Using Social Comparisons to Motivate Health Behavior Over the Lifespan: the Impact of Experience With Health Problems

Jane E.J. Ebert, Brandeis University, USA
Noelle Nelson, The University of Kansas, USA

Public health campaigns often use comparisons with worse-off others to motivate health behavior. We show that such downward comparisons in older adults impact prevention-focus and health behavior (healthy snack choice), moderated by experience of their own and of others’ ill health. The effects in mid-life adults were very different.

[to cite]:

[url]:
http://www.acrwebsite.org/volumes/1018046/volumes/v42/NA-42

[copyright notice]:
This work is copyrighted by The Association for Consumer Research. For permission to copy or use this work in whole or in part, please contact the Copyright Clearance Center at http://www.copyright.com/.
Using Social Comparisons to Motivate Health Behavior Over the Lifespan: The Impact of Experience with Health Problems

Jane Ebert, Brandeis University, USA
Noelle Nelson, University of Kansas, USA

EXTENDED ABSTRACT

The potential benefits for older adults of increased motivation to care for their health are substantial, for example helping them to maintain an independent lifestyle for longer (Shephard 1993). Older adults are a demographic group of increasing size and economic importance globally, with rapid growth in industrialized nations relative to younger demographics. However, it remains an understudied group in marketing (Yoon et al. 2005).

Public health campaigns often use fear appeals to motivate health behaviors in teenagers and adults, and they are increasingly used for older adults. A common approach is to provide comparisons with worse-off others (e.g., a long-time smoker suffering from emphysema) to motivate behavior change. The current research looks at some of the motivational effects of such “downward comparisons,” including effects on older adults’ interest in and motivation by advertising messages (study 1) and health role models (study 2), and the impact on the likelihood that participants will choose a healthy snack following a downward comparison manipulation (study 2). In our studies, we find that motivational effects of downward comparisons on older adults are directionally different from those for midlife adults and, for older adults, the impact of downward comparisons varies substantially with individuals’ experience with ill health (both their own health experience and their experience with the ill health of those close to them). These results caution against assuming that health campaigns will impact older adults in the same ways as for other adults, and they remind us of the substantial heterogeneity of the older adult population.

We have completed two studies. In study 1, we compare 59 older (38 female, mean age = 79.0 years) and 63 midlife (55 female, mean age = 44.6 years) adults on the impact of downward comparisons. All participants wrote about a negative health experience of someone they knew, simply describing the experience (control group) or imagining that it happened to them (downward comparison group). Participants then rated their interest in negatively-framed (prevention-oriented) and positively-framed (promotion-oriented) messages advertising four food items. They also provided information on the recency and amount of experience they had with ill health in others (including illness and death of spouse, close friends and relatives) and rated their own current health. The results differed for midlife versus older adults, F(106) = 4.34, p = .04. For midlife participants, downward comparisons increased their interest in prevention-oriented messages, replicating and extending past research on the motivational impact of downward comparisons, conducted in a different domain with young adults (Lockwood 2002). In contrast, many older participants showed little impact, and the interest in prevention-oriented messages of people with greater experience with others’ ill health even decreased (interaction, F(49) = 3.371, p = .003).

In study 2, we used a similar method, with the following changes. 1) We included only older participants (261, aged 60 to 99 years). 2) We added a second control group, where participants described a vacation experience of someone they knew. 3) We used different dependent variables: participant rated their motivation by six (positive and negative) health role models, and selected three snacks from a choice of six healthy or unhealthy options. 4) We included additional variables (such as affective response and perceived vulnerability) to explore potential explanations for our results.

Similar to study 1, for many participants there was little impact of the downward comparison manipulation relative to controls on prevention-orientation (motivation by negative role models), and any impact was moderated by individuals’ health experience. Older adults who were both relatively healthy and more experienced with ill health in close others were less motivated by negative role models (lower prevention-orientation) after a downward comparison, even when controlling for age (p = .02).

These results were not accounted for by differences between individuals on variables such as perceived vulnerability, similarity to the other, perceived control, and severity (several of which have been found to mediate the impact of downward comparisons in younger adults). The decrease in prevention focus shown by individuals with more experience of others’ ill health (that we saw in study 1, and in study 2 for older adults who are relatively healthy) did not seem to be due to a reduced affective response to downward comparisons for these more experienced individuals. Rather, this result may reflect less informational impact of considering another’s negative health experience in older adults with more experience of others’ ill health.

Finally, individuals’ snack choice was also affected by the downward comparison manipulation. Older adults who were both relatively healthy and more experienced with ill health in close others were more likely to choose healthy snacks following the downward comparison.

The current work contributes to the literature in several important ways. First, the use of experimental methods (such as random assignment to conditions) is relatively unusual in the literature on older adults and preventative health. Research in this literature more commonly relies on longitudinal studies or correlational approaches where it is more difficult to prove cause-and-effect. Second, in much of aging research, age serves as a proxy for other, often unidentified, variables. We identify and measure variables that vary with age and that capture heterogeneity in experience in older adults, and we demonstrate their effects, independent of any other effects of age. Third, we examine the influence of individuals’ experiences with serious health issues in those close to them, a variable that is rarely examined beyond its impact on stress in individuals (as in research on life events). In contrast, in our research, this variable seems to have a buffering or desensitizing effect on individuals’ responses.

REFERENCES

