ann. behav. med. (2022) 56:1244–1258
https://doi.org/10.1093/abm/kaac011

REGULAR ARTICLE

Effects of Social Control on Eating and Relational Behaviors in Romantic Relationships

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Published online: 21 April 2022
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Abstract

Background Prior research has shown that social control strategies can have either positive or negative effects on individuals' health behaviors. However, no research has examined the degree to which social control attempts enacted by romantic partners are associated with individuals' relational behaviors or whether perceptions of a partner's motivation to engage in social control moderate links between the use of social control and either health or relational behaviors.

Purpose This study investigated (a) the degree to which two classes of social control strategies that romantic partners can use to improve their partners' eating behavior (autonomy-supportive and autonomy-limiting strategies) are associated with eating and relational behaviors, and (b) whether perceptions of the partner's motivation for using social control moderate associations between its use and an individual's eating and relational behavior.

Methods This study had a daily diary design. One hundred and forty-seven individuals in romantic relationships completed surveys for 14 consecutive days.

Results On days when individuals reported that their partner used autonomy-supportive social control strategies, individuals reported healthier eating and more constructive relational behaviors. There were no effects of autonomy-limiting strategies on eating or relational behavior. Perceptions of a partner's motives did not moderate associations between reported social control and any behavioral outcomes. Moreover, there were no effects of either reported social control strategies or partner motive perceptions across time.

Conclusion Romantic partners' perceived use of autonomy-supportive—but not autonomy-limiting—social control has benefits for individuals' health behaviors without incurring notable costs to their romantic relationship.

Keywords Health behavior · Close relationships · Social influence · Self-determination theory · Motivations · Interdependence

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Health behaviors such as physical activity [1], smoking [2], and alcohol use [3] tend to be concordant in romantic couples [4] and there is some evidence that health behavior change is similarly concordant in couples (Jackson et al. [5]; but see Brazeau and Lewis [6]). As a result, interventions have turned to romantic relationships as a context for fostering behavior change [7–9]. To date, these interventions have focused primarily on health behavior outcomes rather than on behavioral outcomes tied to the relationship between the target and their partner [7, 10]. This is problematic because behavior change interventions that involve the romantic partner without considering implications for the relationship are likely to be unsustainable, particularly if they impose costs on the relationship. There is a need for evidence that the social exchange processes used to improve health behavior either yield positive benefits or at least have no major negative effects on romantic relationships.

A prominent social exchange process that might impact both health and relationship behaviors is *social control*, which refers to one partner's (i.e., the influence agent's) intentional efforts to change their partner's (i.e., the target's) behavior [11]. Research has confirmed that the use of social control has implications for targets' health behavior and their emotions [11, 12], but has yet to examine their relational responses to social control. The current research blends models from health

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psychology and relationship science to examine whether certain social control strategies lead targets to respond with different health behaviors and relational behaviors.

Theoretical Perspectives on Health Behavior Regulation in Close Relationships

How do targets respond—with respect to both their health and relational behavior—to social control? In formulating our predictions, we relied on two perspectives that offer insights into how targets are likely to respond to the strategies close others use to regulate their health behavior change: social control and self-determination theory (SDT).

Social Control

Most social control research has distinguished between the effects of positive and negative social control strategies and tactics [11]. Although some researchers have defined strategies as positive or negative based on their ends (e.g., how they impact targets' health behavior responses [13]), many researchers have primarily defined strategies based on their means [11]. For example, Lewis and Butterfield [14] define positive social control as the use of persuasion, rational arguments and discussion, modeling, and positive reinforcement, and define negative social control as the expression of negative emotions by the agent or attempts to evoke negative emotions in the target. Researchers have also labeled positive strategies as "persuasion" and negative strategies as "pressure" [15].

How do social control strategies affect targets' health and relational behaviors? To date, only one meta-analysis has examined the effects of social control strategies on health behavior and emotional responses [11]. This meta-analysis relied on Lewis and Butterfield's (2005) definition of positive and negative social control and found that positive strategies tend to be associated with positive emotions and show small but positive associations with health behavior, whereas negative strategies tend to be associated with negative emotions and are unassociated with health behavior [11]. Although most social control research does not make explicit theoretical assumptions about how different strategies affect relational behaviors, different emotional responses to social control likely generate different behavioral responses, with positive affect eliciting more positive relational behaviors and negative affect eliciting more negative ones [11]. Consistent with this premise, there is some evidence that reports of relationship satisfaction are positively associated with the use of positive social control strategies [16, 17].

Self-Determination Theory

With respect to health behavior, SDT claims that the extent to which the psychological needs of autonomy (i.e., feeling to be the origin of one's own behaviors), competence (i.e., feeling efficacious), and relatedness (i.e., feeling understood and cared for by partners) are supported shapes targets' motivation to initiate and maintain health behaviors [18]. *Autonomy support* is provided when an agent acknowledges a target's feelings, refrains from exerting excessive control or pressure, gives the target choices, or provides positive informational feedback [19]. Extending SDT to social control, the provision of autonomy support may be beneficial to a target's health behavior if it promotes personally meaningful reasons for initiating and maintaining healthier behaviors [18, 20]. In contrast, behaviors that limit autonomy tend to facilitate motivations driven by external or internal pressures, which typically undermine health behavior maintenance [18].

In sum, SDT informs predictions regarding how targets are likely to respond to social control attempts from their partners (agents) because the theory offers insights into how different influence strategies should make targets feel within their relational environments. Although research has not examined how autonomy-supportive or autonomy-limiting behaviors are associated with relational *behaviors*, providing autonomy support is associated with greater relationship satisfaction [21] and better relationship quality [22], whereas the use of autonomy-limiting behaviors is either unrelated [22] or negatively related to relationship satisfaction [21].

Integration of Social Control and SDT

Both SDT and research on social control consider intrapersonal determinants of change (e.g., autonomous versus controlled motivation, positive versus negative affect), but neither explicitly account for interpersonal variables in behavior change. Additionally, although SDT's conceptualization of autonomy support is related to some definitions of positive social control, most SDT measures do not assess whether such behaviors serve a regulatory function. For example, one commonly used measure of autonomy support, the ISCQ [23], has items such as "I feel that my important others have provided me with choices and options." Although answers to this question may provide information on the general autonomy support individuals perceive available, they do not reveal whether autonomy support was provided to regulate the individual's behavior. We integrate SDT's definitions and measurement of autonomy support/limitation with social control researcher's definitions and measurement of social control to assess social control with a more inclusive set of

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items, which specify that the behaviors are enacted in an attempt to regulate a partner's health behavior.

More broadly, the current research integrates research on social control and SDT by conceptualizing social control strategies on a dimension from *autonomy supportive* to *autonomy limiting*. Social control tactics high in autonomy support involve offering advice and/or encouragement to the target to engage in the desired health behavior but leave the decision regarding how to achieve it to the target (e.g., by modeling positive health behaviors, encouraging the target to make their own healthier choices). Social control tactics that are autonomy limiting, in contrast, constrain the target's behavioral decisions or apply pressure on the target to think, feel, or behave in a specific way (e.g., by eliciting negative affect in the target, by changing the target's environment to limit their choices).

Effects of Social Control on Relational Behavior: The Range of Relational Responses

Depending on the context, autonomy-supporting and autonomy-limiting strategies can elicit either constructive or destructive relational responses. To date, no research has identified the full range of relational responses that are elicited in social control situations. However, social control situations share similarities with conflict discussions in relationships because social control typically generates conflict in most relationships [24]. Research examining how partners manage conflict has used the exit–voice–loyalty–neglect (EVLN) typology to classify relational responses to conflict [25, 26]. *Exit* involves engaging in behaviors that actively harm the relationship, often resulting in relationship dissolution; *voice* refers to active behaviors that improve the relationship (e.g., seeking solutions); *loyalty* involves passively but optimistically waiting for the relationship to improve (e.g., "waiting it out"); and *neglect* reflects passively allowing the relationship to deteriorate (e.g., ignoring one's partner) [25, 26]. Although social control situations can incite conflict, they also present opportunities for targets to respond with appreciation if they perceive agents are engaging in social control out of concern for the target's health [27]. Thus, we modified the EVLN typology to include the concept of constructiveness/ destructiveness, such that exit and neglect behaviors are destructive for the relationship, voice and appreciation behaviors are constructive, and loyalty behaviors are neutral.

Targets' Perceptions of Agents' Motives: Are You Using Social Control for You or Me?

SDT assumes that most attempts to influence a target's health behavior directly are inherently negative because they undermine the development of autonomous motivation. However, some social control strategies (e.g., positive social control) may be beneficial for targets because they motive them to enact healthier behaviors. One way to reconcile these seemingly opposing perspectives is to consider a target's perceptions of social control and its implications for their relationship with the agent, along with their health. During most social control attempts, targets are likely to make attributions for the agent's behavior based on *why* the agent is enacting social control and its implications for their relationship (e.g., "My partner is trying to change my behavior because he is committed to our relationship"). Perceptions of an agent's motives, therefore, should affect the target's reaction to the influence attempt.

Romantic partners can have various motives for enacting social control, such as wanting their partner to become healthier immediately and in the long term [28], wanting to engage in healthy behaviors with their partner [29], and wanting to improve their partner's appearance [14, 30]. In romantic relationships, the degree to which an agent's motives are perceived as independent (i.e., self-serving) versus interdependent (i.e., partner or relationship-serving) should affect a target's reactions to social control attempts. If, for example, a target perceives that the agent is enacting social control for self-serving reasons (e.g., the agent is embarrassed by the target's behavior), this may communicate that the agent does not respect the target's autonomy or wants to exert control over the target's behavior—cues that the agent is acting on independence motives. Thus, when an agent enacts autonomy-limiting social control and the target makes this attribution, the target is likely to respond with destructive relational behaviors and perhaps even less healthy eating behaviors. If, in contrast, a target perceives that the agent is enacting social control for partner-serving reasons (e.g., the agent is concerned about the target's long-term health), this should communicate that the agent cares about the target and feels interdependent with and committed to them. These interdependent motives should be perceived positively, resulting in more behavioral compliance by the target. Only one study has investigated how targets' perceptions of agents' motives interact with agents' use of social control and found no evidence that targets' perceptions of agents' motives moderated the effects of social control strategy type on targets' behavioral intentions [14]. This study, however, used hypothetical scenarios, assessed behavioral intentions rather than behavior, and examined responses at one time-point. The current research examines perceived social control and targets' perceptions of agents' motives in ongoing relationships, assesses self-reported health behavior, and examines responses to social control across 14 days.

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Current Research

To date, research has not examined: (a) the effects of different social control strategies on relational behaviors or (b) how the effects of different social control strategies are impacted by targets' perceptions of agents' motives for engaging in social control. The current research fills these gaps by assessing the effects of social control on health and relational behavior in ongoing romantic relationships across time, with a focus on eating. Eating is a context in which social control is likely to occur given that partners ought to have many opportunities to regulate each other's behavior. Partners often share meals, cooking responsibilities, and decisions about food purchases [31, 32]. In fact, unhealthy eating habits are among the most frequently reported health behaviors that partners attempt to change in each other [33, 34]. This research tests two sets of hypotheses—one set regarding eating responses, and another set regarding relational responses:

Hypothesis 1

The effect of autonomy-supportive and autonomy-limiting social control strategies on health behavior will be moderated by targets' perceptions of agents' motives.

H1a: Adjusting for the use of autonomy-limiting strategies (to determine whether effects were specific to the focal social control strategy), the use of autonomy-supportive strategies will elicit healthier eating behaviors on the day they are enacted and across time, especially when agents' motives are perceived to be higher in interdependence than in independence.

H1b: Adjusting for the use of autonomy-supportive strategies, the use of autonomy-limiting strategies will elicit healthy eating behaviors on the day they are enacted and across time, especially when agents' motives are perceived to be higher in interdependence than in independence.

Hypothesis 2

The effect of autonomy-supportive and autonomy-limiting social control strategies on relational behaviors will be moderated by targets' perceptions of agents' motives.

H2a: Adjusting for the use of autonomy-limiting strategies, the use of autonomy-supportive strategies will elicit constructive relational behaviors on the day they are enacted and across time, especially when agents' motives as perceived to be higher in interdependence than in independence.

H2b: Adjusting for the use of autonomy-supportive strategies, the use of autonomy-limiting strategies will elicit destructive relational behaviors on the day they are enacted and across time, especially when agents' motives as perceived to be higher in independence than in interdependence.

To assess the effect of social control and motivation on targets' health and relational behavior over time, we also addressed a challenge in research on social control—limitations in the structure of existing social control measures. Most prior studies that have assessed social control have not presented agents or targets with a comprehensive list of possible social control tactics. The prevailing approach is to adapt Butterfield and Lewis' measure of social control [35], which includes 28 tactics derived from (a) prior research assessing social influence in domains other than health and (b) common strategies or tactics mentioned in focus groups with married couples. In this study, we assessed a broader range of social control tactics, which allowed us to collect richer descriptive information on social control use in ongoing relationships.

Materials and Methods

Preregistration and Power Analysis

The hypotheses, methods, and analytic plan were preregistered on the Open Science Framework (OSF) (https://osf.io/w4xdh). The full list of study materials—including items that were not relevant to the current set of analyses but will be used in future exploratory analyses—can be viewed on OSF. At the time of preregistration, we planned for 90 participants to enroll in the study. Due to a subsequent increase in funding for this study, the sample size goal was increased to 150 participants (final n = 147). An a priori power analysis determined that this sample size was adequate to detect a small effect (f = .10) at 99% power [29]. Additionally, it was not planned that there would be social control strategies rated as neutral by coders; we had anticipated that all strategies would be rated as significantly different from the neutral midpoint on a Likert-type scale from 1 = autonomy limiting to 7 = autonomy supportive. Of the 60 tactics included in the social control measurement, 20 strategies were rated as neutral. These were included in analyses, such that all analytic models included whether neutral social control was perceived each day (1 = yes, 0 = no) as a covariate (main effect). We did not include an interaction term between neutral social control and perceptions of agent motives, nor did we include an interaction term between neutral social control and time because our confirmatory hypotheses focused on the interactions between autonomy-supportive and

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autonomy-limiting social control and perceptions of agent motives and time. A final deviation was that, rather than treating reports of destructive and constructive relational behaviors categorically (i.e., presence or absence), we averaged them to capture the amount of constructive or destructive relational behaviors reported.

Participants

The sample consisted of 147 individuals (69% women; 80% > $30,000 annual income; 89% 4-year degree or more education; M_{age} = 28.50 years; SD_{age} = 5.56 years), all of whom were in cohabiting romantic relationships (*M* relationship length = 6.18 years, *SD* = 3.98 years), with 57% engaged or married. Most participants identified their race as White (85%) and their ethnicity as non-Hispanic, Latino/a, or Spanish (94%). Participants were recruited from October 2019 through November 2019 and from January 2020 through April 2020 via online sources (e.g., Facebook.com) and from a large American Midwestern university. Inclusion criteria required that participants be: (a) age 18 or older, (b) cohabiting with their partner, (c) in a relationship with their partner for more than 3 months, (d) fluent in English, (e) eat at least five meals per week with their partner, (f) engage in *very unhealthy* to *somewhat healthy* eating habits, (g) be *a little interested* to *extremely interested* in improving their eating habits, (h) have a smartphone, (i) not work overnight shifts, and (j) typically fall asleep after 8:00 PM. These inclusion criteria ensured that participants had sufficient opportunities to be influenced by their partner at mealtimes, that their partner might be motivated to improve participants' eating behavior, and that they could complete daily diaries at approximately the same time each day.

Procedure

Potential participants were given a study description and then completed a screening survey to determine their eligibility. Those who met inclusion criteria provided their consent and chose a day and time to meet virtually with a researcher. During this meeting, each participant was trained to use the daily diary data collection method and reviewed the daily survey questions. The following day, each participant began completing diary measures once a day for 2 weeks using SurveySignal [36] on their smartphone. Specifically, each evening at 8:00 PM local time for 14 consecutive days, participants were sent a link to the daily survey via SMS. They were paid according to their amount of participation, with a base payment of an Amazon gift card for $15 or $25 or course credit, plus an additional $5 Amazon gift card and an entry into a gift card lottery if they completed 11 or more of the 14 surveys. The amount of the gift card was changed from $15 to $25 at the end of February 2020 to increase study recruitment. Twenty-eight participants were recruited with the $15 compensation rate and 199 participants with the $25 compensation rate. All study procedures were reviewed and approved by the local institutional review board.

Measures

Targets' perceptions of agents' daily use of social control

Participants were shown (in a randomized order) a list of nine categories of behaviors that their partner could have engaged in to affect their eating (e.g., "My partner tried to change our home or routines to help me eat healthier," "My partner showed support, understanding, or acceptance of my eating choices"). For each category that was checked, participants were then shown (in a randomized order) a list of specific behaviors that their partner could have engaged in (e.g., for the category, "My partner tried to change our home or routines to help me eat healthier," example behaviors were: "My partner cooked healthy meals with me" and "My partner avoided buying unhealthy foods"). Sixty social control tactics were included in this measure. (See Supplementary Appendix A for a list of the nine general categories and the social control behaviors that fell under each category as well as information on how these lists were developed and coded). Participants were asked to select all behaviors that their partner engaged in during the last 24 hr. Participants also indicated any additional behaviors their partner engaged in that could affect their eating in an open-ended response format. Those who indicated that their partner engaged in one or more behaviors that could affect their eating were then asked to indicate whether any of the behaviors their partner used were designed to intentionally affect their eating (i.e., if any of the behaviors were social control attempts). Participants were also shown an additional category that they could select to indicate that their partner did something to encourage them to eat less healthy. Sixty-nine percent of participants indicated that their partner engaged in at least one behavior to encourage them to eat less healthy during the study period. This category is not included in the analyses reported here.

Targets' daily eating: healthiness of eating

Participants were also asked, "How would you describe the healthiness of your eating in the last 24 hours, compared to most days? ," which was answered on a 7-point Likert-type scale (1 = *much less healthy than usual*; 4 = *as healthy as usual*; 7 = *much more healthy than usual*).

Targets' daily eating: eating behaviors

Participants were shown a list of 12 items reflecting healthy and unhealthy eating behaviors and were asked

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to select all that were generally true of their eating that day (adapted from [28]). Examples include: "I ate a variety of foods," "I ate foods high in sugar," and "I went long periods without eating during the day."

Targets' daily relational behaviors

Participants were shown 11 items reflecting constructive and destructive relational behaviors and were asked to select all that applied to their interactions with their partner that day ([37], Study 2). Four items assessed destructive relational responses (e.g., "I said something or acted in a way that could be hurtful to my partner") and seven items assessed constructive relational responses (e.g., "I openly shared and discussed my feelings and opinions with my partner").

Targets' daily perception of agents' motives for enacting social control

Participants who indicated that their partner engaged in behaviors to affect their eating on a given day were asked, "To what extent were your partner's behaviors related to your eating today motivated by what is best for them versus what is best for you?" Participants indicated their response on a 5-point Likert-type scale (1 = *their behaviors were completely motivated by what is best for them*; 3 = *their behaviors were equally motivated by what is best for them and what is best for me*; 5 = *their behaviors were completely motivated by what is best for me*).

Baseline characteristics

Participants completed demographic questions and assessments of their relationship in the baseline survey. Relationship quality was assessed with the Perceived Relationship Quality Components (PRQC) Inventory [38], which measures individuals' satisfaction, commitment, intimacy, trust, passion, and love in their relationship (e.g., "How satisfied are you with your relationship?" 1 = *not at all* to 7 = *extremely*). Items across the subscales were aggregated, resulting in a global score ($\alpha = .95$). Participants also completed an item assessing social control norms in their relationship: "Within your relationship, how acceptable is it for your partner to try to change your health behaviors?" (1 = *not at all acceptable* to 5 = *very acceptable*). Participants also indicated their gender identity, age, ethnicity, and race. Finally, participants completed questions about their interest in improving their eating habits, the average number of meals they eat with their partner each week, and questions about their partner and relationship (e.g., relationship length).

Data Analysis Plan

We conducted linear mixed effects modeling in R using the *nlme* package [39] and the *lmerTest* package [40] to examine within-person associations between the target's perception of the agent's use of different social control strategies, perceptions of agent motives, and eating and relational outcomes. Three models were run—one for the healthiness of eating outcome, one for the eating behaviors outcome, and one for the relational behaviors outcome. Restricted maximum likelihood estimation was used to accommodate missing data and data nesting. Diary Day 1 was coded as 0, Day 2 as 1, and so forth. Thus, the slopes reflect changes in the outcome across the study. Continuous Level 1 predictors (e.g., perceptions of agent motives) were person-mean centered to estimate the within-person association between the predictor and outcome [41]. For Level 1 predictors and moderators, random effects of slopes were estimated. When random effects were estimated to be zero, they were dropped from the model to achieve model parsimony. Continuous Level 2 predictors (e.g., covariates such as relationship quality) were grand-mean centered; therefore, the intercept represented the outcome at the average level of those predictors, and their coefficients represented between-person associations between the predictor and daily outcome. For each outcome, exploratory analyses were conducted to determine the best-fitting error structure. A first-order autoregressive error structure was used for the eating behavior and relational behavior outcomes. An independent error structure was used for the healthiness of eating outcomes. These error structures were selected because they had the lowest Akaike information criterion values among the error structures that were tested (i.e., independent, compound symmetry, autoregressive, and unstructured). Each analytic model included the following covariates: gender identity, interest in improving eating habits, number of meals eaten with one's partner per week, relationship quality, and social control norms.

Additionally, whether or not the participant completed the study before or during the COVID-19 pandemic was included as a covariate (69% of the sample completed the study during the COVID-19 pandemic). Differences between participants who completed the study prior to or during the COVID-19 pandemic were examined. Participants who completed the study during the pandemic indicated they interacted with their partner more frequently, their partners paid more attention to their eating, and their partner's behaviors were more supportive than limiting during the study compared to participants who completed the study prior to the pandemic. However, COVID-19 was not a significant predictor in any of the analytic models.

Variable Coding

Predictors

Five research assistants rated the 60 social control strategies and participants' open-ended responses on the

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autonomy-limiting to autonomy-supportive dimension (7-point Likert-type scale with responses ranging from 1 = *extremely limiting*; 4 = *neither limiting nor supportive* [i.e., neutral]; 7 = *extremely supportive*). In each instance, the coders viewed the category that the behavior was in (e.g., "My partner tried to make me feel good about my eating") and the specific behavior in that category (e.g., "Complimented or praised my eating choices"). They then rated the specific behavior on the limiting to supportive dimension. To classify the behaviors as autonomy-supportive or autonomy-limiting, we used the overall mean for each strategy and tested whether it significantly differed from the scale midpoint (which denotes a strategy as neutral) using a one-sample *t* test (see Supplementary Appendix A, Supplementary Table S1 for further details). Of the 60 social control tactics, 9 were categorized as autonomy-supportive, 20 were categorized as neutral (i.e., neither clearly supportive nor clearly limiting), and 31 were categorized as autonomy-limiting. An example of an autonomy-supportive strategy is "avoided criticizing my eating choices." An example of a neutral strategy is "shared healthy eating information or recipes with me." An example of an autonomy-limiting strategy is "avoided buying unhealthy foods." Continuous versions of the social control variables were created by summing the number of autonomy-supportive, autonomy-limiting, and neutral strategies reported by participants each day. These variables were highly skewed (skews = 3.19, 4.43, and 3.29, respectively). Thus, we used dichotomized versions of these variables in the analytic models. Three dichotomous variables were created from participants' reports of daily social control—autonomy-supportive, autonomy-limiting, and neutral social control. Each variable was coded such that 1 = At least one tactic of that strategy type was perceived by the target that day and 0 = No tactics of that strategy type were perceived by the target that day. Perceptions of agents' motives were recoded so that negative values reflect agent motives that were more independent, values of zero reflect agent motives that were neutral, and positive values reflect agent motives that were more interdependent.

Outcomes

Healthiness of eating was recoded such that scores below zero indicated eating that was less healthy than usual, scores at zero indicated eating that was as healthy as usual, and scores above zero indicated eating that was more healthy than usual. The six items reflecting healthier eating behaviors were summed and the six items reflecting less healthy eating behaviors were summed [42]. A balance variable was then created by subtracting the unhealthy behaviors from the healthy behaviors; values above zero indicate that a participant engaged in more healthy behaviors than unhealthy behaviors, and values below zero indicate that a participant engaged in more unhealthy behaviors than healthy behaviors (intraclass correlation coefficient [ICC] = .77).

The destructive and the constructive relational behaviors were each averaged and a balance variable was created by subtracting the destructive behavior average from the constructive behavior average; values above zero indicate that a participant engaged in more constructive than destructive relational behaviors than destructive behaviors, and values below zero indicate the opposite pattern (ICC = .68). A balance variable was used because it allows us to (a) examine the effect of the predictors on the "net" relational behavior that day, and (b) account for both constructive and destructive behaviors together, rather than including the constructive relational behaviors as a covariate when predicting destructive relational behaviors.

Results

Sample Characteristics

The total number of diary entries available for analysis was 1,877. Following standard guidelines [43], daily diaries completed in the fastest 2.5% of response times (i.e., less than 48 s) were excluded from analysis ($N = 181$). Due to an error with SurveySignal, four Day 14 surveys were missing because they were not sent to participants via SMS. Visual inspection of the data indicated that the proportion of diaries missing did not increase over the 14-day diary period. To determine whether missing data accounted for differences in any of the analytic variables or demographics, we examined whether there were differences between participants who completed all or fewer than 14 diaries. There was no evidence that these two groups of participants differed meaningfully in their demographic characteristics, relational behaviors, eating healthiness, eating behaviors, or the amount of social control perceived by the target.

Descriptive Results

The average person reported that, during the 14-day study, their romantic partner (i.e., the agent) used an autonomy-supportive social control strategy on 2.85 days (SD = 2.82, median = 2.00, range: 0–14 days), an autonomy-limiting strategy on 1.96 days (SD = 1.88, median = 2.00, range: 0–10 days), and a neutral strategy on 3.65 days (SD = 3.11, median = 3.00, range: 0–13 days). We also examined the degree to which these strategies were used concurrently. The average person reported that the agent used only

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autonomy-limiting social control on 6% of the diary days, only autonomy-supportive social control on 11% of the days, only neutral social control on 13% of the days, both autonomy-supportive social control and autonomy-limiting social control on <1% of the days, both autonomy-supportive social control and neutral social control on 7% of the days, both autonomy-limiting and neutral social control on 6% of the days, all strategy types on 3% of days, and no strategy types on 54% of days.

On a given day, the average healthiness of participants' diet was −0.17 (*SD* = 0.38, median = −0.15, range: −3 to 3), indicating that the typical participant perceived that their diet was "slightly less healthy than usual." Yet, on a given day, the average eating behaviors score was 1.92 (*SD* = 1.42, median = 2.07, range: −2 to 5), indicating that participants reported typically engaging in more healthy eating behaviors than unhealthy ones. Thus, participants generally engaged in healthier than unhealthy eating behaviors, but perceived their daily eating to be less healthy than usual. On a given day, the average relational behaviors score was 0.35 (*SD* = 0.32, median = 0.43), indicating that the average participant typically engaged in more constructive than destructive relational behaviors. Finally, on a given day, the average participant's motive rating was 0.05 (*SD* = 0.61, median = 0, range: −2 to 2), indicating that their partner's behaviors were perceived to be equally motivated by what was best for them and best for the participant.

Repeated measures correlations were calculated using the *rmcorr* package in R [44] for continuous variables in the analytic models (see Table 1). Relational behaviors were positively, but weakly, associated with eating behaviors and motive perceptions but were unassociated with healthiness of eating. Eating behaviors were strongly and positively associated with healthiness of eating, and both eating outcomes were positively associated with motive perceptions.

Is there an association between targets' perceptions of agents' social control and targets' eating behaviors, and is it moderated by targets' perceptions of the agents' motives? (H1)

Healthiness of eating. For brevity, we report only results that are associated with a conventionally significant *p*-value (*p*s < .05). The estimates, *SE*s, and 95% confidence intervals (CIs) for each model are shown in Table 2. There was a positive effect of autonomy-supportive social control on healthiness of eating ($b = 0.38$, $p = .006$), such that on days when targets reported that agents engaged in at least one autonomy-supportive tactic, targets perceived that they ate healthier than usual. There also was a positive effect of neutral social control on healthiness of eating ($b = 0.67$, $p < .001$), such that on days when targets reported that agents engaged in at least one "neutral" tactic, targets perceived that they ate healthier than usual. However, there was no evidence of moderation by perceptions of agents' motive for enacting social control. Thus, Hypothesis 1a was partially supported and Hypothesis 1b was not supported. Additionally, there were no interactions between either strategy type, motive perceptions, and diary day, indicating no evidence of across time effects. The marginal R^2 coefficient was .08, indicating that 8% of the variance in healthiness of eating is accounted for by all fixed effects in the model.

Eating behavior. Autonomy-supportive social control was positively associated with eating behaviors ($b = 0.54$, $p = .021$), such that on days when targets reported that

Table 1 Correlations between key variables and covariates

	M (*SD*)	1	2	3	4	5	6	7	8
1. Relational behaviors	0.35 (0.32)	1							
2. Eating behaviors	1.92 (2.26)	.07**	1						
3. Healthiness of eating	−0.17 (1.09)	.02	.60***	1					
4. Perceptions of motives	0.06 (0.99)	.09**	.06**	.19**	1				
5. PRQC	5.92 (0.85)	−.03	.01	−.01	−.02	1			
6. Interest in improving eating	3.65 (0.85)	−.03	−.09***	−.04	−.02	−.11**	1		
7. Meals eaten with partner per week	9.32 (3.05)	.04†	.02	−.03	.00	.08**	.15**	1	
8. Social control norms	3.44 (0.92)	.02	−.04†	.05*	.02	.29**	−.01	.03	1

Repeated measures correlations were calculated for variables 1–4. Bivariate correlations were calculated for variables 5–8. *PRQC* Perceived Relationship Quality Components Inventory.

*$p < .05$.

**$p < .01$.

***$p < .001$.

†$p < .10$.

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Table 2 Effects of agents' perceived use of autonomy-supportive social control, autonomy-limiting social control, and perceptions of agents' motives on healthiness of eating, eating behaviors, and relational behaviors

Predictor	Healthiness of eating			Eating behaviors			Relational behaviors		
	Unstandardized		Standardized	Unstandardized		Standardized	Unstandardized		Standardized
	Estimate (*SE*)	95% CI	Estimate	Estimate (*SE*)	95% CI	Estimate	Estimate (*SE*)	95% CI	Estimate
Fixed effects									
Intercept	−0.34* (0.15)	−0.64, −0.04	0.00	0.88† (0.47)	−0.04, 1.80	0.00	0.37*** (0.06)	0.26, 0.49	0.00
Day	0.03*** (0.00)	0.01, 0.05	0.10	0.06*** (0.01)	0.03, 0.08	0.10	0.00 (0.00)	−0.00, 0.01	0.03
Autonomy-supportive SC	0.37* (0.12)	0.11, 0.64	0.06	0.54* (0.24)	0.08, 1.01	0.05	0.06† (0.03)	−0.01, 0.12	0.04
Autonomy-limiting SC	−0.08 (0.15)	−0.38, 0.21	−0.02	0.10 (0.26)	−0.40, 0.61	0.02	0.01 (0.04)	−0.07, 0.08	0.04
Targets' perceptions of agents' motives	0.38 (0.07)	−0.12, 0.17	0.05	−0.03 (0.13)	−0.28, 0.21	0.02	0.02 (0.02)	−0.02, 0.05	0.05
Autonomy-supportive SC × perceptions of motives	0.13 (0.17)	−0.20, 0.46	0.00	0.55† (0.29)	−0.02, 1.13	0.02	−0.02 (0.04)	−0.10, 0.06	−0.03
Autonomy-limiting SC × perceptions of motives	0.18 (0.20)	−0.21, 0.56	−0.03	−0.06 (0.33)	−0.72, 0.61	−0.03	−0.00 (0.05)	-0.08, 0.11	0.00
Autonomy-supportive SC × day	−0.03† (0.02)	−0.07, 0.01	−0.04	−0.03 (0.03)	−0.10, 0.03	−0.03	−0.00 (0.00)	−0.01, 0.01	−0.02
Autonomy-limiting SC × day	0.00 (0.02)	−0.04, 0.04	0.00	−0.00 (0.03)	−0.07, 0.07	−0.00	0.00 (0.00)	−0.01, 0.01	0.02
Perceptions of motives × day	0.01 (0.01)	−0.01, 0.03	0.01	0.01 (0.02)	−0.02, 0.05	0.01	0.00 (0.00)	−0.00, 0.01	0.01
Autonomy-supportive SC × perceptions of motives × day	−0.02 (0.02)	−0.07, 0.02	−0.03	−0.06 (0.03)	−0.14, 0.02	−0.03	−0.00 (0.01)	−0.01, 0.01	−0.01
Autonomy-limiting SC × perceptions of motives × day	−0.05† (0.03)	−0.10, 0.00	−0.05	−0.03 (0.04)	−0.12, 0.05	−0.02	−0.00 (0.01)	−0.01, 0.01	0.00
Neutral SC	0.67*** (0.07)	0.53, 0.81	0.16	0.91*** (0.12)	0.67, 1.15	0.17	0.02 (0.02)	−0.02, 0.05	0.03
Covariates									
Gender	−0.06 (0.07)	−0.20, 0.09	−0.02	0.31 (0.24)	−0.16, 0.78	0.07	0.00 (0.03)	−0.05, 0.06	0.02
PRQC	0.12** (0.05)	0.03, 0.21	0.08	0.40** (0.15)	0.11, 0.69	0.14	0.06*** (0.02)	0.03, 0.10	0.16
Interest in improving eating	0.03 (0.04)	−0.06, 0.12	0.01	0.07 (0.15)	−0.22, 0.36	0.03	−0.01 (0.02)	−0.04, 0.03	−0.03
Meals eaten with partner per week	−0.02 (0.01)	−0.04, 0.00	−0.06	−0.01 (0.04)	−0.09, 0.06	−0.02	0.00 (0.00)	−0.01, 0.01	0.02
Social control norms	0.01 (0.04)	−0.07, 0.10	0.01	0.17 (0.14)	−0.10, 0.44	0.07	0.01 (0.02)	−0.02, 0.05	0.04
COVID-19 timing	0.08† (0.05)	−0.01, 0.17	0.06	0.18 (0.15)	−0.11, 0.48	0.07	−0.03 (0.02)	−0.06, 0.01	−0.08

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Table 2 Continued

Predictor	Healthiness of eating			Eating behaviors			Relational behaviors		
	Unstandardized		Standardized	Unstandardized		Standardized	Unstandardized		Standardized
	Estimate (*SE*)	95% CI	Estimate	Estimate (*SE*)	95% CI	Estimate	Estimate (*SE*)	95% CI	Estimate
Model summary									
Log likelihood	−2079.05			−2858.86			−244.95		
AIC	4202.09			5761.72			537.90		
Marginal R^2	.09			.08			.05		

Standardized estimates are included as an effect size measure. *AIC* Akaike information criterion; *CI* confidence interval; *PRQC* Perceived Relationship Quality Components Inventory; *SC* social control.

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

agents engaged in at least one autonomy-supportive tactic, targets reported more healthy than unhealthy eating behaviors. There was a similar association between neutral social control and eating behaviors ($b = 0.91$, $p < .001$), such that on days when targets reported that agents engaged in at least one "neutral" strategy, targets reported more healthy than unhealthy eating behaviors. Once again, there was no evidence of moderation involving agents' perceived motives. Thus, Hypothesis 1a was partially supported and Hypothesis 1b was not supported. Additionally, there were no interactions between either strategy type, motive perceptions, and diary day, indicating no evidence of across time effects. The marginal R^2 coefficient was .09, indicating that 9% of the variance in eating behavior is accounted for by all model fixed effects.

Is there an association between agents' social control and targets' relational behaviors, and is it moderated by targets' perceptions of the agents' motives? (H2)

Estimates, *SE*s, and 95% CIs are shown in Table 2. There was a positive association between agents' perceived use of autonomy-supportive social control and targets' relational behaviors, but it did not reach conventional levels of significance ($b = 0.06$, $p = .08$). On days when targets reported that agents engaged in at least one autonomy-supportive strategy, targets tended to engage in more constructive relational behaviors. The effects of autonomy-limiting or neutral social control on targets' relational behaviors were not significant. Additionally, targets' perceptions of agents' motives did not show any main effects or interaction effects on targets' relational behaviors. Overall, neither Hypothesis 2a nor 2b were supported. Additionally, there were no interactions between either strategy type, motive perceptions, and diary day, indicating no evidence of across time effects. The marginal R^2 coefficient was .05, indicating that 5% of the variance in relational behaviors is explained by all fixed effects in the model.

Discussion

As health behavior change interventions expand to incorporate romantic dyads, it becomes increasingly important to consider the effects social influence processes such as social control have not only on health behaviors, but relational behaviors as well [45]. The success of dyadic behavior change interventions may depend, at least in part, on the extent to which they induce positive behavior change without causing harm to relationships. Although past research has examined associations between different social control strategies and targets' health behaviors and emotional responses [11], no studies have examined relations between social control

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and targets' relational behaviors. In this study, the use of autonomy-supportive strategies is associated with healthy eating behaviors but is weakly associated with relational benefits. In contrast, autonomy-limiting strategies are not associated with eating behaviors, nor are they associated with relational benefits or harms. These findings are consistent with research showing that autonomy support is related to greater weight loss, whereas autonomy control from close others is not [20]. These results have implications for dyadic behavior change interventions because they suggest that romantic partners can use autonomy-supportive strategies to positively support each other's health behavior change efforts without adversely affecting their relationship.

Although we predicted that responses to social control would be contingent on how targets perceived an agent's motives for enacting social control, we found no evidence that motive perceptions moderated the associations between social control and either relational or eating outcomes. These null findings are consistent with those found in one study examining whether targets' perceptions of agents' motives moderated the effect of social control strategy type on targets' health behavior intentions [14]. One possibility is that the social control strategies that agents use may be more important than targets' perceptions of *why* agents use a specific strategy—actions may speak louder than attributions. Alternatively, the measure of agent motives may not have been sufficiently precise; having assessed targets' perceptions of all of the agent's behaviors related to the target's eating rather than each tactic targets identified. Although this method helped minimize participant fatigue, it precludes us from determining whether participants perceived motives to be associated with some strategies more than others.

These findings should also be considered in the broader context of research examining social control and relationship quality and/or satisfaction. In the current research, we examined targets' perceptions of agents' motives with respect to their interdependence because we predicted that motive perceptions would be an important proximal modifier of the association between social control strategy type and targets' behaviors. Other research has examined macro constructs such as relationship quality and satisfaction, as moderators of the link between social control and targets' health or emotional responses (e.g., [12, 46–48]). For instance, one study of couples in which one partner had undergone radical prostatectomy found that people who report greater relationship satisfaction have better exercise adherence outcomes and more positive affect when receiving social control compared to people who report lower relationship satisfaction [48]. Moving forward, it is important to consider how a broad range of relationship-relevant cognitions and characteristics may affect individuals' responses to social control.

A surprising finding was that on days when people reported that the agent enacted any kind of social control strategy, their relational behaviors were neither especially constructive nor especially destructive. Although there was a weak and positive association between autonomy-supportive social control and relational behaviors, there was not a negative association between autonomy-limiting social control and relational behaviors. One possible explanation is that the relational behaviors measure captured a broad snapshot of individuals' relational behaviors each day but was not specific enough to capture their responses to social control. Future research could use event-contingent diary designs to capture individuals' relational responses to social control immediately after they occur. These designs would help determine whether participants' relational responses to social control are best captured at a more micro level (e.g., small responses that take place immediately following a social control attempt) or at a daily level.

A second, unexpected finding was that, during the social control coding process, a considerable number of social control behaviors were identified as neither autonomy-supportive nor autonomy-limiting. We included these "neutral" behavioral tactics in our models. The results mirrored the autonomy-supportive results, such that use of neutral strategies was positively and significantly associated with healthiness of eating and eating behaviors, but not associated with relational behaviors. The neutral category includes behaviors such as "my partner set healthy eating goals with me" and "my partner purchased healthy foods for me." Further evidence about the properties of these strategies is needed. Independent coders may perceive certain tactics as neither autonomy-supportive nor autonomy-limiting, whereas targets may perceive these same tactics differently within their unique relational context.

One strength of this study is its use of a novel methodology to capture richer data on the use of social control strategies efficiently. For instance, Tucker and Anders [49] asked targets how often during the past 6 months the agent did something to attempt to persuade the target to change their health behavior and found that targets reported agents made 1.87 influence attempts per week. In contrast, Novak and Webster [50] used a prospective study design and presented targets with tactics tailored to be specific to diet, exercise, and weight. They found that targets reported that agents enacted 1.04 strategies per day. Our study presented targets with a broader array of social control tactics specific to eating and found that targets reported agents use an average of 2.10 strategies per day. These findings imply that agents may use more social control tactics than past research has captured. This highlights the need for researchers to use more extensive measures of social control; especially when pursuing questions regarding how the amount or frequency of

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social control affects health and relational outcomes. It should also be noted that our measurement of social control included behaviors (e.g., encouragement, praise) that could be conceptualized as reflecting social support [51, 52]. However, given that our definition of social control emphasized the regulatory intent of social control behaviors, we included such behaviors as social control because participants had indicated they perceived those behaviors were engaged in with the intent to affect their eating behavior. There is a need for future research that further clarifies not only the conceptual distinctions between social control and social support, but also the effects of social control and social support for health and relationship outcomes, together.

Limitations and Future Directions

There are several limitations to this research. First, this study was limited to a 2-week period, which may have been too short to capture the temporal effects of social control fully, especially with regard to eating behavior. SDT posits that autonomy-supportive environments should facilitate autonomous motivation, but that it takes time to develop [53]. Two weeks may not have been sufficient. The current study also did not assess whether autonomous motivation for healthy eating changed over time, so the time course for the effect is unknown. A next step in this line of research is to assess the extent to which autonomy-supportive versus autonomy-limiting social control impacts autonomous motivation enroute to changing eating behavior.

A related limitation is that our eating behavior measures were not comprehensive and our measure of the healthiness of individuals' eating was subjective. The latter measure was chosen because it was quick to complete (which is important for minimizing attrition likelihood in daily diary studies) and it provided a snapshot of individuals' perceived behavior change since it compared individuals' eating each day to their typical eating on most days. In the context of social control, perceived behavior change may be more relevant to the relationship dynamics between the agent and target than actual behavior change to the extent that targets use their own perceptions of their behavior change to determine their relational responses to social control. If, for instance, a target perceives they made a healthy behavior change in response to a social control attempt, they may be irritated if the agent continues using social control (e.g., "I did what my partner wanted – why are they still bugging me?"). This highlights the importance of examining both partners' perspectives of social control interaction(s) in future work.

A third limitation is that most of the sample completed the daily diaries during the COVID-19 pandemic. Most of the participants who completed the study during the pandemic were students at a university in the USA, so they were subjected to restrictions with regard to their ability to go to work and engage in recreational activities. The COVID-19 pandemic and social distancing guidelines most likely affected participants' interactions with their partner along with their level of stress, their ability to engage in normal eating behaviors, and perhaps their partners' motivation to enact social control. Accordingly, the effects of social control may be amplified in those who completed the studying during the pandemic, as partners may have had more opportunities to influence each other's eating and might have been more motivated to help their partners be healthier. Finally, the study sample was mostly White, well-educated, and stable, cohabitating couples, which places limits on the generalizability of these results. Future research needs to examine the manner in which these social control processes unfold in samples of couples from more diverse backgrounds as well as couples who have more fragile relationships.

Conclusion

In a 2-week daily diary study, we found that on days when individuals reported that their partners used autonomy-supportive social control, individuals also engaged in healthier eating behaviors. We also found that autonomy-supportive social control is weakly associated with more constructive than destructive relational behaviors. In contrast, autonomy-limiting social control was unassociated with eating behaviors and relational behaviors. Our results suggest the possibility that autonomy-supportive social control can be beneficial for both health and relational behaviors. This study underscores the importance of examining both health behavior and relational behavior reactions to social control before intervening on social control processes in relationships to improve health behavior.

Supplementary Material

Supplementary material is available at *Annals of Behavioral Medicine* online.

Acknowledgments

We thank Dr. Majel R. Baker for consultation on daily diary methods and analytic techniques and Kaleigh Wallock, Kevin Coons, Emma Traun, Andrew Reimann, Emily Van Tassell, and Tiffany Li for assistance with data collection and coding. This project received support from a Society for Personality and Social Psychology small grant, a scholarship from the American Psychological Foundation, a small grant to the first author

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(C.O.H.) from the American Psychological Association, and the University of Minnesota Doctoral Dissertation Fellowship.

Compliance with Ethical Standards

Author Contributions Dr. Huelsnitz acquired funding for the study, collected the data used in the study, conducted the statistical analysis, and drafted the first version of the manuscript. All authors were involved in the design of the study and contributed to the writing of the final manuscript.

Authors' Statement of Conflict of Interest and Adherence to Ethical Standards The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the University of Minnesota Institutional Review Board and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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