

Health-Related Social Control Within Older Adults' Relationships

Joan S. Tucker

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This study examined the size and composition of older adults' social control networks and investigated behavioral and affective responses to the experience of social control. Social control in the health domain refers to regulatory attempts by others (direct), and feelings of obligation and responsibility to others (indirect), that encourage engagement in a healthy lifestyle. Participants were 181 adults aged 65–80 years who completed a mail survey. On average, older adults reported having 3–5 people in their social network who exerted a positive influence on their health behaviors, with the size and composition of this network varying somewhat by marital and parental statuses. Social control was associated with both positive and negative behavioral and affective responses, depending on both the type of social control (direct vs indirect) and level of relationship satisfaction. Results indicate the importance of better understanding the conditions under which social relationships have beneficial versus detrimental effects on the well-being of older adults.

IT is well established that the physical benefits of a healthy lifestyle are not limited to younger individuals; engagement in healthy behaviors is also associated with lower morbidity and mortality risk for older adults (Amir, 1987; Davis et al., 1994; Kaplan & Haan, 1989). Some older adults attempt to engage in a healthy lifestyle with the intention of avoiding or delaying the onset of illness and disability. Most older adults, however, have at least one chronic illness such as arthritis, hypertension, or heart disease that may require significant and long-term lifestyle changes (Collins, 1997). The importance of engaging in a healthy lifestyle, combined with the potential difficulty of modifying long-standing health habits, makes it particularly critical to identify and understand factors that can facilitate healthy behavior change among older adults.

Research on the determinants of a healthy lifestyle has come from several different perspectives (e.g., Taylor, Repetti, & Seeman, 1997; Tucker et al., 1995). Much of this research has examined social relationships as potentially important influences on lifestyle, largely focusing on the existence of social ties or social support and often finding weak or inconsistent associations with engagement in health behaviors (S. Cohen, 1988; House, Umberson, & Landis, 1988; Potts, Hurwicz, Goldstein, & Berkanovic, 1992; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). However, relationships serve functions other than support and companionship that may be relevant to health behavior. Social control is one such function that has received little empirical attention but promises to play a key role in understanding how social relationships affect engagement in health behaviors.

Social control theory proposes that relationships serve a regulatory function such that socially integrated individuals are less likely than those who are socially isolated to engage in risky or deviant behavior (Anson, 1989; Durkheim, 1897/1951; Ewart, 1991). Applied to health behaviors, individuals who are socially integrated should be more likely to engage in healthy behaviors and avoid unhealthy behaviors, ulti-

mately resulting in better health and greater longevity. The social control of health behavior may operate in two basic ways (Rook, Thuras, & Lewis, 1990; Umberson, 1987, 1992). *Direct social control* involves requests, reminders, threats, or rewards from significant others that prompt individuals to engage in healthy behavior. *Indirect social control* involves feelings of obligation or responsibility to others that encourage engagement in a healthier lifestyle. Of course, social network members may also encourage engagement in unhealthy behavior, as the literature on peer influences on substance use clearly indicates (Hawkins, Catalano, & Miller, 1992). However, the dominant focus of social control theory and research has been on the health-promoting effects of social regulation, which is also the focus of this study.

The few studies examining social control in the context of health behavior have focused primarily on direct social control, providing encouraging (although not entirely consistent) evidence for its relevance to health-related behavior. Umberson (1992) conducted the only published study using a nationally representative sample, asking respondents, "How often does anyone tell or remind you to do anything to protect your health?" Results indicated that direct social control was prospectively associated with engagement in certain health-related behaviors (e.g., cigarette smoking), but not others (e.g., alcohol consumption). Studies of married couples have indicated that intentional social control attempts (such as reminding) by one spouse are associated with greater medication adherence (Doherty, Schrott, Metcalf, & Iasiello-Vailas, 1983) and abstinence from smoking (S. Cohen & Lichtenstein, 1990). The use of positive social control strategies (e.g., positive reinforcement) is also associated with a partner's greater general tendency to engage in healthy behavior, although the use of negative strategies (e.g., criticizing) may backfire (Tucker & Anders, 2001). A study of older adults did not find the expected associations between social control and engagement in health behaviors (Rook et al., 1990), perhaps due to the relatively low prevalence of poor

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health and unhealthy practices in the sample. A subsequent study by these researchers (Lewis & Rook, 1999) asked participants to report on a specific situation in which someone tried to influence them to change a health-related behavior, finding that participants who received more social control reported a greater tendency to make positive behavioral changes in response to these regulatory attempts.

Although experiencing social control may have positive behavioral effects by encouraging individuals to engage in a healthier lifestyle, there has been some suggestion in the literature that it may come at a price in terms of eliciting psychological distress (Hughes & Gove, 1981; Rook & Pietromonaco, 1987). This dual-effects hypothesis suggests, for example, that targets of social control attempts may experience feelings such as irritation and resentment, even as they attempt to comply with others' wishes for them to modify their health habits. The potential for social control to elicit psychological distress may be particularly high for older adults who are already experiencing declines in their sense of control (Mirowsky, 1995); attempts by others to regulate their health behaviors may be perceived as overly intrusive and a threat to their autonomy.

Recent research has suggested that the dual-effects hypothesis may be too simplistic a description of the range of responses to social control. A recent study of married couples, for example, found that direct social control from a spouse was associated with both positive and negative emotional and behavioral reactions by the partner, depending on the type of social control strategy that was used and the frequency of social control attempts (Tucker & Anders, 2001). Other work has suggested that reactions to social control attempts may depend on the extent to which these attempts are perceived by the target as being motivated by interest, caring, or concern for them (Holmila, 1991; Tucker & Mueller, 2000). Indeed, research on compliance has indicated that people are more likely to comply with requests from individuals for whom they hold positive feelings (Cialdini, 1994)—and the most commonly used strategy for attempting to influence others' health behaviors involves making direct requests for behavior change (Tucker & Mueller, 2000). Together, this work highlights the importance of better understanding the conditions under which social control has behavioral and psychological benefits, as well as the conditions under which it is likely to backfire. The present study focuses on older adults' satisfaction with their relationships as a potentially important moderator of whether their experiences of social control tend to elicit positive or negative responses.

Certain relationships may be more relevant than others in terms of the social control of health behaviors. For example, Rook and Ituarte (1999) found that social control was more likely to be provided to older adults by family members than by friends. Two additional studies collected more detailed information on social control networks but did not specifically focus on older adults (Lewis & Rook, 1999; Umberson, 1992). Although both of these studies found that spouses were identified most often as social control agents, they differed in terms of the extent to which other types of relatives versus nonrelatives were identified as providing social control. A more detailed understanding is needed of the size and composition of older adults' social networks, including how

these networks might differ for those who are married versus unmarried, as well as those who have children versus no children. If there is compensation within older adults' social networks for the loss or absence of these close familial ties, this may result in important subgroup differences in social control network characteristics.

The first goal of this study was to describe the size and composition of older adults' social control networks as a function of their marital and parental statuses. Previous research has indicated that unmarried individuals tend to have smaller social networks, less frequent contact with network members, and a lower proportion of kin in their networks compared with married individuals (Ajrouch, Antonucci, & Janevic, 2001), decreasing the pool of potential social control agents. Unmarried individuals also lack the one person (a spouse) most likely to serve as a social control agent. For these reasons, I expected that unmarried participants in this study would report smaller social control networks compared with married participants. On the basis of previous research suggesting that social control is more likely to be provided to older adults by family members than by friends (Rook & Ituarte, 1999), I also expected that among older adults who were married and/or had children, immediate family members would be identified as social control agents more often than other relatives, friends, and doctors. Further, I expected that older adults who were both unmarried and childless would be more likely than those who had immediate family ties to identify other relatives, friends, and doctors as social control agents.

The second goal was to investigate older adults' behavioral and psychological responses to others' attempts to influence their health behaviors. Four behavioral responses to social control attempts were examined: trying to engage in the desired behavior, ignoring the social control attempt, doing the opposite of what the social control agent wants, and hiding the unhealthy behavior from the social control agent. The two psychological responses to social control were positive and negative affect. Because of their stronger feelings of obligation and responsibility to others to be healthy, older adults who experienced more indirect social control were expected to have more positive (and less negative) behavioral and affective responses to others' attempts to influence their health behaviors. Any interactions of indirect social control with relationship satisfaction were expected to show even stronger effects for those with high relationship satisfaction. In contrast, older adults who experienced more direct social control from others were expected to have more positive (and less negative) behavioral and psychological responses to others' attempts to influence their health behaviors only if they were satisfied with their relationships. For those who were dissatisfied with their relationships, experiencing greater direct social control was expected to backfire, resulting in more negative (and less positive) behavioral and psychological responses to others' influence attempts.

METHODS

Participants

The sampling frame for this study consisted of 65–80-year-old residents of four wards in Boston, Massachusetts.

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Names, addresses, sex, and age of prospective participants were obtained through the most recent yearly census list compiled by the City of Boston of all household residents aged 18 or older. To allow for the possibility of examining sex and age differences in certain analyses for this project, I attempted to recruit approximately equal numbers of men and women, as well as individuals aged 65–69, 70–74, and 75–80 years. Within these sex and age groups, 1,200 residents were randomly selected from the census lists and sent an introductory letter inviting them to participate in the study, with a postcard on which they could indicate whether they were interested in participating. Eighty-one of these letters were returned because the addressee had moved or was deceased (these cases are not included in the response rate). Three hundred three individuals returned the postcard, with 234 of them expressing an interest in participating. These individuals were sent the questionnaire and a consent form, along with a postage-paid return envelope. Up to two reminders were mailed to those who did not initially return the questionnaire. Questionnaires were received from 183 individuals, who were paid \$25 for their participation. The final response rate of 16% was lower than the rate typically reported for similar mail surveys (Dillman, 2000). However, it should also be noted that a questionnaire was sent only to those individuals who took the initiative in returning the postcard indicating that they were interested in the study. The response rate would likely have been higher had all prospective participants received the questionnaire and follow-up reminders. It is also possible that response rates for mail surveys such as this one may be lower for older adults to the extent that they are more likely to have cognitive and/or physical impairments that would prohibit completion of a lengthy mail survey. It is a limitation of this study that little information is available on the reasons for nonresponse.

Two individuals were eliminated from the analyses due to excessive missing data, resulting in a final sample size of 181. The sample was 54% male and 90% White (see Table 1 for other demographic information). Self-reports of current engagement in health-related behavior indicated that 10% of participants smoked, 7% drank excessively (three or more drinks at least three times per week, or five or more drinks at least once per week), 39% never exercised, 41% were overweight (body mass index greater than 27), and 23% did not get a yearly physical exam.

Measures

Descriptive statistics for the following measures are provided in Tables 1 and 2.

Control variables.—The following demographic control variables were included in all analyses: sex (0 female, 1 male), highest education completed (1 less than high school, 13 4 or more years of graduate school), and marital status (0 married, 1 single).

Social control.—To obtain information on characteristics of the participants' social control networks, they identified up to 10 individuals (by initials and relationship) who they perceived to influence their health behaviors by encouraging them to engage in healthy behavior or discouraging

Table 1. Sociodemographic Characteristics of Sample

Sociodemographic Characteristic	%
Age	
65–69 years	32
70–74 years	33
75–80 years	35
Education	
Not high school graduate	15
High school graduate	37
Attended college	47
Employment	
Retired	85
Unemployed/homemaker	6
Full time	5
Part time	4
Marital status	
Married	54
Widowed	26
Never married	11
Divorced	7
Separated	2
Household status	
Lives alone	31
Lives with one person	45
Lives with more than one person	24
Has children	84
Parents currently living with children	32
Family income: range	\$2,300–\$200,000, Mdn \$26,500

them from engaging in unhealthy behavior. This information was used to determine the size of participants' social control networks (total number of individuals mentioned), as well as to determine whether participants identified any of the following as a social control agent: spouse, child, relative other than spouse or child, friend, and doctor.

Participants also rated their overall experience of direct and indirect social control on five- and four-item scales, respectively, that were developed for this study and are shown in the Appendix (scale anchors ranged from: 1 never to 4 often; .80 for each scale). Evidence for the convergent and discriminant validity of the Direct Social Control scale comes from an examination of its association with other measures collected as part of the larger study. The Direct Social Control Scale correlated more strongly with the single-item measure of direct social control previously used by Rook and colleagues (1990; $r = .60, p = .001$) than with any of the five subscales of the Social Support Behaviors Scale (Vaux, Riedel, & Stewart, 1987; r s ranged from .27 to .30, $p = .001$).

Behavioral responses to social control.—Participants were asked to rate how often they responded in the following ways to others doing or saying things to try to get them to engage in healthy behavior or to avoid unhealthy behavior: (a) attempt to engage in the desired behavior, (b) ignore the person or do nothing, (c) do the opposite of what the person wants them to do, or (d) hide the unhealthy behavior from the person (ranging from 1 never to 4 often). These items have been used in previous research on married couples, finding that spouses' ratings on these items correlated

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