Successful Aging:
The Ultimate Challenge
From Psychology*

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If we see aging as a life process, as a cycle of maturation and development from conception through death, then it would seem wrong to speak of successful aging as the ultimate challenge. Psychological development and the course of the life cycle unfold in phases. Each phase may be defined by a set of tasks that must be met and conquered by the individual at that time in his developmental career. A number of interlocking factors are central to understanding the meeting of the challenges of life from infancy to old age.

Firstly, physical maturation and the changes which take place in the structure and function of the human body play a major role. No child learns to crawl until the nerve and musculature growth which permit the necessary voluntary discrete movements become functional. No amount of training prior to such maturation will change the normal patterns of such psychomotor development. Once such readiness is established however, the acquisition of such skills is amenable to and enhanced by practice, training, and opportunity for its acquisition. With such understanding of physical maturation, modern parents provide open spaces, climbers, walkers and other such opportunities for the enhancement of such simple skills. Likewise, in later life shifts occur in physical maturation which become a challenge to the developing human being. Adolescence brings internal as well as external physical changes which require adaptation to new ways of functioning.

Secondly, the human being matures and develops within a society. At the earliest stages, the society is represented by one's parents, extended family and throughout life by one's peers, and through the roles established for different age groups and developmental periods. The child entering school brings with him his physical maturation which is put into play with the new
set of demands and expectations which define the role of schoolchild. Later in the life cycle, marriage, parenthood and retirement all provide a subset of society's expectations to which the individual must adapt. New behavior, new abilities, new ways of handling old problems come at different periods of the life cycle and are largely determined by the specific set of norms established by the social setting in which development is taking place.

Finally, a developmental view of the life cycle must also take into account the changing nature of the individual's mental growth and decline. The challenges wrought by the growing capacity to think, to learn, to interpret life's experience, to communicate, to integrate these abilities into a meaningful capacity, to assume responsibility for one's own actions and feelings and to direct one's own life, is also part of the life cycle of adaptation.

Successful aging, then is but a phase in the course of a life which contains a series of crises that arises out of the need to meet new physical, social and psychological challenges common to everyman. Overcoming, resolving these challenges determine the future development of the person, ensure his success or failure in adapting to this inner and outer world to which he must adjust, and draws for him and the world a sense of and evaluation of self.

Growing old successfully from a psychological viewpoint, then, means an adaptation to the changes in structure and function of the human body, to the changes in roles demanded by the social setting and to the changes which a life-time of human experience have imprinted on the human mind.

Earlier papers presented at this Institute have documented fully what the major physical, psychological and social changes are that present challenges for adaptation for the older person. There is a growing body of knowledge in this
multi-disciplinary field of Gerontology which document the variety of declines both physical and psychological which affect the everyday functioning of the older person. Older persons must adjust to a variety of chronic diseases and failing organ and muscle systems. Older people suffer from declines relative to the middle aged or younger adult in 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 steady 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. One reason then, that cross-sectional data show declines with age is that younger generations (due to differential socioeconomic and educational factors) start out at higher level of ability. Furthermore, the tests themselves have often been developed for an 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 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 analyse 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 feed-back 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 of 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.

This last factor, that of the social setting in which adaptation takes place, often determines for the older person, particularly, the balance between success and failure. We have already noted that optimal adjustment or adaptation for any human being involves an integration of available inner resources within the social system surrounding the person. Social systems which make demands above and beyond the capacities of the individual produce stress and tip the balance in the "failure" direction. Just as stressful, however, are those social settings which offer no expectations, no challenge, no opportunity for use of accumulated individual resources. A situation which has become too familiar, that offers no new roles, may result in adaptive failure as well. (Lewin, 1946) The apathetic older person, the older person who seems to show decline in overall psychological functioning manifested by denial of future goals and over attention to the past may be reacting to the social setting which represents a sameness of life, a lack of environmental demands. A routine such as is typical in many institutional settings for the aged calls forth little motivation for change on the part of the older resident and it is reasonable to assume that such drive, and its concomitant behavioral improvement, might be enhanced were the individual offered a more stimulating environment.

Little direct attention has been given to the effect of environmental deprivation or stimulation on cognitive performance. I should like to report on some of my own studies (Weinstein & Bennett, 1971) which were conducted to determine if some types of social environment are related to the maintenance of a high level of cognitive functioning in the aged. In these studies, attention
was given to the relations between cognitive performance and social cognition, social isolation, age and mental status in three populations: "newcomers" and "oldtimers" residing in a home for the aged, and a "waiting list" group residing in the community. The major hypothesis was that aged persons within a stimulating social environment can perform at relatively high levels on tests of cognitive ability as compared with their socially deprived counterparts. Age, per se, was not thought to be the factor accounting for poor cognitive functioning.

Sixty persons, over 65 years of age, comparable on background characteristics such as age, sex, education, religion and place of birth, and differing only as to place and length of residence, were interviewed. Two thirds were female, one third were male. More than half of the total sample was in the 80-89 year old range. Oldtimers had a mean age of 83.7, waiting list subjects, 79.8, and newcomers, 79.3. Forty percent of the total sample had had at least some high school education. Over forty percent of the total sample were native-born Americans. The newcomers had the highest proportion of foreign-born subjects. The sample was divided for place and length of residence as follows: twenty waiting list subjects residing in the community, twenty newcomers to the Home and twenty oldtimers whose length of residence in the Home was more than one year. Newcomers were selected by the investigator and included twenty consecutive new admissions to the Home who were English-speaking and could complete the interview. Oldtimers and waiting list subjects were selected by staff members of the Home's social service department according to their estimate of the subjects' fluency in English and intactness.

A standard interview lasting approximately one hour was administered. It contained the following indices:

1. The Adulthood Isolation Index, which is a measure of the extent of lifetime social contacts with family friends, work and organizations.
2. Past Month Isolation Index, which is a measure of number of social contacts outside the institution in the month prior to the interview.

3. Three Wechsler Adult Intelligence Scale (WAIS) subtests: Information, containing twenty questions measuring basic knowledge of topics ranging from names of composers to the colors in the 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.

4. Socialization Index, which is a measure of the amount of information learned about life in the Home, consisting of 15 questions about formal procedures and norms in the Home such as "what kinds of activities are available during the day?"

5. Mental Status Schedule, which is an instrument containing 350 items worded for true-false judgements of current psychopathology based on data collected during the interview.

The hypothesis that old people, involved in a stimulating environment, would perform best on tests of cognitive abilities was supported. Residents of a home for aged obtained higher mean WAIS total and subtest scores than their waiting list counterparts. In general, newcomers obtained higher scores than both oldtimers and waiting list persons on tests of cognitive ability. The Home seem to provide the type of environment which sustained a high level of cognitive performance. These findings seem best explained by a "disuse" model of cognitive functioning which holds that unless cognitive skills are put to use, they tend to be "forgotten" or possibly lost. Opportunities to put them to use in the Home were many and varied. Newcomers were introduced to a social setting which required new learning on a daily basis. They were actively involved in the process of learning the role of a new member of the
Home. To learn this role it was necessary for them to be aware of, and accumulate information about, the norms and expectations of the Home. Some of this information was communicated to them through talks with social service workers and through printed material sent prior to entry, as evidenced by the fact that waiting list subjects knew some of the rules of the institution. In the main, learning about the role of becoming an institutional resident occurred through a process of daily interaction between newly admitted residents and oldtimers within the Home. This communication process necessitated continual social interaction with other residents, some of whom acted as role models as well as teachers. Staff members also were in constant touch with newcomers, keeping them alert to expectations for behavior, observing them closely and repeatedly sanctioning them. Newcomers were seldom left to their own devices or allowed to sit idle; they were constantly active and involved, possibly to avoid rejection by their peers or admonition by staff members.

One year after the initial study, a follow-up was conducted at the same institution. This longitudinal extension tested the general hypothesis that the socialization process in a salient, highly stimulating learning experience which positively affects other cognitive processes. Therefore, we expected to find that a former waiting list person when interviewed in his new status as a newcomer resident of the Home would show improvement on tests of cognitive ability. We thought former newcomers might show signs of decline. We did not know what to predict for oldtimers grown even older.

Sample

The follow-up sample included all surviving subjects from the original sample whose physical and mental condition permitted their participation in an hour long interview. The survivors constituted a group of twenty-eight females
and twelve males (the original sample of sixty had forty-one females and nineteen males). Mean chronological ages of the groups were 79.1 years for former waiting list persons, 80.1 for former newcomers and 85 for former oldtimers.

A standard interview lasting approximately one hour was administered. It was identical to that given to the original sample in the first study.

The WAIS information test scores showed the most stability for all three groups. Similarities scores showed the highest percentage of gains for the waiting list group but almost half of both newcomers and oldtimers showed drops in similarity scores. One-third of the waiting list gained in their comprehension scores in the time they were institutional residents. Over half of the oldtimers, however, showed losses of more than one point on retest. One-half of the waiting list population showed gains in total WAIS score and only one-third showed losses. Sixty-four per cent of the newcomers either gained points or maintained total WAIS score on retest. However, almost three-quarters of the oldtimers showed losses on total WAIS scores over time. In general, effects of environmental stimulation seemed most evident for the former waiting list group who had become newcomers and least for oldtimers.

It had been hypothesized that a stimulating environment which provides salient new learning situations, and which is supportive through peer and staff social interaction, would positively affect performance on a test of cognitive functioning. This hypothesis was supported. Those individuals who were engaged in the socialization process in order to adapt to the role of newcomer showed gains in cognitive performance on retest. Former newcomers, who were beginning to settle into and accept oldtimer status showed some signs
of loss in cognitive functioning. Oldtimers showed the greatest percentage of loss in scores on all WAIS subtests of any of the three groups. Former waiting list persons, such as new residents stimulate by new experiences, were socially and cognitively alert. But the old age home evidently does not continue to provide this stimulation on a long term basis.

Institutionalization affects people differently. After about one year of residence the transition from newcomer to oldtimer status is achieved, and the lack of challenge and new roles and relationships becomes evident: newcomer status provides residents with daily stimulation and tangible goals, whereas oldtimer status - although not without privileges - provides fewer incentives, since the environment and the residents have stabilized to a great extent. Using a longitudinal design, this study has confirmed earlier findings of our cross-sectional study and those of Lieberman, Prock and Tobin (1968), and Anderson (1964). All these studies demonstrated mixed effects, negative and positive, of institutionalization. However, our longitudinal study has enabled us to pinpoint in time the onset of these negative effects. Presumably, they can be offset with environmental manipulation.

An applicant can anticipate, then prepare for, and finally involve himself in the socialization process - learning and practicing where to go, what to do, whom to meet, when to speak - as a new resident. Performance brings the rewards of acceptance by staff, residents and family. Once orientation is accomplished, continued daily participation, e.g., volunteering for certain privilege jobs, can help newcomers further establish themselves. However, eventually there fail to be new rewards and experiences to prevent the monotony of passing days and the realization that these days are among one's last. Studies by Leiberman and Lakin (1963) and Hadley (1963) have stressed the debilitating and deteriorative aspects of institutionalization of the aged. Programs in institutions seek to
introduce work-like recreation activities to attempt to maintain some semblance of former life patterns. But our data seem to point to the need for some further thought about institutional programming.

If meaningful learning experiences, positive milestones, were provided throughout a resident's length of tenure in an institution, then oldtimers might show fewer cognitive decrements. Furthermore, such deterioration as takes place in waiting list persons, which seems to be overcome by the initial impact of newcomer status, might be avoided altogether through concerted community effort to provide the social and intellectual support and prevent role loss experienced by the non-institutionalized elderly.

Most important perhaps for the socialization of older people is the basic premise that most of what is learned from socialization in childhood and throughout life, is a series of complex interpersonal relationships. In the life of every person, there are a number of people directly involved in socialization who have great influence because of their frequency of contact, their primacy and their control over rewards and punishments. We can say that the individual learns the behavior appropriate to his position in a group through interaction with others who hold normative beliefs about what his role should be and who reward or punish him for correct or incorrect actions. When we begin to analyze the social behavior of older people we begin to recognize that the opportunities for practicing social skills are severely limited by virtue of the ever-increasing losses of social contacts (particularly "significant-others," who have been involved in the life-long socialization process. There is a decrease in frequency of social contact, there are fewer relationships which are intimate, and therefore fewer people to control, to reward appropriate and punish inappropriate behavior. Therefore, with older people we are often dealing
with a phenomenon which may be termed "desocialization", that is, a loss of social knowledge and skills. Given the assumption that frequency of contact, interpersonal significance and reward can influence behavior or is the prime mover in the socialization process, then by offering old people such opportunities, they should be able to relearn what has been lost through disuse and even add new learning for appropriate social roles.

From this conceptual framework, we continued our studies (Weinstock, 1971) with a program initiated for geriatric outpatients of a metropolitan hospital to offer opportunities for older people to interact with a group of their peers to modify their social behavior. An ongoing discussion group of patients was organized with the purpose of giving 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.

Given few other roles to play in our society, and given the severe social isolation suffered by this population, at least some of the older persons' attendance at the clinic was a search for social interaction. These patients, in part, play the "sick role" which is then reinforced by the sympathetic treatment of staff. However, given substitute socially interactive opportunities and negative reactions to constant physical complaints, the "need" to be sick might diminish along with the "need" to attend the clinic.

Since one of the goals of the sessions was to redirect focus away from 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 hesitatingly and briefly offered general ways in which they attempted to cope with some of these problems.
In ongoing sessions, group discussion involved talking about 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 a mixed community 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 meetings 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 do. 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 that an animal cannot make up for the desired human companionship.

As the group focussed more and more on these problems they were gradually led to discussion 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.

Group discussions began 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 themselves 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 other's 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 as well as leader's use of reinforcement techniques, and there was a group of people with whom to relate.

In summary, the group members had entered this program showing signs of loss of social skills, a verbal focusing on physical selves while behaviorally not attending to 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 this 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 participation in the 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, 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 symptomatology 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. Their dress improved. They began using cosmetics. They began meeting with social greetings amongst each other, showing concern for how the time between meetings has been spent. They inquired about problems raised in past sessions and their outcomes. In addition, they communicated to members who had missed sessions, what had taken place. They proudly cited their competence in handling situations which previously had been left to others to handle for them.

It appeared that the problem-solving orientation of the group became a consistent approach for handling situations which previously had been left to others to handle for them.

It is evident then, that successful adaptation to old age is dependent on the recognition and implementation of norms and goals which are appropriate to an individual's physical and psychological capacities.

Margaret Clark's (Clark, 1968) studies of aging in San Francisco have yielded a number of criteria for adaptation used in attitudinal interviews with persons over the age of sixty.

"These, in order of their frequency of mention were as follows: (1) independence (2) social acceptability (3) adequacy of personal resources (4) ability to cope with external threats or losses (5) having significant goals or meaning in later life (6) ability to cope with changes in self"1

She found that those older people who continue to hold to values of achievement, success, individualism, control and orientation toward the future were those she found to be the most maladjusted aged persons.

"To go a step further in generalization, it seems likely that patterns of value appropriate to the middle-aged in our society are deemed inappropriate (or prove dysfunctional) for the elderly."¹

However, adapting to these cultural discontinuities is, as was pointed out earlier, a life cycle process. That is, throughout human development, social goals and expectations, value systems, change which force the individual to change identity. These have their impact on the individual, on his personality, on his ability to see and interpret events around him. An adolescent must move from the dependend family centered child to a new sense of self, a sense of responsibility for one's own actions, a value system or sense of morality which is his own and with which he is comfortable. This is seen as a crisis in identity which must be resolved before one takes on the developmental tasks of adulthood.

Ruth Benedict (Benedict, 1938) suggested that the cultural discontinuities such as those which accompany adolescence in western society are stressful for the individual but that critical support is offered by one's social group, (read:"adolescent peer group"; "family"; "older person's significant reference group") such that

"they can often swing between remarkable extremes of opposite behavior without apparent psychic threat."²

Clark's (Clark, 1968) studies give us evidence to support this point. She found that the older people living in the community had more social relationships

¹Margaret Clark, op.cit. p. 441.
and were more active in their relationships than were those who had been hospitalized for mental illness but were discharged and living in the same community, therefore, having similar opportunities for social interaction. According to Clark:

"A significant reference group, then, may protect the aging individual against the stresses of cultural discontinuity."¹

Another line of research which tends to bolster the developmental framework being put forth comes from the studies done by Charlotte Buhler (Buhler, 1935) who adheres strongly to the notion that the adaptation throughout human life-cycle may be studied by examining the individuals motivation for behavior. Buhler documents through collections of life histories a distinct need for continuous "expansion", a future-orientation underlying human behavior. She sees this in terms of a need to occupy significant roles. Empirically, Kuhlen (Kuhlen, 1952) has shown such changes in goals throughout adulthood by asking schoolteachers what they would like to be doing 10 years from now.

"Most notable in these charts are sex differences in long term goals, differences between single and married individuals in their orientation and evidences of a sequence of goals as life moves on."²

¹Margaret Clark, op.cit., p. 442.
Kuhlen, concludes that:

"In general, though goals may change, the obviously expansive phase of life is determined not only by a strong desire for achievement and "expansion" but by the increasing competence in environmental manipulation which results from the growth of mental and physical capacities, the development of culturally appropriate goals, the accumulation of experience and the chronological achievement of opportunity (granted, in a sense by society) to function with relative independence and in significant roles."\(^1\)

Finally, one last piece of evidence that may be applied by all of us whether we are concerned for our own or others successful aging.

Some years ago, a series of studies were conducted at an all-geriatric hospital by Robert Kastenbaum. (Kastenbaum, 1972) (The studies involved the introduction of wine and beer at specified times on the wards.) Kastenbaum began with a basic assumption that early in life, human beings developed 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 arrange."1

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?2


2Ibid. p. 372.
Wine was originally proposed because of the connotative meaning 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.¹

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 meetings' persisted for more than a year after the termination of the

¹Kastenbaum, R. *op.cit.*, p. 375.
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?

1Kastenbaum, R., op.cit., p. 376.
2Ibid. p. 384.
Firstly, it is possible to apply what the social sciences tell us about human behavior to action programs. If we acquaint ourselves with an understanding of the needs, the motivations, the foundations of human behavior and accept these as important determinants for adaptation throughout the life span, we can begin to provide settings for people which are appropriate to the developmental phase being examined.

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 concomitant 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 continue to overcome.
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