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SOCIAL NETWORK AND THE ELDERLY: Conceptual and Clinical Issues, and a Family Consultation

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ABSTRACT: After a general Introduction to the construct "social networks," this article discusses the progressive transformation of the personal social network—family, friends and acquaintances, work and leisure relationships, et cetera—as individuals reach an advanced age. This is followed by a summary and discussion (from a social-constructionist perspective) of a clinical consultation, with an emphasis on the reciprocal influence between individual and social network.

This article has a double frame of reference: (a) an ecosystemic perspective that highlights, as a crucial level of analysis of human processes, the personal social network of individuals (including family), a dynamic system in permanent evolution actively inserted in the larger sociocultural macrosystem; and (b) a social constructionist frame of reference, through which the therapeutic process can be described as a purposeful evolution of the problematic stories displayed by the consultees into consensually validated alternative stories that enhance competency as well as facilitate change. The first frame will be presented in the sections that follow, the latter will permeate through the closing discussion, and the interview contained in this article will constitute, hopefully, an example of how this double frame of reference translates into practice.

Our personal social network

Our personal social network[i] is a stable but evolving relational fabric constituted by I. family members, II. friends and acquaintances, III. work and study connections, and IV. relations that evolve out of our participation in formal and informal organizations—social, recreational, religious, political, vocational, health-related, et cetera. It includes, in fact, all those with whom we interact and who distinguish us from the faceless, anonymous crowd. This social cocoon constitutes a key repository of our identity, our history, and our sense of satisfaction and fulfillment with life. A substantial and growing body of data is showing both the protective effect of social ties and the detrimental effect of insufficient ties on health and well-being, at all ages (Berkman, 1984; Berkman and Syme, 1979; Bosworth and Schaie, 1997; Choi and Wodarski, 1996; Eriksson, et al., 1999; Kouzis and Eaton, 1998; House, Robbins and Metzner, 1982; Schoenbach et al., 1986).

This level of analysis--the personal social network-- has the curious quality of being both centered on the individual and focused on relational systems. It is individual-

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centered because it is always [re]constructed on the basis of a given informant or reporter; that is, it is my social network, any given individual's social network.[ii] And it is eco-systemic, or relationally based, as it includes as minimal unit of analysis the whole meaningful social fabric that surrounds us[iii].

In spite of their important role in our life, this interpersonal web is frequently taken for granted: we tend to engage in those social exchanges without awareness of their value for self-recognition and their importance as practices related to health and well-being. In fact, until quite recently they have been rather invisible even to scholars and researchers[iv].

The personal social network—that aggregate of all those with whom an individual interacts meaningfully-- constitutes a configuration in a constant process of change, both in its historical evolution and across the life span of individuals. The characteristics of the social network vary from person to person, from circumstance to circumstance, and from culture to culture. However, it follows, in general terms, a rather normative (i.e., predictable) life cycle of its own. This normativity allows one to pinpoint stages in the personal social network, the vicissitudes of which parallel those of the individual life cycle (Erickson, 1959) [v] and those of the family life cycle (Beavers and Hampson, 1990; Carter and McGoldrick, 1980, 1989; Combrick-Graham, 1985; Duvall and Miller, 1985; Falicov, 1988.) [vi]

This paper focuses on one of those stages, namely, the one in which the individual who is our referent has reached an advanced chronological age.

"Old age" is both a biologic reality and a social construct. The ever-changing threshold that, when reached, makes a person of "old age" is defined by the culture—different collectives define a person as old at different chronological ages--; by the changing equilibrium between the bodily decay and the advancement of geriatric medicine—people remain physically and hence emotionally apt at a later age as preventive and therapeutic medicine discovers new ways of delaying the unavoidable physical decay and of keeping older people healthy--; and by genetic lottery—some families display generations of healthy people until an advanced chronological age, and some show a trend toward early death, or higher frequency of Alzheimer's disease, heard disease, or cancer—as well as genetic mutation. As a response as well as reconstitution of the above, "old age" expresses itself with remarkable differences among individuals, in what may be characterized as stylistic or attitudinal differences that make some people remain generative, energetic, and creative while others lose élan vital as time passes. It is also expressed in, and is the expression of, a variety of life plans—the culture of some families leads their members to organize their life on the basis of specific finite tasks (having a job, raising children), and the completion of those duties (retirement, launching of offspring) marks for them the subjective and interactive initiation of old age --they treat themselves and are treated by others as elderly members of the species. Epigenetically, and following the binary model proposed by Erickson (1959), old age corresponds to a period in which the person has already reached the peak of generativity (or, if not, has faced stagnation and self-absorption) and is transitioning toward the final stage, in which all prior stages are integrated with appreciation (or, if failing, the individual falls into despair, regret and fear).

While widely diverse in its manifestations due to the multi-layered, eco-systemic set of intervening variables mentioned above, people in the bracket of advanced age

share a set of common traits. At the individual level, old age is marked by a reduction of sensorial acuity and motor agility, and frequently a shift when not a decline in cognitive functions. At a family level, it is characterized by intergenerational parity, if not shift, in roles, responsibilities and capabilities. And, at the level of the social network, its traits are a progressive attrition of social bonds through (a) the death or migration of its members, (b) an increase in the elderly person's difficulties in carrying on the social tasks required to maintain active social links; and (c) a reduction of the opportunities for renovation of social ties, that is, for establishing new relations. As a result, one can predict an unavoidable impoverishment of the quantity, quality and variety of exchanges and resources. This emptiness is in many cases counter-balanced by the retention and sometimes even intensification of select friendships (Lansford, Sherman & Antonucci, 1998), the expansion or the development of social tasks such as participation in intellectual hubs or in voluntarism, and/or by a reactivation and re-centralization of family ties, an expression of either a steady, rich continuity, or a burdening reactivation of old debts (Van Tilburg, 1998).

The social network of elderly persons

Old age is inevitably accompanied by a progressive loss of the supportive ties of family members—the death of a spouse and of close siblings being the most salient--, of friends and of other relationships from previous, concurrent, and following generations through death or distancing by migration or relocation. That is compounded by the loss of social roles and ties that accompany retirement and the thinning of the parental social functions that result from offspring having achieved autonomy. This substantial attrition of networks is accompanied by an experience of emotional impoverishment, by a reduction in the solidity of the identity, and, indeed, by grief and mourning, not infrequently experienced by the elderly as a pervasive depression "without a reason" (La Gory and Fitzpatrick, 1992).

Old age carries with it an exponential progression of physical foibles and weakness. As a result, if becomes increasingly difficult for the older individuals to maintain their autonomy in everyday-life activities, including carrying on those tasks of network maintenance that are necessary to sustain active relationships. This further contributes to the difficulty in accessing the available social network (Adams and Blieszner, 1995). To complicate matters, old age is usually accompanied by a reduction of socio-economic power—less income and less ability to generate it in a period with increased expenditures: new health care needs as well as previously unnecessary services, such as meal preparation, house cleaning, transportation, and other activities of daily living. [vii]

The increasing paucity of the social network of the elderly unavoidably carries with it qualitative changes in those relationships that remain active. In fact, there is evidence (Glass et al, 1997) that the decreasing network size may not matter if such decline is offset by increased support from those fewer ties. The remaining relationships may persist or even expand over time with solid grounding—a spouse with whom a rich intimacy was established and preserved, a small network of close friends, close ties with siblings and with offspring--, or may experience a rewarding rekindling—a re-encounter of sorts "after all these years." However, on occasion the long-term result of the displaced burden is overload, resentment and an experience of entrapment: a wife who

longed for her husband's company now feels encroached upon after he retires (while he manages and controls her as he was used to doing to his employees), or she feels doubly betrayed and lonely while he engages in a routine of daily golf with his buddies; an offspring who experiences the parents' increasing need for care and attention as an imposition and a dreaded restriction on his or her own life; a long-term friend who feels exhausted, burned out, and exploited due to lack of reciprocity in his or her relational availability; et cetera.

Passing a certain threshold—perhaps the death of the spouse, or an illness--, tension mounts between the treasuring of autonomy and the increasing needs for care. This tension is more or less conflictive depending on cultural expectations as well as individual and family styles. There will be old people who equate increasing relational (mainly family) involvement with decline, or will perceive it as imposing a burden on others, and in fact increase distance as they become more feeble, enveloping themselves in a solitude that depletes them of emotional nourishment and practical resources. In many other cases, once signs appear to indicate the need for increasing care resources, the elderly and/or their immediate family may begin to favor, as a solution, the relocation of the elderly person to a new context (Wilmort, 1998). As a result, frail elderly people migrate—sometimes on their own initiative, sometimes under social pressure by their kin—to a neighborhood, town or region where their offspring live, or to their houses. This relocation may have such positive consequences for the elderly as allowing a ready access to personalized care and to meaningful social contacts with their offspring, their offspring's families and friends, and perhaps some new extended social ties. It also has a powerful negative side, namely, the vanishing of many relationships that were left behind[viii], the loss of many social routines and social resources that are tied to familiar environment, a loss of history when all those "anchors" of memory —from friends to places to that stain in the wall of their bedroom where a picture hung for many years— are left behind, and a subordination to new social norms and social rules with comparative little history for them, namely, that of their offspring's families or of the communities where they live[ix].

An additional, sometimes unexpected, variable may complicate matters: intergenerational patterns may not be easy to alter. More specifically, some elderly individuals may continue to view themselves, and to be perceived by the offspring, as "parents" rather than persons, and vice-versa. This will risk reactivating interactive patterns that in turn regenerate old, sometimes dreaded, relational nightmares: old family stories—alliances and feuds, unexplored assumptions and unsolved resentments—quickly contaminate the present; debts and merits accumulated over the years, many of them actually forgotten or forgiven, are recalled in the new daily exposure to each other. Finally, it may happen that offspring as well as parents discover that they do not share values and even, to their own dismay, that they find each other uninteresting or unattractive. Of course, the opposite may be the case: the relocation reactivates virtuous, rather than vicious, cycles, and the move proves to be a blessing to all parties concerned. Also, a move that includes more than one member—a couple of elderly persons, for instance-- may be experienced as a curse by one and as a blessing by the other, destabilizing further the social environment..

An alternative solution triggered by the evident or perceived inability to live an autonomous life is that of moving (or being moved) to an age-concentrated housing or "mature community" —sometimes adjacent to a Nursing Home, of which they are an ominous prologue, or straight to the Nursing Home itself. Mature communities have the

important redeeming value of facilitating regular social activities and group interactions, which may be uplifting and protect against isolation and despondency (Walsh, 1998). However, more frequently than not these contexts disconnect the elderly from their previous personal social network[x]. In turn, Nursing Homes almost as a rule increase exponentially social isolation, which is broken only by occasional family visits and the daily engagement in structured collective activities, frequently regressive when not meaningless. These avenues of structured living are not infrequently chosen by the elderly persons themselves, assessing that their presence would be burdensome to the family, or finding it inappropriate to impose on them—a philosophy of life that is, as mentioned above, highly culture dependent, and found in the US more frequently among European-American (Italian-American excepted) than among Latino and African-American families (John, Resendiz & De Varga, 1997).

Last but not least, in those circumstances where the family is absent or emotionally detached, and friends have either vanished or were never there, the frail elderly person may not have any choices other than a Nursing Home or a progressive isolation from the community, retaining tenuous connections through occasional community services and minimizing themselves as social beings to reappear in the social world mainly during medical or psychiatric emergencies.[xi]

In should also be noted that, in one context or another, and due to a mixture of interpersonal effects of their reduced mobility and sensory acuity and societal ageist bias, the elderly are frequently infantilized and trivialized. This may appear through social practices, such as a restriction of their driver's license, and in their familial and extra-familial interactions, where they may be treated like children, with condescension, being spoken to slowly and with easy words, with the assumption that they are not fully competent. To compound the difficulty of the situation, the debilitated older person may have to relinquish his or her last vestiges of privacy, as they may require assistance to take a bath or even to clean themselves after going to the bathroom. The effect of these interactions—even when fulfilled by others with the best of intentions and good will—is alienating and regressive, and plays an active part in the cognitive and emotional deterioration of the elderly—they see themselves through the eyes of the others, and fulfill the assumption (Golander, 1995; Harwood et al., 1993; Whitbourne et al., 1995).

The interview that follows illustrates vicissitudes of this stage and will be followed by clinical as well as conceptual comments.

OLD MAN IN THE CLOSET: A CLINICAL CONSULTATION[xii]

I received in my office a phone call from a bilingual Hispanic-American lawyer whom I knew from some shared patients/clients and a couple of light encounters in social events. He was calling, he explained, to request a psychiatric diagnostic interview for his father-in-law, a 79-year-old man who was displaying extremely worrisome symptoms. He had the impression, he confided, that his father-in-law might be showing clear signs of Alzheimer's disease. He explained that the old man was alternating between periods of agitation and distress and periods of retraction and despondency. He would spend hours in his small office, just staring at the wall, but would also have bursts of violence,

uncharacteristic in this until-then extremely gentle person-- including destroying in a furious gesture the photographs of his grandchildren that had been displayed in his house. He added that, the week before, a visiting nurse, concerned about the old man's despondency and assessing the risk of suicide, recommended that all his medications be placed beyond his reach and administered to him when needed. Also, the old man was hoarding in the refrigerator meals brought for his daily consumption by a meals-on-wheels program. The old man seemed at times obviously disoriented and depressed, uttering phrases such as "What is all this?" "I am nothing to anybody"; "I should die and that would solve all problems." The caller asked me to interview the old man for differential diagnosis: Was it Alzheimer's dementia (as suggested by his disorientation, agitation, changes in behavior, unwarranted violence, bizarre behavior such as food hoarding)? Was it an agitated depression (as hinted by his agitation, despondency, suicidality, and violence)? The tension at home around his behaviors had reached crisis proportions, so much so that the two sons of the old man were planning to fly into town to participate in the decision process regarding the future care of their father. Should they send him to a Nursing Home? Hospitalize him in a psychiatric unit? I proposed a consultation for the next day, which the caller accepted immediately. I asked him to invite to my office, in addition to the old man, as many family members as possible. He assured me that he would do his best. .However, he informed me that regrettably he would not be able to participate in the consultation, as he had a legal deposition that very day

The following day, at the appointed hour, two persons appeared for the consultation; the old man, in a wheelchair, rather disconnected but displaying annoyance, and, pushing the wheelchair, one of his sons, an Evangelical minister who lived in a neighboring state and who had arrived the previous day in response to the crisis surrounding his father.

The old man was born in Venezuela but has lived most of his adult life in the US in predominantly Hispanic communities. Both father and son were fluently bilingual. Hence, the consult took place in "Spanglish", with whimsical shifts between English and Spanish depending on the subject and on the moment. The son informed me that the lawyer hadn't been able to change the date of his deposition and sent his regrets. The lawyer's wife, the oldest of the patient's offspring, who not only worked at her husband's firm but was also is involved in community and religious activities, was also unable to come due to a previously scheduled important meeting. The patient's wife, an 81-year-old lady, declined to come on the grounds that "she was too old for that", and also because she was taking care of her daughter's two children, 6 and 8 years old. Another son of the old man, who also was an Evangelical minister and lived at a considerable distance, had planned to attend, but his plane had been delayed due to bad weather, and would not make it in time for the interview. Finally, the youngest daughter of the patient, who also lived several hours away, had informed her siblings that she wouldn't be able to be present during this crisis due to her own family obligations—she had two small children.

Placing the old man's wheelchair at an angle and a bit removed, the son explained to me that his father was somewhat deaf and difficult to engage. He also commented in low voice that his father expected some medical procedures from me, as he was told that this consult had to do with his blood pressure. However, he explained, his father was apprehensive and mistrustful, afraid that he was being brought to my office--which is located at a general hospital--in order to be hospitalized against his will.

During these first few minutes of the encounter, I addressed some questions to the old man, which were diligently answered by the son. A couple of times the old man mumbled something and the son proceeded to inform me what his father has just said. In turn, I relocated the wheelchair center-stage in order to be able to sit face-to-face with him, and addressed my questions to him louder and articulating clearly, waiting for his answers, while gently blocking the son's attempts at answering by proxy. Later in the interview I moved my chair back so as to achieve equidistance between the three of us and be able to carry on a comfortable three-party conversation.

At the beginning of the interview the son—lowering his voice sometimes to make some comments to me below the old man's hearing threshold—introduced the family concern, presenting issues of the same tenor as the ones advanced by the son-in-law during his first phone contact. In turn, I explored the context and recent history of the old couple and the family. As the conversation progressed, an alternative, non-symptom-based, equally plausible description of their current predicament emerged. The evolving story was built (or, perhaps, from their perspective, reconstructed) with the increasingly active participation of the old man, who became by the end a rather lively and coherent interlocutor that appeared to wake up as he was legitimized. As it progressed, the three of us were enlisted by the internal consistency of the new description, evolving guided by my questions and comments and in turn guided by their answers and comments, with everybody's active participation.

This is the story that unfolded. The old man was a retired Evangelical minister, and an erudite student of the Bible, fluent in English and Spanish and with sound knowledge of Latin, Greek, Hebrew and Aramaic. He taught for years in a religious seminar and led a congregation and, when the time came for his retirement, his pension allowed him a modest but satisfying life in a mid-size town in the Southwest. He maintained his interest in Biblical studies, and met regularly with a group of three friends and colleagues to discuss their respective discoveries. His marriage, already passing its 50th anniversary, was described as satisfactory or "at least, tolerable", and he maintained a gratifying contact with his offspring --the daughters were described as more connected with their mother, and the sons, both of whom had followed his vocational religious path, had stronger ties with their father. Things changed seven years ago, when "age caught with him": he developed diabetes, and suffered a heart attack followed by

quintuple bypass surgery. He lost his physical stamina, and progressively restricted his social activities and, up to a point, his self-reliance. Three years ago, considering the strain of their modest resources due to their increasing health expenses and the progressive limitations of their self-reliance inherent to their advanced age, the old couple accepted the invitation of their favorite and comparatively more affluent daughter to move to an in-law apartment attached to her house, located in a neighboring state. An added argument provided was that the daughter needed somebody trustworthy to take care of her young children while she was involved in her many activities, and she trusted her mother more than anybody else.

The in-law apartment, while comfortable, was considerably smaller than their previous dwelling. They described several additional factors that compounded the problem of a reduced space. The patient's wife was portrayed as a pack rat that, unable to get rid of any clothing or even loose pieces of fabric, accumulated them all, new and old. As a result, the entire apartment's closets ended up filled with her bounty, while her husband's closet space was limited to a large armoire located in the bathroom. During weekdays, as the two active and joyful grandchildren, 8 and 6 years old, arrived back from school, they installed themselves at the grandparent's apartment, where they completed their homework, played, watched TV and had dinner. When their mother arrived, she also tended to stay in their apartment to chat with her mother or with the kids, and watch some soap operas together. According to the description of the old man, corroborated by his son, the level of activity and noise in that dwelling was quite remarkable, all taking place in a rather large consolidated living-dining room with an open kitchen area, where no privacy was possible.

The old woman enjoyed very much her newly acquired role as caretaker of her grandchildren which, they underscore, had also the function of reciprocating in part the generosity of the daughter and her husband--an issue emphasized by the old man, while his son provided a second text: his father had always been proud and autonomous, and this situation of dependence was somewhat humiliating for him.

In the new apartment the old man didn't have a designated space where he was able to place his books and maps to continue his studies. In order to try to remedy that, a broom closet of a reasonable size was emptied and defined as "his study room". However, the space is so limited that, if he entered into the closet with his wheelchair, he could not turn it around, and, in order to exit, he had to back it out. Nonetheless, he took frequent refuge in it, attempting to escape the noise and read in peace...to end up feeling "just like another broom in the closet."

As an introductory remark to the topic of the crisis around meals, the old man stated that he had never cooked in his life—a role designated to his wife, who also served the meals at the table-- and he doesn't plan to change that rule

now. However, as their grandchildren ate an early dinner with them, his wife attended to them first. And when he was finally served, the food, which was frequently brought by a meals-on-wheels program and was already only tepid upon arrival, sometimes reached him cold. He found that unacceptable, a sign of lack of care if not of disrespect. When that was the case, he simply refused to eat, and placed the plate in the refrigerator "to be eaten later"—as, in his view, to throw away perfectly good food was sinful as well as inconsiderate toward his daughter and son-in-law's economic effort in supporting them. In that way, the refrigerator ended up sometimes packed with plates of food from previous days. Illustrating his frustration, the old man described a recent episode when, offended by receiving is food cold, and overwhelmed by the tumultuous hubbub of the children, wanted to leave the table but found himself unable to maneuver his chair around the table, as his way was blocked by the refrigerator. Exasperated, he brushed down the photographs of his grandchildren, held up with magnetic strips to the door: he needed some free space. And, he added, his wife made it into a major scandal, as if he had committed a mortal sin.

His life had indeed suffered major changes during the past few years. In their previous house space was divided with equanimity, with public spaces and private space for both of them. Since they moved to the new apartment, he felt like "a visitor in his own home." Aside, he complained, he didn't have anybody with whom to talk about "serious" (fundamentally Biblical) matters, as their move distanced him from his friends and colleagues from the prior town. He also felt more distanced from his sons, whose marginal economical condition as ministers of small congregations do not allow them to travel frequently to visit their parents at the new location. He commented shyly that he even missed his laundry man, who really knew how to press his pants, and some of his neighbors, with whom he routinely exchanged a few words—about the weather, perhaps, or occasional comments in passing about their respective health-- during his daily walks around the block.

In sum, throughout the interview a story was consolidated, characterized by multiple progressive losses of social network, social acknowledgment, intellectual stimulation, personal space, and even rituals that allowed him to recognize himself. And as this story was being validated by the three of us, the alternative story--his dementia, his psychosis--reduced its presence and its hold, to finally disappear.

One of the interesting byproducts of the consolidated description was that it presented problems that, while not trivial, were potentially solvable, or at least reasonable. For instance, the legitimization of the experience of lack of privacy led to an exploration of what, if anything, could be done about it within the limitations of their current dwelling; a recognition of the intellectual isolation of the old man, an expert on the Bible without any interlocutors that would recognize him as such, led to exchanges about ways of expanding his network.

The hour-long consultation--which evolved into an animated and friendly conversation--finished with expressions of appreciation on their part. We agreed that the whole family would meet again with me the following day to continue this exchange of ideas--my intention being to affiliate as many members of the family as possible to the new story. The old man announced that he probably would not come, as outings like this exhausted him, but added that his son would represent him well. We bid good-bye, following the Latino protracted rituals of closure of a friendly-but-formal encounter.

The next interview took place twenty-four hours later, with the participation of the oldest daughter--a woman exuding strength and command--and the two sons. Again, the lawyer had excused himself, and the old lady stayed at home fulfilling her duties as caretaker of the children. During this consultation I had little to do beyond expressing my interest, agreement and support. They reported to me that, when father and son returned from the first consultation, the whole family gathered to hear a report of the event, which the son transcribed in detail, with occasional footnotes from the father, including the new understanding that derived from it. Everybody found it extremely shrewd and reasonable, adopted that description as their own, and began a discussion aimed at solving some of the problems that were defined by that description. They detailed how they would modify the distribution of rooms in the house as well as the furniture in order to create a study room for the old man, who was also going to have a phone line of his own. They were going to change the location of the TV and modify some routines in order to reduce the social overload at the small apartment, and they were going to change and enforce some emblematic routines during dinner time. The sons pledged to take turns to visit their father more frequently, et cetera, et cetera.

That was the end of the consultative process. A follow up phone conversation with the old man one year later and a fortuitous encounter in an airport with the lawyer and his wife shortly after confirmed a substantial improvement on the part of the old man, who seemed reasonably satisfied with life, a statement echoed by both the attorney and his wife. Her mother, she added, was also pleased with the new arrangement, that brought back peace to the household and space for all—as mother and daughter ended up moving some of their activities to the "big house", to everybody's satisfaction.

THE PROCESS OF TRANSFORMATION OF THE STORY DURING THE CONSULTATION

What was the "official" story provided by the family at the beginning of the interview? The nucleus and summary of the narrative had been already offered by the lawyer during his first phone contact: an old man displaying signs of declining cognition, perhaps demented, depressed, agitated, bizarre, that is, a story of loss of capacity centered in a frail elderly person. That same story was reconfirmed at the beginning of the interview by the very behavior of the old man, who appeared disconnected if not

obtunded, irritable, and difficult to reach. The son that accompanied him was clearly colonized by that story and therefore his actions and commentaries contributed to maintaining it.

Had I assumed that the old man was demented, I would have tended to use the son as an informant; and my doing so would have reconstituted—that is, reconfirmed—the "official" story. However, as I did not behave according to the guidelines derived from those assumptions (for instance, I addressed complex questions to the father that contradicted the assumption of his lack of cognitive capacity), my behaviors and interventions throughout the interview progressively destabilized that story. It should be noted that at no time did I criticize the original story: I simply did not behave in a manner that conveyed or assumed its premises.

Once the son was participating in those "revisionist" behaviors--for instance, when he would engage in complex conversations with me and his father--, I would yield center stage and let them interact. This experience, cemented in their reciprocal views-in-action, progressively re-legitimized the voice of the old man. It was also facilitated by the introduction of subtle but meaningful grammatical transformations (such as shifting from past to present tense when responding to the son's comments about his father's intelligence, to notice that the son was also using present tense in reference to his father at the end of the interview).

One of the key elements in my conduction of this consultation was that of maintaining a stance of positive connotation, centered on an assumption of good intent on the part of all the characters of the story, and that there are reasonable explanations for why people do what they do. This posture facilitated the participants' enrollment into the new story--including the potential resolution of the old problems embedded in the new story--, as nobody was placed on a negative role or locus, a trait that would have acted as aversive to those located in those roles. In fact, as stories unavoidably assign roles, many potential stories may rely on, and evoke, a distribution of roles that place some characters into negative, or undesirable locations, such as that of victimizer, irresponsible, crazy or mean. Needless to say, when such is the case, those individuals will not rally around such a story, favoring instead one that will place them in positive roles...and others in negative ones.

The story that emerged in that interview entailed assumptions of good intent by all participants. The move to their new locale was reasonably described as perhaps necessary for both but especially desirable for the old man's wife, who recovered the company of her daughter as well as an active role in raising their grandchildren (even though she neglected rituals that were dear to her husband's identity). His tenacity in maintaining his studies was praised (while acknowledging that that concentration marginalized his wife in a period in which her other roles had been minimized). The generosity of the daughter was praised (in spite of the unintentional negative consequences for her father). The reduction of the contact with the sons since the move was defined as predictable and unavoidable given the financial limitations of the family (regardless of the isolative effect on the father). And so on.

It included also an optimistic stance that assumes that deviant or annoying behaviors do not represent symptoms but are reasonable expressions of unreasonable

circumstances (until otherwise proven). It embeds the notion, already traditional in the field of family therapy, that the so-called symptomatic behaviors are complementary with behaviors of others, in a reciprocally maintaining process. It also entails the social constructionist assumption that those behaviors are held by a set of collective explanations—the “official” story. A consensual shift in that story would necessarily change the behaviors of all the participants—as behaviors are part of, or at least congruent with, the stories that give them meaning--, including, in many cases, the vanishing of those behaviors previously labeled as symptomatic. [xiii]

It could be argued: where is the social network in the consultation proper, if it only consisted of family members? This has not been, indeed, a "social network intervention” in the traditional sense (such as those described by Speck and Rueveni, 1969; Speck and Attneave 1973, Klefbeck et al.1986). Even if I had wanted to do such convocation, there was no current extra-familial network to speak of in the life of this old man. However, a social network perspective permeated my view as well as many of my, and later their, comments: relational losses were highlighted throughout the interview by all of us, currently unmet social needs were acknowledged, and the new story was built around the understandable effects of social alienation on this man’s identity and, ultimately, on his cognition, together with a revival of the centrality of his wife that also had to be preserved. The whole ecology of this individual, and, in fact, of the different members of the family, bore an important role in the story that evolved, facilitated by my own sensitization to this level of analysis.

Maintaining an inclusive optic that encompasses the personal social network, and therefore highlights the vicissitudes of the ecological niche of patients, brings into focus processes that are at the same time familiar and totally novel. In fact, this double feature of being a process generally beyond awareness and at the same time being recognizable when highlighted constitutes one of most attractive features of the inclusion of a Social Networks perspective. When this level of micro-social processes is introduced—through questions and comments--, people understand what are we talking about, they grasp it experientially from the moment we begin to bring it into focus. Further, the relationship between individuals and their social network can be expressed in everyday language. As the dynamics of those processes are reciprocal—the relationship between individuals and their social network is dialectic—, it facilitates descriptions that are not pathology-oriented and also not blaming, allowing for

the development of explanatory hypotheses without victims or victimizers. A golden corollary is that this opens up ways to reverse or enhance processes that are common sense and frequently proposed, and owned, by those who consult us.

The many losses that accompany the retraction of the personal social network of the elderly tend to be minimized by our culture, by health and mental health workers, and by the elderly themselves. To make it explicit and to legitimize the impact of the subject’s diminished sources of identity, history, and both emotional and intellectual validation has a profound therapeutic value. Attempting to reverse processes that lead to the progressive extinction of the social network in the elderly proves to be, in some cases, impossible. However, these attempts often bear surprising results: a reawakening

of the social process that both gives and receives recognition, care, and, ultimately, identity and their crucial experience of a meaningful insertion in the world.

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[A POST-PUBLICATION NOTE: An interesting added variable –not considered in this paper --in the social dynamics of aging derives from the "socio-emotional selectivity theory" that predicates that age enhances emotional regulation, with enhanced primacy of emotional experiences and improved emotional regulation –maintenance of positive affect and decrease of negative affect-- as the life horizon reduces. Cf. Charles ST, Mather M and Carstensen, LL: Aging and emotional memory: The forgettable nature of negative images in older adults. J Experimental Psychology: General. 132(2):310-324, 2003]

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[i] It is beyond the scope of this paper to discuss the dimensions and attributes of the construct "social network." A minimal listing follows. The structural characteristics of social networks include size, density, distribution, dispersion or accessibility, homogeneity, and prevalent function. The functions of the network include social companionship, emotional support, cognitive guidance, social regulation, material support, and access to new links. And links can be analyzed in terms of attributes such as the predominant function(s), its multidimensionality, reciprocity, intensity or commitment, frequency, and history. For a detailed discussion of these variables, cf. Pilsuk and Hiller Parks, 1986; Sluzki 1997.

[ii] It can be also a useful construct to explore the social ties of a given couple, or another small stable social aggregate. However, that exploration may encompass ties that are not shared, that is, relations that each may have, for instance, at work, or in another independent activity, not to mention relations that may be defined as intimate by one member and more distant by the other.

[iii] This "meaningfulness" –as opposed to simple recognition--is subjective but crucial, and may relate to one of the necessary attributes of relational links, namely, reciprocity. "Celebrities"—well known movie actors or actresses, opera divas, popular figures of any sort—may be recognized, differentiated from the anonymous mass, and even idolized,

by a large number of people. However, that may not entail for them any meaningful personal resource in times of crisis—as dramatically portrayed by the suicides of people of the popularity of a Maria Callas, or a Marilyn Monroe.

[iv] The disciplinary field of Social Networks is as young as the field of Family Therapy. It was practically launched with a pioneering study conducted in an isolated Norwegian fisherman village, where the sociologist J. A. Barnes (1954) was able to unveil the crucial importance of the informal, non-kin, social exchanges in the daily life of its inhabitants.

[v] As already mentioned, the mapping of a given social network—family included-- is built around an informant –it is this or that person's social network —and therefore it is necessarily dependent on the individual's position in his or her life cycle.

[vi] Combrinck-Graham (1985) has proposed a particularly attractive paradigm of the family life cycle, depicted as a multigenerational spiral in which several generations can be simultaneously portrayed in their interlocking relation while each generation can be seen as lodged in its own evolution.

[vii] Morgan's (1988) study shows that the drop in income—which is consistent in the older end of the life cycle—has a significant impact on network size, number of roles, and number of social contacts. However, the reduced capacity to substitute for losses in social relations is characteristic of old age, regardless of income: income allows continued contact with long-standing members of the network rather than facilitating new additions.

[viii] Arling's (1976) survey of elderly widows showed that friendship-neighboring is associated with less loneliness and worry, and with a feeling of 'usefulness" and individual respect in the community, when compared to contact with offspring.

[ix] A thorough discussion of the process of migration /relocation from a social networks perspective can be found in Pilisuk and Minkler (1980) and in Sluzki (1979,1992,1998).

[x] The compensatory assumption—as offspring disconnect, neighbors increase their role--as been disconfirmed. In fact, there is evidence that there is a cumulative, rather than compensatory, effect between assistance from offspring and from neighbors (Sherman, 1975).

[xi] Even further, the combination of high distress and low social support by a confidante results in a fourfold increase of medical utilization (Kouzis and Eaton, 1998).

[xii] Identificatory information has been distorted to preserve confidentiality.

[xiii] For a particularly elegant discussion of therapeutic optimism and, overall of the constructionist view, cf. Hoffman, 1998, and the references cited in her paper.