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ABSTRACT

Some older adults experience difficulty in decentering their own viewpoint on tasks requiring spatial and communicative role-taking. To examine the social perspective-taking skills of older adults and the kinds of strategies older people would suggest to solve social dilemmas, adults were interviewed about their typical interpersonal problems. A positive relationship was found between role-taking and engagement. The greatest amount of disengagement was found among the institutionalized elderly respondents, who also selected lower perspective-taking alternatives. The findings suggest that these individuals may perceive their social interactions as less significant. In addition, the results indicate that reasoning among older adults does not tend to regress, but reflects an adaptation to the constraints of the environment. Future research should focus on the impact of the loss of friends and the role of mobility. (JAC)

SOCIAL-PERSPECTIVE-TAKING AND SOCIAL INTERACTION : IN THE ELDERLY

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SOCIAL PERSPECTIVE-TAKING AND SOCIAL INTERACTION IN THE ELDERLY

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The present study was concerned with the older person's skill at taking the social viewpoint of another. Previous research has demonstrated that some older adults experience difficulty in decentering their own viewpoint on tasks requiring spatial and communicative role-taking (e.g. Rubin, 1974; Rubin, Attewell, Tierney and Tumolo, 1973). The tasks used to measure perspective-taking, however, were for the most part developed for use with children and thus may pose problems of validity in the measurement of adult cognitive skills (Labouvie-Vief and Chandler, 1978). Thus, before an attempt is made to develop theoretical models to account for the performance of older adults, their role-taking abilities should be first assessed on measures which more truly reflect their competencies. The first purpose of this study, then, was to examine the social perspective-taking skills of older adults using a measure thought to be appropriate for this age group. In order to accomplish this, adults were interviewed about typical interpersonal problems they encountered. On the basis of these interviews, hypothetical dilemmas about adult-centered interpersonal problems were developed. In order to categorize subjects' reasoning in response to questions about these social dilemmas, Robert Selman's (1976) five-stage model of perspective-taking was used. Selman describes the development of role-taking as one that progresses from an egocentric embeddedness in one's own

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perspective to a gradual awareness of the impact that another's perspective has on one's own. Since this model was based on the responses of subjects between 3 and 34-years, we recognized that older adults might generate responses which did not correspond with Selman's stages. These latter responses would be examined to determine whether any distinctive categories emerged.

The second purpose of the present study was to examine the kinds of strategies older people would suggest to solve the social dilemmas. Previous researchers, (e.g., Neugarten, 1977) have found a change from active to passive mastery of the environment with increased age. In order to examine this issue in present day older people, we asked our subjects to describe as many ways as they could to solve the dilemmas. Their strategies were then categorized along an active/passive dimension.

This study was also concerned with the relationship between role-taking response and social interaction in the elderly. It has been argued (e.g., Looft, 1972) that the older person becomes more egocentric in thought due to increased social isolation. We measured social interaction by means of a Social Disengagment Scale developed by Norris, (Note 1). This scale assesses both the number of social roles and the committments an individual has to these roles. In addition, respondents were asked to rate their life satisfaction (Morris and Sherwood, 1967) and perceived health. The extent to which the latter two variables influenced the relationship between social engagement and perspective-taking could therefore be examined.

Method

The older adult sample consisted of 35 people: 8 men and 27 women, with an average age of 75.09 and range of 62 to 89 years. Seventeen of the older subjects were drawn from a minimal health care retirement villa and 18 from their homes in a suburb of a large Canadian city. The average age of the community sample was 72.3 years and of the institutionalized sample, 78.2 years. All older subjects were retired and from the middle-class. In addition, a sample of young adults was obtained in order to compare the social perspective-taking responses of older and younger adults on this measure. The young adults were 68 male and female first year university students.

Briefly the three hypothetical dilemmas were as follows: the first, dealt with resolution of a conflict after one friend accused another of theft without sufficient evidence; the second story concerned the reactions of an individual to an intimidating waitress when that individual's friend had received unsatisfactory service; and the third described individuals caught in the dilemma of conformity to group goals when these goals conflicted with their own pleasure.

Older individuals were interviewed privately in their own dwellings. Written responses from the university students were obtained in a group setting. In the first session, all subjects were presented with two randomly chosen dilemmas. Social perspective taking was measured in two ways: first, subjects were asked to respond to open-ended questions concerning their thoughts about conflict resolution, the role of trust in friendship, or group goals. Second, subjects were asked to select one of five alternatives role-taking responses to each of the two dilemmas. Each

of the five alternatives was based on reasoning from one of Selman's five stages.

Subjects were then asked to generate as many solutions to the dilemmas as they could.

Only elderly subjects participated in the second session, in which they were asked to respond to measures of social engagement, life satisfaction, and perceived health.

Results and Discussion

Subjects' open-ended responses were scored by attempting to match their statements with those contained in Selman's (Note 2) scoring manual. Two judges independently scored all the responses and were in agreement 76% of the time. All disagreements were resolved to the mutual satisfaction of the two judges. Twenty-eight percent of the responses were not scoreable and there were no group differences in frequency of scoreable responses. The majority of responses were not scoreable due to lack of elaboration. This occurred with many older subjects in spite of additional probing. The need for more extensive questioning and probing, particularly with older subjects is recommended for future work in this area. There were some unique responses generated by older subjects, but the numbers were small. We are now attempting to replicate these findings.

Considering now those responses that could be scored according to Selman's stages, subjects' stage scores on the open-ended measure are indicated in Table 1. As can be seen, college students obtained a mean stage score of 3.50, older community residents, 2.50, and institutionalized subjects, 2.81. One-way analysis of variance indicated significant differences among the groups.

Follow-up comparisons indicated that the university students' scores were significantly higher than those of both older groups, but the scores of the 2 older groups did not differ significantly for each other. Modal patterns indicated that the majority of university students' responses were classified at Stage 4, and most older subjects responses were classified at Stage 3.

According to Selman (Note 2), the major difference between a stage 3 and 4 response is that, whereas, stage 3 responses objectively recognize that role-taking is a process that mutually affects both members of a dyad, stage 4 responses go beyond an objective third person perspective and use a perspective based on societal expectations. For example, a stage 3 individual might reason that friendship is important because it provides one with confidants and allows for shared intimacy. A stage 4 individual, however, might value the above but in addition would reason that friendship allows one to develop a personal or social identity. Thus, the major difference between the two stages may be viewed as a movement away from the perspectives of each in the dyad to a consideration of how the dyad influences one in all relationships. Selman (Note 2) reports that adults frequently used reasoning from both stages 3 and 4. The significance of these differences as found here between university and older respondents will be elaborated on further after the remaining data are presented.

Next, consider the scores obtained on the multiple-choice part of the measure. These data also appear on Table 1. University students' scores were significantly higher than institutionalized respondents, but for this measure university students' scores were not significantly different from those of the older community adults. The two older adult groups did not differ significantly

from each other. As can be seen, the modal response was the same for the university students on both open-ended and multiple-choice measures, but community aged adults selected stage 4 responses most frequently on the multiple-choice measure. Institutionalized subjects, on the other hand, showed a bimodal pattern, selecting both stage 2 and 3 responses most frequently.

In order to interpret the institutionalized subjects preference for the lower level responses, a closer consideration of stage 2 reasoning appears in order here. According to Selman, (Note 2) the stage 2 individual is not egocentric and can take the role of another but a meeting of perspectives is only seen necessary around specific, concrete incidents or issues and not as an underlying system upon which relationships are structured. For example, to a stage 2 individual, trust in a relationship means the person can be counted on to perform a specific action which was promised. A stage 3 individual, on the other hand, believes trust allows a sense of predictability or permits intimate sharing.

Insight into why a higher frequency of institutionalized subjects preferred the situation-specific stage 2 alternatives may be gained from examining their reasons for making their choices. The majority of these individuals indicated that they thought fulfilling a promise to visit was more important to friendship than shared intimacy because if a friend did not show up, there was little likelihood that they would ever see them. Their own failing health and lack of mobility made them dependent on the actions of visitors. Similar responses to other dilemmas indicated that their limitations in controlling their environment led them to make situation-specific judgments instead of relying on general principles which they may not have the freedom to carry out. Older community residents and

university students expressed much less frequently their failure to control the environment or the need to make situation-specific judgments.

The analyses of problem-solving strategies suggested in response to the dilemmas will be considered next. Five different categories emerged from the responses and the proportion of subjects using each is indicated in Table 2. Overall and individual group X^2 comparisons were all significant. As can be seen in Table 2, all groups were similar in their relatively frequent suggestion of Interpersonal solutions. Further, it can be noticed that, whereas, community aged and university students frequently suggested Impersonal strategies, these were infrequently suggested by institutionalized respondents. An impersonal strategy is an active one in which the problem is solved without personal action, e.g., "tie the item around your neck so no one can get at it". The remaining 3 passive strategies were suggested more frequently by the older adults. Two exceptions are worthy of note: first, institutionalized adults rarely suggested avoiding the problem, but more frequently suggested that someone else be called in to solve the problem. This diverse pattern of responses appears to be best described, not as developmental, but rather as adaptive responses to the environment. For example, living in a home for the aged, in close proximity to others, is most likely to encourage interpersonal problem solution or reliance on staff to solve disputes, but this environment also makes avoidance more difficult than living in the community. Thus the expected change from active to passive mastery was not supported by these findings and contrary to Neugarten's findings, a developmental trend is not indicated.

The next question that will be dealt with is the relationship between social perspective-taking and social interaction. The older subjects' scores on the measures of engagement, life satisfaction and perceived health are presented in Table 3. Institutionalized respondents were significantly more disengaged than the community residents, but were not significantly more disatisfied with their lives nor did they perceive themselves in poorer health. Social perspective-taking scores were positively related to social engagement scores for all elderly subjects combined. This relationship remained significant when the effects of age and place of residence were partialled out. For institutionalized subjects, the longer they had been institutionalized, the lower their role-taking scores. Perspective-taking was not significantly related to life satisfaction or perceived health. Social disengagement, however, was related to lower life satisfaction.

The finding of a positive relationship between role-taking and engagement supports previous findings in the literature (e.g., Rubin, Note 3). A consideration of the nature of this relationship indicates, however, that the argument that decreased role-taking ability is due to social isolation, may not be complete. The greatest amount of disengagement was found in the institutionalized sample who also selected lower perspective-taking alternatives. This group, however, cannot be described as lacking in social contacts. These individuals, though, may have perceived their social interaction in the home to be less significant as their contacts there are generally not self-chosen. Further, recall that this group, more than the other two groups, expressed a sense of inability to control the actions of others in their reasons for choosing stage 2 alternatives. Perhaps, then, individuals who find

themselves in conditions where they lack significant control over their relations with others, begin to develop more concrete social-perspective taking judgments. The findings of Ellen Langer and her colleagues (e.g., Langer, Rodin, Beck, Winman and Spitzer, 1979) on the effects of perceived social control on cognitive functions in institutionalized aged is supportive of this interpretation.

In conclusion, a dialectical perspective has been provided to account for the lower perspective-taking responses of older adults - that is, their reasoning has not regressed but is reflecting adaptation to the constraints of their environment. One area of future research that is suggested by the present findings is the study of the role of mobility and loss of life-long friends and their effects on social-perspective taking in older populations. Methodologically, future research on social perspective-taking should take into account the failure of many older subjects to elaborate on what seem like common-sense issues.

Two additional considerations are also worth noting based on our experiences with older subjects. First, there was a strong reluctance on their part to participate in "university" research. The thought that they were being tested was very intimidating. The use of the dilemmas may have caused this. Presently, we are pursuing our study of friendship patterns with semi-structured interviews about their own thoughts and feelings and we have not experienced the same reluctance to participate on their part. Second, the use of multiple-choice techniques presented many difficulties particularly with subjects who were partially blind or deaf. The alternatives had to be placed in front of them and read repetively. Care was taken that they had considered all alternatives. But unless special care is taken problems of sensory

and memory deficits may affect the reliability of their responses.

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Table 1. Social perspective-taking scores by subject group.

		Open-ended	Multiple
University students:			
	$\bar{X}$ (S.d.)	3.50 (.74)	3.46 (.83)
	mode (%)	4 (64%)	4 (97%)
	N	65	68
Community aged:			
	$\bar{X}$ (S.d.)	2.50 (1.3)	3.08 (.94)
	mode (%)	3 (48%)	4 (50%)
	N	16	18
Institutionalized aged:			
	$\bar{X}$ (S.d.)	2.81 (.69)	2.59 (.83)
	mode (%)	3 (57%)	2 (29%) 3 (32%)
	N	13	17

Table 2. Proportion of strategies suggested by category and subject group.

	University	Community	Institution
Active:			
Interpersonal	.41	.30	.39
Impersonal	.36	.34	.14
Passive:			
Accept	.08	.20	.27
Avoid	.09	.14	.06
Intervene thru others	.06	.02	.14

Table 3. Means and standard deviations of disengagement, life satisfaction, and perceived health scores for elderly subjects.

Measure:		Community	Institution
Disengagement*			
	$\bar{X}$	111.17	94.94
	Sd	19.70	18.74
Life Satisfaction†			
	$\bar{X}$	12.32	11.35
	Sd	4.5	4.47
Perceived Health×			
	$\bar{X}$	2.11	2.53
	Sd	.81	.94

* Range = 46-192; high score = more engagement

† Range = 0-17; high score = more satisfaction

× Range = 1-4; high score = poorer health.