

6-1-2014

Social integration and pulmonary function in the elderly.

Crista N. Crittenden

Carnegie Mellon University, cccritten@andrew.cmu.edu

Sarah Pressman

University of California - Irvine

Sheldon Cohen

Carnegie Mellon University, scohen@cmu.edu

Denise Janicki-Deverts

Carnegie Mellon University, djanicki@andrew.cmu.edu

Bruce W. Smith

University of New Mexico

See next page for additional authors

Follow this and additional works at: <http://repository.cmu.edu/psychology>



Part of the [Psychology Commons](#)

Published In

Health psychology, 33, 6, 535-543.

This Article is brought to you for free and open access by the Dietrich College of Humanities and Social Sciences at Research Showcase @ CMU. It has been accepted for inclusion in Department of Psychology by an authorized administrator of Research Showcase @ CMU. For more information, please contact research-showcase@andrew.cmu.edu.

Authors

Crista N. Crittenden, Sarah Pressman, Sheldon Cohen, Denise Janicki-Deverts, Bruce W. Smith, and Teresa E. Seeman

RUNNING HEAD: Social Integration and Peak Flow

Social Integration and Pulmonary Function in the Elderly

Crista N. Crittenden^a, Sarah D. Pressman^b, Sheldon Cohen^a, Denise Janicki-Deverts^a,
Bruce W. Smith^c, & Teresa E. Seeman^d

^a Department of Psychology, Carnegie Mellon University, Pittsburgh, PA

^b Department of Psychology and Social Behavior, University of California, Irvine, CA

^c Department of Psychology, University of New Mexico, Albuquerque, NM

^d Division of Geriatrics, David Geffen School of Medicine, University of California, Los Angeles, CA

Conflict of Interest Statement: All authors declare that there are no conflicts of interest.

Correspondence: All correspondence concerning this manuscript should be addressed to Crista

Crittenden, ccritten@andrew.cmu.edu

Acknowledgements: Data collection was supported by funding to the Network on Successful Aging from the John D and Catherine T MacArthur Foundation. Data analysis and article preparation was supported by a grant from the National Center for Complementary and Alternative Medicine (AT00694). We thank Ellen Conser for her comments on an earlier draft.

Abstract

Objective: This study sought to determine whether social integration, defined as number of social roles, is associated with better pulmonary function in the elderly and which roles are associated with greatest benefit. It also examined pathways that connect social integration to better lung health.

Methods: High functioning men (N = 518) and women (N = 629) ages 70-79 were recruited as part of the MacArthur Study of Successful Aging and data were collected on social roles as well as pulmonary function as assessed by peak expiratory flow rate (PEFR). Multiple regressions predicting PEFR from the number of social roles controlled for age, sex, race, education, weight and height. Physiological, behavioral, social and psychological factors were tested as mediators of the association between the number of social roles and PEFR.

Results: More social roles were associated with better PEFR. Analysis of specific roles indicated that marriage was the strongest positive correlate of PEFR. However, greater numbers of roles were also associated with better PEFR independent of marriage. Being a relative or friend were each also individually associated with better PEFR. Even so, greater numbers of social roles were associated with better PEFR independent of relative and friend. The data were consistent with greater happiness, not smoking, and more physical activity acting as pathways linking the number of roles to PEFR.

Conclusions: Number of social roles is an important correlate of healthy lung function in the elderly. This association may be driven by healthier behaviors and greater feelings of well-being.

Keywords: social integration, social roles, lung function, pulmonary function, happiness, catecholamines

Social integration (SI)— the total number of social roles one participates in (Brissette, Cohen, & Seeman, 2000), has been associated with better mental and physical health, including decreased morbidity and mortality (reviewed by Berkman, 1995; Helgeson, Cohen, & Fritz, 1998; Holt-Lunstad, Smith, & Layton, 2010; Seeman, 1996). However, it is still not clear what behavioral and physiological processes explain the link between number of social roles and better health. Also unclear is whether there are specific social roles that matter most and whether the potency of specific roles depends on where one is in the life course.

Here we address these questions by examining the association between SI and pulmonary function—an important marker of general physical health, in a healthy elderly sample. Pulmonary function is an indication of the efficiency of the lungs to inhale and exhale. Poor lung function is an independent risk factor for mortality (Cook et al., 1991; Knuiman et al., 1999) and a wide range of diseases associated with aging such as diabetes (Engstrom et al., 2003), cardiovascular disease (Engstrom et al., 2003; Sin, Wu & Man, 2005), dementia (e.g., Albert et al., 1995; Emery, Finkel, & Pedersen, 2012), and depression (Giltay, Nissinen, Giampaoli, Zitman, and Kromhout, 2010).

Although the association of SI and pulmonary function has not been studied, that the respiratory system has repeatedly been found to be sensitive to social and psychological stimuli (Kotses, Westlund & Creer, 1987; Lehrer, Isenberg & Hochron, 1993; Ritz, Steptoe, DeWilde & Costa, 2000; Ritz & Steptoe, 2000; Ritz, George, & Dahme, 2000) suggests that such a relationship is possible. For example, experimental studies with asthmatic patients have shown changes in lung function in response to laboratory mood induction, facial expression manipulation and exposure to laboratory stressors (see Ritz, George & Dahme 2000 for review).

There are several possible pathways linking SI to health. They include: 1) health practices such as smoking, alcohol consumption, physical activity, and sleep (e.g., Cohen, 1988; Berkman & Breslow, 1983; House, Landis, & Umberson, 1988; Umberson, 1987); 2) biological pathways such as function of the hypothalamic pituitary adrenocortical (HPA) axis and sympathetic nervous system, and immune and inflammatory responses (e.g., Cacioppo, Hawkley, & Bernston, 2003; Cohen, 1988; 2004; House et al., 1988; Uchino, Cacioppo, & Kiecolt-Glaser, 1996; Uchino, 2004) and 3) psychological processes, especially feelings of purpose, control, identity, self-acceptance, affect regulation and coping (e.g., Cohen, 1988; 2004; Thoits, 1986; 1995; Uchino, 2004). Health practices may link to lung function through smoking and physical activity, with smoking leading to faster pulmonary decline and increased physical activity being associated with slower decline in lung function (U. S. Department of Health and Human Services, 1984; Polkonen et al., 2003). Biological factors may operate by way of neuroendocrine reactivity and sympathetic nervous system (SNS) activation. Both have been found to be sensitive to social environments in both animals and humans (Seeman & McEwen, 1996). Moreover, both have been associated with decreased lung function; HPA-axis dysregulation, by means of lower levels of cortisol (Sparrow, O'Connor, Rosner, DeMolles, & Weiss, 1993) and prolonged SNS activation indicated by increased norepinephrine and epinephrine (Wright, Rodriguez, & Cohen, 1998). Decreased levels of cortisol may lead to prolonged airway inflammation due to the lack of instigation of cortisol's downstream anti-inflammatory mechanisms (e.g., reduction of histamine release) and SNS activation may alter lung function through nerve pathways that directly connect the SNS to lung tissue (Barnes, 1986).

Few studies, however, have investigated the relationship between psychological factors and pulmonary function. Prospective data tying higher levels of optimism and better pulmonary

function have been reported (Kubzansky et al., 2002). High hostility has also been associated with poorer pulmonary function in both cross-sectional (Jackson, Kubzansky, Cohen, Jacobs, & Wright, 2007) and prospective (Kubzansky et al., 2006) studies.

Studies examining the presence or absence of specific social roles in the context of health do not typically compare roles to one another. Roles that have been studied in isolation include marriage, frequently tested as a possible health predictor (e.g., Holt-Lunstad, Birmingham, & Jones, 2008; Robles & Kane, 2012), being a parent (Sneed, Cohen, Turner, & Doyle, 2012; Umberson, 1987), being employed (e.g., Repetti, Matthews, & Waldron, 1988) and being a volunteer (e.g., Lum & Lightfoot, 2005; Sneed & Cohen, 2013). An exception is the analysis of participants ranging from 18 to 69 years of age from the Alameda County Study (Berkman & Breslow, 1983; Berkman & Syme, 1979) that found that both an aggregate measure based primarily on number of social roles, as well as all five individual roles they assessed (marriage, friendship, relatives, church or social group members) were individually associated with lower risk for mortality. This work suggests the possibility that these roles make similar contributions to SI, and thus are interchangeable in terms of aggregate scores, when it comes to health benefits.

One issue not addressed in these data from the Alameda County Study was whether there was a difference in the importance of specific roles for elderly adults in contrast to other age groups. The social networks of the elderly are known to shrink in size, with declines being limited to relatively peripheral ties (Carstensen, 1992) and the remaining network including people who offer the greatest emotional rewards (Carstensen, 1998). In fact, in another analysis of the Alameda County Study (Seeman, Kaplan, Knudsen, Cohen, & Guralnik, 1987), it was found that among participants aged 60 and older, close friends and/or relatives played a larger role in predicting 17-year mortality than they did in those younger than 60. These data provide

initial evidence for the hypothesis that more intimate ties (e.g., marriage, close friends and family members) are more important constituents of SI's potential influence on the health of older adults than more peripheral roles.

This study seeks to determine the importance of SI—the number of social roles one endorses, for pulmonary function, in a healthy elderly population. In addition, analyses are conducted to determine the importance of each social role within SI, in order to ascertain the interchangeability of roles with regards to their influence on pulmonary function. Possible behavioral, biological, social and psychological mediators between SI and lung function will also be explored.

Methods

Participants

Data were from the MacArthur Research Network on Successful Aging Community Study, a three-site longitudinal study of 603 men and 749 women aged 70-79 years. The sample was limited to high functioning participants based on 6 health criteria: 1) no reported disability as measured by the Activities of Daily Living Scale (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963), 2) no more than one reported limitation on a measure of range of motion and mobility disability (Nagi, 1976; Rosow & Breslau, 1966), 3) ability to hold semi-tandem balance for at least 10 seconds, 4) ability to stand from a chair at least five times in 20 seconds, 5) a score of 6 or more on the Short Portable Mental Status Questionnaire (Pfeiffer, 1975), and 6) remembering 3 or more items from a 6-item short story (Pfeiffer, 1975). Participants were excluded from the present analyses if missing data on the outcome measure, SI, or any of the standard control variables (see below). The remaining sample included 1147 with a mean age of 74.3 (SD = 2.7).

Fifty-five percent were women, 48% were married, 19% were non-White and 19% were employed. The median income was \$12,500 and the median years of education was 11.

Procedure

Baseline data collection was completed between 1988 and 1989. It included a 90-minute face-to-face interview covering detailed assessments of social and psychological characteristics, physical and cognitive performance, and health status. Lung function was assessed during the interview. A urine sample was also collected on the night after the interview for hormone assessments.

Measures

Peak Expiratory Flow. The interview included three measurements of peak expiratory flow rate (PEFR) with a mini-Wright peak flow meter (Armstrong Industries, North Brook, IL). The participant was asked to blow as hard and fast as possible into the instrument while in a standing position. The score used for the analyses was the mean (L/min) of the three measurements.

Social Integration. The measure of SI consisted of the number of social roles (types of social relationships) in which participants reported active participation. The social roles that were assessed included: spouse, parent, other relative, friend, church member, club member, volunteer, and employee. The participant was considered a parent, other relative, or friend if they reported seeing a child, other relative, or friend, respectively, at least once a month. They were considered a church or club member if they reported attending the church or club at least once a month. They were considered a spouse or employee if they reported being currently married or employed and a volunteer if they volunteered for an organization during the previous year.

Control Variables. Information was collected on a range of variables that might account for both more roles and better pulmonary function. These included age, race (white versus non-white), sex, education (in years), weight and height. Height and weight were used, as opposed to body mass index, because they are more commonly included in linear models to explain variance in PEFr (Mishra et al., 2013).

Potential Mediators. The potential mediators of effects of SI on PEFr include a range of health behavior, physiological, social and psychological variables. Health behaviors assessed included smoking, alcohol consumption, and physical activity. Smoking status was determined using a dichotomous variable where 0 = nonsmoker or former smoker and 1 = current smoker. Alcohol use was assessed by self-reported ounces per month of beer, wine and hard liquor. Physical activity was measured using the Yale Physical Activity Survey (YPAS; Dipietro, Caspersen, Ostfeld, & Nadel, 1993) which asked about frequency and intensity of work- and leisure-related activity. Physical activity scores were derived by multiplying frequency by intensity and summing over all activities. The measure yields a score between 0 and 4, with 0 indicating inactive and 4 indicating engagement in both moderate and strenuous activity.

The physiological variables assessed included cortisol, epinephrine (EPI), and norepinephrine (NE) assayed in a 12 hour urine sample collected the night after the interview. Pilot data had indicated that 12 and 24 hour urine collections were highly correlated (for EPI $r=.95$, NE $r=.80$, cortisol $r=.81$, all $ps<.001$) providing justification for the 12 hour (8pm to 8am) sampling frame. These data were adjusted for creatinine concentration, to account for daily variability in urine volume. Samples were sent to Nichols Laboratories (San Juan Capistrano, CA) and determinations were made by high performance liquid chromatography, with interassay variation for cortisol being 1% in low range and 8% in high. Interassay variation for

catecholamines was 8-9% regardless of range. Systolic and diastolic resting blood pressure was based on the average of the second and third of three seated readings.

Measures of potential social mediators included assessments of social support (frequency of receipt of emotional and instrumental support), and negative social interactions (frequency of interactions involving conflict or excessive demands among social ties) (Seeman, Bruce, & McAvay, 1996). The psychological measures included assessments of depression, somatization, anxiety, mastery, self-efficacy, life satisfaction and happiness. Depression, somatization and anxiety were measured using the Hopkins Symptoms Checklist (Derogatis, Lipman, & Rickels, 1973), mastery using the Pearlin Scale (Pearlin & Schooler, 1978), and self-efficacy via a scale developed by Rodin and McAvay (1992). Life satisfaction and happiness were measured with brief questionnaires (Campbell, Converse, & Rodgers, 1976; Karasek & Thorell, 1990).

Statistical Approach. Phi correlations were used to assess the associations between individual social roles. Linear regression models were used to assess the associations between SI and lung function. Lung function was regressed on number of social roles controlling for age, sex, education, race, weight and height. A set of separate mediational analyses were then performed where in each regression we added a single hypothesized mediator and assessed the extent of reduction in variability accounted for by SI. We performed Sobel Tests (Sobel, 1982) to determine whether the reduction in variability was statistically significant. Finally, all of the potential mediators were entered into a single equation to evaluate their total effect on the magnitude of the association between SI and pulmonary function. Two-tailed tests of significance were used. The same procedures were used to examine associations of individual social roles with pulmonary function. Here each role was dichotomized using dummy codes (1 = participant endorsed role, 0 = participant did not endorse role).

Results

The normal range for PEFr is between 60 and 800 L/min and varies with height and weight. The mean PEFr in this sample was 426.94 L/min (SD=116.78) for men and 298.73 (SD=86.62) for women. This is comparable to a similar study of healthy men (55 years and over) and women (65 years and over) where the mean PEFr was 480 (SD=100) L/min for men and 320 (SD=85) L/min for women (Nunn & Gregg, 1989).

The mean number of social roles was 4.36 (SD = 1.48) out of 8. The percentage of people endorsing each social role is shown in Figure 1. Age, sex, education, race, weight and height were controlled in all regression analyses because they were correlated with PEFr ($r_s = -.12, -.53, .17, -.10, .32, .22$, respectively with all $p_s < .001$).

Correlations between Roles

Phi correlations among the 8 social roles are presented in Table 1. As apparent from the table, marriage was positively correlated with being a parent and with being employed, but was negatively related with belonging to clubs and having friends. Being a relative was only associated with being a church member. On the other hand, roles positively correlating with being a friend included club membership, church membership, and volunteering, indicating that friendship had greater overlap with a cluster of less intimate roles.

Social Roles and Lung Function

First, total number of social roles was entered along with controls. Greater numbers of social roles were associated with better PEFr ($\beta = .11, p < .001$; without controls $\beta = .17, p < .001$; see Figure 2). Next, to determine which specific social roles predicted PEFr, we fit separate regressions for each of the 8 roles. The results of these analyses are reported in Table 2.

As apparent from the table, being married, being a relative and being a friend were each associated with better lung function. No other roles were related to PEFr.

Marriage has been shown to be a potent predictor of better health (including the largest regression coefficient here), and might itself, as a component of SI, account for an association between the total social roles index and PEFr. Consequently, we created a second social role composite measure *without* the marriage variable. Entered in a regression separately, a greater number of social roles (not including marriage) was associated with better PEFr ($\beta = .083, p = .001$). When marriage and the composite of the other social roles were entered together, both were significant independent predictors of better PEFr ($\beta = .110, p < .001$ and $\beta = .079, p < .001$, respectively). Greater numbers of social roles were also associated with better PEFr when the roles of relative and friend were excluded from the total social roles score ($\beta = .090, p < .001$) as well as when all three (marriage, relative and friend) were excluded ($\beta = .055, p = .025$).

Independence of social roles. We were interested in which roles were independent predictors of PEFr. Because marriage was such a strong predictor of PEFr, we began by testing the association of the other roles that predicted PEFr individually controlling for marriage along with the standard covariates. We ran separate regressions entering friend, or relative or the aggregate of the remaining roles (employee, parent, club member, church member and volunteer). The relative role still predicted PEFr ($\beta = .057, p = .019$) as did the friend role ($\beta = .074, p = .002$), and the composite of the remaining social roles ($\beta = .048, p = .049$). We then fit a single model including marriage, friend, relative and the total of remaining social roles. When entered together, marriage was the strongest predictor of PEFr *independent of the other roles* ($\beta = .115, p < .001, \Delta R^2 = .011$), followed by the friend role ($\beta = .062, p = .013, \Delta R^2 = .003$).

Relative ($\beta = .047, p = .052, \Delta R^2 = .002$) approached significance, while the composite of all other social roles was not significant ($\beta = .033, p = .191, \Delta R^2 = .001$).

Mediators of Social Integration and Pulmonary Function

Exploratory mediation analyses were conducted to determine whether any of the assessed psychological, social, physiological, or health behaviors might mediate the effect of the number of social roles on PEFR. In order to be considered a possible mediator, a variable had to be related to both SI and PEFR, and had to also substantially reduce the association of the social variable with PEFR (MacKinnon, Fairchild, & Fritz, 2007). Sample sizes in these analyses vary some due to missing data (see below).

A number of the potential mediators were associated with both greater number of social roles and better lung function ($p < .05$). Behavioral/physiological variables meeting both criteria included lower EPI, not being a smoker, and greater overall physical activity, while psychological variables included higher levels of mastery, efficacy, life satisfaction, and happiness. Alcohol intake, cortisol, measures of blood pressure and measures of social support did not meet these criteria. Of those variables associated with both SI and lung function, significant mediators based on Sobel tests are presented here. Happiness emerged as the strongest psychological variable ($\Delta\beta = -13\%$, Sobel's $t = 3.17, p < .001, n = 1139$). In terms of behavioral/physiological variables, level of physical activity and smoking both reduced the relationship between SI and PEFR (physical activity, $\Delta\beta = -27\%$, Sobel's $t = 3.65, p < .001, n = 937$; smoking, $\Delta\beta = -19\%$, Sobel's $t = 3.55, p < .001, n = 1096$). When including all of the above discussed significant mediators in a single regression equation, the relationship between SI and PEFR was reduced 44% ($n = 892$). Table 3 displays mean happiness and physical activity scores

and smoking status distribution separately for those who did and did not endorse engaging in each of the 8 social roles.

Discussion

This study is the first to explore the connections between SI and lung function. Results indicate that greater numbers of social roles are associated with higher levels of lung function (Figure 2), and that plausible pathways connecting the variables include physical activity, not smoking, and greater happiness.

Social Roles and Lung Function

When examining individual roles, we found that marriage was the strongest predictor of lung function. This is consistent with research showing that married people have lower levels of morbidity and mortality (Kiecolt-Glaser & Newton, 2001). Marriage confers many benefits, including increased levels of socioeconomic status via dual incomes, which can lead to increased access to health care and decreased medical costs. Spouses may also be constant monitors of their partner's behavior and provide encouragement in health and well-being goals (Tucker & Anders, 2001; Umberson, 1992). Finally, the presence of an intimate and close relationship that is consistently available may provide stability that leads to better well-being and to social support in the face of adversity (Cohen & Wills, 1985).

We then asked whether the association of number of social roles with PEFR was attributable to the individual role of marriage. Although marriage is associated with employment and parenthood, it is also associated with not belonging to clubs or being a friend. When marriage is removed from the calculation of number of social roles, number of roles still predicts lung function, and does so independently of marriage. Overall, these data indicate that marriage does not account for the association of SI and lung function, but merely contributes to it.

We also addressed what other roles contributed to the relation between SI and lung function. There were individual associations of marriage, friends and relatives, with increased lung functioning indicating benefits of having these roles. This is consistent with the findings discussed earlier by Seeman et al. (1987) demonstrating that close relatives and/or friends had a greater impact on 17-year mortality in those 60 and older than their younger counterparts. Although the remaining roles (employee, parent, club member, church member and volunteer) were not individually associated with lung function, the number of these 5 roles combined was associated with lung function, indicating that they also contribute to the association of SI and PEF. The relatively small rates of employees and volunteers may account for their not individually predicting, although parenthood and club and church membership rates were high enough to expect relationships. Possibly, these roles are less salient for this age group and more than one is required to reach a threshold of influence. Alternatively, these roles may represent less intimate relationships. In the case of parenthood, such an interpretation would need to assume that children are not close to their parents at this age. It may also be the case that parents do not have as much exposure to their adult children as they do to friends and relatives. For example, parents reported that the mean number of children they saw once a month was 2.19 (SD =1.48), whereas those reporting friends saw an average of 5.83 (SD=7.87) friends in a month and exposure to other relatives was reported as a mean of 3.62 (SD=4.29) per month. This lack of statistical significance of social interactions with children for health in this population of American elderly has also been found in a study of the role of negative interactions in hypertension in the Health Retirement Study (Sneed & Cohen, manuscript under review). It is also important to note that the assessment of parent role (reporting having “seen” the child in the past month) may not have tapped important phone, text, email or social media interactions that

can occur between parent and child. This may be of particular importance in this elderly population as their adult children may no longer be living in close proximity, making physical contact difficult or impossible.

Which are the key social roles for this population? As suggested earlier, marriage accounts for the greatest percent of variance, and friends and relatives each are also individually related to PEFR. When these three roles are entered together into the equation, all three (although at $p=.052$ for relatives) remained independently predictive. This suggests that one can account for much of the association with just these three intimate roles. However, this does not preclude the possibility that any of these roles could be replaced by correlated roles whose effects are wiped out in the regression with all roles included. In sum, this suggests that among this population of healthy 70-79 year olds, marriage, as well as other intimate relationships, are important social roles for health, while other roles, such as church member, volunteer, parent, etc. also contribute as interchangeable parts of one's SI. In other words, what matters most is the diversity of roles with which the person identifies, irrespective of which specific roles are involved.

The importance of marriage, relatives, and friends may be particular to this healthy older age group, as previous studies with younger populations have found other specific roles, such as parent (Sneed et al., 2012), employee (Repetti et al., 1988) and volunteer (Lum & Lightfoot, 2005), to be important for health outcomes as well. That intimate relationships are important in this elderly sample may be a consideration when developing SI and social role related health interventions for older healthy adults.

Social Isolation or Social Integration?

There have been two explanations for the association between SI and better health (Cohen, 2004). One is that the association is attributable to those with the lowest SI (socially isolated) being at increased risk for morbidity and mortality (e.g., House et al., 1988), presumably due to the stress associated with isolation. The other is that there is a graded relation with each increase in number of social roles associated with an increase in health and this continues beyond the social isolation threshold (Cohen, 2004), with benefits presumably being attributable to positive effects of greater SI on cognition, affect and physiology, and improved health practices. Figure 2 indicates that our data are consistent with the operation of both mechanisms, with the greatest difference in PEFR between the most isolated and those with a few social roles, but a positive association with PEFR apparent along the entire SI continuum.

What Mediates the Association between Social Integration and Lung Function?

Of the psychological variables, happiness was particularly important, accounting for 14% of the association between SI and lung function. This is consistent with research showing relations between positive affect and health (Pressman & Cohen, 2005; Steptoe, Wardle, & Marmot, 2005; Davidson, Mostofsky, & Whang, 2010). Happiness could improve lung function through several pathways that are not explored in this study, including improved sleep quality, better diet, exercise and nutrition, all which have been shown to be related to both positive affect (Pressman & Cohen, 2005) and lung function (Cooper & Phillips, 1982; Grievink, Smit, Ocke, van t'Veer, & Kromhout, 1998; Bentley et al., 2012). In addition, those with increased happiness may spend more time relaxing and more time outdoors (Smith & Baum, 2003), away from potential indoor environmental determinants of poor lung function (e.g. Moran, Strachan, Johnston, & Anderson, 1999).

That being said, behavioral measures were the strongest potential mediators of the social integration-PEFR connection, explaining 19% (smoking) and 27% (physical activity) of the variability. For physical activity, the root of this connection and the direction of causality are unclear. It may be that more social roles result in greater physical activity because social activities involve more physical activity, or because of the social pressure placed on individuals by their network members to engage in a healthy lifestyle (Lewis & Rook, 1999). Of course, there is always the possibility that physically active individuals have access to more social roles (Holt-Lunstad et al., 2010).

The fact that we found no mediational role for social support was not surprising. SI and support are generally only moderately correlated at best (Cohen & Wills, 1985). Moreover, while social support is thought to operate primarily by providing protection in the face of stress, SI is thought to influence health through a range of mechanisms, e.g., social control, more positive and less negative emotions, greater feelings of personal control, greater self-regard, that directly (whether or not someone is experiencing stress) promote health (Berkman, Glass, Brissette, & Seeman, 2000; Cohen & Wills, 1985; Cohen, 2004). This difference may be exacerbated here because the participants in this study were quite physically and cognitively healthy and hence not experiencing any serious health events, nor likely to have experienced other major events that generally would put them at high risk for health deficits.

Conclusions

This is the first study examining the association of SI and its constituent roles with pulmonary functioning. While this work explores a relatively unstudied question, these data are from a single time point and the analyses are cross-sectional, making the direction of causality uncertain. It is of course possible that poor pulmonary function resulted in an inability to create

or maintain social relationships. However, based on the strict eligibility criteria, we believe that few, if any, of the participants had deficits in pulmonary function that would influence their ability to participate in social interactions. For example, endorsing any difficulties in breathing or history of pulmonary problems, difficulty going up and down stairs, difficulty with walking, inability to stand from a chair at least 5 times in 20 seconds or any reported disability on the Activities of Daily Living Scale would have excluded participation in the study. Although we controlled for multiple third variables, such as age, sex, race, education, weight and height, there is also the possibility that an unaccounted for factor might cause both changes in social networks and pulmonary function. Lastly, this data is almost 25 years old. While the methods of measuring lung function, social integration and other variables have not changed significantly within these years, there still may be cohort effects that make this data less generalizable to today's population of 70-79 year olds.

This study included an extremely healthy sample of the elderly population which may account for the broader range of social roles than reported by others studying this age group and in turn for the effectiveness of these roles in promoting health. That is, the loss of roles with aging may be attributable to a great extent to declines in health and functionality one finds in unselected samples of the elderly.

The data reported here make several contributions to the existing literature. First, they demonstrate an association between SI and an important marker of health in the elderly, such that lung function should now be considered as a potential pathway that may link SI to rates of morbidity and mortality. Second, while marital status is associated with better lung function, marriage is not a necessary component of SI in order to benefit health in older adults. Third, there are a set of social roles that are interchangeable in terms of their contributions to SI, with

many roles serving similar functions in relation to lung health. These roles do not, however, include being a parent which is not associated with lung function in our elderly sample. Fourth, we have explored possible pathways by which SI can influence health identifying the specific health behaviors of smoking and physical activity, along with the psychological parameter of happiness. The identification of these pathways may inform targeted interventions. Lastly, this study provides evidence consistent with the hypothesis that the association between SI and health is attributable to both the negative influences of social isolation on health, as well as to the positive effects of increasing numbers of social roles.

References

- Albert, M. S., Jones, K., Savage, C. R., Berkman, L., Seeman, T., Blazer, D., & Rowe, J. W. (1995). Predictors of cognitive change in older persons: MacArthur studies of successful aging. *Psychology and Aging, 10*, 578–589. doi: 10.1037/0882-7974.10.4.578.
- Barnes, P. J. (1986). Neural control of human airways in health and disease. *The American Review of Respiratory Disease, 134*, 1289. PMID: 3538958
- Bentley, A. R., Kritchevsky, S. B., Harris, T. B., Holvoet, P., Jensen, R. L., Newman, A. B., ... & Cassano, P. A. (2012). Dietary antioxidants and forced expiratory volume in 1 s decline: The Health, Aging and Body Composition study. *European Respiratory Journal, 39*, 979-984. PMID: 22005919
- Berkman, L. F. (1995). The role of social relations in health promotion. *Psychosomatic Medicine, 57*, 245-254. PMID: 7652125
- Berkman, L. F., & Breslow, L. (1983). *Health and ways of living: The Alameda County Study*. New York: Oxford University Press.
- Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine, 51*, 843-857. PMID: 10972429
- Berkman, L. F., & Syme, S. L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents. *American Journal of Epidemiology, 109*, 186-204. PMID: 425958
- Brissette, I., Cohen, S., & Seeman, T. E. (2000). Measuring social integration and social networks. In S. Cohen, L. G. Underwood, & B. Gottlieb (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 53-85). London: Oxford University Press.

Cacioppo, J. T., Hawkley, L. C., & Bernston, G. G. (2003). The anatomy of loneliness. *Current Directions in Psychological Science*, *12*, 71-74. doi: d 10.1111/1467-8721.01232

Campbell, A., Converse, P. E., & Rodgers, W. L. (1976). *The quality of American life: Perceptions, evaluations, and satisfactions*. New York: Russell Sage Foundation.

Carstensen, L. L. (1992). Social and emotional patterns in adulthood: Support for socioemotional selectivity theory. *Psychology and Aging*, *7*, 331-338. PMID: 1388852

Carstensen, L. L. (1998). A life-span approach to social motivation. In J. Heckhausen & C. Sweck (Eds.), *Motivation and self-regulation across the life span* (pp. 341-364). New York: Cambridge University Press.

Cohen, S. (1988). Psychosocial models of the role of social support in the etiology of physical disease. *Health Psychology*, *7*, 269-297. PMID: 3289916

Cohen, S. (2004). Social relationships and health. *American Psychologist*, *59*, 676-684. PMID: 15554821

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, *98*, 310-357. PMID: 3901065

Cook, N. R., Evans, D. A., Scherr, P. A., Speizer, F. E., Taylor, J. O., & Hennekens, C. H. (1991). Peak expiratory flow rate and 5-year mortality in an elderly population. *American Journal of Epidemiology*, *133*, 784-794. PMID: 2021145

Cooper, K. R., & Phillips, B. A. (1982). Effect of short-term sleep loss on breathing. *Journal of Applied Physiology*, *53*, 855-858. PMID: 6818200

Davidson, K.W., Mostofsky, E., & Whang, W. (2010). Don't worry, be happy: Positive affect and reduced 10-year incident coronary heart disease: The Canadian Nova Scotia Health Survey. *European Heart Journal*, *31*, 1065-1070. PMID: PMC2862179

- Derogatis, L. R., Lipman, R. S., & Rickels, K. (1973). The Hopkins Symptom Checklist (HSCL): A measure of primary symptom dimensions in psychological measurement. In Pichot, P. (Ed.), *Modern Problems in Pharmacopsychiatry* (p. 974). Basel, Karger.
- Dipietro, L., Caspersen, C. J., Ostfeld, A. M., & Nadel, E. R. (1993). A survey for assessing physical activity among older adults. *Medicine and Science in Sports and Exercise*, 25, 628-642. PMID: 8492692
- Emery, C. F., Finkel, D., & Pedersen, N. L. (2012). Pulmonary function as a cause of cognitive aging. *Psychological Science*, 23, 1024-1032. doi: 10.1177/0956797612439422
- Engström, G., Hedblad, B., Nilsson, P., Wollmer, P., Berglund, G., & Janzon, L. (2003). Lung function, insulin resistance and incidence of cardiovascular disease: A longitudinal cohort study. *Journal of Internal Medicine*, 253, 574-581. PMID: 12702035
- Giltay, E. J., Nissinen, A., Giampaoli, S., Zitman, F. G., & Kromhout, D. (2010). Low respiratory function increases the risk of depressive symptoms in later life in men. *Psychosomatic Medicine*, 72, 53-60. PMID: 19933509
- Grievink, L., Smit, H. A., Ocké, M. C., van't Veer, P., & Kromhout, D. (1998). Dietary intake of antioxidant (pro)-vitamins, respiratory symptoms and pulmonary function: The MORGEN study. *Thorax*, 53, 166-171. PMID: 9659349
- Helgeson, V. S., Cohen, S., & Fritz, H. L. (1998). Social ties and the onset and progression of cancer. In J. C. Holland & W. Breitbart (Eds.), *Textbook of psycho-oncology* (pp. 99-109). New York: Oxford University Press.
- Holt-Lunstad, J., Birmingham, W., & Jones, B. Q. (2008). Is there something unique about marriage? The relative impact of marital status, relationship quality, and network social

- support on ambulatory blood pressure and mental health. *Annals of Behavioral Medicine*, 35, 239-244. doi: 10.1007/s12160-008-9018-y
- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 7, e1000316. doi: 10.1371/journal.pmed.1000316
- House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science*, 241, 540-545. PMID: 3399889
- Jackson, B., Kubzansky, L. D., Cohen, S., Jacobs, D. R., Jr., & Wright, R. J. (2007). Does harboring hostility hurt? Associations between hostility and pulmonary function in the Coronary Artery Risk Development in (Young) Adults (CARDIA) study. *Health Psychology*, 26, 333-340. doi: 10.1037/0278-6133.26.3.333
- Karasek, R. A., & Thorell, T. (1990). *Healthy work: Stress, health, and the reconstruction of working life*. New York. Basic Books.
- Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. A., & Jaffe, M. W. (1963). Studies of illness in the aged. The index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association*, 185, 914-919. PMID: 14044222
- Kiecolt-Glaser, J. K., & Newton, T. L. (2001). Marriage and health: His and hers. *Psychological Bulletin*, 127, 472-503. PMID: 11439708
- Knuiman, M. W., James, A. L., Divitini, M. L., Ryan, G., Bartholomew, H. C., & Musk, A. W. (1999). Lung function, respiratory symptoms, and mortality: Results from the Busselton Health Study. *Annals of Epidemiology*, 9, 297-306. PMID: 10976856

Kotses, H., Westlund, R., & Creer, T.L. (1987). Performing mental arithmetic increases total respiratory resistance in individuals with normal respiration. *Psychophysiology*, *24*, 678-682. doi: 10.1111/j.1469-8986.1987.tb00349.x

Kubzansky, L. D., Sparrow, D., Jackson, B., Cohen, S., Weiss, S. T., & Wright, R. J. (2006). Angry breathing: A prospective study of hostility and lung function in the Normative Aging Study. *Thorax*, *61*, 863-868. doi: 10.1136/thx.2005.050971

Kubzansky, L. D., Wright, R. J., Cohen, S., Weiss, S., Rosner, B., & Sparrow, D. (2002). Breathing easy: A prospective study of optimism and pulmonary function in the normative aging study. *Annals of Behavioral Medicine*, *24*, 345-353. PMID: 12434946

Lehrer, P.M., Isenberg, S., & Hochron, S.M. (1993). Asthma and emotion: A review. *Journal of Asthma*, *30*, 5-21. doi: 10.3109/02770909309066375

Lewis, M. A., & Rook, K. S. (1999). Social control in personal relationships: Impact on health behaviors and psychological distress. *Health Psychology*, *18*, 63-71. PMID: 9925047

Lum, T. Y., & Lightfoot, E. (2005). The effects of volunteering on the physical and mental health of older people. *Research on Aging*, *27*, 31-55. PMID: 21069597

MacKinnon, D. P., Fairchild, A. J., & Fritz, M. S. (2007). Mediation analysis. *Annual Review of Psychology*, *58*, 593. doi: 10.1146/annurev.psych.58.110405.085542

Mishra, J., Mishra, S., Satpathy, S., Manjareeka, M., Nayak, P. K., & Mohanty, P. (2013). Variations in PEFr among males and females with respect to anthropometric parameters. *IOSR Journal of Dental and Medical Sciences (IOS JDMS)*, *5*, 853-861.

Moran, S. E., Strachan, D. P., Johnston, I. D. A., & Anderson, H. R. (1999). Effects of exposure to gas cooking in childhood and adulthood on respiratory symptoms, allergic sensitization

- and lung function in young British adults. *Clinical and Experimental Allergy*, 29, 1033-1041. PMID: 10457105
- Nagi, S. Z. (1976). An epidemiology of disability among adults in the United States. *The Milbank Memorial Fund quarterly. Health and society*, 439-467. PMID: 137366
- Nunn, A. J., & Gregg, I. (1989). New regression equations for predicting peak expiratory flow in adults. *BMJ: British Medical Journal*, 298, 1068. PMID: 2497892
- Pearlin, L. I., & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior*, 19, 2-21. PMID: 649936
- Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of the American Geriatrics Society*, 23, 433. PMID: 1159263
- Polkonen, M., Notkola, I. L., Lakka, T., Tukiainen, H. O., Keivinen, P., & Nissenin, A. (2003). Delaying decline in pulmonary function with physical activity: A 25 year follow-up. *American Journal of Respiratory and Critical Care Medicine*, 168, 494-499. PMID: 12791579
- Pressman, S. D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin*, 131, 925-971. doi=10.1037/0033-2909.131.6.925
- Repetti, R. L., Matthews, K. A., & Waldron, I. (1988). Employment and women's health: Effects of paid employment on women's mental and physical health. *American Psychologist*, 44, 1394-1401.
- Ritz, T., George, C., & Dahme, B. (2000). Respiratory resistance during emotional stimulation: Evidence for nonspecific effect of experienced arousal? *Biological Psychology*, 52, 143-160. doi: 10.1016/S0301-0511(99)00026-5,

- Ritz, T., & Steptoe, A. (2000). Emotion and pulmonary function in asthma: Reactivity in the field and relationship with laboratory induction of emotion. *Psychosomatic Medicine*, *62*, 808-815. PMID: 11139001
- Ritz, T., Steptoe, A., De Wilde, S., & Costa, M. (2000). Emotions and stress increase respiratory resistance in asthma. *Psychosomatic Medicine*, *62*, 401-412.
- Robles, T. F., & Kane, H. S. (2012). Marriage. In S. Segerstrom (Ed.), *The Oxford handbook of psychoneuroimmunology* (pp. 197–213). New York: Oxford University Press
- Rodin, J., & McAvay, G. (1992). Determinants of change in perceived health in a longitudinal study of older adults. *Journal of Gerontology*, *47*, P373-P384. doi: 10.1093/geronj/47.6.P373
- Rosow, I., & Breslau, N. (1966). A Guttman health scale for the aged. *Journal of Gerontology*, *21*, 556-559. PMID: 5918309
- Seeman, T. E. (1996). Social ties and health: The benefits of social integration. *Annals of Epidemiology*, *6*, 442-451. PMID: 8915476
- Seeman, T. E., Bruce, M. L., & McAvay, G. J. (1996). Social network characteristics and onset of ADL disability: MacArthur Studies of Successful Aging. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *51*, S191-S200.
- Seeman, T. E., Kaplan, G. A., Knudsen, L., Cohen, R., & Guralnik, J. (1987). Social network ties and mortality among the elderly in the Alameda County study. *American Journal of Epidemiology*, *126*, 714-723. PMID: 3631060
- Seeman, T. E., & McEwen, B. S. (1996). Impact of social environment characteristics on neuroendocrine regulation. *Psychosomatic Medicine*, *58*, 459-471. PMID: 8902897

- Sin, D. D., Wu, L., & Man, S. P. (2005). The relationship between reduced lung function and cardiovascular mortality: A population-based study and a systematic review of the literature. *CHEST Journal*, *127*, 1952-1959. PMID: 15947307
- Smith, A. W., & Baum, A. (2003). The influence of psychological factors on restorative function in health and illness. In J. Suls & K. A. Wallston (Eds.), *Social psychological foundations in health and illness* (pp. 431-457). Malden, MA: Wiley-Blackwell.
- Sneed, R. S., & Cohen, S. (unpublished manuscript). *Negative social interactions and hypertension in a representative sample of older adults*.
- Sneed, R.S., & Cohen, S. (in press). A prospective study of volunteerism and hypertension risk in older adults. *Psychology and Aging*.
- Sneed, R. S., Cohen, S., Turner, R. B., & Doyle, W. J. (2012). Parenthood and host resistance to the common cold. *Psychosomatic Medicine*, *74*, 567-573. doi: 0.1097/PSY.0b013e31825941ff
- Sobel, M. E. (1982). Asymptotic intervals for indirect effects in structural equations models. In S. Leinhardt (Ed.), *Sociological methodology* (pp. 290-312). San Francisco: Jossey-Bass.
- Sparrow, D., O'Connor, G. T., Rosner, B., DeMolles, D., & Weiss, S. T. (1993). A longitudinal study of plasma cortisol concentration and pulmonary function decline in men. The Normative Aging Study. *American Review of Respiratory Disease*, *147*, 1345-1348. PMID: 8503543
- Stephens, A., Wardle, J., & Marmot, M. (2005). Positive affect and health-related neuroendocrine, cardiovascular and inflammatory processes. *Proceedings of the National Academy of Sciences U S A*, *102*, 6508-6512. PMID: PMC1088362

- Thoits, P. A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology, 54*, 416-423. doi: 10.1037/0022-006X.54.4.416
- Thoits, P. A. (1995). Stress, coping, and social support processes: Where are we? What next? *Journal of Health and Social Behavior, 35*, 53-79. PMID: 7560850
- Tucker, J. S., & Anders, S. L. (2001). Social control of health behaviors in marriage. *Journal of Applied Social Psychology, 31*, 467-485. doi: 10.1111/j.1559-1816.2001.tb02051.x
- Uchino, B. N. (2004). *Social support and physical health: Understanding the health consequences of relationships*. New Haven: Yale University Press.
- Uchino, B. N., Cacioppo, J. T., & Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. *Psychological Bulletin, 119*, 488-531. doi: 10.1037/0033-2909.119.3.488
- Umberson, D. (1987). Family status and health behaviors: Social control as a dimension of social integration. *Journal of Health and Social Behavior, 28*, 306-319. PMID: 3680922
- Umberson, D. (1992). Gender, marital status and the social control of health behavior. *Social Science & Medicine, 34*, 907-917. doi: 10.1016/0277-9536(92)90259-S,
- U. S. Department of Health and Human Services. (1984). *The health consequences of smoking: Chronic obstructive lung disease. A report of the Surgeon General*. Washington, DC: U. S. Government Printing Office.
- Wright, R. J., Rodriguez, M., & Cohen, S. (1998). Review of psychosocial stress and asthma: An integrated biopsychosocial approach. *Thorax, 53*, 1066-1074. doi:10.1136/thx.53.12.1066

Table 1. Phi - Correlations among social roles.

<i>Role</i>	Club	Church						
	Member	Member	Volunteer	Employee	Spouse	Parent	Relative	Friend
Church Member	.199***	-	-	-	-	-	-	-
Volunteer	.394***	.153***	-	-	-	-	-	-
Employee	.005	.063*	.043	-	-	-	-	-
Spouse	-.092**	-.025	-.001	.105***	-	-	-	-
Parent	-.091**	-.053†	-.103***	.043	.183***	-	-	-
Relative	.015	.126***	-.020	.016	-.007	.021	-	-
Friend	.184***	.156***	.155***	-.017	-.091**	.011	.130***	-
Total Social Roles	.522***	.509***	.533***	.394***	.369***	.317***	.418***	.471***

† $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$

Table 2. Regression Coefficients for Association between Individual Social Roles and PEFR

	B	SE	β	t	P
Club Member	7.12	6.03	.030	1.18	.237
Church Member	5.04	6.77	.019	.74	.457
Volunteer	9.24	6.71	.034	1.38	.169
Employee	9.47	7.59	.031	1.25	.213
Spouse	27.24	6.35	.114	4.29	.001
Parent	7.80	6.68	.029	1.17	.243
Relative	15.17	6.39	.058	2.38	.018
Friend	21.23	7.75	.067	2.74	.006

Results from 8 separate analyses, all analyses control for age, sex, education, race, height and weight.

Table 3. Mean Happiness and Physical Activity Scores and Smoking Status Distribution by Whether Participants Endorsed Each of the 8 Social Roles.

	Happiness		Physical Activity		Smoker Status	
	n	Mean (SD) ^a	n	Mean (SD) ^a	n	% ^b
Club member						
No	642	13.93 (2.52)	507	2.77 (.60)	613	17.8
Yes	497	14.49 (2.28)***	430	2.77 (.62)	483	13.3*
Church member						
No	305	13.91 (2.56)	223	2.84 (.57)	286	21.7
Yes	834	14.28 (2.38)*	714	2.74 (.62)*	810	13.7****
Volunteer						
No	827	13.94 (2.49)	670	2.71 (.61)	795	17.6
Yes	312	14.80 (2.16)***	267	2.90 (.59)***	301	11.0**
Employee						
No	927	14.07 (2.46)	760	2.74 (.62)	893	15.3
Yes	212	14.63 (2.27)**	177	2.89 (.56)**	203	17.7
Married						
No	590	13.94 (2.48)	487	2.66 (.65)	571	16.8
Yes	549	14.43 (2.36)***	450	2.88 (.54)***	525	14.7
Parent						
No	316	14.01 (2.42)	258	2.70 (.64)	313	16.6
Yes	823	14.24 (2.44)	679	2.79 (.60)*	783	15.5

	Happiness		Physical Activity		Smoker Status	
	n	Mean (SD) ^a	n	Mean (SD) ^a	n	% ^b
Relative						
No	338	14.18 (2.55)	275	2.75 (.62)	331	17.8
Yes	801	14.18 (2.38)	662	2.78 (.61)	765	14.9
Friend						
No	195	13.46 (2.77)	146	2.74 (.53)	187	21.9
Yes	944	14.33 (2.33)***	791	2.77 (.63)	909	14.5*

* $p < .05$. ** $p < .01$. *** $p < .001$

^a significant difference based on independent sample t-tests

^b significant difference based on chi-square analysis.

Figure 1: Percentage of Participants Endorsing Each Social Role

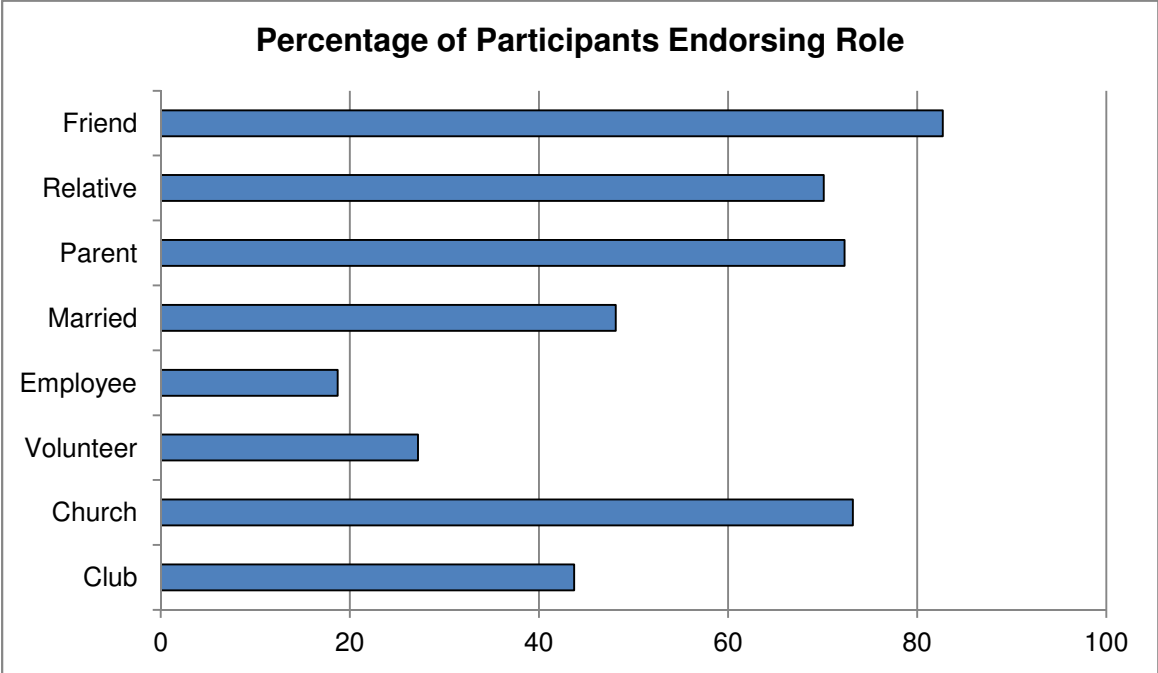


Figure 2. Linear Association between Total Number of Social Roles and Mean Average Peak Expiratory Flow Rate (PEFR)

