DEVELOPMENT OF A SOCIALIZATION PROGRAM FOR GERIATRIC OUTPATIENTS.*

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When old people experience ever-increasing losses of social contacts with age, they have fewer opportunities to practice their social skills and fewer people around to help them recognize that they are breaking social rules. The process of desocialization, that is, loss of social knowledge and skills, becomes for the isolated old person, a vicious cycle leading to loss of general knowledge and skills such as conceptualization, information and memory. However, assuming that these social skills are lost primarily through disuse, then by offering an opportunity to put them to use once again, the process may be reversible. Aging persons can thus be resocialized given meaningful setting with salient objectives. The exploratory hypotheses of this study were that, if socially isolated aged persons are given the opportunity to practice socially normative behavior in a stimulating structured setting, they can relearn those behaviors that have been lost and that in the process there will be changes effected in social competence and intellectual awareness.

Our initial connection with the Geriatric Outpatient Clinic population began with participant observation in the clinic waiting area watching the interaction amongst the patients. This clinic was set up by the hospital for the purpose of providing medical as well as social services once a week to people over 65 residing in the hospital district. The clinic is staffed by an internist who heads the clinic team, a registered nurse, a psychiatric nurse and a social work trainee.

All of the patients make appointments for the major purpose of seeing the physician, but at the same time, if there are any social problems such as welfare payments, housing, or home nursing care, the auxiliary team members are called upon.

Our observations revealed that the geriatric patients regularly came to
the clinic at least an hour earlier than their appointments were scheduled. We speculated that the time spent in the clinic waiting room was as important to these people as meeting with the professional staff. These patients were using the clinic as much as a social experience or at least a place to be surrounded by people as they were as a place to meet their medical needs. However, although the patients often sat next to one another they did not appear to interact much with one another.

During this observation period we also set up conferences between ourselves and the clinic team to discuss our program and its purpose. Namely, that we were going to develop and maintain an ongoing discussion group of the patients to meet each clinic session; and that the purpose of the discussion group was to give the patients a chance to socialize with peers, to share and resolve common daily problems and to offer a focus for social interaction other than that of bringing medical problems to the doctor. We pointed out to the team that given no other roles to play in our society, and given the severe social isolation suffered by this population, at least some of their attendance at the clinic was a search for social interaction and that these patients in part "played the sick role" which was then reinforced by the sympathetic treatment of the staff. However, given substitute socially interactive opportunities and negative reactions to constant physical complaints, the "need" to be sick might diminish along the "need" to attend the clinic.

The team was willing to allow our sessions to take place, if no further responsibility was required of them. However, at no time, in those orientation sessions, did the team members express optimism over the positive possibilities of the group sessions. It was felt by the team members that the older people attending this clinic were only carrying out a pattern intrinsic to the aging personality characterized by dependency on a medical authority and best handled
by catering to their physical complaints.

Measurements of social isolation of this population showed that all members of our group had suffered severe losses in social contacts in their later years. The indices used were the Adulthood Isolation Index, which is a measure of the extent of lifetime social contacts with family, friends, work and organizations the Past Month Isolation Index which is a measure of number of social contacts in the month prior to the interview. The average Adulthood Isolation score for the group tested was 13.1 out of a possible 30 social role contact points. This meant, on the average, that this group had been actively involved in meaningful social roles during most of their adult lives. However, the average Past Month Isolation score for this group was 2.1 which indicate the precipitous drop in social contacts in their old age.

In addition, when Wechsler Adult Intelligence Scale subtest scores were analyzed, (we used the subtests of Information, Comprehension and Similarities), we found that those group members who fell below the mean on Past Month Isolation, had an average total WAIS score of 10.4, whereas the less isolated half of the group had an average score of 26.4. Our hypotheses about the relationship between social isolation and intellectual awareness were validated in our first testing.

To begin our first meeting in April of 1970 we approached the seven elderly people who had been sitting in the waiting room and invited them to join us in a small examining room that had been set up for the group meeting. The session began with general introductions and explanations by the group leader (a clinical psychologist with experience in group therapy with geriatric mental patients) of the nature of the meeting. All the members seemed pleasantly surprised to hear that this would be an ongoing function.
When questions pertaining to health were asked, one member enumerated her many ailments and complained about each. Anxiety over health aroused, other members also stated their somatic complaints, the length of time they had been with them and so on. The physician, reinforcing this pattern, added information about their ailments in terms of how long each of the patients had them and how much time is spent at the clinic.

Since one of the goals of the session was to redirect the focus on physical complaints, the group leader attempted to use one of the members as a "solution" model asking the member to talk about some positive ways to cope with physical ailments and help oneself. Although surprised that their opinions might be listened to or deemed worthy, the members hesitantly and briefly offered general ways in which they attempted to cope with some of these problems.

By the next session, group discussion was easily turned to the living conditions of the members with all expressing their feelings about living alone. Each appeared eager to tell about her own loneliness, the difficulties with shopping and the fear when one becomes sick and no neighbors were around. The group leader introduced the topic of living among age peers versus age integrated housing. All but one member appeared to favor living in mixed communities and all gave cogent reasons.

It became more and more evident as the sessions continued that the group considered social isolation their major problem. Members began meeting telling the group how depressed they were over the weekends or how whole weekends had been spent in bed. These were contrasted to the few experiences of getting out into the world like a Tuesday night Bingo game where "there are people, there is excitement and things to on. That's when I glow...not like when you're alone and have no one to talk to". Attempts to counteract loneliness with a pet and stories of the affection they give and the joy they brought were
scoffed at by some members who expressed the notion than an animal cannot make up for the desired human companionship.

As the group focused more and more on these problems they were gradually led to discussions of the possibility of planning activities as a group, going on trips and the like. Soon after, the members themselves organized a buddy system whereby telephone numbers and addresses were exchanged and group members kept in touch with each other between sessions.

We found the group discussions beginning to change not just with regard to content, but with regard to structure and function as well. That is, where in the early meetings, the group leader was continually working to focus and refocus the discussions around issues relevant to all, as the meetings progressed, group members were beginning to orient the discussions in a problem solving direction. Throughout the sessions, members expressed problems, the group offered solutions, alternate ways of handling situations, and more realistic ways of coping. They respected each others ability to offer solutions more as they began to recognize the commonality of problems they shared.

The sessions provided them with the kind of normative social feedback that they had all been deprived of prior to these meetings. A setting had been provided in which there were behavioral expectations, there was some regulation of behavior, in the form of the group leader's structuring of the discussion and there was a group of people with whom to relate.

I think we should clarify at this juncture just who was attending the meetings and what general ramifications the meetings had in terms of the changes observed. The group members consisted of female patients who had made appointments each week to see the doctor at the geriatric clinic. This meant that in the early meetings our patient population changed from session to
session. However, by the third session, we found that members were coming, just to participate in the group session and were not making appointments with the doctor. The group grew with each consecutive week, so that we were made up of a core of members who just wanted to attend the group, mixed with those who had had doctor's appointments. The psychiatric nurse and the social worker trainee reported to us after two months of sessions, that they were being called on less frequently. Members of the group were requesting fewer appointments with the physician, to such an extent that the rolls of the clinic which prior to our intervention had been closed because the team could not handle any greater numbers, were opened to allow new patients because the team's services were not needed by our group members. As the clinic team became aware of this consequence of our session, their attitudes toward the progress being made by the patients as well as their behavior toward the patients began to change. Where the physician had sat in on early meetings listening to and encouraging listings of medical symptomology, he in recent sessions began to participate along with the members in problem solving suggestions for wider social involvement of these elderly people in the community.

Although social group work had been done with older people in community settings such as recreation centers, few if any, attempt to change the behavior of elderly persons in any specified direction. This program has been specifically directed toward moving a group of chronically ill geriatric clinic outpatients from subjective involvement with bodily ailments to more socially committed involvement in the life of the community. Through group meetings on a regular basis, we have attempted to overcome some of the medical as well as psychological ramifications of the socially isolated lives these patients have been experiencing.
In summary, the group members entered our program showing signs of loss of social skills, a verbal focusing on physical selves while behaviorally not attending the appropriate dress or cosmetics, and manifesting grossly inappropriate social behavior. Amongst the latter, for example, was hoarding when refreshments were served, a lack of concern for another’s needs during this time and interrupting one another or ignoring conversations during meeting time. In other words, social cues, practiced by most adults in order to respond relevantly to others, were ignored by our group. Also observed were memory losses while giving physical histories to the physician. They showed highly dependent behavior with the nurse and social worker, asking for help with any minor everyday routine. Thus, social competence, independent thinking and action were ignored and put to rest, whereas dependency, and socially inappropriate behavior had been reinforced prior to our intervention.

After six months of participation in our program, given an opportunity and encouragement by the group leader to voice independent thinking and manifest self-sufficient behavior, and given a socially interactive setting, we found that our members began to censure each other’s socially inappropriate behavior. They began to show renewed interest in activating social roles, through exchanging telephone numbers and offering suggestions for meeting daily problems. They became less concerned with their own medical symptomology and more concerned with exploring though in a limited way, the tackling of objective problems of aging such as housing, transportation, social activities and finances. Now they dress better and use cosmetics. They begin meetings with social greetings amongst each other, showing concern for how the time between meetings has been spent. They inquire about problems raised in past sessions and their outcomes. In addition, they communicate to members who have missed sessions, what had taken place. They proudly cite their com-
petence in handling situations which previously had been left to others to handle for them.

Many of these changes that have occurred are difficult to measure by quantitative standards. One thing our program has shown us is the need for such instruments. We know that such field settings lack the advantages of control when attempting to measure behavioral changes. However, since 95% of older people do live in the community, it would seem that despite measurement problems, exploratory research of a social-action nature is certainly necessary in this setting. In spite of utilization of different techniques it does appear to date, that there exist a dearth of controlled studies on the effectiveness of goal-oriented group work with the aging in the community. It is this void, of attempting to work with and change "here and now" behavior that our program attempts to fill.