. When she was asked if she felt that she could not (due to physical strength) do the things that she sought help for, she replied, "I can, but not as well as they do".

The dependency of some older people appeared to be cases of interdependence rather than interpersonal dependency. Their dependency was associated with a moderate fear of physical injury due to falling and with sensible caution rather than with a dependent personality style. Several of the tasks that the older focus group members reported that they have sought help with required climbing or reaching, such as changing light bulbs, pruning trees and taking curtains down. In the case of one 80-year-old woman, however, the development of a dependent personality style did seem to develop as a result of iatrogenic dependency that occurred after a fall. This woman, who had previously described herself as

nondependent since the death of her spouse when she was 50 years old, explained that since falling she would not leave her house unless she was with another person (focus group 3, Appendix A). By the time she had recovered from the broken hip she received in the fall she had lost confidence, not only in doing tasks requiring physical dexterity, but also in tasks requiring cognitive ability such as handling finances. She believed her younger family members were better able, "to cope with life these days" than she was.

Motivational component of dependency. A motivational component of interpersonal dependency was also identified in the responses from members of each focus group. These responses match the view proposed by Bornstein (1993b), that dependent people do desire to obtain and maintain nurturant supportive relationships. Older focus group participants suggested:

"They need to have somebody to speak for them, you know." (focus group 2, Appendix A).

"And act for them too" (focus group 2, Appendix A).

Another stated that dependent people are;

"...always wanting to know what other people are doing so that they know who they can use..." (focus group 1, Appendix A). The latter comment implied, as Bornstein's integrative theory of interpersonal dependency proposes,

that a certain level of social skills development is required in order for dependent people to be able to get their dependency needs met. The person with a reasonable level of social skill development, in this case, will be able to take note of, and remember who can provide them with what. The person with poorer social skills might not notice and therefore miss an opportunity to get particular dependency needs met.

The idea that a dependent person's level of social skills development would assist in determining whether or not he/she gets his/her dependency needs met was raised by another older participant who suggested that, "...[Dependent people] have more experience in getting [others to do things for them] when they're older" (focus group 2, Appendix A). This implied the view that older people, due to their life-long experience, were better at getting their dependency needs met than were younger people.

Behavioural component of dependency. Older focus group participants described the behaviour of interpersonally dependent people as help seeking. When faced with some difficulty, according to a member of focus group one, dependent people "... get someone else to do it". Furthermore, interpersonally dependent people were

thought by another older group member to sometimes display manipulative behaviours (Appendix A). He said that dependent people are always asking someone to do things for them because, "... they're dominant. Very dominant". He further suggested that dependent people might use, "... any trick in the book ... to encourage other people to do things". These comments support the results of Bornstein's (1995a) research mentioned in Chapter 2, which found that dependent people do not always behave passively. But a member of the group of allied health professionals clearly reiterated Bornstein's argument:

[Dependent people are] people who aren't shy at coming forward ... [they] have confidence in lots of ways but are lacking in confidence in other ways. So they sort of push themselves forward, but at the same time if they're ... knocked back they are immediately very upset about it. [They] have difficulty ... dealing with emotions, dealing with any criticism. ... [They] can be quite aggressive at times to actually gain, to get what it is they actually require. But [the]... aggressiveness passes quite quickly if ... someone challenges that behaviour (focus group 4, Appendix A).

In further support of Bornstein's (1993b) integrated theory of dependency, the group of allied health

professionals also identified compliance as a characteristic of dependent behaviour. A member suggested that once dependent older people obtain the supportive relationships that they believe they need, they become compliant in order to maintain those relationships. In response to a question about the positive aspects of an older person having a dependent personality, an allied health professional replied, "They fit in well to all services really because their [dependency] needs are met. ... they fit in because they are exactly what people want them to be. Once they've got the service they are quite compliant. They're acting the type of personality behaviour that people [the helpers or supporters] anticipate. ... they're in need, they're dependent and that's what, well certainly support services and nursing homes are set up to encourage to a certain extent" (focus group 4, Appendix A). This comment supports Rosowsky's et al. (1997) research, which found that dependent people fit into nursing homes systems very well. It also highlights the risks suggested by both Baltes (1996) and Rosowsky (2000) that learned dependency might be the result of this compliant behaviour, which for older people can hasten functional decline.

Affective component of dependency. Several fears were thought by focus group participants to be associated with the dependent personality. A "fear of failure" was considered by older participants to be a major concern for dependent people. One suggested that, "They don't want to try something in case they make a mess of it." (focus group 2, Appendix A). This fear of failure, which could cause a person to become anxious about his or her performance as suggested by Bornstein's (1993b) description of the affective component of interpersonal dependency, might stem from the dependent person's cognitions of him/herself as being less able than others to complete a task well. Alternatively, it might stem from a fear of the negative evaluation of others, which is linked to a fear of abandonment or rejection.

A fear of abandonment was also identified more directly as a fear belonging to interpersonally dependent people. According to an older participant, dependent people fear, "Not having someone to do things for them when they need something done" (focus group 4, Appendix A). An allied health professional thought that a dependent older person would worry most about, "Having their services taken away from them [or] things that they rely on taken away". Another added, "[Being] left to be on their own.

Isolated. People not responding. Lack of response from other people" (focus group 4, Appendix A).

As mentioned previously, some older people avoid tasks because they fear that they will fall and injure themselves or they avoid leaving their homes alone because, "It's not safe" (focus group 3, Appendix A).

Social skills. Focus group participants suggested that depression could result if the dependency needs of dependent people are not met due to poor social skills or formal health services not being available. According to an allied health professional, dependent people use a set of learned social strategies to get their dependency needs met. They do this by, "Making you feel sorry for them. Making you feel that they are in need. Or in more need than you are. ... your natural response is to try to assist somebody who ... appears to have more ... need than you do"(focus group 4, Appendix A). She continued, "... if no [health services were] available anywhere or ... just ... limited priority, I would still imagine they would be getting the service before anybody else because of their ability to be able to ... use a system ... to get what they require. ... they've always been able to have all the strategies there to be able to deal with it and to get what they require". If unable to get their service needs

met, the allied health professional said, "They've no strategies to be able to deal with knock-backs so they would be more likely to plummet into ... depression and all those sorts of things because there's no coping strategies there".

On the other hand however, support was found from older participants for both Baltes' (1996) and Rosowsky's (2000) suggestion that the provision of too much service or help could have adverse effects on the functional abilities of older people. An older participant said it was her observation that when older people stop doing things they, "go down" implying that they decline physically.

Discussion

The major themes that emerged from the focus group transcripts, the details within those themes and the links between them matched Bornstein's (1993b) integrated theory of dependency. The cognitive, motivational, behavioural and affective components of dependency as described by Bornstein were all identified in the focus groups' transcripts. A belief in the importance of having the necessary social skills to get dependency needs met in order to avoid depressive illness was also identified. In addition, participants agreed largely with

Bornstein's view of the aetiology of dependency but with one major difference.

According to Bornstein, over-protective parenting and sex-role socialisation lead a person to believe that he/she is incapable and ineffective in terms of altering outcomes. He/she also believes that others are more powerful than he/she is. The focus group participants agreed with both of these assertions but thought that for older interpersonally dependent people, a fear of physical injury due to cognitions of themselves as physically vulnerable could also be a factor and might result in avoidant behaviour such as not leaving home alone. It appeared as though some older people generalise their beliefs about being physically vulnerable (and therefore dependent) to include cognitive aspects of their functioning as well. This suggests that an older dependent person's cognitions are not only the result of overprotective parenting and sex role socialisation but of the socialisation process in general and of the person's life experiences.

Participants believed that a person's beliefs about his/her ability might change over time as a result of his/her experiences and expectations associated with ageing. For example, he/she might learn through

experience and the reinforcement of others that he/she is capable and therefore his/her dependency is reduced. Or he/she might accept society's over-generalisation that older people become increasingly dependent with time and his/her dependency increases. Although participants' ideas about the aetiology of dependency differed somewhat, they agreed with the components and characteristics of dependency as defined by Bornstein (1993b). Therefore, Bornstein's theory appears to be a valid description of dependency in older people. In view of this observation, interpersonal dependency items selected for the initial pool were based on Bornstein's interactive theory and working definition of dependency.

Stage 1 - INTERPERSONAL DEPENDENCY SCALE ITEM

DEVELOPMENT

Part-2: Initial Item Pool Selection Process

Method

Procedure

Most of the 108 items that formed the initial pool of items to be used in the item selection process (see Appendix B) were from commonly used interpersonal dependency scales (Blatt, Quinlin, Zuroff, & Mongrain, 1995; Hirschfeld, Klerman, Gough, Barrett, Korchin, & Chodoff, 1977; Livesley, Schroeder, & Jackson, 1990; Sinha, 1968;). Those selected for the initial pool matched the four components of dependency, as defined by Bornstein (1993b) and supported by the participants of the focus groups.

A group of three Doctor of Philosophy (Clinical Psychology) students were given a copy of Bornstein's (1993b) description of his proposed interactive theory of dependency along with copies of the commonly used dependency scales and a summary of the focus group discussions (described in Stage 1, part 1). They were asked to select and categorise items from the scales

according to both Bornstein's (1993b) defined components of interpersonal dependency and the items perceived to be relevant to an older (over 65 years) population. The group members reached consensus about the items that represented one or more of the components of dependency defined by Bornstein. They also reached consensus about the component(s) that the items appeared to be tapping. They developed some additional items to ensure that important aspects of the definition were represented and were relevant to older people (aged over 65 years). The items and categories are shown in the table of initial items in Appendix B.

Because of the dimensional nature of interpersonal dependency (it exists in varying degrees in different people) and to ensure ease of responding, the response scale selected was a continuous seven-point rating scale. Furthermore, the scale was being developed to measure older people's degree of interpersonal dependency and not their levels of independence so a bipolar rating scale was selected. The number "one" on the scale (which was labelled "not at all like me") corresponded to a score of non-dependency for that item and number "seven" (labelled "just like me"), a score of very high dependency. It was expected that most people would score towards the "nondependent" end of the scale. Thus, to counteract a

possible ceiling effect due to the probability of strongly skewed responses (Streiner & Norman, 1995) number "one" was selected as the "average" response. Responses were expected to show a skew towards the favourable end because most people do not demonstrate the higher levels of interpersonal dependency (American Psychiatric Association, 2001). By placing the "average" response at the number "one" position of the 7-point scale instead of the usual mid-point position, the number of possible responses beyond "average" is increased and greater variability in scores is likely. Instructions for completing the scale were written and are shown in Appendix B.

To ensure that older people would understand and be able to respond to the scale completion directions and items, the focus group participants were asked by the researcher, at later separate meetings of each group, to complete the scale without assistance, and then to assist in the scale editing process. The group of allied health professionals was only asked to assist with the editing of the scale items. Of the older focus group participants, only one was not able to complete the scale without assistance. This person had not read the instruction page first so another direction was added to the top of the page requesting in large, bold type that

respondents read all of the directions before completing the items (see Appendix B). The order of the directions was also changed and some additional directions included improving comprehension.

Twenty-three items were deleted during the editing phase of the item development process with the assistance of the focus group participants. Most of the deleted items were thought to be redundant. One was deleted because it was thought not to be relevant to older populations and another because it was ambiguous. A few items were reworded due to their multiple meanings. The remaining 85 items are presented in Table 1.

Table 1

Interpersonal Dependency Scale Items (85 items)

Item Number	Item
1.	I think people should do a lot more for me at my stage of life.
2.	I try to have people around me as much as possible.
3.	I am willing to ignore other people's wants in order to accomplish something that's important to me.
4.	If my friends or family disapprove of my actions, I am likely to change what I'm doing.
5.	Worry tends to make me cling to those I am closest to.
6.	In social situations it is better to go along with the majority than to have my own way.
7.	I believe people could do a lot more for me if they wanted to.
8.	Even if the person closest to me were to leave I could still manage by myself.
9.	I am most likely to be able to help someone with a problem.
10.	I avoid doing many tasks that I could do myself.
11.	I find it difficult to be separated from people I love.
12.	I need people to reassure me that they think well of me.
13.	I tend to be influenced by people with strong opinions.
14.	Other people tend to come to me for help.
15.	Often I think I have disappointed others.
16.	I worry about being abandoned.
17.	I have a lot of trouble making decisions by myself.
18.	I am very sensitive to others for signs of rejection.
19.	I am afraid of hurting other people's feelings.

20. I am very sure about the kind of person I am.
21. I like to be fussed over when I am sick.
22. I try to make friends with people who can help me.
23. When someone close to me is away, I count the hours until his or her return.
24. I will do anything I can to ensure that I get help from others.
25. I need people to tell me what to do.
26. After a fight with a family member or friend I must make amends straightaway.
27. I am very sensitive to others for signs of their willingness to help people like me.
28. I hesitate to accept help from others.
29. To be left alone by others would be the worst part about growing old.
30. It is hard for me to make up my mind about a TV show or movie until I know what other people think.
31. I have always had a terrible fear that I will lose the love and support of people I need.
32. I am usually sure of myself when I have to face complicated situations alone.
33. As a child, my parents preferred to do most things for me rather than risk mishaps.
34. I am afraid of physically injuring myself whilst doing everyday tasks.
35. I really only feel safe when I am with the person I am especially close to.
36. When I go shopping I always take someone with me to help choose items.
37. Most people are more powerful than I am.
38. I would much rather be a follower than a leader.
39. I tend to be a loner.
40. I often change my mind about decisions if my friends or family disagree.
41. I feel panicky when I am separated from those I love.
42. I become extremely anxious if I think I have to do something new by myself.
43. I tend to go along with what other people want even when it is not what I want.

even when it is not what I want.

44. I am a leader.
45. Even if things are not in my best interest, it is usually best to do them anyway in order to please others.
46. I always consult another person before taking a decision.
47. I become anxious when I have to be alone for any length of time.
48. I generally follow other people's suggestions.
49. I tend to worry about what other people think of me.
50. If I think that somebody might be upset with me I want to apologise.
51. I am afraid to leave my home alone.
52. I am only really comfortable when I have someone to keep me company.
53. I only enjoy what I am doing when I think that someone really cares about me.
54. The thought of being alone doesn't bother me at all.
55. When things go wrong, I need to be with someone I am close to.
56. Other people are much better at doing things than I am.
57. I would be helpless without support from others who are close to me.
58. I often worry when people ask favours of me.
59. I hesitate to express opinions that I think others will disagree with.
60. I avoid getting attached to anyone.
61. Even when things go wrong I get along without asking for help from anyone.
62. I find it difficult to feel completely secure in a close relationship.
63. I often think about the danger of losing someone close to me.
64. It is very important to me to be approved of by others.
65. When I meet new people, I'm afraid that I will act the wrong way.

66. In my relationships with others I am interested in what they can do for me.
 67. I often change the way I think to be more like those around me.
 68. I easily get discouraged when I don't get what I need from others.
 69. I am very confident about my own judgement.
 70. I am more comfortable with taking decisions made by other people.
 71. I almost always avoid going out alone.
 72. I become attached to people who help me.
 73. If a friend has not called for a while I get worried that he/she has forgotten me.
 74. I need more help with things than other people seem to need.
 75. When I am with other people I look for signs of whether or not they like being with me.
 76. I usually make my own decisions.
 77. I worry about people not liking me.
 78. I cannot tell someone directly that I am angry with him or her.
 79. When I am sick, I prefer that my friends leave me alone.
 80. I feel helpless in many situations.
 81. I almost always behave according to the wishes of my family, friends or my doctor.
 82. I often feel threatened by change.
 83. My worst fear is being rejected by someone.
 84. I am confident of my ability to deal with most of the personal problems I am likely to meet in life.
 85. It is hard for me to ask a favour of someone.
-

The possible range of scores for the 85-item

interpersonal dependency scale was 85-595. A high score corresponded with high dependency. Scores for the 15 older focus group participants on the 85 retained items

ranged from 211 - 535 ($M = 335$). Although the psychometric properties of the scale had not been determined, the range in scores suggested that the focus group participants ranged from low to high in interpersonal dependency.

In the following stage (Stage 2, Chapter 4) the scale was tested for its internal consistency reliability and the number of items in the scale was reduced in the process.

CHAPTER 4

Stage 2 - Scale Reduction: Initial Internal Consistency Reliability Analyses and Principal Components Analyses

Aims

The aims of Stage 2 were to:

1. Test the internal consistency reliability of the 85 interpersonal dependency items selected in Stage 1.
2. Reduce the number of items in the scale to the 20-40 most reliable items in order to produce a short screening tool for use with older adults entering health services.
3. Summarise the correlations of the final set of scale items. It was expected that when analysed using principal components analyses the scale items would reduce to one component (in line with Bornstein's (1993b) unidimensional theory of dependency, or one major component and one minor component for each of the samples (Tabachnick & Fidell, 1996)).

Method

Participants

The dependency scale was distributed to 700 people aged 65-90 years from two Perth organisations. A computer-selected random sample of 350 new (3 months or less) recipients of Silver Chain (SC) home care services received the scale, as did a computer-selected random sample of 350 Positive Ageing Foundation (PAF) members aged 65-90 years. The SC sample was also stratified according to service needs. Only new clients assessed by SC as having low service needs were included in the SC sample because those clients were unlikely to have dependencies that had been affected by the use of the service. A total of 298 people responded. Two hundred and nineteen were PAF members (75 males, 142 females, 2 did not indicate their gender) and 79 SC clients (24 males, 55 females). The age range for the PAF and SC respondents was 65-85 years ($M=71.4$, $SD=5.0$), and 65-90 years ($M=79.1$, $SD=7.0$) respectively. The response rate of the PAF members and SC clients was 62.57% and 22.57% respectively.

Instrument

The interpersonal dependency scale items to be tested consisted of the 85 items representing the four components of dependency defined by Bornstein (1993b) that were selected in Stage 1 of this project (see Appendix C). The instructions preceding the scale items (see Appendix C) requested that respondents rate themselves on each of the items using a 7-point rating scale (1= not at all like me, 7= just like me). Low scores correspond with low levels of interpersonal dependency and high scores with high levels. Demographic information sought included gender and age.

Procedure

A package of materials was posted to each prospective respondent. This package consisted of an "Information and Disclosure Form" (see Appendix C), "Consent Form" (see Appendix C), a covering letter from the appropriate organisation (see Appendix C), the 85 interpersonal dependency items to be tested and a reply-paid envelope. The information and disclosure form described the nature and the purpose of the research, informed the prospective respondent that participation was voluntary and

information provided would be kept confidential, informed him/her of the possibility of the research results being published and provided him/her with contact numbers of the principal researchers should he/she have any questions pertaining to the research. The covering letters from the organisations included a return date for the completed scales. SC requested that the completed scales be returned within a two-week period and PAF requested response within four weeks. The different return periods were in keeping with the organisations' usual practices and were maintained to maximise the response rate from each organisation.

Scale reduction and reliability analyses

The dataset for analyses contained the responses of 298 participants to the 85 items that were intended to be measuring interpersonal dependency in older adults. These items constituted the initial item pool from which a final 20-40-item scale was to be developed.

The participants' responses to each item were entered into SPSS for Windows (version 10) and negatively scored items were reversed. Responses to items 30, 66 and 67 lacked enough variability to be useful in the interpersonal dependency measure. Ninety-five percent or

more respondents scored in the same direction on the 1-7 rating scale for these items (i.e., either higher or lower than a score of 4). Therefore they were deleted from further analyses. Separate estimates of the scale's internal consistency reliability were obtained using the SPSS for Windows (version 10) Scale Reliability Analysis for the 70 SC and 206 PAF respondents with no missing item data. Another estimate was obtained for the two samples combined. A coefficient alpha of .95 was obtained for each of the samples and for the samples combined. These high reliability figures were more likely due to the length of the scale than they were to item redundancy. Although there were still several items in the scale that appeared to be measuring semantically similar things, inter-item correlations were moderate, but not high.

Due to inadequate sample size, component analyses were not undertaken during the scale reduction stage of the project. The sample was drawn from two different sources so separate analyses would have been required for respondents from each source given that each might have produced different component groupings. There were fewer SC respondents than there were variables in the data set. Therefore, scale items were deleted from further analyses based on their low item-total correlations (Streiner &

Norman, 1995) (see Appendix D). As demonstrated by Helmstadler (1957) item-total correlations are a function of the first component of a component analysis.

Further estimates of internal consistency reliability were obtained from the 40 items with the highest item-total correlations when both samples' data were combined in the analysis. Again, a very high coefficient alpha was obtained when the data for both samples were combined in an analysis (.95). Separate analyses for the SC and PAF samples also resulted in high coefficients (.96 and .95 respectively). This indicated that internal consistency reliability was unlikely to be sacrificed with a further reduction in scale length. From these 40 items, the 20 with the highest item-total correlations (resulting again from analyses that combined both samples' data) were entered into another reliability analysis. These items are shown in Table 2. The coefficient alpha obtained for the SC sample was .94, for the PAF sample was .93 and for the two samples combined was .94. Twenty items was the ideal length for the final scale. The 20-item scale was short enough to provide a quick, simple and reliable means for screening older adults seeking home-care services, yet it was long enough to achieve a reasonable balance of items that sampled the

four components of interpersonal dependency described by Bornstein (1993b).

Table 2

20 Items with the Highest Item-total Correlations

Item Number	Item	Dependency Component
5.	Worry tends to make me cling to those I'm closest to.	M
17.	I have a lot of trouble making decisions by myself.	C
25.	I need people to tell me what to do.	M
35.	I really only feel safe when I am with the person I am especially close to.	C
41.	I feel panicky when I am separated from those I love.	A
42.	I become extremely anxious if I have to do something new by myself.	A
43.	I tend to go along with what other people want even if it is not what I want.	B
46.	I always consult another person before taking a decision.	B
47.	I become anxious when I have to be alone for any length of time.	A
48.	I generally follow other people's suggestions.	B
49.	I tend to worry about what other people think of me.	M/A
53.	I only enjoy what I am doing when I think that someone really cares about me.	M
55.	When things go wrong, I need to be with someone I am close to.	M/C
57.	Without support from others who are close to me, I would be helpless.	C

- | | | |
|-----|---|-----|
| 64. | It is very important to me to be approved of by others. | A |
| 70. | I am more comfortable with taking decisions made by other people. | B |
| 77. | I worry about people not liking me. | M/A |
| 80. | I feel helpless in many situations. | A |
| 82. | I often feel threatened by change. | A |
| 83. | My worst fear is being rejected by someone. | A |
-

C=Cognitive component of interpersonal dependency
M=Motivational component of interpersonal dependency
B=Behavioural component of interpersonal dependency
A=Affective component of interpersonal dependency
(Bornstein, 1993b)

Upon inspection of the 20 remaining items it was found, however, that four pairs of items (77/49, 41/47, 46/17, 70/48), although somewhat different in phrasing and with moderate inter-item correlations (.64, .57, .53 and .46 respectively), appeared to be too semantically similar to coexist in the short version of the scale. Therefore, the item of each pair with the lower item-total correlation (i.e., items 77, 41, 46, 70,) was replaced with the item from the analysis with the next highest item-total correlation (i.e., items 75, 74, 73, 71). Table 3 presents the final set of 20 items.

Table 3

Final 20-Item Interpersonal Dependency Scale

Item Number	Item	Dependency Component
5./1.	Worry tends to make me cling to those I'm closest to.	M
17./2.	I have a lot of trouble making decisions by myself.	C
74./3.	I need more help with things than other people seem to need.	C
35./4.	I really only feel safe when I am with the person I am especially close to	C
42./5.	I become extremely anxious if I have to do something new by myself.	A
73./6.	If a friend has not called in a while I get worried that he/she has forgotten me.	M
25./7.	I need people to tell me what to do.	M
49./8.	I tend to worry about what other people think of me.	M/A
47./9.	I become anxious when I have to be alone for any length of time.	A
82./10.	I often feel threatened by change.	A
64./11.	It is very important to me to be approved of by others.	A
57./12.	I would be helpless without support from others who are close to me.	C
55./13.	When things go wrong, I need to be with someone I am close to.	M/C
75/14.	When I am with other people I look for signs of whether or not they like being with me.	B
43./15.	I tend to go along with what other people want even if it is not what I want.	B
80./16.	I feel helpless in many situations.	A
71./17.	I almost always avoid going out alone.	B
83./18.	My worst fear is being rejected by someone	A

someone.

- 53./19. I only enjoy what I am doing when I think that someone really cares about me. M
- 48./20. I generally follow other people's suggestions. B
-

C=Cognitive component of interpersonal dependency
M=Motivational component of interpersonal dependency
B=Behavioural component of interpersonal dependency
A=Affective component of interpersonal dependency
(Bornstein, 1993b)

The final set of 20 items was entered into scale reliability analyses for the SC sample, the PAF sample and the two samples combined. The coefficient alphas obtained were .94, .92 and .93 respectively. The final 20-item version was considered to be a highly reliable, short screening scale that achieved a good balance of items that sampled all elements of interpersonal dependency (Bornstein, 1993b) as they relate to an older population. The minimum possible score on the 20-item scale was 20 and the maximum possible score was 140.

Principal components analyses

To further test the internal consistency of the 20 interpersonal dependency variables and to discover and summarise the correlations among the variables, principal components analyses with oblimin rotation were performed

for the SC sample and the PAF sample, using the factor analysis procedure in SPSS for Windows (version 10). The interactive dependency theory (Bornstein, 1993b) upon which the development of items for the interpersonal dependency scale was based is unidimensional. It was therefore expected that the items would reduce to one component, or one major component with one or two minor components for each of the samples. While it is recognised that a sophisticated procedure entitled DIMTEST (Stout, 2002; Stout, Froelich, & Gao, 2001) has been developed for determining the dimensionality of scales, the aim of this study was to examine how the variables group together rather than with underlying structures driving responses. Principal components analysis was selected for that purpose.

For the SC sample, an initial principal components analysis extracted four components with eigenvalues greater than one. These components accounted for 68.3% of the variance. The component loadings and communalities (h^2) after oblimin rotation are shown in Table 4. Component correlations are shown in Table 5.

Table 4

Oblimin Rotated Component Pattern Matrixes for
Interpersonal Dependency Variables (Initial and 2
Components Solutions)- SC Sample

Item	Components-Initial				h ²	2 component	
	1	2	3	4		1	2
43	.84	-.04	.16	-.08	.80	.88	-.04
80	.82	-.07	-.15	.15	.66	.77	-.09
25	.79	.03	.07	-.02	.69	.79	.02
35	.76	-.02	.08	.05	.66	.81	-.03
53	.75	.24	.05	-.08	.74	.70	.24
48	.72	-.02	-.04	.08	.55	.70	.02
47	.68	.13	-.12	.19	.59	.65	.12
57	.62	-.18	.40	-.01	.70	.87	-.19
71	.54	-.15	.39	.07	.58	.78	-.16
83	.54	.38	-.11	.26	.69	.55	.37
74	.45	.18	.37	-.14	.55	.59	.18
64	-.13	.88	.14	-.03	.76	-.08	.89
49	-.13	.87	.06	.17	.77	-.03	.88
75	.21	.77	-.18	.01	.69	.05	.78
73	.30	.64	.19	-.31	.73	.24	.66
55	.06	.01	.81	.16	.78	.67	.01
5	-.02	.20	.72	-.09	.69	.54	.20
82	.14	-.05	.11	.81	.79	.61	-.08
42	.11	.09	.44	.52	.69	.65	.07
17	.21	.29	.19	.43	.57	.53	.28

% of
variance* 46.1 11.0 6.0 5.3 68.3 46.1 11.0

Label Support Approval

* % of variance prior to rotation

Table 5

Component Correlation Matrix (Initial Solution)- SCSample

Component	1	2	3	4
1	1.00			
2	.34	1.00		
3	.46	.21	1.00	
4	.35	.15	.16	1.00

After examination of the scree plot eigenvalues (i.e., 9.22; 2.20; 1.19; 1.06; .94; .67; .60; .57; .54; .48; .43; .40; .37; .32; .27; .25; .17; .14; .13; .01), pattern matrix and component correlations, only two of the four components appeared to be stable. The scree plot indicated that three components might be stable, however, the pattern matrix showed that only two items loaded highly on the third component, which correlated moderately with the first. A Parallel Analysis Routine (PAR) (Holden, Longman, Cota, & Fekken, 1989; Longman, Cota, Holden, & Fekken, 1989) was performed which identified two stable components (see Appendix D). Following the PAR, a further principal components

analysis requesting the extraction of two components was performed. The two-component solution, which accounted for 57.1% of the variance, is shown in Table 4. Items that loaded highly on the first component, which accounted for 46.1% of the variance, included cognitive, motivational, behavioural and affective components of dependency and were concerned with needing the support of others. Items loading highly on component two, which accounted for 11.0% of the variance, were concerned with needing the approval of others. Thus, the two components were labelled as *Support* and *Approval* respectively.

The PAF sample's item responses also produced four components with eigenvalues greater than one, which accounted for 57.8% of the variance, in the initial principal components analysis. The component loadings and communalities (h^2) explained after oblimin rotation are shown in Table 6. Component correlations are shown in Table 7.

Table 6

Oblimin Rotated Component Pattern Matrix for
Interpersonal Dependency Variables (Initial Solution) and
Unrotated Structure Matrix 1 Component Solution - PAF
Sample

Item	Components					1 Component
	1	2	3	4	h^2	1
5	.73	-.27	-.06	.24	.61	.58
17	.71	.23	.11	-.17	.67	.72
25	.62	.03	.11	-.10	.43	.57
55	.61	.06	.21	-.03	.55	.69
57	.60	.18	-.14	.27	.58	.68
42	.57	.34	-.11	.22	.65	.73
80	.51	-.00	.13	.18	.45	.64
49	.48	.22	.36	-.04	.65	.78
74	.39	-.22	.31	.09	.36	.49
71	-.01	.81	-.06	.09	.66	.44
83	-.02	.53	.17	.47	.71	.69
35	.30	.39	.27	-.05	.48	.63
73	-.07	-.08	.81	.13	.64	.57
75	.12	-.00	.73	.04	.64	.66
64	.13	.14	.57	.07	.53	.66
48	.18	.36	.42	-.02	.52	.65
82	.24	.30	.31	.09	.46	.65
53	-.18	.08	.31	.72	.67	.57
43	.34	.09	-.15	.71	.76	.67
47	.20	-.02	.24	.50	.54	.65
% of variance*	40.9	6.0	5.7	5.3	57.8	40.9
Label	Situational support					

* % of variance prior to rotation

Table 7

Component Correlation Matrix - PAF Sample

Component	1	2	3	4
1	1.00			
2	.31	1.00		
3	.47	.26	1.00	
4	.38	.21	.31	1.00

Inspection of the scree plot eigenvalues (i.e., 8.18; 1.19; 1.13; 1.05; .98; .91; .77; .70; .67; .63; .55; .49; .48; .42; .40; .39; .32; .27; .25; .23) indicated that two components might be stable. Component loadings, however, indicated that only two items loaded highly on the second component suggesting a possible one-component solution for this sample. A PAR identified only one stable factor (see Appendix D). The one-component solution, which accounted for 40.9% of the variance, is shown in Table 6. The items loading on the retained component differed somewhat from the items loading on the first component for the SC sample. They included cognitive, motivational and affective components of dependency and were concerned with a situational rather

than general need for support from others. It was therefore labelled *Situational Support*.

Interpretation

The results of the separate principal components analyses for the two samples indicated that one major component emerged for both the groups. Although some of the items loading on that component differed for each sample, the theme of the major component that emerged was the same. That component concerned a belief in the need for support from other people. For the SC sample, items loading on the major components indicated a general need for support from others whereas items loading on the major component for the PAF sample indicated a situational need for support from others. For the SC sample, a second, minor stable component also emerged. Items loading highly on the second component were associated with the fear of rejection and need for approval.

The difference in the components between the groups might be explained by the difference in the dependency needs of the two groups. For the SC sample (which was the more dependent sample - see *t*-test results below) the need for approval, which is likely to be due to a fear of abandonment, emerged as a salient component in dependency

but for the PAF sample (the less dependent sample) it did not. This made sense according to the interactive theory of dependency as proposed by Bornstein (1993b). As people become more dependent, their perceived need for the support of others and thus the approval of others to minimise the possibility of abandonment is likely to increase. So this difference in the samples could be the reason for the different component groupings that emerged between them and actually adds support to both the theory of dependency as described by Bornstein and to the validity of the scale developed here.

From the results of the principal components analyses, it appeared that the difference in the components that emerged for the groups could be expected, given the basis upon which the samples were selected, and were not likely to be due to some other fundamental difference between the samples. In order to get a clearer picture of the dimensions of interpersonal dependency, a principal components analysis was conducted on the two data sets combined. Combining the data sets would maximise the variability of item scores for the analysis and increase the statistical power of the analysis. The analysis performed was identical to the previous analyses.

For the SC and PAF samples combined, three components with eigenvalues greater than one were extracted in the initial principal components analysis accounting for 57.5% of the variance. Component loadings, and communalities (h^2) explained after oblimin rotation are shown in Table 8. Component correlations are shown in Table 9.

Like the analysis of the SC sample, only two components, which accounted for 52.5% of the variance, were retained. Inspection of the scree plot eigenvalues (i.e., 8.96; 1.53; 1.00; .88; .79; .72; .67; .64; .58; .56; .51; .48; .45; .43; .39; .36; .31; .29; .24; .22) indicated that only two components were stable. In addition, there was a moderate to high negative correlation (-.58) between components one and three. A PAR identified only two stable components (see Appendix D). A further principal components analysis requesting the extraction of two components was conducted. The two-component solution is shown in Table 8. The structure of the two retained components for the combined samples was very similar to that found for the SC sample. Items loading highly on both component one (which accounted for 44.8% of the variance) and component two (which accounted for 7.7% of the variance) were the same items that loaded highly on the first and second components for the SC analysis. The

two components were thus labelled *Support* and *Approval* respectively.

Table 8

Oblimin Rotated Component Pattern Matrix for
Interpersonal Dependency Variables (Initial and 2
Component Solutions)- SC Sample and PAF Sample Combined

Item	<u>Components-Initial Solution</u>				<u>2 Component</u>	
	1	2	3	h^2	1	2
53	.81	.18	.23	.63	.57	.18
43	.86	-.07	-.03	.64	.81	-.07
47	.72	.10	.05	.54	.63	.11
25	.67	.00	-.07	.51	.69	.01
71	.65	-.27	-.20	.53	.83	-.28
57	.63	-.19	-.34	.66	.89	-.19
80	.62	-.06	-.19	.54	.75	-.05
48	.61	.17	-.00	.48	.55	.18
35	.59	.05	-.16	.51	.67	.07
83	.57	.27	-.05	.55	.53	.29
74	.49	.08	-.14	.38	.55	.10
64	-.02	.74	-.23	.68	.01	.82
75	.15	.72	-.05	.64	.03	.78
49	-.07	.67	-.43	.72	.13	.75
73	.36	.60	.11	.58	.14	.64
55	.05	.14	-.73	.66	.58	.19
5	.04	.08	-.71	.58	.56	.13
17	.17	.20	-.57	.58	.55	.25
42	.35	-.01	-.54	.63	.74	.02
82	.23	-.05	-.51	.48	.60	.09
% of variance*	44.8	7.7	5.0	57.5	44.8	7.7
Label	Support		Approval			

*% of variance prior to rotation

Table 9

Component Correlation Matrix-(Initial Solution) SC and
PAF Samples Combined

Component	1	2	3
1	1.00		
2	.38	1.00	
3	-.58	-.26	1.00

Interpretation

Results indicate that interpersonal dependency consists of one major dimension that includes the cognitive, motivational, behavioural and affective components defined by Bornstein (1993b), but part of the affective component, the need for approval emerges as a second minor dimension. It might be that need for approval is associated with the dependent person's perceived risk for abandonment and/or rejection. The dependent person who does not perceive he/she is at high risk of abandonment might score high on need for support (factor 1 items) but low on approval (factor 2 items). This is in line with Bornstein's proposed theory of dependency, which suggests that dependent people can have either good or poor social

skills. According to Bornstein, those with good social skills are more likely to get their dependency needs met and are therefore less likely to suffer from depression and anxiety.

Interpersonal dependency comparison between samples

An independent t test was computed on the final 20-item scale scores of the SC ($N = 70$) and PAF ($N = 207$) samples. Because of violation of the assumption of equality of variances, the t test for unequal variances was computed, and was found to be significant, $t(94.61) = 4.36$, $p < .05$. The SC sample scored significantly higher on the interpersonal dependency scale ($\underline{M} = 62.57$; $\underline{SD} = 28.56$) than the PAF sample $\underline{M} = 46.42$; $\underline{SD} = 20.67$).

Interpersonal dependency comparison between gender

An independent t test was computed on the final 20 item scale scores for men ($N = 92$) and women ($N = 183$). The assumption of homogeneity of variance was met and the result indicated a significant difference between the scores of men and women, $t(273) = 2.21$, $p < .05$. The

mean interpersonal dependency score for men was 55.09 (SD = 25.72) compared to 48.38 for women (SD = 22.73).

Relationship between age and interpersonal dependency scores

A Pearson product-moment correlation was conducted between age and the interpersonal dependency scores for respondents with no missing data on either variable ($N = 274$). A significant positive correlation was found between age and interpersonal dependency, $r(272) = .18$, $p < .05$. This indicated that interpersonal dependency increases as age increases, but the relationship between the two variables was weak.

Discussion

The main aim of this stage of the study was to reduce the 85 items selected in Stage 1 to a short reliable screening tool (20-40 items) that could be used in the initial assessment of older people seeking health services designed to support/promote their non-dependence. This aim was achieved. A reliable scale with 20 items representing each of the components of dependency identified by Bornstein (1993b) was developed.

The scale was named the Interpersonal Dependency Scale for Older Adults (IDS-OA).

Another aim was to summarise the correlations of the scale variables. It was expected that when analysed using principal components analyses, the scale items would reduce to one component in line with Bornstein's (1993b) unidimensional theory of dependency, or one major and one minor component for each of the samples. For both the SC and the PAF groups, one major component did emerge. That component was concerned with belief in the need for support from others. But a minor component, which was concerned with the fear of rejection and need for approval emerged only for the SC group. It emerged again when the groups' data were combined in a further analysis. It was suggested that the difference in the components between the groups might be explained by a difference in dependency needs between the two groups. As people become more dependent (the SC group scored significantly higher on the IDS-OA than did the PAF group), an increase in the need for approval, which is likely to be due to a fear of abandonment, could cause the emergence of the second minor factor. This theory is explored further in Chapter 5.

Another hypothesis that was tested in this stage was that older people seeking home-care services who had been assessed by SC as having low home-care service needs would score higher in interpersonal dependency than older people who were members of the PAF. Results supported the hypothesis and previous research that has found dependent people access health services more often and remain in them longer than people who are not dependent (Bornstein, 1993b; Bornstein et al., 1993). Thus, the construct validity of the new interpersonal dependency scale was also supported.

These results might have been affected, however, by the difference in the return rates of the questionnaires between the samples. The PAF response rate was 62.57% while only 22.57% of the SC sample returned their questionnaires. The difference in the return rates between samples suggests a difference in the samples' representation of the populations from which they are drawn. The low return rate of the SC sample suggests that the results might not represent the SC population. Nevertheless, it is more likely that the SC clients who did not return their questionnaires are the more dependent people and not those who did. As pointed out by one of the older focus group participants in Stage 1 of this study, "...filling out forms" (focus group 1,

Appendix A) might be a task that dependent people are not often confident in. Therefore, the difference in interpersonal dependency found between the groups is likely to be an underestimate.

Contrary to previous research that has found women score higher on objective interpersonal dependency measures than men (Bornstein et al., 1996), this research found the opposite. On the IDS-OA developed in this study, older men scored slightly higher than older women. A possible reason for men scoring higher than women in this study is that men might believe that it is socially acceptable for older men to report interpersonal dependency. This would support the stereotypical but inaccurate view that it is normal for older people to become dependent (Baltes, 1996). Another possibility is that the item selection process used for the development of the IDS-OA that attempted to suppress social desirability (Jackson, 1970) was successful and resulted in a scale that does not correspond with social desirability. The IDS-OA's correspondence with social desirability is examined in stage 4 of this study (Chapter 6).

Finally, the relationship between age and interpersonal dependency as measured by the IDS-OA was examined in this

study. Given that characteristics of personality dysfunction tend to remain stable across the life-span (American Psychiatric Association, 2000) it was expected that no relationship would be found. Results supported that expectation and thus further supported the construct validity of the IDS-OA. A significant but very small correlation was obtained between age and the new interpersonal dependency scale (.18). This result, however, should be interpreted with caution. A cross-sectional design was utilised in this study. It is not known therefore, whether individuals' scores have remained or will remain stable over time. Longitudinal research would be necessary to answer that question. Nevertheless, taken together the very promising preliminary results found in this stage of the study suggest that IDS-OA might provide a simple, reliable and valid means of screening older people entering health services for interpersonal dependency.

CHAPTER 5

Stage 3 - Between Sample Dependency Scale Score

Comparison and Component Examination

Aim

The main aim of Stage 3 of the study was to test the theory formulated in the previous stage (Stage 2) that only one component is likely to be produced from principal components analyses of the IDS-OA by less dependent samples while one major and one minor component will emerge from the analyses of more dependent samples. To test this theory, responses to the IDS-OA were requested from three samples of older people; a sample thought to be high in interpersonal dependency [a new Silver Chain (SC) sample], a sample thought to more closely represent older adults in interpersonal dependency in Western Australia [a new Positive Ageing Foundation (PAF) sample] and a sample thought to be low in interpersonal dependency [a sample of Council on the Ageing (COTA) members].

The SC sample was hypothesised to be higher in interpersonal dependency than the other two groups for two reasons. First, SC staff members observed an over-reliance on services by SC clients whom they described as being "dependent by nature" (Gardner, 1999). Second, research has found interpersonally dependent people to seek health services more often and remain in them longer (even once the need for the service has gone), than non-interpersonally dependent people (Bornstein, 1993b; Bornstein et al., 1993).

The PAF sample was thought to be a sample more closely representing older adults in interpersonal dependency in Western Australia because membership of the PAF is open to any individuals and is unlikely to be of particular attraction to excessively interpersonally dependent people. Membership of the PAF supports the Foundation's research project collaborations with universities, commercial organisations and development projects. It was recognised that it would be unlikely for interpersonally dependent people to be proportionally represented in the PAF sample. The PAF is not an organisation that would fulfil a dependent person's immediate dependency needs so excessively dependent people might not actively seek membership.

It was expected that the COTA sample would be low in interpersonal dependency because membership of that organisation supports the active pursuits of older individuals to manage their own social, legal and financial affairs. It also provides forums to enable the voices of older adults to be heard by government, business and industry. It was considered therefore, that older people who seek membership of an organisation such as the COTA were likely to be confident in making decisions and in offering their opinions on issues affecting the lives of older people in general.

A between samples IDS-OA score comparison was to be conducted followed by principal components analyses on each of the samples' item responses and on the samples' item responses combined. Further internal consistency reliability analyses were also to be conducted on each of the samples' data and on the data sets combined in order to add support to the high reliability of the IDS-OA found in Stage 2.

Method

Participants

The dependency scale was distributed to 750 people from three Perth organisations. These were computer selected random samples of 250 people between the ages of 65 and 90 years from each of the SC, PAF and COTA databases. As for Stage 2, the SC sample was also stratified according to the length of time that people had been receiving SC services and the type of service they were receiving. Only new clients (those who had been receiving services for 3 months or less) with low service needs (were receiving only home help) were included in the SC sample. A total of 300 people responded. Sixty-eight were SC clients (49 women, 18 men, 1 one did not indicate his/her gender), 139 were PAF members (82 women, 46 men, 11 did not indicate their gender) and 93 were COTA members (53 women, 39 men, 1 did not indicate his/her gender). Response rates were 27.2% for SC clients, 55.6% for PAF members and 37.2% for the COTA members. The age range of respondents for each of the samples was 65-90 years. Mean ages for the SC, PAF and COTA samples were 80.22 (SD = 7.27), 76.86 (SD = 7.21) and 70.73 years (SD = 6.21) respectively.

Instrument

The 20-item final version of the interpersonal dependency scale developed in the previous chapter was used in this sample comparison study (see Appendix E). The instructions preceding the scale items and the scoring of the items were also the same as for the previous study (see Appendix E). Low scores corresponded to low levels of interpersonal dependency and high scores to high levels. Demographic information sought included gender and age.

Procedure

A package of materials was posted to each prospective respondent. This package consisted of an "Information and Disclosure Form" (see Appendix E), "Consent Form" (see Appendix E), a covering letter from the appropriate organisation (see Appendix E), the 20-item interpersonal dependency scale and a reply-paid envelope. The information and disclosure form included the same information for the prospective respondent as was provided for respondents in Stage 2. The covering letters from the organisations included a return date for the

completed scales. SC and COTA requested that the completed scales be returned within a two-week period and PAF requested response within four weeks. The different return periods were in keeping with the organisations' usual practice and, as in Stage 2, were maintained to maximise the response rate from each organisation.

Results

Gender x organisation interpersonal dependency score comparison

Using SPSS for Windows (version 10), gender and sample interpersonal dependency scores were compared with a factorial analysis of variance (ANOVA). Twenty-eight cases with missing data were excluded from the analysis leaving 272 valid cases. Due to large cell sizes the factorial ANOVA was considered to be robust against a violation of the assumption of homogeneity of variance. Main effects were found to be statistically significant: Gender, $F(1,266) = 6.18, p < .01$; Organisation, $F(2,266) = 16.75, p < .001$. The interaction was not found to be statistically significant, Gender by Organisation, $F(2,266) = .23, p > .05$. Descriptive statistics are given in Table 10.

Table 10

Mean Interpersonal Dependency Scale Scores as a Function
of Gender and Sample (Organisation)

	<u>Gender</u>			
	Women		Men	
Sample	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Silver Chain	60.20	25.92	68.81	32.57
Positive Ageing Foundation	41.61	19.22	46.52	21.23
Council on the Ageing	39.24	16.19	48.12	24.87

Post hoc pair-wise comparisons were conducted among the six cell means using the Tukey HSD test. These revealed that the mean interpersonal dependency score for the Silver Chain men was significantly higher than the mean score for Silver Chain women. Both the Silver Chain men and the Silver Chain women scored significantly higher than any of the other cells. No other comparisons were significant.

Relationship between age and interpersonal dependency scores

Using SPSS for Windows (version 10), a Pearson product-moment correlation was conducted between age and interpersonal dependency scores of respondents with no missing data on either variable ($N = 266$). A significant positive relationship was found between age and interpersonal dependency scores, $r(264) = .16, p < .05$. This indicated that dependency increased only slightly with age amongst the sample of elderly people.

Interpersonal dependency scale internal consistency reliability analyses

The set of 20 items was entered into scale reliability analyses for the SC sample, the PAF sample, the COTA sample and the three samples combined. The coefficient alphas obtained were .93, .92, .95 and .94 respectively.

Principal components analyses

To explore further and summarise the correlations of variables among samples, principal components analyses with oblimin rotation were performed for the SC, PAF and COTA samples using the factor analysis procedure in SPSS for Windows (version 10). Following the results of the principal components analyses performed in the previous study, it was expected that the items would reduce to one major component for the less dependent samples (i.e., PAF and COTA) and to one major and one minor component for the more dependent sample (i.e., SC).

For the SC sample, four components with eigenvalues greater than one were extracted in an initial principal components analysis. These components accounted for 70.36% of the variance. The component loadings and communalities (h^2) after oblimin rotation are shown in Table 11. Component correlations are shown in Table 12.

Table 11

Oblimin Rotated Component Pattern Matrix for
Interpersonal Dependency Variables (Initial and 2
Component Solutions) - SC Sample (Stage 3)

Item	<u>Components-Initial Solution</u>					<u>2 Component</u>	
	1	2	3	4	h^2	1	2
17	.77	-.17	.13	.12	.69	.78	-.13
5	.67	.31	-.13	.10	.73	.56	.32
16	.57	.12	.30	.19	.74	.73	.17
2	.56	.31	.28	-.17	.60	.37	.40
9	.47	.36	-.04	.12	.58	.48	.38
11	-.27	.90	.14	.05	.79	-.18	.91
8	-.07	.84	-.07	.09	.70	.03	.83
6	.24	.79	-.09	-.12	.74	-.05	.83
18	.20	.77	-.11	.04	.73	.11	.78
14	.04	.67	.32	.04	.69	.13	.73
19	.30	.50	-.13	.29	.66	.43	.48
15	.04	-.07	.84	-.13	.68	.21	.07
20	.02	-.05	.71	.33	.74	.56	.11
7	.11	.29	.53	.23	.65	.47	.35
1	-.12	.10	.05	.90	.80	.74	-.00
13	.01	-.08	.13	.86	.77	.86	-.17
3	.08	.25	-.10	.68	.67	.63	.17
12	.52	-.16	.12	.55	.83	.98	-.18
4	.46	-.03	-.16	.53	.67	.80	-.10
10	.37	.06	.06	.49	.62	.77	.03

% of

variance* 45.40 11.9 7.9 5.2 70.4 45.4 11.9

Label Support Approval

* % of variance prior to rotation

Table 12

Component Correlation Matrix (Initial Solution)- SCSample

Component	1	2	3	4
1	1.00			
2	.34	1.00		
3	.23	.20	1.00	
4	.48	.31	.19	1.00

After examination of the scree plot eigenvalues (i.e., 9.08; 2.38; 1.58; 1.04; .86; .79; .62; .49; .45; .42; .39; .34; .31; .29; .24; .21; .20; .14; .11; .01), pattern matrix and component correlations, it appeared that three of the four components might be stable. However, a PAR identified only two stable components (see Appendix F). Following the PAR analysis, a further principal components analysis requesting the extraction of two components was performed. The two-component solution, which is also shown in Table 11, accounted for 57.3% of the variance. Items that loaded highly on the first component, which accounted for 45.4% of the variance, represented the cognitive, affective and

behavioural components of dependency and were concerned with needing the support of others. Items loading highly on the second component, which accounted for 11.9% of the variance, represented the motivational, affective and behavioural components of dependency and were concerned with needing the approval of others. The correlation between the two components was .34. They were labelled *Support* and *Approval* respectively.

For the PAF sample, five components with eigenvalues greater than one were extracted in an initial principal components analysis. These components accounted for 68.3% of the variance. The factor loadings, communalities (h^2), and percentages explained after oblimin rotation are shown in Table 13. Component correlations are shown in Table 14.

The scree plot eigenvalues (i.e., 8.34; 1.78; 1.30; 1.16; 1.08; .86; .77; .73; .55; .47; .46; .41; .37; .34; .31; .28; .26; .22; .16; .15) indicated that two of these components might be stable. A PAR also identified two stable components (see Appendix F). Following the PAR, a further principal components analysis was performed requesting the extraction of two components. The two-component solution is shown in Table 13. Nevertheless, following examination of the pattern matrix and component

correlations in the two-component solution, only one component (see Appendix F) was retained.

Table 13

Oblimin Rotated Component Pattern Matrix for
Interpersonal Dependency Variables (Initial and 2
Component Solutions)- PAF Sample (Stage 3)

Item	<u>Components-Initial Solution</u>						<u>2 Component</u>	
	1	2	3	4	5	h^2	1	2
8	.88	.02	-.01	-.05	.05	.78	.77	-.27
18	.82	-.17	-.16	.07	.04	.71	.68	-.30
14	.81	.15	.27	-.13	.05	.78	.74	-.32
11	.75	-.18	.16	.08	.13	.71	.71	-.45
7	.56	.48	-.15	.03	-.06	.69	.72	.20
10	.55	.37	-.18	.17	.00	.73	.79	.16
17	-.05	.75	-.05	.07	.10	.62	.47	.50
4	-.08	.57	-.39	.08	.44	.78	.58	.26
9	.33	.50	.00	.27	-.11	.62	.69	.20
6	.40	.14	-.55	.20	-.05	.69	.64	-.35
19	.42	.09	.46	.15	.09	.59	.62	-.34
2	.50	.36	-.46	.14	.42	.69	.55	.54
12	-.10	.17	.31	.83	-.06	.78	.60	-.05
3	-.03	.14	-.16	.73	-.05	.57	.53	.18
20	.25	-.37	.23	.56	.16	.66	.55	-.44
15	.05	-.15	-.11	.53	.38	.56	.57	.00
16	.37	-.07	-.38	.47	.01	.69	.68	.13
1	.07	.00	.02	-.12	.93	.80	.48	.13
13	.32	.03	.04	.21	.42	.56	.70	-.05
5	.29	.36	-.24	.11	.36	.66	.72	.32

% of variance*

41.7 8.9 6.5 5.8 5.4 68.3 41.7 8.9

Label Dependency

* % of variance prior to rotation

Table 14

Component Correlation Matrix-(Initial Solution) PAFSample (Stage 3)

Component	1	2	3	4	5
1	1.00				
2	.25	1.00			
3	.07	-.04	1.00		
4	.48	.26	.03	1.00	
5	.36	.21	.05	.33	1.00

The two-component solution indicated that only one item, which was concerned with going out alone, loaded highly on the second component. This indicated that the item might not be measuring a facet of dependency for this sample. Therefore, the one component solution accounting for 41.7% of the variance was endorsed. The items in this component represented the cognitive, motivational, affective and behavioural components of dependency. They were concerned with the need for both approval and support from others. Therefore, the component was labelled *Dependency*.

An initial principal components analysis extracted three components with eigenvalues greater than one from the COTA sample's data. These components accounted for 66.3% of the variance. The component loadings, communalities (h^2), and percentages explained after oblimin rotation are shown in Table 15. Component correlations are shown in Table 16.

Table 15

Oblimin Rotated Component Pattern Matrix for
Interpersonal Dependency Variables (Initial and 2
Component Solutions)- COTA Sample (Stage 3)

Item	<u>Components-Initial Solution</u>				<u>2 Component</u>	
	1	2	3	h^2	1	2
7	.89	.06	.15	.73	.82	-.10
2	.87	.03	.05	.73	.85	-.09
3	.73	-.00	-.13	.64	.81	-.05
12	.71	-.08	-.27	.70	.88	-.09
10	.63	.35	-.13	.59	.52	.24
9	.62	-.05	-.38	.71	.84	.00
16	.53	.23	-.27	.68	.65	.26
5	.48	.30	-.25	.67	.58	.34
6	.35	.30	-.27	.51	.45	.36
11	-.03	.84	-.09	.75	-.01	.91
8	.19	.83	.12	.75	.01	.80
14	.02	.83	.04	.67	-.12	.85
18	-.01	.78	-.15	.72	-.04	.87
19	.25	.51	-.26	.66	.32	.59
17	.31	-.15	-.71	.69	.72	.04
15	-.25	.31	-.71	.62	.08	.59
4	.41	-.14	-.66	.75	.79	.02
13	.15	.23	-.60	.66	.44	.42
1	.13	.26	-.56	.61	.40	.44
20	.02	.38	-.41	.45	.19	.52

% of
 variance* 50.2 10.2 5.9 66.3 50.2 10.2

Label Support Approval

* % of variance prior to rotation

Table 16

Component Correlation Matrix (Initial Solution) - COTASample

Component	1	2	3
1	1.00		
2	.38	1.00	
3	-.46	-.42	1.00

After examination of the scree plot eigenvalues (i.e., 10.05; 2.04; 1.17; .89; .86; .73; .65; .53; .50; .42; .35; .33; .29; .26; .24; .22; .17; .15; .01; .01), pattern matrix and component correlations it appeared that only two of the components might be stable. A PAR was performed which also identified two stable components (see Appendix F). Following the PAR, a further principal components analysis requesting the extraction of two components was conducted. Results of the two-component solution are shown in Table 15. The two retained components accounted for 60.4% of the variance. The correlation between these two components was .38. Like the analysis for the SC sample, items loading highly on the first component for this sample (which accounted for

50.2% of the variance) were concerned with the need for the support of others and included the same items as for the SC analysis along with two additional items. Items loading on the second component for this sample (which accounted for 10.2% of the variance) were the same items that loaded highly on the second component for the SC analysis and were concerned with the need for approval. Thus, the two components were again labelled *Support* and *Approval* respectively.

Although item component loadings differed among the samples' results, the patterns of factor loadings found for the SC and COTA samples were considered to be similar enough to be able to combine the data sets. The difference between the PAF sample's results and those of the other two samples was likely to be due to a lack of variability in the PAF sample scores. Whilst the ANOVA analysis found no significant difference between the Mean PAF and COTA scores, inspection of the distribution of scores for each sample produced by SPSS for Windows version 10 (see Figures 1, 2, and 3) supported the expectation that the PAF sample's scores would include a smaller proportion of extreme scores (either very high interpersonal dependency scores or very low interpersonal dependency scores) than the other two groups.

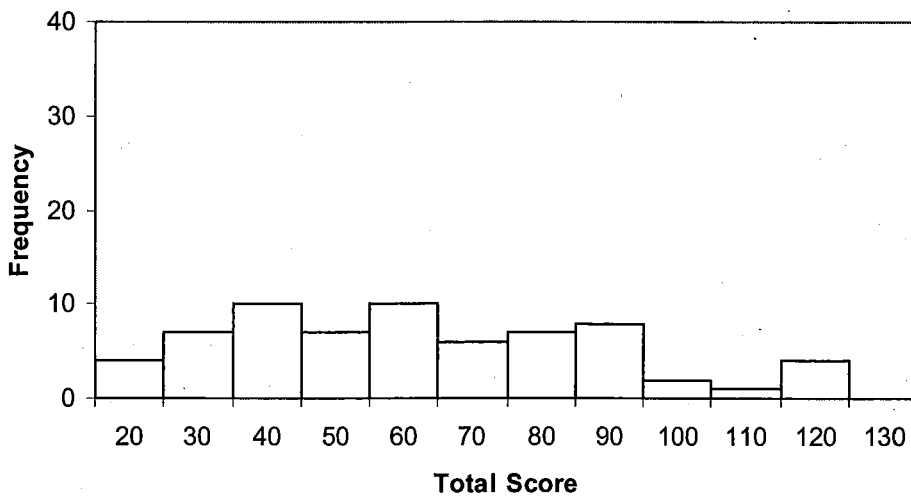


Figure 2. Distribution of interpersonal dependency scores for the SC sample.

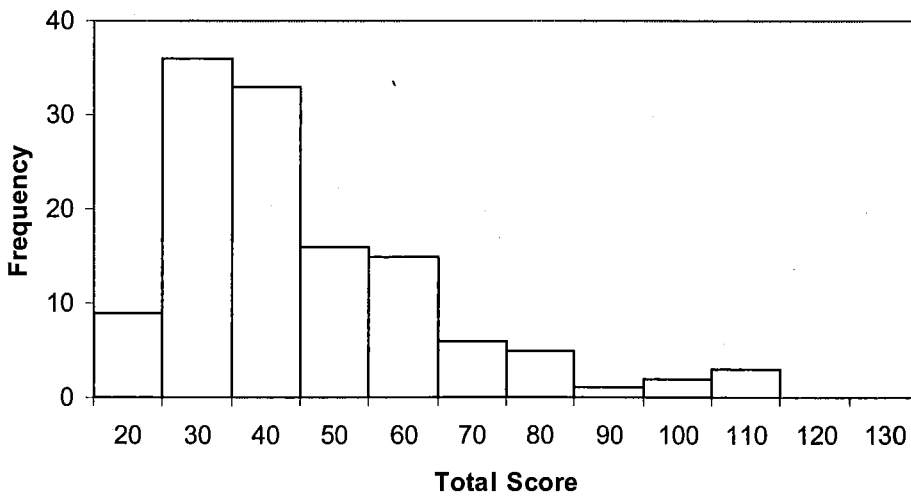


Figure 3. Distribution of interpersonal dependency scores for the PAF sample.

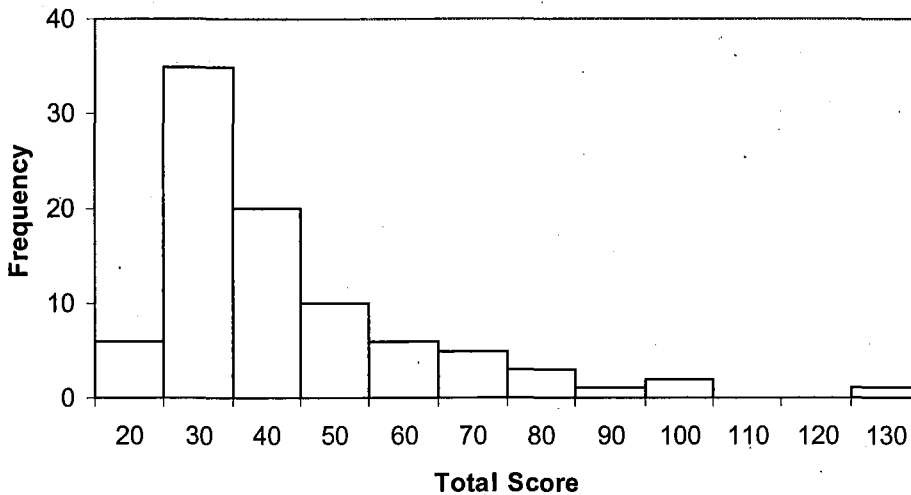


Figure 4. Distribution of interpersonal dependency scores for the COTA sample.

Unlike the principal components analyses in the previous study (Chapter 4) the scores of the sample presumed to be least dependent (COTA) in this study produced both the major and the minor component in interpersonal dependency. The results found here might further explain the differences that occurred between the SC and PAF samples' principal components analyses in the previous study. The second, minor component might not have emerged in the PAF sample's analysis due to insufficient variability in that sample's scores.

To increase the statistical power of the analysis, the three data sets were combined and further principal components analyses were conducted. The initial analysis

extracted three components with eigenvalues greater than one, which accounted for 61.74% of the variance. The component loadings, communalities (h^2), and percentages explained after oblimin rotation are shown in Table 17. Component correlations are shown in Table 18.

Table 17

Oblimin Rotated Component Pattern Matrix for
Interpersonal Dependency Variables (Initial and 2
Component Solutions) - Combined Samples (Stage 3)

Item	<u>Components-Initial Solution</u>				<u>2 Component</u>	
	1	2	3	h^2	1	2
17	.83	-.21	.06	.59	.87	-.22
4	.80	-.10	.05	.60	.83	-.12
12	.80	-.15	.21	.70	.89	-.12
3	.74	.04	.07	.54	.72	-.00
16	.71	.08	.12	.66	.76	.09
9	.70	.21	-.15	.61	.65	.15
5	.70	.19	-.02	.65	.69	.16
2	.70	.08	-.12	.49	.66	.03
10	.67	.19	-.02	.61	.67	.16
7	.58	.24	-.02	.52	.57	.21
1	.52	.06	.24	.47	.61	.10
13	.50	.11	.31	.55	.61	.17
11	-.15	.89	.15	.76	-.14	.94
8	.07	.84	.06	.74	.01	.84
14	.02	.77	.09	.67	.02	.80
18	.07	.76	.05	.67	.06	.78
6	.25	.61	-.01	.58	.22	.60
19	.30	.50	.11	.56	.32	.52
15	.02	.05	.80	.68	.30	.25
20	.07	.19	.73	.72	.32	.38
% of variance*	47.3	9.2	5.3	61.7	47.3	9.2

Label Support Approval

* % of variance prior to rotation

Table 18

Component Correlation Matrix (Initial Solution)- Combined
Samples (Stage 3)

Component	1	2	3
1	1.00		
2	.51	1.00	
3	.39	.31	1.00

After examination of the scree plot eigenvalues (i.e., 9.45; 1.83; 1.06; .97; .78; .68; .62; .57; .50; .45; .42; .39; .37; .36; .33; .29; .28; .23; .22; .20), pattern matrix and component correlations it appeared that only two of the three components might be stable. A PAR (see appendix F) confirmed the stability of two components. Following the PAR a further principal components analysis was undertaken requesting the extraction of two components. The two-component solution, which accounted for 56.5% of the variance, is shown in Table 17. Items loading highly on the first component represented the cognitive, motivational, behavioural and affective components of dependency (Bornstein, 1993b) and were concerned with the need for support from other people.

Items loading highly on the second component represented the motivational, behavioural and affective components of dependency and were concerned with the need for approval. Again, the components were labelled *Support* and *Approval* respectively. The correlation between the two components was .51 indicating possible instability of the second factor. Results of this and the previous study suggest however, that the stability of the second component might depend upon the number of extreme scores in the sample towards the dependent end of the scale.

Discussion

As hypothesised, SC clients scored significantly higher on the IDS-OA than members of either the PAF or the COTA. This result supports the finding in Stage 2 that SC clients scored higher than the PAF members and also adds further support to the construct and discriminant validity of the IDS-OA. It also supports the observations made by SC direct care staff members (Gardner, 1999) that many of the SC clients classified as having low services needs appear to have dependent personality styles. While it is not likely for very mild, recently developed physical functional disabilities to cause people to score highly on a measure of dependent

personality, it is possible that they are linked. It is more likely that those with dependent personality characteristics seek the support of home-care services as soon as they begin to notice some difficulty in managing any tasks. Another possibility is that depression, which has been linked to the use of non-mental health services by older people (Banerjee & MacDonald, 1998; Kempen & Stuurmeyer, 1991) and to interpersonal dependency in a number of studies (Birtchnell, 1988; Bornstein, 1992; Hirschfeld, Klerman, Chodoff, Korchin, & Barret, 1976; Overholser, 1996), might cause older people to seek home-care services. The relationship between interpersonal dependency, depression and physical functional disability in a SC sample will be examined in Stage 4.

In support of the findings in the previous stage of this study (Stage 2), men scored higher than women on the IDS-OA, although only in the SC sample did the results reach statistical significance. This finding is different from results of previous research that has found women to score higher than men on objective interpersonal dependency measures (Bornstein et al., 1996). As suggested in Stage 2, it might be that older men believe there is less social stigma attached to reporting interpersonal dependency than younger men. At the same time, while statistically significant, the differences

across gender did not show significant effects (effect size = .32). Another possibility is that the IDS-OA more accurately measures interpersonal dependency than do previously developed measures. The significant difference between the scores of men and women in the SC sample might indicate that a greater proportion of interpersonally dependent men seek home-care services than interpersonally dependent women. Although older men might attach less social stigma to being interpersonally dependent in older age, dependency might still be considered to be more pathological for men than it is for women.

In support of results in the previous stage of this study (Stage 2), no relationship between age and interpersonal dependency scores was found. Although the SC respondents were older than the other samples, this difference in age was not related to interpersonal scores. These results suggest that people do not become increasingly dependent with age. But, due to the cross-sectional design of this study, caution is again required in interpreting the result this way. A longitudinal design would be needed to determine whether individuals' level of interpersonal dependency remains stable over time.

The high internal consistency reliability of the IDS-OA found in the previous stage (Stage 2) was further supported by the findings in this stage of the study. Furthermore, the theory formulated from the principal components analyses in the previous stage was supported by the results in this stage of the study. Like the results in Stage 2, the principal components analyses described here suggest that as people become more interpersonally dependent, a need for the approval of others might emerge as a separate salient component resulting in a greater fear of abandonment.

CHAPTER 6

Stage 4 - Interpersonal Dependency Scale

Validation Study

Aim

The purpose of this study was to examine correlations between the new interpersonal dependency scale and other measures as indications of the scale's convergent and discriminant validity. The new interpersonal dependency scale was developed as a dispositional measure. It was expected that it would correlate strongly with another measure of dependent personality, moderately with both depression and anxiety and weakly with a measure of physical function. Although many functional disabilities arise from long-standing impairments and might result in trait dependencies, such disabilities sometimes produce state dependencies. Nevertheless, it was expected that the new interpersonal dependency measure would correlate moderately with a mobility measure that is less concerned with physical functional ability (for tasks such as basic personal care, walking and climbing flights of stairs) and more concerned with travelling about the community and moving about the home without the assistance of

another person. A fear of leaving home alone was mentioned by older focus group participants in Stage 1 of this study as common to dependent older people.

This study also tested the hypothesis derived from Bornstein's (1993b) proposed interactive theory of dependency that scores on the new interpersonal dependency scale would contribute to a greater proportion of the variance in the measure of mobility than would scores on depression and anxiety measures. According to Bornstein's theory, an inability to get dependency needs met leads to anxiety and/or depression, which in turn, can lead to physical illness. Observations of SC staff suggest that many older people entering the service have no apparent functional disability requiring the support of the service but instead appear to be either dependent by nature or suffering from depression. These conditions in turn, are likely to affect the mobility of older people who tend to present their psychiatric symptoms as somatic symptoms (Small, 1997). It was expected therefore, that a dependent personality would predict mobility (a global measure of functional disability) but not dependencies resulting from physical functional impairment as measured by activities of daily living (ADL) scales. But ADL functional impairment should be linked to both mobility and depression.

Method

Participants

The questionnaire package was distributed to a computer-selected random sample of 300 new (three months or less) Silver Chain (SC) clients aged 65-90 years. As with the previous studies, only clients assessed by SC as having low service needs were included in the sample. A total of 105 people responded (response rate = 35%). Sixty-five were women and 34 were men. The age range of the respondents was 65-90 years ($\underline{M} = 76.09$, $\underline{SD} = 7.15$).

Instruments

Interpersonal Dependency. The new interpersonal dependency scale developed in stages two and three of this project was tested for its convergent validity in this study. In addition, the dependency sub-factor items of the Depressive Experiences Questionnaire - Dependency Factor (Quinlin, Zuroff & Mongrain, 1995) (see Appendix G) were used as a validation measure. The DEQ is a commonly used 66-item questionnaire with a 7-point Likert-type scale response format ranging from one

(strongly disagree) to seven (strongly agree). The 18 dependency sub-factor items of the DEQ- Dependency Factor measure feelings of helplessness, fears and apprehensions about separation and rejection, intense concerns about loss and feelings of loss and loneliness in reaction to disruption of a relationship (Blatt et al., 1995). Alpha reliability coefficients for the dependency factor items have ranged from .66 to .75 ($M = .70$) (Blatt et al., 1995).

Physical Dependency. The Medical Outcomes Study (MOS) Physical Functioning Measure (Stewart & Kamberg, 1992) (see Appendix G) was used to measure participants' physical abilities. The MOS Physical Functioning Measure, which was developed for use with relatively healthy people, consists of 10 items on functioning [referred to as the Physical Functioning (PF) measure in this study], one on dissatisfaction with physical activity [referred to as Physical Activity Dissatisfaction (PAD) measure] and three on mobility [referred to as Mobility (Mob) measure]. The 10 physical functioning items include some items on basic activities such as dressing, as well as items concerning ability to undertake more strenuous activities such as climbing stairs (McDowell & Newell, 1996). The mobility items are concerned with ability to travel about the community and

move about the home unassisted. Three scores are derived for the scale: a physical function score, a mobility score and a dissatisfaction score (based on item 2). Stewart and Kamberg (1992) reported an internal consistency reliability for the physical functioning and mobility scales of .92 and .71 respectively. They also reported that the physical functioning scale correlated moderately with both the mobility score (.58) and the dissatisfaction score (.63).

Depression. Depression was measured using the Geriatric Depression Scale (GDS) (see Appendix G), a commonly used and well-validated screening tool (Yesavage, Brink, Rose, & Aday, 1983). The GDS consists of 30 "yes/no" items that were selected from a pool of 100 by clinicians and researchers because of their ability to distinguish elderly depressed people from non-depressed people. Several studies have reported good reliability of the GDS with alpha coefficients ranging from .82 to .94 (McDowell & Newell, 1996).

Anxiety. Anxiety was measured using the Goldberg Anxiety Quiz (GAQ) (Goldberg, Bridges, Duncan-Jones & Grayson, 1988) (see Appendix G). The GAQ was developed to assist general practitioners and other non-psychiatrists in the recognition of anxiety. It is a

screening tool, which provides a dimensional measure of the severity of anxiety. The GAQ was found by Goldberg et al.(1988) to have a sensitivity of 82% and a specificity of 91%. The scale consists of nine "yes/no" items. One point is scored for each "yes" response.

Social Desirability. The Personality Research Form-Form E-Desirability items (Jackson, 1999) (see Appendix G) were used as a measure of social desirability in this study. The Personality Research Form (PRF) Form-E, which consists of 352 "true/false" items, was designed to measure the functioning styles of individuals in a range of situations that are associated with broad personality traits derived from Murray's (1938) system of needs. A high score on the 16 PRF-Social Desirability (PRF-SD) items is associated with descriptions of one's self in "terms judged desirable" (Jackson, 1999). Low scores are associated with no conscious or unconscious effort to present a desirable impression of one's self (Jackson, 1999). One point is scored for each response that follows a true then false responding pattern. Test-Retest reliability figures for the PRF-Desirability items have ranged from .81-.86 (Jackson, 1999). Internal consistency reliability (Kuder Richardson-20) was estimated to be .68 for a college sample (Jackson, 1999).

Procedure

A package consisting of an "Information and Disclosure Form" (see Appendix C), "Consent Form" (see Appendix C), a covering letter from Silver Chain (see Appendix C), the set of scales described above and a reply-paid envelope was posted to each prospective respondent. The information and disclosure form contained the same information for the prospective respondent as was provided in the previous two stages. The covering letter from SC requested a two-week return date for the completed scales, in keeping with usual procedure.

Results

The intercorrelations of all of the variables are shown in Table 19 along with the means and standard deviations of the continuous variables.

Correlations of the demographic measures (age and gender) with other variables were not significant. A statistically significant strong correlation was obtained for the new interpersonal dependency measure (IDS-OA) and the other measure of dependent personality (DEQ-Dependency Factor/Dependency Sub-factor). A moderate

statistically significant correlation was obtained between the interpersonal dependency measure and the depression variable.

Although statistically significant, the correlation obtained between the new interpersonal dependency measure and the anxiety (GAQ) measure was negligible. A low to moderate statistically significant correlation was obtained between the mobility variable and the IDS-OA measure. The correlation between the IDS-OA and the social desirability measure (PRF-SD) was low.

Moderate statistically significant correlations were obtained among the scales of the MOS Physical Functioning Measure (Stewart & Kamberg, 1992) (PF, PAD and Mob) and low to moderate correlations were obtained between the GDS and each of the PF, PAD and Mob measures. A statistically significant moderate correlation was obtained between the GDS and the PRF-SD. Moderate statistically significant correlations were found among the GDS, DEQ-Dependency Factor/Dependency Sub-factor and the PRF-SD.

The correlations of each of the IDS-OA items with the PRF-SD measure are given in Table 20.

Table 19

Intercorrelations for the Variables

	Gender	Age	PF	PAD	Mob	GDS	GAQ	PRF	IDS-OA	DEQ
Gender	1.00									
Age	.03	1.00								
PF	.10	.01	1.00							
PAD	-.01	-.04	-.54**	1.00						
Mob	.10	.04	.62**	-.54**	1.00					
GDS	.05	.00	-.40**	.54**	-.44**	1.00				
GAQ	-.10	.16	-.16	.22*	-.05	.53**	1.00			
PRF-SD	-.03	-.12	.17	-.24*	.20*	-.60**	-.55**	1.00		
IDS-OA	.02	.14	-.19	.27**	-.44**	.56**	.27**	-.27**	1.00	
DEQ	-.06	.14	-.20	.33**	-.41**	.60**	.38**	-.41**	.86**	1.00
Mean		76.09	29.90	61.83	6.87	11.11	3.35	10.72	62.51	60.46
SD		7.15	25.31	24.87	2.88	7.18	2.34	3.06	32.36	20.30
N		99	105	102	102	105	105	105	99	96

** = $p < .01$; * = $p < .05$

PF = Physical Functioning; PAD = Physical Activity Dissatisfaction; MOB = Mobility; GDS = Geriatric Depression Scale; GAQ = Goldberg Anxiety Quiz; PRF-SD = Personality Research Form - Social Desirability; IDS-OA = Interpersonal Dependency Scale - Older Adults; DEQ = Depressive Experiences Questionnaire

Table 20

Interpersonal Dependency Item and Social Desirability
Score Correlations

Item	Correlation	Item	Correlation
1	-.17	11	-.09
2	-.17	12	-.18
3	-.15	13	-.15
4	-.31**	14	-.19
5	-.23*	15	-.15
6	-.18	16	-.40**
7	-.23*	17	-.22*
8	-.10	18	-.23*
9	-.26**	19	-.19
10	-.26**	20	-.10

** = $p < .01$; * = $p < .05$

Significant negative relationships were found between scores on the interpersonal dependency and social desirability measures for items 4, 5, 7, 9, 10, 17 and 18. Correlations, however, were low and the relationships between scores for these items were considered to be negligible. For item 16, a low to

moderate negative relationship was found between interpersonal dependency and social desirability scores. Although statistically significant, the correlation between the full-scale scores for the new interpersonal dependency scale (IDS-OA) and the social desirability scale (PRF) was negligible ($-.27$).

Hierarchical Multiple Regression Analysis

The aim of the study was to examine the relative unique contribution of individual variables (anxiety, depression and interpersonal dependency) in a predetermined set of variables to the prediction of mobility in older adults. Using SPSS for Windows (version 10), a hierarchical multiple regression was performed between mobility as the criterion variable and physical function, dissatisfaction with physical ability, anxiety, depression and interpersonal dependency as predictor variables. Physical function and physical ability dissatisfaction, both previously established predictors of mobility (MOS - Physical Functioning Measure), were taken as the first level of the analysis, with each of the additional variables added in separate analyses. Interpersonal dependency was the main variable of interest in the analysis. Results of evaluation of assumptions were satisfactory

after two multivariate outliers were deleted from the analysis. Nine other cases were excluded from the analysis because of missing data. A significant overall model was produced in the hierarchical multiple regression analysis (i.e., requesting the R Square Change statistic),

$F(5,90) = 21.29, p < .05$. Results are shown in Table 21.

Table 21

Results of the Hierarchical Multiple Regression Analysis
on Mobility

Variable	B	Beta	Step	R ² Change
Phys Function	.04	.36	1	
Phys Ability (Dissat)	-.04	-.31	1	.46***
Anxiety	.23	.19	2	.01
Depression	-.02	-.05	3	.03*
Interpersonal Dependency	-.03	-.28	4	.05**

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

Physical Function and Physical Ability Dissatisfaction, which were entered at the first step, contributed a

significant 46% to the variance in Mobility, $F(2,93)=38.78, p < .05$. Anxiety was entered at the second step and did not contribute significantly to the variance of Mobility, $F(3,92)=26.65, p > .05$. At the third step Depression contributed a further significant 3%, $F(4,91)=22.12, p < .05$. Interpersonal Dependency added a further significant 5% to the variance in Mobility after the other predictor variables had been controlled at the final stage, $F(5,90)=21.29, p < .05$.

Discussion

Results supported the hypothesis that scores on the new interpersonal dependency scale would correlate strongly with scores on another commonly used interpersonal dependency measure (DEQ-Dependency Factor/Dependency Sub-scale). Therefore the convergent validity of the new scale was supported. Unlike many dispositional measures that have been criticised for associating either highly positively or highly negatively with a socially desirable responding style (Jackson, 1999), the new interpersonal dependency scale corresponded only weakly with that responding style. Thus, its correspondence with other measures in this study was not likely to be due to that response style. Scores on the dependency sub-factor of the DEQ-Dependency Factor,

on the other hand, did correspond negatively with scores on the PRF-SD. Therefore, its correspondence with, for example, the GDS and with the GAQ in this study could be due to the negative social desirability responding style of respondents because each of the three scales correlated negatively with the PRF-SD. Correspondence among the DEQ-Dependency Factor, GDS and GAQ do, however, support the results of previous research that have found interpersonal dependency to be associated with scores on depression and anxiety measures (Birtchnell, 1991; Bornstein, 1992, 1993b). But the moderate correlation found between scores on the IDS-OA and the GDS is more suggestive, however, of a true link between dependency and depression given also the negligible correspondence between the IDS-OA and the PRF-SD. For the same reason, the low correlation found between the IDS-OA and the GAQ leave questions open about a possible link between dependency and general anxiety measures. But the moderate correlation found between the IDS-OA and the mobility measure appears to offer some support for the links found previously between dependency and the anxiety disorder "agoraphobia" (McCarthy & Shean, 1996) given that the mobility scale used in this study was concerned with travelling about the community

unassisted. These results further support the convergent validity of the IDS-OA.

No association was found between scores on the IDS-OA and the PF suggesting no link between physical functioning ability (for activities such as basic personal care, home-care, walking, running and climbing stairs) and interpersonal dependency (dependent personality) in this home-care population. This is a particularly important finding for two reasons. First, it supports the discriminant validity of the new interpersonal scale as a dispositional dependency measure and not one that taps reliance on others due to physical functioning disabilities. It is important to be able to discriminate between the two, particularly in populations of older people, because better information provided about the dependency needs of a person will more accurately and appropriately direct intervention decisions. Second, in light of the results in previous stages of this study that found SC clients to score higher on the IDS-OA measure than the non-home-care samples, it provides support for the reported observations of SC direct care staff (Gardner, 1999) that many SC clients did not have functional disabilities that required the support of a home-care service but they appeared to be dependent by nature.

Although it is recognised that people with long-standing functional disability might develop dependent personality traits, and that some of those people are likely to be receiving home-care services, they are not likely to have been highly represented by the sample in this study. This study sampled new SC clients with low home-care service needs, who were assessed by scores on a physical functional ability measure and were supported by scores on the PF scale here. According to direct care SC staff members (Gardner, 1999), people in that category do not typically have long-standing functional impairments. Therefore, it is unlikely that people in that category have impairments that might have led them to develop dependent personality traits. Interpersonal dependency might be one factor that has contributed to them receiving home-care service support.

Age and gender were not found to be associated with scores on any of the Medical Outcomes Study (MOS) Physical Functioning Measures (Stewart & Kamberg, 1992) (PF, Mob and PAD). Age and gender were also not found to be associated with interpersonal dependency as measured by either the IDS-OA or the DEQ-Dependency Factor/Dependency Sub-factor. These results suggest

that physical functioning, mobility, dissatisfaction with physical ability and interpersonal dependency scores do not increase as age increases past age 65 years in this population, nor do they differ according to gender. Therefore, age and gender do not appear to be factors contributing to the reception of home-care support for people 65 years of age or older. Caution, however, is again required in interpreting the results this way. A cross-sectional design was utilised in this study. Longitudinal research would be necessary to determine whether the physical functioning, mobility and interpersonal dependency scores of individuals increase as they age past 65 years and affect their receipt of home-care services.

As predicted, interpersonal dependency contributed significantly more to the variance in Mobility independent of the other variables than did both depression and anxiety. Although the amount of variance in Mobility accounted for by interpersonal dependency was comparatively small, it was more than either depression or anxiety.

If there is a relationship between depression, interpersonal dependency and mobility in older people, as suggested by this study, experimental interventions

are needed in this area to determine the factors that influence mobility. For example, it might be that older people who enjoy mobility are the people who are not anxious about autonomous functioning or who are able to achieve a balance between dependency and autonomy strivings. Or, as suggested by Emery and Leshner (1982), it might be that those who are able to achieve a balance between dependency and autonomy strivings might also be less depressed and therefore engage in more activities. If factors that influence mobility are teased out then home-care service like SC will be able to design and provide interventions that more appropriately meet the needs of its clients; particularly those clients whose service needs are low when they enter the service. Such interventions would have personal benefits for both home-care clients and home-care services. Clients could achieve a healthier balance between their dependency and autonomy strivings and thus reduce their reliance on home-care services. Home-care services could reduce their service costs by promoting and facilitating a balance between dependency and autonomy instead of supporting the physical functional dependencies of older people.

Conclusion

The overall aim of this research was to develop a reliable and valid measure that could be used by health services to screen older adults for interpersonal dependency. It was argued that the development of such a tool would assist health services in identifying levels of interpersonal dependency in older adults. This would aid them in the provision of services more attuned to the needs of individuals. Such interventions would not only facilitate a balance between the dependency and autonomy strivings of older people but would also minimise the likelihood of learned dependency exacerbating their dependency needs. An interpersonal dependency measure would also provide a means by which the effectiveness of such interventions could be evaluated.

The provision of services that are attuned to the needs of interpersonally dependent people relies upon an understanding of the effects of interpersonal dependency on the people involved and on the ways that they engage and receive health services. The development of an interpersonal dependency scale for older adults would enable more research to be undertaken that determines the

correlates of interpersonal dependency in elderly populations. This has been a neglected area of research that would have the potential to assist in developing understandings about connections between the mental and physical health of older people. Understandings in this area would assist health service providers to design services that improve the mental and physical well-being of dependent older people as well as reduce service provision costs.

The overall aim was achieved with the development of the Interpersonal Dependency Scale for Older Adults (IDS-OA). The procedures undertaken in this research found the IDS-OA to be both a reliable and valid measure of interpersonal dependency for older people. In addition, unlike most dependent personality measures that have been found to correlate highly with a socially desirable response style, a negligible correlation was found between scores on the IDS-OA and a social desirability measure. Further research must be undertaken, however, to determine the test-retest reliability of the new scale.

Answers to the two subsidiary questions posed at the beginning were found in the scale development process. The first question asked whether older people in a home-

care population were higher in their levels of interpersonal dependency than older people in non-home-care populations. The results in stages 2 and 3 indicated that for the samples in these studies, the home-care participants did score significantly higher on the new interpersonal dependency scale than people in the non-home-care populations. These results supported the construct validity of the IDS-OA and the need for the development of the scale. They also supported the observations of the SC staff (Gardner, 1999) that suggested many of their new clients were dependent by nature.

The second subsidiary question was concerned with the relationships among anxiety, depression, interpersonal dependency and physical dependency in an older home-care population. Previous research had found associations among anxiety, depression, interpersonal dependency and physical illness in younger populations but interpersonal dependency in older adults had not been the focus in other studies. The correlations among the variables of interest in this research supported the convergent and discriminant validity of the IDS-OA. Furthermore, links were found among depression, interpersonal dependency and mobility in the older home-care population. Both depression and interpersonal dependency were found to be

significant predictors of mobility. This result also supported the SC staff's observations (Gardner, 1999) and might explain the over-reliance on services by some SC clients. In addition, interpersonal dependency predicted a greater proportion of the variance in mobility than did depression.

Clearly more research is needed in the areas of interpersonal dependency and other factors that influence mobility in older adults. Health care services like SC will then be in a better position to be able to provide their clients with services that facilitate a healthy balance between their dependency and autonomy needs while at the same time reduce the service costs. The IDS-OA developed in this research will assist with this process.

REFERENCES

- Ainsworth, M.D.S. (1969). Object relationships, dependency and attachment: a theoretical review of the infant-mother relationship. *Child Development*, 40, 969-1025.
- American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders* (2nd Ed). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd Ed). Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th Ed-TR). Washington, DC: American Psychiatric Association.
- Australian Bureau of Statistics. (2001). *Population by Age and Sex, Western Australia*. Australian Bureau of Statistics, Perth, WA: Australian Bureau of Statistics Western Australian Office, 1031-8577.
- Avlund, K., Davidsen, M., & Schultz-Larsen, K. (1995). Changes in functional ability from ages 70-75. *Journal of Aging and Health*, 7, 254-282.
- Baltes, M.M. (1995). Dependency in old age: gains and losses. *Current Directions in Psychological Science*, 4, 14-19.

Baltes, M.M. (1996). *The many faces of dependency in old age*. Cambridge: Cambridge University Press.

Baltes, M.M., Burgess, R.L., & Stewart, R. (1980). Independence and dependence in self-care behaviors in nursing home residents: an operant-observational study. *International Journal of Behavioral Development*, 3, 489-500.

Baltes, M.M., Honn, S., Barton, E. M., Orzech, M.J., & Largo, D. (1983). Dependence and independence in nursing home residents: a replication and extension. *Journal of Gerontology*, 38, 556-564.

Baltes, M.M., Neuman, E-M., & Zank, S. (1994). Maintenance and rehabilitation of independence in old age: an intervention program for staff. *Psychology and Aging*, 9, 179-188.

Baltes, M.M., & Silverberg, S.B. (1994). The dynamics between dependency and autonomy: illustrations across the life-span. In D. L. Featherman, R.M. Lerner, & M. Perlmutter (Eds.), *Life-span development and behavior* (Vol. 12, pp. 41-90). Hillsdale, NJ: Lawrence Erlbaum Associates.

Baltes, M.M., & Wahl, H-W. (1992). The dependency-support script in institutions: generalization to community settings. *Psychology and Aging*, 7, 409-418.

Baltes, M.M., Wahl, H-W., & Reichert, M. (1991).

Institutions and successful aging for the elderly?

Annual Review of Gerontology and Geriatrics, 11, 311-337.

Baltes, P.B. (1989). Theoretical propositions of life-span development: the dynamics between growth and decline. *Developmental Psychology*, 23, 611-626.

Baltes, P.B., & Baltes, M.M. (1990). Psychological perspectives on successful aging: the model of selective optimization with compensation. In P.B. Baltes & M.M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 1-34). Cambridge: Cambridge University Press.

Banerjee, S., & MacDonald, A.J.D. (1996). Mental disorder in an elderly home care population: associations with health and social service use. *The British Journal of Psychiatry*, 168, 750-756.

Barton, E.M., Baltes, M.M., & Orzech, M.J. (1980). Etiology of dependence in older nursing home residents during morning care: the role of staff behavior. *Journal of Personality and Social Psychology*, 38, 423-431.

Birtchnell, J. (1988). Defining dependence. *British Journal of Medical Psychology*, 61, 255-266.

- Birtchnell, J. (1991). The measurement of dependence by questionnaire. *Journal of Personality Disorders*, 5, 281-295.
- Blatt, S.J., Quinlin, D.M., Zuroff, D.C., & Mongrain, M. (1995). Sub-scales within the dependency factor of the Depressive Experiences Questionnaire. *Journal of Personality Assessment*, 64, 319-339.
- Blatt, S.J., & Shichman, S. (1983). Two primary configurations of psychopathology. *Psychoanalysis and Contemporary Thought*, 6, 187-254.
- Blum, G.S. (1949). A study of the psychoanalytic theory of psychosexual development. *Genetic Psychology Monographs*, 39, 3-99.
- Bornstein, R.F. (1992). The dependent personality: Developmental, social and clinical perspectives. *Psychological Bulletin*, 112, 3-23.
- Bornstein, R.F. (1993a). Dependency and patienthood. *Journal of Clinical Psychology*, 49, 397-406.
- Bornstein, R.F. (1993b). *The dependent personality*. New York: The Guilford Press.
- Bornstein, R.F. (1994a). Adaptive and maladaptive aspects of dependency: an integrative review. *American Journal of Orthopsychiatry*, 64, 622-635.

- Bornstein, R.F. (1994b). Dependency in psychotherapy: effective therapeutic work with dependent patients. In L. VandeCreek, & S. Knapp (Eds.), *Innovations in clinical practice: A source book* (Vol. 13, pp. 139-150). Washington, DC: American Psychiatric Association.
- Bornstein, R.F. (1995a). Active dependency. *The Journal of Nervous and Mental Disease*, 183, 64-77.
- Bornstein, R.F. (1995b). Comorbidity of dependent personality disorder and other psychological disorders: an integrative review. *Journal of Personality Disorders*, 9, 286-303.
- Bornstein, R.F. (1995c). Interpersonal dependency and physical illness: the mediating roles of stress and social support. *Journal of Social and Clinical Psychology*, 14, 225-243.
- Bornstein, R.F. (1998a). Implicit and self-attributed dependency needs in dependent and histrionic personality disorders. *Journal of Personality Assessment*, 71, 1-14.
- Bornstein, R.F. (1998b). Implicit and self-attributed dependency strivings: differential relationships to laboratory and field measures of help-seeking. *Journal of Personality and Social Psychology*, 75, 778-787.

- Bornstein, R.F. (1998c). Interpersonal dependency and physical illness: a meta-analytic review of retrospective and prospective studies. *Journal of Research in Personality*, 32, 480-497.
- Bornstein, R.F. (1999a). Criterion validity of objective and projective dependency tests: a meta-analytic assessment of behavioral prediction. *Psychological Assessment*, 11, 48-57.
- Bornstein, R.F. (1999b). Dependent and histrionic personality disorders. In T. Millon, P.H. Blaney, & R. D. Davis (Eds.), *Oxford textbook of psychopathology* (pp. 534-555). New York: Oxford.
- Bornstein, R.F. (2000). From oral fixations to object relations: changing perspectives on the psychodynamics of interpersonal dependency an illness. In P.R. Duberstein, & J. M. Masling (Eds.), *Psychodynamic perspectives on sickness and health* (pp. 3-37). American Psychological Association: Washington, DC.
- Bornstein, R.F., & Bowan, R.F. (1995). Dependency in psychotherapy: toward an integrated treatment approach. *Psychotherapy*, 32, 520-534.
- Bornstein, R.F., Bowers, K.S., & Bonner, S. (1996). Relationships of objective and projective dependency scores to sex role orientation in college students. *Journal of Personality Assessment*, 66, 555-568.

- Bornstein, R.F., & Johnson, J.G. (1990). Dependency and psychopathology in a nonclinical sample. *Journal of Social Behaviour and Personality*, 5, 417-422.
- Bornstein, R.F., Krukonis, A.B., Manning, K.A., Mastrosimone, C.C., & Rossner, S.C. (1993). Interpersonal dependency and health service utilization in college student sample. *Journal of Social and Clinical Psychology*, 12, 262-279.
- Bornstein, R.F., Riggs, J.M., Hill, E.L., & Calabrese, C. (1996). Activity, passivity, self-denigration, and self-promotion: toward and interactionist model of interpersonal dependency. *Journal of Personality*, 64, 639-673.
- Bornstein, R.F., Rossner, S.C., & Hill, E.L. (1994). Retest reliability of scores on objective measures of dependency: relationship to life events and interest level. *Journal of Personality Assessment*, 62, 398-415.
- Bowsher, J.E. (1994). A theoretical model of independence for nursing home elders. *Scholarly Inquiry for Nursing Practice*, 8, 207-228.
- Bruce, M.L. (2000). Depression and disability. In G.M. Williamson, D.R. Shaffer, & P.A. Parmelee (Eds.), *Physical illness and depression in older adults: A handbook of theory, research, and practice* (pp.11-28). New York: Kluwer Academic/Plenum Publishers.

- Casey, J.E., & Joyce, P.R. (1999). Personality disorder and the temperament and character inventory in the elderly. *Acta Psychiatrica Scandinavica*, 100, 302-308.
- Dant, T. (1988). Dependency and old age: theoretical accounts and practical understandings. *Aging and Society*, 8, 171-188.
- Davila, J., & Beck, G. (2002). Is social anxiety associated with impairment in close relationships? A preliminary investigation. *Behavior Therapy*, 33, 427-446.
- Dougherty, L.M. (2000). Determining personality disorders in older adults through self-identification and clinical assessment. In V. Molinari (Ed.), *Professional psychology in long-term care: A comprehensive guide* (pp. 119-133). NY: Hatherleigh Press.
- Emery, G., & Leshner, E. (1982). Treatment of depression in older adults: personality considerations. *Psychotherapy*, 19, 500-505.
- Gallagher, D., Thompson, L.W., & Levy, S. M. (1980). Clinical psychological assessment of older adults. In L.W. Poon (Ed.), *Aging in the 1980s* (pp. 19-40). New York: American Psychological Association.
- Gardner, D. (1999). *Home independence project: Report on the identification of target groups*. Silver Chain WA: Unpublished Paper.

- Gibson, D.M. (1985). The doormouse syndrome-restructuring the dependency of the elderly. *Australian and New Zealand Journal of Sociology*, 21, 44-63.
- Goldberg, D., Bridges, K., Duncan-Jones, P., & Grayson, D. (1988). Detecting anxiety and depression in general medical settings. *British Medical Journal*, 297, 897-899.
- Grainger, K. (1993). "That's a lovely bath dear": reality construction in the discourse of elderly care. *Journal of Aging Studies*, 7, 247-262.
- Grainger, K., Atkinson, K., & Coupland, N. (1996). Responding to the elderly: Troubles-talk in the caring context. In H. Giles, N. Coupland, & J.M. Weimann (Eds.), *Communication, health and the elderly* (pp. 192-212). London: Manchester University Press (in association with the Fulbright Commission).
- Greenberg, R.P., & Bornstein, R.F. (1988a). The dependent personality, I: risk for physical disorders. *Journal of Personality Disorders*, 2, 126-135.
- Greenberg, R.P., & Bornstein, R.F. (1988b). The dependent personality, II: risk for psychological disorders. *Journal of Personality Disorders*, 2, 136-143.
- Greenberg, R.P., & Fisher, S. (1977). The relationship between willingness to adopt the sick role and attitudes towards women. *Journal of Chronic Diseases*, 30, 29-37.

- Guralnick, J.M., & Simonsick, E.M. (1993). Physical disability in older Americans. *Journal of Gerontology*, 48, (Special Issue), 3-10.
- Helmstadter, G.C. (1957). Procedures for obtaining separate set and content components of a test score. *Psychometrika*, 22, 381-393.
- Hendricks, J., & Leedham, C.A. (1989). Creating psychological and societal dependency in old age. In P.S. Fry (Ed.), *Psychological Perspectives of Helplessness and Control in the Elderly*. B.V. North Holland: Elsevier Science Publishers.
- Hirschfeld, R.M., Shea, M.T., & Weise, R. (1991). Dependent personality disorder. *Journal of Personality Disorders*, 5, 135-149.
- Hirschfeld, R.M.A., Klerman, G.L., Chodoff, S., Korchin, S., & Barret, J. (1976). Dependency, self-esteem, and clinical depression. *Journal of the American Academy of Psychoanalysis*, 4, 373-388.
- Hirschfeld, R.M.A., Klerman, G.L., Gough, H.G., Barrett, J., Korchin, S.J., & Chodoff, P. (1977). A measure of interpersonal dependency. *Journal of personality assessment*, 41, 610-618.
- Holden, R.R., Longman, R.S., Cota, A.A., & Fekken, G.C. (1989). PAR: Parallel Analysis Routine for random data eigenvalue estimation. *Applied Psychological Measurement*, 13, 192.

Jackson, D.N. (1970). A sequential system for personality scale development. In C.D. Spielberger (Ed.), *Current Topics in Clinical and Community Psychology* (Vol. 2, pp. 61-96). New York: Academic Press.

Jackson, D.N. (1999). *Personality research form manual*. (3rd Ed.). Port Huron, MI: Sigma Assessments Systems, Inc.

Johnson, M. (1990). Dependency and interdependency. In J. Bond, & P. Coleman (Eds.), *Ageing in Society: An Introduction to Social Gerontology* (Chp. 10, pp. 209-228). London: Sage Publications.

Kempen, G. I. J. M. & Stuurmeyer, T.P.B.M. (1991). Professional home care for the elderly: an application of the Anderson-Newman model in the Netherlands. *Social Science in Medicine*, 33, 1081-1089.

Lewin, G. (1999). *Home independence: A paradigm shift for home care services*. Silver Chain, WA: Unpublished paper.

Livesley, W.J., Jang, K.L., & Vernon, P.A. (1998). Phenotypic and genetic structure traits delineating personality disorder. *Archives of General Psychiatry*, 55, 941-948.

Livesley, W.J., Schroeder, M.L., & Jackson, D.N. (1990). Dependent personality disorder and attachment problems. *Journal of Personality Disorders*, 4, 131-140.

- Longman, R.S., Cota, A.A., Holden, R.R., & Fekken, G.C. (1989). A regression equation for the parallel analysis criterion in principal components analysis: mean and 95th percentile eigenvalues. *Multivariate Behavioral Research, 24*, 59-69.
- Maccoby, E.E. (1980). *Social development*. New York: Harcourt-Brace.
- Masling, J.M., Rabie, L., & Blondheim, S.H. (1967). Obesity, level of aspiration, and Rorschach and TAT measures of oral dependence. *Journal of Consulting Psychology, 31*, 233-239.
- Masling, J.M., O'Neill, R.M., & Katkin, E.S. (1982). Autonomic arousal, interpersonal climate and orality. *Journal of Personality and Social Psychology, 42*, 529-534.
- Mazure, C.M., Bruce, M.L., Maciejewski, P.K., & Jacobs, S.C. (2000). Adverse life events and cognitive-personality characteristics in the prediction of major depression and antidepressant response. *American Journal of Psychiatry, 157*, 896-903.
- McCarthy, L., & Shean, G. (1996). Agoraphobia and interpersonal relationships. *Journal of Anxiety Disorders, 10*, 477-487.
- McDowell, I., & Newell, C. (1996). *Measuring Health: A Guide to Rating Scales and Questionnaires* (2nd Ed.). New York: Oxford University Press.

- Miller, A. (1984). Nurse/patient dependency: A review of different approaches with particular reference to studies of the dependency of elderly patients. *Journal of Advanced Nursing*, 9, 479-486.
- Miller, A. (1985). Nurse/patient dependency- is it iatrogenic? *Journal of Advanced Nursing*, 10, 63-69.
- Mischel, W., & Shoda, Y. (1995). A cognitive-affective system theory of personality: reconceptualising situations, dispositions, dynamics and invariance in personality structure. *Psychological Review*, 102, 246-268.
- Moane, G. (1993). Dependency and caring needs among the elderly. *The Irish Journal of Psychology*, 14, 189-203.
- Morgan, D.L. (1988). Focus groups as qualitative research. *Qualitative Research Methods Series* 16. Newbury Park: Sage Publications.
- Murray, H.A. (1938). *Explorations in personality*. New York: Oxford University Press.
- Oldman, C., & Quilgars, D. (1999). The last resort? Revisiting ideas about older people's living arrangements. *Ageing and Society*, 19, 363-384.
- O'Neill, R.M., & Bornstein, R.F. (2001). The dependent patient in a psychiatric inpatient setting: Relationship of interpersonal dependency to consultation and medication frequencies. *Journal of Clinical Psychology*, 57, 289-298.

- Overholser, J.C. (1989). Accurate diagnosis of personality disorders: some critical factors. *Journal of Contemporary Psychotherapy*, 19, 5-23.
- Overholser, J.C. (1996). The dependent personality and interpersonal problems. *The Journal of Nervous and Mental Disease*, 184, 8-16.
- Overholser, J.C., & Fine, M.A. (1994). Cognitive-behavioral treatment of excessive interpersonal dependency. *Journal of Cognitive Psychotherapy*, 8, 55-70.
- Parker, G., & Lipscombe, P. (1980). The relevance of early parental experiences to adult dependency, hypochondriasis and utilisation of primary physicians. *British Journal of Medical Psychology*, 101, 470-486.
- Peterson, C. (1993). Helpless behavior. *Behaviour Research and Theory*, 31, 289-295.
- Peterson, C., Maier, S.F., & Seligman, M.E.P. (1993). *Learned Helplessness: A Theory for the Age of Personal Control*. New York: Oxford University Press.
- Pincus, A.L., & Gurtman, M.B. (1995). The three faces of interpersonal dependency: structural analyses of self-report dependency measures. *Journal of Personality and Social Psychology*, 69, 744-758.

- Rosowsky, E. (2000). Interventions for older adults with personality disorders. In V. Molinari (Ed.), *Professional psychology in long-term care: A comprehensive guide* (pp. 161-171). NY: Hatherleigh Press.
- Rosowsky, E., & Dougherty, L.M. (1998). Personality disorders and clinician responses. *Clinical Gerontologist*, 18, 31-42.
- Rosowsky, E., Dougherty, L.M., Johnson, C.J., & Gurian, B. (1997). Personality as an indicator of "goodness of fit" between the elderly individual and the health service system. *Clinical Gerontologist*, 17, 41-53.
- Schwartz, A. N. (1979). Psychological dependency: An emphasis on the later years. In P.K. Ragan (Ed.), *Aging parents* (pp. 116-125). California: University of Southern California Press.
- Segal, D.L., Hersen, M., Van Hasselt, V.B., Silberman, M.S., & Roth, L. (1996). Diagnosis and assessment of personality disorders in older adults: a critical review. *Journal of Personality Disorders*, 10, 384-399.
- Sinha, J.B.P. (1968). A test of dependence proneness. *Journal of Psychological Research*, 16, 66-70.
- Small, G. (1997). Recognising and treating anxiety in the elderly. *Journal of Clinical Psychology*, 38, 381-389.

- Stewart, A.L., & Kamberg, C.J. (1992). Physical functioning measures. In A.L. Stewart, J.E. Ware Jr. (Eds.). *Measuring functioning and well-being: The Medical Outcomes Study approach*. Durham, North Carolina: Duke University Press.
- Stewart, D.W., & Shamdasani, P.N. (1990). Focus groups: theory and practice. *Applied Social Research Methods Series, 20*. Newbury Park: Sage Publications.
- Stone, S.D. (2003). Disability, dependence, and old age; Problematic constructions. *Canadian Journal on Aging, 22*, 59-67.
- Stout, W. (2002). Psychometrics: From practice to theory and back. *Psychometrika, 67*, 485-518.
- Stout, W., Froelich, A.G., & Gao, F. (2001). Using resampling to produce an improved DIMTEST procedure. In A. Boomsma, M.A.J. vanDuijn, T.A.B. Snijders (Eds.), *Essays on item response theory* (pp. 357-376). New York: Springer-Verlag.
- Streiner, D.L., & Norman, G.R. (1996). *Health measurement scales: A practical guide to their development and use* (2nd Ed). Oxford: Oxford University Press.
- Tabachnick, B.G., & Fidell, L.S. (1996). *Using multivariate statistics* (3rd Ed). California: Harper Collins College Publishers.

- Townsend, P. (1981). The structured dependency of the elderly: a creation of social policy in the twentieth century. *Aging and Society*, 1, 5-28.
- Wahl, H-W. (1991). Dependence in the elderly from an interactional point of view: verbal and observational data. *Psychology and Aging*, 6, 238-246.
- Wan, T.T.H., Odell, B.G., & Lewis, D.T. (1982). *Promoting the well-being of the elderly: A community diagnosis*. New York: Haworth Press.
- Whiffen, V.E., Aube, J.A., Thompson, J.M., & Campbell, T.L. (2000). Attachment beliefs and interpersonal contexts associated with dependency and self-criticism. *Journal of Social and Clinical Psychology*, 19, 184-205.
- Yesavage, J.A., Brink, T.L., Rose, T.L. & Aday, M. (1983). Development and validation of a geriatric depression screening scale: a preliminary report. *Journal of Psychiatry Research*, 17, 37-49.
- Zuroff, D.C., Stotland, S., Sweetman, E., Craig, J.A., & Koestner, R. (1995). Dependency, self-criticism and social interactions. *British Journal of Clinical Psychology*, 34, 543-553.

Appendix A

1. Information and disclosure form used in stage 1 (chapter 3).
2. Consent form used in stage 1 (chapter 3.)
3. Focus group transcripts – stage 1.

Information and Disclosure Form

Project Title: *Individual Differences in Dependent Personality in Older Adults: Development of a measure and its Evaluation in Health Care Services.*

This research project is being conducted to satisfy part-requirement for a Doctor of Philosophy, Psychology degree at Edith Cowan University, Joondalup, WA. The project aims to develop, with the assistance of older adults, a questionnaire for the purpose of measuring dependent personality in older people.

You can help with this project by taking part in a small group discussion and, at a later date, completing a questionnaire. The questionnaire will have been developed using both the information you provided during the discussion and previously published information about dependent personality. Our purpose for asking you to complete the questionnaire is to provide us with feedback about its instructions, content and response format.

A research group consisting of the research student and the research student's supervisors will be involved in this project and will have access to the information that you provide.

The discussion will be tape-recorded but the recording will be erased as soon as the information on it has been transcribed.

All information given in the discussions and questionnaire is strictly confidential. We appreciate your assistance but you are under no obligation to participate in the group discussion or to complete the questionnaire. You may also withdraw from the study at any time.

The results from this research will be published but there will be no way that you will be able to be identified in the publication. Your name will not be required during the discussions or on the questionnaire.

The questionnaire consists of questions and statements to do with various aspects of dependency. It is hoped that the results will increase knowledge and understanding of the dependency needs of older people. The researcher will provide you with detailed instructions for answering each set of questions and will assist you with any queries you might have. The questionnaire will require 20-30 minutes to complete.

Should you have any queries or concerns in the future about the study, please contact Deborah Gardner on [REDACTED] or Dr Craig Speelman, School of Psychology, Edith Cowan University on 9400 5724.

Thank you for your time and participation.

Deborah Gardner
School of Psychology Ph.D. Student
Edith Cowan University

Craig Speelman Ph.D.
School of Psychology
Edith Cowan University

CONSENT FORM Project Title: *Individual Differences in Dependent Personality in Older Adults: Development of a Measure and its Evaluation in Health Care Services*

Should you wish to participate in this project, please sign below to indicate your consent.

- I _____ freely agree to participate in this study realising that I may withdraw at any time. I have read and received a copy of the "Information and Disclosure Form" and any questions I have asked have been answered to my satisfaction. I have no objections to the results of the study being published in a report so long as I cannot be identified in these results.

ParticipantDate.....

Researcher.....Date.....

Focus Group 1: Transcript

September 17th 2001

[Following introductions, providing information about the research and obtaining informed consent]

Researcher: OK the first question that I have, um, here for you is: What characteristics would a person with a dependent personality have? We're talking about people who are dependent by nature not people who are dependent because they necessarily have a disability. We're thinking of dependent people rather than independent people. What sorts of characteristics do you think they would have?

Participant 1: You mean people that, er, they've got to have somebody to do something for them all the time. You mean that sort of thing?

Researcher: Yes, that could be.....

Participant 1: They're very selfish. They just think of themselves all the time. I've got a friend like that. Her husband does everything for her. Her family's done everything for her when she was a child now she's just so selfish. So I said to her one day, "A poor old Italian lady - she can't water her garden I said, because there's no water and that's her life," She said, "So what? I lost my John she said, and I depended on him," and she's just grizzling away all the time you know. She won't mix with anybody or do anything. She just thinks about herself.

Researcher: mmm

Participant 1: She's always been like this. Her brother-in-law said she's been spoilt from a child. She's had everything done for her so therefore she's always wanting

everyone to do things for her. She says to me, "Why don't you come 'round more often?" I said, "Well my legs are bad. There's nothing wrong with your legs". She says, Well I 've got an angina. Well so have I so what's the matter? I still make myself go out.

Researcher: So this is what you think is the difference between having a disability and being independent or having a disability and having a dependent personality? You have the same physical disability but you see things differently? You still want to do things?

Participant 1: Even when she didn't have that angina she's always been that way. She's always been, self, self, self. She's definitely selfish.

Researcher: Oh. So you see this as a pattern of behaviour that has nothing to do with her physical health?

Participant 1: Yes I do. Yes she's been like that right from when she was a child. She's always been self, self, self.

Participant 2: I think that's bad. I've always been independent.

Participant 1: So have I. And I make myself do things myself.

Participant 3: And you've got an angina.

Participant 4: I think I should, um, be more independent. My son likes to, er, do some things for me. I think it makes him feel, you know, important.

Researcher: That's something that...

Participant 4: But I'm pretty independent, er, like to be independent.

Participant 1: If you take a person's independence away...

Researcher: Mmm

Participant 1: the person goes down. They've got no interest in life (pause)...

Researcher: No

Participant 1: Once you take their independence away, that's it. They just go down.

Researcher: You think that if we do things for older people that they could do for themselves their physical ability might decline further?

Participant 1: Yes I do.

Participant 3: Yes.

Participant 1: You see it all the time.

Participant 5: You often say to people when they retire... I know I've said it to plenty of people that I know of who've retired, "Have you got a hobby?" " Oh, I can't do this, I can't do that." "You'll have to do something." "You'll just die because you just do nothing."

Researcher: So you think that having a dependent sort of personality does make people "go down" you say?

Participant 1: Oh yes. If you take a person's independence away they lose interest in things and they think, "Oh well I can't do that, I've got to get someone to do it," so they just don't care.

Researcher: Oh

Participant 1: And then they just go down. They drop down. Like nothing's important now.

Researcher: Mmm

Participant 1: That's what I say. They lose interest in life. There's nothing for them. It's best to try and be a bit independent.

Researcher: What about the people who seem to choose to be dependent. You mentioned you can't take someone's independence away or else they'll go down. What about the one who chooses, wants to be dependent? Do they go down too?

Participant 1: Oh, I seem to think they do because they just seem to sit around and whinge and go on. They just don't want to have an interest in anything around.

Researcher: Mmm

Participant 3: They won't go out with other people. They won't help other people. You know. I mean...

Participant 1: It's just self all the time.

Participant 3: Self.

Researcher: So you see dependent people as selfish?

Participant 1: Yes, very selfish. They can NOT think of anybody else, you know, or be concerned about anybody else. They just sit around and loaf.

Participant 3: It's just their way of life, that's all. And they suffer for it. Other people won't suffer for them.

Participant 1: Amy says she's lonely but no-one wants to go and see her because she just grizzles all the time. Just won't go out of the house. Won't mix with, they don't want to socialise or anything.

Researcher: Why do...

Participant 4: I'd rather be the exact opposite. I'm very independent. I've got to be really handicapped not to do anything.

Participant 1: Yes, that's right.

Participant 4: I feel it's my own home and, er, I do what's necessary.

Participant 2: Mmm. That's how I feel too.

Participant 1: Yes.

Participant 4: Oh, I, um, know I've got help if I need it. I know help is there if I need it but I won't get it unless, unless I have to because I think the people that are helping you, well they've got other people to do... People that really need help. Why should I use them up?

Researcher: Would you like to be able to call on people more often to help you? Or are you happy with things the way they are?

Participant 4: I like to battle myself. Struggle and do things myself.

Participant 2: The only thing I ask...

Participant 1: But everyone's different.

Participant 2: The only thing I ask for is I get my son to pick out my colours.

Participant 1: Yes. But that's understandable (participant 2 has a sight impairment)

Participant 2: Cause this morning too I was very busy and by the time I got up at seven and I was messing about and a friend of mine rang me up and he said to me it's quarter to nine. And I said, "Oh! Goodbye!" (laughs) and raced around and, er, had a pommy wash and er got dressed.

Researcher: (laughs) Right. Um, you said that your son picks out your colours?

Participant 2: No, if I've got the wrong colour. I pick them. But I just like to get checked as I'm going out. They're nearly always right.

Researcher: OK. So you do pick them yourself but then you check.

Participant 2: Yes.

Researcher: Does it bother you that you have to check?

Participant 2: No normally it doesn't, but I was in such a rush this morning. Seeing as how I was going to be late and I don't like keeping the bus late.

Researcher: Yes, there are times when getting help is necessary.

Participant 2: Yes, but they tell me I still am very independent. I don't know. I say I'll take your word for it.

Researcher: Do you feel as though you're independent?

Participant 2: Yes.

Participant 1: The only thing I'd like personally is to know is when I'm dressing if I look alright. But there's no-one there to ask. You know?

Researcher: Yes.

Participant 1: That's the only thing I notice.
Other than...

Researcher: You've probably wanted to
know that all your life.

Participant 1: Yes, you look in the mirror
and if your hair's not right or something's
not right you just don't feel right. You
know? But other than that you'd like to do
for yourself.

Participant 2: Yes, I ask my son if I look
alright and I never have to change anything.
And it's only been the last 12 months that
he's been there.

Researcher: OK. Do you um think that for a
dependent older person the characteristics
are the same as they are for a dependent
younger person?

Participant 1: You mean do you look after
them more than you would somebody who
was young?

Researcher: A young dependent person.
Would they have the same characteristics as
an older dependent person? Or does
something change as the dependent person
gets older?

Participant 1: Well you'd definitely change, I
would think, as you get older.

Participant 2: You get more assured of
yourself as you get older. Not with going
about difficult things but just in your own
right.

Researcher: You become more self-assured?
What about the person who was dependent,
when they were young? Do they also

become more self-assured as they become older?

Participant 2: I don't know about the young ones.

Participant 4: A dependent young person would be the last person I'd associate with.

Participant 3: I helped my daughter with four children you know. She'd say, "Mum I'm not a child, I'm grown up." You think you're helping because she's a midwife you know, and she works shifts. But sometimes you feel you shouldn't even be offering. You know.

Researcher: Mmm

Participant 4:..... because she's so independent. And yet she's really tired looking. "Oh You forget that I'm older. I've got a mind of my own now." I don't want to interfere, but she's...I just go and hang some washing out and do something.

Participant 2: I have a 15 month old great grandson and my daughter's having her house all carpeted to I went 'round and I nursed him and I carried him around and then I started to feed him so he looked at me and took the spoon off me and he fed himself cause I thought he was fed and we got on marvelously. And like my daughter said, they finished their work much sooner because I was there to watch him. And he was a venturesome little soul. You can't let him go.

Participant 3: Well, he's independent.

Participant 2: Oh yes. He's going to be.

Participant 3: He'll be no trouble by the sound of him.

Participant 2: I think his family though, are all independent.

Researcher: Do you think that maybe...It sounds like what you are saying to me is that independent people like to be able to give to others - that they like to be depended upon sometimes.

Participant 2: Oh yes. Nothing gives you more heart than to know that you have helped somebody. I like to help people. I like to be depended upon. I don't like to be dependent myself. And I'm not dependent. Though I can't see very well, I can see enough to get around.

Researcher: (looking at Participant 1) Does the dependent lady with the angina like to do things for other people?

Participant 1: She doesn't like to do anything for anybody else. She wants to do for herself and not do a thing for anyone else.

Researcher: So it's not a two-way thing?

Participant 1: No. No. She says, "I don't care about anybody. I care for myself. Me myself and I", she says.

Researcher: Oh. OK

Participant 1: But she wants everybody else to come 'round and do for her or something. But she doesn't.

Researcher: So dependent people are selfish and they want other people to be helping them to do things for them that they could be doing for themselves?

Participant 1: Yeah. They want other people to do things but they won't do nothing for other people, I find.

Participant 3: They use everybody else wherever they can.

Participant 1: Yes.

Researcher: Are they happy doing that, do you think?

Participant 1: No. I don't think so. I think they're miserable. They're miserable all the time.

Researcher: What do you think they are thinking about themselves?

Participant 1: Her husband used to dote on her all the time and she says she misses him and she can't do it herself.

Researcher: She can't do it?

Participant 1: She seems... She thinks she can't do things.

Researcher: Do you think that that is a characteristic of dependent people? They don't think they can do things?

Participant 1: Yes. She won't try. She wants everybody else to.

Researcher: Why then do you think that people behave like this? Why do some people who are not disabled in any way and are not lonely still depend on others to do so much?

Participant 1: Because they're like spoiled children.

Participant 4: I guess because all their lives they've depended on someone.

Participant 1: Yes, Amy's been like it since a child.

Participant 4: They've never had to deal with that sort of thing.

Researcher: Yes

Participant 4: My grandchildren and my great grandchildren are all the same. I mean they're all very independent because that's what they've been taught by everyone.

Participant 2: All my children and one grandson - they're all teachers so they're pretty good at telling you what to do. I don't always listen to what they say (laughs).

Researcher: (laughs) You listen but don't always take any notice. So do you think it comes from parents' expectations of children.

Participant 1: Yes. I think it starts when you are young I think.

Participant 2: My mother worked most of my young life so I had to do things myself. No-one was there to do them for me. I surprised visitors from Sydney once when I put the supper on. When they found out that I did all the cooking they were amazed. But, oh, to me it was just normal. I used to cook the dinner, do the washing and do everything. Not always the washing, sometimes she did that if she was alright.

Participant 2: Well my little granddaughter came in the other day and she said, "Well Gran, are you going to be my slave for the day or am I going to be your slave?" (laughs) She's 10 and she's on to me about coffees. She says I drink too much coffee. And at about 10 o'clock she said, "Would you like a cup of caffeine Gran?" I said, "Yes thanks." She puts to coffee in front of me and every time I went to pick it up she took it away. (laughs) She's trying to take me off coffee. And she's only 10. But the

way she said, "Will you be my slave for the day or will I be yours". You know, it's how they sort of start from when they're young I think.

Researcher: Do you agree that people learn dependency when they are young?

Participant 3: Yes, if everyone takes over and won't let them do anything or try anything they learn they can't do anything.

Participant 2: The way it works in my house is if you need help you get it. If you're not in need of help then you do it yourself.

Tape inaudible. Asian woman (participant 5) with respiratory illness (demonstrated by coughing and wheezing), "broken" English and speaking in a whisper contributed her experience of dependency associated with diagnosed depression. She said she was never dependent on anyone until she became depressed. While depressed she relied on her daughter to do many things for her, such as cooking, cleaning and shopping but when her depression is in remission she does all these things for herself. She accepts her daughter's help when she is depressed and does not feel guilty.

Participant 1: I have days when I don't feel too cheerful but you couldn't call it depression really because it doesn't last very long. You worry about things and then you think, "Well why did I worry?" 'cause it turned out alright.

Researcher: Yeah. That's usually the case.

Participant 1: Yeah.

Participant 2: My daughter had a baby. Her youngest was 13. She came tearing into me one day. I'm making an apple pie and I can hear these footsteps coming up. (gasp)

'cause the doctor couldn't find out what was wrong with her. I just stood there and I said, "Well?". She said, "I'm pregnant!!" I said, "Oh! Is THAT all?"

Researcher: Laughs

Participant 2: And she said she was running the school canteen and all and I said, "Never mind. I'll take the baby." But at three weeks old they all went to the show and left me with the baby. And from then on ... Mind you now we have a special bond between the two of us...

Researcher: Yes, yes

Participant 2:...because he stayed with me every day until he went to school. And then he absolutely adored my husband. They were great mates. And even now... An instance of it was, I turned 88 a couple of months ago and er all the talkative ones were there. So I thought, "Oh well, I'll sit in the middle. I'll be able to talk to everyone then. But no. I was sat down this end of the table. I was a bit annoyed about it 'cause I was sitting next to this grandson of mine's, er, wife and she never opens her mouth. She never talks at all. And so I sat there.

Anyway, whether my daughter realised it or not - I don't know, but she said to me the next day, "Oh I put you down the end of the table because Jason said, "Put Nanna near me. I don't see half enough of her." So I forgave them all. (Laughs)

Researcher: Laughs. That's a really nice story". (Pause). What do you think it is that older dependent people believe they need?

Participant 3: Independence.

Researcher: You think they believe they need to be independent?

Participant 3: Yes. Why not?

Participant 1: Yes. As long and you can be.

Researcher: Are you thinking about people who have a disability or people who are dependent by nature?

Participant 1: Oh, the ones who can do things but won't?

Participant 3: They need to wake up to themselves.

Participant 1: They want everything. My friend says if you want something done ask a busy person. She's only 74 and I'm nearly 80 and she's asking me to do things (group laughs). And I think to myself. Her husband's home mopping the floor, her husband's put the washing on the line, her husband's doing something else...the ironing. What does she do? She comes and has coffee with me. Nick said, "Why don't you go to Lorna's and have a coffee? She said, "I think he wants to get rid of me." She talks all the time non-stop so he wanted to have a sleep I think

Participant 2: I don't know how they can do it. I...

Participant 1: I think, "What does she do with her life?"

Researcher: What do you think dependent people think about themselves?

Participant 1: They just think, "Oh, I can't do it". They think, "You're stronger than me or you can do it but I can't".

Researcher: Oh. OK

Participant 1: My friend says, "I can't do what you do. How do you do what you do?"

She says, "I often see L doing things and I wonder, how does she do it all?" I say, "I just make myself do it." She says, "Oh, I couldn't. I just don't feel I could."

Participant 3: Lazy. I think they want to wake up to themselves.

Participant 1: She doesn't want to do things I don't think.

Researcher: So she thinks you're stronger and more able than she is?

Participant 1: Yes. So does this other lady I was talking about. She says, "You are stronger and better at things than me or something." But she's four years older than me and she said that perhaps that is what makes the difference. I said, " Oh, I don't know. I think it's just a matter of whether you want to do it or not."

Researcher: What sort of situations do dependent people find themselves in that they feel they need help with?

Participant 4: I think that their upbringing - their early years must have a lot to do with it.

Researcher: But what kinds of things do older dependent people think they need help with?

Participant 1: Well, they're always wanting to know what other people are doing so that they know who they can use. They'll be looking out the window watching what everyone else is doing.

Researcher: Are there certain tasks they seek help for?

Participant 1: Just anything really.

Researcher: Do you find yourselves that there are particular things that you have difficulty doing that you have to rely on others to help you with?

Participant 2: Sometimes you ask them to do something so they feel better. Young ones like to feel better.

Participant 3: I find that if there's a light blown or something. I've got to get someone to do that.

Researcher: Right. So there's the lights...

Participant 3: Gardening. Pruning in the garden. There's things like that when you need some help. I do.

Researcher: Uh huh.

Participant 1: I can't take my curtains down.

Participant 2: Filling out forms. I think we all need help at times.

Researcher: Yes.

Participant 1: The young bloke next door said, "Sing out if you need any help at any time", but it would only be a light globe or something 'cause I'd do it myself otherwise. You know.

Participant 4: You've got to try to do things.

Participant 3: Yes. But I can't get up on a ladder, you know, but I'd do anything else. With the top of the wardrobe I just hook everything out with my walking stick and then just push it all back and hope for the best, you know.

Researcher: What would a dependent person do in that situation?

Participant 3: They'd probably just leave it there.

Participant 1: Yeah

Participant 3: Or get someone else to do it. That's what they're doing all the time.

Participant 1: That's what this lady said, "If you want something done, ask a busy person. She'll come and do it". All they have to do is work out who is a busy person.

Researcher: If you went to a dependent person's house, what do you think they'd be asking you to do?

Participant 3: Anything.

Researcher: Anything.

Participant 1: Anything. Take them somewhere.

Researcher: Things they could do for themselves?

Participant 1: Yes. Anything that you'd think they could do for themselves.

Participant 3: They're just useless. That's all.

Participant 1: They say they can't but they don't try. If they don't try then they can't get anywhere.

Participant 3: No. They don't try.

Researcher: People will usually get something out of behaving in certain ways. What do you think dependent people get out of being dependent? What's good about being dependent?

Participant 3: I think they think they're better than the rest of us.

Researcher: You think they think they're better than us?

Participant 1: I think they do.

Participant 3: They might do. They mightn't want to get their hands dirty or something like that, you know. They're just selfish that's all. It's the same thing. They're just selfish.

Researcher: What do you think is bad about being dependent?

Participant 4: I think it'd be boring.

Participant 1: Oh yes. No interest in life.

Participant 3: There is nothing good about it I don't think. I mean if you need help, really need help then that's alright. That's different, but if you drop your bundle and then expect somebody else to come along and pick it up all the time that's not funny.

Participant 1: Mmmm. No interest in life.

Participant 3: No way.

Researcher: So then if there's nothing good about being dependent then why do you think dependent people continue to behave that way?

Participant 2: I think it is their make up. And I suppose too, see I was brought up as I said to you, to do things and all when I was very young. You get that way that you can do things without even thinking. But some people aren't brought up to do that. I have always just known automatically what to do without thinking.

Participant 3: I reckon it starts at home. It starts in your young years. It depends on how you are brought up.

Participant 4: Some people had parents dote on them too much and just do everything for them. They don't learn. So it could be the parent's fault.

Participant 3: They've just brought them up wrong and they're just stuck with it. It's too bad.

Participant 1: My mother always said, "When you get married and have a child and they want to do something then let them do it. Even if you can do it better yourself. Just do it again when they're not looking or else they'll never do it again." And it's quite true. If they see you straighten it up then that will upset the child and they'll learn that they're not good at things. And that's not good.

Participant 2: My family are all teachers and they say to me, "Come on, you can do it".

Researcher: So it continues right throughout life. It starts with your parents encouraging you to do things for yourself or not and you either learning that you can or can't. Then other people you come into contact with either encouraging you or not.

Participant 2: Yes. Right throughout life. But it's harder to learn to be independent if you didn't learn as a child.

Participant 1: Yes. It goes right through life.

Researcher: OK. We're going to have to leave it there because it's your lunch-time. Thank-you all very much for your help. You've been wonderful.

Focus Group 2: Transcript

September, 18th 2001

Researcher: The first question that I've got for you today is: What characteristics would a person with a dependent personality have, do you think? And this is opposed to somebody with a dependency that's caused by physical or mental illness. So somebody who's dependent by nature – has a dependent personality. What do you think they would be like?

Participant 1: Well I think he's got a ...Most people who've got a dependent personality - they got a problem. And I reckon that problem is dominance.

Researcher: Alright.

Participant 1: They want to, they want to dominate the person that's in their presence.

Researcher: Uh Huh.

Participant 1: When you think about it, they want to dominate them and run them.

Researcher: Ok.

Participant 1: You'll find, you'll find I'm not far wrong.

Researcher: Mmm Mmm (pause) So you feel as though they're controlling?

Participant 1: That's right, yes, yes . They're controlling - yes they are. They are. Make no mistake about that.

Researcher: Mmm Mmm What is it that you think they are trying to control? What are they doing?

Participant 1: They want their own way.

Participant 2: Their life I suppose, you know. Everything in your life.

Participant 3: Attention. Doing...

Participant 1: Attention is the word...

Participant 3: Attention

Participant 1: Attention, yes.

Researcher: Attention?

Participant 1 Yes

Researcher: Alright. OK. So what do they do to get this attention?

Participant 1: Dominate you.

Researcher: How do they do that?

Participant 1: "Get me that. Give me that. Give me that. Give me that. Give me that. I want that. I need that. I can't do without this. I can't do without that". They'll let you know.

Researcher: OK. They're trying to get you to give them things?

Participant 1: Well, dominate you. (cough)
Pardon me.

Researcher: So somebody who's dependent on someone else...

Participant 1: You'll find they're dominant. Very dominant.

Researcher: Mmm. Mmm. Anything else that they might be?

Participant 1: Selfish too.

Participant 2: They're insecure.

Researcher: Selfish. Insecure.

Participant 2: They're insecure. They're not only dominant. They can be the opposite. They can be insecure.

Researcher: So you've got the extremes.
You've got the ones who want to control
and....

Participant 2: They haven't got confidence in
doing things themselves and so they feel,
you know that they have to rely on someone
else.

Researcher: So they're lacking in
confidence.

Participant 1: Yeah. That would be right.
Yeah.

Researcher: Any other ideas on that?

Participant 1: Well, they've got to be lacking
in initiative.

Researcher: Mmm Mmmm

Participant 1: Very much lacking in
initiative.

Researcher: Lacking in confidence, lacking
in initiative....

Participant 1: Leadership. Leadership is the
base of initiative.

Participant 3: They need to have somebody
to speak for them, you know.

Participant 1: And act for them too.

Participant 3: They can't do anything.

Researcher: OK. So why do you think they
need somebody to speak for them?

Participant 3: They can't. Like my son...

Participant 2: Lack of confidence and they
can't.

Participant 3: That's right. Lack of
confidence mainly. Sometimes they really
need it too. The information of what to do.

Researcher: OK. So they need information?
So is this decision making that we're talking about? Making decisions?

Participant 3: Yes, that's right. Yes.

Researcher: Is it dependent older people that you're talking about?

Participant 2: No. Just general. Any dependent people. Child or adult, yes.

Researcher: Do you think that dependent older people have any characteristics that are different from the characteristics that dependent younger people have? Is dependency different at all for older people?

Participant 2: They can be insecure as a child but learn as they go through from things that have happened in their life. They can end up being very dependent. I mean very independent.

Researcher: OK. So they can become independent through experience?

Participant 2: Yes.

Researcher: What if they don't?

Participant 2: Well that would mean that people haven't helped them to get away from that.

Researcher: Mmm Mmm.

Participant 4: Sometimes they won't listen to what you say, you know. Young ones. They think they're grown up I think.

Researcher: Mmm. Mmm. So how does that affect them when they're older do you think? If a young dependent person is still dependent when they're older, is the dependency different for them when they are older than it was when they were young?

Participant 4: Well they have more experience in getting what they want when they're older.

Researcher: So do you think that some people are still dependent in older age?

Participants 2 3 & 4 (in unison): Yes

Participant 4: It can happen that way.

Researcher: They're still seeking help?

Participant 4: Oh yes. They can be like it all their life.

Researcher: What sorts of things are they dependent on other people for?

Participant 4: A lot of things in life you can be dependent for.

Participant 3: Anything. It depends on the circumstances that you are in. There's a lot of things that old people can go through. I don't think anybody could pinpoint that because it depends on your circumstances.

Researcher: OK. What are the situations in which older people are dependent mostly.

Participant 2. Oh, it could be in anything. It could be in anything at all. Even in picking out what colour dress or what sort of clothes to wear. Or anything like that. It doesn't have to be any specific thing. Just filling out a form. All their life they could never fill out a form because they've never tried at home. They got someone to do it for them and they'll continue to get someone to do it for them.

Participant 1: Lack of initiative. Lack of initiative.

Participant 2: Confidence.

Participant 5: Lack of experience more or less.

Researcher: So lack of initiative, lack of confidence, lack of experience.

Participant 2: And because they have had someone to do it for them.

Participant 1: Yeah.

Participant 3: Yes, that's right.

Participant 5: Some people just haven't had the experience before so they need help.

Participant 2: But then they should know what to do the next time but dependent people don't. They don't seem to learn. They just think they can't. And a lot of things are born into people. Like dependence. You know. Like an independent person can come from an independent parent. And that can carry through.

Researcher: Mmm.

Participant 2: I've seen that happen quite a lot. Yes, you know, you see a person and their child and they might have one, two or three children and they're all the same or they can be totally different.

Researcher: What do you think the fears of a dependent person are? Their biggest fear or worry?

Participant 1: I, I, I believe it's a fear of failure.

Participant 2: I think it all comes down to.....

Researcher: A fear of failure?

Participant 1: Oh yes. They don't want to try something in case they make a mess of it.

Participant 2: That's right. Exactly. That comes from childhood too, you know. You can have a parent who says, "You can't do this" or, "You're an idiot" or "You're ugly"

or "You're too tall". And all that adds to the flatness of a child and the child can grow up with that on its back and carries it for the rest of its life. But then again it can get to the stage where all of a sudden somebody thinks, "Oh, you're beautiful, you can do this, you've proved yourself. You don't have...and they can lose that flatness and they can gain, you know, and they can grow from that.

Researcher: What I hear you saying is that the dependent person lacks confidence, lacks initiative, lacks experience because he or she...

Participant 1: Lacks intelligence.

Researcher: ...has got the message that he or she can't do things. So they rely on other people to do things for them? Like?

Participant 3: Some people just can't think for themselves. So they need someone to think for them.

Researcher: Some people can't think for themselves and they fear failure?

Participant 1: Oh yes. 'Course. Of course they do. Yeah.

Researcher: So what do dependent people do then to avoid feeling like a failure?

Participant 1: Well, any trick in the book. They'll try to encourage other people to do things.

Researcher: Encourage other people to do things for them?

Participant 1: You hit the nail on the head.

Researcher: So what do you think are the good things about being dependent?

Participant 4: I don't know if there's anything good about it but how can they ever change? You've been through so much

to get where you are. How can they ever change?

Researcher: So you see dependency as a way of coping that people have learned throughout their lives and it would be very difficult to change?

Participant 4: Yes. Yes. You need the will to be independent.

Researcher: Are you saying that dependent people haven't developed that will throughout their lives? They've learned something else. They've learned to be dependent.

Participant 4: Yes.

Researcher: How do you think they've learned that?

Participant 4: Through hardship.

Participant 2: Experience

Researcher: They've learned to be dependent through experience?

Participant 2: Yes. The things that have happened to you make you that way. The Depression made some people learn to stand on their own feet. Things like that.

Researcher: So some things have made people become independent but they haven't done the same for others who may have experienced things differently?

Participant 4: Yes. I think it's to do with circumstances.

Researcher: So what circumstances do you think a dependent person would have experienced?

Participant 1: Half the time they're sooks. I reckon half of them are sooks. That's right, sooks. You've got to watch 'em. It won't take

you long to sort out who they are in the bank.

Participant 2: They're not only in banks they're in every walk of life.

Participant 1: But banks are where money is and money controls everything. Never mind what the trouble is. Money controls everything.

Researcher: Are you saying that a lack of money leads people to develop a dependent personality?

Participant 1. That's right. You lose your confidence when you haven't got it.

Participant 2. It can be just the opposite. If you haven't got the confidence you might not get a good job.

Participant 1. You're right.

Researcher: Are there other bad things about being dependent?

Participant 3: It's frustrating, when you want to do something you can't do it.

Participant 1: They have to manipulate people into doing things. They try anything they can to pull off what it is they want. They try anyway to get there.

Researcher: Are you saying they're dishonest?

Participant 1: They become dishonest.

Researcher: They can become dishonest.

Participant 3: Independent people become dishonest?

Researcher: No, he says dependent ones.

Participant 1. 'Cause that's the only way they can get what they want. It's the only way they can get from point A to point B.

Researcher: You have said that dependent people try to get other people to do things for them that they probably could do but they don't believe they can because of experience, insecurities lack of confidence and that sort of thing. And you did mention a fear of failure. Is that the main fear of dependent people?

Participant 2: No. Not having someone to do things for them when they need something done. They would feel frustration at not being able to do something.

Researcher: Would that be the same for both older dependent people and younger dependent people.

Participant 2: Younger people could brush it off but the older people can't. They brood. They would get depressed because they want to do something but they can't. You'd feel hopeless.

Participant 3: If you're really very independent it can be a thing against you. People say, "Oh she doesn't really need that help. Oh she's very independent. She can do it, she can do it. She can do it."

Participant 1: You're right. You're right.

Participant 3: And you don't get any help from people. And then you can pick out a person - and it might be a very nice person - but they'll take any help they can get from anybody and they're the ones that'll get that help. The independent person will never get that help. They bring that on themselves.

Researcher: So there are times when people should have help from other people.

Participant 3: Yes, that's right.

Researcher: ...and times when perhaps they should try to do things for themselves?

Participant 3: Yes that's true but independent people are left always to themselves.

Researcher: So they haven't learned how to accept help from others when they need it?

Participant 3: No. No they haven't. They started out being independent and it's grown on them. Now they're so independent that if anybody did anything for them the first thing they'd have to be doing is to be doing something back for them.

Participant 2: The difference between an independent and dependent is that if you're an independent person you are a giver. But a dependent person is a taker.

Researcher: What is it best to be?

Participant 2: The best thing to be is to just hit the medium.

Researcher: So being dependent is not all bad.

Participant 2: Oh no. There are times when people need help from other people and they should get it.

Researcher: We'll leave it there everyone. Thank-you so much. You've been a great help.

Focus Group 3: Transcript

September 21st, 2001

Researcher: The first question that I have for you today is: What characteristics would a person with a dependent personality have? So I'm asking you to think about the things that tell us that a person has a dependent personality.

Participant 1: Is this about yourself or somebody else?

Researcher: Well if it is about yourself that's fine. You don't have to tell us that. But just think about what you think a dependent personality would be like.

Long silence.

Researcher: How is a dependent person different from an independent person?

Participant 2: Oh. There's a big difference there. Depends on what subject you're dependent. Er.. Er..I can't explain it.

Participant 3: Well, I'm dependent on my son. Now.

Participant 2: But what about when you were younger?

Participant 3: Oh, no.

Researcher: Alright. Well let's talk about how you are dependent on your son.

Participant 3: Oh well, he does a lot of work for me. You know. Financial and all that. I depend on him.

Researcher: Financial?

Participant 3: Yes. I ask his advice.

Participant 2: I'm in that same position.

Researcher: Right

Participant 2: Mmm. My daughter and my granddaughter. I won't do anything without querying and I am totally dependent on them for paying accounts. I just give it to them - money - it comes back.

Researcher: OK

Participant 2: I have no worry. I try not to be any more dependent. My daughter will bring meals down to me. I just do a little bit of cooking myself but I am totally dependent on her and her daughter, my granddaughter.

Researcher: Right. Mainly for doing things of a financial nature?

Participant 2: Finance. I wouldn't do a thing. I wouldn't allow myself to make a decision, a big decision, without first asking her. I've often wondered if I am right or if I am wrong but I feel that, um, especially my granddaughter, can cope with life these days so I am really totally dependent.

Researcher: OK.

Participant 1: I'm the same - on my son and my daughter-in-law who do all the business for me. They arrange for the lawns to be mowed - you know - and anything 'round the place. I couldn't. I'd be in a home if it weren't for them.

Researcher: Right. So you feel as though you can't do these things?

Participant 1: I can, but not as well as they do.

Researcher: But not as well as they do?

Participant 1: No.

Participant 2: It's the getting out. See I won't go out on my own. So if they didn't look after things and accounts had to be paid um, how would they get paid? 'cause I won't go out and do that.

Participant 3: Silver Chain will come and do that for you.

Participant 2: What?

Participant 3: Your bills and that.

Participant 2: Oh, well at the moment, I have my granddaughter. She says, "Don't worry Nanna, don't worry Nanna. And I've got that way now that if an account comes in I've got the money in part of my dressing table. I bring it out when I they come down and that's it. I have not got one act of worry. They will be paid on time and the receipt will come back. Posting letters - that sort of thing. Only getting out once a week - so if it's your birthday and Shelly comes, I just write on the back of the envelope - the date. She just takes it up there - my granddaughter takes it to them. She's never let me down.

Participant 2: My son's the same. They come over Saturday morning, he comes into the lounge and gets all the bookwork and they do all that - write the cheques and I just sign them. And then they take me shopping.

Researcher: Then you would say then that a dependent person then is somebody who relies on other people to do things for them that they feel they can't?

Participant 2: I could still do them.

Participant 3: If you could drive.

Participant 2: If I could get out - and I will not go out on my own.

Participant 1: No. You're not safe.

Participant 2: And that happened seven years ago. I broke my hip. By the time I'd got over it I'd lost confidence in driving. Yes. I don't go out. I could do it myself. I don't know about managing business affairs. But er, my daughter she's got power of attorney. I have no fear. She can go into the bank and get my money. There's no problem there. I sit on a chair and I'm quite happy for her to do it and I've got explicit faith in both of them and they would never do anything wrong.

Participant 2: That's exactly how we are.

Researcher: Are you saying that you have a physical reason for this dependency?

Participant 2: Not now. I have had a physical reason that caused the fear.

Researcher: You can put your finger on an incident that caused the change in your dependency?

Participant 2: Yes. That's right. Exactly.

Researcher: What about people who are dependent who seem to have had no particular event in their lives, and they might be young or old, that has caused a change in their dependency? They are not lonely and they have no physical disability. What is the difference between them and somebody who's independent?

Participant 4: I think other people say, "Can I do that for you?" and they think, "Oh yes that's easier than me doing it." I mean I do everything for myself. I've only got one son and he's earned his retirement. He goes away fishing. I have a shopping list worked out and I just work out. There's a post office where I go so I just do my bills there and

everything's there. My son says to me, "Mum, while you can do it, do it. Do it."
Participant 2: Oh I believe in that.

Participant 1: Well yes. Yes if you can.
Yes.

Participant 4: He said, "I know you can do it". But I do get help. I take my shopping basket. I do shop myself. A bus drops us there. It takes us to the shopping centre and gives us two hours. We all roam around on our own and do the shopping. I depend on the bus but I still work out all my money, bills and Medicare or whatever.

Researcher: How does someone become dependent if they needn't be?

Participant 4: Because someone says, er, "I'll do that for you".

Participant 5: Mmm. I think it gives the young ones peace of mind to know everything's been done. And they can go off and do what they want and not worry. Then you start to lose your confidence.

Participant 2: I feel also it depends on what age you are when you are widowed. I was widowed early fifties years of age. My son had a breakdown. I had to be very forceful. I've always believed I could control things. I've always believed I was a forceful woman. But being widowed early and my husband had done all the business then I had to take over, which I did - up until seven years ago.

Researcher: How do you feel someone who is not so forceful, or who doesn't feel in control of things, would cope in that situation?

Participant 2: Er. It depends on whether they have someone to help them. If they don't they might just have to learn to be,

um, independent - because of their situation.

Researcher: Do you think then that people who don't get the opportunity to do things or aren't given the opportunity to do things for themselves can become dependent?

Participant 1: Ah yes. There was one lady and all day she walked down to the letter box and somebody said, "Oh don't do that. I'll do that for you". And I noticed in that time she'd bend over and she couldn't get back up easily. It was the only walking she'd done.

Researcher: If people are dependent all their lives, where do you think this starts?

Participant 3: Well, I've always had to look after things. I had a hard life, put it that way. And my husband had dementia for many years and I had to look after him, you know, and everything. I had to do it. I did it.

Researcher: Are you saying that people with a dependent personality didn't have a hard life?

Participant 3: That's right. They probably never had to do anything themselves.

Researcher: What do you think is the biggest fear, or one of the biggest fears of people with a dependent personality?

Participant 1: Pure laziness.

Participant 2: Something happening.

Researcher: Something happening?

Participant 2: When my hip happened I was about seven hours before I got any help and I've never got over it. I didn't know how...I had two phones in the

house one near my bed and one out near the, um, playroom and I'm in the kitchen. And I have thought about it over and over again. How did I get...and I eventually got onto my bed and rang my doctor. His first question was: "How did you get on this bed?" And I said, "I can't tell you." And I was from a quarter past nine in the morning till about half past one, and that's only a short time to some people.

Researcher: But it's a long time when you are in pain.

Participant 2: Oh those hours - and so now I wear this and all I have to do is press the button and it comes through the phone and I get help. It's not cheap. It's quite expensive really. The only time I don't wear it is when I'm in bed and I could wear this particular one in the shower. It's all just been updated. Now I'm covered from my back fence to the street. It's not much good on fear - now that gives me that sense. Now that's where I lost my nerve 'cause up until then I thought I was a strong woman. 'Cause I had to get my son...well my son's still not real good but I had lost two years with him in a breakdown. Now he was more important than my missing my husband. He lost his father. I didn't lose anybody.

Researcher: So are you saying that an independent person is strong?

Participant 2: Yes I think they are.

Participant 3: I think so too.

Participant 1: Yes, yes.

Researcher: What other characteristics does a dependent person have?

Participant 1: Well they want you to do everything.

Participant 3: They want you to wait on them hand and foot.

Researcher: OK. So a dependent person wants others to do things for them?

Participant 1. Yes.

Participant 4: Yes, that's right.

Participant 2: Really, really, I'm spoilt at the moment - if you can understand - I'm spoilt at the moment. My daughter and my granddaughter and my daughter-in-law, who's fighting her husband who is still not right at 53...they are my stay and I admit. I am almost totally dependent.

Participant 1: You know doctors can be fuss-pots. You know, just because I was up on the roof at 86 cutting the creeper off he came to the surgery and he objected to it. (everyone laughs)

Researcher: I'm sure he did. Now when you say you are almost totally dependent - for what things? What do you need done for you?

Participant 2: Well, just keep life smooth, running smoothly.

Researcher: Right.

Participant 2: So you've got no...

Participant 1: They do your business for you.

Participant 2: No, all life. Life. Like over the recent, what we've had [referring to the September 11th terrorist attacks on New York and Washington] this time last week I was not well and then my daughter said, "But Mum." Now I think of what she said to me. So I can't say to her when I see her next week, "But it's still going on," I've got to stop that. I would not talk anymore about the

events. I told her on Tuesday and I was stressed and I told my daughter-in-law yesterday and I had to step out of it. Now it's finished but I had to tell somebody. I feel that when I heard all of that, I never felt so lonely in all my life. And I'm not ashamed to admit that I think I was frightened and I had nobody to talk to or to turn to. Now that was just my opinion. That's how it affected me.

Researcher: Mmm

Participant 1: But if you rang them and that couldn't they advise you - the family?

Participant 2: Well if I had rung her to let her know that I was worried then she would have come down.

Participant 1: Well?

Participant 2: I didn't want...that's... I can't go that far.

Participant 1: Why not?

Participant 2: Because I can't. I don't know how much more I'm going to have to depend on them. But I couldn't ring Lesmurdie and let her come. Oh, no. I couldn't do that. I'm not that dependent.

Participant 3: No. I think that a dependent person's biggest fear is the fear of the unknown and not being able to control things.

Participant 2: Yes, it's the unknown. That's just me.

Researcher: A fear of the unknown and not being able to control what happens. What do dependent people think about themselves?

Participant 3: Just not capable.

Researcher: Can't do things?

Participant 3: They can't do it. They don't try.

Researcher: So they lack confidence in their ability to do things.

Participants 1,3 and 5: Yes

Participant 2: They won't have a go.

Participant 5: Sometimes when you are not well you need some help but you don't get it because you've always been strong.

Researcher: Is it a disadvantage to be too independent then?

Participant 5: People say, "She's OK".

Researcher: Mmm

Participant 5: "She's strong". And she says, "I'm OK". You've got to admit you need help when you do. Everybody needs a different kind of help.

Participant 4: Yes. I need help to go shopping.

Researcher: What about your families? You say you depend on them quite a bit for various things, do they also depend on you for some things?

Participant 2: Oh yes. Yes.

Researcher: So it's a two-way thing?

Participant 2: Yes. It's Nanna can always do it or Nanna has always got it. If I've got time I'll tell you what happened a fortnight ago. My daughter came down and she said, "Mum, Debra's broken her little mirror in her purse". She knows Nanna's got one. Is that any help to you to tell you that?

Researcher: Yes. It's an example dependence on you for something by your granddaughter.

Participant 1: If you've got one to spare. Well why couldn't they go and buy another one?

Participant 2: She's got more money than I will ever have. It wasn't that. Nanna has always been able to fix it. If she wants anything done it's, "Don't you touch it Mum. Give that to Nanna". Mother is not allowed to touch alterations, anything that she gets. It's Nanna. Why didn't she go and buy another mirror? Can you help me with that?

Researcher: She has probably learnt that she can always rely on Nanna.

Participant 2: It is nice to know that we are not on the scrap heap yet. We are still needed.

Researcher: How do you think people who are dependent go about getting their needs met?

Participant 5: They have no trouble. They just ask for it but an independent person doesn't ask for it.

Researcher: The dependent person will seek the help. They will ask for it.

Participant 5: The dependent ones ask for help that's why they get it.

Researcher: They get it.

Participant 5: We don't get it. The independent person won't ask unless they really have to.

Researcher: How do you feel about asking for help?

Participant 5: It depends.

Researcher: Do you sometimes not feel good about it?

Participant 5: Absolutely. Absolutely.

Researcher: Can you give an example of a circumstance in which you didn't?

Participant 2: I won't ask for help unless I absolutely need it.

Researcher: And then how do you feel about it?

Participant 2: I hope that they say, "Well, Mum doesn't ask for help unless she really needs it." I don't want to burden them with my trouble. My daughter says, "Is there anything you want doing Mum?" If I think I could do it I don't say, "Yes, I want this done."

Researcher: What do you think is good about being dependent?

Participant 3: You're mollycoddled.

Researcher: Is there anything else that people get out of being dependent?

Participant 1: Well they've asked for help and they always get it.

Researcher: It's always been given?

Participant 1: They're spoilt some of them.

Participant 3: Yes, if they can do it themselves and they don't they're spoilt.

Researcher: What do you think is bad about being dependent.

Participant 2: I haven't ever really thought about it. I don't think there is anything that bad about it.

Participant 1: I think if you can get about and do things for yourself then you can count your blessings. The bad thing about being dependent is that you feel you can't do things yourself.

Participant 5: That's true.

Participant 1: The person you're asking for help might be worse off than you.

Participant 3: It's only laziness.

Participant 4: Some haven't got the confidence.

Researcher: They haven't got confidence?

Participant 4: A man in our complex had his toilet overflow. Now I'm the oldest one in the complex but he said, "Give it to J---. She'll see to it".

Researcher: Does he see you as having more confidence in those situations than he has?

Participant 4: Well I can do it. If I said, "There's the phone number go and do it." Well, it gives you a little bit of a lift I suppose.

Researcher: That they rely on you?

Participant 4: Yeah. That's right. That you're not useless.

Participant 2: Why sometimes do they say to you, "Don't try to be so independent Mum".

Participant 1: Well that's just because they like to help you.

Researcher: Yes. They were dependent upon you for so long and now they would like the opportunity to give something back. They don't always understand that it would be best for you

to continue doing some things for yourself. (pause) OK....

Participant 1: I hope we've been helpful.

Researcher: You have been very helpful.

Participant 2: 'Cause all we've done is pour out our lives.

Researcher: You might be surprised at what we can learn from you pouring out your lives. Thank you very much for sharing your stories with me.

Focus Group 4: Transcript

23rd October, 2001

Allied Health Professionals

Researcher: The first question is, what characteristics would a person with a dependent personality have do you think? This is opposed to a person with dependent behaviours that result from a physical or mental disability.

Participant 1: I imagine a dependent personality would be someone who relied on another person for things that they could actually do for themselves. Um...

Participant 2: Not as a result of their disability.

Participant 1: Yeah.

Participant 3: More likely to ask for assistance when they don't require it - whatever the form of assistance.

Researcher: Mmm

Participant 3: Er. Yeah. Relying on other people is the main thing. As you say, for things that they could actually do for themselves.

Participant 1: And more as a way of getting attention for themselves. So if they can get someone to do something for them they're actually getting attention and that's their way of assuring it keeps happening.

Researcher: So when they get that attention it reinforces the dependent behaviour?

Participant 3: Yes. The dependency. Yeah.

Participant 2: Yes.

Participant 3: They strike me as people who aren't shy at coming forward. They appear to be very, um, emotional. Sort of people who

have confidence in lots of ways but lacking in confidence in other ways. So, they sort of push themselves forward, but at the same time if they're um knocked back they are immediately very upset about it. So I think they have difficulty um dealing with emotions, dealing with any criticism. That side of things. Is that the same question do you think or have I moved off...

Researcher: No, no that's alright. So what's their motive. Their motive is to...

Participant 3: Gain what they want...gain what they want to achieve by whatever method necessary.

Researcher: OK. So they are active in getting what they want - they're not passive.

Participant 3: No. They can be quite aggressive at times to actually gain, to get what it is they actually require. But when...I think aggressiveness passes quite quickly if, if someone challenges that behaviour.

Researcher: Ok. What, questions their ability to do it themselves?

Participant 3: Yes. Yes. Why can't you do that yourself? Haven't you got legs?

Researcher: Mmm.

Participant 3: You know those sort of joky things that come back, um, when someone's always sort of like asking you to do something. You say, "Well what did your last servant die of then?" Get up and do it yourself. And then often I think those sort of people become quite hurt.

Researcher: Mmmm.

Participant 3: They can't really understand why you wouldn't want to do something for them.

Researcher: OK. The next question I have for you is: Are these characteristics the same

for both dependent older adults and dependent younger adults? Would dependent personality manifest itself in older people the same way as it does in younger people?

Participant 1: I suppose to some degree but older people have also got society views that when you get older you need help anyway. So that would actually support their dependent personality. If they had it already it would just be reinforced.

Participant 2: And that would fit in with what you're saying because young people would have to be aggressive to gain that dependency as well.

Participant 3: Yes, that's right because people don't expect you to be dependent when you're young. They expect you to go out... You're expected to be a go-getter. Aren't you?

Researcher: So they don't have to be as aggressive when they're older to get what they want?

Participant 3: No. The aggression is dissipated. Well, it's still there but they just don't have to use it.

Researcher: If the situation occurred that would require it, would they still become aggressive do you think?

Participant 3: I would think. If it's a life-time behaviour pattern, when the need was there, it would come out.

Participant 1: Yeah.

Participant 3: For example if it's something and there's no services available anywhere or just it was limited priority, I would still imagine they would be getting the service before anybody else. Because of their ability to be able to, um, gain... their ability to be able to sort of, use a system in some ways to get what they require. Because

they've always been able to have all the strategies there to be able to deal with it and to get what they require.

Researcher: OK. So they've learnt a whole lot of strategies for meeting their needs.

Participant 3: Yes.

Researcher: What do you think would happen to these people if they could not get the help they want?

Participant 3: I think they would plummet far quicker than anybody else because they'd have no - no back-up to that. They wouldn't have had to deal with...

Participant 2: They're so reliant

Participant 3: They've no strategies to, um, deal with knock-backs. So they would be more likely to plummet into, er, whatever...

Participant 2: No coping strategies

Participant 3: ...depression and all those sorts of things because there's no coping strategies there.

Researcher: So why do you think some of these people are dependent on others even though they're not lonely and not disabled in any way? Why - um, where does it come from I guess?

Participant 3: We don't know if we're answering the right thing really.

Participant 1: Yes.

Researcher: There are, um, no right or wrong answers. It's just your opinion.

Participant 3: The first thing to say is it's come from childhood.

Participant 1: Yes, it could be something...

Participant 3: You develop the pattern from a very early age.

Participant 1: It could be they've had a parent who was very protective or um made the child feel they were dependent when they were young so it's always carried on. Up to their teenage and on.

Participant 3: Yes. Perhaps it came from a very early age...I would have thought. Yeah. Yeah. Due to events or family or whatever.

Researcher: So they develop the pattern in their childhood that they look for people to fulfill their needs?

Participant 3: Yes. That's right

Researcher: What do you think it is, er, that older adults believe they need? Dependent older adults. What do you think it is that they believe they need?

Participant 1: Someone to look after them. Someone to

Participant 2: Because they are older they think that they, they'll get what they request.

Participant 1: Yeah. That they have a right to... That they should just get a service... whether they have needs or not.

Participant 3: Yeah. Yep. Because they're a certain age and therefore and they've worked for their country and that sort of stuff and... Yep. They're entitled to a service. They're entitled to company as well. And if they don't have a big social network then the GP, that the health services, that side of things, should respond as and when that is required. Um, and that they're a priority.

Participant 1: And maybe they're fearful as well. They're fearful that they'll be lonely. They'll be left alone if they don't continue ... 'cause it's hard when you're younger to get

out and find people to fill that need but as you get older it may be harder.

Researcher: Mmm. What were some of those strategies you were talking about? About how they go about getting some of their needs met?

Participant 3: I think by, um, over-emphasising, by over-exaggerating, by um...

Participant 2: Making you feel guilty.

Participant 3: ...making you feel guilty, a lot of emotional guilt, um, yeah blowing situations out of all proportion, um, using words and language, using language that um, is dramatic.

Participant 2: Mmm. And they know what things they need to say to be able to request a service.

Participant 3: Yep.

Participant 2: We had a couple of people who had chronic illnesses and neurology and they knew that if they come into ED and they said something specific that the hospital would have to admit them because they'd said they had a seizure even if they hadn't. They knew that if they said that the hospital would have to admit them for investigations. They knew what to say to get a service.

Researcher: Mmm.

Participant 3: Making, making you feel sorry for them. Making you feel that they are in need. Or more in need than you are. You, you know, your natural response is to try and assist somebody who, who appears to have more, more need than you do.

Researcher: Mmm. Mmm.

Participant 3: It's a human response isn't it.

Researcher: Mmm. Yeah.

Participant 3: The person may be strong, healthy and have a, what appears to be a very good social system behind them but they still have more need than you do.

Researcher: So you help them?

Participant 3: Yes, whether it's right or wrong to help them.

Researcher: What do you think the dependent person would worry about most? The dependent older person.

Participant 2: Having their services taken away from them. Things that they rely on taken away.

Researcher: Having the things that they rely on taken away, not there?

Participant 3: Left to be on their own. Isolated. People not responding. Lack of response from other people.

Researcher: What are the good things about being a dependent older adult?

Participant 1: They fit in very well to residential care. (all laugh)

Participant 3: They fit in well to all services really because...

Participant 1: their needs are met.

Participant 3:their needs are met. So they fit in extremely well. They, they, yeah they fit in because they, they are exactly what people want them to be. Once they've got the service they are quite compliant, they're acting the type of personality behaviour that people anticipate. Um, they're in need they're dependent and that's what well certainly support services and nursing homes are set up to encourage to a certain extent.

Participant 2: That's what you're supposed to be.

Participant 3: That's what you're supposed to be.

Researcher: Right. OK. What are the bad things about being a dependent older adult?

Participant 3: Bad for the person or bad for the people who they're with?

Researcher: For the person. Themselves.

Participant 3: OK. Well, the fact that they have no strategies, no personal strategies if services are suddenly reduced.

Researcher: Mmm.

Participant 3: If they're. I guess they could always transfer onto somebody else. Say they're reliant on their GP considerably and that GP is suddenly no longer around I guess they'd transfer onto somebody else's as well but once those strategies, once those services are withdrawn or not available then that's a pretty major problem. And I guess they probably haven't gone through very many self-help and healthy activities and all those sorts of things because it's not been necessary to do so.

Researcher: Do you think that dependent personality is an issue in health services?

Participant 1: Yes.

Participant 3: We know it is. 'Cause they access more services than most people and they would ensure that they got everything.

Researcher: Mmm.

Participant 1: ...and they're more likely to have more health issues because of it. It would compound health problems.

Participant 3: I think one of the bad things would be as well that, apart from services

being withdrawn, but because they're reliant on someone else always doing something that they haven't developed any ways of um, working out for themselves that they have a problem. 'Cause they're always expecting someone else to solve the problem for them. And that might be a health issue because they may be taking very little preventative type care 'cause there's always someone coming around there to tell them. So in some ways it's detrimental to them because they haven't got that back-up for themselves

Researcher: Right. So do you think that for these people their physical health declines more rapidly because of their dependent personality?

Participant 3: Could do.

Participant 1: It could.

Participant 3: Yeah, yeah.

Researcher: OK

Participant 3: It depends which theory you follow isn't it really. Like with A. H., she's talking about a little bit of help for everybody. These people I guess would receive quite a lot of help um, and she's saying that would be supportive and that they require it. But we would say that you, you wouldn't know how good you could be if you didn't have the services. But they [dependent personalities] would never know that so they're always going to be happy in that respect.

Researcher: Well, that's it. Thank you.

Appendix B

1. Chapter 3, stage 1 - Initial item pool.
2. Initial instructions for completion of the interpersonal dependency scale.
3. Amended instructions for completion of the interpersonal dependency scale.

Initial Item Pool (108 items)

Number	Item	Component
1.	I think people should do a lot more for me at my stage of life.	C
2.	I am quick to agree with the opinions of others.	B
3.	I try to have people around me as much as possible.	M
4.	I am willing to ignore other people's wants in order to accomplish something that's important to me.	B
5.	If my friends disapprove of my actions, I am likely to change what I'm doing.	B
6.	Worry tends to make me cling to those I am closest to.	M
7.	In social situations it is better to go along with the majority than to have my own way.	M
8.	I think I have to be nice to other people.	C
9.	I have to force myself to keep going when the person I am closest to is away.	A
10.	I become very worried when a person close to me is angry.	A
11.	I believe people could do a lot more for me if they wanted to.	C
12.	Even if the person closest to me were to leave I could still manage by myself.	C/A
13.	I am most likely to be able to help someone with a problem.	C
14.	I avoid doing many tasks that I could do myself.	B
15.	I find it difficult to be separated from people I love.	A
16.	I need people to reassure me that they think well of me.	A/M
17.	I tend to be influenced by people with strong opinions.	C
18.	If I really need something I don't mind using someone to get it.	B
19.	Other people tend to come to me for help.	C
20.	Often I think I have disappointed others.	C
21.	I worry about being abandoned.	A
22.	I have a lot of trouble making decisions by myself.	C
23.	I am very sensitive to others for signs of rejection.	A
24.	Being accepted by others is very important to me.	M

- | | |
|---|---|
| 25. I am afraid of hurting other people's feelings. | A |
| 26. I am very sure about the kind of person I am. | C |
| 27. I like to be fussed over when I am sick. | M |
| 28. I try to make friends with people who can help me. | M |
| 29. In an argument, I give in easily. | B |
| 30. When someone close to me is away, I count the hours until his or her return. | A |
| 31. I will do anything I can to ensure that I get help from others. | B |
| 32. I need people to tell me what to do. | M |
| 33. I censor what I say because I am concerned that the other person might disapprove or disagree. | B |
| 34. I am concerned about how people evaluate the choices I have made in my life. | A |
| 35. After a fight with a family member or friend I must make amends straightaway. | B |
| 36. I am very sensitive to others for signs of their willingness to help people like me. | M |
| 37. I hesitate to accept help from others. | B |
| 38. I usually keep quiet when someone makes me angry. | M |
| 39. To be left alone by others would be the worst part about growing old. | A |
| 40. It is hard for me to make up my mind about a TV show or movie until I know what other people think. | C |
| 41. I have always had a terrible fear that I will lose the love and support of people I need. | A |
| 42. I am usually sure of myself when I have to face complicated situations alone. | C |
| 43. As a child, my parents preferred to do most things for me rather than risk mishaps. | M |
| 44. I am afraid of physically injuring myself whilst doing everyday tasks. | A |
| 45. I become frightened when I feel alone. | A |
| 46. I really only feel safe when I am with the person I am especially close to. | C |
| 47. In a discussion I usually end up agreeing with the other persons' point of view. | B |
| 48. When I go shopping I always take someone with me to help choose items. | B |
| 49. Most people are more powerful than I am. | C |
| 50. I would much rather be a follower than a leader. | C |
| 51. I tend to be a loner. | M |

52. I often change my mind about decisions if my friends or family disagree. B
53. I feel panicky when I am separated from those I love. A
54. I become extremely anxious if I think I have to do something new by myself. A
55. I am only really comfortable when I have someone to keep me company. A
56. I am a leader. C
57. Even if things are not in my best interest, it is usually best to do them anyway in order to please others. M
58. I always consult another person before taking a decision. B
59. I become anxious when I have to be alone for any length of time. A
60. I generally follow other people's suggestions. B
61. I tend to worry about what other people think of me. M/A
62. If I think that somebody might be upset with me I want to apologise. B/M
63. The very thought that the person I am closest to may leave me fills me with panic. A
64. I am afraid to leave my home alone. A
65. I am very concerned with how other people respond to me. M
66. I tend to go along with what other people want even when it is not what I want. B
67. I only enjoy what I am doing when I think that someone really cares about me. M
68. I would rather stay free of involvements with others than to risk disappointments. M
69. The thought of being alone doesn't bother me at all. A
70. When things go wrong, I need to be with someone I am close to. M/C
71. Other people are much better at doing things than I am. C
72. Without support from others who are close to me I would be helpless. C
73. I often worry when people ask favours of me. A
74. I hesitate to express opinions that I think others will disagree with. B
75. I don't go out unless someone goes with me. B
76. I avoid getting attached to anyone. M
77. I am much more concerned that people like me than I am about making important achievements. M
78. I always check out my decisions with someone else. B
79. Even when things go wrong I get along without asking for help from anyone. B

- | | | |
|------|--|-----|
| 80. | I am upset when the person I am closest to is away for a few days. | A |
| 81. | I find it difficult to feel completely secure in a close relationship. | A |
| 82. | I often think about the danger of losing someone close to me. | A |
| 83. | I would feel helpless if deserted by someone I love. | A |
| 84. | It is very important to me to be approved of by others. | A |
| 85. | When I meet new people, I'm afraid that I will act the wrong way. | A |
| 86. | In my relationships with others I am very concerned with what they can do for me. | M |
| 87. | I tend to act in ways that others expect. | B |
| 88. | I often change the way I act and think to be more like those around me. | B |
| 89. | I easily get discouraged when I don't get what I need from others. | M |
| 90. | I am very confident about my own judgement. | C |
| 91. | I am more comfortable with taking decisions made by other people. | B |
| 92. | I almost always avoid going out alone. | B |
| 93. | I become attached to people who help me. | M |
| 94. | I have a clear sense of my own identity. | C |
| 95. | I usually go along with other people's suggestions. | B |
| 96. | If a friend has not called for a while I get worried that he/she has forgotten me. | M |
| 97. | I need more help with things than other people seem to need. | C |
| 98. | When I am with other people I look for signs of whether or not they like being with me. | B |
| 99. | I usually make my own decisions. | B |
| 100. | I worry about people not liking me. | M/A |
| 101. | I cannot tell someone directly that I am angry with him or her. | B |
| 102. | When I am sick, I prefer that my friends leave me alone. | M |
| 103. | I feel helpless in many situations. | A |
| 104. | I almost always behave according to the wishes of my family, friends or my doctor. | B |
| 105. | I often feel threatened by change. | A |
| 106. | My worst fear is being rejected by someone. | A |
| 107. | I am confident of my ability to deal with most of the personal problems I am likely to meet in life. | |

C = Item representing the Cognitive component of interpersonal dependency

M=Item representing the Motivational component of interpersonal dependency

B=Item representing the Behavioural component of interpersonal dependency

A=Item representing the Affective component of interpersonal dependency

Questionnaire

Name/Code _____

Male _____

Age _____

Female _____

Directions

PLEASE READ ALL OF THIS PAGE BEFORE BEGINNING

Everyones' needs and behaviours differ. This questionnaire contains statements about interpersonal needs and behaviours. You are asked to rate yourself on each of these statements using a rating scale. Below is an example of a statement and rating scale.

Example:

1. I like to have someone with me most of the time.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

If the statement sounds just like you, circle the number "7". If it sounds not at all like you, circle the number "1". If the statement sounds a little like you somewhat like you or quite like you, then circle a number in between. The more like you the example sounds, the higher the number you circle.

For each statement in the questionnaire, circle the number that is most like you. **Please respond to every statement even if you are unsure of how much the statement is like you.**

Thank you

PLEASE READ ALL OF THIS PAGE FIRST

Questionnaire

Name (optional)_____

Please Circle: Male / Female

Age_____

Everyone's needs and behaviours differ. This questionnaire contains statements about interpersonal needs and behaviours. You are asked to rate yourself on each of these statements using a rating scale. See the following directions for using the scale.

Directions

After each statement in the questionnaire is a rating scale numbered from 1 to 7. You will find an example below of a statement followed by a rating scale. If the statement sounds just like you, circle the number "7". If it sounds not at all like you, then circle the number "1". If the statement sounds a little like you, somewhat like you or quite like you, then circle a number in between. The more like you the example sounds, the higher the number you circle.

Example:

1. I like to have someone with me most of the time.

Not at all										Just like
like me										me
1	2	3	4	5	6	7				

For each statement in the questionnaire, circle the number that is most like you. **Please respond to EVERY statement even if you are unsure of the number to circle for some statements.**

Thank you for your participation.

Appendix C

1. Information and disclosure form used in chapters 4 and 6 (stages 2 and 4).
2. Consent form used in chapters 4 and 6 (stages 2 and 4).
3. Information letters to participants from the organisations involved in stage 2.
4. The 85 interpersonal dependency items tested in chapter 4, stage 2 and the instructions for completing the scale.

Information and Disclosure Form

Project Title: *Individual Differences in Dependent Personality in Older Adults: Development of a measure and its Evaluation in Health Care Services.*

This research project is being conducted to satisfy part-requirement for a Doctor of Philosophy, Psychology degree at Edith Cowan University, Joondalup, WA. The project aims to develop, with the assistance of older adults, a questionnaire for the purpose of measuring dependent personality in older people.

You can help with this project by completing a questionnaire. The questionnaire consists of questions and statements to do with various aspects of dependency. It is hoped that the results will increase our understanding of the dependency needs of older people. Detailed instructions for answering the questions are given on the first page. It will take you about 5-10 minutes to complete the questionnaire.

The research student and the research student's supervisors will be involved in this project and will have access to the information that you provide.

All information given in the questionnaire is strictly confidential. We appreciate your assistance but you are under no obligation to complete the questionnaire. You may also withdraw from the study at any time.

The results from this research will be published but you will not be able to be identified in the publication. Your name will not be required on the questionnaire.

Should you have any queries or concerns in the future about the study, please contact Deborah Gardner (the research student) on () or Dr Craig Speelman, School of Psychology, Edith Cowan University on 9400 5724.

Thank you for your time and participation.

Deborah Gardner
School of Psychology Ph.D. Student
Edith Cowan University

Craig Speelman Ph.D.
School of Psychology
Edith Cowan University

CONSENT FORM Project Title: *Individual Differences in Dependent Personality in Older Adults: Development of a Measure and its Evaluation in Health Care Services*

Should you wish to participate in this project, please sign below to indicate your consent.

- I freely agree to participate in this study realising that I may withdraw at any time. I have read and received a copy of the "Information and Disclosure Form" and any questions I have asked have been answered to my satisfaction. I have no objections to the results of the study being published in a report so long as I cannot be identified in these results.

ParticipantDate.....

Researcher.....Date.....



SILVER CHAIN

7 March 2002

CARING IN THE COMMUNITY

6 Sundercombe Street Osborne Park

Western Australia 6017

Telephone (08) 9242 0242

Facsimile (08) 9444 6158

Email info@silverchain.org.au

Web www.silverchain.org.au

Dear Mr.

RESEARCH PROJECT: INDIVIDUAL DIFFERENCES IN DEPENDENT PERSONALITY IN OLDER ADULTS - DEVELOPMENT OF A MEASURE AND ITS EVALUATION IN HEALTH CARE SERVICES

I am writing to invite you to participate in a study to develop a questionnaire to measure dependency being conducted by Ms Deborah Gardner, a research student from Edith Cowan University.

Silver Chain is committed to providing the best care possible for its clients. It is for this reason that Silver Chain conducts research projects and also supports many research projects being undertaken by university staff and students.

Please find enclosed an Information and Disclosure Form, providing details about the study, with a Consent Form on the back. Detailed instructions for completing the questionnaire are given on the first page. If you do decide to participate, please return the completed **questionnaire and consent form** in the reply paid envelope by Monday, **25 March 2002**.

Whilst we would greatly appreciate your participation in the project, you are under no obligation to complete the questionnaire. Your decision to participate or not will in no way affect any services that you are currently receiving from Silver Chain.

If you have any questions about the study, please contact Ms Gardner on [REDACTED] or Dr Craig Speelman on ☎ 9400 5724.

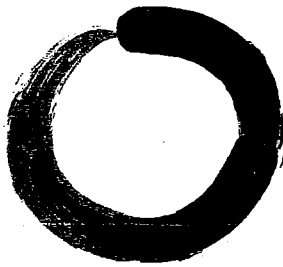
Thank you.

Sincerely,

[REDACTED]

Dr Gill Lewin
Research Manager

GL [G1.14]



**POSITIVE AGEING
FOUNDATION**

creating Age Friendly communities

Patron His Excellency Lieutenant General
John Sanderson, AC Governor of Western Australia

Vice Patron Hon. David Malcolm, AC
Chief Justice of Western Australia

Founding Chairman
Dr Eric Tan, AM

National Office
Old Cloisters Building
200 St Georges Terrace
Perth Western Australia 6000
Telephone + 61 8 9482 2000
Facsimile + 61 8 9482 2001
Freecall 1800 757 555
ABN 74 897 181 527
Email info@positiveageing.com.au
Website www.positiveageing.com.au

14/3/2002

Dear ..

Welcome to the Positive Ageing Foundation of Australia Research Group. Many of our research partners are very keen to work with seniors and gain first hand knowledge of how you feel about certain issues. The Positive Ageing Foundation of Australia wishes to develop these partnerships and ensure that seniors have a voice in framing new research and responses to important issues that affect their lives.

An Edith Cowan University Psychology PhD student, recently approached the Foundation with a request to invite members of the Research Group to participate in a study to assist in developing a questionnaire for the purpose of measuring dependency in older people.


If you are interested in assisting with this study, please complete the enclosed questionnaire and return in the reply paid envelope by Friday 19 April 2002.

We have enclosed information from Edith Cowan University on the details of the research project, together with a disclosure form and questionnaire

If you require any further general information please contact Marlene Robins at the Foundation on 9482 2012.

Thank you for taking the time to consider becoming a participant in this important study.

Yours sincerely


DIANNE MORAN
Executive Director

Chairman
John Hewson

Deputy Chairman
Dr Penny Flett

Secretary
Hon Kay Hallahan

Treasurer
Mr Harry W Sorensen

Board Members
Sir James Cruthers
Prof Charles Watson

Executive Director
Ms Dianne Moran

Positive Ageing Foundation is a national not-for-profit organisation dedicated to working with and for older Australians to improve the quality of their lives.

PLEASE READ ALL OF THIS PAGE FIRST

Questionnaire

Name (optional)_____

Please Circle: Male / Female

Age_____

Everyone's needs and behaviours differ. This questionnaire contains statements about interpersonal needs and behaviours. You are asked to rate yourself on each of these statements using a rating scale. See the following directions for using the scale.

Directions

After each statement in the questionnaire is a rating scale numbered from 1 to 7. You will find an example below of a statement followed by a rating scale. If the statement sounds just like you, circle the number "7". If it sounds not at all like you, then circle the number "1". If the statement sounds a little like you, somewhat like you or quite like you, then circle a number in between. The more like you the example sounds, the higher the number you circle.

Example:

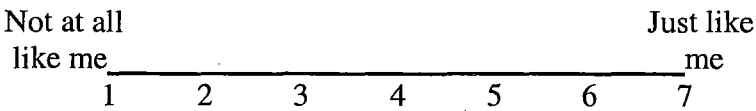
1. I like to have someone with me most of the time.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

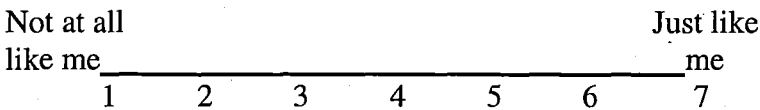
For each statement in the questionnaire, circle the number that is most like you. **Please respond to EVERY statement even if you are unsure of the number to circle for some statements.**

Thank you for your participation.

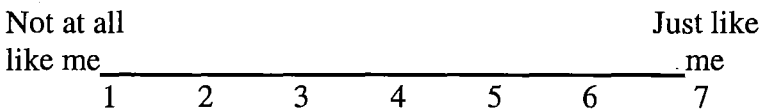
1. I think people should do a lot more for me at my stage of life.



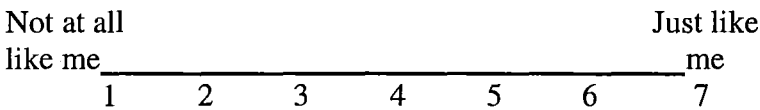
2. I try to have people around me as much as possible.



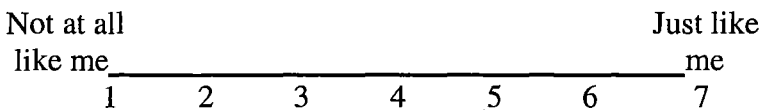
3. I am willing to ignore other people's wants in order to accomplish something that's important to me.



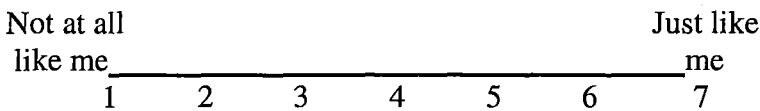
4. If my friends or family disapprove of my actions, I am likely to change what I'm doing.



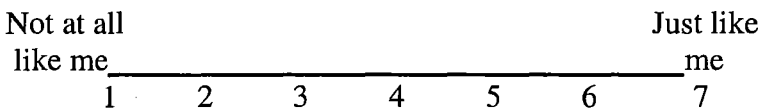
5. Worry tends to make me cling to those I am closest to.



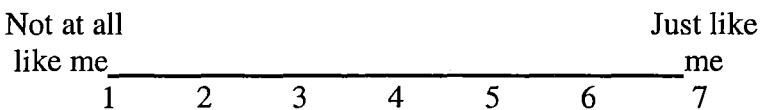
6. In social situations it is better to go along with the majority than to have my own way.



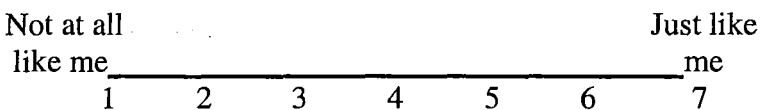
7. I believe people could do a lot more for me if they wanted to.



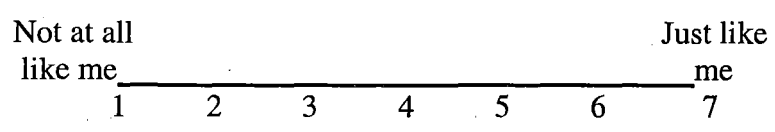
8. Even if the person closest to me were to leave I could still manage by myself.



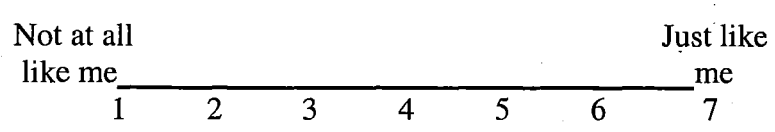
9. I am most likely to be able to help someone with a problem.



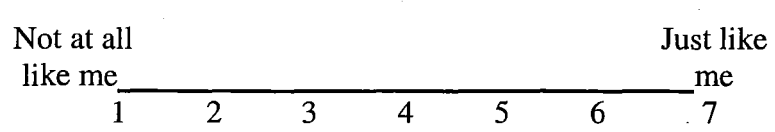
10. I avoid doing many tasks that I could do myself.



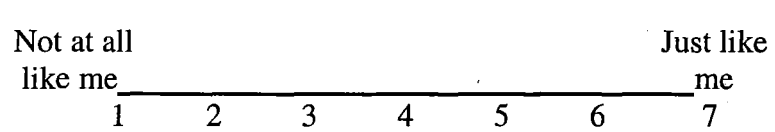
11. I find it difficult to be separated from people I love.



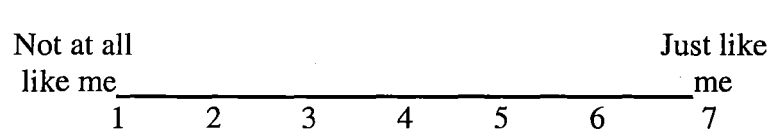
12. I need people to reassure me that they think well of me.



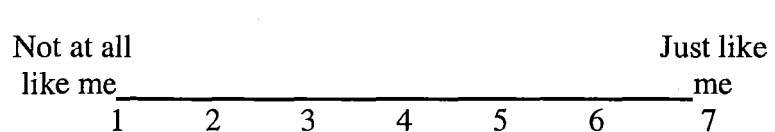
13. I tend to be influenced by people with strong opinions.



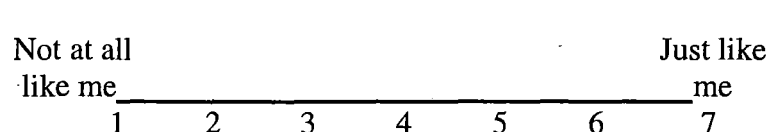
14. Other people tend to come to me for help.



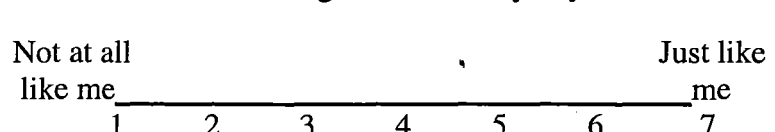
15. Often I think I have disappointed others.



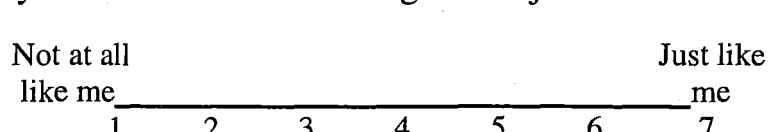
16. I worry about being abandoned.



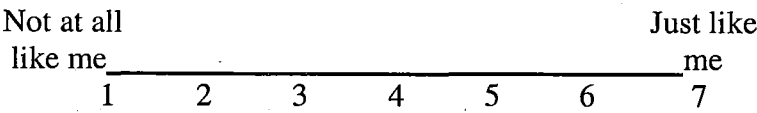
17. I have a lot of trouble making decisions by myself.



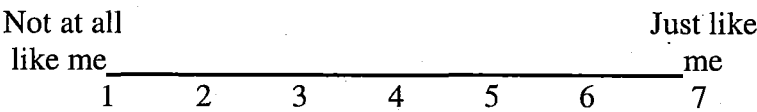
18. I am very sensitive to others for signs of rejection.



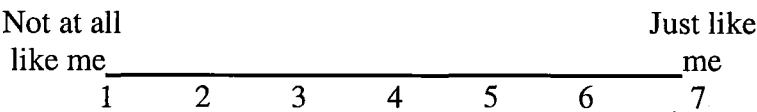
19. I am afraid of hurting other people's feelings.



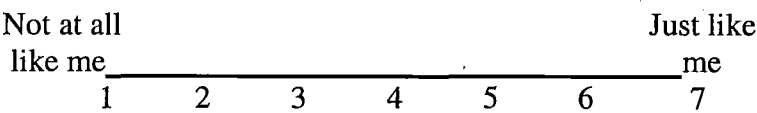
20. I am very sure about the kind of person I am.



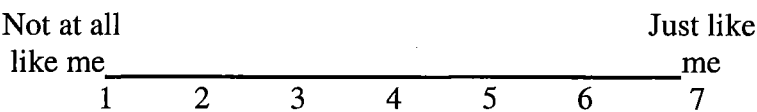
21. I like to be fussed over when I am sick.



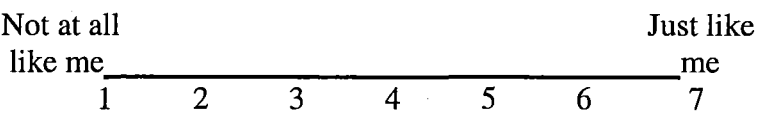
22. I try to make friends with people who can help me.



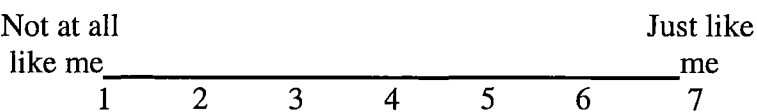
23. When someone close to me is away, I count the hours until his or her return.



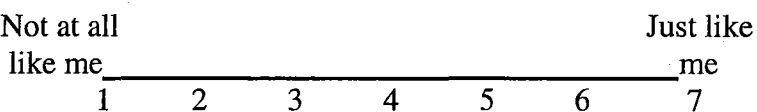
24. I will do anything I can to ensure that I get help from others.



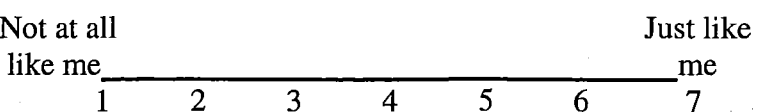
25. I need people to tell me what to do.



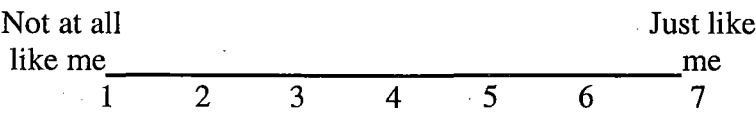
26. After a fight with a family member or friend I must make amends straightaway.



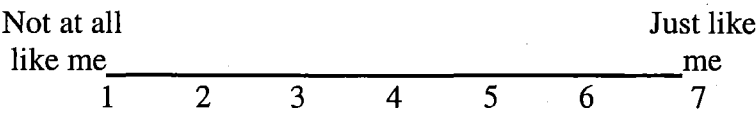
27. I am very sensitive to others for signs of their willingness to help people like me.



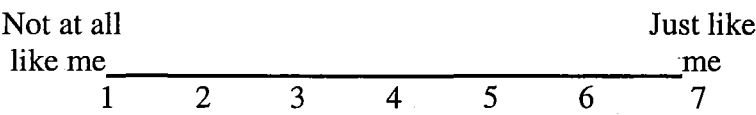
28. I hesitate to accept help from others.



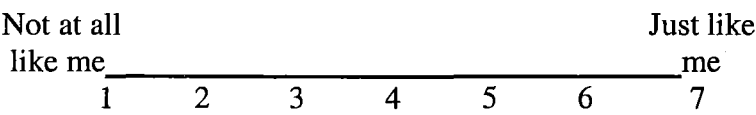
29. To be left alone by others would be the worst part about growing old.



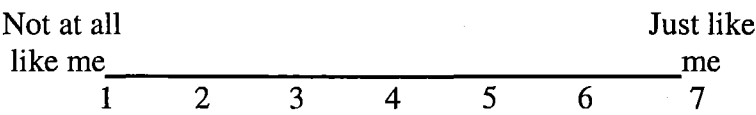
30. It is hard for me to make up my mind about a TV show or movie until I know what other people think.



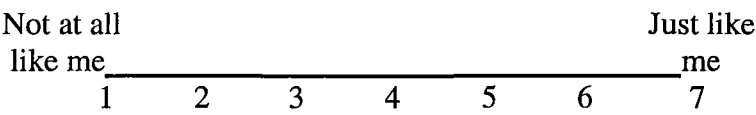
31. I have always had a terrible fear that I will lose the love and support of people I need.



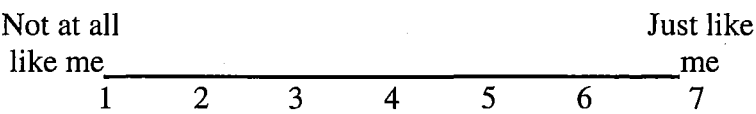
32. I am usually sure of myself when I have to face complicated situations alone.



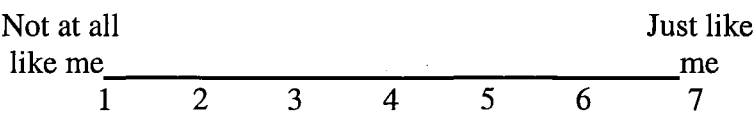
33. As a child, my parents preferred to do most things for me rather than risk mishaps.



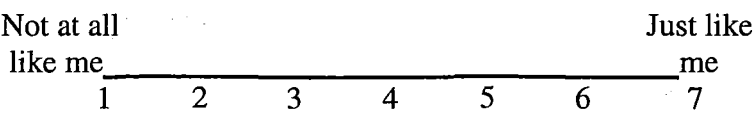
34. I am afraid of physically injuring myself whilst doing everyday tasks.



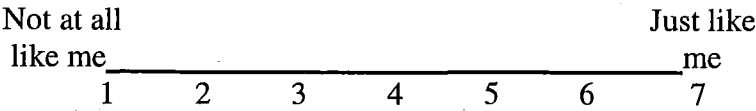
35. I really only feel safe when I am with the person I am especially close to.



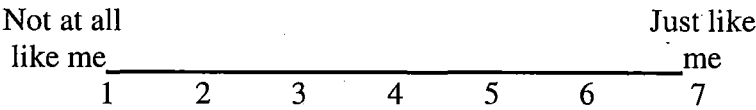
36. When I go shopping I always take someone with me to help choose items.



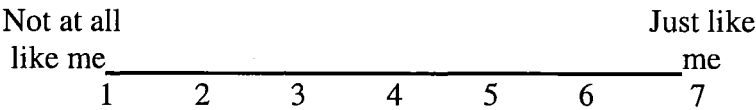
37. Most people are more powerful than I am.



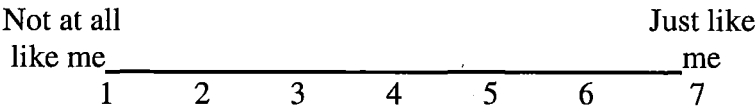
38. I would much rather be a follower than a leader.



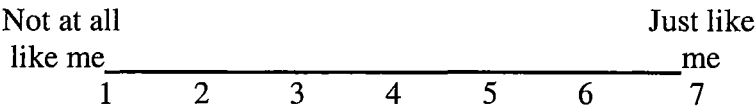
39. I tend to be a loner.



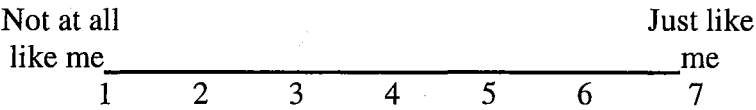
40. I often change my mind about decisions if my friends or family disagree.



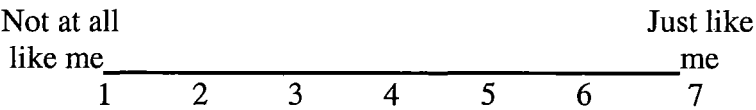
41. I feel panicky when I am separated from those I love.



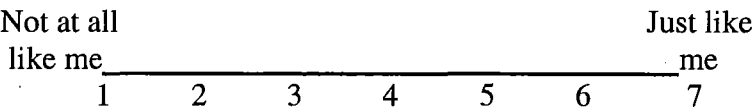
42. I become extremely anxious if I think I have to do something new by myself.



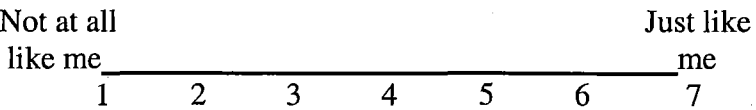
43. I tend to go along with what other people want even when it is not what I want.



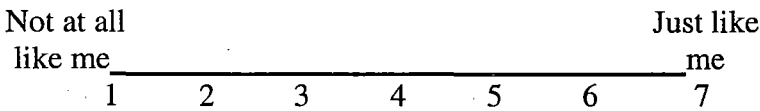
44. I am a leader.



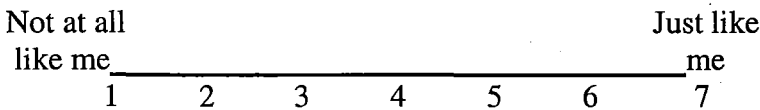
45. Even if things are not in my best interest, it is usually best to do them anyway in order to please others.



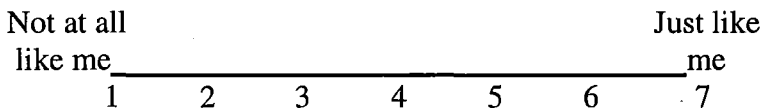
46. I always consult another person before taking a decision.



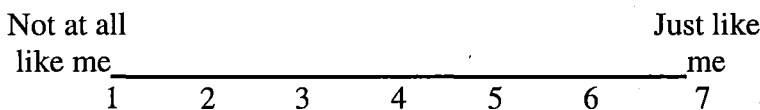
47. I become anxious when I have to be alone for any length of time.



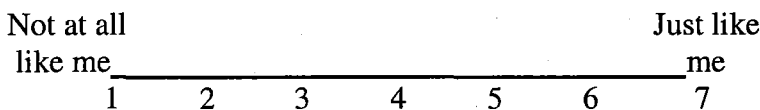
48. I generally follow other people's suggestions.



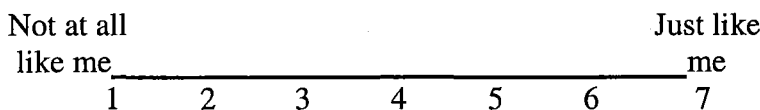
49. I tend to worry about what other people think of me.



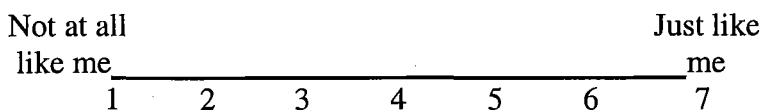
50. If I think that somebody might be upset with me I want to apologise.



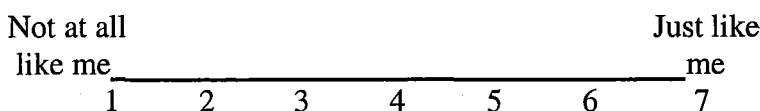
51. I am afraid to leave my home alone.



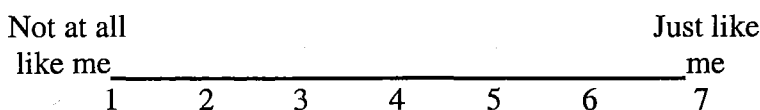
52. I am only really comfortable when I have someone to keep me company.



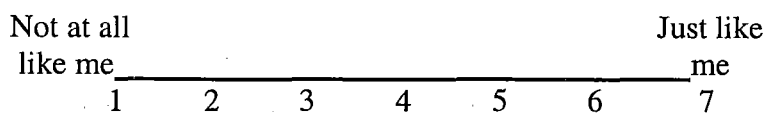
53. I only enjoy what I am doing when I think that someone really cares about me.



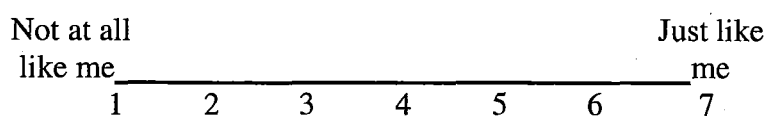
54. The thought of being alone doesn't bother me at all.



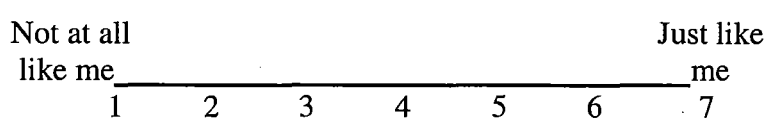
55. When things go wrong, I need to be with someone I am close to.



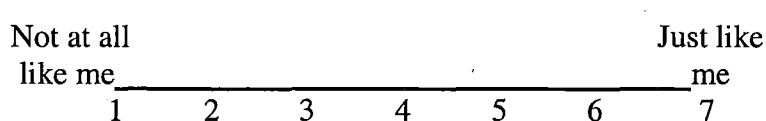
56. Other people are much better at doing things than I am.



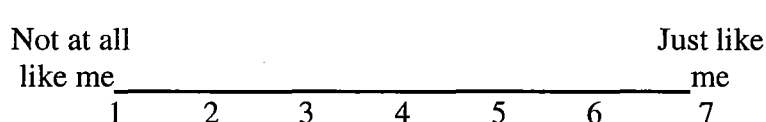
57. I would be helpless without support from others who are close to me.



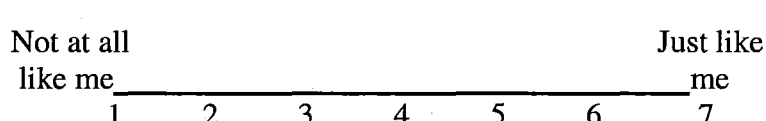
58. I often worry when people ask favours of me.



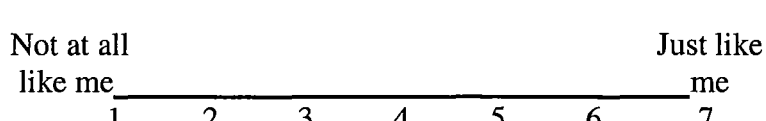
59. I hesitate to express opinions that I think others will disagree with.



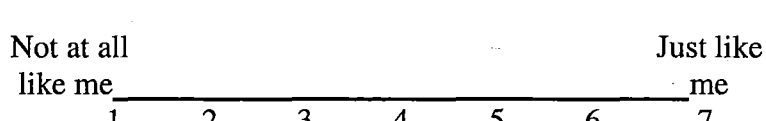
60. I avoid getting attached to anyone.



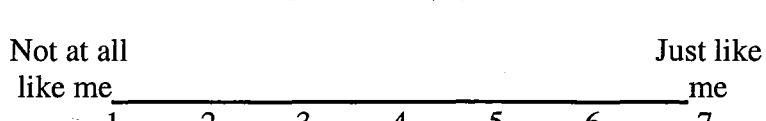
61. Even when things go wrong I get along without asking for help from anyone.



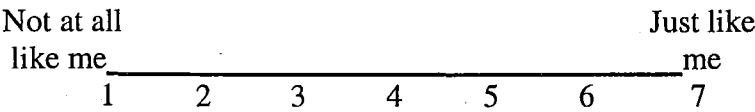
62. I find it difficult to feel completely secure in a close relationship.



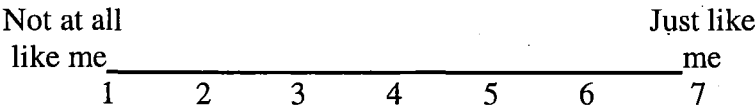
63. I often think about the danger of losing someone close to me.



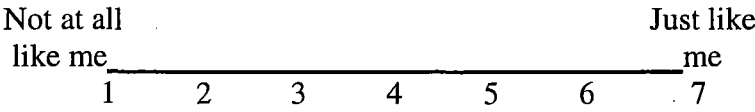
64. It is very important to me to be approved of by others.



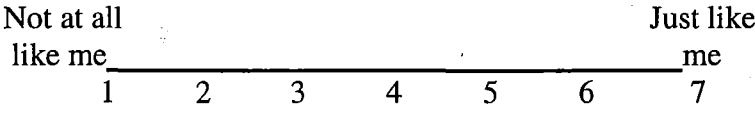
65. When I meet new people, I'm afraid that I will act the wrong way.



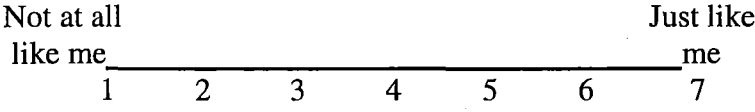
66. In my relationships with others I am interested in what they can do for me.



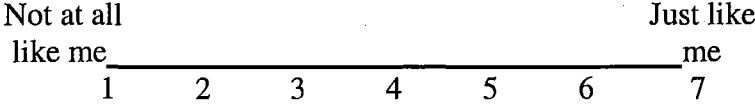
67. I often change the way I think to be more like those around me.



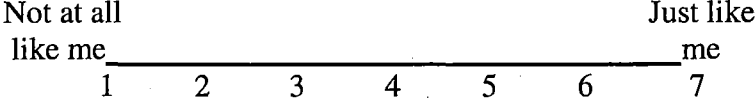
68. I easily get discouraged when I don't get what I need from others.



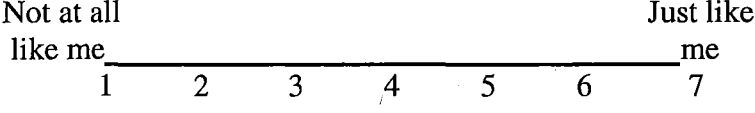
69. I am very confident about my own judgement.



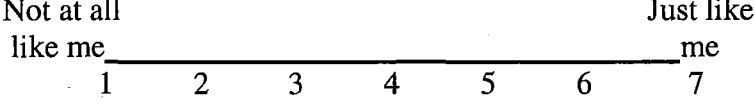
70. I am more comfortable with taking decisions made by other people.



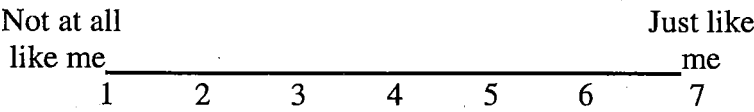
71. I almost always avoid going out alone.



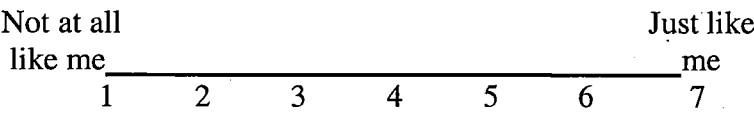
72. I become attached to people who help me.



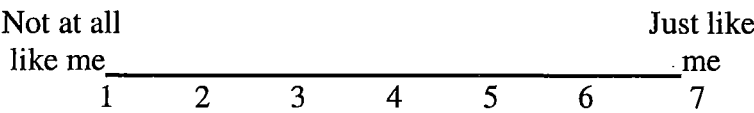
73. If a friend has not called for awhile I get worried that he/she has forgotten me.



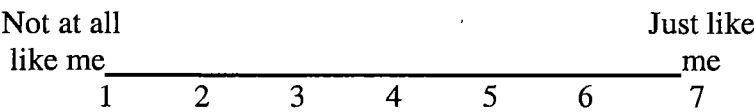
74. I need more help with things than other people seem to need.



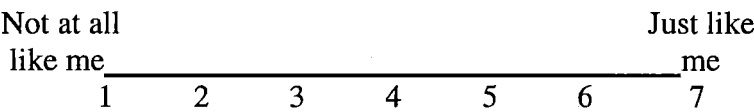
75. When I am with other people I look for signs of whether or not they like being with me.



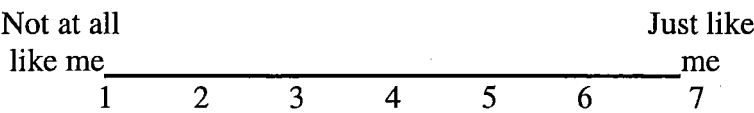
76. I usually make my own decisions.



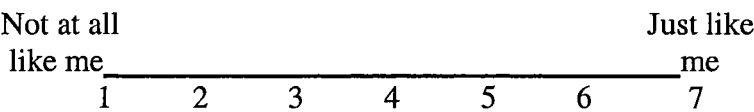
77. I worry about people not liking me.



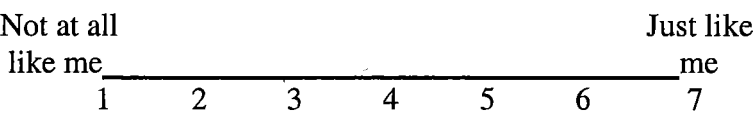
78. I cannot tell someone directly that I am angry with him or her.



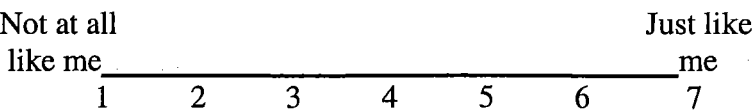
79. When I am sick, I prefer that my friends leave me alone.



80. I feel helpless in many situations.



81. I almost always behave according to the wishes of my family, friends or my doctor.



82. I often feel threatened by change.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

83. My worst fear is being rejected by someone.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

84. I am confident of my ability to deal with most of the personal problems I am likely to meet in life.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

85. It is hard for me to ask a favour of someone.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

Please tick:

_____ I have checked that I have responded to all of the statements on both sides of each page.

PLEASE RETURN THE COMPLETED QUESTIONNAIRE TO THE RESEARCHER IN THE REPLY PAID ENVELOPE PROVIDED

Thank you for your participation.

Appendix D

Statistical analyses undertaken in Chapter 4, stage 2.

RELIABILITY ANALYSIS - SCALE (ALPHA)

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Alpha if Item Deleted
ITEM43	234.7826	4605.0362	.6772	.9534
ITEM44	233.3043	4676.6489	.3414	.9545
ITEM45	234.0072	4662.3781	.4283	.9542
ITEM46	234.4565	4623.7181	.5967	.9536
ITEM47	235.2319	4646.9569	.6341	.9537
ITEM48	234.6667	4650.6085	.6196	.9537
ITEM49	234.3188	4614.7562	.6370	.9535
ITEM50	233.0109	4639.5817	.4966	.9539
ITEM51	235.5326	4690.0971	.4429	.9542
ITEM52	234.2899	4654.8902	.5164	.9539
ITEM53	234.5543	4618.2043	.6142	.9536
ITEM54	233.6558	4654.1247	.3673	.9545
ITEM55	233.1957	4586.0343	.6885	.9533
ITEM56	233.9348	4645.4066	.5335	.9539
ITEM57	234.6775	4610.9975	.6803	.9534
ITEM58	234.7899	4700.6248	.3353	.9544
ITEM59	234.6812	4668.8943	.4802	.9540
ITEM60	231.7428	4812.9409	-.1547	.9560
ITEM61	233.4203	4713.7936	.2137	.9549
ITEM62	234.2935	4718.2226	.1950	.9550
ITEM63	233.3043	4612.9325	.5473	.9538
ITEM64	233.7065	4631.6117	.5767	.9537
ITEM65	234.7101	4670.0684	.4453	.9541
ITEM68	235.1304	4672.6375	.5220	.9540
ITEM69	234.0797	4698.7209	.2816	.9546
ITEM70	234.7971	4656.5260	.5901	.9538
ITEM71	234.9783	4631.7450	.5543	.9538
ITEM72	233.4783	4637.6104	.4856	.9540
ITEM73	234.6087	4646.7409	.5579	.9538
ITEM74	234.6630	4640.2824	.5478	.9538
ITEM75	234.3442	4639.0702	.5314	.9538
ITEM76	234.8043	4704.4489	.2768	.9546
ITEM77	234.4058	4614.8747	.6125	.9536
ITEM78	233.0652	4691.0212	.3071	.9546
ITEM79	233.2174	4709.9235	.2121	.9549
ITEM80	234.6739	4628.1187	.6316	.9536
ITEM81	233.6159	4621.5320	.5274	.9538
ITEM82	234.1014	4616.5933	.5945	.9536
ITEM83	234.4928	4612.0399	.6657	.9535
ITEM84	234.8406	4704.7890	.3111	.9545
ITEM85	233.4239	4801.6996	-.1124	.9559

Silver Chain

Chapter 4

PAR

EIGEN.OUT

ESTIMATED EIGENVALUES FOR RANDOM DATA CORRELATION MATRICES

70 SUBJECTS 20 VARIABLES

ALLEN & HUBBARD PROCEDURE			LONGMAN, COTA, HOLDEN & FEKKEN PROCEDURE	
		MEAN	MEAN	95% C.I.
EIGENVALUE	1	2.117499	2.135179	2.350190
EIGENVALUE	2	1.879930	1.901137	2.049898
EIGENVALUE	3	1.703155	1.730086	1.849098
EIGENVALUE	4	1.558388	1.571722	1.677603
EIGENVALUE	5	1.429742	1.447046	1.540148
EIGENVALUE	6	1.308230	1.331138	1.421882
EIGENVALUE	7	1.193714	1.222613	1.307830
EIGENVALUE	8	1.081082	1.118467	1.201923
EIGENVALUE	9	.982916	1.036478	1.111278
EIGENVALUE	10	.888912	.951469	1.024256
EIGENVALUE	11	.799028	.869006	.940178
EIGENVALUE	12	.708920	.789387	.859089
EIGENVALUE	13	.617579	.710684	.779683
EIGENVALUE	14	.542320	.670419	.731153
EIGENVALUE	15	.467760	.605875	.666014
EIGENVALUE	16	.402639	.544260	.601980
EIGENVALUE	17	.334418	.484180	.539902
EIGENVALUE	18	.275683	.424199	.480347
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

2

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

-601980				
EIGENVALUE	17	.334418	.484180	.539902
EIGENVALUE	18	.275683	.424199	.480347
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME .863909

EIGENVALUE	30	2.393129	.887892	.865991
EIGENVALUE	31	2.586278	.841228	.842414
EIGENVALUE	32	2.943460	.820138	.817431
EIGENVALUE	33	2.943460	.795929	.817431
EIGENVALUE	34	3.386311	.774775	.798131
EIGENVALUE	35	3.810064	-99.000000	-99.000000
EIGENVALUE	36	4.269237	-99.000000	-99.000000
EIGENVALUE	37	5.047493	-99.000000	-99.000000
EIGENVALUE	38	6.239259	-99.000000	-99.000000
EIGENVALUE	39	8.636198	-99.000000	-99.000000
EIGENVALUE	40	10.165180	-99.000000	-99.000000
EIGENVALUE	41	12.279750	-99.000000	-99.000000
EIGENVALUE	42	15.912110	-99.000000	-99.000000
EIGENVALUE	43	21.400290	-99.000000	-99.000000
EIGENVALUE	44	33.005260	-99.000000	-99.000000
EIGENVALUE	45	54.575600	-99.000000	-99.000000
EIGENVALUE	46	-99.000000	-99.000000	-99.000000
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000

		EIGEN.OUT		
EIGENVALUE	49	-99.000000	-99.000000	-99.000000
EIGENVALUE	50	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
 THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
 SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

-99.000000				
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000
EIGENVALUE	49	-99.000000		

PAR

Positive Ageing

EIGEN.OUT

ESTIMATED EIGENVALUES FOR RANDOM DATA CORRELATION MATRICES

206 SUBJECTS 20 VARIABLES

ALLEN & HUBBARD PROCEDURE			LONGMAN, COTA, HOLDEN & FEKKEN PROCEDURE	
		MEAN	MEAN	95% C.I.
EIGENVALUE	1	1.692201	1.659041	1.771881
EIGENVALUE	2	1.559350	1.535148	1.616740
EIGENVALUE	3	1.457373	1.443707	1.511007
EIGENVALUE	4	1.372060	1.354237	1.414556
EIGENVALUE	5	1.294220	1.284170	1.337845
EIGENVALUE	6	1.219955	1.217635	1.270751
EIGENVALUE	7	1.148221	1.154637	1.205669
EIGENVALUE	8	1.077024	1.093151	1.143976
EIGENVALUE	9	1.014475	1.039621	1.085724
EIGENVALUE	10	.952917	.987332	1.031702
EIGENVALUE	11	.891775	.935154	.979847
EIGENVALUE	12	.829199	.883612	.927882
EIGENVALUE	13	.762854	.830818	.876443
EIGENVALUE	14	.708349	.799258	.840445
EIGENVALUE	15	.653714	.754185	.794432
EIGENVALUE	16	.601701	.709613	.750227
EIGENVALUE	17	.545881	.664451	.705072
EIGENVALUE	18	.493427	.617530	.660832
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

	750227			
EIGENVALUE	17	.545881	.664451	.705072
EIGENVALUE	18	.493427	.617530	.660832
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME .863909

		.887892	
EIGENVALUE	30	2.393129	.841228
EIGENVALUE	31	2.586278	.820138
EIGENVALUE	32	2.943460	.795929
EIGENVALUE	33	3.386311	.774775
EIGENVALUE	34	3.810064	-99.000000
EIGENVALUE	35	4.269237	-99.000000
EIGENVALUE	36	5.047493	-99.000000
EIGENVALUE	37	6.239259	-99.000000
EIGENVALUE	38	8.636198	-99.000000
EIGENVALUE	39	10.165180	-99.000000
EIGENVALUE	40	12.279750	-99.000000
EIGENVALUE	41	15.912110	-99.000000
EIGENVALUE	42	21.400290	-99.000000
EIGENVALUE	43	33.005260	-99.000000
EIGENVALUE	44	54.575600	-99.000000
EIGENVALUE	45	-99.000000	-99.000000
EIGENVALUE	46	-99.000000	-99.000000
EIGENVALUE	47	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000

		EIGEN.OUT		
EIGENVALUE	49	-99.000000	-99.000000	-99.000000
EIGENVALUE	50	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

-99.000000

EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000
EIGENVALUE	49	-99.000000		

PAR

Chapter 4

Booled

EIGEN.OUT

ESTIMATED EIGENVALUES FOR RANDOM DATA CORRELATION MATRICES

276 SUBJECTS 20 VARIABLES

		ALLEN & HUBBARD PROCEDURE	LONGMAN, COTA, HOLDEN & FEKKEN PROCEDURE	
		MEAN	MEAN	95% C.I.
EIGENVALUE	1	1.592882	1.549389	1.641307
EIGENVALUE	2	1.482648	1.448716	1.516006
EIGENVALUE	3	1.397369	1.374614	1.430541
EIGENVALUE	4	1.325726	1.300665	1.350662
EIGENVALUE	5	1.259912	1.243277	1.287750
EIGENVALUE	6	1.197178	1.188577	1.232634
EIGENVALUE	7	1.136248	1.136875	1.179384
EIGENVALUE	8	1.075932	1.086390	1.128759
EIGENVALUE	9	1.023160	1.040474	1.078901
EIGENVALUE	10	.970960	.997282	1.033729
EIGENVALUE	11	.918590	.953933	.990883
EIGENVALUE	12	.865008	.911032	.947457
EIGENVALUE	13	.807594	.866738	.904675
EIGENVALUE	14	.761271	.838255	.872781
EIGENVALUE	15	.715490	.800294	.833314
EIGENVALUE	16	.670575	.762512	.796351
EIGENVALUE	17	.623030	.723961	.757964
EIGENVALUE	18	.577333	.683687	.720504
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

EIGENVALUE	17	.623030	.723961	.757964
EIGENVALUE	18	.577333	.683687	.720504
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

EIGENVALUE	30	2.393129	.887892	.865991
EIGENVALUE	31	2.586278	.841228	.842414
EIGENVALUE	32	2.943460	.820138	.817431
EIGENVALUE	33	2.943460	.795929	.798131
EIGENVALUE	34	3.386311	.774775	.798131
EIGENVALUE	35	3.810064	-99.000000	-99.000000
EIGENVALUE	36	4.269237	-99.000000	-99.000000
EIGENVALUE	37	5.047493	-99.000000	-99.000000
EIGENVALUE	38	6.239259	-99.000000	-99.000000
EIGENVALUE	39	8.636198	-99.000000	-99.000000
EIGENVALUE	40	10.165180	-99.000000	-99.000000
EIGENVALUE	41	12.279750	-99.000000	-99.000000
EIGENVALUE	42	15.912110	-99.000000	-99.000000
EIGENVALUE	43	21.400290	-99.000000	-99.000000
EIGENVALUE	44	33.005260	-99.000000	-99.000000
EIGENVALUE	45	54.575600	-99.000000	-99.000000
EIGENVALUE	46	-99.000000	-99.000000	-99.000000
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000

		EIGEN.OUT		
EIGENVALUE	49	-99.000000	-99.000000	-99.000000
EIGENVALUE	50	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
 THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
 SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

-99.000000				
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000
EIGENVALUE	49	-99.000000		

Stage 2. (5-10)

T-Test

Group Statistics

organisation		N	Mean	Std. Deviation	Std. Error Mean
total 20 item scale	silver chain	70	62.57	28.56	3.41
	Positive Ageing	207	46.42	20.67	1.44

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
total 20 item scale	Equal variances assumed	12.941	.000
	Equal variances not assumed		

Independent Samples Test

		t-test for Equality of Means			
		t	df	Sig. (2-tailed)	Mean Difference
total 20 item scale	Equal variances assumed	5.100	275	.000	16.15
	Equal variances not assumed	4.361	94.605	.000	16.15

Independent Samples Test

		t-test for Equality of Means		
		Std. Error Difference	95% Confidence Interval of the Difference	
			Lower	Upper
total 20 item scale	Equal variances assumed	3.17	9.92	22.39
	Equal variances not assumed	3.70	8.80	23.50

T-Test

Group Statistics

Gender (SC/PAF - Sugar)

		gender	N	Mean	Std. Deviation	Std. Error Mean
total 20 item scale	female		183	48.38	22.73	1.68
	male		92	55.09	25.72	2.68

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
total 20 item scale	Equal variances assumed	3.133	.078
	Equal variances not assumed		

Independent Samples Test

		t-test for Equality of Means			
		t	df	Sig. (2-tailed)	Mean Difference
total 20 item scale	Equal variances assumed	-2.207	273	.028	-6.70
	Equal variances not assumed	-2.119	163.906	.036	-6.70

Independent Samples Test

		t-test for Equality of Means		
		Std. Error Difference	95% Confidence Interval of the Difference	
			Lower	Upper
total 20 item scale	Equal variances assumed	3.04	-12.69	-.72
	Equal variances not assumed	3.16	-12.95	-.46

Correlations

Correlations

		age	total 20 item scale
age	Pearson Correlation	1.000	.180**
	Sig. (2-tailed)	.	.003
	N	295	274
total 20 item scale	Pearson Correlation	.180**	1.000
	Sig. (2-tailed)	.003	.
	N	274	277

** . Correlation is significant at the 0.01 level (2-tailed).

Appendix E

1. Information and disclosure form used in chapter 5 (stage 3).
2. Consent form used in chapter 5 (stage 3) .
3. Information letters to participants from the organizations involved in stage 3.
4. Twenty-item final version of the Interpersonal dependency scale for older adults developed in chapter 3 (stage 2) and used in chapters 5 and 6 (stages 3 and 4) along with instructions for completing the scale.

Information and Disclosure Form

Project Title: *Individual Differences in Dependent Personality in Older Adults: Development of a measure and its Evaluation in Health Care Services.*

This research project is being conducted to satisfy part-requirement for a Doctor of Philosophy, Psychology degree at Edith Cowan University, Joondalup, WA. The project aims to develop, with the assistance of older adults, a questionnaire for the purpose of measuring dependent personality in older people.

You can help with this project by completing a questionnaire. The questionnaire consists of questions and statements to do with various aspects of dependency. It is hoped that the results will increase our understanding of the dependency needs of older people. Detailed instructions for answering the questions are given on the first page. It will take you about 5-10 minutes to complete the questionnaire.

The research student and the research student's supervisors will be involved in this project and will have access to the information that you provide.

All information given in the questionnaire is strictly confidential. We appreciate your assistance but you are under no obligation to complete the questionnaire. You may also withdraw from the study at any time.

The results from this research will be published but you will not be able to be identified in the publication. Your name will not be required on the questionnaire.

Should you have any queries or concerns in the future about the study, please contact Deborah Gardner (the research student) on (08) 9448 4275 or Dr Craig Speelman, School of Psychology, Edith Cowan University on 9400 5724.

Thank you for your time and participation.

Deborah Gardner
School of Psychology Ph.D. Student
Edith Cowan University

Craig Speelman Ph.D.
School of Psychology
Edith Cowan University

CONSENT FORM Project Title: *Individual Differences in Dependent Personality in Older Adults: Development of a Measure and its Evaluation in Health Care Services*

Should you wish to participate in this project, please sign below to indicate your consent.

- I freely agree to participate in this study realising that I may withdraw at any time. I have read and received a copy of the "Information and Disclosure Form" and any questions I have asked have been answered to my satisfaction. I have no objections to the results of the study being published in a report so long as I cannot be identified in these results.

ParticipantDate.....

Researcher.....Date.....

COUNCIL ON THE AGEING



23rd July 2002

Dear COTA member,

RESEARCH PROJECT: INDIVIDUAL DIFFERENCES IN DEPENDENT PERSONALITY IN OLDER ADULTS - DEVELOPMENT OF A MEASURE AND ITS EVALUATION IN HEALTH CARE SERVICES

Your name has been randomly selected by Council On The Ageing from our membership database to invite you, as a COTA(WA) member, to participate in a study to develop a questionnaire that will be used to measure dependency in older adults. This study is being conducted by Ms Deborah Gardner, a research student from Edith Cowan University. Participation in this study is entirely optional and your personal address has not been revealed.


Please find enclosed an Information and Disclosure Form, providing details about the study. A Consent Form is also included. If you do decide to participate, would you please return the completed **questionnaire and consent form** in the reply paid envelope by Monday, **12 August 2002**. Detailed instructions for completing the questionnaire are given on the first page.

Whilst we would greatly appreciate your participation in the project, you are under no obligation to complete the questionnaire.

If you have any questions about the study, please contact Ms Gardner on (08) 9448 4275 or Dr Craig Speelman on (08) 9400 5724.

Thank you.

Yours Sincerely



Nigel Barker
Executive Director

Council on the Ageing (WA) Incorporated
ABN 79 970 893 100
2nd Floor, WESLEY CENTRE, 93 William Street, Perth 6000
P.O. Box 7794, Cloisters Square Perth W.A. 6850
Telephone: (08) 9321 2133 Facsimile: (08) 9321 2707
Website Address: www.cotawa.asn.au
Email Address: admin@cotawa.asn.au



SILVER CHAIN

Caring In The Community

6 Sundercombe Street Osborne Park
Western Australia 6017

Telephone (08) 9242 0242

Facsimile (08) 9242 0268

Email info@silverchain.org.au

Website www.silverchain.org.au

16 July 2002

RESEARCH PROJECT: INDIVIDUAL DIFFERENCES IN DEPENDENT PERSONALITY IN OLDER ADULTS - DEVELOPMENT OF A MEASURE AND ITS EVALUATION IN HEALTH CARE SERVICES

I am writing to invite you to participate in a study to develop a questionnaire to measure dependency being conducted by Ms Deborah Gardner, a research student from Edith Cowan University.

Silver Chain is committed to providing the best care possible for its clients. It is for this reason that Silver Chain conducts research projects and also supports many research projects being undertaken by university staff and students.

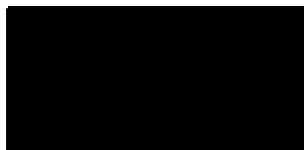
Please find enclosed an Information and Disclosure Form, providing details about the study, and a Consent Form. Detailed instructions for completing the questionnaire are given on the first page. If you do decide to participate, please return the completed **questionnaire and consent form** in the reply paid envelope by Tuesday, **30 July 2002**.

Whilst we would greatly appreciate your participation in the project, you are under no obligation to complete the questionnaire. Your decision to participate or not will in no way affect any services that you are currently receiving from Silver Chain.

If you have any questions about the study, please contact Ms Gardner on ☎ 9448 4275 or Dr Craig Speelman on ☎ 9400 5724.

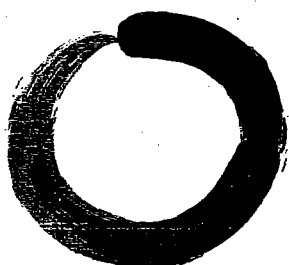
Thank you.

Sincerely



Dr Gill Lewin
Research Manager

GL [G1.30]



**POSITIVE AGEING
FOUNDATION**

creating Age Friendly communities

National Office
Old Cloisters Building
200 St Georges Terrace
Perth Western Australia 6000
Telephone + 61 8 9482 2000
Facsimile + 61 8 9482 2001
Freecall 1800 757 555
ABN 74 897 181 527
Email info@positiveageing.com.au
Website www.positiveageing.com.au

Patron His Excellency Lieutenant General
John Sanderson, AC Governor of Western Australia

Vice Patron Hon. David Malcolm, AC
Chief Justice of Western Australia

Founding Chairman
Dr Eric Tan, AM

14/3/2002

Dear

Welcome to the Positive Ageing Foundation of Australia Research Group. Many of our research partners are very keen to work with seniors and gain first hand knowledge of how you feel about certain issues. The Positive Ageing Foundation of Australia wishes to develop these partnerships and ensure that seniors have a voice in framing new research and responses to important issues that affect their lives.

An Edith Cowan University Psychology PhD student, recently approached the Foundation with a request to invite members of the Research Group to participate in a study to assist in developing a questionnaire for the purpose of measuring dependency in older people.

If you are interested in assisting with this study, please complete the enclosed questionnaire and return in the reply paid envelope by Friday 19 April 2002.

We have enclosed information from Edith Cowan University on the details of the research project, together with a disclosure form and questionnaire

If you require any further general information please contact Marlene Robins at the Foundation on 9482 2012.

Thank you for taking the time to consider becoming a participant in this important study.

Yours sincerely


DIANNE MORAN
Executive Director

Chairman
Dr John Hewson

Deputy Chairman
Dr Penny Flett

Secretary
Hon Kay Hallahan

Treasurer
Mr Harry W Sorensen

Board Members
Sir James Cruthers
Prof Charles Watson

Executive Director
Ms Dianne Moran

The Positive Ageing Foundation is a national not-for-profit organisation dedicated to working with and for older Australians to improve the quality of their lives.

PLEASE READ ALL OF THIS PAGE FIRST

Questionnaire

Name (optional)_____ Please Circle: Male / Female

Age_____

Everyone's needs and behaviours differ. This questionnaire contains statements about interpersonal needs and behaviours. You are asked to rate yourself on each of these statements using a rating scale. See the following directions for using the scale.

Directions

After each statement in the questionnaire is a rating scale numbered from 1 to 7. You will find an example below of a statement followed by a rating scale. If the statement sounds just like you, circle the number "7". If it sounds not at all like you, then circle the number "1". If the statement sounds a little like you, somewhat like you or quite like you, then circle a number in between. The more like you the example sounds, the higher the number you circle.

Example:

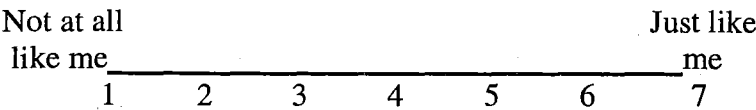
1. I like to have someone with me most of the time.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

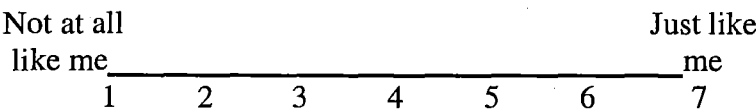
For each statement in the questionnaire, circle the number that is most like you. **Please respond to EVERY statement even if you are unsure of the number to circle for some statements.**

Thank you for your participation.

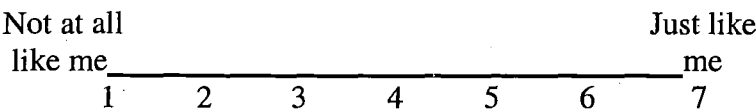
1. Worry tends to make me cling to those I am closest to.



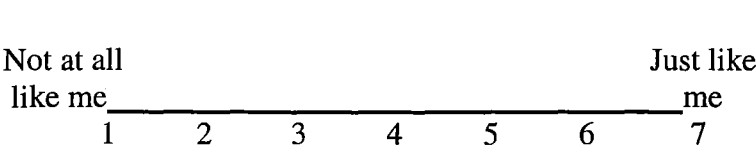
2. I have a lot of trouble making decisions by myself.



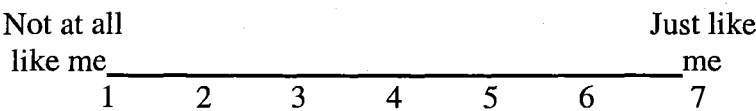
3. Other people seem to need less help with things than I need.



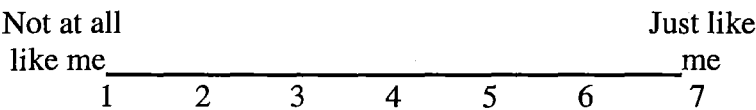
4. I really only feel safe when I am with a person I am especially close to.



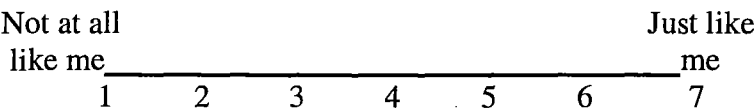
5. I become extremely anxious if I think I have to do something new by myself.



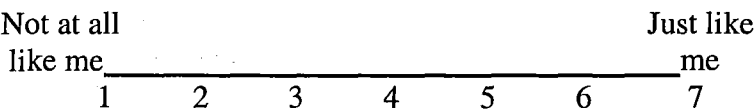
6. If a friend has not called in a while I get worried that he/she has forgotten me.



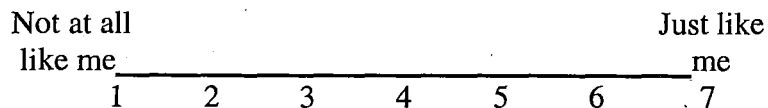
7. I need people to tell me what to do.



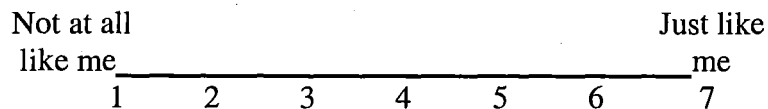
8. I tend to worry about what other people think of me.



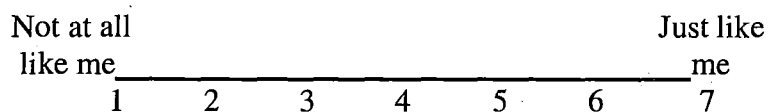
9. I become anxious when I have to be alone for any length of time.



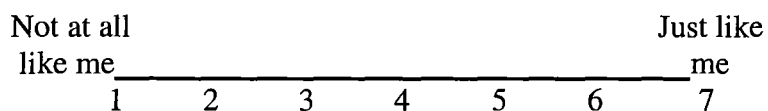
10 I often feel threatened by change.



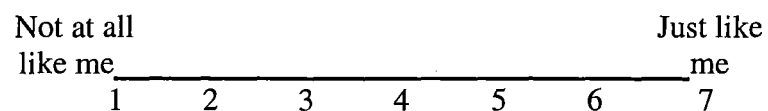
11. It is very important to me to be approved of by others.



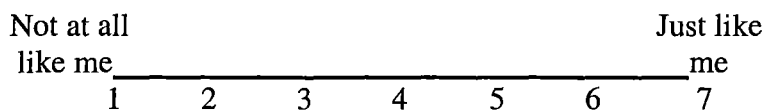
12. I would be helpless without support from others who are close to me.



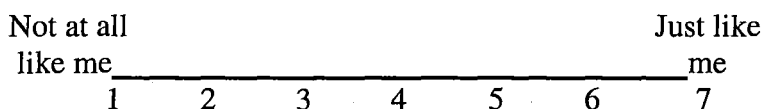
13. When things go wrong, I need to be with someone I am close to.



14. When I am with other people I look for signs of whether or not they like being with me.



15. I tend to go along with what other people want even if it is not what I want.



16. I feel helpless in many situations.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

17. I almost always avoid going out alone.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

18. My worst fear is being rejected by someone.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

19. I only enjoy what I am doing when I think that someone really cares about me.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

20. I generally follow other people's suggestions.

Not at all							Just like
like me							me
1	2	3	4	5	6	7	

Please tick:

_____ I have checked that I have responded to all of the statements on each page.

PLEASE RETURN THE COMPLETED QUESTIONNAIRE TO THE RESEARCHER IN THE REPLY PAID ENVELOPE PROVIDED

Thank you for your participation.

Appendix F

Statistical analyses undertaken in Chapter 5, stage 3.

Oneway

Descriptives

total score

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean	
					Lower Bound	Upper Bound
SC/female	49	60.20	25.92	3.70	52.76	67.65
SC/male	16	68.81	32.57	8.14	51.46	86.17
PAF/female	76	41.61	19.22	2.20	37.21	46.00
PAF/male	42	46.52	21.22	3.28	39.91	53.14
COTA/female	50	39.24	16.19	2.29	34.64	43.84
COTA/male	39	48.13	24.87	3.98	40.07	56.19
Total	272	47.82	23.68	1.44	44.99	50.64

Descriptives

total score

	Minimum	Maximum
SC/female	20	123
SC/male	25	123
PAF/female	20	111
PAF/male	20	100
COTA/female	20	83
COTA/male	20	132
Total	20	132

Test of Homogeneity of Variances

total score

Levene Statistic	df1	df2	Sig.
4.450	5	266	.001

ANOVA

total score

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	21256.299	5	4251.260	8.653	.000
Within Groups	130684.51	266	491.295		
Total	151940.81	271			

Post Hoc Tests

Homogeneous Subsets

total score

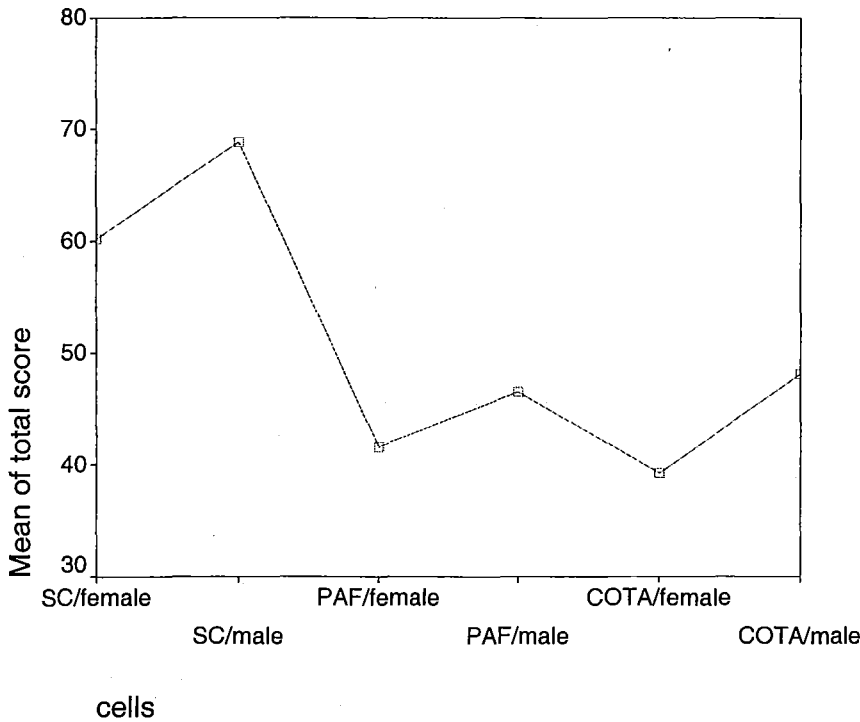
Tukey B^{a,b}

cells	N	Subset for alpha = .05		
		1	2	3
COTA/female	50	39.24		
PAF/female	76	41.61		
PAF/male	42	46.52		
COTA/male	39	48.13	48.13	
SC/female	49		60.20	60.20
SC/male	16			68.81

Means for groups in homogeneous subsets are displayed.

- a. Uses Harmonic Mean Sample Size = 36.250.
- b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Means Plots



Correlations

Correlations

		age	total score
age	Pearson Correlation	1.000	.159**
	Sig. (2-tailed)	.	.009
	N	281	266
total score	Pearson Correlation	.159**	1.000
	Sig. (2-tailed)	.009	.
	N	266	282

** . Correlation is significant at the 0.01 level (2-tailed).

Reliability

PAR

Chapter 5

Silver Chain

EIGEN.OUT

ESTIMATED EIGENVALUES FOR RANDOM DATA CORRELATION MATRICES

68 SUBJECTS 20 VARIABLES

		ALLEN & HUBBARD PROCEDURE	LONGMAN, COTA, HOLDEN & FEKKEN PROCEDURE	
		MEAN	MEAN	95% C.I.
EIGENVALUE	1	2.130362	2.149696	2.368085
EIGENVALUE	2	1.889449	1.912086	2.063008
EIGENVALUE	3	1.710340	1.738514	1.859153
EIGENVALUE	4	1.563757	1.578021	1.685305
EIGENVALUE	5	1.433593	1.451694	1.545984
EIGENVALUE	6	1.310701	1.334328	1.426179
EIGENVALUE	7	1.194967	1.224492	1.310689
EIGENVALUE	8	1.081192	1.119155	1.203519
EIGENVALUE	9	.982077	1.036394	1.111972
EIGENVALUE	10	.887244	.950525	1.024057
EIGENVALUE	11	.796661	.867296	.939135
EIGENVALUE	12	.705925	.787000	.857314
EIGENVALUE	13	.614065	.707710	.777237
EIGENVALUE	14	.538421	.667262	.728422
EIGENVALUE	15	.463549	.602322	.662868
EIGENVALUE	16	.398293	.540396	.598431
EIGENVALUE	17	.330021	.480082	.536046
EIGENVALUE	18	.271381	.419942	.476249
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

		.598431		
EIGENVALUE	17	.330021	.480082	.536046
EIGENVALUE	18	.271381	.419942	.476249
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME .863909

EIGENVALUE	30	2.393129	.887892	
EIGENVALUE	31	2.586278	.841228	.865991
EIGENVALUE	32	2.943460	.820138	.842414
EIGENVALUE	33	3.386311	.795929	.817431
EIGENVALUE	34	3.810064	.774775	.798131
EIGENVALUE	35	4.269237	-99.000000	-99.000000
EIGENVALUE	36	5.047493	-99.000000	-99.000000
EIGENVALUE	37	6.239259	-99.000000	-99.000000
EIGENVALUE	38	8.636198	-99.000000	-99.000000
EIGENVALUE	39	10.165180	-99.000000	-99.000000
EIGENVALUE	40	12.279750	-99.000000	-99.000000
EIGENVALUE	41	15.912110	-99.000000	-99.000000
EIGENVALUE	42	21.400290	-99.000000	-99.000000
EIGENVALUE	43	33.005260	-99.000000	-99.000000
EIGENVALUE	44	54.575600	-99.000000	-99.000000
EIGENVALUE	45	-99.000000	-99.000000	-99.000000
EIGENVALUE	46	-99.000000	-99.000000	-99.000000
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000

		EIGEN.OUT		
EIGENVALUE	49	-99.000000	-99.000000	-99.000000
EIGENVALUE	50	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
 THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
 SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

-99.000000				
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000
EIGENVALUE	49	-99.000000		

PAR

Chapter 5 Positive Ageing

EIGEN.OUT

ESTIMATED EIGENVALUES FOR RANDOM DATA CORRELATION MATRICES

139 SUBJECTS 20 VARIABLES

		ALLEN & HUBBARD PROCEDURE	LONGMAN, COTA, HOLDEN & FEKKEN PROCEDURE	
		MEAN	MEAN	95% C.I.
EIGENVALUE	1	1.835867	1.818841	1.964009
EIGENVALUE	2	1.668993	1.659572	1.762845
EIGENVALUE	3	1.542304	1.542135	1.626403
EIGENVALUE	4	1.437052	1.429779	1.505276
EIGENVALUE	5	1.341921	1.341294	1.408301
EIGENVALUE	6	1.251327	1.257837	1.323877
EIGENVALUE	7	1.164551	1.178963	1.241945
EIGENVALUE	8	1.078497	1.102311	1.164765
EIGENVALUE	9	1.002889	1.038474	1.094969
EIGENVALUE	10	.929138	.974107	1.028982
EIGENVALUE	11	.856883	.910481	.965199
EIGENVALUE	12	.783289	.848033	.902193
EIGENVALUE	13	.706473	.784845	.839859
EIGENVALUE	14	.642822	.749658	.798837
EIGENVALUE	15	.578836	.696335	.744986
EIGENVALUE	16	.519963	.644213	.692382
EIGENVALUE	17	.456830	.592058	.639712
EIGENVALUE	18	.399337	.538539	.588300
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

EIGENVALUE	17	.456830	.592058	.639712
EIGENVALUE	18	.399337	.538539	.588300
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME .863909

EIGENVALUE	30	2.393129	.887892	.865991
EIGENVALUE	31	2.586278	.841228	.842414
EIGENVALUE	32	2.943460	.820138	.817431
EIGENVALUE	33	3.386311	.795929	.798131
EIGENVALUE	34	3.810064	.774775	.798131
EIGENVALUE	35	4.269237	-99.000000	-99.000000
EIGENVALUE	36	5.047493	-99.000000	-99.000000
EIGENVALUE	37	6.239259	-99.000000	-99.000000
EIGENVALUE	38	8.636198	-99.000000	-99.000000
EIGENVALUE	39	10.165180	-99.000000	-99.000000
EIGENVALUE	40	12.279750	-99.000000	-99.000000
EIGENVALUE	41	15.912110	-99.000000	-99.000000
EIGENVALUE	42	21.400290	-99.000000	-99.000000
EIGENVALUE	43	33.005260	-99.000000	-99.000000
EIGENVALUE	44	54.575600	-99.000000	-99.000000
EIGENVALUE	45	-99.000000	-99.000000	-99.000000
EIGENVALUE	46	-99.000000	-99.000000	-99.000000
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000

		EIGEN.OUT		
EIGENVALUE	49	-99.000000	-99.000000	-99.000000
EIGENVALUE	50	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
 THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
 SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

-99.000000

EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000
EIGENVALUE	49	-99.000000		

PAR Chapter 5

COTA

EIGEN.OUT

ESTIMATED EIGENVALUES FOR RANDOM DATA CORRELATION MATRICES

93 SUBJECTS 20 VARIABLES

		ALLEN & HUBBARD PROCEDURE	LONGMAN, COTA, HOLDEN & FEKKEN PROCEDURE	
		MEAN	MEAN	95% C.I.
EIGENVALUE	1	1.995714	1.997986	2.181802
EIGENVALUE	2	1.789327	1.797095	1.925739
EIGENVALUE	3	1.634454	1.649614	1.753389
EIGENVALUE	4	1.506832	1.511301	1.603960
EIGENVALUE	5	1.392616	1.402272	1.484108
EIGENVALUE	6	1.284306	1.300275	1.380441
EIGENVALUE	7	1.181522	1.204342	1.280129
EIGENVALUE	8	1.080009	1.111747	1.186392
EIGENVALUE	9	.991157	1.037304	1.104494
EIGENVALUE	10	.905391	.960781	1.026211
EIGENVALUE	11	.822550	.885949	.950461
EIGENVALUE	12	.738888	.813167	.876685
EIGENVALUE	13	.653029	.740508	.804064
EIGENVALUE	14	.581969	.702167	.758460
EIGENVALUE	15	.511008	.641819	.697651
EIGENVALUE	16	.447722	.583623	.637893
EIGENVALUE	17	.380638	.526244	.579196
EIGENVALUE	18	.321515	.468270	.522419
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

		.637893		
EIGENVALUE	17	.380638	.526244	.579196
EIGENVALUE	18	.321515	.468270	.522419
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME .863909

		.887892		
EIGENVALUE	30	2.393129	.841228	.865991
EIGENVALUE	31	2.586278	.820138	.847414
EIGENVALUE	32	2.943460	.795929	.817431
EIGENVALUE	33	3.386311	.774775	.798131
EIGENVALUE	34	3.810064	-99.000000	-99.000000
EIGENVALUE	35	4.269237	-99.000000	-99.000000
EIGENVALUE	36	5.047493	-99.000000	-99.000000
EIGENVALUE	37	6.239259	-99.000000	-99.000000
EIGENVALUE	38	8.636198	-99.000000	-99.000000
EIGENVALUE	39	10.165180	-99.000000	-99.000000
EIGENVALUE	40	12.279750	-99.000000	-99.000000
EIGENVALUE	41	15.912110	-99.000000	-99.000000
EIGENVALUE	42	21.400290	-99.000000	-99.000000
EIGENVALUE	43	33.005260	-99.000000	-99.000000
EIGENVALUE	44	54.575600	-99.000000	-99.000000
EIGENVALUE	45	-99.000000	-99.000000	-99.000000
EIGENVALUE	46	-99.000000	-99.000000	-99.000000
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000

		EIGEN.OUT		
EIGENVALUE	49	-99.000000	-99.000000	-99.000000
EIGENVALUE	50	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
 THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
 SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

	-99.000000			
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000
EIGENVALUE	49	-99.000000		

PAR

Chapter 5
booked

EIGEN.OUT

ESTIMATED EIGENVALUES FOR RANDOM DATA CORRELATION MATRICES

300 SUBJECTS 20 VARIABLES

		ALLEN & HUBBARD PROCEDURE	LONGMAN, COTA, HOLDEN & FEKKEN PROCEDURE	
		MEAN	MEAN	95% C.I.
EIGENVALUE	1	1.565675	1.519482	1.605883
EIGENVALUE	2	1.461500	1.424983	1.488460
EIGENVALUE	3	1.380735	1.355532	1.408400
EIGENVALUE	4	1.312817	1.285787	1.332983
EIGENVALUE	5	1.250308	1.231861	1.273817
EIGENVALUE	6	1.190768	1.180422	1.221980
EIGENVALUE	7	1.132861	1.131862	1.171997
EIGENVALUE	8	1.075622	1.084470	1.124459
EIGENVALUE	9	1.025648	1.040717	1.076964
EIGENVALUE	10	.976162	1.000136	1.034308
EIGENVALUE	11	.926375	.959354	.994052
EIGENVALUE	12	.875488	.919002	.953112
EIGENVALUE	13	.820811	.877259	.912888
EIGENVALUE	14	.777056	.849715	.882225
EIGENVALUE	15	.734132	.813946	.844742
EIGENVALUE	16	.691598	.778300	.810010
EIGENVALUE	17	.646936	.741880	.773755
EIGENVALUE	18	.603745	.703810	.738479
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

		.810010		
EIGENVALUE	17	.646936	.741880	.773755
EIGENVALUE	18	.603745	.703810	.738479
EIGENVALUE	19	-99.000000	-99.000000	-99.000000
EIGENVALUE	20	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
SEE THE ACCOMPANYING READ.ME .863909

EIGENVALUE	30	2.393129	.887892	.865991
EIGENVALUE	31	2.586278	.841228	.842414
EIGENVALUE	32	2.943460	.820138	.817431
EIGENVALUE	33	2.943460	.795929	.798131
EIGENVALUE	34	3.386311	.774775	.798131
EIGENVALUE	35	3.810064	-99.000000	-99.000000
EIGENVALUE	36	4.269237	-99.000000	-99.000000
EIGENVALUE	37	5.047493	-99.000000	-99.000000
EIGENVALUE	38	6.239259	-99.000000	-99.000000
EIGENVALUE	39	8.636198	-99.000000	-99.000000
EIGENVALUE	40	10.165180	-99.000000	-99.000000
EIGENVALUE	41	12.279750	-99.000000	-99.000000
EIGENVALUE	42	15.912110	-99.000000	-99.000000
EIGENVALUE	43	21.400290	-99.000000	-99.000000
EIGENVALUE	44	33.005260	-99.000000	-99.000000
EIGENVALUE	45	54.575600	-99.000000	-99.000000
EIGENVALUE	46	-99.000000	-99.000000	-99.000000
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000

		EIGEN.OUT		
EIGENVALUE	49	-99.000000	-99.000000	-99.000000
EIGENVALUE	50	-99.000000	-99.000000	-99.000000

EIGENVALUES OF -99.000000 REPRESENT INCALCULABLE VALUES.
 THEY OCCUR BECAUSE OF PROCEDURAL LIMITATIONS.
 SEE THE ACCOMPANYING READ.ME FILE FOR THESE LIMITATIONS.

-99.000000				
EIGENVALUE	47	-99.000000	-99.000000	-99.000000
EIGENVALUE	48	-99.000000	-99.000000	-99.000000
EIGENVALUE	49	-99.000000		

Appendix G

Validation scales used in chapter 6, (stage 4).

1. Dependency sub-factor items of the depressive experiences questionnaire (Blatt, Zohar, Quinlin, Zuroff & Mongrain, 1995).
2. Medical outcomes study physical functioning measure (Stewart & Kamberg, 1992).
3. Geriatric depression scale (Yesavage et al., 1983).
4. Goldberg anxiety quiz (Goldberg, Bridges, Duncan-Jones & Grayson, 1988).
5. Personality research form – form E – desirability items (Jackson, 1999).

Letter to the participants from Silver Chain.

1. [Dependency sub-factor of the depressive experiences questionnaire]

Please circle the number on the rating scale that corresponds with how strongly you agree or disagree with the statement.

1. Without support from others who are close to me I would be helpless.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

2. I urgently need things that only other people can provide.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

3. Many times I feel helpless.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

4. I become frightened when I feel alone.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

5. I have difficulty breaking off a relationship that is making me unhappy.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

6. I often think about the danger of losing someone who is close to me.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

7. I am not very concerned with how other people respond to me.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

8. No matter how close a relationship between two people there is always a large amount of uncertainty and conflict.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

9. I am very sensitive to others for signs of rejection.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

10. Often, I feel as though I have disappointed others.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

11. I never really feel secure in a close relationship.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

12. I often feel threatened by change.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

13. Even if the person who is closest to me were to leave, I could still "go it alone".

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

14. I am a very independent person.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

15. Anger frightens me.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

16. After a fight with a friend, I must make amends as soon as possible.

Strongly disagree _____ Strongly agree _____
1 2 3 4 5 6 7

17. In my relationships with others, I am very concerned about what they can give me.

Strongly disagree _____ Strongly agree
1 2 3 4 5 6 7

18. Very frequently, my feelings towards someone close to me vary: there are times when I feel completely angry and other times when I feel all-loving towards that person.

Strongly disagree _____ Strongly agree
1 2 3 4 5 6 7

2. [Medical Outcomes Study-Physical Functioning Measure]

1. The following items are activities you might do during a typical day. **Does your health limit you** in these activities? (Circle One Number on Each Line).

Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports.....	1	2	3
b. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf.....	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling or stooping ...	1	2	3
g. Walking more than two kilometres (one mile)	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself ...	1	2	3

1. How satisfied are you with your physical ability to do what you want to do?

(Circle One Number)

Completely satisfied1
Very satisfied2
Somewhat satisfied3
Somewhat dissatisfied4
Very Dissatisfied5
Completely Dissatisfied.....6

2. When you travel around your community, does someone have to assist you because of your health?

(Circle One Number)

Yes, all of the time.....1
Yes, most of the time2
Yes, some of the time3
Yes, a little of the time4
No, none of the time5

3. Are you in bed or in a chair **most** or **all** of the day because of your health?

(Circle One Number)

Yes, every day1
Yes, most days2
Yes, some days3
Yes, occasionally4
No, never5

4. Are you able to use public transportation?

(Circle One Number)

No, because of my health1
No, for some other reason2
Yes, I'm able to use public
transportation3

3. [Geriatric depression scale]

For the following items, choose the best answer for how you felt over the past week. (Circle yes or no).

1. Are you basically satisfied with your life? yes/no
2. Have you dropped many of your activities and interests? yes/no
3. Do you feel that your life is empty? yes/no
4. Do you often get bored? yes/no
5. Are you hopeful about the future? yes/no
6. Are you bothered by thoughts you can't get out of your head? yes/no
7. Are you in good spirits most of the time? yes/no
8. Are you afraid that something bad is going to happen to you? yes/no
9. Do you feel happy most of the time? yes/no
10. Do you often feel helpless? yes/no
11. Do you often get restless and fidgety? yes/no
12. Do you prefer to stay at home, rather than going out and doing new things? yes/no
13. Do you frequently worry about the future? yes/no
14. Do you feel you have problems with memory more than most? yes/no
15. Do you think it is wonderful to be alive now? yes/no
16. Do you often feel downhearted and blue? yes/no
17. Do you feel pretty worthless the way you are now? yes/no
18. Do you worry a lot about the past? yes/no

- | | |
|--|--------|
| 19. Do you find life very exciting? | yes/no |
| 20. Is it hard for you to get started on new projects? | yes/no |
| 21. Do you feel full of energy? | yes/no |
| 22. Do you feel that your situation is hopeless? | yes/no |
| 23. Do you think that most people are better off than you are? | yes/no |
| 24. Do you frequently get upset over little things? | yes/no |
| 25. Do you frequently feel like crying? | yes/no |
| 26. Do you have trouble concentrating? | yes/no |
| 27. Do you enjoy getting up in the morning? | yes/no |
| 28. Do you prefer to avoid social gatherings? | yes/no |
| 29. Is it easy for you to make decisions? | yes/no |
| 30. Is your mind as clear as it used to be? | yes/no |

4. [Goldberg anxiety quiz]

- | | |
|---|--------|
| 1. Have you felt keyed up or on edge? | yes/no |
| 2. Have you been worrying a lot? | yes/no |
| 3. Have you been irritable? | yes/no |
| 4. Have you had difficulty relaxing? | yes/no |
| 5. Have you been sleeping poorly? | yes/no |
| 6. Have you had any of the following: trembling
tingling, dizzy spells, sweating, diarrhoea or
needing to pass water more often than usual? | yes/no |
| 7. Have you had difficulty falling asleep? | yes/no |
-

5. [Personality research form – form E – desirability items]

isted below are a number of statements concerning personal attitudes and traits. Please read each item and decide whether the statement is true or false as it applies to you personally. If you feel the statement is true, then circle the capital letter “T” following the item. If you feel that the item does not apply to you, then circle the letter “F” that follows the item.

- | | | |
|--|---|---|
| 1. I am quite able to make correct decisions on difficult questions. | T | F |
| 2. I am never able to do things as well as I should. | T | F |
| 3. My life is full of interesting activities. | T | F |
| 4. I believe when people tell lies anytime it is to their advantage. | T | F |
| 5. If someone gave me too much change I would tell him. | T | F |
| 6. I would be willing to do something a little unfair to get something that was important to me. | T | F |
| 7. I get along with people at parties quite well. | T | F |
| 8. I did many very bad things as a child. | T | F |
| 9. I am glad I grew up the way I did. | T | F |
| 10. I often question whether life is worthwhile. | T | F |
| 11. I am always prepared to do what is expected of me. | T | F |
| 12. My daily life includes many activities I dislike. | T | F |
| 13. I am one of the lucky people who could talk with my parents about my problems. | T | F |
| 14. Many things make me uneasy. | T | F |
| 15. I am careful to plan for my distant goals. | T | F |
| 16. I find it very difficult to concentrate. | T | F |
-

16 September 2002



049

Dear Mrs

RESEARCH PROJECT: INDIVIDUAL DIFFERENCES IN DEPENDENT PERSONALITY IN OLDER ADULTS - DEVELOPMENT OF A MEASURE AND ITS EVALUATION IN HEALTH CARE SERVICES

I am writing to invite you to participate in a study to develop a questionnaire to measure dependency being conducted by Ms Deborah Gardner, a research student from Edith Cowan University.

Silver Chain is committed to providing the best care possible for its clients. It is for this reason that Silver Chain conducts research projects and also supports many research projects being undertaken by university staff and students.

Please find enclosed an Information and Disclosure Form, providing details about the study, and a Consent Form. Detailed instructions for completing the questionnaire are given on the first page. If you do decide to participate, please return the completed questionnaire and consent form in the envelope provided by Tuesday, **1 October 2002**.

Whilst we would greatly appreciate your participation in the project, you are under no obligation to complete the questionnaire. Your decision to participate or not will in no way affect any services that you are currently receiving from Silver Chain.

If you have any questions about the study, please contact Ms Gardner on [REDACTED] or Dr Craig Speelman on ☎ 9400 5724.

Thank you.

Sincerely

Dr Gill Lewin
Research Manager

GL [G1.30]