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A key concept driving the field of both clinical and applied gerontology is that of personal control. Seminal work conducted in the late 1970s to early 1980s by Ellen Langer and Judith Rodin, who examined the effect of choice and enhanced responsibility on older adults, not only contributed to the discussion of the relevance of control in contemporary theories and practices of aging but also aided in the development of today’s philosophy of how to serve and care for older adults in ways that are passionate, humanistic, and empowering. In their early research, residents at a nursing home were randomly assigned to 2 groups: 1 group was told they could arrange their furniture as they wanted, go where they wanted, spend time with whom they wanted, and so forth and were given a plant to care for; the other group was told that the staff was there to take care of and help them, including watering a plant given to each of them. During this study, and 18 months later, residents who were given control and personal responsibility had improved health; among those for whom control had not changed, a greater proportion had died. Since these original studies, research has continued to support the need for personal control as we age. This paper presents a brief overview of literature informed by Langer and Rodin’s seminal findings, as well as the role of control to theory, policy, and practice.

Key Words: Advocacy, Independence, Public policy, Health, Theory, Literature, Person-centered care, Successful aging, Attitudes and perception toward aging/aged, Autonomy and self-efficacy

It would not be an understatement to say that the research findings of Ellen Langer and Judith Rodin in the late 1970s and early 1980s, examining the salutary health benefits of enhancing personal choice, responsibility, and control in the lives of older adults, has significantly shaped the field of gerontology. Although not the first to study the importance of these constructs, Langer and Rodin were among early researchers to examine their impact on older adults, whereas previous studies were limited to children and college students (see Lachman, Neupert, & Agrigoroaei, 2011). Their research contributed to a reexamination of
prevailing notions of older adults as homogenously feeble, vulnerable, and unable to contribute to their own or anyone else’s care (Morris, 1989). This mentality that aging was synonymous solely with decline was reflected in the institutionalization of nursing home (NH) settings, which took general approaches to care based solely on medical models of aging as diseased- or deficit-based. Unfortunately, this was at the expense of incorporating psychosocial needs and providing residents with opportunities to make their own choices. Rodin and Langer’s research, however, documented that older adults can indeed engage in continued growth if given opportunities to have personal control over their own outcomes.

Additionally, in contrast to earlier studies that solely examined the negative consequences of lack of control (e.g., Rotter, 1966; Seeman, 1972; Seeman & Evans, 1962), Langer and Rodin’s (1976; Rodin & Langer, 1977), seminal research documented the beneficial impacts of enhancing control through choice. Although Langer and Rodin examined the influence of control in NH residents, today we know that it has significant implications for all older adults and in a variety of settings and contexts. Thus, Langer and Rodin’s findings not only inspired the advancement of others interested in aging to explore the role of control in gerontological-related theories, practices, and policies but also contributed to today’s philosophy of caring for older adults in ways that are empowering, humanistic, and holistic (Langer and Rodin, 1976; Rodin & Langer, 1977).

In their early research, residents at a NH were randomly assigned to one of two groups: one group were given more opportunities for personal responsibility than what was normally given to residents. For example, they were given choices about how they could arrange their furniture, go where they wanted when they wanted, spend time with whom they wanted, and were given the option of accepting a plant to care for. The other group was told that the staff was there to take care of them, including watering a plant given to each of them. Though only marginally significant, results indicated that during this study period and 18 months later, residents in the group that were given increased control had improved health; among those for whom control had not changed as part of the study, a small proportion had died (Langer & Rodin, 1976; Rodin & Langer, 1977; Rodin & Langer, 1978). Such findings brought to the forefront the importance of “bolster[ing] individual predispositions for increased choice and self-control” (Rodin & Langer, 1977, p. 175).

As research on control and aging gained attention, the late 20th century witnessed a gradual redefinition of the aged as a diverse group, many of whom were seeking increased engagement with society. Rodin and Langer’s work contributed to this dynamic paradigm shift in thinking about older adults as necessitating support from others to a group of people capable of utilizing their personal skills and resources. This latter approach is founded on the belief that people have an inherent potential to engage in vital and successful growth across the life span. This subtle yet profound change in thinking aided in the evolution of thought and practice regarding how to best meet the needs of an ever-growing and diverse aging society, one capable of adaptation. Emphasis today is placed on strength-based approaches to promoting biopsychosocial health and well-being among aging adults (e.g., Nelson-Becker, 2013; Ronch, 2003). And thus, instead of assuming that we should only do for older adults, we now make salient the significance of older adults as doing for themselves. Active participation in one’s own well-being hinges in part on the belief that one is capable of having some control over one’s own successful functioning within one’s particular environment. Understanding how best to provide older adults with opportunities to engage in and enhance self-control has become a goal of researchers and practitioners aiming to improve the lives of aging individuals.

Control and Older Adults

Since the initial work on control and aging, a considerable amount of research has been explored, much influenced by Langer and Rodin’s original research. Today, we know that the construct of control is multidimensional in nature, with several nuances and iterations. As summarized by Lachman and colleagues (2011), “In psychology and related fields, control is studied in many different forms with many different labels and subtle variations, including self-efficacy, sense of control, personal mastery, perceived control, locus of control, learned helplessness, and primary and secondary control . . .” (p. 176). However, one important distinction today made in the control literature is between objective control and subjective perceptions of control. Objective control can refer to “the actual ability to regulate or influence intended outcomes through selective responding” (Rodin, 1990, p. 4), whereas
subjective control typically refers to one’s cognitive appraisal regarding the conditions necessary to obtain control (Mossbarger, 2005). This is oftentimes measured by asking respondents’ to report on their perceptions of their ability to control certain outcomes. Although a full discussion regarding the difference between objective and subjective control is beyond the scope of this article, it is important to note that both serve as positive influences in an aging person’s life (for reviews, see Lachman et al., 2011; Mossbarger, 2005).

Thus, irrespective of the definition or form or measurement, Rodin and Langer highlighted that when older adults are empowered with personal control, there are beneficial outcomes. Addressing control in the aging arena allowed other researchers to more closely examine the concept of control among diverse populations and in various settings. For example, today we know that control can be achieved for frail older adults who may be dependent on others. Researchers who studied autonomy have shown that well-being can be enhanced through chances to make voluntary choices, understand options, and have goals supported, even if assistance is required (Lidz, Fisher, & Arnold, 1992). Although traditional notions of autonomy placed emphasis on “choice without interference” (Reinardy, 1999, p. 60), more current research findings indicate that wellness can also be enhanced through opportunities to make choices to rely on others and to ask for and receive assistance, especially if this dependency on others allows for consistency with one’s identity or self-worth (e.g., Agich, 1993; Callopy, Boyle, & Jennings, 1991). These opportunities are thus particularly critical in the case of long-term care facilities where residents are most often dependent. Overall, autonomy and choices for decision making among older persons, irrespective of actual level of independence, remain critical (Agich, 1993).

Overall, research consistently finds that when personal control is lacking, there exist negative effects on wellness, and that when control is enhanced, individuals experience positive outcomes and overall successful aging (e.g., Brandtstädter & Baltes-Götz, 1990; Rowe & Kahn, 1998; Ryff, 1989). Among findings in the literature, it has been shown that control is positively related to exercise and engagement in leisure activities (Lachman & Firth, 2004), which are predictive of better perceived health and greater life satisfaction (Menec & Chipperfield, 1997). This is in sharp contrast to research indicating that older adults who report low self-efficacy have diminished physical function (Mendes de Leon, Seeman, Baker, Richardson, & Tinetti, 1996). Moreover, older adults who are not able to perform activities of daily living report low self-efficacy and depression, and many older adults who accept negative stereotypes of aging as being solely a time of decline have reduced feelings of control, including mastery and efficacy (Hess, 2006; Levy, Zonderman, Slade, & Ferrucci, 2009; Rodin & Langer, 1980; West & Berry, 1994).

Additionally, research shows clear benefits of control among older adults on physical, cognitive, and psychological health and pain management (Coughlin, Bandura, Fleischer, & Guck, 2000) and on the ability to employ effective strategies to improve memory (Lachman & Andreoletti, 2006). Although individual differences in control are relatively stable across time (e.g., Grover & Hertzog, 1991; Lachman & Leff, 1989), they are responsive to situational and environmental influences. It has been found that control can be significantly improved with increased responsibility in one’s environment (Banzinger & Roush, 1983). For example, daily alterations to an older adult’s environment, such as control over timing and duration of residential visits (Schulz & Hansua, 1978) or leisure activities (Searle, Mahon, Iso-Ahola, Sdrolias, & van Dyck, 1995), have been shown to positively affect physical and psychological well-being (Avorn & Langer, 1982; Slivinske & Fitch, 1987), whereas lack of choice and self-determination can lead to poor physical fitness, decreased social support, and depression (Krampe, Hautzinger, Ehrenrich, & Kroner-Herwig, 2003). Also, increasing self-control is related to increased happiness and a positive future outlook (e.g., Flammer, 1995). Thus, given that many inevitable losses and changes do occur with aging, intervention programs to enhance perceived control become especially critical for older adults. Again, despite later variations in control constructs, Langer and Rodin reminded us that being empowered in one’s environment is essential to well-being among older adults.

Implications for Theory, Policy, and Practice

Control plays a significant role in current gerontological conceptual models and theories, policy, and practice. The following review incorporates literature that discusses ideas put forth by Rodin and Langer’s original studies. Due to the scope of this article, we focus our review to examples of
leading research fundamental to the evolution of the gerontological field.

**Models and Theories**

The concept of control has been adopted by several contemporary life-span developmental psychologists and gerontologists. For example, Heckhausen, Wrosch, & Schulz (2010) motivational theory of life-span development is in part based on their earlier life-span theory of control (Heckhausen & Schulz, 1995; Schulz & Heckhausen, 1996). The motivational theory proposes two control strategies: primary (the extent to which an individual realizes control over his or her environment and engages in choices that will ensure or increase the likelihood of having successful outcomes) and secondary (the extent to which an individual’s motivation supports one to engage in primary control to achieve developmental goals). Engaging in primary and secondary control processes is essential to achieving adaptive development (Heckhausen et al., 2010). Brandstätter, Wentura, & Rothermund (1999, p. 375–376) proposed a model that helped to explain the aging-related “paradox” of stability of well-being despite the inherent experience of loss in later adulthood. According to their model, people engage in assimilation (modifying circumstances to fit one’s personal needs) and accommodation (modifying one’s personal needs to fit the current circumstances), two distinct coping processes that, together, allow people to “achieve a match between actual developmental outcomes or prospects and personal goals and ambitions.” The ability to enhance control, by either changing the environment or one’s response to it, is necessary for healthy development, even in the later stages of life, just as Rodin and Langer demonstrated.

The notion of control has also directly informed models of successful aging (Baltes & Baltes, 1990; Rowe & Kahn, 1998; Ryff, 1982, 1989). Ryff (1982) argues for emphasis on “attentiveness to conceptualizations of new dimensions of growth in adulthood and aging” (p. 213) and later presents an integrated model of development and well-being; among its six dimensions are autonomy (extent to which an individual is self-determining/independent) and environmental mastery (extent to which an individual has a sense of mastery/competence in managing the environment, can control external activities, and can choose contexts suitable to one’s needs and values). Interestingly, Baltes and Baltes (1990) note that some dependent behaviors of older adults are beneficial; many older adults may gain or secure increased social contact from friends and loved ones due to dependence on them for assistance, and thus experience decreased loneliness or isolation. In fact, a sense of personal control is critical to maintaining social support systems (Bisconti & Bergeman, 1999). In addition, older adults also proactively develop more meaningful social relationships by choosing to terminate relationships with less significant others (Baltes & Carstensen, 2002). This process, known as socioemotional selectivity theory, also explains the increased motivations among aging adults to experience more positive emotions (Carstensen, Fung, & Charles, 2003).

After reviewing the psychosocial literature on control and aging, Rowe and Kahn (1987) concluded that “the extent to which autonomy and control are encouraged or denied may be a major determinant of whether aging is usual or successful on a number of physiologic and behavioral dimensions” (p. 146). Later, they promoted the notion that successful aging is more than just aging without disease; instead, successful aging is the ability to maintain (a) low risk of disease and disease-related disability, (b) high mental and physical function, and (c) active engagement in life, which refers to “people who demonstrate little or no loss in a constellation of physiological functions” and who therefore “would be regarded as more broadly successful in physiologic terms” (Rowe & Kahn, 1998, p. 38). Baltes and Baltes (1990) refined this conclusion, explaining that a person with chronic illness or disability can also successfully age. They described a process called selective optimization with compensation, whereby all people can make the most of their abilities to live a full and engaged life. Specifically, those who successfully age tend to select activities that are important to them and that allow them to optimize their abilities, and when they can no longer perform the activity, they compensate for their losses by setting new goals or priorities, or even asking for assistance. Related concepts to selective optimization with compensation are the concepts of miniaturization of satisfaction (Rubinstein, Kilbride, & Nagy, 1992), which is the ability to find satisfaction in one’s reduced capacities, and the miniaturization of autonomy (Ball et al., 2005; Perkins, Ball, Whittington, and Hollingsworth, 2012), which is the ability of people to reduce one’s self-expectations and assign greater salience to one’s remaining control and independence. These strategies can help older adults to maintain well-being by making it acceptable to...
ask for help, by developing interdependency, and by continuing to feel empowered. Interestingly, all of these conceptualizations are congruent with Lawton’s (1982) person-environment fit theory, which acknowledges the importance of being able to make choices over the direction of one’s life and in engaging in behaviors that allow for necessary environmental adaptation.

In the realm of stress and coping theory, the concept of control is highly salient. For example, transactional stress theorists emphasize an individual’s personal beliefs about a stressor and its key role in how one actually copes with stress and therefore adapts to changing environments (e.g., Folkman & Lazarus, 1988; Lazarus & Folkman, 1984; Taylor, 1983). Lazarus and Folkman (1984) highlight two types of appraisal, primary and secondary, as key components by which people determine the meaning or significance of stressors, and if they have the necessary resources to meet the demands of such stressors. This cognitive process requires the ability to make choices and exert control about how the stressor is defined and managed. Taylor’s (1983) transactional theory of cognitive adaptation to stressful events also emphasizes meaning, attempts to regain mastery over an event, and efforts to restore self-esteem. Such models build on the concept of control as necessary to change underlying beliefs and thus effectively engage in the coping process. Finally, among the most current research about the significance of control and aging, Lachman and colleagues (2011) present a conceptual model to describe the role of perceived control on aging outcomes including cognitive function, physical function, and overall well-being, as well as common mediators of such outcomes, including stressor mechanisms.

Policy

Although it is unlikely that the work of Langer and Rodin directly influenced the passage of policies that improved the well-being of NH residents, their work contributed to the wider conversation about the importance of control. Certainly, the issue of personal control has found its way into policies that address the needs of older adults. One such example of a far-reaching policy that enhanced control among a vulnerable group of older adults, NH residents, is the Nursing Home Reform Law of 1987. In response to findings that residents of NHs were being abused, neglected, and given inadequate care, the Institute of Medicine (IOM; 1986) proposed reform to ensure that NH residents received personalized quality care that attended to their physical, psychological, and social needs. They found “residents who receive good personalized care and opportunities for choice have higher morale, greater life satisfaction, and better adjustment” (IOM, 1986, p. 67). Prior to the Nursing Home Reform Law, based largely on the IOM report, legislation about resident rights, including control over life and care choices, was overruled by medical needs (Bump, 2010). The Resident Bill of Rights was developed as a result of the passage of the Nursing Home Reform Law, which aims to protect the autonomy of NH residents by providing, for example, control over one’s own money and health care, among other aspects of care. Federal law ensures that NH residents have control over their own participation in activities at the facility, contact with others inside and outside of the facility, and have membership in a residents’ council or a group made up of residents that meet regularly to discuss concerns and suggestions. The Older Americans Act authorized the Long-Term Care Ombudsman Program, which provides trained advocates to support NH residents and their families if residents’ rights have been violated. Another policy designed to improve individuals’ sense of control is the Patient Self-Determination Act of 1991. Although designed to protect patients of all ages, this policy greatly enhanced the participation with which an older adult could participate in one’s own care, especially end-of-life care. This is achieved primarily through the use of advanced directives, or documents (also known as living wills) that allow an individual of any age to indicate in writing preferences for health care should communication become impossible. They give both healthy and ailing individuals control over end-of-life decisions, especially when personal choices are contrary to the cultural, religious, or personal beliefs of other individuals who may be providing care and support during another’s end-of-life experience. Research has linked the use of advance directives with greater patient autonomy (Emanuel, Barry, Stoeckle, Ettelson, & Emanuel, 1991; President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983; Wenger et al., 1994). Unfortunately, despite evidence that the use of advance directives can greatly assist those planning for end-of-life care, this method of decision making is not widely used (U.S. Department of Health & Human Services, 2008).
As noted earlier, the 20th century saw a growing understanding of the significance of older adults living a life of dignity and autonomy. This approach to treating older adults can be seen most significantly in NH care. For example, the NH culture-change movement, formally born in 1997, initiated a transformation of NHs from sterile settings to environments that empowered both residents and staff to enhance resident quality of life in this setting. This included providing opportunities for residents to give their opinion about daily routines and care plans. The Eden Alternative (Thomas, 1994), though conceived earlier than the NH culture-change movement, eventually became part of the movement as it advocated for the inclusion of children, pets, and plants to combat feelings of loneliness and helplessness. Although the NH culture-change movement has struggled to gain support in the NH industry in part due to regulations and limited resources, today it has increased support from consumers. However, this increased support has not yet translated to a transition in NH culture for most facilities. Increased resident control and autonomy have been achieved through the development of assisted living as an alternative to NH care (Polivka & Salmon, 2011). Assisted living provides residential long-term care for individuals who are not able to live independently, but do not need the 24-hr medical care provided by a NH. As a philosophy of care, assisted living aims to promote independence as a component to quality of life (e.g., National Center for Assisted Living, n.d.). The inclusion of personal control for older adults, as discussed by Rodin and Langer, has significantly informed these contemporary long-term care approaches.

In the arena of death and dying, the infusion of the hospice philosophy greatly transformed how we care for the terminally ill. First introduced in the United States in 1963 as an approach to specialized care for the dying, its popularity and merit gained momentum as it became clear that providing control to dying patients was the key to dignity for the patient and family. Kron (1978) discussed the significance of creating facilities that encouraged patients to be part of their own care. Additionally, studies indicate that communication about illness-related matters is critical for the dying patient to adequately prepare for his or her death. The information patients are given about their prognosis affects their treatment choices (e.g., Haidet et al., 1998), and for dying patients specifically, such information can assist in revising wishes resulting in “integrated dying” versus “disintegrating dying” (McCormick & Conley, 1995). As such, allowing a sense of control may aid one’s quality of life even when facing death, and because personal control is oftentimes minimized among dying persons, control-related decision making, such as how and where to die, becomes even more critical. Indeed, research has shown that dying patients report high-quality care as including a sense of personal control (Singer, Martin, & Kelner, 1999). Also, more current research indicates that terminally ill older adults, when given opportunities, will exercise adaptive and compensatory control strategies in their dying process (Schroepfer, Noh, & Kavanaugh, 2009).

Intervention strategies that enhance control among older adults are growing in popularity. For example, the U.S. Administration on Aging, Centers for Disease Control and Prevention, and the Centers for Medicare and Medicaid Services established the Communities Putting Prevention to Work: Chronic Disease Self-Management Program (Administration on Aging, n.d.). These educational programs provide older adults with the action plans and tools necessary to cope with chronic diseases, manage related stress, and communicate more effectively with their health providers. Interestingly, research has shown that such programs can increase older adults’ self-efficacy and decrease health-related distress (Lorig et al., 2001).

Conclusions

Influential research by Rodin and Langer beginning in the 1970s on the benefits of enhancing control among older adults served to demonstrate the unique capacity of people to vitally age if given choice, autonomy, and opportunities to stay engaged. As written by Friedan (1993), “Langer warned: In situations in which people over time gradually and insidiously lose control, they don’t take risks and they retreat into an all too familiar world. When people feel they can exercise some control over their environment, they seek out new information, plan, strategize . . . they behave mindfully” (p. 90). An opportunity to engage in mindful activity indeed opposes the stereotype of aging as mere decline; instead, aging can be full of possibilities, plasticity, and reserve capacity (Baltes & Baltes, 1990); in essence, aging truly can include continued growth as long as personal control remains.

Researchers, policy makers, and practitioners continue to incorporate this invaluable construct
into understanding the aging process. The concept of control plays a significant role in several current directions shaping the field of gerontology. For example, innovations in aging, such as cohousing and intentional neighborhoods, have expanded aging-in-place to community-in-place, whereby residents have voice and environmental control over the design and sustainability of communities in which they live. Additionally, with current trends in aging, such as the "graying of America," increased telecaring, and changing familial structures, coupled with limited economic resources for older adults, there will be continued challenges to providing effective health care, financing, and program delivery to older adults. To address such issues, it is imperative we remember to offer activities that promote health and disease prevention for older adults, as well as strategies for older adults to enhance their quality of life. In today's world, supporting older adults to do for and decide for themselves thus becomes even more critical to successful aging.

References


