Health Psychology
Series editors Sheila Payne and Sandra Horn

Published titles

*Stress: Perspectives and Processes*
Dean Bartlett

*Psychology and Health Promotion*
Paul Bennett and Simon Murphy

*Rethinking Health Psychology*
Michele L. Crossley

*The Social Context of Health*
Michael Hardey

*Pain: Theory, Research and Intervention*
Sandra Horn and Marcus Munafò

*Loss and Bereavement*
Sheila Payne, Sandra Horn and Marilyn Relf

*Control and the Psychology of Health: Theory, Measurement and Applications*
Jan Walker
Control and the psychology of health
Theory, measurement and applications

Jan Walker

Open University Press
Buckingham · Philadelphia
Contents

Series editors’ foreword viii
Preface ix
Acknowledgements xi

1 Summary of control concepts 1
2 Perceived or personal control 8
3 Locus of control 42
4 Self-efficacy 74
5 Learned helplessness 96
6 Social support 121
7 Emotional states 151
8 A unifying theory of control 174

References 199
Index 243
This series of books in health psychology is designed to support postgraduate and postqualification studies in psychology, nursing, medicine and healthcare sciences, as well as the study of health psychology at undergraduate level. The framework in which the books are set is psychosocial rather than a medical disease, physiological systems or organic disease approach. Health psychology is growing rapidly as a field of study and a profession. Concerned as it is with the application of psychological theories and models in the promotion and maintenance of health, and the individual and interpersonal aspects of adaptive behaviour in illness and disability, health psychology has a wide remit and an important part to play in the future.

In this book, Jan Walker presents a comprehensive overview of concepts related to control. She covers such topics as perceived and personal control, locus of control, self-efficacy, mastery, social support and the emotional states that accompany them. The origins of these psychological concepts are explored and set within the context of developing ideas and theory in psychology. The reader can therefore understand how the ideas are both a product of their times and also influential in developing new ways to construe the world. The book is well referenced back to original sources. For health psychologists and other health professionals working with today’s problems and issues, it is enlightening to realize that others have struggled with these concerns. However, this is not merely a theoretical book, it is also concerned with issues of measurement and practical applications, and is rich with examples drawn from Jan’s practice as a nurse working predominantly with elderly people in Pain Clinics. The final chapter offers a new integrative model, which will challenge readers to explore the concept of control in more depth. The past few years have witnessed an important rethink about the way we approach the concept of control; this book aims to contribute to the debate.

Sheila Payne and Sandra Horn
Introduction

This book serves two key purposes. The first is to clear up many personal confusions and frustrations about terms and variables associated with the concept of control. The word ‘control’ is so much part of our everyday language that we all take its meaning for granted. When we read about ‘control’ in psychological terms, many of us tend to impose our own interpretation on it. Yet it is clear from the literature that it conceals a variety of different meanings, each of which has important theoretical implications. The information explosion means that students rarely have time to conduct extensive literature searches that go back beyond the past ten years. Obtaining recent material is a matter of some ease. But while recent research findings are clearly important, their interpretation requires knowledge of the theoretical and empirical contexts in which they are situated. In this book, I have set out a fairly comprehensive review of each of the main control-related concepts. I have explored the origins of each concept, together with subsequent theoretical and empirical developments, anomalies and dilemmas. In so doing, I have been able to focus on important and relevant information that is in danger of being lost to a new generation of students and researchers.

My second purpose is to offer a new theoretical analysis of the concept of control. This is one that seeks to account for the apparent anomalies identified by previous researchers and links each of the concepts reviewed in this book. Ultimately, I have sought to enhance theoretical clarity and generate testable hypotheses. I hope that this will inform improvements in research designs and generate new ideas for applications in health and health care.
Who is the book intended for?

The book is intended for undergraduate and postgraduate students who already have a reasonable understanding of basic psychological theories. It is aimed particularly at those who are preparing dissertations or research studies on topics related to health and well-being, for which the concepts in this book are of relevance.

How to use this book

Chapter 1 presents a brief overview of the key concepts included in this book, explaining briefly how each relates to a theory of control. Chapters 2 to 7 focus on each of these concepts in turn. In each chapter, I have set out the origins and development of the concept, drawing on contributions from key theorists, research studies and review articles. I have presented this material in a relatively raw form so that readers can trace the chronology of theoretical development and judge for themselves the nature and value of each contribution. This has also enabled me to set out the theoretical dilemmas, conflicts and resolutions or outstanding problems that have developed over time. Chapter 8 is devoted to my own contribution to theory development. It contains a critical review of some of the existing theoretical interpretations and offers a way of integrating the concepts previously reviewed. There I am able to explain some of the theoretical dilemmas identified. I also offer some new hypotheses and pointers for future research.

Each chapter contains a section on measurement and health care applications. While these are not exhaustive, they will provide the reader with an idea of the range of measurements and applications in the field of health and health care. At the end of each chapter are some recommendations for further reading. Some of the recommended texts are out of print, but they should not be considered out of date and are worth obtaining for those who wish to gain a deeper understanding of a particular concept.

Readers will note that in some places I have referred to the first name of a theorist or researcher. This is to enable the reader to identify the gender of certain key authors and also attempts to break down the sense of ‘facelessness’ that pervades some psychology texts.
My sincere gratitude is given to: Sheila Payne and Sandra Horn for giving me the opportunity and impetus for writing this book and for their helpful comments; my husband, Mike, who encouraged, cajoled and supported me when the task seemed overwhelming; Hugh Baldwin, Brenda Goddard and the staff in the Postgraduate Library at the Royal Hampshire County Hospital, Winchester, without whose help the material could not possibly have been gathered; Helena Morton, for her encouraging review and very useful observations.
Summary of control concepts

Overview of contents

- Control theory
- Control research
- Perceived or personal control
- Locus of control
- Self-efficacy
- Learned helplessness
- Social support
- Emotional states and responses
- A unifying theory of control
- Further reading

Control theory

Control is a key concept in the psychology of health. It has important applications in the fields of stress, coping and adaptation, health promotion, health education, rehabilitation and care in acute and chronic illness, disability and terminal illness. It also has important implications for the management of the relationship between patients or clients, carers and health care professionals in all health care settings.

Control is used predominantly to refer to the attainment of a desired outcome or, using the language of systems theory, the system goal or ‘reference criterion’ (Hyland 1987). Desired outcomes thus encompass those that assure the survival of the individual and the species, protect individual health and well-being, and meet cultural, ideological, social and material demands. The term control is commonly used to refer to both process (of attainment) and outcome.
2 Control and the psychology of health

Although ‘control’ is frequently used to refer to personal control, I will illustrate later in this book how control may be achieved through the activities of either self or others, or even belief in an external force. ‘Others’ in a health context may include family, relatives, friends, doctors and other professionals, employers and support agencies. Control is normally associated with positive outcomes and with adaptation, yet control may in some circumstances be associated with deviant or maladaptive consequences. The classification of an outcome as adaptive or maladaptive may depend on the different perspectives of the actor and the observer.

Although frequent reference is made in the literature to ‘control theory’, there is to date no accepted unifying theory of control. Rather, there is a multiplicity of theories and concepts associated with control. These include perceived control, personal control, locus of control, self-efficacy and learned helplessness. While these concepts have provided useful heuristics in health and health care, the search for a theory of control has remained illusive. Systems theory has come closest to achieving this and I refer to this again in Chapter 8, where I offer a theoretical framework that integrates all the concepts reviewed in this book.

Control research

The development and testing of control-related concepts has involved a number of different approaches over time. Research in the 1940s and 1950s involved objective testing of the effects of giving or withholding of control over aversive stimuli, much of which took place in the animal laboratory (Lefcourt 1966a, b). The theory of learned helplessness emerged directly from this type of research. The 1960s saw a general shift towards relatively small-scale human experiments involving university undergraduates. Hypotheses were developed and tested in a reductive way, but with considerable attention to methodological rigour. Meanwhile, research into control beliefs emerged from studies of the responses of human participants in health care and education settings. From the mid-1970s onwards, most researchers favoured field-based experiments and surveys in naturalistic settings. However, it has proved difficult to demonstrate the power of variables associated with the concept of control to predict health outcomes. Important reasons put forward in this book include the lack of a clear distinction between independent, mediating and dependent variables, the neglect of most researchers to consider the interaction between perceived personal control and different types of social support, as well as the failure to provide unambiguous definitions of concepts and terms.

Below is an overview of each of the concepts reviewed in this book, together with a brief rationale for inclusion.
Summary of control concepts

Perceived or personal control

Perceived control reflects the beliefs of an individual about the actual or potential availability of control achievable by self or others in different types of situation. Perceived control may differ from the actual level of personal control available within an environment, since it is influenced by the actor’s frame of reference, knowledge and skills, past history of control or lack of control in similar situations, personality traits and cultural beliefs. Under normal circumstances it appears that most people demonstrate an illusion of control, with attribution bias towards personal control.

Most researchers, when referring to perceived control, imply perceived personal control, omitting the possibility that perceived control may also be achieved with assistance from others. Most research supports the view that perceived personal control is generally advantageous in relation to physical and psychological health outcomes. However, total reliance on personal control is likely to be maladaptive in uncontrollable situations. Hence, it is argued during the course of this book that a balance of personal control and social support is desirable when an individual is in difficulties, sick or disabled. Perceived or personal control, unlike other control-related concepts, is not associated with a key theorist or group of theorists. The terminology used is very variable and there is little or no agreement about appropriate forms of measurement. Despite this, the concept has had a profound impact on a range of health care practices; for example, in the field of pain management.

Locus of control

Locus of control refers to beliefs about responsibility for outcomes. The concept accounts for different sources of control, including self, others and chance. However, its conceptualization has changed over the years as a result of research, reviews and reanalysis. Starting as a unidimensional concept (internal–external), it was revised in the 1970s to reflect three orthogonal dimensions: internal, external (powerful others) and external (chance). More recently, it has been suggested that chance beliefs are not independent of internal locus of control, but reflect the opposite pole of the same dimension.

Research findings in relation to locus of control have proved somewhat contradictory. Despite its initial promise, locus of control has been shown to be a relatively weak predictor of health-related behaviour. The most consistent finding is that chance locus of control is associated with poor motivation to engage in preventive or protective health behaviours, and poor health outcomes. Logically, high scores on both internal and external (powerful others) locus of control would appear to be most adaptive in terms of health outcomes. Such scores indicate a belief in personal responsibility for health but a willingness to seek help from others and take advice
Control and the psychology of health

when necessary. Beliefs in luck, fate or chance are generally associated with failure to engage in health-protective behaviours and depression in the face of chronic illness.

Self-efficacy

Self-efficacy is fundamental to the achievement of internal or personal control. It refers to the ability/capability of the individual to achieve a desired outcome. Hence it implies a body of requisite knowledge and skills. However, in order to achieve a desired outcome, it is necessary for people not only to have the knowledge and skills, but also to believe that they have them. Therefore self-efficacy normally refers to sense of self-efficacy or perceived self-efficacy. Self-efficacy is particularly important when a task requires specific knowledge and skills. Therefore, specific rather than general measures of self-efficacy are usually used and a wide range of these is currently available. The concept of self-efficacy emerged from research by Albert Bandura on social learning theory. Bandura has, over the past three decades, remained at the centre of research to develop and test the concept in a variety of health-related contexts.

Self-efficacy has proved to be an important variable, in conjunction with other variables, in predicting health-related behaviours and behaviour change. The importance of promoting beliefs in self-efficacy is central to many health care interventions, particularly in the field of chronic disease. Sense of self-efficacy is a good indicator of motivation and a measure of self-efficacy may therefore be a useful indicator of the sustainability of interventions designed to enhance personal control.

Learned helplessness

Learned helplessness refers to the belief that one’s actions have no effect on outcomes. It is thus a belief in total lack of personal control over the situation. In the experimental context, a period of exposure to total loss of control leads subsequently to the total failure to attempt any response that could lead to a desired outcome or to the cessation of an aversive or undesired outcome. The concept originated from observations in the animal laboratory and is most commonly associated with Martin Seligman. Seligman and his colleagues demonstrated that learned helplessness is associated with three deficits: behavioural, cognitive and motivational. Seligman subsequently presented learned helplessness as an analogue for human depression.

The concept of learned helplessness has undergone numerous revisions over the past three decades. It was reformulated using attribution theory to represent human beliefs about helplessness. More recently, it was revised again to account only for a hopelessness subtype of depression. The literature
reveals a concept that has failed to live up to its original promise in terms of theoretical prediction and appears, according to recent reviews, to have lost its way.

Nevertheless, despite recent threats, the concept of learned helplessness continues to hold great intuitive appeal for health care professionals and has been extensively used as an explanatory framework within health care. It implies that what is learned can be unlearned, a prediction supported by early experimental evidence. Learned helplessness appears to imply situational, rather than personal, causes, thus avoiding victim-blaming. However, some applications in general health care settings have been based on theoretical misunderstandings. For example, most health care professionals from non-psychology backgrounds use the term 'learned helplessness' to refer to a state of induced dependence. This is an inference which, though logical, goes beyond its original conceptual meaning.

The term 'learned helplessness' appears ripe for a thorough review and this I attempt to do in Chapter 8 in this book. There I examine loss of control in a social context to refer to a failure to achieve desired outcomes through the actions of either self or others. This reanalysis allows for a distinction between hopelessness and helplessness. According to this reanalysis, hopelessness is associated with prolonged failure to gain control by any means (self or others) and failure to foresee any possibility of so doing. Helplessness refers to the perception of threat of loss of control brought about by perceptions of persistent uncertainty or unpredictability, or in response to an episode of sudden temporary but total loss of control, as in post-traumatic stress. In accordance with these definitions, I propose that a generalized sense of 'learned hopelessness' is associated with clinical depression. A generalized sense of 'learned helplessness' is associated with chronic anxiety states, with or without depression.

Social support

Social support appears to be the missing variable in our current understanding of control. Based on the definitions and propositions presented in this book, it is evident that control may be achieved through the actions of others as well as those of self. The actions of others, whether through helping, sharing or giving information or advice, constitute social support.

Social support would appear to serve a number of distinct control functions. It can remove or replace personal control, or it can enhance or increase it. Instrumental social support may exert direct control on behalf of, or over, the individual. This can complement the personal control of the individual or usurp it. It may therefore be beneficial or deleterious, depending on circumstances or context. Similarly, informational support may be used to exert power over an individual or to facilitate personal control. Emotional support is usually considered to bolster individual sense of
Control and the psychology of health

personal control and self-efficacy and enhance self-esteem. This explains why informational and emotional support, in health care contexts, are usually found to have a positive impact on health and well-being. Instrumental support, in contrast, has been found to be associated with dependence and increased depression.

Researchers must therefore distinguish between different types of support if they are to make sense of the direct and buffering effects of social support in different circumstances. It is also necessary to take account of individual desire for control and the controllability of the situation. Placing social support in the context of a theory of control enables researchers to understand how different types of support are likely to impact on health outcomes. Failure to do so will continue to lead to conflicting and confusing research findings.

Emotional states and responses

Control has a direct effect on emotional states (and possibly vice versa). Perceived lack or loss of control is associated with both anxiety and depression, and measures of depression and/or anxiety are commonly used in studies of perceived control and self-efficacy. However, little attention has been given to the positive emotional impact of perceived control, including feelings of confidence and satisfaction. The causal relationship between emotional state and control remains unclear. Some researchers use the term ‘affect’, implying a causal link between emotional state and beliefs and behaviours. Other researchers have assumed that emotional states such as depression and anxiety are effects of loss of control. In reality, feedback loops between physiological state, cognitive set and behavioural pattern make it difficult if not impossible to distinguish between cause and effect. The possible relationship between event, arousal, cognition and action are illustrated in Chapter 8, Figure 8.8.

A unifying theory of control

In Chapter 8 of this book, I present a theoretical framework that proposes a direct link between control beliefs, social support and emotional states. In it I illustrate how a range of mood states may be mapped on to different beliefs about control and support. In Figure 8.9, I present a flow diagram that illustrates the likely relationships between each of the concepts reviewed in this book and summarizes a proposed new unifying theory of control. I believe that this has important implications for the development of health care interventions based on the enhancement of both personal control and social support. It also assists in guiding the selection of dependent and independent measures for use in future health care research.
Further reading


This text provides brief but comprehensive overviews of the key concepts contained in this book (and much else) by authors who are well recognized in their respective fields.