Control-Related Motivations, Capabilities, and Preferences Among Patients
The Roles of Primary and Secondary Control in Older Adulthood

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Despite the economic importance of a growing population of older consumers, many services researchers have ignored service quality issues related to elderly consumers. Perceived control is one psychological dimension wherein older adults may differ from their younger counterparts and among themselves. This paper proposes that efforts to enhance control perceptions of older adult patients should be a planned component of interactions between those patients and all health-care personnel. At least three categories of benefits may accrue: patients benefits (emotional and physical); social benefits (financial benefits to society); and managerial benefits (improvements in patient satisfaction, service quality perceptions, and loyalty). Two categories of control-enhancing behaviors, primary and secondary, are presented. Two evaluative dimensions, motivation and (perceived) ability to control, are advocated as means for assessing control-related behavior preferences among older adult patients. Techniques health-care personnel can use to enhance both primary and secondary control opportunities are suggested.

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Although different from their younger peers in many ways, Wolfe (1994, p. 32) notes that “profound” psychological differences exist between—as well as within—younger and older groups of adults. Examples of such differences can include discrepancies in the valuation of autonomy, social connectedness, altruistic behavior, personal growth, and revitalization.

The focus of this paper, perceived (personal) control, is another important psychological dimension wherein older adults differ from younger adults (Heckhausen and Schulz, 1995) and, consistent with literature arguments that elderly persons are not a homogeneous market, among themselves (e.g., Moschis, 1991; Moschis, Mathur, and Smith, 1993). Perceived control is defined here as the judgement that the events in one’s life are or can be ordered (by the self or by another) or that adaptation to them is possible (see Rotbaum, Weisz, and Snyder, 1982). Although the marketing literature pertaining to perceived control is relatively sparse, the construct has become important in the psychological literature. The favorable effects of sensing control have been demonstrated in numerous domains, including academic achievement (e.g., Menec, Perry, Struthers, Ward, and Schonwetter, Hechter, and Eicholz 1994), aging (e.g., Burns and Seligman, 1989; Rodin, Timko, and Harris, 1985), and stress, health, and health maintenance behaviors (e.g., Helgeson, 1992; Schiaffino and Revenson, 1992; Thompson, Sobolew-Shubin, Galbraith, Schwankovsky, and Cruzen 1993). For example, Taylor (1990) showed that patients who chose to and were allowed to make choices in their recovery processes tended to use less medication, were more active, and recovered faster.

Over the past decade, services marketing researchers have extensively explored many aspects of delivering high-quality, satisfying service experiences to clients (e.g., Cronin and Taylor, 1994; Parasuraman, Zeithaml, and Berry, 1988), and a parallel stream has emerged in the health-services literature (e.g., John, 1992; Taylor and Cronin, 1994). The perceived...
control construct has attracted some notice. For example, Hui and Bateson (1991) demonstrated that higher levels of control lead to increased client satisfaction, perceptions of greater service quality, and strengthened client loyalty. Despite the economic importance of the older adult population, many services researchers have ignored service satisfaction and quality issues in relation to elderly clients (see Rahtz, Meadow, and Sirgy, 1991 as an example of exceptions). Furthermore, an extensive review of the services literature failed to identify any research that incorporates the psychological dimension of perceived control to explain the service quality perceptions of older adults.

Because older adults represent an important consumer segment for health-care services and because higher control perceptions have been shown to result in various favorable outcomes, this paper argues that efforts to enhance the control perceptions of older adult patients should be a planned component of the interactions that occur between those patients and all health-care personnel. Furthermore, it proposes that benefits of such control enhancement may accrue on at least three fronts. At issue may be implications for patients’ emotional and physical well-being (patient benefits), financial costs and benefits to society (social benefits), and improvements in patient satisfaction, service quality assessments, and loyalty (managerial benefits). The paper begins by considering these benefits at greater length. An examination of control perceptions and their determinants among older adults in a health-care context follows. The paper concludes with a discussion of techniques health-care professionals can use to enhance control perceptions among older adult patients.

Benefits of Higher Patient Control Perceptions

The gerontological literature consistently demonstrates that the feeling of being in control is beneficial to personal physiological well-being for older adults (e.g., Baltes and Baltes, 1986). In addition to such patient-specific benefits, however, the control-related literature suggests many ways in which society as a whole, as well as health-care institutions specifically, can benefit financially through the enhancement of patient control perceptions. Accordingly, three corresponding categories of benefits are identified and discussed here.

Patient Benefits

Patients who enjoy a sense of control in health-care experiences exhibit more positive adaptational outcomes to disease and aversive treatment (i.e., more favorable emotional and behavioral tendencies). For example, Affleck, Tennen, Pfeiffer, and Fifield (1987) found that high-control patients (i.e., patients who perceive themselves capable to predict, interpret, and/or influence their condition), when faced with a chronic disease such as rheumatoid arthritis were less anxious, less depressed, more clear-headed about their decisions, and felt more energetic. In addition, they scored better on measures of daily functioning, were less focused on the limitations imposed by the disease, and exhibited better interpersonal relationships.

Second, high control perceptions contribute to physical well-being by: (1) helping to avoid negative physiological results associated with loss of control; and (2) increasing the likelihood that patients will engage in appropriate health maintenance or health-enhancing behaviors. Illustrative of the first point, research indicates that stressed subjects with high levels of control perceptions exhibit physiological profiles similar to organisms undergoing no stress at all. On the other hand, high levels of stress among low-control subjects has been shown to lead to elevated peripheral levels of catecholamines (Frankenhaeuser, 1975; Frankenhaeuser, Lundberg, and Forsman, 1978; Lundberg and Frankenhaeuser, 1978), secretions associated with increased blood pressure and heart rate, elevation of blood lipids, and provocation of ventricular arrhythmias (Krantz, Glass, Contrada, and Miller, 1981). Taylor (1990) provides evidence that patients high in control perceptions are more likely to engage in professionally advised health behaviors (e.g., participation in exercise, cessation of smoking, relaxation).

Social Benefits

The average length of a stay in the hospital increases with age from an average for all ages of 6.5 days, to 8.1 days for men 65 to 74, to 9.1 days for men over 85 (older adult women’s stays are slightly longer; Spotts and Schewe, 1989). A significant portion of the cost associated with these stays are borne by the public in the form of Medicare payments to institutions and attending care providers. Rodin (1986) discusses results of numerous studies that demonstrate the favorable health effects of increased perceptions of control specifically for elderly patients, including faster recovery time and long-term (measured over 18 months) improvements in health measures. Faster recovery times that lead to shorter hospital stays can reduce over-all Medicare payments. If control enhancement can lead to improved health among older adults, it may be the case that their use of prescription drugs, which accounts for one-third of all drug use (Business and Health, April 1996), can be reduced. In addition, healthier older adults may prove to be more active consumers of other products and services.

Managerial Benefits

Hui and Bateson (1991) demonstrated that increased control perceptions are valued by customers, and, thus, lead to higher levels of client satisfaction. In turn, service researchers have established the positive effects of client satisfaction on perceptions of service quality, loyalty to the service provider (for example, intent to continue the patient–provider relationship), and positive word of mouth communications (e.g., Boulding, Kalra, Staelin, and Zeithaml, 1993). Such results argue persuasively that health-care facility managers and ad-
ministrators should instruct and encourage care providers to enhance patient control perceptions. Loyal clients and a favorable reputation can be important contributors to competitive advantage in today's health-care market.

**Control-Related Preferences, Motivations, and Capabilities of Older Adults in the Health-Care Context**

**Primary and Secondary Control**

It is important at this point to make the distinction between the perception (sensation) of control and the associated tactical behaviors that can lead to that perception. Rothbaum, Weisz, and Snyder (1982) outlined a theory of perceived control that identifies two categories of control-related behaviors to encompass this variety of tactics, *primary control* behaviors and *secondary control* behaviors.

Primary control behaviors are active, first-person attempts to change the world to fit the needs and desires of the individual and are directed at salient elements of the external environment (e.g., a source of stress or its consequences). Exemplary tactics include those that Averill (1973) categorized as (overtly) *behavioral*. For example, Band and Weisz (1988) found that young children faced with getting a shot are likely to kick and scream, a primary control strategy aimed at avoidance. Thompson, Nanni, and Levine (1994) studied perceived control in HIV-positive men and found that, even when the patient could not control the major stressor (i.e., the disease itself), controlling other aspects of daily life affected by the condition (e.g., emotions and symptoms) was a primary means of maintaining control perceptions. This form of primary control behavior, characterized as control over consequences, was also noted among cancer patients by Thompson, Sobolew-Shubin, Galbraith, Schwankovsky, and Cruzen (1993). Granting patients power to make decisions about important aspects of their treatment regimen also enables patients to exercise primary control (Taylor, 1990).

Secondary control behaviors, on the other hand, are attempts to change the self to fit with perceived realities of the environment. These include: (1) attempts to conform cognitively and emotionally; (2) overt or decisional behavior affecting goals or objects tangential to the event itself (Averill, 1973); and/or (3) trust in or alignment with a powerful other (Rothbaum, Weisz, and Snyder, 1982). These forms of control behaviors are examined in turn.

Cognitive control refers to the way a potentially harmful event is understood and can be achieved in two nonexclusive ways (Averill, 1973). *Information gain*, for example, the acquisition of information about a disease, its prognosis, or a care procedure, increases predictability of the event and enhances certainty in anticipation. *Appraisal*, on the other hand, consists of an evaluation of the event, has an interpretive connotation, and may involve scaling back expectations. Band and Weisz (1990) found that older, informed children with diabetes tended toward appraisal (“... I can still live a full life”) and away from the avoidance attempts often noted in younger children. Similarly, an adult patient with a chronic, debilitative condition might interpret activity restrictions as an opportunity to “stop and smell the roses.” Schulz and Decker (1985) found that one way in which elderly, spinal cord injured persons coped with their disability was to emphasize the importance of “brain” over “brawn” in defining the quality of their lives. Together, information gain and appraisal can enhance perceptions of control by increasing patients’ capacity to predict, adjust to, and accept the outcomes they receive (Thompson, Sobolew-Shubin, Galbraith, Schwankovsky, and Cruzen, 1993; Thompson, Nanni, and Levine, 1994).

Secondary, achievement of control perceptions through tangential means implies opportunities to control overly or to make decisions about objects or goals disconnected from the aversive event itself. Averill (1973) proposed that, by changing the focus of achievement, a person may achieve a (secondary) sense of control in a stressful situation even when little or no (primary) control over the situation is possible. Band and Weisz (1988) noted that older children spontaneously or, on the advice of a parent, doctor, or nurse, chose to look away or think of something else when getting a shot—an approach that carries through into adulthood. Appraisal strategies (e.g., “stopping to smell the roses,” or emphasizing “brain” over “brawn”) often find fruition in decisions that change the focus of achievement (see Heckhausen and Schulz, 1995), such as deciding to spend more time with grandchildren, or pursuing a self-development activity such as artwork, crafts, or reading. Such decision making is distinctly secondary in nature, because it does not involve decisions about the stressor or its consequences. As with other secondary control behaviors, control perceptions gained by diverting one’s attentions contribute to the patient’s over-all or generalized sense of control.

Finally, Rothbaum, Weisz, and Snyder (1982) add to Averill’s (1973) concept of control when they propose that secondary control strategies include alignment with a powerful other (e.g., trusting in the advice or aid of another who is believed to be able to affect an event the individual cannot). Heckhausen and Schulz (1995) include “praying to God” (p. 285) as a behavior of this sort; Koenig, George, and Siegler (1988) identified religious coping as an effective means for dealing with challenges encountered in old age. Parasuraman, Zeithaml, and Berry (1988) also identified trust in the provider to be a critical factor in a variety of service types. Koernher (1994) found that some patient–provider relationships, particularly those in intense medical situations (e.g., giving birth, coping with terminal illness, or watching a loved one die) exhibit “sacred” qualities. Such qualities include acts of kindness, personal sacrifice, and high personal commitment on the part of providers; these and similar behaviors may enable patients to feel aligned with their health-care provider.
Roles of Primary and Secondary Control

Following White (1959), who identified the ability to exercise control over important aspects of one's life as fundamental to emotional well-being, most services researchers explicitly or implicitly presume that people's control perceptions derive from their capacity to exercise some form of primary control (e.g., Hui and Bateson, 1991). However, it has also been noted that clients do not always want this sort of control; for example, in highly stressful (e.g., funeral arrangements for a loved one; see Gentry, Kennedy, Paul, and Hill, 1995) or in uninvolving (e.g., opening a bank account; see Suprenant and Solomon, 1987) service situations. However, services literature maintains the concomitant hypothesis that higher control perceptions can be orchestrated by offering opportunities for only primary control. This is a unidimensional view of control, because it ignores secondary control and, therefore, may be of limited use to health-care managers and providers.

Efforts to enhance client control perceptions by simply offering primary control opportunities presume that the client is both motivated to and capable of performing appropriate behaviors (see Heckhausen and Schulz, 1995; Reich and Zautra, 1990; Rothbaum, Weisz, and Snyder, 1982). In health care, it is often the case that these conditions are not satisfied because of the nature of the patient's condition or treatment, for only primary control. This is a unidimensional view of control, because it ignores secondary control and, therefore, may be of limited use to health-care managers and providers.

Enhancing Control Perceptions for Older Adult Patients

Assessing Motivation and Ability To Exercise Primary Control

Enhancing control perceptions requires providing opportunities and encouragement for the patient to engage in appropriate and preferred control-enhancing activities. Assessing older patients' preference for primary (relative to secondary) control opportunities hinges on the questions of whether the patient: (1) possesses motivation; and (2) perceives him or herself to possess the ability to engage in primary control activities. For each of these two assessment variables, this paper identifies two contributing factors. An interesting avenue for future research would be the identification and empirical assessment of these and additional factors.

MOTIVATION. Motivation for primary control is proposed to depend upon both a subjective personality factor, Desire for Control (DC; Burger and colleagues, 1979, 1985), and a somewhat more objective factor, Involvement. DC is a relatively stable personality trait that reflects the extent to which individuals generally are motivated to strive for primary control over events in their lives (Burger, 1985). Consistent with Burger's observations, it is proposed that persons high in DC prefer making care decisions and taking part in activities central to their care regimen; those low in DC may prefer that someone else make decisions for them. Patients high in DC should be relatively more assertive, decisive, and active in their quest for both care and information (Burger and Cooper, 1979). Patients low in DC, for whom primary control is less valued, tend to be nonassertive, indecisive, and passive.

Involvement is a variable that occurs in a variety of forms. Consumer researchers generally agree that sources of involvement are of three types: personal, object, and situational (see Zaichkowsky, 1985). Personal factors (e.g., intensity of desire for full and quick recovery) interact with object factors (e.g., perceived triviality or centrality of the health condition) and situational factors (e.g., salience of condition relative to other current situations of concern). In health care, myriad sources of involvement exist, including risk to life and life enjoyment, expectations of pain, potential cosmetic change, hope for cure or healing, and a host of others. Although many medical experiences are highly involving, others are not. Routine office visits for minor illnesses, for example, may be relatively uninvolving for the patient, and may lead to a lower motivation for primary control.

ABILITY. Perceptions about one's ability to exercise primary control depend upon both a subjective personality factor, Internality of Control (see Rotter, 1966) and the objective characteristics of the care situation. Internal individuals perceive themselves to possess a high capacity to control aspects of their lives. They have greater expectancy that their strategies, plans, and behaviors will contribute to goal attainment than do external individuals, who perceive that control over goal attainment resides largely outside themselves. External persons seem to exhibit a preference for secondary control strategies in most circumstances; internal persons exhibit secondary control preferences only when their motivation to exercise primary control is low or objective realities preclude it (Reich and Zautra, 1990; Rothbaum, Weisz, and Snyder, 1982). Although a number of assessment instruments exist for identifying internal and external individuals in experimental settings (e.g., Rotter, 1966), a less formal evaluation might be made on the basis of patients' answers to questions about their self-confidence levels for exercising primary decisional control over, or for carrying out, aspects of care regimens.
Finally, health professionals can assess patients’ capacity for exercising primary control on the basis of their own knowledge of the characteristics of the care required. Clearly, there are aspects of care plans that are not amenable to patient influence. In such cases, the role of secondary control opportunities is great in contributing to general control perceptions. However, as with other services, health-care regimens consist of a bundle of attributes (activities). At one extreme; for example, surgical procedures, the patient is forced into the role of a passive recipient of care. However, other aspects may be subject to some patient influence; for example, extent of pain relief medication taken or participation in exercise.

Control Enhancement Techniques for Older Adult Patients

As previously indicated, increasing control perceptions for older adult patients requires that health-care providers offer opportunities and encouragement for the patient to engage in appropriate control-enhancing activities. These activities will likely be some combination of primary and secondary control behaviors (cf., Rothbaum, Weisz, and Snyder, 1982), the determination of which should be based upon an assessment of the patient’s primary control motivations and ability perceptions. Figure 1 is a decision matrix based upon these two dimensions. Persons high in control motivation and perceived ability fall into the upper left quadrant. It is suggested here that these people will be most favorably responsive to combinations that emphasize primary control opportunities.

Persons high in one dimension but low on the other fall into the lower left or upper right quadrant and respond best to control opportunities that more equally combine primary and secondary control. Evidence cited by Heckhausen and Schulz (1994, 1995), suggests that the majority of older adult patients can be located here. Nevertheless, the control preferences of patients in these two categories probably differ as well. Patients in the lower left quadrant, although possessing sufficient ability to exercise primary control, are less motivated to do so because of low involvement or DC. These patients still value a degree of (i.e., do not abandon) primary control (cf., Heckhausen and Schulz, 1994, 1995), but are likely to exhibit a preference for secondary control. The upper right quadrant, on the other hand, is exemplified by patients who are motivated to take a primary role in their care but lack the ability. These patients probably would respond favorably to instruction or aid that enables them to take a more primary role in their care, while concurrently using secondary control opportunities.

Finally, the lower right quadrant represents patients who score low on both motivation and perceived ability to exercise primary control. For these patients, offering control perception by enabling them to engage in secondary control behaviors is especially critical.

ENHANCING PRIMARY CONTROL. Providing primary control opportunities requires that care providers empower the patient to take action that is either decisional or behavioral. Such action must be perceived by the patient to have a direct influence on the care (regimen) itself, its consequences, or the consequences of the treated condition. For example, patients can be invited to convey information about their condition and made to perceive that this information is influential to the provider’s diagnosis or prescription of treatment. Recovering surgical patients can be empowered to request pain relief medication according to their perceived need (subject to a maximal schedule). Patients with debilitating conditions can be educated as to how they can carry on with familiar activities by changing their tactics or tools. A patient with a back injury may need to switch to slip-on shoes; arthritis may necessitate the use of effort-saving appliances when cooking. In such cases, however, primary control enhancement goals may be subordinate to the objective of minimizing perceptions of control loss, which requires enhancement of secondary control.
ENHANCING SECONDARY CONTROL. Providing secondary control opportunities requires that the care provider aid the patient to: (1) conform cognitively and emotionally to the condition, its treatment, and their consequences; (2) choose and affect tangential goals; and/or (3) trust the provider. The following paragraphs illustrate tactics that can be used to implement these strategies.

Enabling the patient to conform cognitively to the realities of his or her condition or treatment implies helping him or her to gain sufficient information about it and/or guiding the patient to a positive appraisal of it. The result of such conformity should be an emotionally healthy view of these realities. Medical conditions and procedures can be made more predictable simply by providing information that enables the patient to know what to expect. Information about schedules and delays can minimize dissatisfaction caused by time spent waiting (see Taylor, 1995). Assisting clients in appraisal might imply helping them to see the benefits of aversive procedures. Alternatively, it may be desirable to help them change their frame of reference; Heidrich and Ryff (1993) found that elderly women facing health-related threat or loss profited most from self-enhancing comparisons with others perceived as being “worse off.”

A variety of tangential goals can be imagined, which vary with the nature of the stressor. With a relatively mundane event such as an inoculation or lab procedure, the caregiver can change the focus of the moment simply by engaging the patient in conversation. At the other extreme, a cancer patient enduring the hardships of radiation or chemotherapy, more meaningful and long-lasting activities can be encouraged (e.g., recording a family history, pursuing learning activities, etc.).

Physicians, nurses, and other health-care providers represent obvious targets of trust in the health-care context. However, patients must have reason to trust in these professionals. Two general categories of such reasons come readily to mind: assurance cues and experience cues. Assurance cues are tangible or intangible evidences conveyed by the provider. For example, certificates of professional accreditation provide visual evidence that the provider possesses at least a minimum level of competence to administer care. In addition, the health-care professional is her or himself a powerful assurance cue of trustworthiness. The patient may assess the care provider’s competence based upon his or her demeanor (i.e., thoroughness, decisiveness, etc.). Experience cues stem from past experience with the provider, and represent the major source of word of mouth communications.

Conclusion and Opportunities for Research

This paper makes the conceptual argument that health-care managers and providers have the opportunity to create: (1) patient benefits; (2) social benefits; and (3) managerial benefits by enhancing control perceptions among older adult patients. To achieve these benefits, control-enhancing strategies should be made an integral component of all patient–provider interactions. Although valuation of control perceptions is pervasive across age groups, there is strong evidence that older adults may differ from younger adults, and among themselves, in terms of their preference for secondary control opportunities. On the whole, older adults continue to value primary control opportunities, but seem to have a greater capacity and propensity to make use of secondary control, particularly in such low control circumstances as those often encountered in the health-care setting. This may explain research results that indicate generalized control perceptions remain stable well into old age, even when primary control opportunities diminish in number (e.g., Brandstadder and Rothermund, 1994). Successfully incorporating control enhancement strategies, therefore, requires that managers and care providers assess the control-related preferences of these patients and be prepared to help patients engage in primary and secondary control behaviors. Such a control preference assessment should be grounded in an evaluation of patients’ motivations for and perceived ability to exercise primary (relative to secondary) control behaviors.

Further research, both conceptual and empirical, is called for on a variety of fronts. A deeper consideration of the benefit categories identified earlier would raise the issue that some patient or social benefits may be at odds with managerial goals. For example, a reduction in length of hospital stays or medication usage may be desirable from a personal or societal standpoint, but translates into a reduction in revenue for the health-care industry. This issue exceeds the scope of this paper, but is only a special case of the current debate regarding the growing cost of health care.

At a more personal level, exemplified by patient–provider interactions, there are likely to be circumstances where offering primary control to the patient implies that the provider must relinquish some control. This would certainly be the case when a provider offers care choices to the patient she or he would normally have reserved for her or himself. However, the enhancement of control perceptions need not be a zero-sum game; as we have seen, there are primary control opportunities that can be constructed rather than transferred (e.g., control over consequences). Investigating the dynamics of such control trade-offs and identifying primary control opportunities that do not involve such trade-offs are only two avenues of research that relate to this issue.

The discussion regarding the control preference decision matrix (see Figure 1) is an assertion that patients can be categorized according to their control preferences. In addition to an empirical test of such an assertion, further consideration of the two combinatorial quadrants is in order. For example, attempting to enhance primary control ability perceptions for patients who exhibit high motivation (but low perceived ability) may accomplish more than simply increasing control perceptions in the care context. It may prove to be a means...
of “treating the whole patient”; that is enhancing generalized perceptions of personal coping skills. On the other hand, offering numerous primary control opportunities to the patient who lacks motivation (but not ability perceptions) may simply engender irritation and ill will.

In sum, the evidence presented here suggests that enhancement of control perceptions for older adult patients can result in improved physical and emotional well-being among patients, reduced costs to society, greater patient satisfaction, and an improved, long-term relationship with the care provider. However, the enhancement of control requires a greater understanding of the control construct itself, as well as the control-related preferences of these patients. Knowledge about primary and secondary control behaviors, and patients’ motivation and ability to engage in them, is key to the development of such understanding.

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References


Rahtz, Don R., Meadow, H. Lee, and Sirgy, M. Joseph: Healthcare


Rodin, Judith: Health, Control, and Aging, in The Psychology of Control and Aging, Margaret M. Baltes and Paul B. Baltes, eds., 1986, pp. 139–165.


