Age and Decline in Role-Specific Feelings of Control

Neal Krause

School of Public Health and Institute of Gerontology, University of Michigan, Ann Arbor.

Objectives. The purpose of this study was to see if feelings of control over highly valued social roles decline across late life. I also made an effort to see if two types of social support explained age-related decline in control.

Methods. Harris Interactive of New York conducted interviews with a nationwide longitudinal sample of older adults. Survey questions assessed feelings of control over the most highly valued role, anticipated support (i.e., the belief that support will be forthcoming if needed), and enacted support.

Results. The data suggested that feelings of control over the most highly valued role tend to decline across late life. The results also revealed that anticipated support is associated with a stronger sense of control over time, but I observed this relationship only through age 75. Beyond that point, anticipated support was less helpful. In contrast, enacted support did not appear to help older people maintain a strong sense of role-specific control at any age.

Discussion. Current research has largely been concerned with age-related change in feelings of control over life as a whole. The findings from this study suggest that it may also be helpful to consider control over the most highly valued role while studying this process.

A number of researchers have observed that the construct of control is one of the most important variables in social psychological research (Krause, 2003a). In fact, some investigators argue that strong feelings of personal control are a key marker of successful aging (Rowe & Kahn, 1998). Although researchers have measured the construct of control in a number of different ways, most scales share a common conceptual core. Embedded in these measures is the notion that individuals with a strong sense of control believe the external social world is responsive to their efforts to change it, whereas people with a weak sense of control believe they are unable to influence the things that happen to them. The construct of control is important because a vast literature suggests that strong feelings of personal control are associated with better physical health, better mental health, and the adoption of beneficial health behaviors (Krause, 2003a).

Because there are clear benefits associated with having a strong sense of control, it is not surprising to find that researchers have studied how feelings of control change as people grow older. Unfortunately, the findings from this work are not encouraging. More specifically, a small cluster of high-quality studies suggest that feelings of personal control tend to decline with advancing age (Mirowsky, 1995, 1997; Ross & Mirowsky, 2002; Wolinsky & Stump, 1996; Wolinsky, Wybrick, Babu, Kroenke, & Tierney, 2003). In fact, as the work of Mirowsky (1995, 1997) revealed, the relationship between age and feelings of control may be nonlinear: As people grow older, feelings of control tend to decline at an accelerating rate.

Because feelings of control appear to decline across the life course, researchers have made an effort to identify the factors that are responsible for this trend. Two are especially important. First, Mirowsky (1995) reported that functional disability is associated with a decline in feelings of personal control across the life course. When contrasted with the findings on the impact of control on health that were cited in the preceding paragraph, this suggests that there may be a reciprocal relationship between feelings of personal control and physical health status. Second, a later study by Mirowsky (1997) indicated that subjective life expectancy may be an important factor, as well. The findings from this study revealed that individuals who believe they will live longer (i.e., people with a longer subjective life expectancy) maintain a stronger sense of personal control as they grow older.

The purpose of the current study was to contribute to the literature on the age-related decline in personal control in two potentially important ways. First, researchers have devised two broad ways to assess feelings of personal control. The first measurement strategy takes a global approach that focuses on feelings of personal control over life as a whole. Scientists have used global measures in the majority of the studies on age-related decline in feelings of personal control (e.g., Mirowsky, 1995; Wolinsky et al., 2003). However, other researchers have argued that it is possible to assess feelings of personal control at the domain or role-specific level (Lachman & Weaver, 1998; McAvay, Seeman, & Rodin, 1996). This work is important because it suggests that feelings of control in some domains tend to decline with age while a sense of control over other areas in life either remains stable, or even becomes stronger, as people grow older. For example, Lachman and Weaver reported that feelings of control over the parental role decline with age, but feelings of control in the financial realm are stronger for older than for younger people. Although the study by Lachman and Weaver made a valuable contribution to the literature, their sample did not contain anyone older than 75 years of age. As the findings provided here will reveal, important insights may be lost if samples exclude participants older than age 75. McAvay and colleagues also examined feelings of control in specific areas of life. The findings from their longitudinal study indicated that over time, older people feel they can exercise less control over their living arrangement options, their level of productivity, and their finances. In contrast, McAvay and associates observed only minimal decline in
feelings of control over issues involving transportation. However, the study organizers had not selected the sample used in that study at random. Instead, these investigators pooled responses of older people who were on waiting lists for senior citizen housing units with the responses of older adults who were on the tax rolls in cities in south central Connecticut.

The first goal of the present study was to see if feelings of control over specific roles in life tend to decline with age. In the process, I made an effort to address limitations in prior work by using data from a nationwide longitudinal survey of older people.

The second goal of the current study was to contribute to the literature by delving more deeply into the potentially important role that social support may play in maintaining feelings of personal control in late life. Researchers have argued for some time that support provided by significant others helps bolster and maintain strong feelings of personal control (Caplan, 1981). However, Wolinsky and colleagues (2003) were not able to find that social support offsets age-related decline in feelings of personal control in late life. Even so, a careful examination of their measure reveals that these investigators focused solely on one dimension of social support—enacted support (i.e., support that family members and friends have actually provided). As research reviewed by Krause (2003b) reveals, social support is a vast multidimensional domain that can be assessed in a number of different ways. As a result, exploring the influence of other types of support may be more illuminating. The analyses provided here contribute to the literature by comparing and contrasting the influence of two key dimensions of social support—enacted support and anticipated support (i.e., the belief that support would be forthcoming should the need arise).

The theoretical framework for this study rests on two core issues. First, I make an effort to explain why it is important to focus specifically on feelings of control in the most highly valued role. Second, I extend the theoretical underpinnings of this study by probing the potentially important role that social support plays in this process.

**Exploring Role-Specific Feelings of Personal Control**

The analyses presented here focus on one specific type of control—control over the role that is valued most highly by older study participants. The study emphasizes specific roles instead of broader domains of life (e.g., the ability to get transportation or preferred housing) because it is almost axiomatic in social psychology that social life is organized into social roles (Stryker, 1987). To the extent this is true, the experiences that one encounters within these roles may shape the amount of control an older person believes that he or she can exert. Although this observation is helpful, it does not go far enough, because it is not clear why control in the most highly valued role is especially important. There are two reasons for focusing on this particular construct. First, there is some evidence that feelings of control over the most highly valued role have an especially important impact on health and well-being in late life. More specifically, research reveals that control over the most highly valued role is a more important predictor of mortality than global feelings of personal control (Krause & Shaw, 2000). Second, feelings of personal control are, at their base, beliefs about one’s ability to alter the external world. But in order for beliefs about personal control to impact the lives of older people, individuals must carry them over into action and behavior. A number of factors undoubtedly influence attempts to exercise control. The objective circumstances surrounding the role are obviously important. But other causal factors may be involved, as well. As Rotter (1966) observed a long time ago, people with a strong sense of control are more highly motivated than people with a weak sense of control to change their worlds, and they are more persistent in their efforts to do so. The distinction between control beliefs and the motivation to exercise control is important because, as Rodin and Langer (1980) have argued, factors such as age-related stereotypes and over-attributions to aging often result “... in a lack of motivation to engage in a variety of behaviors, rather than the inability to do so” (p. 24). So if researchers may assess control in different roles, an important issue involves specifying when the motivation to exercise control is likely to be the strongest. Identity theory provides a valuable way to address this issue (Thoits, 1991).

Social roles and identities assume a pivotal position in identity theory. According to this perspective, a social role is defined structurally as a position within a group (e.g., father, husband, or provider), whereas identities are self-evaluations that emerge from occupying one of these roles. In essence, identities refer to the kinds of information people use when thinking about themselves (e.g., “I am a father”) and when presenting themselves to others. But identity theory specifies that some roles are more important than others. Even casual observation suggests that people occupy multiple roles. Consequently, there is a separate identity associated with each of these social positions. A basic tenet of identity theory specifies that people attach more importance to some role-specific identities than others. As a result, individual identities are arrayed in a hierarchy reflecting varying levels of commitment to, and investment in, the roles underlying these identities (Thoits, 1991).

As Hobfoll (1998) pointed out, events and ongoing experiences that impinge on identity-related values are likely to be very emotionally significant. Cast within the context of the current study, this suggests that if emotionally significant events arise in roles that lie at the core of an older person’s identity, then he or she will be especially motivated to control them. These insights have broader implications for the study of age-related decline in feelings of personal control. If people value some roles more highly than others, and if individuals try harder to maintain control in these highly valued roles, then perhaps feelings of control over highly valued roles may not decline as people grow older. Lachman and Weaver (1998), as well as McAvay and associates (1996), found that control in some roles does not decline with age, but they did not determine how highly study participants valued these domains. As a result, no researchers have addressed the issue of whether control over the most highly valued role declines with age. This represents one way in which the current study may contribute to scientists’ understanding of the relationship between age and feelings of personal control in late life.

**Bringing Social Support into the Picture**

As discussed earlier, Wolinsky and colleagues (2003) were unable to find that support provided by social network members...
is related to feelings of control among older people. There may be a straightforward explanation for these results. If significant others take direct action to help an older person with a problem, then it is not clear why having someone else take charge of a situation should make the older individual feel that he or she is personally in control. A central premise in the current study is that social support may still be involved in the process of bolstering control, but it is necessary to turn to another aspect of the social support process (i.e., anticipated support) to see how this may happen.

As defined earlier, anticipated support is the belief that significant others stand ready to help should the need arise in the future. This is important because Wethington and Kessler (1986) argued that the realization that others are willing to help if need be constitutes a social safety net that promotes risk taking. According to this view, people will be more willing to try new solutions and approaches to resolving problems and implementing plans because they know that if these new solutions are not successful, they can count on significant others to help them reach their goals. Being able to work out problems without the direct intervention of others is important, because the skills that older people gain through these self-initiated actions are likely to enhance their sense that they are personally in control of their lives.

Two important conclusions follow from these observations. First, if older people value some roles highly and they are especially motivated to exercise control in them, then they should be more likely to rely on those facets of the social support process that help them reach these goals (i.e., anticipated support). Second, if anticipated support functions in this manner, then it may slow age-related decline in feelings of personal control that are associated with the most highly valued role.

METHODS

Sample

The data for this study came from an ongoing longitudinal study by Krause (1994). When collecting the baseline data, I defined the study population as all household residents who were noninstitutionalized, spoke English, were 65 years of age or older, and were retired. In addition, I excluded residents of Alaska and Hawaii from the study population.

The sampling frame consisted of all eligible persons contained in the beneficiary list maintained by the Centers for Medicare and Medicaid Services. I collected three waves of data between 1992 and 1999. Harris Interactive (New York) conducted all interviews. Harris Interactive successfully completed a total of 1,103 interviews at baseline in 1992–1993. The response rate was 69.1%. Following this, Harris Interactive reinterviewed 605 of the Wave 1 study participants in 1996–1997. Then, a third wave of interviews took place in 1998–1999. At Wave 3, Harris Interactive successfully reinterviewed a total of 530 older people who had participated in the earlier rounds of interviews.

In 2002–2003, a fourth wave of interviews took place. However, the sampling strategy was complex. Harris Interactive interviewed two groups of respondents at Wave 4. The first consisted of older people who had participated in Waves 1–3. Harris Interactive successfully reinterviewed a total of 269 of these individuals at Wave 4. We supplemented this group with a sample of new study participants who had not been involved in the study previously. I also selected this sample from the Centers for Medicare and Medicaid Services files. However, in this case, I selected the sample so that when I combined it with those who had participated in the study before, there would be an approximately equal number of people in the following age groups: 65–74 (n = 491), 75–84 (n = 515), and 85 and older (n = 509). So altogether the Wave 4 sample consisted of 1,518 older adults. The overall response rate for the Wave 4 survey was 54% (see Rodgers & Herzog, 1992, for a discussion of problems with response rates when interviewing the oldest old population).

Harris Interactive completed a fifth wave of interviews in 2005. A total of 1,166 of the Wave 4 study participants were successfully reinterviewed, 102 refused to participate, 45 were too ill to take part in the survey, 76 could not be located, and 108 were deceased. Not counting those who had moved to a nursing home or who had died, the reinterview rate for the Wave 5 survey was 83.9%.

The data used in the analyses presented below came from the Wave 4 and Wave 5 surveys. I selected these data points because they provided the greatest number of people in the oldest old age category (i.e., those 85 years of age and older). After using listwise deletion of cases with item nonresponse, I based the analyses on 1,013 cases. Preliminary analysis revealed that the average age of the respondents was 78.2 years at Wave 4 (SD = 8.1 years), approximately 40% were older men, and 92% were White. The respondents reported that they had completed an average of 12.2 years of schooling (SD = 3.4 years).

Measures

The Appendix contains the measures of the core constructs in this study as well as information on the procedures used to code these indicators.

Control in the most highly valued role.—The outcome variable in this study assessed feelings of control over the one role that was most important to older study participants. I administered identical measures of this construct in the Wave 4 and Wave 5 surveys. I devised the measures of control in the most highly valued role especially for this study, using a two-step process to develop the items. First, study participants were presented with a list of eight roles: spouse; parent; grandparent; other relative; friend; homemaker; provider; and voluntary worker, church, or club member. Respondents selected the role that was the most important to them. Once the participant identified his or her most highly valued role, interviewers administered a series of questions to determine how much control the older person felt that he or she could exercise in it. A high score on these items denotes greater feelings of personal control. The internal consistency reliability estimates at Wave 4 (.851) and Wave 5 (.862) were good.

Anticipated support.—I assessed anticipated support with three items that asked study participants if they felt significant others would be willing to provide emotional, tangible, and informational support in the future should the need arise. These indicators, which Liang (1990) devised, came from the Wave 4
survey. A high score stands for more anticipated support. The reliability estimate for this brief composite was .869.

**Enacted support.**—Interviewers also asked study participants how often family members and close friends had actually provided emotional, tangible, and informational assistance during the year prior to the Wave 4 interview. These items came from the research of Krause (1995). A high score represents more enacted support. The internal consistency reliability estimate was .845.

**Age.**—I coded age continuously in years.

**Functional disability.**—Based upon research by Mirowsky (1995), I included three health-related measures in the analyses presented below. The Appendix does not describe these measures. The first health measure was functional disability. I assessed this construct with 15 items taken from the work of Liang (1990). This index includes indicators of instrumental activities of daily living as well as activities of daily living. A high score on this measure, which comes from the Wave 4 survey, denotes greater difficulty with basic and instrumental activities of daily living.

**Depressive symptoms.**—I assessed symptoms of depression with four indicators from the Center for Epidemiologic Studies–Depression scale (Radloff, 1977). The depressive symptom items were administered in the Wave 4 survey. A high score represents more depressive symptoms. The internal consistency reliability estimate was .863.

**Cognitive disability.**—I measured cognitive functioning at the Wave 4 survey with the Short Portable Mental Status Questionnaire (Pfeiffer, 1975). A high score on this scale stands for greater cognitive disability.

**Demographic control measures.**—I evaluated the relationships between control in the most important role, anticipated support, enacted support, and age after controlling statistically the effects of gender, education, and race. I included these demographic measures in the analyses because research reveals that feelings of control tend to be lower among older women (Ross & Mirowsky, 2001), people with less education (Mirowsky & Ross, 2003), and older minority group members (Shaw & Krause, 2001). Education reflects the total number of years of schooling that the respondent had completed successfully. In contrast, I measured gender (1 = man, 0 = woman) and race (1 = White, 0 = otherwise) with binary variables.

**Results**

I present the results from this study in three sections. First, I present the results of a preliminary set of analyses performed to see if the loss of participants over time may have biased study findings. Following this, I present results from the analyses that were performed with the Wave 4 data to evaluate the relationships among age, control in the single most salient role, anticipated support, and enacted support. Finally, I reevaluate the relationships among these constructs with data from both the Wave 4 and Wave 5 interviews.

Probing the Effects of Sample Attrition

Although it was difficult to determine if the loss of participants over time had biased study findings, I could obtain some preliminary insight by seeing if select data from the Wave 4 survey was related significantly to study participation status at Wave 5. Evidence of bias would be present if any statistically significant relationships emerged from this analysis. I used the following procedures to implement this strategy. First, I created a nominal variable consisting of three categories to represent older adults who remained in the study (scored 1), older people who were alive but did not participate in Wave 5 (scored 2), and older adults who had died (scored 3). Then, using multinomial logistic regression, I regressed this categorical measure on the following Wave 4 measures: control in the most highly valued role, anticipated support, enacted support, functional disability, cognitive disability, depressive symptoms, and the demographic control variables. The category representing older people who had remained in the study served as the reference group.

The findings (not shown here) revealed that only one independent variable differentiated those who were alive but who did not participate in the Wave 5 survey from those who remained in the study. More specifically, the findings suggested that older people who were alive but who had dropped out of the study had higher levels of cognitive impairment than older adults who participated in the Wave 5 interview ($b = .251; p < .001$). The data further suggested that, compared to those who remained in the study, respondents who had died were more likely to be older ($b = .062; p < .001$), more likely to be men ($b = .743; p < .01$), and more likely to have greater difficulty with physical functioning ($b = .147; p < .001$). Readers should keep in mind the potentially biasing influence of nonrandom sample attrition as I review the substantive findings from this study.

Cross-Sectional Analyses

Table 1 contains results from the hierarchical ordinary least squares multiple regression analyses that assess the relationships among age, control in the most highly valued role, anticipated support, and enacted support with the Wave 4 data only. I conducted these analyses in four steps. First, I regressed control in the most highly valued role on age. I evaluated the effects of gender, education, race, and the additive effects of enacted support and anticipated support in Step 2. Then, I performed tests for the proposed statistical interaction effects between anticipated support and age, as well as enacted support and age, in Step 3. Finally, I added measures of functional disability, cognitive disability, and depressive symptoms in Step 4. I centered all variables on their means prior to performing these analyses.

The findings from the first step in the hierarchical regression analysis (Model 1) indicated that as people grew older, they were less likely to feel they could control things that happened in the role that was most important to them. This is consistent with other studies that report age-related decline in global feelings of personal control (Mirowsky, 1995). However, other investigators (e.g., Mirowsky, 1995) have reported a nonlinear relationship between age and personal control. I performed additional analyses (not shown here) in order to evaluate this
Table 1. Age and Role-Specific Control, Wave 4
Only (N = 1,013)

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>−.110***</td>
<td>−.091***</td>
<td>−.092**</td>
<td>−.062</td>
</tr>
<tr>
<td>(unstandardized)</td>
<td>(−.038)</td>
<td>(−.032)</td>
<td>(−.032)</td>
<td>(−.022)</td>
</tr>
<tr>
<td>Gender</td>
<td>.114***</td>
<td>.113***</td>
<td>.088***</td>
<td>.051</td>
</tr>
<tr>
<td>(unstandardized)</td>
<td>(.652)</td>
<td>(.650)</td>
<td>(.502)</td>
<td>(.480)</td>
</tr>
<tr>
<td>Education</td>
<td>.041</td>
<td>.041</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>(unstandardized)</td>
<td>(.034)</td>
<td>(.034)</td>
<td>(.001)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>.048</td>
<td>.047</td>
<td>.047</td>
<td></td>
</tr>
<tr>
<td>(unstandardized)</td>
<td>(.487)</td>
<td>(.482)</td>
<td>(.485)</td>
<td></td>
</tr>
<tr>
<td>Anticipated support</td>
<td>.182***</td>
<td>.183***</td>
<td>.150***</td>
<td>.072</td>
</tr>
<tr>
<td>(unstandardized)</td>
<td>(.245)</td>
<td>(.246)</td>
<td>(.203)</td>
<td>(.107)</td>
</tr>
<tr>
<td>Enacted support</td>
<td>−.027</td>
<td>−.026</td>
<td>−.046</td>
<td></td>
</tr>
<tr>
<td>(unstandardized)</td>
<td>(−.011)</td>
<td>(−.011)</td>
<td>(−.019)</td>
<td></td>
</tr>
<tr>
<td>(Age X anticipated support)</td>
<td>—</td>
<td>—</td>
<td>(−.003)</td>
<td>(−.002)</td>
</tr>
<tr>
<td>(Age X enacted support)</td>
<td>—</td>
<td>—</td>
<td>(−.001)</td>
<td>(−.001)</td>
</tr>
<tr>
<td>Functional disability</td>
<td>−.172***</td>
<td>−.136</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>−.051</td>
<td>−.061</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive disability</td>
<td>−.021</td>
<td>−.057</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple $R^2$</td>
<td>.012</td>
<td>.063</td>
<td>.063</td>
<td>.092</td>
</tr>
</tbody>
</table>

Notes: Data are presented as standardized regression coefficient (metric [unstandardized] regression coefficient).

* $p < .01$; ** $p < .001$.

Findings From the Longitudinal Data

I also used a four-step hierarchical regression analysis to evaluate the relationship between age and change in feelings of control over time. Table 2 provides the results from these longitudinal analyses. The findings from the first step (see Model 1) revealed that advancing age was associated with a decline in feelings of control over the role that was valued most highly. Adding the social support and demographic control variables to the model reduced the relationship between age and change in feelings of control by about 23%. Similar to the cross-sectional findings, the results in Model 2 indicated that more anticipated support was associated with greater feelings of role-specific control. However, the data further suggested that enacted support was associated with a slight decline in feelings of control over the most salient role.

In contrast to the results that emerged with the cross-sectional data, the findings provided by Model 3 revealed that there was a statistically significant interaction between age and anticipated support on change in feelings of role-specific control. But a similar interaction effect was not present with respect to enacted support. I took steps to clarify the nature of the interaction between age and anticipated support by performing some calculations with a formula provided by Aiken and West (1991). This formula produced an estimate of the effects of anticipated support on change in control at select age levels. If the hypothesis derived above was valid, then the effects of anticipated support on change in control should have become progressively stronger with advancing age. Although I could have used any ages to derive these estimates, I selected the following ages for this purpose: 65, 75, and 85.

The additional computations (not shown in Table 2) suggested that at age 65, greater anticipated support was associated with greater feelings of control over the role that was valued most highly ($\beta = .217$; $b = .296$). However, contrary to the hypothesis that I had developed for this study, the calculations further revealed that the relationship between
anticipated support and change in control was somewhat lower for people who were 75 years old ($\beta = 0.115$; $b = 0.156$), and it was reduced even further for individuals who were 85 years old ($\beta = 0.012$; $b = 0.016$). Taken together, these additional calculations suggested that age-related decline in control over the most highly valued role could be explained by anticipated support, but only for people younger than age 75 or so. The findings from the final model (Model 4) suggested that it was also important to take the effects of health-related constructs into account when studying the factors that affect decline in feelings of personal control. More specifically, the data indicated that greater functional disability and greater cognitive disability were associated with diminished feelings of control over the most highly valued role. However, it is important to point out that including these health-related measures in the equation had little effect on the interaction between age and anticipated support.

It is important to briefly comment on two additional aspects of the findings in Table 2. First, as the comparison of the $R^2$-square values associated with Models 2 and 3 reveals, the interaction term involving age and anticipated support appeared to explain relatively little additional variance in feelings of control over time. However, as Chaplin (1991) reported in his extensive review of the literature, interaction effects typically explain between 1% and 3% of the variance in study outcomes. Although there are a number of reasons for this finding, research suggests that one may attribute it to the fact that including interaction terms in a model accentuates the effects of measurement error (Bohnmstedt & Marwell, 1978). The second issue arises from the fact that enacted support exerted only a weak effect on change in role-specific control. One possibility is that this was a statistical artifact created by a high correlation between enacted and anticipated support (i.e., multicollinearity was present in the model). I performed an additional set of analyses (not shown here) by examining the effects of enacted support without including anticipated support in the model. The results were virtually the same as those shown in Table 2.

**DISCUSSION**

A number of studies suggest that global feelings of personal control tend to decline with advancing age (Mirowsky, 1995). The findings from the current study contribute to this literature in four potentially important ways. First, the results revealed that feelings of control over the most highly valued role also decline with age. This was somewhat surprising, because the theoretical framework that I had developed for this study suggested that older people may be even more highly motivated to exert control in roles they value the most. But the motivation or desire to maintain control may still matter even if greater decline occurs in feelings of control over roles that are not important to older study participants. Unfortunately, this study did not evaluate feelings of control over roles that are not important. Second, the data for this study were longitudinal, making it possible to show that age is also related to change in role-specific control over time. Wolinsky and colleagues (2003) also used longitudinal data, but the current study used a longer between-round interval (2 years instead of the roughly 1-year interval used by those investigators), thereby providing an opportunity to observe greater change in control. Third, this appears to be the first study to evaluate the influence of more than one dimension of social support. The data revealed that anticipated support, but not enacted support, is related to change in feelings of control in the most important role over time. Fourth, the findings from this study contribute to the literature by highlighting the importance of examining change across the entire course of late life. This was possible because I oversampled individuals between the ages of 75 and 84, as well as those aged 85 and older.

The data from this study revealed that anticipated support helps bolster feelings of role-specific control, but these beneficial effects are only evident until about age 75 or so. Physical health status, depressive symptoms, and cognitive functioning do not fully explain what happens beyond this point because I included the effects of these health-related constructs in analyses. Perhaps, as Heckhausen (1997) pointed out, being personally in control of things may simply become less important to the oldest-old population. The data on enacted support suggest that oldest old individuals do not benefit from assistance provided by significant others, so perhaps they are relying on some other coping resource. Perhaps the oldest old population is turning to religion. However, Wolinsky and associates (2003) were unable to show that general measures of religiousness explained age-related decline in control. Even so, more focused measures of religion may shed some light on this issue. Perhaps people turn control of their lives specifically over to God in advanced old age. This is important because a recent study by Krause (2005) suggests that older people who believe in God is helping them control the things that happen in their lives are more optimistic, have a greater sense of self-worth, and are more satisfied with their lives. It would be important to see if God-mediated control helps offset the decline in feelings of personal control in late life.

Because both global and role-specific feelings of control appear to decline with age, it is important to examine the interface between these measures. A useful way to study this issue is found in Diener’s (1984) distinction between top-down and bottom-up theories of life satisfaction. As with feelings of personal control, researchers may assess life satisfaction globally by asking about satisfaction with life as a whole or by asking about satisfaction with specific domains in life, such as marriage. Diener asked whether global measures of life satisfaction determine the level of satisfaction with specific domains (i.e., top-down), or whether global life satisfaction is some sort of summary or amalgamation of domain-specific feelings of life satisfaction (i.e., bottom-up). When it comes to assessing feelings of personal control, the theoretical rationale that I developed for the current study appears to support the bottom-up view. Further support from this possibility is provided by the findings from the studies by Lachman and Weaver (1998) and McAvay and colleagues (1996). These investigators reported that feelings of control were stronger in some domains of life than in others. If global feelings of control determine control in specific domains (i.e., top-down), then one would expect to find that feelings of control are more similar across multiple domain-specific measures. But instead of arising from a simple summation of feelings of control in specific roles, feelings of global control may arise from a more complex process. More specifically, feelings of control that are associated with the single most highly valued role may play the
greatest part in shaping global feelings of control than do feelings of control associated with less important roles.

More research is also needed to pinpoint how the potentially beneficial effects of anticipated support arise. An intriguing possibility is found in a study by Ross and Mirowsky (2002) that was designed to explore the factors that influence subjective life expectancy. They reported that two dimensions of social support are associated with subjective life expectancy. The first is enacted emotional support, whereas the second has to do with something they called informal health support. This refers to the belief that someone would take care of a respondent if he or she was sick. This is, in effect, a measure of anticipated support. Ross and Mirowsky reported that informal health support exerts a greater effect on subjective life expectancy than does enacted support. Cast within the context of the current study, this suggests that anticipated support may affect feelings of control indirectly by increasing subjective life expectancy.

The findings from this study suggest that some facets of the social support process (i.e., anticipated support), but not others (i.e., enacted support), help explain age-related decline in feelings of control. However, looking at just two dimensions of social support does not go far enough, because social support is a vast conceptual domain. Researchers should see if other dimensions of support, such as satisfaction with support (Krause, 1995), affect age-related decline in control in late life.

Another priority for future studies involves the need to explore the potentially important influence that specific types of stress may play in shaping the decline in feelings of personal control over time. For example, chronic strains over which an older person has little control (e.g., ongoing financial difficulty) may be especially troublesome in this respect.

In the process of examining these issues, researchers would benefit from paying attention to the shortcomings in this study. Because I did not gather the data with a true experimental design, it is not possible to rule out the effects of an excluded third variable. For example, the death of a loved one may result in a loss of both anticipated support and feelings of personal control. In addition, the theoretical framework that I developed for this study specified that older adults were more highly motivated to maintain feelings of control in the role that was most important to them. In order to fully evaluate the importance of role salience, researchers should contrast feelings of personal control over roles that are important with feelings of control over roles that are not important. Unfortunately, measures of control in roles that were not important were not available in this study. Finally, even though the data for this study were longitudinal, researchers would benefit from working with data that have been collected over longer periods of time.

Although there are clearly limitations to this study, perhaps its greatest contribution arises from the fact that it made an effort to bring feelings of personal control in the most highly valued role to the foreground. One can find the roots of this perspective in the classic work of Charles Horton Cooley. Writing more than a century ago, Cooley (1902/2003) argued that

What we are all forced to do is to choose a field of action which for some reason we look upon as especially interesting or important, and exercise our choice in that; in other matters protecting ourselves, for the most part, by some sort of mechanical control . . . Indeed, to know where and how to narrow the activity of the will in order to preserve its tone and vigor for its most essential functions, is a great part of knowing how to live. (pp. 69–70).

By better understanding the factors that shape feelings of control in the most highly valued role, social gerontologists may be able to take an important step toward improving the quality of life for older people.

ACKNOWLEDGMENTS

This research was supported by Grant RO1 AG009221 from the National Institute on Aging.

Address correspondence to Neal Krause, Department of Health Behavior and Health Education, School of Public Health, University of Michigan, 1420 Washington Heights, Ann Arbor, MI 48109-2029. E-mail: nkrause@umich.edu

REFERENCES


APPENDIX

Core Study Measures

1. Control Over the Most Important Role—Wave 4 and Wave 5
   A. Thinking about yourself as a (MOST SALIENT ROLE), select the number that comes closest to how you feel as a (MOST SALIENT ROLE).
      Cannot influence what happens | Can influence what happens
      1 | 2 | 3 | 4 | 5
   B. Please pick the number that comes closest to how you feel when you think of yourself as (MOST SALIENT ROLE).
      Cannot manage problems that arise | Can manage problems that arise
      1 | 2 | 3 | 4 | 5
   C. Which number best reflects how you think about yourself as a (MOST SALIENT ROLE)?
      Cannot make plans work | Can make plans work
      1 | 2 | 3 | 4 | 5

2. Anticipated Support—Wave 4a
   A. If you were sick in bed, how much could you count on the people around you to help out?
   B. If you needed to talk about your problems and private feelings, how much would the people around you be willing to listen?
   C. If you needed to know where to go to get help with a problem you were having, how much would the people around you be willing to help out?

3. Enacted Support—Wave 4b
   A. How often has someone provided you with transportation?
   B. How often has someone pitched in to help you do something that needed to be done, like household chores or yard work?
   C. How often has someone helped you with your shopping?
   D. How often has someone been right there with you (physically) in a stressful situation?
   E. How often has someone comforted you by showing you physical affection?
   F. How often has someone listened to you talk about your private feelings?
   G. How often has someone expressed interest and concern in your well-being?
   H. How often has someone suggested some action you should take to deal with a problem you were having?
   I. How often has someone given you some information that made a difficult situation easier to understand?
   J. How often has someone told you what they did in a stressful situation that was similar to one you were experiencing?

---

*These items were scored in the following manner (coding in parentheses): not at all (1), a little (2), some (3), a great deal (4).

*These items were scored in the following manner: never (1), once in a while (2), fairly often (3), very often (4).