Conversational skills training with socially isolated nursing home residents.

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CONVERSATIONAL SKILLS TRAINING WITH SOCIALLY ISOLATED NURSING HOME RESIDENTS

A Thesis Presented
by
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Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the degree of

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CONVERSATIONAL SKILLS TRAINING WITH SOCIALLY ISOLATED NURSING HOME RESIDENTS

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CHAPTER I
INTRODUCTION

Review of the Literature

It is well known that most residents of nursing homes experience some degree of social isolation from the community (MacDonald, 1973; Patterson, 1980). Residents seldom venture out of the nursing home to either socialize, shop, play, or conduct business, and visitations from friends and family living in the community are usually few and far between. The problem of social isolation is compounded by and contributes to problems such as depression, decreased self-esteem and life satisfaction, and further withdrawal from social activities or involvement (Pfeiffer, 1977).

Two factors which affect the development of social isolation are physical disability, which makes it difficult for residents to leave the nursing home without assistance, and loss of significant others through illness and death, which leaves a diminished group of possible contacts in the community. But these two factors do not fully explain the extent of the social isolation experienced by residents who clearly have the capacity to be more fully involved in
social relationships, and who do have surviving friends or relatives in the community. Also left unanswered is why isolated residents have not succeeded in replacing relational losses as would perhaps be expected of persons from other age groups.

Social learning theory proposes an explanation for social isolation of the institutionalized aged based on the principles of learning (MacDonald, 1973; Ullmann and Krasner, 1969). Most nursing homes are run on a medical model and are usually under staffed. Because of this, nursing home staff generally interact with a resident only to provide some form of nursing care and seldom simply to socialize. This pattern, in effect, sets up a contingency in which dependent, self-centered, and passive social behaviors are reinforced while more active, relationship-centered social behaviors are extinguished. When a nursing home resident then interacts with community members, his/her dependency and passivity is tolerated because it fits with societal expectations of the elderly person's role. But because this behavior is aversive or non-reinforcing, these community members interact with the resident as little as possible.

The implications of this viewpoint are that it provides for a possible solution to the problem. Social isolation might be reversed if isolated nursing home residents were
instructed and encouraged to interact socially with others in a way that others find pleasing, enjoyable, and engaging. Community members interacting with residents would then be more likely to seek increased contact with these residents. This, in turn, would reinforce the maintenance of these positive interactional behaviors and would encourage further social engagement on the part of the residents.

The technology for implementing just such a training program has already been developed within the field of behavior therapy. Commonly referred to as social skills training, a set of behavioral procedures consisting of instructions, modeling, rehearsal, feedback, and reinforcement has been developed to train persons in a variety of adaptive social behaviors (Kelly, 1982). Such behaviors have included conversational skills, commendatory/refusal assertion, heterosocial dating skills, and job interview skills. As is usual with the development of most behavior therapy techniques, though, empirical demonstrations of the effectiveness of social skills training with the institutionalized elderly lag far behind demonstrations of its effectiveness with other populations. This lag persists, in spite of several researchers' observations on the applicability of behavioral techniques with the aged (Corby, 1975; MacDonald, 1973; Patterson and Jackson, 1980; Wisocki, 1984). What follows is a brief
review of the pertinent literature relating to the applicability of social skills training to the institutionalized elderly.

Two studies have shown that it is possible to increase the rate of verbalization between socially isolated nursing home residents by altering the antecedent and consequent events of their verbalizations. Kleitsch, Whitman and Santos (1983) trained four elderly, socially isolated, moderately mentally retarded men in the following manner. Four subjects and a group leader were seated around a table. Whenever the subjects talked to each other, the group leader would smile and praise them for talking. If a 10-second interval elapsed without any of the subjects talking, the group leader would prompt one of the subjects to talk with another subject. When a subject failed to respond to another subject if spoken to by that person, the group leader would prompt him to respond. Prompts were simple and direct statements such as "Joe, try talking with Bill," or "Bill, can you answer Joe's question?". Analysis of the data indicated that this training procedure was highly effective in increasing the rate of the residents' verbalizations both during training and under two generalization conditions: the four subjects speaking amongst themselves without the group leader present; and, the subjects speaking with eight untrained residents in a
different setting. Follow-up data indicated that these results were maintained at four months.

The design and results obtained by the Kleitsch et al. (1983) study were basically an extension of a previous study conducted by MacDonald (1978). Using verbal prompting and response contingent social reinforcement, MacDonald demonstrated dramatic increases in the level of verbalization between three isolated, elderly, male, nursing home residents during the few minutes that these residents spent waiting together at the dining room table for their evening meals to arrive. At the conclusion of the study, staff informally noted that the men continued to sit and talk together without the presence or prompting of the experimenter, and in settings other than the dining room.

Where the two studies just described focused their interventions on increasing verbalization, the following study was designed to increase the amount of social contact elderly nursing home residents had with the community. Goldstein and Baer (1976) were able to demonstrate that a simple training procedure focused on the social behavior of letter writing is an effective way of increasing the amount of personal mail received by nursing home residents. Three residents who had no family members living in the vicinity of the nursing home and who wished to receive more mail from friends and relatives were selected for a training procedure
consisting mainly of verbal prompts and specific instructions. Residents were encouraged to initiate and maintain letter writing to persons with whom they would like to have correspondence. They were also instructed to incorporate specific component behaviors into their letter writing which were thought to increase the likelihood of a reply. These skill components consisted of asking at least one question, a request for a reply, no reprimands for not writing, and if applicable, a thank-you statement for having written. The residents were also told to include a stamped, self-addressed envelope with each letter sent. As a result of these simple procedures, all three residents experienced an increase in both the rate of letters received and in the rate of acquiring new correspondents. No follow-up data were obtained in order to determine if these gains were maintained after training.

Two studies which follow in this review are especially relevant to the purpose of this investigation because these studies included an experimental procedure which incorporated instructions, modeling, behavior rehearsal, feedback, and reinforcement for the training of specific social behaviors. These studies are also relevant in that they tended to focus on qualitative features of verbal interaction such as verbal content or interpersonal effectiveness, as opposed to quantitative features such as
amount of verbalization or frequency of social contact. Berger and Rose (1977) designed a training program to help nursing home residents deal more effectively with various interpersonal situations they might commonly encounter. It was hypothesized that the training would result in increased competence in social interactions and this, in turn, would lead to increased self-confidence. Before the training was begun, a list of interpersonal situations, possible responses to these situations, and evaluations of these possible responses were empirically derived through extensive interviews of residents, staff, and professionals. This information determined the content of the training program and provided a standardized method of assessing performance level. Twenty-five residents were randomly assigned to one of three conditions: an interpersonal skill training condition; a discussion control condition; and, an assessment-only control condition. Training in the experimental condition began with the experimenter introducing an interpersonal situation to the subject. The experimenter then provided instructions on possible responses to this situation, modeled these responses, and pointed out the likely consequences that would follow these responses. The subject would then role-play a possible response. This role-play was followed by feedback and reinforcement from the experimenter. A post-test and an
eight-week follow-up assessment was done for all three groups on eight interpersonal situations that were targeted for training, as well as eight novel situations. Results showed the interpersonal skill training group's performance to be superior to the control group's performance at post-test for the trained as well as for the untrained situations, but this difference was maintained only for the trained situations at the eight-week follow-up. Contrary to the hypothesis that increased competence would lead to increased self-confidence, no differences were found between the experimental and the control groups on a self-report measure of interpersonal competence, or on self-ratings of competence on the assessment role-plays. The authors observe that these non-supportive results could be due to the short duration of the training (3 one-hour sessions), the lack of procedures to promote generalization, and the possibility that enhanced self-evaluations tend to lag behind performance change. Nevertheless, given the short duration of the training, the study provides strong support that social skills training procedures are effective with an institutionalized elderly population.

A study by Patterson, Smith, Goodale and Miller (1979) provides evidence for the effectiveness of a communications training procedure which incorporates a modeling, instruction, rehearsal, feedback, and reinforcement training
format for teaching psychogeriatric patients to express feelings of pleasure and displeasure more effectively.

Eleven day and residential patients were trained as a group in the following manner: Pairs of subjects would role-play a loosely scripted situation in which one subject would express either pleasure or displeasure to the other subject. The group members and the instructors would then provide the subject with feedback and further instruction on the effectiveness of his or her performance. Component behaviors that were focused on were verbal content, loudness, facial expression, hand gestures, voice feeling quality, and body position and movement. Reinforcement was given in the form of extravagant praise and tokens which could later be exchanged for various items or privileges. Training was conducted in one-hour sessions, three times a week, until all subjects achieved what appear to be stringent pre-established criterion levels on each of the component behaviors. This required a total of 61 training sessions. This training format which incorporated instruction on specific component behaviors was shown to be highly superior to an operant procedure which only focused on increasing the rate of verbalization for improving expressiveness of psychogeriatric patients.

The preceding studies demonstrate the potential usefulness of behavioral procedures for training nursing
home residents in a variety of social behaviors. Rate of verbalization can be increased by altering antecedent and consequent events and successful letter writing skills can be trained through a procedure of instruction and prompting. The training of more complex interactional behaviors, such as response effectiveness in interpersonal situations and expressing pleasure and displeasure effectively to others, appear to demand a more comprehensive skills training procedure.

The present study hypothesized that socially isolated nursing home residents could be trained in telephone conversational skills through a social skills training procedure. That is, it was expected that a procedure consisting of instructions, modeling, behavior rehearsal, feedback and reinforcement would be effective in training socially isolated nursing home residents to use behaviorally specific conversation skills in telephone conversations. Furthermore, it was expected that the increased skillfulness of these residents would, in turn, provide a basis for increased levels of telephone contact with members of the community.
CHAPTER II
EXPERIMENT 1

Experiment 1 was conducted to evaluate the effectiveness of a conversational skills training program with socially isolated nursing home residents. Four discrete telephone conversational skills components were designated as areas in which a socially isolated nursing home resident might experience deficits. These components were drawn from prior social skills research (Kelly, 1982), as well as from informal observations of the conversations of socially isolated nursing home residents.

1. Expressing common courtesies: statements of greeting and farewell, and statements which demonstrate consideration and appreciation of the conversational partner's time and attention.

2. Making positive self-disclosures: statements which convey information concerning current interests, activities, events, and so forth, which are likely to be of interest to the conversational partner.

3. Asking conversational questions: questions designed to elicit conversation by the partner.
4. Making conversational interjections and acknowledgments: statements which convey attentiveness, interest, or some reaction to what the conversational partner is saying.

A multiple baseline design across behaviors was chosen in order to be able to rule out effects due to factors other than training. This design involved conducting the training in sequential steps. Subjects were to be trained to criterion on one skills component before training proceeded to another skills component. Criterion was defined as a significant and stable improvement in the subject's performance of the skills component as could be determined by a visual plot of the data.

Training focused on using the four conversational skills components during telephone conversations. One advantage to focusing on telephone conversations as opposed to face-to-face conversations in general, was that it made it possible to concentrate on verbal content. The other benefit was that the ease and convenience of telephone communication increased the likelihood that the effects of training would extend to increased contact with persons living outside the nursing home. Most elderly nursing home residents experience greatly diminished mobility due to accident, illness, or the aging process. This decreased mobility often makes it physically difficult for residents
to leave the nursing home without making special arrangements for transportation. Because picking up and dialing a telephone is much more accessible to nursing home residents, increased social contact with the community could more easily show up in telephone calls.

Method

Subjects. Four elderly residents were selected from the Amherst Nursing Home to participate in a conversational skills training program. The selection procedure began by asking the social worker at the nursing home to nominate as many residents as possible who fit the following criteria: (1) having friends or relatives living in the local community with whom contact was less frequent than once every two weeks; (2) being free of severe cognitive-emotional impairments which would prevent carrying on a normal conversation; (3) being free of severe cognitive or physical impairments which would make it impossible either to follow verbal training directions or to carry on a telephone conversation; and (4) being at least 65 years of age. Eleven residents who fit these criteria were then approached by the conversational skills trainer and asked if they would like to participate in a project which might make their conversations with family or friends more enjoyable. The following four subjects agreed to participate.
Subject 1 was a 68-year-old woman who had resided at the nursing home for the past year-and-a-half. She was admitted following a violent head injury inflicted by her husband when both were residents of a state hospital. Subject 1's medical records indicated that she had been institutionalized for most of her adult life due to a grand mal seizure disorder which began when she was 17. IQ testing placed her in the range of "borderline" mental retardation. Subject 1 failed to respond correctly to four out of ten questions on the Kahn, Goldfarb, Pollack, and Gerber (1960) mental status exam, indicating that she suffered significant cognitive impairment. Routine physical examination at the nursing home discovered a left bundle branch block -- a minor cardiac illness being controlled with cardiac drugs. She also received anti-convulsants to treat her epilepsy. This subject was ambulatory with a stroller and often spent time in the common areas of the nursing home. She was willing to socialize, but most residents found her to be overbearing, condescending, and intrusive and therefore tended to keep their social distance. This subject received no visitors at the nursing home. Potential contacts were her sister and several nieces, living about 50 miles away, with whom the subject had not been on friendly terms for several years according to her own report. Subject 1 was selected to participate in
the study despite not fitting the selection criteria perfectly because she was able to respond to verbal commands and she seemed capable of carrying on a normal conversation.

Subject 2 was an 85-year-old woman who had resided at the nursing home for the past four years. Prior to her admission she had lived alone for 14 years; she was admitted to the nursing home due to severe weight loss and depression. She suffered from cerebral insufficiency and osteoarthritis, and she was being medicated with Mellaril to treat her depression. On the Kahn et al. (1960) mental status exam administered by the experimenter, she failed to respond correctly to three out of ten items, indicating she suffered significant cognitive impairment. Subject 2 was ambulatory with a stroller and spent most of her days sitting quietly in the communal areas of the nursing home. A son visited her several times a week and she had a daughter living in the area who visited occasionally on holidays. Subject 2 was selected for participation despite showing signs of cognitive impairment because she seemed able to respond to verbal commands and she seemed capable of carrying on a normal conversation.

Subject 3, aged 66, had been residing at the nursing home for the past two-and-a-half years. Medical records were incomplete, but indicated that he had been institutionalized for the past 25 years following a
misdiagnosis of schizophrenia. He responded correctly to all ten items on the Kahn et al. (1960) mental status exam which indicated no cognitive impairment. He suffered from anemia and bronchial asthma, and received medication for each of these conditions. Although fully ambulatory, Subject 3 tended to remain isolated in his room either watching TV or listening to his extensive phonograph record and audiotape collection. He almost never socialized with other residents and he received no visitors. A brother who lives in another part of the country corresponded with him monthly. Despite having no potential contacts in the community, Subject 3 was selected for participation because he seemed capable of responding to conversational skills training.

Subject 4 was an 87-year-old woman who had lived at the nursing home for the past year-and-a-half. Before coming to the nursing home, she had lived in congregate housing for the elderly. She was admitted following an introchanteric fracture of the left hip, which had left her wheelchair-bound. Her medical diagnosis also included hypertension, cerebral vascular accident, osteoporosis, and acute brain syndrome secondary to anemia. Subject 4 failed to respond correctly to three items on the Kahn et al. (1960) mental status exam which indicated the presence of significant cognitive impairment. She was sociable and gregarious and
had frequent visitations from her son and his family who lived in the area. Potential contacts for Subject 4 were two daughters who lived out of state and whom she saw occasionally on holidays. Although Subject 4 showed signs of severe cognitive impairment, she was selected to participate because it seemed she might possibly respond to the training.

Setting and apparatus. The Amherst Nursing Home is an 81-bed proprietary facility located in Amherst, Massachusetts. The nursing home staff of 200 is composed 70% of nursing assistants, 20% of ancillary services, and 10% of professionals. Additional ancillary medical services are provided by consultants according to need. The nursing home also employs one full-time activities director and one half-time social worker. Residents at the nursing home can participate voluntarily in regularly scheduled recreational activities such as exercise class, bingo, church services, and singing. In addition to residential treatment, the nursing home provides an adult day center which is licensed to accept up to 18 participants daily. The Amherst Nursing Home provides no direct psychological services and there is not presently any program to train social skills.

Training sessions took place in the activities room of the nursing home. This room is a large, pleasantly decorated room and is used primarily by the nursing home's
day care center for group recreational therapy. During the training, the subject was seated in front of a long table. A telephone, a stop clock, and a microphone were placed on the table directly in front of the subject. A female research assistant, who acted as a conversational role-play partner, sat to the right of the subject, facing the table, approximately four feet away from the subject. A cloth partition separated the two so that the subject could easily hear, but not see, the training assistant. A male conversational skills trainer sat to the left of the subject, facing the subject. Three reel-to-reel audiotape recorders were placed on a table directly to the left of the trainer. One recorder was used to play a prepared modeling audiotape. A second recorder was used to record the assessment role-plays which occurred after each training session. The third recorder provided a back-up recording of the assessment role-plays.

**Training Procedure.** Training sessions were held at the same time of day, during the afternoon, on Mondays, Wednesdays, and Fridays, over a period of six-and-a-half months. At the first session, before training had begun, the session began with a brief discussion of the purpose of the training and of the general format of future training sessions. The subject was told:
The reason we'll be working together is to learn some ways that will make your conversations with people you might like to talk to on the telephone more enjoyable both for you and for the person you'll be talking to. Having a conversation is a skill, just like riding a bicycle, which we can become better at by learning some rules and practicing these rules. The way that we'll be working together is like this: first, I'll introduce a new rule of the day; next, we'll listen to someone on the tape recorder who will be using the rule while talking to another person on the phone; then, I'll ask you to practice using the rule by giving me some examples of using the rule; the last thing we'll do is, I'll ask you to use the rule while having a short conversation over the phone with Diane (the research assistant). Do you have any questions?

Each training session lasted approximately 30 minutes and followed the same general format. This format included the following components across all experimental conditions:

1. Praise person for coming.
2. Review content from previous sessions.
3. Introduce new conversational skills component and provide a rationale.
4. Modeling exposure to new component.
5. Behavior rehearsal of new and old components.

More specifically, at the outset of each session subjects were praised for appearing that day. Subjects were told, "Thank-you for coming to meet with me. Your participation really helps." The training then began with a
review of material covered previously. The review was conducted by asking the subject to recall the conversational skills component, and then to provide examples of the component. The subject was verbally praised for every correct response. Incorrect responses were gently, but directly, modified through corrective feedback. The skills trainer prompted any components that were not recalled and encouraged the subject to either elaborate further on the abstract component description or give more concrete examples of the prompted component, depending on what was appropriate. An example of this process follows:

T: The next rule we learned was to "keep them talking." Now, how do we keep them talking?

S: By asking questions.

T: That's right! By asking plenty of questions. Mary, what are some good questions you can ask Anne today?

S: Have you seen anything good on T.V. lately?

T: Good! What else could you ask her?

As the subject provided examples of each component, the trainer took notes of them for the subject on 5"x8" index cards.
After the review period was completed, a new conversational skills component was introduced and a rationale for using the component was provided. The conversational skills components were presented as "rules" and were described in direct, easily understood terms. Descriptions and examples of each component are presented in Table 1. An example of how a component was introduced and explained is the following example for the conversational skills component "making conversational interjections and acknowledgments:"

T: Today's rule is "show interest."
When a person is talking to you, it's important to let them know you're interested in listening to them talk. A person enjoys talking to you much more when they know that you're listening carefully and are interested in what they have to say. You can show interest by either repeating back their last three words, by showing some reaction to what they are saying, or by simply saying "uh-huh."

As the conversational skills trainer introduced and described the skills components, he would lay a 5"x8" index card in front of the subject on which was printed the "rule" and the elements involved in carrying out the rule.

Modeling exposure followed the introduction of each new skills component. A modeling audiotape was prepared before the start of the training which consisted of models demonstrating the correct use of each of the training
Table 1.
The Four Conversational "Rules"

1. The "rule" corresponding to the skills component "expressing common courtesies" consisted of the following:

RULE: **BE POLITE**

1. Say "Hello."
2. Ask if they have time to talk.
3. Tell them you like talking to them.
4. Say "Good-bye."

2. The "rule" corresponding to the conversational skills component "making positive self-disclosures" consisted of:

RULE: **BE ENTERTAINING**

1. Tell them what's new.
2. **Elaborate** -- tell them lots about each topic.
3. Talk about things you like.

3. The "rule" corresponding to "asking conversational questions" consisted of:

RULE: **KEEP THEM TALKING**

1. Ask lots of "you" questions.
2. Give them a few moments to answer.
3. Ask "follow-up" questions.
4. Remember the five "W"s: Who?; What?; Where?; Why?; When?; and, How?

4. The "rule" corresponding to the skills component "making conversational interjections and acknowledgements" consisted of:

RULE: **SHOW INTEREST**

1. Repeat back their last three words.
2. Show some reaction to what they say. For example, "That's nice."
3. Say "Uh-huh."
components. This tape was made by soliciting the help of several male and female elders similar in age to the nursing home residents who would be participating in the training. The elders were asked to provide a number of their own examples of using the conversational skills components; their responses were audio recorded. A final modeling tape was produced by selecting four or five clear examples of each of the training components to use as models.

During the training, the modeling audiotape was played and the subject was asked to listen to a model demonstrating the correct use of the skills component. A 5"x8" index card preprinted with the model's response was also placed in front of the subject so that the subject could simultaneously hear and read the model's statement. Modeling exposure was used primarily during the first few sessions that a component was being trained.

The next portion of the training session was devoted to behavioral practice of the conversational skills component. The subject was asked to provide a one sentence example of the skills component just described and demonstrated. Incorrect usage of the skills component was corrected through immediate and direct verbal feedback. Correct usage was verbally praised. The subject was then asked for another example of the skills component, and the feedback and reinforcement process was repeated. During behavioral
practice, the subject was encouraged to use the skills component in as many novel ways as possible.

At the end of the training session, the subject was given a copy of the index card used in the training of the skills component. The subject was told that a helpful way of learning the conversational skills component was to read and think about the information on the card a few times between training sessions.

**Dependent measures.** After each day's training session, the subject enacted two four-minute role-played telephone conversations with a trained research assistant; the first ten role-plays, which occurred before training was begun, served as a baseline assessment. During the role-play, the research assistant was introduced as someone who would be portraying a character chosen out of the possible friends or family members that the subject could possibly call on the telephone. Care was taken to choose a person with whom the subject was friendly, but who didn't visit the subject often. This character was held constant throughout all the role-plays.

At the start of each role-play, the subject was instructed to pick up a prop telephone laying on the table in front of him/her and to have a four-minute conversation with the training assistant while pretending that the training assistant was the friend or relative. The training
Table 2.
Role-Play Instructions.

1. Let the subject introduce themselves first.

2. Let the subject open the conversation.
   a) If the subject remains silent, remain silent for up to 15 seconds.
   b) If the subject directs the topic to you, give a short response and reverse the conversation back to the subject.

3. Let silences stand for 15 seconds.
   a) After the first 15 second silence, spontaneously self-disclose for one or two statements.
   b) On subsequent 15 second silences, alternate between making a spontaneous self-disclosure, and asking a conversational question.

4. If the subject asks you a question, respond with one or two statements about that topic.

5. Speak at a slow to moderate pace. Take your time and relax -- there's no hurry.

6. When the subject is self-disclosing you can make short interjections at natural pauses in the subject's speech.

7. If the subject continuously self-discloses, let them talk as long as they want without interruption.

8. If the subject asks six questions, reverse the conversation back to the subject by asking a question.
assistant was seated next to the subject but behind an opaque screen. Laid out in front of the subject were cue cards containing the conversational "rules" trained up to that point and notes of examples the subject had provided during the behavior rehearsal portion of the training. Also in front of the subject was a stop clock which the subject was instructed to use in order to know when four minutes had passed. Before the first role-play, the trainer cued the subject with a statement similar to this:

T: O.K. Ready to try a telephone conversation? I want you to pick up the telephone and pretend to talk to Anne just like if it were a real conversation. And remember to include all the rules and examples we've talked about. There are the four parts to "be polite and all the topics that you came up with in order to "be entertaining." Go ahead and use these cards that we've made notes on as a reminder. Pick up the telephone and start. (Trainer starts the stop clock.)

Each role-play was followed by non-specific praise consisting of the statement, "That was a good conversation."

A second role-play would immediately follow the first role-play.

During the role-play, the research assistant carried out her part of the conversation according to the structured plan outlined in Table 2. This structured plan, in effect, limited the research assistant's responses in order to
maintain standardization in a fashion that would allow the subject to exercise maximum control over the course of the conversation. To insure that the research assistant followed the structured plan, the research assistant was trained to record each discrete response on a check-list in front of her.

Audiotapes were made of each role-play and these audiotapes were rated by research assistants not associated with the training according to the procedure outlined in Table 3.

Common courtesies were scored as present (1), or absent (0), during each role-play conversation. The number of common courtesies (0-8) was summed across the two role-plays that occurred after each training session. Positive self-disclosures, conversational questions, and conversational interjections and acknowledgments occurring during the first four minutes of each role-play were counted and summed across the two role-plays that occurred after each training session.

Each role-play was independently coded by two different raters who had no knowledge of what components were trained for each subject, or of when training was applied to a component. These two raters would listen to a role-play and code each discrete response, in sequence, onto a coding sheet. When all the role-plays had been coded, a third
Table 3.
Role-Play Rating Procedure

Listen to the audiotaped role-play and code each discrete event according to one of the four scoring categories which follow. A discrete event is a statement to the conversational partner which is one sentence long.

1. **Common courtesy:** Score the following four statements as either present, or absent, during the conversation.
   a) Greeting statement: a direct greeting.
   b) Consideration statement: asking the conversational partner if it is a convenient time to talk, or whether the partner has a few minutes to talk.
   c) Appreciation statement: a statement which expresses enjoyment in talking or in having talked to the conversational partner.
   d) Farewell statement: a direct farewell.

2. **Positive self-disclosure:** a statement which conveys information about oneself which the conversational partner might find interesting. The statement may refer to current interests, activities, thoughts, or opinions. Responses to the partner's questions are scored as a positive self-disclosure only if there is elaboration beyond simply answering "yes" or "no". Exclude statements about death or illness.

3. **Conversational question:** a direct request for information from the partner, for the partner to talk about a particular topic, or, for the partner to talk more about a topic already being discussed. Exclude questions which refer to not hearing what was said, such as, "Huh?," or, "What?".

4. **Conversational interjection or acknowledgement:** a statement interjected while the partner is talking, or at a natural pause in speech, which conveys interest, attentiveness, or some reaction to what the partner is saying. Examples are, "That's nice," "I'll bet it is," or, "Uh-huh."
rater would go back and listen to each role play with the two corresponding coded protocols in front of him/her. It was the task of this third rater to arbitrate any differences in coding between the first two raters. Differences due to a matter of opinion were left to stand. Differences that were due to incorrectly following the coding procedures were corrected. Six sets of role-plays were randomly selected for each of the four subjects and interrater reliability was computed using a Kappa coefficient, a statistic which takes into account chance agreement. Kappa coefficients ranged from .81 to .97.

Results and Discussion

A visual presentation of the results for Subject 1 appears in Figure 1. Baseline data collected during the first five sessions indicated that before conversational skills training, Subject 1 emitted a moderate number of common courtesies. She tended to make a high number of positive self-disclosures, although her performance on this component varied considerably across the first five sessions. She was also low on the number of conversational questions, and she made few conversational interjections and acknowledgments.

An informal examination of the baseline role-plays indicated that Subject 1 emitted an excessively high number
Fig. 1. Conversational Skills Performance Levels for Subject 1.
Fig. 1
of positive self-disclosures at the expense of asking conversational questions or emitting conversational interjections and acknowledgments. It was therefore decided to withhold training for the positive self-disclosure component. Data continued to be gathered on positive self-disclosures, and it was hoped that training on components other than positive self-disclosures would indirectly cause the excessive frequency of positive self-disclosures to diminish.

On the sixth session, conversational skills training was introduced for the common courtesies component, and this training resulted in an immediate and reliable increase in performance on that variable. During the sessions that Subject 1 was being trained on the common courtesies component, her rate of positive self-disclosures began to stabilize. Her response level on both conversational questions and conversational interjections and acknowledgments remained stable.

Conversational skills training was introduced for the conversational questions component during session 12. This training was immediately followed by a dramatic increase in Subject 1's rate of conversational questions. As compared to the baseline level, the increase in the conversational questions response rate was maintained over every session following training, although there was considerable
variability in the data points. Also, training on the conversational questions component introduced some variation in performance on the common courtesies component and the conversational interjections and acknowledgments component. Performance on the positive self-disclosures component remained steady.

During session 20, training was applied to the conversational interjections and acknowledgments component; this training resulted in an increase in Subject 1's response rate on that component. Performance gains on the conversational interjections and acknowledgments component and on the two other components previously trained continued to hold until the final training session, although with some intersession variability.

A four-week follow-up assessment role-play demonstrated that increases in Subject 1's conversational skills due to training were maintained over time.

The results for Subject 2 are presented graphically in Figure 2. Baseline data collected over the first five sessions indicated that Subject 2 was low on her frequency of common courtesies, moderate on number of positive self-disclosures, fairly high on number of conversational questions, and low on number of conversational interjections and acknowledgments. During baseline period, there was a declining trend in the number of conversational questions.
Fig. 2. Conversational Skills Performance Levels for Subject 2.
Conversational skills training for common courtesies was introduced during session number six. Training resulted in a rapid increase in the number of common courtesies made by Subject 2; her simultaneous performance on the other three components did not appreciably vary, except that the number of conversational questions she asked continued its baseline trend of declining.

Conversational skills training for positive self-disclosure was applied on session number 13. Training resulted in a significant increase in Subject 2's rate of positive self-disclosures, independent of her performance on the other components. The increase in level of positive self-disclosures remained constant over the following several training sessions. Subject 2's simultaneous performance on the two untrained components did not appreciably vary, except that the rate of conversational questions continued its baseline trend of declining steadily until session 19, at which point her performance on this component was fairly low.

Training was introduced on the conversational questions component on session number 35. This resulted in an immediate rise in the number of conversational questions, but a drop in the number of positive self-disclosures. There was a slight drop in Subject 2's overall high number
of common courtesies, and no change on frequency of conversational interjections and acknowledgments.

On the forty-second session, training was introduced on the conversational interjections and acknowledgments component. Training resulted in a slight increase in Subject 2's performance on the component, independent of the other components. During training on the conversational interjections and acknowledgments component, response levels were maintained on the other three components, so that Subject 2 was emitting a high number of common courtesies, a moderate number of positive self-disclosures, and a high number of conversational questions. Subject 2's level of conversational interjections and acknowledgments was above baseline level. A two-week follow-up assessment indicated that gains made on each of the four components were maintained over time.

The results for Subject 3 may be seen in Figure 3. Baseline data taken over five sessions indicated that before training, Subject 3 was emitting very few common courtesies. During the conversational role-plays, his level of positive self-disclosures was moderate, he asked virtually no conversational questions, and he made almost no conversational interjections or acknowledgments. At the sixth session, training was applied on the common courtesies component and his response rate on that variable increased
Fig. 3. Conversational Skills Performance Levels for Subject 3.
Fig. 3
independently of scores on the other three components. Over the next three sessions the number of common courtesies declined to the baseline level. A personal appeal to increase his performance on the ninth session was followed by a gradual increase over several sessions. On the fourteenth training session, Subject 3 emitted the maximum number of common courtesies. This significant improvement was maintained; on the twenty-first session, training was introduced on the positive self-disclosures component. The intervention was followed by a gradual and moderate increase over the next eleven training sessions in the rate of positive self-disclosures, independent of the other three components. During session number 34, Subject 3's rate of positive self-disclosures began to decline to baseline levels. Further training over several more sessions on the positive self-disclosures component did not change his response rate on that variable. Subject 3's rate of common courtesies dropped slightly during session 36 and became more variable over the following sessions.

On the forty-first session, training was applied to the conversational questions component. Subject 3 responded to the training by asking a few questions during the next three sessions, but this gain disappeared by training session 44. Subject 3 asked no questions over the next several sessions. An additional contingency was introduced on session 48: it
was stated that asking five questions would be compensated by one phonograph record. Phonograph records were chosen because it was known that Subject 3 had an almost singular fondness for collecting old phonograph records. This contingency resulted in a marked increase in the rate of conversational questions, which was maintained for several sessions.

Training was introduced on the conversational interjections and acknowledgments component on the fifty-sixth session. At the same time, the contingency was changed so that Subject 3 was required to ask five questions and make five conversational interjections or acknowledgments in order to earn one phonograph record. The training intervention resulted in no change in the number of conversational interjections and acknowledgments, and a decrease to baseline level in conversational questions during the final seven training sessions. The rate of common courtesies also dropped slightly during the remaining sessions to a frequency midway between the maximum level and baseline level. Subject 3's performance at a two-week follow-up assessment indicated a moderate increase over baseline levels on the conversational questions component, the positive self-disclosures component, and the conversational interjections and acknowledgments component.
A visual presentation of the results for Subject 4 appears in Figure 4. Baseline data collected during the first five sessions indicated that before conversational skills training, Subject 4 emitted few common courtesies, and was low on number of conversational interjections and acknowledgments. Subject 4 also tended to ask few conversational questions, although her performance on this skill component was extremely variable. Subject 4 tended to be high on number of positive self-disclosures. Her performance on this component was also highly variable.

Conversational skills training began for the common courtesies component during session six. After three training sessions, Subject 4's number of common courtesies increased to slightly above the baseline level for one session, and dropped on the following two sessions. Continued training on common courtesies resulted in increased variability on this component, with greater than baseline performance levels on several of the assessment points that occurred at this time. During these sessions, Subject 4's performance on the three untrained skills components showed high variability.

Training was introduced for the conversational questions component during session 22. Training resulted in increased variability in the number of conversational
Fig. 4. Conversational Skills Performance Levels for Subject 4.
Fig. 4
questions asked by Subject 4. Her performance on the other three skills components continued to be variable.

On session 39, conversational skills training was begun on conversational interjections and acknowledgments. Training again resulted only in increased variability.

When training was discontinued after session 53, Subject 4 was showing a moderate improvement over baseline performance on the common courtesies component. No clear performance gains were evidenced on conversational interjections and acknowledgments. Training was not conducted for positive self-disclosure due to Subject 4's already high performance level on that skill component.

A two-week follow-up assessment indicated that the moderate gain in common courtesies was maintained over time. Again, no clear performance gains were made on conversational questions or conversational interjections and acknowledgments.

Overall, conversational skills training was shown to be effective in increasing the conversational skill level for three of the four subjects who participated in Experiment 1. Subject 1 and Subject 2 were most responsive to the training. Both responded to the training with increased skill levels after training was introduced on successive skills components. Follow-up assessments indicated that increased conversational skill was maintained over time.
Conversational skills training was less effective with Subject 3. Training resulted in increased skill level on only two of the four skills components trained, and treatment gains were maintained on only one component. Conversational skills training was not effective in increasing the skill level of Subject 4.
A second experiment was conducted to test the social validity of the content included in the conversational skills training. As was described in Experiment 1, four elderly nursing home residents were trained on four conversational skills components: (1) common courtesy; (2) positive self-disclosure; (3) conversational questions; and, (4) conversational interjections and acknowledgments. For three of the four subjects, data collected during the role-plays indicated marked increases in conversational skills as a function of training. An experiment was designed to determine if untrained observers would perceive the subjects after training as more conversationally skillful.

Method

Subjects. The untrained observers were 24 female and 15 male undergraduate students who participated in this experiment for research participation credit points to be used in their psychology classes. Of the 29 observers, 14 were psychology majors and the remaining 15 comprised an assortment of other majors. Their mean age was 20.8, with a
distribution ranging from age 18 to 35. All but two subjects fell between the ages of 18 and 23.

Procedure. Two conversational role-plays were selected from Experiment 1 to represent each subject's conversational skill level before and after training. For each elderly subject, one before training role-play was randomly selected from one of their baseline role-plays, and one after training role-play was randomly selected from one of the two role-plays occurring after their final training session.

To control for order effects, the eight conversations were arranged to be presented to the subjects in four different orders. The first order was selected by randomly assigning subjects to each of the first four positions, randomly selecting either a before or after training role-play for each subject and then randomly assigning the remaining role-plays to the four positions which followed. The second order consisted of presenting the first order backwards. The third order was selected by repeating the random selection procedure described for selecting the first order. The fourth order was comprised of presenting the third order backwards.

Observers were run in groups, and each administration lasted about 60 minutes. At the start of the experiment, the observers were told that they would be listening to eight different conversations, each between an elderly
nursing home resident and a younger person, and that they would be asked to provide a subjective rating of how enjoyable they thought it would be to talk to the subject. Each conversation was then played for the observer, one at a time, and at the end of each conversation the observers were asked to provide a rating based on the following statement and corresponding ten-point Likert scale:

Based on the conversation I just heard, I would find talking to this person:

1 2 3 4 5 6 7 8 9 10
(not enjoyable at all) (extremely enjoyable)

Results and Discussion

Table 4 presents mean ratings for the before and after conversations for the four elderly subjects who participated in Experiment 1. Table 5 presents results from a 4 x 2 (Elder x Time) mixed-design analysis of variance on the rating data. There was a significant main effect for Subject ($F = 58.18, p < .01$). The main effect for Time was not significant; however, the Elder x Time interaction was significant ($F = 10.28, p < .01$).

A Bonferroni procedure (Myers, 1979) with an error term based on subject variability was used to test planned comparisons between mean before training and mean after training ratings for each subject. The only comparison that
### Table 4
Mean Ratings: Experiment 2

<table>
<thead>
<tr>
<th>Subject (Elder)</th>
<th>Training (Time) Before</th>
<th>After</th>
<th>Collapsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5.641</td>
<td>5.231</td>
<td>5.436</td>
</tr>
<tr>
<td>2</td>
<td>3.231</td>
<td>4.744</td>
<td>3.987</td>
</tr>
<tr>
<td>3</td>
<td>1.923</td>
<td>1.897</td>
<td>1.910</td>
</tr>
<tr>
<td>4</td>
<td>5.051</td>
<td>4.333</td>
<td>4.692</td>
</tr>
<tr>
<td>Collapsed</td>
<td>3.962</td>
<td>4.051</td>
<td></td>
</tr>
</tbody>
</table>
### Table 5
Analysis of Variance: Experiment 2

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elder</td>
<td>3</td>
<td>179.611</td>
<td>58.18*</td>
</tr>
<tr>
<td>Error (SxE)</td>
<td>114</td>
<td>3.067</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>1</td>
<td>.628</td>
<td>.26</td>
</tr>
<tr>
<td>Error (SxT)</td>
<td>38</td>
<td>2.424</td>
<td></td>
</tr>
<tr>
<td>Elder x Time</td>
<td>3</td>
<td>19.115</td>
<td>10.28*</td>
</tr>
<tr>
<td>Error (SxExT)</td>
<td>114</td>
<td>1.859</td>
<td></td>
</tr>
</tbody>
</table>

*P < .01
was significant was for Subject 2, which reached significance at family error rate (EF) = .01; \( t \) (38) = 3.96, \( p < .01 \). This indicated that conversational skills training resulted in greater perceived conversational skillfulness for Subject 2. Significance was not obtained for Subject 1, \( t \) (38) = 1.28, \( p > .05 \); Subject 3, \( t \) (38) = .13, \( p > .05 \); or Subject 4, \( t \) (38) = 2.32, \( p > .05 \).

A Bonferroni \# was also used to test the six possible planned comparisons between overall mean ratings given to each subject. In Table 6 is seen a summary of \( t \) (38) values obtained from the data. Subject 1, Subject 2 and Subject 4 were all rated significantly higher than Subject 3; \( t \) (38) = 11.25, \( p < .01 \); \( t \) (38) = 8.01, \( p < .01 \); \( t \) (38) = 9.83, \( p < .01 \), respectively. Additionally, Subject 1 received significantly higher ratings than Subject 2: \( t \) (38) = 5.96, \( p < .01 \).

Overall, Experiment 2 failed to conclusively validate the content included in the conversational skills training. Untrained observers rated only one of the four subjects who participated in conversational skills training as showing increased skillfulness due to the training. This occurred despite the fact that two other subjects had shown increased skill levels as measured by assessment role-plays.
Table 6
Bonferroni $t(38)$ Values: Experiment 2

<table>
<thead>
<tr>
<th></th>
<th>Elder 2</th>
<th>Elder 3</th>
<th>Elder 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elder 1</td>
<td>5.96*</td>
<td>11.25*</td>
<td>2.47</td>
</tr>
<tr>
<td>Elder 2</td>
<td></td>
<td>8.01*</td>
<td>2.71</td>
</tr>
<tr>
<td>Elder 3</td>
<td></td>
<td></td>
<td>9.83*</td>
</tr>
</tbody>
</table>

* $p < .01$
CHAPTER IV

DISCUSSION

The results of Experiment 1 are highly supportive of the effectiveness of a conversational skills training program which incorporates instructions, modeling, behavior rehearsal, feedback, and reinforcement to train content related conversational skills to socially isolated residents of a nursing home. On three out of four replications, it was shown that elderly nursing home residents could follow and make use of conversational skills training to increase their skill in using common courtesies, positive self-disclosures, conversational questions, and conversational interjections and acknowledgments during interpersonal conversations.

The effects of training were most clear and pronounced for Subject 1 and Subject 2. Both subjects showed clear deficits on several skill components before training. As training proceeded from one skill component to another, Subject 1 and Subject 2 responded to treatment with clear increases in performance. For both subjects, the effects of conversational skills training was maintained on follow-up assessment.

Before training, Subject 1 generally tended to ask few questions and only occasionally acknowledged a partner.
during a conversation. Training resulted in immediate and lasting performance gains on the number of common courtesies, conversational questions, and conversational interjections and acknowledgments Subject 1 made during assessment role-plays. Training for components other than positive self-disclosure also indirectly caused a decrease in Subject 1's excessively high number of positive self-disclosures. In summary, conversational skills training had the effect of training Subject 1 to be more sensitive and capable of sharing a conversation with a partner.

Assessment role-plays occurring before training for Subject 2 confirmed that her social withdrawal and isolation tended to be associated with being passive and disinterested during her conversations. She made few common courtesies, made few positive self-disclosures, tended to ask few questions, and made few conversational interjections or acknowledgments. Conversational skills training resulted in increased performance levels on all four conversational skills components trained, which made her a much more active and involved conversational partner. These gains were shown to be maintained two weeks after training.

The gains made by Subject 3 as a result of conversational skills training were equally clear, but on a much smaller scale than for Subject 1 and Subject 2. This can partly be explained by the fact that Subject 3 made a
moderate number of positive self-disclosures during conversation, but expressed almost no common courtesies, asked virtually no conversational questions, and rarely made conversational interjections or acknowledgments. Training resulted in very substantial gains in expressing common courtesies and asking conversational questions. The increase in common courtesies was maintained throughout the training and at a two-week follow-up assessment. Unfortunately, Subject 3's gain in asking conversational questions deteriorated after several sessions, and did not reoccur at follow-up.

Conversational skills training was not effective in increasing the conversational skill level of Subject 4. Training very probably failed because of the presence of severe cognitive dysfunction, probably caused by a cerebral vascular accident. This disability left Subject 4 too impaired to follow and make use of training procedures which rely on higher cognitive processes. The extent of Subject 4's impairment could be seen in the extreme variability of her data and her missed items on a mental status exam (Kahn et al., 1960).

An important consideration in understanding the results of Experiment 1 is the low cognitive functioning level and extreme social isolation of the particular subjects that were selected for the study. Before the experiment was
conducted, it was assumed that the type of elderly nursing home resident who would most be able to make use of conversational skills training would be individuals at a good level of cognitive functioning, who were only mildly socially isolated, and who had several potential contacts living in the local community. In general, this would be the type of resident who under better circumstances would not be living in an institution, but once there, has begun to withdraw socially and take on the sick/aged role. The assumption was that conversational skills training would be enough to reverse a decline in interpersonal functioning not yet firmly established through time or severity. An attempt was made to recruit subjects who fit the optimum profile, but practical demands made it impossible to do so. There were few residents who matched the description at the Amherst Nursing Home, a facility which focuses its services on nursing care and, therefore, tends to attract residents with a greater degree of medical disability. Additionally, the few residents who came closest to fitting the description did not agree to participate. As a result, the residents ultimately recruited to participate as subjects deviated substantially from the optimum profile. It was thought that in spite of not fitting the optimum profile, these socially isolated elders could benefit from conversational skills training. Of the three subjects for
which an effect was shown, Subject 1 showed significant cognitive impairment, had been institutionalized most of her adult life, and had almost no personal contact with anyone in the community; Subject 2 showed significant cognitive impairment, had been institutionalized for four years, and had frequent contact with only one person in the community; and Subject 3 had been institutionalized for 25 years, and was almost completely isolated from the community. The subject for which an effect was not shown, Subject 4, proved to be too cognitively impaired to respond to the training.

Knowing the extent of Subject 1, Subject 2 and Subject 3's cognitive and/or interpersonal deficits lends further support to the effectiveness of conversational skills training with socially isolated nursing home residents. It demonstrates that the procedure is robust enough to have good effects with extremely isolated elders who experience some cognitive impairment. It also provides a context for explaining: the length and difficulty of the training; the difficulty in obtaining generalization; and, the mixed results obtained in Experiment 2.

All four subjects required an extended series of training sessions to progress through all phases of the training. The total number of training sessions for each ranged from 19 to 57. In part, this high number reflects the subjects' differing levels of motivation for doing the
work involved in the training. As was just discussed, the subjects had adapted to institutionalization and developed longstanding and deeply ingrained interactional patterns which maintained their sick/aged roles. Subject 2 and Subject 3, especially, mobilized passive behaviors to cope with the demands of the training to use skills that had long remained dormant. For example, Subject 2 would frequently state that she could not come up with any good examples, that she did not know what to say, or that the training was too difficult. This was responded to with gentle prodding, effusive encouragement, and praise for all correct responses. Several times the trainer would acknowledge that the training was difficult but that she had worked hard and made very good progress. Subject 3 proved especially recalcitrant. The sessions for him began with a few minutes of chatting about his current interests or activities. When the training portion began, he often balked and would stop responding. At those times he would sit, sullenly looking down at his lap. The progress that was made with Subject 3 occurred after employing two very direct interventions. The first involved making a personal appeal. The trainer told Subject 3 that he enjoyed meeting with Subject 3 and appreciated his coming to the meetings, but that this project was very important to the trainer and in order for the project to work, Subject 3 would have to come up with
some examples and use those examples in the role-plays. The second intervention came after repeated personal appeals resulted in no change in the number of conversational questions asked. A reinforcement contingency was established in which Subject 3 received a phonograph record upon meeting the criterion of asking five questions within two role-plays.

It was hoped that increased conversational skillfulness would lead to increased contact with friends or family living in the community through increased telephone calls. Before training began, the subjects were asked how frequently they used the telephone. All four said they never used the telephone except for Subject 3, who said he occasionally received a telephone call from his brother. During the six-and-a-half months that the training and follow-up assessments were conducted, the subjects reported no telephone calls to or from friends or relatives. The training did result, though, in Subject 3 making two telephone calls to a local department store to request that the store manager place a hold on a tape recorder that was on sale until Subject 3 could arrange transportation to the store. Additionally, Subject 2 began to express an interest in calling her daughter towards the end of training. Although steps were taken to facilitate this, Subject 2 did not make the call.
Informal reports from the staff at the nursing home did indicate that Subject 2 and Subject 3 became slightly more sociable with others in the nursing home. Several staff commented on Subject 2's appearing to be in a happier mood, often greeting the staff and asking conversational questions where she had not previously done so. Even more striking were changes seen in Subject 3. Prior to training, Subject 3 would tend to isolate himself in his room. Towards the middle of the training, Subject 3 was more frequently seen outside his room, either walking through the nursing home, or sitting in the main common area. Additionally, after the training was completed, the director of the day care program at the nursing home announced that Subject 3 had joined her group on a field trip to a local park -- the first field trip in which any of the staff could remember Subject 3 participating.

A simple explanation for the failure to find generalization to increased telephone contacts with friends or family is that the subjects who participated in conversational skills training had almost no potential contacts living in the community. Stated simply, generalization was not possible at least partially because these elders had almost no one to call. An increase in conversational skillfulness was not enough to reverse the severe isolation which had developed over a number of years.
It was only enough to begin to counter some of the behaviors that the subjects had developed in order to cope with aging in an institution.

Experiment 2 failed to completely validate the content included in the conversational skills training. It was a disappointment to find that untrained observers were able to find an increase in skillfulness for only one out of the three elders in Experiment 1 for which training had an effect. Before jumping to conclude that common courtesies, positive self-disclosures, conversational questions, and conversational interjections and acknowledgments have no relationship to conversational skill, though, two alternatives are in order. First, it is possible that the selection procedure for the conversations used in Experiment 2, although random, did not yield conversations that were representative of the before and after training phases. If a better than average before training conversation and a poorer than average after training conversation were chosen, this would have obscured any actual differences, especially in the scores of raters who were unaware they were making a comparison rating and instead thought they were providing global ratings. Second, perhaps asking observers to rate how "enjoyable" they would find talking to the subjects was not the appropriate question to ask when the purpose of the study was to determine how "skillful" observers thought the
subjects were. Asking observers directly to rate the subjects on conversational skillfulness might have led them to listen differently and, therefore, have provided different results. Also, the question that was asked implied that the elders might be enjoyable to talk to. When Experiment 2 was conducted and the conversations were played for the observers, it was clear that many of the observers felt uncomfortable and anxious listening to conversations with unusually long silences, and with disorganized or depressing content. Considering these points, if Experiment 2 were to be conducted over so that differences due to training could be maximized, the following changes should be made. First, a selection procedure that ensures that conversations selected are representative should be used. One possibility would be to compute each elder's average score on each conversational skill component during the two phases of training, and then choose the conversation which most closely resembles the composite average. Second, observers should be asked to compare before training and after training conversations, a procedure which tends to highlight differences. Last, the question posed to the observer should ask directly for a rating of the elders' conversational skillfulness.

Although further research needs to be conducted in order to confirm the results obtained by this study and to
establish the parameters of the effectiveness of conversational skills training with socially isolated elderly nursing home residents, some tentative recommendations can be made. Given that social isolation is known to be a contributing factor to emotional stress, depression, and suicide, a conversational skills training program should be considered a viable intervention for treating the social isolation experienced by many elderly nursing home residents. A program which includes instruction, modeling, behavior rehearsal, feedback, and reinforcement can be effective in training content related conversational skills to elders whose conversational skill deficits are probably associated with withdrawal and isolation. Such a program is thought to be most effective with elders whose degree of cognitive/emotional functioning is within the normal range, and whose social isolation is not advanced to the point of having no potential contacts within the community. These individuals would be the ones most likely to be responsive to conversational skills training, both in terms of increased conversational skillfulness and in terms of generalization and maintenance of these gains. Conversational skills training would also have some utility and effectiveness with elders who did not completely fit an optimum profile. To increase the effectiveness of conversational skills training with elders
whose social isolation has become advanced to the point of being cut-off from the community, conversational skills training could be paired with adjunct programs designed to introduce elders to peers and other members in the community. It is also recommended that conversational skills training be incorporated as a routine social activities group in the curriculum of a nursing home to counter the insidious effects of institutionalization and ageism. Conversational skills training, perhaps modified to incorporate group training, could easily be applied by a trained staff member and run similar to recreational therapy groups that are commonly found in nursing homes.
REFERENCES


