

26 Control beliefs

Control refers to the ability to influence what is happening or what will happen. *Beliefs* about control in the context of health refer to the thoughts (or cognitions) an individual has regarding the ability to influence health behavior, health status (or other health outcomes), or health care. Control beliefs are one of a number of determinants of health behavior and health outcomes. A person's health status can be influenced by and can influence his or her control beliefs. Individuals who believe they have control over their health behavior are more likely to engage in healthy behavior; thus, they are more likely to have better health outcomes. Better health outcomes are associated with more positive control beliefs. Also relevant are beliefs about control over health care delivery. Believing that one can influence one's own health care is a primary determinant of satisfaction with health care. Perceived control over one's health behavior, health outcomes, and/or health care is different from *desire* for control over these aspects. It is assumed that most individuals desire control over their health behavior and health outcomes; no such assumption is made regarding control over how health care is delivered.

1. Locus of control

"Locus" refers to the *place* where control (over outcomes) resides—either "internal" to the individual (i.e., based on his or her own behavior or enduring characteristics) or "external" to the individual (e.g., due to other people's behavior, fate, luck or chance). Although it was once thought that *internal* and *external* beliefs were at opposite ends of a continuum (Rotter, 1966), it is now understood that these two belief orientations are independent of one another. That is, a person might simultaneously hold internal and external beliefs about the locus of control of a given phenomenon (e.g., his or her health status; Wallston, 1989, in press). For example, a person newly diagnosed with lung cancer might attribute the diagnosis to such internal factors as a lifetime of smoking cigarettes as well as poor dietary and exercise habits. At the same time, the person might attribute the lung cancer to such external causes as "bad genes" (inherited from one's parents), punishment from God, pollution in the environment, and/or poor luck. Furthermore, one's locus of control orientation about the cause of a health problem (its etiology), is unrelated to one's beliefs about responsibility for the course of the problem (i.e., whether it will get better or worsen). It is possible to attribute the etiology of a disease to external causes (e.g., a virus) and to adopt an internal orientation to dealing with the condition once diagnosed (e.g., learn everything one can about the condition and its treatment). Many patients with a medical condition believe that health care professionals either fully or partially control what happens to their health status.

Better health outcomes are typically associated with more internal beliefs about control of one's health. However, an internal health locus of control orientation does not necessarily signify that one attributes only good health outcomes to one's own behavior. For some individuals, having "internal" beliefs may mean blaming oneself for one's poor health outcomes. Being "responsible for" one's outcomes does not always translate into being in control of those outcomes. Furthermore, internal beliefs about one's health are only weakly predictive of engaging in healthy behavior or avoiding health risks. Internal beliefs are somewhat more predictive of healthy behaviors for people who highly value

having good health compared to those for whom good health is less important, but locus of control only explains a relatively small amount of variance in health behavior even for people who highly value good health (Wallston, 1992). Valuing good health and believing that one's health is contingent on one's own actions are necessary, but not sufficient, determinants of health behavior.

2. Self-efficacy, mastery, and competence

Locus of control is only one type of control belief. Other psychological constructs that are similar to locus of control are *self-efficacy* (Bandura, 1977); *mastery* (Pearlin & Schooler, 1978), and *competence* (White, 1959). Self-efficacy, or the belief that one *can do* a specific behavior in a specific situation, is much more predictive of actually engaging in that behavior in that situation than is an internal locus of control orientation. Both mastery and competence are more generalized constructs than self-efficacy, and they encompass control over the situation and outcomes as well as control over behavior. Individuals with a sense of self-efficacy, mastery, or personal competence (as well as those with an internal locus of control orientation) generally feel very good about themselves (i.e., have high self-esteem and psychological well-being) and are receptive to learning about and engaging in new behaviors. An internal locus of control orientation coupled with a high degree of self-efficacy, mastery, or personal competence is a potent resource for helping individuals cope with health-related stressors.

3. Perceived behavioral control

Ajzen introduced the construct "perceived behavioral control" into his Theory of Planned Behavior (Ajzen, 1988) as a determinant of both behavioral intention and of the behavior itself. On a conceptual basis, perceived behavioral control is similar to self-efficacy—both constructs refer to the person's belief that the behavior in question is under his or her control—but, operationally, perceived behavioral control is often assessed by the ease or difficulty of the behavior (e.g., "I find it difficult to exercise three times a week"), while self-efficacy is operationalized by the individual's confidence in being able to carry out the behavior in the face of extenuating circumstances (e.g., "I am confident that I can exercise three times a week even when I am away on vacation").

Like Ajzen's Theory of Planned Behavior, most psychosocial theories of health behavior [e.g., the Health Belief Model (Rosenstock, 1990); Protection Motivation Theory (Prentice-Dunn and Rogers, 1986); the Health-Action Process Approach (Schwarzer, 1999)] have incorporated perceived behavioral control as a major determinant of intention to engage in a health behavior and/or as a determinant of actually engaging in the behavior, but these latter three theories explicitly label this construct as "self-efficacy." Regardless of the label attached to the construct, believing that one has control over a behavior is highly associated with actually doing that behavior.

4. Perceived situational control

Beliefs about control encompass control over one's situation, as well as control over one's behavior and outcomes. One example of a situation is being a patient in a clinical facility. Does the patient know why he or she is there? Does the patient know what will happen to him or her, and why? What it will feel like? Does the patient have any choice

over what will happen? The answers to these questions partially determine the patient's degree of perceived situational control. In turn, the more control the patient believes he or she has in that situation, the less distressed and more satisfied the patient will be, and the more likely the patient will be able to participate in his or her own care, including adhering to situational demands. This is true regardless of how much control the patient wants in that situation (cf. Wallston, 1989).

5. Helplessness

Helplessness is the belief that there is nothing that anyone can do to improve a bad situation (such as being diagnosed with an illness). In many ways, then, helplessness is a belief that control over the situation or its outcomes is impossible. Like all beliefs, helplessness is learned (Seligman, 1975). Learned helplessness is analogous to a chance locus of control orientation (i.e., the belief that one's outcomes are due to fate, luck or chance). Helplessness beliefs can be either *universal* (i.e., there is nothing that *anyone* can do) or *personal* (i.e., there is nothing that *I* can do). Either type of helplessness belief is associated with motivational, behavioral, and/or affective deficits. People with learned helplessness are not inclined to learn or engage in new, potentially effective behaviors, and they exhibit higher than normal levels of anxiety and depression.

6. Assessing control beliefs

A number of well-developed, standardized instruments exist for the purpose of assessing individual differences in control beliefs applicable to health and health-care settings (see Wallston, 1989; in press). Some of these measures (e.g., Pearlin & Schooler's Mastery Scale) are general, personality-like instruments, consisting of a single dimension. Others, such as the Health Locus of Control scales developed by the author and his colleagues, are multidimensional and can be adapted to assess control over one's health status in general or control over specified health conditions (e.g., cancer or diabetes). Researchers have also had some success in asking one or two pointed questions about subjects' perceptions of control (see Wallston, in press, for examples), but the psychometric soundness of this approach is questionable. Measures of desire for control are only weakly correlated with measures of perceived control

7. Altering control beliefs

Because control beliefs are learned, they can easily change as a function of life events (e.g., receiving a new medical diagnosis), or they can be systematically modified through the application of some form of cognitive-behavioral therapy. Shapiro and Astin (1998) have developed an integrated approach to psychotherapy, health, and healing that they term "control therapy." Their therapeutic approach is based on a unifying theory of human control "which is organized around three broad postulates: (1) Gaining and maintaining a sense of control is a major motivational force across the human life cycle; (2) There are both higher and lower levels of control-related goals, desires, and strategies by which people seek to gain a sense of control; and (3) There are individual differences with respect to how and why control is sought." (Shapiro and Astin, p. 20).

See also: Attributional style and health; Self-efficacy and health; Health behavior, psychosocial theories of

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