THE DEVELOPMENT & USE OF A BEHAVIORAL INTERACTION SCALE WITH GROUPS OF COMMUNITY BASED ELDERLY*

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The use of groups in effecting behavioral changes, particularly with older populations is a growing phenomenon. Most reports indicate that positive changes do occur over time. However, evaluation or measurement of such changes has always presented a problem. Are changes ongoing, individual, peculiar to the group process, in what areas of human behavior do they occur, and are they measurable in such a manner so as not to intrude upon group process itself. These were questions which intrigued us when we were attempting to compare the effects of different kinds of group experiences in an elderly population.

It was easy enough to quantify peer interaction, to measure self-reported health status, to determine cognitive changes through use of standardized tests. It was more difficult to determine what kinds of interactions were observable, measurable and in what ways they changed overtime. Furthermore, since one of the goals for one of the groups was to "resocialize" (that is, bring back the appropriate social behaviors which these older adults had learned earlier in life but had lost through disuse) it was necessary to keep a record of the kinds of behaviors that called for change. As mentioned earlier it was our intent to record these behaviors in such a way as to allow the group process to be ongoing and allow the group leader to be unencumbered by the taking of notes or in any other way concerned with on-the-spot data collection. Methods for such collection were tried out while pilot-testing our group process. We found that the easiest way to do this was to have a trained participant observer.
in the room with the group, noting on an individual basis empirically derived behaviors of the members.

Perhaps, examples of the kinds of behaviors we recorded would serve best to clarify our scale for you.

We noted early that our group members were often sloppily dressed, interrupted conversations constantly focusing on "me," "mine," "I," rather than responding to the topic at hand. They showed a great deal of concern with medical and physical complaints and symptomatology, and there was evidence of loss of basic social skills in serving refreshments to self and others e.g., hoarding cookies, getting "my" coffee first, and so forth.

At first then, we just listed for each group member, the variety of behavior she showed during the hour's meeting. Did she greet people as she entered the room, was her hair combed, did she join the ongoing discussion or engage in a private conversation with the person next to her? These were recorded by a participant observer and written out specifically as they occurred. It became evident that there was a commonality to the individual responses which could be listed and checked off as appropriate or inappropriate modes of behavior. It was also clear that these behaviors could easily be classified according to the areas of functioning they represented. For instance, grooming was categorized as Personal Behavior. When a member was unwashed, uncombed, or sloppily dressed, this was
checked off next to her name under the Personal category. When a
member's contribution to the group conversation revolved around medical
complaints, she was checked for this with a note as to the specific type
of complaint. Social behaviors were more complex to derive as they
involved specific interactions on the part of the individual. These took
a longer time to validate. Eventually we were able to list 12 major
individual responses which covered the range of specific social inter-
actions taking place. For instance, we noted the frequency with which
members joined the discussion. This was not just a quantitative measure
but reflects the nature of the social response as well. Joining the dis-
cussion involved a reality component in that it meant that the individual
showed awareness of topic, interest in topic and ability to accurately per-
ceive group expectations and implement them.

These social behaviors formed a rather crude rating scale of
appropriate/inappropriate behavior in a group setting. In the course
of pilot testing it became clear that the group leader as well as the
group members, positively sanctioned certain kinds of responses and
censured others. The interruption of a conversation was met with
criticism by group members or by an attempt on the part of the group
leader to ignore the interruption and continue the train of the original
conversation. Therefore the checklist for social behaviors is comprised of
12 items, six of them being considered "appropriate" behaviors and six in the
inappropriate" range. In analyzing social behavior in the group then,
amount of appropriate vs. inappropriate behavior is measurable not just
as a frequency count but when the two are compared, an individual or a group can be rated on this parameter. It should be noted here that the usefulness of this scale for measuring behavioral change was most evident in the kinds of feedback this ongoing listing offered the group leader. Two distinct groups meetings on different days were being directed by the same group leader. One had as its goal, the specific resocialization of its members. That is, the group leader established apriori as well as empirically derived goals which had to do with renewing interest in activating social roles improving problem solving behavior, increasing independent thinking and functioning, and overcoming preoccupation with medical problem and complaints. This was called the Resocialization group. The leader (a trained clinical psychologist) used techniques such as interrogation (used by the leader to help her document points that promised to be clinically decisive); clarification (used by leader to make clear some point which had not been adequately dealt with); illustration (the use of an anecdote, simile or comparison that followed a successful confrontation for the purpose of reinforcing the confrontation); confrontation (the use of information to disconcert the patient by pointing out an inconsistency), explanation (an attempt on the leader's part to strengthen the patient). Therefore, weekly review of the data from the behavioral interaction scale, gave the leader ongoing feedback as to the changes occurring in in-
dividual members as well as in group process. This allowed the leader to focus in on the areas requiring reinforcement as well as extinction.

The other group which met over the same time period but on different days was called the "Talk" group. The leader's role in this group was one of "member" rather than "leader". The leader responded to member's comments with sympathy and some support but did not offer a directed problem-solving approach. No attempts were made to reinforce appropriate behaviors or extinguish inappropriate ones.

Comparison of the two groups, results over the 12 sessions indicated that for "Personal" behaviors there were no discernible differences. Members of both groups exhibited an equal amount and variety of grooming and greeting behavior, most of which fell into the appropriate range. However, for "Social" behavior the effects of the intervention techniques were observable. That is, overtime, there was a growth in frequency of appropriate behavior in the experimental group, both as a group as well as for individuals, which was not true for the "talk" group. As a matter of fact, the "talk" group evidenced more inappropriate behavior over time.

Medical complaints also showed differences between the two groups. Using a time-sampling method, checks were counted each time a medical complaint was expressed during a session. These checks were then divided by the number of members attending a session. For the experimental group average number of complaints were low, and with the exception
of one member who continued to contribute to the low average, showed no change over time. For the talk group, however, they showed continual increase in average number of complaints, with all members contributing to the averages.

To summarize then, using a structured experimental setting, an attempt was made to record categories of behavior within an ongoing group process which would aid in analyzing the changes expected, overtime, in the subjects being studied. We started out with a considerable number of categories but due to the exigencies of observation and problems in reliably interpreting certain behaviors, categories were combined and formulated more clearly.

Using two trained non-participant observers during a twelve session experimental situation, the index was found to have an inter-rater agreement for reliability of 98.1%. These behavioral measures were judged valid in the sense that they helped to distinguish individuals within the groups from one another as well as to differentiate the groups on the basis of goals set for group process. It allowed for feedback to the group leader in setting new and ongoing group and individual goals for change. It was an unobtrusive measure in that the subject was not aware of being tested and therefore some of the reactive threats to the subjects that questionnaires or interviews often have were diminished. Data was collected at first hand through simple observation allowing for a sampling of ongoing behavioral phenomenon. Evaluation of specific
individual changes in specific areas of behavioral interaction overtime was made possible. For either researcher or practitioner such measures offer data which neither testing nor interviewing permit.
### Behavioral Interaction Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social</td>
<td>0</td>
</tr>
<tr>
<td>Personal</td>
<td>0</td>
</tr>
</tbody>
</table>

**Instructions:**

1. **Social**:
   - c. Self-cohesive behavior
   - g. Is self-focused
   - h. Is self-effacing

2. **Personal**:
   - f. Use check mark for "yes" if correct interaction is not present.

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**Notes:**

- Use check mark for "yes" if correct interaction is not present.
- Date:
- Group Session #1
Figure 1. Social Behavior: Appropriate-Experiential Groups
Sessions - Behavioral Interaction Measures
Sessions--Behavioral Intonation Measures

Legend: Tuesday

The "L"--Social Behavior: Interpersonal "Talk" Group
51.0

Complaint Index

Legend

Monday

Tuesday

Wednesday

Thursday

Friday

Weekend

Figure 6. Behavioral Irritation in the Groups