Living Conditions and Everyday Needs of the Elderly with
Particular Reference to Social Isolation *

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One of the major distinguishing social characteristics of the aged is their social isolation. Social isolation or, perhaps social marginality, is the absence of meaningful social roles or rolelessness. The very names by which the social positions of the aged are designated imply that former role partners are not available for support, nurturance, stimulation, interest-sharing or other forms of social interaction. Terms like widow or widower and retiree or emeritus imply the absence of role partners. Social isolation may be thought of as socially induced sensory or stimulus deprivation.

Little is known about absolute or relative numbers of social isolates among the aged cross-nationally nor does it make sense to guess at them. Clearly the phenomenon of social isolation of the aged is well-known cross-nationally. Very recently, concern was expressed in a UN General Assembly report on aging about the impact on the elderly of rapid urbanization and industrialization in newly developing countries, where young families are encouraged to move to cities, thereby abandoning the old in rural areas. Probably the rates of isolated, aged persons will increase, largely because most of the aged are women who are usually found in more marginal positions in society than men.

As has been noted many times but it bears repetition, the census report item of "living alone" probably is not a true indicator of social
isolation in the aged. Unfortunately at this point in time there seems to be no agreement on an index of social isolation to be put into immediate use to survey the incidence of social isolation in the aged cross-nationally. However, there seems an urgent need to conduct such surveys\(^3\).

Many factors beyond the control of any single aged person probably contribute to the social isolation of the aged. These are mandatory retirement roles and attendant meager financial resources, reduced mobility due to physical infirmity, deaths of spouse, relatives, friends and other age peers, social and geographic mobility of offspring and widespread prejudice against the aged\(^4\).

There seems ample evidence indicating that there is a relationship between isolation and low morale, a concept sometimes used interchangeably with personal adjustment\(^5\).

By virtue of the seeming involuntary nature of social isolation in the aged and its negative consequences, some of which will be described later in discussing my own work, there seems a need for policies and programs aimed directly at preventing and compensating for social isolation. Some of our research to be described also touches on the development and evaluation of such programs.

Our research, to which I will devote most of the remainder of this paper has focussed not only on the relationship between social isolation and
moralé, but also on the variables of social adjustment, mental status and
cognitive functioning. Our research on social isolation was begun 15 years
ago with a study in which 100 case records of a home for aged were used to
identify those characteristics which differentiated residents who were trans-
ferred to a mental hospital from those who were not. Fifty residents of the
Home who were transferred were compared to controls matched for age, sex
and length of residence who remained in the Home. The findings showed
that poor scores on a combined index of social isolation experienced prior
to entering the Home were related to inability to get along with staff members
and other residents and sometimes resulted in transfer to a mental hospital.

Given the limitations of case record studies, a direct survey was
undertaken of 100 elderly residents, two thirds of whom were women in their
late 70's. One hundred consecutive admissions to the Home were interviewed
three times, once on admission and again at one 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.

The findings in Table 1 show that residents who experienced isolation
before entering the Home had difficulty becoming socialized. The relation
between socialization and isolation was greater than the relation between
isolation and any of the three components of adjustment. Desocialization
or inaccurate perceptions of life in the Home seemed to be an intervening
factor mediating the relationship between isolation experienced prior to entry
<table>
<thead>
<tr>
<th></th>
<th>2 Months</th>
<th>1 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Two Months</td>
<td>One Month</td>
</tr>
<tr>
<td></td>
<td>Isolation</td>
<td>and Socialization</td>
</tr>
<tr>
<td></td>
<td>Socialization and Adjustment</td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Rank-Order (Rho) Correlations Between Isolation, Socialization, and Resilience in a Home and Adjustment After One, Two and Six Months.
and subsequent poor adjustment. Early or rapid socialization, rather than socialization per se related best to adjustment. That is, those with accurate perceptions of life in the Home in the first month adjusted better than those who subsequently became socialized.

Four patterns of isolation were differentiated. They were: non-isolation, old age non-isolation, involuntary isolation and voluntary isolation. These patterns were studied in relation to socialization. Table 2 shows that all patterns of isolation had negative effects on socialization, in contrast to non-isolation. The score differences between non-isolates and the group next in line were greater than between any two types of isolates.

Table 2. Relation Between Pattern of Isolation and Socialization at Two Months

<table>
<thead>
<tr>
<th>Isolation Pattern</th>
<th>Adulthood</th>
<th>Pre-entry</th>
<th>N</th>
<th>% Above Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Isolate</td>
<td>Not Isolate</td>
<td>Not Isolate</td>
<td>31</td>
<td>77</td>
</tr>
<tr>
<td>Early Isolate</td>
<td>Isolate</td>
<td>Not. Isolate</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Involuntary Isolate</td>
<td>Not Isolate</td>
<td>Isolate</td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td>Voluntary Isolate</td>
<td>Isolate</td>
<td>Isolate</td>
<td>45</td>
<td>29</td>
</tr>
</tbody>
</table>
This led to the suspicion that there were two or, possibly, more "syndromes" related to similarly maladjusted behavior found among the residents: one was mental disorder which probably resulted in hospitalization; the other has since been termed the isolation-desocialization syndrome, for want of a better name. The isolation-desocialization syndrome is a process that may look something like the following: an old person in the community becomes isolated, then desocialized; he enters a home for the aged or some other setting, misperceives the norms and blunders socially soon after entry; others single him out, perhaps as a "troublemaker" and avoid him; he then becomes resentful and alienated; finally, he deviates further from the norms by becoming involved in overt conflict with staff members and/or other residents. Presumably, a history of social isolation would not be as great a handicap to an old person who remained in the community as it is to one who is relocated and must adjust socially. However, also presumably, the effects of social isolation may be remediable whereas those resulting from mental disorders of the senium were more nearly hopeless.

It was not clear from our early studies just described whether some of the maladjusted behavior observed was the result of the isolation-desocialization syndrome or of mental disorder, nor did we know if both isolation and maladjusted behavior resulted from mental disorder. It was
our good fortune to have working with us a visiting psychiatrist, trained in Britain, who wanted to study in a non-clinical manner the relationship between social isolation, mental disorder and social adjustment in the aged. Fifty-three successive admissions who had been studied two years earlier were independently evaluated by the psychiatrist using a crude standard diagnostic form he designed to determine presence or absence of organic or functional mental disorder. This measure was designed to exclude data on early social isolation or social adjustment and was based largely on current cognitive functioning. Findings showed no relationship between social isolation and mental disorder.¹³

The next series of studies which were conducted were designed to determine if increased social interaction, in the form of actual admission to the Home, improved social adjustment and cognitive functioning. Using whatever standard measures were available for social performance and which could be administered to the aged both in and out of the Home, we studied in waiting list persons, newcomers and oldtimers the relationships between isolation, socialization, mental state and cognitive functioning both on admission to and after one year of residence at the Home.¹⁴

The distribution of means on the Wechster Adult Intelligence Scale (WAIS) test scores for waiting list subjects, newcomers and oldtimers are seen in Table 3. They show that on all the WAIS subtests means were
higher for the resident groups than for the waiting list group. The newcomers' scores on WAIS total and on all WAIS subtests with the exception of WAIS comprehension were higher than those of both the waiting list group and the oldtimers. Differences in mean total WAIS scores were significant at the .01 level across groups. Newcomers seemed to perform best possibly because they were in the midst of being socialized\(^\text{15}\). Oldtimers appeared to have reached a performance plateau and waiting list persons performed worst of all, perhaps because they were the most socially isolated and deprived of cognitive experiences and stimulation\(^\text{16}\).

Table 3. Mean Scores on WAIS Subtests and Socialization Index in Waiting List, Newcomer and Oldtimer Groups

<table>
<thead>
<tr>
<th>Mean WAIS Scores</th>
<th>Waiting List Group</th>
<th>Newcomers</th>
<th>Oldtimers</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAIS information</td>
<td>13.10</td>
<td>15.00</td>
<td>13.55</td>
</tr>
<tr>
<td>WAIS similarities</td>
<td>5.95</td>
<td>7.40</td>
<td>6.35</td>
</tr>
<tr>
<td>WAIS comprehension</td>
<td>13.50</td>
<td>15.65</td>
<td>16.45</td>
</tr>
<tr>
<td>WAIS Total</td>
<td>32.55</td>
<td>38.05</td>
<td>36.35</td>
</tr>
<tr>
<td>Socialization Index</td>
<td>10.10</td>
<td>18.50</td>
<td>20.30</td>
</tr>
</tbody>
</table>

\(^*\) Chi square were computed for differences found among groups for all tests. They were as follows:

- WAIS information: \(\chi^2 = 2.73\ p < .10\)
- WAIS similarities: \(\chi^2 = 3.16\ p < .10\)
- WAIS comprehension: \(\chi^2 = 6.13\ p < .02\)
- Total WAIS: \(\chi^2 = 9.57\ p < .01\)
- Socialization Index: \(\chi^2 = 64.56\ p < .001\)
Residents as a group obtained markedly higher socialization scores than people on the waiting list, which came as no surprise since they knew more about life in the Home. The waiting list group, despite some exposure to the admission interview and intake procedure, was largely unaware of norms and practices in the Home.

To determine if waiting list persons' scores actually increased after admission, a one year follow-up study was undertaken. Forty survivors of the waiting list, newcomer and oldtimer groups were seen again. As may be seen in Table 4, waiting list persons improved when they became newcomers, indicating a "spill-over" effect of socialization or, perhaps, increased motivation to perform on tests. Oldtimers and former newcomers, however, seemed to deteriorate. Perhaps, had the Home continued to offer them salient learning experiences this would not have occurred. From these studies, it was concluded that isolation reduced social and other performance while interaction stimulated good performance.

Table 4. Mean Scores on WAIS subtests and Socialization Index for Interviews 1 and 2 for Survivors (N = 40)

<table>
<thead>
<tr>
<th>Subtest</th>
<th>Waiting List</th>
<th>Newcomers</th>
<th>Oldtimers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
<td>Time 1</td>
</tr>
<tr>
<td>WAIS information</td>
<td>13.1</td>
<td>13.6</td>
<td>17.1</td>
</tr>
<tr>
<td>WAIS similarities</td>
<td>6.6</td>
<td>8.1</td>
<td>8.6</td>
</tr>
<tr>
<td>WAIS comprehension</td>
<td>13.9</td>
<td>14.9</td>
<td>17.1</td>
</tr>
<tr>
<td>WAIS total</td>
<td>33.7</td>
<td>36.6</td>
<td>42.8</td>
</tr>
<tr>
<td>Socialization Index</td>
<td>10.1</td>
<td>22.8</td>
<td>18.5</td>
</tr>
</tbody>
</table>
At one point in our series of studies, we looked for the brighter side of social isolation if there was one. We thought isolation may well have some salutary personality effects, possibly resulting in attitudinal independence, in the "rugged individualist" or "old codger" will to do battle against any restraints. This was not found to be the case; in fact the opposite was true.\textsuperscript{18}

From our past research as well as that of others we concluded, tentatively, that the involuntary nature of social isolation and its attendant negative consequences indicate a great need for social policies, practices and programs to combat isolation. It seems hardly necessary to repeat this idea, yet its repetition has not seemed to provoke any major programmatic efforts in this direction. This may be because the problem of social isolation of the aged seems insurmountable or, perhaps, because some of the solutions seem so simple, though expensive, that they have no news value.\textsuperscript{19}

Or, perhaps, it is because those community programs which have been aimed specifically at the aged have not been evaluated systematically and it is assumed they have not reduced isolation, or improved mental state, morale, social adjustment, cognitive functioning or any other process indicative of maladaptation in the aged.\textsuperscript{20}

Therefore, we were led to develop several experimental resocialization programs aimed at the isolated aged in the community and to develop assessment techniques so that their impact could be evaluated systematically.
There is enough time left to describe only one of these experimental programs, The Teachers College (Columbia University) Friendly Visiting Program (TC-FVP) which we have been conducting over the past three years. The TC-FVP was developed by several groups of graduate students and some faculty members in a training program in gerontology, who ferreted out isolated aged persons in the Morningside Heights health catchment area, a high crime rate, densely populated, apartment dwelling section of New York City surrounding Columbia University. Pilot research was conducted during the first two years to determine if it was possible to locate isolated elderly persons, if they would cooperate in a study, and if measures could be developed to assess as unobtrusively as possible the behavior of old persons residing in their own homes.

In the most recent and methodologically sound study in this series, eight graduate students were paired in order to visit and assess twelve isolated aged community residents who comprised the experimental group. The experimental group was visited every two weeks for a total series of twelve visits and were assessed at each visit. Another pair of graduate students assessed twelve persons matched approximately for age and also for sex and whether or not they lived alone and they formed the control group. The control group was visited to collect data only twice; these data were comparable to those collected at the initial and final visits with the
Experimental group.

Early results of the present TC-FVP study are shown in Table 5.

Table 5. A Comparison of Selected Scores of Persons In and Not In the T.C. Friendly Visiting Program (TC-FVP)

<table>
<thead>
<tr>
<th>Persons in the Friendly Visiting Program (Experimental Group)</th>
<th>Persons Not in the Friendly Visiting Program (Control Group)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
<td>76</td>
</tr>
<tr>
<td><strong>Past Month Isolation Score:</strong></td>
<td>79</td>
</tr>
<tr>
<td>1st Visit N = 12</td>
<td>1st Visit N = 13</td>
</tr>
<tr>
<td>$\bar{X} = 1.3$</td>
<td>$\bar{X} = 2.4$</td>
</tr>
<tr>
<td>12th Visit N = 12</td>
<td>12th Visit N = 12</td>
</tr>
<tr>
<td>$\bar{X} = 1.3$</td>
<td>$\bar{X} = 2.3$</td>
</tr>
<tr>
<td><strong>Grooming (Rating of Neat and Clean):</strong></td>
<td></td>
</tr>
<tr>
<td>1st Visit = 92%</td>
<td>54%</td>
</tr>
<tr>
<td>12th Visit = 92%</td>
<td>54%</td>
</tr>
<tr>
<td><strong>Apartment (Rating of Neat and Clean):</strong></td>
<td></td>
</tr>
<tr>
<td>1st Visit = 63%</td>
<td>54%</td>
</tr>
<tr>
<td>12th Visit = 82%</td>
<td>54%</td>
</tr>
<tr>
<td><strong>Number of Ailments Reported:</strong></td>
<td></td>
</tr>
<tr>
<td>1st Visit = 1.9</td>
<td>2.7</td>
</tr>
<tr>
<td>12th Visit = 1.9</td>
<td>3.1</td>
</tr>
</tbody>
</table>
The data indicate that Past Month Isolation scores were not affected by the friendly visitors. That is, those visited frequently did not rush out and become more social as a result of the visits. Nor did the old people in the control group do so. Both the experimental and control groups remained socially isolated over time, however the experimental group received visitors from the TC-FVP program.

Personal grooming was initially better in the experimental group than in the control group: however both groups remained constant in their personal grooming ratings. On the other hand, apartment upkeep improved in the experimental group only. Neither group complained initially of many physical ailments, however number of complaints about ailments went up only in the control group.

Unfortunately, time does not permit presentation of detailed visiting process or case reports, many of which are of great interest. However, one case will be briefly summarized to illustrate the extent of neglect experienced by the isolated aged residing in the community:

Mrs. D., age 83, received three negative ratings on a twelve item physical health observation schedule. She had swollen legs, swollen ankles, and a bandaged wrist. She claimed she only visited a "foot doctor" and never saw a medical doctor. She took many pills. Her vials of medications were unclearly marked for Rx, dates and dosages. Of the assortment of some twelve vials, only two were labeled but their dates were smeared. She lacked knowledge of what the pills were. On the only two of the twelve labels which were legible, the names Digoxin and Hydriodil took were found both of which require a degree of intact intellect for proper dosage and usage.
Other, similar case reports have caused those in the TC-FVP to make a concerted effort to link our program with community hospitals willing and able to provide medical as well as multiple services to the elderly residing in the community.

It is too soon to draw any definitive conclusions about the impact of the TC-FVP program in particular and friendly visiting programs in general. However, the presence of visitors does seem to have some direct, salutary effects particularly on behavior which can be influenced by frequent visiting, namely apartment upkeep and amount of complaining about illnesses.

It is necessary but difficult to summarize all of our research on social isolation, its consequences and the measures which may possibly combat it. We, as well as others, have located extremely isolated aged persons who reside in the community. All of our early correlational studies indicated that social isolation has a negative impact on the aged: it desocializes them, hampers social adjustment and seems to reduce attitudinal independence. Isolation in the aged does not seem to be correlated with age, sex, mental status or education. It is not synonymous with mental disorder though it may result in some behavior patterns associated with mental disorder, specifically poor social adjustment and cognitive functioning. If not compensated for in time, the effects of isolation may lead to
serious and, possibly, irreversible cognitive and other impairments. However, unlike senile mental disorders, the effects of isolation may be reversible through resocialization programs, such as friendly visiting, which are currently being developed for systematic evaluation.

Until social isolation and other social stresses concomitant with aging are out of the picture, many of the aged probably will be at risk of developing physical, behavioral and emotional disabilities which may have little if anything to do with the aging process per se and much to do with rejection and neglect.
Footnotes and References

1 A somewhat different view of the usefulness of the concept of rolelessness was taken by Carroll J. Bourg in "Aging: Role, Rolelessness and Relations (theoretical background for research grant AA-4-69-101-01, "Life Styles and Mobility Patterns of Aging Persons"), circulated for administrative use by Administration on Aging of the United States Department of Health, Education and Welfare, N.D. ca, 1971. Bourg, basing some ideas on the 1967-1969 research of Robert S. Weiss, suggests that "the development of role theory and the application of a theoretical perspective on 'rolelessness' with regard to aging made much sense in the rapidly developing industrial society. Today, further developments have brought changes not previously anticipated. These directions point to the lessening significance of the stylized roles of an earlier, more steadily developing society. The changes in sensibility and expectation in contemporary society indicate that the more fruitful locus for our empirical studies will be the basic assumptions and functions of various relationships. Thereby, we will draw near to the source and context of meaning for the participants in various situations, whether indeed there may also be within them role alterations or increasing rolelessness." (p. 14)


3 Epidemiological surveys of the mental health of the community aged have been conducted in the U.S. and U.K. since the 1950's and some have collected some information on isolation. Some of the early U.K. surveys indicated that social isolation appeared to place the elderly at risk of developing mental illness or, at least, of hospitalization for mental illness. In
Newcastle-Upon-Tyne, 10.3% of those 65+ residing in the community were suffering from organic disorders as compared with 12.9% in mental hospitals, a difference of only 2.6%. The findings seemed to show that people with organic disorders can be maintained with equal facility out of institutions but that those with functional disorders needed hospitalization, possibly due to their isolation. Indeed, 31% of those 65+ in the community were found suffering from functional disorders while 42% in the hospitals were similarly impaired. This research team revisited Newcastle-Upon-Tyne several years later and found again that only a very small fraction of old people with psychiatric disorders were being cared for either as hospital in-patients or as residents of Homes. (D. W. Kay, P. Beamish, and M. Roith, "Old Age Mental Disorders in Newcastle-Upon-Tyne - I," British J. of Psychiatry, Vol. 110, No. 465, March, 1964.) Several small-scale U.S. surveys of the community aged conducted in the 1950's also indicated that there were many isolated, as well as mentally ill elderly persons at risk of hospitalization. Gruenberg studied residents of Syracuse; (E. M. Gruenberg, A Mental Health Survey of Older Persons, N.Y. State Department of Mental Hygiene Report, 1956). This report may well have served as a background for the recent development of Gruenberg's concept of social breakdown syndrome (SBS).

Perlin studied elderly volunteers from the community near the U.S. National Institutes of Health. He found many to be impaired but the extent to which they resembled in-patients was not determined. (S. Perlin, Psychiatric aspects of senile nervous diseases: Part I, A normal control study, Paper read at 4th International Congress of Gerontology, Merano, 1957.)


4 Isolation of the aged occurs against a background of pervasive negative stereotypes of the aged and negative attitudes toward aging. According to a recent review, these negative attitudes are found cross-nationally, among old and young people alike and among people who work with the aged, as well as those who do not. (Ruth Bennett and Judith Eckman, Attitudes in the U.S. Aged: A critical survey of the literature 1950-70 aimed at determining
gaps in knowledge. Proceedings of the American Psychological Association Task Force for the White House Conference on Aging. Washington, A.P.A. (In Press.) While there is not necessarily a cause and effect relationship between negative attitudes toward the aged and their social isolation, there seems reason to believe they are mutually reinforcing.

Most research on the effects of social isolation has focussed on the subjective aspects of adjustment, namely morale. Correlational surveys have been conducted in a number of settings and have not yielded straightforward findings. In rural areas, well-adjusted aged persons are found to be active, eager to participate and eager to go on doing so into old age. (J. H. Britton, Change in adjustment of older community residents after six years. Paper presented at the 6th International Congree of Gerontology, Copenhagen, 1963; E. G. Youmans, Orientations to old age, The Gerontologist, Vol. 8, No. 3, 1968, 153-158.) However, in large cities the variables of age density and adequacy of living conditions seem to intervene. Participation seems needed to preserve morale in the aged mainly where age density is low, that is, when there are not many other old people in a neighborhood. (I. Rosow, Social integration of the aged, New York: Free Press, 1967.) In some housing projects studied, presence of age-appropriate peer groups with age appropriate normative expectations were thought to condition the isolation-morale correlation. (M. Messer, Possibility of an age-concentrated environment becoming a normative system, The Gerontologist, Vol. 17, No. 4, December, 1967, pp. 247-251.) In a recently completed, U.S. National Survey of 4,000 elderly persons the overall relationship between participation and morale was a weak one. The relationship seemed entirely conditioned by whether or not old people perceived their surroundings as favorable. (K. K. Schooler, The relation between characteristics of residential environment, Social behavior and the emotional and physical health of the elderly in the United States, Paper read at the 7th International Congress of Gerontology, Washington, D. C., 1969.) Perhaps, the morale of an elderly person is low regardless of degree of isolation if he thinks of his poor housing conditions as a sign of rejection and neglect.

In an article based on a part of this research, the following findings concerning the relation between pre-entry isolation and subsequent social adjustment were described: 1) Residents who were isolated prior to entry encountered significantly more difficulties in interacting with their peers ($X^2 = 14.6$, $p < .01$ and with rank order correlation, $Ta_4$ was 1, $p = .008$); 2) Residents who were isolated prior to entry encountered significantly more difficulties in interacting with staff members ($X^2 = 8.3$, $p < .05$; $Ta_4 = 1$); 3) Residents who were isolated prior to entry appeared to be more likely to be transferred out of the home to a mental hospital but this relationship was not significant.

7 In this research, social isolation experienced prior to entry as well as during adulthood was studied in relation to socialization, integration (participation), evaluation and conformity. Social isolation was found to be inversely and significantly related to socialization and integration. There was no significant relation between isolation and evaluation (a concept similar to morale) or conformity after either one or two months of residence in the Home. With time, however, there was an increase in the inverse relation between isolation and conformity. As length of residence in the Home increased, isolated age persons engaged in deviant behavior. One explanation for this delay, may be that it took time to learn to deviate or to learn the forms of deviance in the Home. (Ruth Granick, Social Isolation, Socialization and Social Adjustment in Residents of a Home for Aged, Unpublished Ph.D. Thesis, Columbia University, 1962.)

8 The following measures were constructed for this research: (1) Adulthood Isolation Index (AI), which was a measure of the extent of lifetime role contacts with family friends, work and organizations; (2) Pre-Entry Isolation Index (PII), which was a measure of number of social contacts outside the institution in the year prior to entry; (3) Socialization Index which was a measure of the amount of information learned about life in the Home, consisting of questions about formal practices and informal norms in the Home such as "What kinds of activities are available during the day?"; (4) Integration Index, which measured amount of participation in the Home's activities; (5) Evaluation Index, which measured how the resident felt about various aspects of life in the Home such as the food and medical care; and (6) Conformity Index, which measured the extent to which the resident behaved in terms of the norms of the Home. (Ruth Granick, op. cit.)

9 Scores on the Pre-entry Isolation Index ranged from 1-9 (0-10 was possible) with a median of 4.5. Over one half of the respondents reported contact with fewer than 5 people in the year prior to admission and were regarded as isolated for that measure. (Ruth Granick and Lucille D. Nahernow, Preadmission Isolation as a Factor in Adjustment to an Old Age Home, in: P. Hoch and J. Zubin (Eds.), Psychopathology of Aging, N.Y. Grove and Stratton, 1961, pp. 285-302.)

10 After two years, a follow-up study of the process of long-term social adjustment of residents of the Home was undertaken. Changed in adjustment patterns over time, interrelations between components of adjustment, relations
between early and late adjustment and the relations between socialization and both early and later adjustment were studied. Forty-five residents who had been seen two years earlier were interviewed once more. Findings showed the relation between one month socialization and integration was stable over time. There was a systematic decrease in the correlation between socialization and evaluations with time, mainly because evaluations became differentiated. There was a continued increase in the relation of socialization to conformity, which had been indicated by the six-month social workers' adjustment report, an evaluation thought to reflect conformity more than any other behavior. (Ruth Bennett and Lucille Nahemow, A two year follow-up study of the process of social adjustment in residents of a home for aged, Paper read at Annual Meetings of the Gerontological Society, Los Angeles, November, 1965.)

11 Pattern of isolation was obtained as follows:
1. Lifelong Isolates: those residents who had below median scores on both the AII and the PII.
2. Old Age Isolates (Involuntary Isolates): those residents who had above median scores on the AII but below median scores on the PII.
3. Old Age Non-Isolates: those residents who scored below the median on the AII but above the median on PII.
4. Lifelong Non-Isolates: those residents who scored above the median on both the AII and the PII.

While the lifelong (voluntary) isolates (who were, perhaps, mentally ill) did worst of all, it was not much worse than involuntary isolates. However, the gap widened between involuntary isolation and early isolation and widened most between early isolation and no isolation at all. The findings suggest there may be critical periods for isolation and that it may have more negative consequences for socialization if it occurs late in life and is uncompensated. (Ruth Bennett and Lucille Nahemow, The relations between social isolation, socialization and adjustment in residents of a home for aged. In: M. P. Lawton (Ed.), Mental Impairment in the Aged, Phila, Maurice Jacob Press, 1965, 90-108.)

12 From these series of studies, it was concluded that the consequences of isolation are such that socialization and social adjustment to a home for aged are impaired. Age, sex, physical status and other background factors did not relate systematically to isolation nor did they explain the obtained findings. (R. Granick, op. cit.)

13 Residents suffering from senile and/or arteriosclerotic dementia were differentiated from those with functional psychiatric disorders by their social adjustment patterns. Those with mild dementia adjusted to the institutional environment much like normal residents; those with functional disorders behaved much like

14. The hour long, standard interview contained adaptations of all of the measures used in earlier research described above and an additional three measures, all of which were subtests of the Wechsler Adult Intelligence Scale (WAIS), a standardized test of cognitive ability. The subtests used were: Information, containing 20 questions measuring basic knowledge about topics ranging from names of composers to the colors in the American flag; Comprehension, containing 14 items, designed to measure the ability to combine information into new forms; and Similarities, which is a measure of conceptualization with 13 items of paired association. (Comilda Weinstock and Ruth Bennett, From "Waiting on the List" to Becoming a "Newcomer" and an "Oldtimer" in a Home for the Aged: Two studies of socialization and its impact upon cognitive functioning, J. of Aging and Human Development, Vol. 2, No. 1, 1971.

15. For newcomers, correlation coefficients for the relations between all WAIS subtests and the socialization index were significantly higher than for those of the other two groups. The correlation coefficients were as follows: .77 for information and socialization, .51 for similarities and socialization, .78 for comprehension and socialization and .74 for WAIS total and socialization. Newcomers appeared to be so highly involved in a salient learning experience which seemed to "spill over" to performance on tests of cognitive ability. (Weinstock & Bennett, op. cit.)

16. Age, per se, did not relate to poor cognitive functioning. The waiting list sample, although somewhat younger than the total resident sample, did not perform well on any tests. In general, when groups were divided at their median ages and younger residents were compared with older ones, the older ones performed better. This was specifically true of older residents in general but especially of older newcomers, who were found to have higher scores than the younger waiting list sample. This seemed to indicate that older residents benefitted most from increased stimulation in the Home.

Similarly, education did not account for high scores. Since all groups had a similar high level of education, they should have performed alike at the outset. In point of fact, they did not. Level of education did not correlate
with either WAIS subtests or the socialization measure. This was most
evident in the newcomer group who, by virtue of being stimulated by in-
volvement in the socialization process were more likely to perform well on
tests. (Weinstein & Bennett, op. cit.)

17 The mean Socialization Index score for the waiting list group was 10.1 out
of a possible score of 30, which was the lowest score for the three groups.
Oldtimers obtained higher socialization scores than newcomers; their mean
was 20.3; the mean obtained by newcomers was 18.5. These differences
were significant at the .001 level across the three groups. Unlike score
patterns on the WAIS subtests, on which newcomers obtained the highest
scores, socialization scores seemed to reflect increments in experience ob-
tained with increased tenure in the Home. The pattern of scores also indi-
cated that the socialization measure and the WAIS measure, with the possible
exception of WAIS comprehension, were independent of one another. (Wein-
stock and Bennett, op. cit.)

18 In order to study the relation between isolation and attitudinal independence,
ninety-six residents, all those who had been in the Home for about two years,
were interviewed twice by two interviewers. Persuasibility, the opposite of
independence, was defined as the tendency to agree with contradictory opinions
expressed by two interviewers. Social integration was measured sociometrically
by using staff members' reports about the activities in which residents partici-
pated and residents' friendship choices. One salient and one topic free measure
of persuasibility were used. Paradoxically and unexpectedly, the socially
isolated residents were attitudinally dependent, but socially deviant. (Lucille
 Nahemow, Social Integration, Persuasibility and Conformity in Residents of
Lucille Nahemow and Ruth Bennett, Persuasibility and Persuasion in the Aged.
Paper read at the Eastern Psychological Ass'n, 1964; Lucille Nahemow and
Ruth Bennett, Social adjustment and persuasibility in two branches of a home
for the aged. Paper read at the American Psychological Ass'n, 1965.)

The relationship between conformity to social norms, persuasibility and
counternormative persuasion was also intensively studied. While some resi-
dents were highly persuasible, no relationship was found between the
persuasibility tendency and conformity to real social norms operant in the
Home. Highly conforming residents were found to be well-adjusted and
most resistant to counternormative persuasive appeals. Conforming residents
had positive evaluations of the Home and regarded it as a positive reference
group while simultaneously indicating a lack of interest in people and events
outside the Home. From this series of studies, it was concluded that con-
formity was less dependent on a general compliance tendency in the personality
than upon commitment to the norms and activities of the Home. (Lucille
There are several reviews available of the various mental health and quasi-mental health programs developed in the U.S. to serve community residents. According to Mensh, there is a "significantly less than optimal availability of community care for older patients." (Ivan N. Mensh, Studies of Older Psychiatric Patients, The Gerontologist, Vol. 3, No. 3, Sept., 1963, pp. 100-104.) In the U.S., special community psychiatry programs are not aimed specifically at the aged. In general these programs have vague aims, are not standard in their structure, compete among themselves and with other agencies and contribute to a general atmosphere of fragmentation of service, which tends to confuse the aged. Moreover, few if any of these programs have been evaluated systematically. (Ruth Bennett, Community Mental Health Programs with specific reference to those aimed at the aged. Paper read at Institute of the Gerontological Society, Asheville, N.C., August, 1971.) In an updated review of community mental health care for the aged in the U.S., Mensh included as mental health programs any sort of program specifically aimed at the aged. He found there were no special psychogeriatric facilities for the aged, but included as community mental health programs for the aged the following: (a) nursing homes, homes for the aged, V.A. domiciliaries all of which serve less than 5% of those 65+; (b) senior centers which serve only about one third of those eligible to belong and which offer no medical, psychiatric or work services but which do provide information, referrals, food and recreation; (c) special programs such as the Foster Grandparent Program, which provide no health or psychiatric services; (d) Friendly Visiting Programs which provide no health or psychiatric services and (e) community mental health programs designed to serve people of all ages in which the aged are notably under represented. (Ivan Mensh, Community Mental Health and Other Health Services for the Aged, Paper read at APA Task Force, op. cit., Washington, D. C., 1971.)

In a U.S. nationwide survey of patterns of utilization of psychiatric services for the aged using NIMH statistics collected up to June, 1964, it was found that persons 65 and over occupied about 30% of all public mental hospital beds and showed higher resident patient rates than any other age group. They then turned to the new approaches for reducing mental hospital resident populations, stressing community-based psychiatric and auxiliary services for the aged. They found only 8% of the aged was served on an outpatient basis. Only 2% of the aged were served in clinics, a figure which had not changed in the past decade. While an estimated 200,000 nursing home patients have mental disorders, their care was largely custodial. Of 175 mental health day care facilities available in 1965, only one was designed specifically for the aged. While 175 day care facilities accepted older patients, only about 200 persons aged 65 and over were served. Only 9% (19,000) private physicians'
patients were 65 and over. Married people in contrast to the widowed were less likely to be institutionalized. There were marked differences in the care of the "young old" and the "old old." The "young old" (65-74) were treated; the "old old" (75+) received custodial care. (Beatrice M. Rosen, Thomas E. Anderson and Anita K. Bahn, Psychiatric Services for the Aged; A Nationwide Survey of Patterns of Utilization," J. Chron. Dis., Vol. 21, 1968, pp. 167-177.) Similar findings were obtained in more recent NIH figures. (Morton Kramer, Carl A. Taube and Richard W. Redick, Patterns of Use of Psychiatric Facilities by the Aged, Past, Present and Future. Paper read at meeting of the APA Task Force for the White House Conference on Aging, Washington, D. C., 1971.)

There are several programs in the U.S. which seem to provide some mental health care to the aged in the community and which have been evaluated systematically. The findings on a treatment service conducted by the Visiting Nurse Service in New York City indicated that three-fourths of the community elderly were chronically but not mentally ill and that a majority of them did not need hospital care. Seventy-four percent of the old people at home were not thought by visiting nurses to need institutionalization, though 42% were reported as depressed. In 13% of the cases, the home situation was not deemed adequate and old age home or nursing home care was thought to be needed. Three percent of the patients were sick enough to need referral to a general hospital. These proportions were found to resemble health estimates made by others of aged community residents. (Dorothy L. Mitchell and Avin I. Goldfarb, Psychological Needs of the Aged Patients at Home, Am. J. of Public Health, Vol. 56, No. 10, Oct. 1966, pp. 1716-1720.) There had been described a program of services to the widowed and outlined first steps in a program of intervention for the fairly young elderly. (Phyllis R. Silverman, Services to the Widowed: First Steps in a Program of Preventive Intervention, Community Mental Health J., Vol. 3, No. 1, Spr. 1967, pp. 37-44.)

Stotsky randomly assigned comparable mentally ill aged patients in state hospitals in Boston to remain in the hospital or to go to nursing homes. No changes in the course of mental or physical illnesses were found; however, death and rehospitalization occurred less in the nursing homes. (Bernard Stotsky, A Systematic Study of Therapeutic Interventions in Nursing Homes, Genetic Psych. Monographs, Vol. 76, Nov., 1967, pp. 257-320.

In England, while general approaches were taken simultaneously, few programs have been evaluated to determine their impact on the isolation or mental or physical health of the aged. The several approaches taken simultaneously include establishing (1) geriatric facilities in mental hospitals, (2) clinic facilities based in general hospitals, and (3) psychogeriatric hostels geared to limited periods of institutionalization. They are described in the following publications:


J. A. Whitehead and J. V. Graham, Boarding out Elderly Psychiatric Patients, Mimeo, N. D.

One such English program was evaluated systematically and findings showed that mentally ill old people at home did not get better or worse than those in hospital but also were not a burden to their families as had been feared. (Peter Salisbury, Principles and Methods in Evaluating Community Psychiatric Services. Paper read at 8th International Congress of Gerontology, Washington, D. C., 1969.)

A friendly visitor program reduces social isolation by reconnecting the elderly to others, by indicating an awareness of their presence in the community and by showing concern with their well-being. The Friendly Visitor Program should result in improved morale initially, as well as in improved social and personal adjustment and mental state. The friendly visitor should not only help reduce isolation but also attendant feelings of abandonment, as well as feelings of loneliness, depression and anxiety. Moreover, by providing opportunities to engage in discussion they should expect to bring about improvement in some
cognitive aspects of the mental state of the elderly persons visited. The pilot work to develop extensive interview and observation schedules was conducted over a two year period. (Ruth Bennett, et. al., Development and evaluation of a friendly visitor program for the community aged, Paper read at the annual meeting of the Gerontological Society, Toronto, 1970; Ruth Bennett, et. al.: New concepts in services to the aging: progress in the development and evaluation of a Friendly Visitor Program for the Community Aged, Paper read at the annual meetings of the N.Y. State Parks and Recreation Association, Monticello, N.Y., 1971.)

There are several Friendly Visitor Programs in operation in the U.S., but none have been evaluated systematically. Among others, there were or are the (a) Family and Children's Service, Inc. of Monmouth County, New Jersey; (b) Project FIND in New York City (National Council on Aging, Jack Ossofsky, Project Director), The Golden Years: A Tarnished Myth, Report prepared for OEO on Project FIND, Washington, D. C., 1970); (c) Project PATH in New York City; (d) Project PILOT in New York City, (e) Friendly Visiting Project of the International Ladies' Garment Workers Union's (ILGWU) Retiree Service (Retiree Service Department, ILGWV. After a Life of Labor: A Pioneering Union's Program for Retirees, N. Y., 1971 and (f) the San Francisco Program for the "Hard to Reach" Older Persons. (Estelle Booth, "Involving the 'Hard to Reach' Older Persons in Social Activities", paper read at the annual meeting of the Gerontological Society, Los Angeles, 1965.)


The case of Mrs. D., age 83, was described in greater detail in a term paper submitted to the author by Audrey Harris, M.S.W., a social worker who has worked in a nursing home for many years, and is presently doing doctoral work in the program in gerontology at Teachers College, Columbia University. She developed and is continuing to work on the medical observation measures.

Another of our resocialization programs was recently completed, which was conducted first at Manhattan Westside Hospital and then at Coney Island Hospital both in N.Y. City. Decreases in complaints about illness was obtained in the resocialization group led by a trained leader who was a clinical psychologist. In this group scores went up on the Pre-entry Isolation Index which assesses number of relationships in which the elderly individual engaged in the past month, probably because the clinic group in contrast to the T.C.-F.V.P. actually put elderly members into contact with age peers who were potential friends outside the clinic. (Comilda Weinstock and Marcella Weiner, "Resocialization of Geriatric Outpatients: The Problems of Implementing Innovative Programs for the Aged." Paper read at annual meetings of the Gerontological...