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Construct Validity of the Relationship Profile Test: A Self-Report Measure of Dependency–Detachment

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This study evaluated the construct validity of the Relationship Profile Test (RPT; Bornstein & Languirand, 2003), a 30-item self-report measure of dependency-detachment that yields three subscale scores: (a) destructive overdependence, (b) dysfunctional detachment, and (c) healthy dependency. Scores on the RPT subscales generally showed the expected patterns of intercorrelations and gender differences, and comparison of RPT scores with scores on other tests supported the convergent and discriminant validity of each RPT subscale. Results of internal and retest reliability analyses were generally supportive as well, and suggested that the three RPT subscales assess aspects of the traits they purport to measure.

In recent years, researchers have delineated the underlying structure of a dependent personality orientation and examined links between dependency and a broad array of personality traits (Bornstein & Cecero, 2000; Gurtman, 1992; Livesley, Schroeder, & Jackson, 1991; Overholser, 1996; Pincus & Gurtman, 1995). Two sets of findings from these investigations are particularly noteworthy because they help explain observed variations in the overt expression of underlying dependency needs and provide a framework for researchers to explore the relationship between dependency and its converse—detachment.

Contemporary definitions of detachment emphasize the person’s inability to cultivate social ties or engage in situation-appropriate affiliative behaviors (Birchnell, 1987, 1996). Detachment is associated with deficits in social, sexual, and occupational functioning (Kantor, 1993; Millon, 1996) and studies suggest that it can result from an array of underlying factors, alone or in combination. These include early learning and socialization experiences that emphasize independence and self-sufficiency at the expense of social connectedness (Clark & Ladd, 2000; Colgan, 1987), intrapsychic conflicts regarding closeness and intimacy (Birchnell, 1996; Bornstein, 1998b), and biologically based differences in temperament that elicit detachment-promoting responses from parents and peers (Coolidge, Thedy, & Jang, 2001).

Studies indicate that dependency—like detachment—is more complex and multifaceted than theoreticians initially believed. In this context, several researchers (e.g., Bornstein, 1995, 1998a; Cross, Bacon, & Morris, 2000; Kobayashi, 1989) have distinguished destructive overdependence (characterized by maladaptive, inflexible dependency) from healthy dependency (characterized by flexible, adaptive, help- and support-seeking). Destructive overdependence stems in part from a sustained pattern of overprotective and/or authoritarian parenting (Head, Baker, & Williamson, 1991), although certain infantile temperament variables (e.g., low soothability) may play some role in eliciting these parenting styles (Bornstein, 1993). Even in adulthood, overdependent individuals exhibit a pattern of insecure, clinging behavior that alienates potential caregivers and undermines the dependent person’s efforts to cultivate affiliative ties (Blatt & Homann, 1992; Pincus & Gurtman, 1995).

In contrast to destructively overdependent persons, healthy dependent individuals show considerable behavioral flexibility, along with the ability to delay short-term gratification to strengthen long-term supportive relationships (Bornstein, 1998a; Bornstein & Languirand, 2003). Studies suggest that healthy dependency is rooted in a history of exposure to authoritative parenting, which instills in the child a sense of confidence and self-directedness (Lee & Robins, 1995), and consistent messages from parents and other authority figures that it is acceptable to ask for support when needed (Clark & Ladd, 2000; Lang-Takac & Osterweil, 1992). As a result, the child learns that looking to others for help is not a sign of weakness or failure. Research on the de-
developmental antecedents of healthy dependency is scanty, but preliminary findings indicate that only when authoritative parenting is coupled with active encouragement of situation-appropriate help-seeking is an individual likely to develop a healthy dependent personality style (Kobayashi, 1989; Singelis, 1994; Wang, Bristol, Mowen, & Chakraborty, 2000).

As several researchers have noted (e.g., Bornstein, 1998a; Cross et al., 2000; Pincus & Wilson, 2001), healthy dependency is similar in certain ways to secure attachment, but there are some important differences between these two constructs as well. Secure attachment is associated with substantially greater behavioral consistency than is healthy dependency, which may be expressed very differently in different relationships (Bornstein, Riggs, Hill, & Calabrese, 1996; Heiss, Berman, & Sperling, 1996). In fact, studies show that healthy dependency is associated with a broad array of self-presentation styles that are tailored to situational constraints and demands (Gurtman, 1992; Pincus & Gurtman, 1995). This behavioral variability is quite predictable within the context of an interactionist framework, and it derives from the healthy dependent person’s beliefs regarding which interpersonal strategies are likely to produce the desired outcome in a given situation (Bornstein & Kennedy, 1994; Bornstein, Riggs, et al., 1996).

Beyond the behavioral differences that characterize healthy dependency and secure attachment, psychometric data support the distinctiveness of these two constructs. Studies using different measures and participant samples converge to confirm that healthy dependency scores are only modestly related to scores on measures of secure attachment, which may be expressed very differently in different relationships (Bornstein, Riggs, Hill, & Calabrese, 1996; Heiss, Berman, & Sperling, 1996). In fact, studies show that healthy dependency is associated with a broad array of self-presentation styles that are tailored to situational constraints and demands (Gurtman, 1992; Pincus & Gurtman, 1995). This behavioral variability is quite predictable within the context of an interactionist framework, and it derives from the healthy dependent person’s beliefs regarding which interpersonal strategies are likely to produce the desired outcome in a given situation (Bornstein & Kennedy, 1994; Bornstein, Riggs, et al., 1996).

Myriad frameworks have explored the underpinnings of the dependency–attachment relationship. These include Leary’s (1957) two-dimensional grid; Millon’s (1990, 1996) evolutionary framework; circumplex models (Gurtman, 1992; Pincus & Gurtman, 1995); Benjamin’s (1974) Structural Analysis of Social Behavior model; and the five-factor model (Costa & Widiger, 1994; McCrae & Costa, 1990). Although considerable effort has been devoted to explicating the relationship between dependency and attachment, however, no theoretical framework has made explicit the links among dependency, detachment, and healthy dependency.

Bornstein’s (1992, 1993) four-component model represents a useful starting point in this regard. Following Bornstein (1992, 1993), destructive overdependence (DO), dysfunctional detachment (DD), and healthy dependency (HD) may be broken down into four components: cognitive, emotional, motivational, and behavioral. As Table 1 shows, each style reflects a particular set of beliefs regarding the self and other people, longstanding emotional responses to social contact, one or more affiliative/isolating motives, and an array of behaviors designed to attain some optimal level of interpersonal closeness-distance. This four-component model is consistent with findings regarding the inter- and intrapersonal dynamics of these three personality styles (Birchnell, 1987; Millon, 1996; Rude & Burnham, 1995; Wiggins & Pincus, 1989) and provides a framework for conceptualizing change processes in dependent, detached, and healthy dependent psychotherapy patients (Beck & Freeman, 1990; Blatt & Schichman, 1983; Overholser & Fine, 1994).

Continued exploration of the relationships among DD, DO, and HD may have important theoretical, empirical, and clinical implications, but no single measure is available to assess all three constructs. This study provides construct validity data for a newly developed self-report scale, The Relationship Profile Test (RPT; Bornstein & Languirand, 2003), which taps these dimensions, yielding three subscale scores. The construct validity of the RPT was assessed in four areas, and the following hypotheses were tested.

- **Internal reliability and intersubscale relationships:** Each RPT subscale should show acceptable levels of internal consistency (i.e., coefficient $\alpha > .60$), and acceptable ranges of item-total correlations (e.g., all item-total correlations $> .30$, with most item-total correlations $> .50$; see Nunnally & Bernstein, 1994). In addition, HD scores should be negatively correlated with DO and DD scores in women and men; DO and DD scores should be negatively correlated with each other. These latter hypotheses are based on research examining the dynamics of DO, DD, and HD (Birchnell, 1987; Bornstein, 1998a).

- **Gender differences:** Women should obtain significantly higher scores than men on the RPT DO and HD subscales; men should obtain significantly higher scores than women on the DD subscale. The hypotheses involving DO and DD are based on studies demonstrating gender differences in self-reports of dependency (Bornstein, 1995) and detachment (Birchnell, 1996). The hypothesis that women should score higher than men on the HD scale is based on an array of gender-role socialization findings indicating that in most Western societies, a key feature of healthy dependency (i.e., situation-appropriate help seeking) is encouraged more strongly in girls than in boys (Baumeister &

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1The term healthy dependency overlaps with several other concepts, including adaptive dependency (Bornstein, 1998a), compensatory dependency (Baltes, 1996), interdependence (Cross & Madson, 1997), connectedness (Clark & Ladd, 2000), relatedness (Blatt, Zohar, Quinlan, Luthar, & Hart, 1996), mature dependency (Baumeister & Leary, 1995), and mature object relations (Sundin, Armelius, & Nilsson, 1994).
HD Perception of self as competent; others as trustworthy

- **Convergent and discriminant validity:** RPT subscales should show meaningful patterns of intercorrelations with theoretically related measures of affiliativeness/support-seeking, isolation/alienation, and life satisfaction/subjective well-being. Because six comparison measures were used, yielding 18 separate convergent and discriminant validity predictions, these hypotheses are not detailed here but are summarized in Table 5 and in the Comparison Measures section. All statistically significant RPT-comparison measure correlations are expected to be in the .25 to .50 range, and comparable in women and men.

- **Retest reliability:** All three RPT subscales should show adequate retest reliability over 23 and 85 weeks. As psychometricians have pointed out, no single cutoff defines acceptable retest reliability, which is affected by numerous variables (e.g., intertest interval, participant characteristics; see Anastasi & Urbina, 1997; Messick, 1995). In line with previous findings involving similar constructs (e.g., Bornstein, 1997; Millon, 1987), we hypothesized that retest reliability coefficients (rs) should exceed .60 in each case. Because all three RPT subscales assess longstanding traits that should be minimally affected by environmental events, we further hypothesized that long-term (i.e., 85-week) RPT retest reliability coefficients would remain acceptable after controlling for daily hassles and life event scores.

### METHOD

#### Participants

Participants in the Time 1 testing sessions were 130 undergraduates (75 women and 55 men) enrolled in General Psychology classes at Gettysburg College who took part in the study for $5 payment and to fulfill a course requirement. Fifty participants (25 women and 25 men) from this sample were paid an additional $5 to take part in one of the 23-week follow-up testing sessions. Fifty previously prescreened participants (25 women and 25 men) who had not taken part in other aspects of the study were paid $10 to take part in one of the 85-week follow-up testing sessions. Mean age of participants during initial RPT testing was 19.12 years (SD = 0.86, range = 17 to 21).

#### Measures

**RPT.** The RPT is a rationally derived 30-item questionnaire that asks participants to respond to a series of self-statements. Each statement is rated on a 7-point scale ranging from 1 (not at all true of me) to 7 (very true of me). The RPT yields three 10-item subscale scores: DO, DD, and HD. Representative items from the three RPT subscales include: “Being responsible for things makes me nervous” (DO), “Other people want too much from me” (DD), and “It is easy for me to trust people” (HD).

RPT statements were derived from the theoretical and empirical literature on dependency, detachment, and healthy dependency. Statements were written to tap the four components of each personality style (i.e., cognitive, emotional, motivational, behavioral) as well as other core features of the dimension in question. Sources used to derive RPT item content included Baillie and Lampe (1998), Benjamin (1996), Birchnell (1987, 1996), Bornstein (1992, 1993, 1998a, 1998b), Gurtman (1992), Kantor (1993), Kobayashi (1989), Livesley (1995), Millon (1996), Overholser (1996), Paris (1998), Pincus and Gurtman (1995), and Rude and Burnham (1995). In addition, the Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM–IV]; American Psychiatric Association, 1994) dependent personality disorder (PD), avoidant PD, and schizoid PD symptom criteria were used to develop certain DO and DD items.

Using these sources, an initial pool of 60 potential RPT items was generated (20 per subscale). From this, a final pool

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Note: Detailed discussions of the characteristics of DO, DD, and HD are provided in Bornstein and Languirand (2003). DO = destructive overdependence; DD = dysfunctional detachment; HD = healthy dependency.
of 30 items was selected based on three criteria: (a) obtaining a reasonable distribution of items across process domains (i.e., cognitive, motivational, emotional, behavioral); (b) having parallel item wording across subscales; and (c) minimizing overlap and redundancy in item content. Once the final pool of 30 items was selected, these items were revised to maximize clarity and eliminate ambiguity in phrasing. All aspects of RPT item development and refinement were carried out by Robert F. Bornstein and Mary A. Languirand.

**Comparison measures.** Six measures were used to assess the convergent and discriminant validity of the three RPT subscales:

Interpersonal Dependency Inventory (IDI; Hirschfeld, Klerman, Gough, Barrett, Korchin, & Chodoff, 1977): The IDI is a 48-item questionnaire that asks participants to rate the degree to which each of a series of dependency-related self-statements applies to them. The IDI consists of three subscales: Emotional reliance on others (ER), Lack of social self-confidence (LS), and Assertion of autonomy (AA). IDI scores are derived by summing the person’s scores on the ER and LS subscales, and subtracting from this total their score on the AA subscale. Thus, high IDI scores reflect high levels of dependency. Information regarding the construct validity of the IDI is provided by Bornstein (1994).

Hypotheses: IDI scores should be positively correlated with DO scores, negatively correlated with DD scores, and unrelated to HD scores.

Separateness Scale (SS; Wang & Mowen, 1997): The SS is a 9-item questionnaire that assesses the extent to which an individual feels separate from other people. Each SS item is rated on a 5-point scale for the degree to which the statement in that item applies to the respondent. SS items form two factors: independence/individuality and self–other boundary. Total SS scores are derived by summing a participant’s scores on these two factors; higher scores indicate greater separateness. Information regarding the construct validity of the SS is provided by Wang and Mowen and Wang et al. (2000).

Hypotheses: SS scores should be positively correlated with DD scores and unrelated to HD scores. (Although one might expect that DO persons should show high levels of connectedness, studies indicate that dependent people typically feel isolated, alienated, and lonely, even when immersed in ostensibly supportive relationships; see Mahon, 1982; Wiseman, 1997.)

Satisfaction With Life Scale (SWL; Diener, Emmons, Larsen, & Griffin, 1985): The SWL scale consists of five self-statements tapping aspects of an individual’s current life satisfaction and subjective well-being. Each item is rated on a 7-point scale for the degree to which the statement in that item applies to the participant. SWL scores are derived by summing the five item ratings, with higher scores indicating greater life satisfaction. Information regarding the construct validity of the SWL scale is provided by Diener et al. and Pavot and Diener (1993).

Hypotheses: SWL scores should be positively correlated with HD scores and negatively correlated with DO and DD scores.

Toronto Alexithymia Scale (TAS; Taylor, Bagby, & Parker, 1992): The TAS is a 20-item self-report measure wherein participants rate the self-relevance of each statement on a 5-point scale. Statements tap various features of alexithymia (e.g., difficulty identifying and verbalizing feelings, confusion regarding moods and other internal states) with high TAS scores indicating stronger alexithymic tendencies. Information regarding the construct validity of the TAS is provided by Taylor et al. and Taylor, Ryan, and Bagby (1985).

Hypotheses: TAS scores should be positively correlated with DD scores, negatively correlated with HD scores, and unrelated to DO scores.

Need for Approval Scale (NAPP; Crowne & Marlowe, 1964): The NAPP is a 33-item true–false measure assessing the degree to which a participant strives to present himself or herself in a favorable light. High NAPP scores are associated with higher levels of positive self-presentation. Evidence supporting the construct validity of the NAPP is provided by Crowne and Marlowe and Wiggins (1968).

Hypotheses: NAPP scores should be positively correlated with DO scores, negatively correlated with DD scores, and unrelated to HD scores.

Relational-Interdependent Self-Construal Scale (RISC; Cross et al., 2000): The RISC is an 11-item questionnaire assessing the extent to which an individual feels close to and connected with other people. Each item is rated on a 7-point scale for the degree to which the statement in that item is true of the respondent; higher scores reflect greater connectedness/interdependence. Evidence supporting the construct validity of the RISC is provided by Cross et al.

Hypotheses: RISC scores should be positively correlated with HD scores, negatively correlated with DD scores, and unrelated to DO scores.

Two measures were used to assess the impact of daily hassles and life events on 85-week retest reliability of the three RPT subscales:
Hassles Scale–Revised (HS–R; DeLongis, Folkman, & Lazarus, 1988): The HS–R is a 53-item scale listing common minor stressful life events and challenges (e.g., “Meeting deadlines or goals on the job,” “Family-related obligations”). In completing the HS–R, participants: (a) report which of these 53 “hassles” they have experienced during the past month and (b) rate the severity of each reported hassle on a 4-point scale ranging from 1 (none) to 4 (a great deal). HS–R scores are calculated by summing the individual item ratings. Evidence supporting the construct validity of the HS–R is provided by DeLongis et al.

Social Readjustment Rating Scale (SRRS; Holmes & Rahe, 1967): The SRRS consists of 43 life events that range in severity from those that are expected to have a relatively modest impact (e.g., “Change in sleeping habits,” “Minor violations of the law”) to those that are maximally disruptive and require greater coping effort (e.g., “Death of spouse,” “Jail term”). Each SRRS item has been assigned a point value reflecting the stressfulness of the event described in that item, with more stressful events having higher point values. In completing the SRRS, participants check each item they have experienced during the past 12 months. SRRS scores are derived by summing the point values of all items checked by a participant. Information regarding the construct validity of the SRRS is provided by Holmes and Rahe and Theorell and Rahe (1971).

Procedure

**Time 1.** Participants completed batteries of measures in two 30-min sessions separated by 7 to 14 days. In the first session, participants completed the RPT, IDI, SS, and SWL. In the second session, participants completed the RISC, TAS, and NAPP. Within each session, measures were presented in random order.

**Twenty-three-week follow-up.** These sessions took place approximately 23 weeks after the participant had initially completed the RPT ($M = 22.90, SD = 1.13, \text{range} = 21$ to 25). Participants were randomly selected from the male and female Time 1 participants after these data were separated by gender. Participants were contacted by phone and offered $5 to return to the laboratory for additional testing. Recruitment continued until 25 women and 25 men had completed the 23-week follow-up. Experimenters were unaware of participants’ Time 1 scores when recruitment and follow-up testing was underway.

**Eighty-five-week follow-up.** These sessions took place approximately 85 weeks after the participant had initially completed the RPT ($M = 85.42, SD = 0.49, \text{range} = 85$ to 86). Participants were randomly selected from a pool of approximately 400 prescreened participants after these data were separated by gender. Participants were contacted by phone and offered $10 to return to the laboratory for additional testing. Recruitment continued until 25 women and 25 men had completed the 85-week follow-up. Experimenters were unaware of participants’ Time 1 scores when recruitment and follow-up testing was underway. During the 85-week testing, participants completed the RPT, HS–R, and SRRS, with order of measures counterbalanced across participants.3

**RESULTS**

The results of this study are summarized in Tables 2 through 7.

**RPT Subscale Gender Differences**

Table 2 summarizes participants’ scores on each RPT subscale. Consistent with expectations, women obtained significantly higher scores than men on the DO and HD scales. Contrary to expectations, there were no gender differences on the DD scale. As the right column in Table 2 shows, both significant RPT subscale gender differences were of medium magnitude, according to Cohen’s (1988) criteria.

**RPT Internal Reliability and Subscale Intercorrelations**

The left portion of Table 3 summarizes the intercorrelations among scores on the three RPT subscales. As these data show, similar patterns of RPT subscale correlations were obtained in women and men. Consistent with predictions, HD scores were inversely related to DO and DD scores. Contrary to predictions, DO and DD scores were unrelated to each other.

The right portion of Table 3 summarizes internal reliability data for the RPT. As the third column shows, alpha coefficients for each RPT subscale reached acceptable levels. As the fourth column shows, mean item-total correlations were virtually identical for each RPT subscale. For DO, item-total correlations ranged from .55 to .72. For DD, these correlations ranged from .38 to .59, with four items having correlations < .50. For HD, item-total correlations ranged from .37 to .66, with two items having correlations < .50. When items correlating with their assigned subscale at < .50 were dropped, coefficient alphas for the DD and HD scales increased to .80 and .84, respectively.

To examine the construct validity of the 30-item RPT and a truncated 24-item RPT excluding those items that correlated with their assigned subscale at < .50, convergent validity, discriminant validity, and retest reliability analyses were conducted using the full and truncated versions of the scale.

3To obtain follow-up samples of 25 women and 25 men, approximately 40 women and 40 men were contacted and asked to participate in the 23-week follow-up testing and approximately 40 women and 40 men were contacted and asked to participate in the 85-week follow-up testing.
Subjective Validity of the RPT

Table 4 summarizes gender differences in the six comparison measures used to assess the convergent and discriminant validity of the RPT subscales. Women obtained significantly higher scores than men on the IDI, NAPP, and RISC, whereas men obtained significantly higher scores than women on the SS and TAS. There were no statistically significant gender differences in SWL scale scores, but as the right column of Table 4 shows, the effect size ($r$) associated with the obtained SWL gender difference was quite similar to those associated with the other comparison measures.

Because identical RPT-comparison scale correlations were predicted for women and men, and women and men did in fact obtain very similar patterns, these data were combined for overall analysis. As Table 5 shows, when the full scale version of the RPT was examined, the number of statistically significant correlations decreased from 15 to 11 (61%).

To further contrast the full and truncated versions of the RPT, the convergent validity effect sizes obtained with these two versions of the scale were compared, using only those comparison measures that were expected to correlate positively or negatively with DD or HD. To calculate these pooled effect sizes, the signs of obtained RPT-comparison measure correlations were aligned so that all predicted/obtained correlations were positive. Results of these analyses indicated that for both subscales, the truncated version was less strongly correlated with relevant outcome measures than was the full version of the scale (mean decline in convergent validity $r$ was .09 for DD and .07 for HD).

Retest Reliability of RPT Subscale Scores

Mean DO score for 23-week retest participants was 27.86 ($SD = 7.22$, range = 12 to 47), whereas the mean DD score was 31.06 ($SD = 6.15$, range = 15 to 42) and the mean HD score was 35.54 ($SD = 6.05$, range = 21 to 47). As Table 6 shows, when the full version of the RPT was used, all three RPT subscales showed acceptable levels of retest reliability in women (though the HD retest correlation coefficient was slightly lower than the anticipated .60). In men, the DO and DD subscales showed good retest reliability, but the HD subscale was not stable over the 23-week intertest interval ($r = .23$). Focused comparisons of effect size indicated that retest reliability correlations did not differ across gender for the RPT.
DO and DD scales; for the HD scale, there was a trend ($p < .10$) for scores to be more stable in women than in men.

Mean DO score for 85-week retest participants was 26.42 ($SD = 6.48$, range = 12 to 41), whereas the mean DO score was 32.02 ($SD = 4.80$, range = 18 to 43) and the mean HD score was 35.60 ($SD = 5.79$, range = 22 to 48). As Table 7 shows, the full version of the RPT demonstrated acceptable 85-week retest reliability. Long-term retest reliability coefficients for the DO scale were virtually identical to those obtained at 23 weeks. Although the 85-week reliability of the DD scale was somewhat lower than that obtained at 23 weeks (.55 and .75, respectively, for the combined sample), retest reliability of the HD scale actually increased slightly from 23 to 85 weeks (.41 and .48, respectively, for the combined sample). There were no significant gender differences in long-term retest reliability for any RPT subscale.

Mean HS–R score was 87.20 ($SD = 13.28$, range = 59 to 118), whereas the mean SRRS score was 83.56 ($SD = 25.60$, range = 44 to 183). There were no gender differences on either measure. Correlations between HS–R scores and Time 2 DO, DD, and HD subscale scores were .13, .32, and −.19, respectively (all $ps > .10$). Correlations between SRRS scores and Time 2 DO, DD, and HD scores were −.03, −.08, and −.18 (all $ps > .10$).

Finally, as Table 7 shows, RPT subscale 85-week retest reliability coefficients did not change appreciably when these coefficients were recalculated controlling for daily hassles experienced in the month preceding retesting, or life events experienced in the year preceding retesting. When retest reliability analyses were calculated using the truncated version of the RPT, the following retest indexes ($r$s) were obtained for the combined sample at 23 weeks: .63 (DO), .75

### TABLE 4

<table>
<thead>
<tr>
<th>Comparison Measure</th>
<th>Women</th>
<th>Men</th>
<th>t</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDI</td>
<td>47.01</td>
<td>42.01</td>
<td>1.95*</td>
<td>.17</td>
</tr>
<tr>
<td>SS</td>
<td>27.57</td>
<td>29.24</td>
<td>2.40*</td>
<td>.21</td>
</tr>
<tr>
<td>SWL</td>
<td>24.92</td>
<td>26.99</td>
<td>1.91</td>
<td>.17</td>
</tr>
<tr>
<td>TAS</td>
<td>46.77</td>
<td>51.03</td>
<td>1.95*</td>
<td>.19</td>
</tr>
<tr>
<td>NAPP</td>
<td>15.48</td>
<td>13.60</td>
<td>1.98*</td>
<td>.19</td>
</tr>
<tr>
<td>RISC</td>
<td>61.15</td>
<td>56.48</td>
<td>2.58**</td>
<td>.25</td>
</tr>
</tbody>
</table>

*Note. For SS and SWL, $N = 130$ (75 women and 55 men); for IDI, $N = 128$ (73 women and 55 men); for TAS, NAPP, and RISC, $N = 102$ (62 women and 40 men). Gender differences were assessed via two-tailed $t$ tests; $r$s reflect standardized gender difference effect sizes derived from corresponding $t$ values. IDI = Interpersonal Dependency Inventory; SS = Separateness Scale; SWL = Satisfaction With Life Scale; TAS = Toronto Alexithymia Scale; NAPP = Need for Approval Scale; RISC = Relational-Interdependent Self-Construal Scale.

* $p < .05$. ** $p < .01$. 

### TABLE 5

**Convergent and Discriminant Validity of RPT Scores**

<table>
<thead>
<tr>
<th>Comparison Measure</th>
<th>Predicted</th>
<th>DO</th>
<th>DD</th>
<th>Full Scale</th>
<th>HD</th>
<th>Truncated Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDI</td>
<td>+, −, 0</td>
<td>.71**</td>
<td>.01</td>
<td>.13</td>
<td>.09</td>
<td>−.16</td>
</tr>
<tr>
<td>SS</td>
<td>0, +, 0</td>
<td>.06</td>
<td>.27**</td>
<td>−.09</td>
<td>.20*</td>
<td>−.09</td>
</tr>
<tr>
<td>SWL</td>
<td>−, +, +</td>
<td>−.20*</td>
<td>−.26**</td>
<td>.46**</td>
<td>−.19*</td>
<td>−.39**</td>
</tr>
<tr>
<td>TAS</td>
<td>0, +, −</td>
<td>.18</td>
<td>.47**</td>
<td>−.48**</td>
<td>.41**</td>
<td>−.37**</td>
</tr>
<tr>
<td>NAPP</td>
<td>+, −, 0</td>
<td>−.08</td>
<td>−.31**</td>
<td>.32**</td>
<td>−.11</td>
<td>−.25*</td>
</tr>
<tr>
<td>RISC</td>
<td>0, −, +</td>
<td>.11</td>
<td>−.21*</td>
<td>.33**</td>
<td>−.20*</td>
<td>−.28*</td>
</tr>
</tbody>
</table>

*Note. For SS and SWL, $N = 130$; for IDI, $N = 128$; for TAS, NAPP, and RISC, $N = 102$. Predicted relationships are as follows: + = positive correlation predicted, − = negative correlation predicted, 0 = scores expected to be uncorrelated. Full Scale correlations were computed using the 30-item RPT. Truncated Scale correlations were computed excluding RPT items with item-total correlations < .50. Because no DO items were dropped to form the truncated scale, these correlation coefficients are not repeated in the right portion of the table. RPT = Relationship Profile Test; IDI = Interpersonal Dependency Inventory; SS = Separateness Scale; SWL = Satisfaction With Life Scale; TAS = Toronto Alexithymia Scale; NAPP = Need for Approval Scale; RISC = Relational-Interdependent Self-Construal Scale.

* $p < .05$. ** $p < .01$. 

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At 85 weeks, the following retest reliability indexes were obtained: .61 (DO), .45 (DD), .45 (HD).

### DISCUSSION

Preliminary evidence supports the construct validity of the RPT as a measure of dependency-detachment. With certain exceptions (discussed in detail later), scores on the three RPT subscales showed the expected patterns of gender differences, interscale correlations, and relationships with scores on other personality measures. All three RPT subscales showed acceptable levels of internal consistency, and elimination of items with the lowest subscale correlations did not improve the convergent validity, discriminant validity, or retest reliability of the RPT. Moreover, except for HD scores in men, RPT subscale scores showed good retest reliability over 23 weeks. All three subscales showed reasonably good retest reliability over 85 weeks, and these long-term retest reliability coefficients were unaffected by daily hassles and life events experienced by participants prior to follow-up testing.

One unanticipated finding in this study is intriguing. First, contrary to predictions, DO and DD scores were unrelated in both men and women. Prevailing theoretical frameworks generally contend that DO and DD represent opposing personality styles: To the extent that one is overdependent, one cannot be dysfunctionally detached, and vice versa (see Benjamin, 1996; Costa & Widiger, 1994; Millon, 1996). It is tempting to attribute the nonsignificant DO–DD correlation to problems with the RPT subscales, but the compelling patterns of convergent and discriminant validity data suggest that these scales are in fact tapping the dimensions they purport to assess. Moreover, similar findings have emerged in other studies of the DO–DD relationship. For example, Ekselius, Lindstrom, von Knorring, Bodlund, and Kullgren (1994) found that psychiatric patients and nonclinical participants who obtained high scores on a measure of dependent PD also scored high on schizoid PD ($r = .30$) and avoidant PD ($r = .66$), although these latter disorders are thought to be

### TABLE 6

**Retest Reliability of RPT Scores: 23-Week Intertest Interval**

<table>
<thead>
<tr>
<th>RPT Subscale</th>
<th>Women</th>
<th>Men</th>
<th>Combined</th>
<th>Z</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO</td>
<td>.68**</td>
<td>.63**</td>
<td>.65**</td>
<td>0.30</td>
<td>.04</td>
</tr>
<tr>
<td>DD</td>
<td>.71**</td>
<td>.80**</td>
<td>.75**</td>
<td>0.70</td>
<td>.10</td>
</tr>
<tr>
<td>HD</td>
<td>.56*</td>
<td>.23</td>
<td>.41*</td>
<td>1.33</td>
<td>.19</td>
</tr>
</tbody>
</table>

*Note. N = 25 women and 25 men. Mean intertest interval was 22.90 weeks (SD = 1.13, range = 21 to 25). Relevance reliability indexes are Pearson correlation coefficients. Gender difference Zs represent focused comparisons of retest reliability effect sizes across gender; gender difference rs are standardized effect sizes derived from corresponding Zs. RPT = Relationship Profile Test; DO = destructive overdependence; DD = dysfunctional detachment; HD = healthy dependency. *p < .01. **p < .001.*

### TABLE 7

**Retest Reliability of RPT Scores: 85-Week Retest Correlations and Moderating Effects of Daily Hassles and Life Events**

<table>
<thead>
<tr>
<th>RPT Subscale</th>
<th>Women</th>
<th>Men</th>
<th>Combined</th>
<th>Z</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO Uncorrected</td>
<td>.63***</td>
<td>.66***</td>
<td>.65***</td>
<td>0.17</td>
<td>.02</td>
</tr>
<tr>
<td>Cont for HS–R</td>
<td>.61**</td>
<td>.66***</td>
<td>.64***</td>
<td>0.26</td>
<td>.04</td>
</tr>
<tr>
<td>Cont for SRRS</td>
<td>.67***</td>
<td>.63***</td>
<td>.65***</td>
<td>0.23</td>
<td>.04</td>
</tr>
<tr>
<td>DD Uncorrected</td>
<td>.66***</td>
<td>.44*</td>
<td>.55***</td>
<td>1.06</td>
<td>.15</td>
</tr>
<tr>
<td>Cont for HS–R</td>
<td>.66***</td>
<td>.51**</td>
<td>.59***</td>
<td>0.76</td>
<td>.11</td>
</tr>
<tr>
<td>Cont for SRRS</td>
<td>.46*</td>
<td>.64***</td>
<td>.55***</td>
<td>0.86</td>
<td>.12</td>
</tr>
<tr>
<td>HD Uncorrected</td>
<td>.46*</td>
<td>.49*</td>
<td>.48***</td>
<td>0.13</td>
<td>.02</td>
</tr>
<tr>
<td>Cont for HS–R</td>
<td>.45*</td>
<td>.54**</td>
<td>.50***</td>
<td>0.36</td>
<td>.05</td>
</tr>
<tr>
<td>Cont for SRRS</td>
<td>.48*</td>
<td>.46*</td>
<td>.47****</td>
<td>0.07</td>
<td>.01</td>
</tr>
</tbody>
</table>

*Note. N = 25 women and 25 men. Mean intertest interval was 85.42 weeks (SD = 0.49, range = 85 to 86). RPT = Relationship Profile Test; DO = destructive overdependence; Cont for HS–R = retest reliability (partial correlations) controlling for Hassles Scale–Revised scores; Cont for SRR = retest reliability (partial correlations) controlling for Social Readjustment Rating Scale scores; DD = dysfunctional detachment; HD = healthy dependency. *p < .05. **p < .01. ***p < .001.*
Clearly, the relationship between dependency and detachment is more complex than diagnosticians and psychometricians have realized. It may be that certain individuals show features of both personality styles, albeit in different domains (e.g., a person may be overdependent around friends, but detached in romantic relationships). Additional research is needed to determine whether our findings are unique to this sample, or whether DO and DD are best conceptualized as orthogonal—rather than complementary—personality styles. Circumplex analyses of DO and DD may be useful for addressing this question (see Gurman & Pincus, 2000; Wiggins & Pincus, 1989).

The marginally significant gender difference in 23-week HD score stability also warrants scrutiny. HD scores were somewhat more stable in women than men over this interval (although focused comparison indicated that this gender difference did not reach conventional levels of statistical significance). It may be that the core characteristics of HD are more stable in high-achieving college women than in high-achieving college men over relatively brief intervals. However, there were no gender differences in HD retest reliability over 85 weeks, suggesting that the marginally significant 23-week gender difference is not robust. Further research is needed to examine the variables that influence the temporal stability of HD, DO, and DD scores in women and men.

In this context, it is worth noting that the lower retest stability of HD scores relative to scores on the DO and DD scales might be in part a product of the participant sample assessed in this investigation. Participants in this study were older adolescents, and it is likely that certain traits associated with healthy dependency (e.g., the ability to balance intimacy and autonomy) continue to develop past this age period. Dependency and detachment, in contrast, are firmly entrenched by early adolescence (see Bornstein, 1992, 1993; Kantor, 1993; Millon, 1996) and should therefore be more stable in college students over the intervals assessed in this investigation.

Although these preliminary construct validity data are promising, many questions regarding the validity and utility of the RPT remain unaddressed. Studies are underway to examine additional aspects of RPT construct validity, including: (a) exploration of the behaviorally referenced criterion validity of each RPT subscale, (b) assessment of the relationship of RPT scores to gender role, and (c) delineation of psychiatric patient–nonclinical participant differences in RPT scores. These latter data will not only contribute to the construct validity of the RPT itself, but will also provide important information regarding clinical and nonclinical RPT score norms. As Block (1995) and others (e.g., Livesley, Jackson, & Schroeder, 1992) noted, the construct validity of a personality or psychopathology measure can only be firmly established when parallel findings are obtained in a variety of participant groups, including clinical populations. Thus, replication of our results in psychiatric inpatients and/or outpatients is an important next step in establishing the validity and utility of the RPT.

Although speculative, it is useful to delineate some potential applications of the RPT if the test continues to yield strong evidence of construct validity in different participant groups. In research settings, the RPT will enable investigators to assess the relationships of DO, DD, and HD to scores on other trait and psychopathology measures and allow diagnosticians to assess DO, DD, and HD differences across Axis I and Axis II categories. The RPT may also be a useful tool for exploring age and cultural differences in DO, DD, and HD, testing theoretical frameworks involving these constructs, and refining conceptual and operational definitions of the constructs themselves.

In clinical settings, the RPT can be used to assess changes in DO, DD, and HD during therapy. It may be that different patterns of DO, DD, and HD shifts occur during successful versus unsuccessful treatment and in response to different therapeutic modalities (e.g., insight-oriented vs. behavioral). Along slightly different lines, a psychometrically sound RPT will enable researchers to assess whether pre-existing DO, DD, and HD scores predict therapy outcome: Preliminary evidence suggests that patients with high levels of DO benefit more fully from insight-oriented therapy than do patients with high levels of DD. Although HD per se has never been studied as a predictor of therapy outcome, findings from myriad investigations suggest that qualities associated with HD (e.g., stable self-concept, mature interpersonal relationships) predict positive outcome in insight-oriented treatment (Hoglund et al., 2000; Hoglund & Piper, 1997; Piper et al., 2000; Summers, 1999).

In this context, Bornstein (1994) and Overholser (1996; Overholser & Fine, 1994) noted that effective therapeutic work with overdependent patients should focus on helping the person become more autonomous while strengthening interpersonal skills that stem from dependency (e.g., sensitivity to interpersonal cues). Conversely, psychotherapeutic work with detached patients must strengthen social connectedness and affiliative motivation without compromising the individual’s autonomy and self-directedness (Colgan, 1987; Kantor, 1993). Put another way, treatment of overdependence and detachment involves a common goal: shifting the individual toward healthy (i.e., flexible, relationship-facilitating) dependency. If future construct validity studies continue to produce promising results, studies involving the RPT—along with those utilizing other, re-
lated measures (e.g., Blatt & Ford, 1994; Piper et al., 2000)—may help clinicians tailor therapeutic interventions to each patient’s relationship style, maximizing benefit and minimizing cost.

REFERENCES


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