DISTINGUISHING CHARACTERISTICS OF THE AGING FROM A SOCIOLOGICAL VIEWPOINT*

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DR. LORENZE: The first paper at this session will be given by Dr. Ruth Granick Bennett, who received her Bachelor's Degree at Brooklyn College and her Ph.D. in Sociology at Columbia. She has been a teaching fellow in Sociology at Brooklyn College, a university fellow of Columbia University and, at the present time, is a senior research scientist at Biometrics Research, New York State Department of Mental Hygiene.

DR. BENNETT:

Biologically, aging is viewed as mental, physical and functional deterioration; in its various aspects, it may be thought of as either natural or pathological. Sociologically, aging is viewed as a process accompanied by social isolation, voluntary and involuntary. As a voluntary process, the individual disengages himself from society as his energy level diminishes. As an involuntary process, isolation results from the simultaneous occurrence of physical deterioration, death of peers, stigma, enforced retirement, and the predominance of the mobile, nuclear family. In our society the label “aged” is usually applied to persons 65 and over, irrespective of how they act or feel. This label implies anticipation of a range of behaviors in accordance with a predetermined role and status structure available to older persons. In some societies, the term “aged” implies expansion of roles, particularly those involving exercise of judgment and wisdom. Presumably, this is the case in traditionalist societies where age is honored because the aged are seen as the transmitters of cultural norms and knowledge. In other societies, particularly rapidly changing ones, the term “aged” is to be avoided because it brings with it role construction and, therefore, isolation and segregation. (It should be noted that isolation and segregation are usually reserved for all categories of social undesirables and public nuisances; for example, the mentally ill, people infected with serious contagious diseases, deviants and criminals.) Isolation and segregation of the aged seem normative and acceptable to both young and old in this society. This is indicated by the fact that little has been done to alter the situation.

Moreover, various “myths” have developed to justify ways of treating those categorized as aged. Segregation and isolation of the aged are usually rationalized on practical, moral and medico-psychiatric grounds. The practical ap-


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proach takes for granted the mobile, nuclear family, within which the aged are superfluous. The moral approach may result from an unconscious stigmatization of aging, possibly because of its nearness to death, and those assuming this point of view sometimes refer to the aged as morally bankrupt. The medico-psychiatric viewpoint, which has gained currency, regards aging as pathological. The terms care, treatment and rehabilitation are used to justify segregating old people into specialized institutions.

Whether voluntary or involuntary, and regardless of persuasive rationales, the social isolation which accompanies the process of aging has a marked impact in older persons. At the psychological level, isolated old people are found to feel lonely, depressed and worthless. Serious depression, classified psychopathically as involutional melancholia, is chiefly a mental disorder of old age. Less serious reactive depressions are also found mainly in the elderly. However, the role played by isolation in causing these serious depressive disorders is not known.

One might ask, “Why not let the aged disengage themselves if that’s what they want to do?” Well, why not let people become obese, smoke heavily or experiment with drugs? Physicians are used to thinking in terms of long-range consequences of a course of action, and presumably they agree that people should be allowed to do as they please only if they are informed of the consequences.

During the past ten years, I’ve been engaged in research on the social and psychological consequences of isolation of the aged. This research assumed that isolation was an irreversible concomitant of aging (as has been recently demonstrated empirically). If one role and its contacts were lost, there was no adequate substitute for them. Isolation resulted in desocialization or inability to respond appropriately to social cues which, in turn, led to poor social adjustment.

Some of our studies were devoted to learning if isolation had some salutary effects, that is, if isolated older persons became independent, rugged individualists, able to stand up to the group. We found that isolated persons were less attitudinally independent than those with many social contacts. In general, our studies, which are described in greater detail below, showed that isolated and desocialized older persons were socially disruptive, as well as personally miserable.

Our research on aging was begun in 1956 by Dr. Joseph Zubin. The case records of 100 residents of an old age home were used in a study to identify those characteristics which would differentiate residents who were transferred to mental hospitals from those who were not.

The pre-entry characteristics of the aged which were predictive of transfer from the home to a mental hospital were: 1) their attitudes toward entering the home, 2) their evaluations of themselves, 3) their childhood socio-economic level, 4) the degree to which they had been socially isolated prior to entry, and 5) their being labeled as management problems in the home. Characteristics 4, 5 were related, that is, the more the aged people were socially isolated before entry, the more likely they were to get into trouble after entry.
Because of limitations of the case record data, a direct longitudinal study of elderly residents of an old age home was undertaken. The relation between social isolation and social adjustment to the home was evaluated. One hundred consecutively admitted subjects were interviewed three times, once on admission and again at the end of one-month and two-month intervals.

Data on six-month adjustment were collected from social-work case records and from interviews with recreation workers in the home. Indices of social isolation, socialization and social adjustment were constructed. Participant observation, sociological analysis, interviews and content analysis were used to determine the normative structure of the home for purposes of constructing socialization and social adjustment indices.

Social isolation was defined as the absence of specified role relationships which are generally activated and sustained through direct personal interaction. Two indices of social isolation were constructed: 1) a pre-entry isolation index which measured the number of social contacts in connection with five specified roles during the year prior to entry into the home, and 2) an adulthood isolation index which measured contacts in connection with ten specified roles in which adults usually participate—for example, friendship, marriage and occupational roles.

Most of the residents were found to be quite isolated during the year before entry; 43 per cent could not recall having seen a single friend or acquaintance and 15 per cent had seen only one friend. Of the total sample, 57 per cent did not attend a single meeting of any organization, including religious services. The best predictor of pre-entry isolation was adulthood isolation, though this was not startling since the two measures were not independent. Socialization was defined as the ability to learn and internalize social norms. Adjustment was defined as consisting of integration, evaluation and conformity, which were measured independently. Integration was indicated by participation in group activities; evaluation referred to opinions held of various aspects of life in the home; and conformity was defined as behavior enacted in accordance with social norms. Results showed that people who experienced isolation before entering a home for the aged had difficulty becoming socialized. The relation between the measures of socialization and isolation were greater than the relation between these of isolation and any of the three components of adjustment, thus supporting an hypothesis that socialization was an intervening factor which mediated between the isolation prior to entry and the subsequent adjustment.

Early or rapid socialization, rather than socialization per se, related best to adjustment. That is, those who learned the measured norms in the first month adjusted better than those who learned them subsequently. Isolation was inversely related to all three components of social adjustment, though all were not statistically significant.

The relations of isolation to evaluation and conformity were not significant after either one month or two months of residence. However, there was a systematic though not significant increase in the relation between isolation and nonconforming (or deviant behavior) as length of tenure in the home for the
aged increased. Socialization was an intervening process mediating between isolation and integration and evaluation, but not conformity. Apparently most of the newly admitted aged conformed initially, and deviant behavior took time to develop, perhaps because the new residents were cautious until they learned the sanctions.

Contrary to expectation, adjustment to the home for the aged was not affected by the duration of social isolation per se. Rather it was the pattern of isolation that mattered, particularly for socialization. When the persons who were relatively isolated in adulthood but not in old age were compared with those who were isolated for the first time as a concomitant of aging, it was the latter who had greater difficulty becoming socialized.

One interpretation of this finding is that there are critical periods for desocialization, just as there are for learning. Thus, gradual as opposed to abrupt isolation may be less likely to result in desocialization and may have less of an impact on resocialization. As a result of this study, it was concluded that the consequences of isolation are such that socialization and social adjustment are impaired. Background factors such as age, sex, and physical and mental status did not relate to isolation nor did they explain the findings.

In order to investigate the antecedents of extreme social isolation, Dr. Fredric Zemán and I conducted exploratory research on aged recluses. Descriptions of recluses were obtained from newspaper accounts of 105 cases reported with varying degrees of completeness by newspapers in the New York City metropolitan area over a period of seventeen years. The median age of the recluses was 80 years. There were an equal number of males and females in the group. They lived in cities, were apartment dwellers, and about one-third had worked at middle-class occupations. They were economically comfortable and even wealthy, judging from the amount of rent paid and the fact that they sustained themselves on their property and savings.

It was found that these recluses started on the road to seclusion early in life, as shown by the fact that a large proportion had never married. Other than this, nothing extraordinary was unearthed by this method. However, improved case finding was thought necessary to collect an unbiased sample of aged recluses in contrast to those who attracted the attention of newspapers.

From our studies it wasn't clear whether the socially maladjusted behavior found in the aged was a result of isolation or of mental disorder. Possibly mental disorder caused both isolation and maladjustment. Therefore, a study of psychiatric illness and adjustment was undertaken. Fifty-three successively admitted residents of a home for the aged who had already been studied in earlier research were independently evaluated by a psychiatrist for the presence of dementia (impairment of intellectual ability) or of functional psychiatric illness.

The findings showed no relation between isolation before entry and mental disorder. Some forms of mental disorder did result in extreme maladjustment. Residents who had senile and arteriosclerotic dementia differed from those with functional psychiatric disorders in their social adjustment patterns.
Those with dementia adjusted to the institutional environment with a sense of subjective satisfaction and in accordance with the expectations of the institutional milieu. But those with a functional psychiatric disorder were personally miserable and, in addition, did not conform to social rules or live up to the expectations and requirements of other residents. The evidence that intellectual impairment did not throw the old person out of step with the environment indicated that mildly demented persons were suitable for care in homes for the aged.

All mentally disordered residents were characterized by low participation in home activities such as clubs, games, concerts and friendship groups. Thus, non-participation should alert staff members that mental disorder may be present, and that diagnostic and remedial measures are called for. Demented subjects, like the normal aged, evaluated the home positively and were positively identified with it. Those with functional disorders, on the other hand, evaluated the home negatively. They were the residents who had no positive affective bonds with their present environment. Failure to conform was associated with functional psychiatric disorders. Therefore, difficult and malcontented residents should be assessed psychiatrically for the presence of functional psychiatric disorders, some of which may be remediable.

It was concluded: 1) that if functional illnesses were not treated appropriately or were fatalistically misdiagnosed as due to brain pathology, social impairment might persist, and 2) that residents with a functional psychiatric disorder would be so uniformly maladjusted on social dimensions that a home for the aged would fail to meet their needs. The results seemed to show that although isolation and functional mental disorder were not related, they both led to poor social adjustment in a home for the aged. It may be important to distinguish between isolation and mental disorder because the effects of isolation may be more reversible than those of mental illness, and may require different treatment.

The next study was undertaken to determine the long-term effects of early social adjustment. If initial adjustment to a home was impaired, would this be true over a long period? Our earlier research indicated that the various adjustment processes were more specifically correlated to each other than to social isolation. The correlations between the various components of adjustment increased over the two-month interval. To extend this period, a two-year follow-up of social adjustment was undertaken. Changes in adjustment patterns with time, interrelations between components of adjustment relations between early and late adjustment, and the impact of socialization on both early and late adjustment were studied.

Subjects from the earlier study who had survived after two years of residence were investigated. The average resident was 80 years old; about two-thirds of the sample were women. Standard interview schedules were used. Findings showed that the components of adjustment had distinctive characteristics. With increased tenure, integration increased, evaluation became differentiated (that is, more people said some things were good and some things
were bad), and conformity showed a complex of patterns. Socialization at
one month was the best single predictor of integration at one month, two
months and two years. Thus, if a new resident did not become rapidly social-
ized, his long-range adjustment was also likely to be poor.
Up to this point, all of our research had been conducted in a single home for
the aged, and it was not clear if the findings would hold true in other settings.
Therefore, a comparative study was undertaken to determine if there were
some settings in which adjustment would not be affected by isolation and de-
socialization. This three-year study was recently completed.
The residential settings varied in degree of institutional totality on an index
of totality constructed for research. A mental hospital, nursing home, super-
vised apartment residence and public housing development with special fa-
cilities for the aged received ratings of extremely high, high, medium and low
totality respectively. During the first stage, participant observation and inter-
views with administrative personnel and "old timers" were conducted in each
residential setting for the aged. Subsequently, a total of 107 persons newly
admitted to the four settings were interviewed. The final analyses of the data
were based on interviews with 10 mental hospital patients, 20 nursing home
patients, 10 apartment house residents and 20 tenants of a public housing de-
velopment. These were compared to 100 residents of the home for the aged stud-
ied earlier. Indices of social isolation, socialization, and adjustment were con-
structed and administered.
In the course of this work it became apparent that important factors in
social adjustment were the expectations or criteria for adjustment held by the
staff and other residents of the particular institution. These expectations varied
considerably in the different institutions. On the basis of an analysis of the
literature and results of the participant observation, there appeared to be a
T-shaped relation between totality and both the explicitness and complexity
of social adjustment criteria.
This relation was not anticipated because it seemed logical that in the more
total institutions, the rules, regulations, sanctions and adjustment criteria
would be very explicit. As it turned out, residential settings with either ex-
tremely high or extremely low totality ratings had in common the fact that
adjustment criteria were vague, i.e., most administrative personnel and resi-
dents were unaware of them.
In institutions with a rating of medium totality, such as the supervised
apartment residence, adjustment criteria were explicit, though complex. In the
supervised apartment residence, staff members recognized that the institution
functioned as a terminal one into which people came for the remaining years
of their lives. Therefore, they tried to help the residents to adjust. In the men-
tal hospital, which was rated extremely high in totality, staff members thought
in terms of discharging patients back to the community despite their advanced
age. Therefore, they gave little thought to the requirements of institutional
living. In the public housing development, which ranked extremely low in
totality, very little thought was given to the special social needs of the aged. The development did not serve as a community for the old.

It appeared that the degree to which adjustment criteria were made clear depended upon the extent to which a residential setting approximated a functioning, continuing community. The findings indicated that the experience of pre-entry isolation had a negative effect on socialization in all but one residential setting, the apartment residence. That is, isolates had a more difficult time learning what was expected of them in four out of five residential settings.

The correlation was significant in a home for the aged \( r = .27 \), though it was higher in a public housing project \( r = .42 \) where the sample size was smaller. Isolation experienced immediately prior to entry was a better predictor of poor socialization than was isolation experienced during adulthood. It had been found in earlier research that the relation between isolation prior to entry and poor adjustment was mediated through the mechanism of socialization. This finding was supported in this research particularly in regard to the aspect of adjustment which we have termed integration. The correlations between pre-entry isolation and integration were generally lower than those between socialization and integration. However, they all went in the same direction. Institutional integration correlated positively with both socialization and absence of pre-entry isolation. The degree of correlation was generally higher in the moderately total institutions than in settings at both extremes of totality. Thus, in regard to the moderately total institutions such as the nursing homes, homes for the aged and apartment residences, the newly admitted old person who had been isolated and unsocialized was less likely to participate in institutional activities. Isolated residents were more handicapped in the moderately total settings with explicit but complex adjustment criteria.

It was concluded that isolation may have a worse effect on the behavior most valued in any given setting. These isolates would be unable to learn that an ongoing community values participation, and they would behave inappropriately.

At one point we wondered if there might not be a brighter side to social isolation. It was thought that although isolation resulted in poor social adjustment, it might have some more salutary social psychological effects. Possibly isolation would result in attitudinal independence, as represented by the cantankerous rugged individualist willing to do battle against society or at least not bother with it.

A study was undertaken of the relation between isolation and attitudinal persuasibility in the aged. The relationships between conformity, persuasibility and counternormative persuasibility also were studied. Counternormative persuasibility was measured by willingness to reject an ongoing, institutional norm or practice. Ninety-six residents—all those who had been residing in the home for one to three years—were interviewed twice.

Persuasibility was defined as the tendency to agree with contradictory opin-
ions expressed by two interviewers. Two measures of persuasibility were used: one measure consisted of statements about current events and social practice; the other was a topic-free, picture-choice measure. Social integration was assessed sociometrically by using staff members' reports about the activities engaged in by the residents, and the friendship choices of other residents in the home. Socially isolated persons were found to be highly persuasible. Paradoxically and unexpectedly, the socially integrated residents were both attitudinally independent and socially conforming. In general, the residents were highly persuasible. No relationship was found between persuasibility and conformity to the norms of the home.

On the other hand, highly conforming residents were found to be the most resistant to counternormative persuasion. Conforming individuals evaluated the home positively and regarded it as a positive reference group, while simultaneously indicating a lack of interest in people and events outside the home. Thus, conformity indicated a commitment to the home's normative standards and to the home, rather than a general tendency to comply.

Current research involves studies on the effects of desocialization, to determine the extent to which social learning is related to other learning processes. Length of residence in a home for the aged, and chronological age are the independent variables. Residents will be evaluated by tests of mental status, information, comprehension and conceptualization, and adulthood isolation. The amount of social learning as measured by tests of socialization will be compared to other measures of intellectual ability and tests of mental status. An attempt will be made to assess the influence of environment in maintaining, stimulating or reinforcing learning experiences.

Hopefully, the studies just described will help the development of a more realistic approach toward the aged, which will integrate their needs with those of our society. A new approach seems called for because the practical, the moral and the medico-psychiatric approaches tend to reinforce isolation, while the traditionalist one is unrealistic for our society. In order to develop a new approach toward the aged, more research is necessary to: 1) evaluate the condition of the aged, 2) study their interactions with society, 3) decide which conditions and which interactions need altering, and 4) determine how to alter them. If we want to alter the process of aging, we'll have to make some decisions about our variables. Do we want to prolong life and thus increase the population of older persons, or do we want to improve the conditions of those who are old? We can do both, but they are to some extent independent problems. Increasing the population of older persons seems to be chiefly a biological and medical problem. Improving the condition of older persons seems chiefly a social problem requiring alterations in myths, values, norms, attitudes and social institutions.

GENERAL REFERENCES