PSYCHO-SOCIAL ASPECTS OF AGING:

PROGRAM IMPLICATIONS*

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The preamble of the Nutrition Section Report of the 1971 White House Conference on Aging states that adequate nutrition is a basic right along with life, liberty, and the pursuit of happiness. It also admits that food is more than a source of adequate nutrition -- it is an "enjoyable interlude in an otherwise drab existence." Nutrition programs for the older American then, are supposed to provide for more than the basic biological needs. They are to provide for the social or psychological ones as well.

In order to implement such programs it is vital that those who will work within it be knowledgeable about the population to whom it is being directed.

Essentially then, this paper will attempt to describe in psychological and social terms, the population of elderly in our society.

Who are the elderly? By most definitions they consist of all men and women over the age of 65. In the United States, approximately 10% of the total population are over 65 with a little over 6% between the ages of 65 and 74 and little over 3% aged 75+. Whereas future projections call for a leveling off in the long-term increase in the overall aged sector of the population, a continuous growth in the oldest category is expected i.e., the proportion of 75, 80, and 85 year olds will increase. In the U.S. there is an appreciably smaller proportion of males than females in the older population. And the sex ratio decreases with advancing age, so that whereas at 65 we can expect to find 87 males to every 100 females, by age 75 it falls to 73 per 100, and by 85 to less than 70 males per 100 females.
Starting at age 65 the proportion of men and women in the labor force begins a precipitous drop; at age 65 approximately 50% of men and 20% of women are still working. By age 70 only 30% of men and 10% of women are still in the labor force and by age 80 approximately 15% of men and 5% of women hold jobs.

For men, those with higher education levels are more likely to continue working, whereas for women those with lower education and less advantageous economic or social sectors are likely to remain in the labor force. The financial status of old people represents the lowest bracket of income of families. For two-person families (which constitute 74% of the older families versus 25% of the younger families) the median income for older families remains only about 1/2 that for younger families. Given the fact that larger proportions of the older population are living on fixed rather than earned income, as we can see from our figures on the aged population in the work force, expectations are that the gap between younger and older families will continue to widen.

Older people do not have the educational attainment of younger people. Approximately 23% of the population over the age of 75 have less than four years of elementary school. Less than 50% of 65+ have completed elementary school. Less than 20% have completed high school. Of course this describes the present aging or aged population and we would expect a very different picture of educational attainment with coming generations, but certainly older people will continue to represent the least educated sector of the population.

Most older people live in urban areas (70%) but they are not evenly distributed geographically. There are higher concentrations of
older people in the New England states and Florida than in the Southwestern and southern states. Sex ratios are different for rural and urban areas. In contrast to 76 males for every 100 females 65+ in urban areas there are 94 for rural non-farm areas and 117 for rural farms.

Most older people live in their own rather than rented homes and large proportions of these have been owned for 30 or more years. Their general condition and value tends to be somewhat lower than that of U.S. housing as a whole. Approximately 5% of all older people 65+ live in institutions of one kind or another. However, with increasing age, there are marked increases in the proportion of elderly who are institutionalized. Over 15% of the 85+ population are either in homes for the aged, nursing homes or mental hospitals.

The marital status of older people, presents a changing picture with increasing age and according to sex. Among men age 65-69 approximately 80% are married, with decreasing proportions through the 70's and 80's such that by ages 80-84 only 54% are married and in the 85+ group less than 40% are married. For women ages 65-69 only 52% are married. This falls off to 39% in the 70's and 16% in the 80's. For females age 85+ only 8.2% are married.

Because of mortality rate differences between sexes, among older people 65+ 68% of the men but only 34% of the women are living with a spouse. This must be seen, however, in its larger social context which means that those few women that are married are living with husbands that are at least three years older than they are and their chances of losing their husbands are always greater than of leaving their husbands widowed.
Three quarters of older people have living children, although there is variation with class such that white collar workers are more likely than blue collar or farm workers to have fewer or no children. Less than 30% live in the same household as their children. The proportions of older people sharing households with their children tend to decrease with advancing age among married older people, but increase with age among non-married for both men and women. Very sick old people are more likely than those who are well to live with their children.

If we integrate all these statistics into an idealized graphic representation of the average older American, we have a 75 year old white widowed female, with less than an 8th grade education living in a rented apartment in an urban setting, existing at or about poverty level. Through widowhood, death of friends and relatives and geographic mobility of younger generations (such as her children), she is also likely to be more socially isolated than she was when a younger adult.

But let us go on to describe her more fully in psychological terms as well.

Older people suffer from declines relative to the middle aged or younger adult in a variety of sensory and perceptual abilities. The average 75 year old can see at 20 feet what the younger person with normal vision can see at 70 feet. There is a decline with age in dark adaptation. The ability of the eye to focus on near objects by changing its focal length decreases with age. That is, essentially we tend to get more far-sighted as we get older. Here, the changes which take place, however, are more marked through the middle aged period as all of you whose arms have gotten steadily shorter holding books or newspapers are aware. There are gradual hearing losses from age 60 upwards, particularly for higher frequencies.
Other sensory changes include loss of sensitivities in taste and smell although the evidence is somewhat contradictory depending on who was studied and with whom they were compared.

Tests of strength, reaction time and sensori-motor coordination all show declines with age again, when compared with those of younger adults.

It has been widely assumed that declining intelligence is also typical or normal in aging. However, much of the literature on aging and cognitive behavior has been concerned with describing how older individuals differ from younger people at a given point in time. This is valid and worthwhile if we are interested in the standardization of our measurements or in comparing older with younger persons on a specific measure. But, such cross sectional data tells us nothing about the changes in the cognitive abilities of an individual which take place throughout the life-span. Furthermore, given the fact that we know that the older population has been exposed to less education and has been away from school for longer than younger people, we are penalizing them unnecessarily by characterizing their performance on measures so closely related to school achievement. We find that longitudinal studies (i.e., following the performance of the same individuals over time) show a different pattern of cognitive changes with age from those of cross-sectional ones. Longitudinal data usually show a steadily increment in cognitive abilities during childhood, slight improvement in middle age and continued increases in certain tests such as vocabulary, verbal abilities and general information in old age. The reason then, that cross-sectional data show declines with age is that younger generations (due to differential socioeconomic and educational factors) start out
at a higher level of ability. Furthermore, the tests themselves have often been developed for and normalized on young adult populations, such as college students or army selectees. The resulting data have seriously limitations then, for an understanding of adult abilities. Observed decrements in test performance noted with increasing adult age may simply reflect the structure of the test. Asking an older adult (who we saw before probably has less than an 8th grade education and who has been removed from any kind of school learning situation for upwards of 60 years) to tell you "who wrote Hamlet" or "the Iliad," is hardly a measure of his cognitive ability. More likely, it is a measure of exposure to information, to school experience and a commentary on the lack of opportunities for continued education through the life-span.

A similar problem arises when we attempt to assess the memory function of older adults. We all know that older people are forgetful, that they dwell on the past, not the present. Most of what we commonly call senility has to do with an older person's inability to remember names dates, to confuse events and people, to reminisce about other times and other places inappropriate to the situation in which they are behaving. When we analyze memory in older people then, we recognize that their memory for past events seems unimpaired if inappropriate at times. So, it would seem that what they learned and experienced early in life remains with them through old age. What are the factors then that affect recent memory in older persons and cause its deficits?

Firstly, we must hark back to the sensory declines we outlined earlier. Older people suffer visual handicaps and auditory handicaps. On a very concrete and simple level, this means that the world in which they are operating is severely limited. Because mental functioning
operates on the level of a feedback system, sensory handicaps act to limit the amount and kinds of stimulation available to the individual. If I cannot see clearly, am limited in my vision by the amount of light which reaches the retina, or cannot hear clearly and am limited by my hearing deficit in understanding conversations which go on around me, it is clear that the higher mental processes such as comprehension, storage or information, organization of learned material and the like, are going to be affected as well. Furthermore, if my social world is also being narrowed by the loss of its important members (spouse, peers, children), the stimulation from the environment undergoes further deprivation. Therefore, when we draw a picture of a socially isolated, visually handicapped, hard-of-hearing old woman, we are also describing a human being whose information about the world around her has been cut back. Without such information, such feedback, such environmental stimulation, mental functioning suffers. Again, all of this takes place in a larger social context in which older people are viewed as less able, as non-productive, where the ability to find continued gratification through jobs or voluntary association are curtailed by age, where reduced mobility economically and physically offer restrictions, where the general attitude is that when you are old you are unwanted. The older person would like to continue to participate in everything belonging to society, but society shows a hostile and rejecting attitude towards him.

It is interesting to note that if we were to have described the social and psychological aspects of childhood, we would have concluded that compared with adults, children show sensory, perceptual and cognitive deficits. They are excluded from much of the larger framework of society and held back throughout adolescence even, from independent
functioning in the mainstream of adult society. When children don't remember, however, we say they have not yet learned or that the school system is not doing its job. We recognize the crippling effects of social isolation on children and attempt to offer and provide special social worlds in which they can function at their own levels. We are protective of his dependencies and yet encouraging of the child's mastery in the intellectual and social world. The older person is not viewed in such a protective light. The aged person is viewed as inferior (up against a norm of younger adults) and cannot counteract inferiority feelings by demonstrating his superiority in the open market. The older person is faced with an inability to fulfill needs and drives which is accompanied by doubts which develop when he is reminded of the decreasing efficiency of his bodily functions. Basic to an understanding then, of the differences in mental functioning of the older adult are the interactive forces of the biological, social and psychological alterations taking place over a life span.

All of which brings us to the final question, how can these bits of knowledge, this picture of the aged displayed here be used to suggest or implement programs for our elderly population?

Some years ago, a series of studies were conducted at an all-geriatric hospital by Robert Kastenbaum.¹ (The studies involved the introduction of wine and beer at specified times on the wards.) At the core of the introduction of such a program was a theoretical approach to human behavior known as the developmental-field approach. Human behavior, according to this model is best explained as organized systems of action that operate to interact with

their environment and to construct their own experience and knowledge of themselves and the world. This means that the individual has been endowed with all the necessary inner resources and potentialities to insure development and self-actualization, given a milieu in which such development can take place.

Within this framework, Kastenbaum began with a basic assumption that early in life, human beings develop a need for mutual gratification, the need for pleasurable interactions with others. In meeting this need, by the time a person reaches adulthood, he has learned to interact with many others within his life space in a number of different roles proscribed by society. He is a son, a father, a husband, an employee, a friend, a church member, a neighbor and so forth. Through these roles, he has built a picture of himself. Loss of roles in young adulthood tends not to affect the stability of the self-picture because the young adult has many environmental opportunities in which to play out or substitute other roles. The older adult faces a different situation, however. We have noted that role loss is a concomitant of the aging process. Wives and husbands die, children move, friends and relatives deaths cause considerable shrinkage in the social world in which the older adult operates. Substitution through other roles is limited either by the environment (i.e., substituting a "job" for the loss of parental role), or by the lack of fit between loss and substitution (a new friend for an old). If this is true for the average elderly person it becomes even more exaggerated for the geriatric patient in an institution. The only role open to the institutional resident is that of "patient".

As Kastenbaum puts it, speaking of the institutionalized older person:

"Clearly he is expected to follow, not to lead; to receive, not to give. Just a shade less obviously, the staff is also bolted into position. Most of 'us' make a determined effort to be helpful to 'them'. We do not expect 'them' to help 'us'. Both sides have
allowed themselves (ourselves) to be trapped and at least half-persuaded that this is the best, if not the only, possible arrangement. 

Application of a "mutual gratification" model was proposed to answer the question:

Could staff and patients be enticed to seek each other out not because they "have to", or "should" but simply because the contacts might be enjoyable? 

Wine was originally proposed because of the connotative meanings it has for most adults. It arouses thoughts of pleasure in social situations, of family togetherness, of special occasions, of mutual gratification in adult socialization.

The initial introduction of the program took place in a male ward whose patients were among the least impaired in the hospital. As per Kastenbaum's description:

Medically and mentally, these men were capable of leading relatively normal lives within the protective environs of the institution. In point of fact, however, they tended to constrict themselves to parallel, isolated existence....Clinical experience with these patients indicated that they felt they had little that was worth communicating to each other.

Groups were asked to meet every day at 3:00 p.m. in the day rooms. Red port wine was served. A Participant Observer from staff was assigned to be with the group as a group member (not leader) and for record-keeping functions.

The major findings were:

For the first time in the history of the hospital, patients spontaneously formed themselves into groups. The simple beverage-administration situation became elaborated into something of a social club. The "members" increasingly stepped outside of the patient role to function in an equalitarian manner as adults who enjoyed each other's company, the company of the Participant Observer and of those staff members who dropped in from time to time. The daily 'club meet-

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1 Kastenbaum, R., op. cit. 2 Ibid. 3 Ibid.
ings' persisted for more than a year after the termination of the study per se....The group became a place where pleasures and complaints could be aired and shared with little fear of rejection or reprisal....Patient behavior with the group improved markedly—more communication, more positive in spirit, more varied."

Despite such positive results, there were disasters, too. An attempt to implement a similar program in an intensive treatment unit, proved to be problematic. Despite some staff resistance, the favorable response of the patients seemed to generate a general acceptance. However, even after it appeared that the project had succeeded with patients, ward staff, administration, and visitors, failure came in the form of the objections from an influential member of the professional staff.

"Essentially his position was that such a development was unprecedented, unnecessary, and improper. There should not be such goings on in a medical setting; it lacked dignity. Furthermore, such a program invited the wrath of relatives, and there were relatives who know how to make trouble for a public institution if they so choose."2

Despite some efforts by hospital administration to support the continuation of the project, the ward personnel found it difficult to remain spontaneous and active. No matter what they did they were bound to incur someone's wrath. The program was terminated for this reason.

What was learned from the positive and negative results of these studies?

Firstly, it is possible to apply what the social sciences tell us about human behavior to action programs. These intervention programs can also be subjected to scientific evaluation. And given a research methodology which provides data not just on staff qualifications or numbers of patients served, but on impact of the program on all those involved in the program

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1Kastenbaum, R., op. cit. 2Ibid.
(staff and patient alike) even negative findings serve to heighten our knowledge of the process we are viewing.

Finally, accepting a developmental viewpoint about human behavior and acquainting ourselves with the knowledge gathered about the elderly within this framework, we enable ourselves to recognize the special as well as universal needs of the elderly population. Like the rest of us, they need a host of interpersonal relationships to maintain their human qualities. Like the rest of us, these interpersonal relationships must provide mutual gratification. Whether child, adolescent, young or older adult, no human being can develop positively when he is the taker and everyone else is the giver. And particularly when one has spent a lifetime successfully coping with the environment it must be a particularly defeating notion to accept total dependence on others. However, it is possible to attempt to search for the kind of meanings that are mutually gratifying even in the most limited of environments.

If we accept the premise that old age and its comcomitant limitation are only another phase in the developmental process which calls for maximizing the fit between psychological needs and an area in which they can be met, we can build programs that are rehabilitative rather than welfare oriented, that focus on the life experience skills gained with age, that recognize that old age is part of our own life-cycle as well as of others. Working with elderly does not mean separating ourselves from them, but rather, allowing us to learn more about how, despite biological, social and psychological handicaps, human beings do overcome.