Perceived Control: How Is It Related to Daily Occupation in Patients With Mental Illness Living in the Community?

Mona Eklund

Perceived control is of significance in occupational therapy, as revealed in empirical research and suggested in practice models. This study investigated the relationship between perceived control and occupational performance in persons with long-term mental illness. The 177 participants were assessed regarding perceived control (locus of control and self-mastery) and occupational performance (activity level and satisfaction with daily occupations). Subgroups with respect to diagnosis and having gainful employment or not were also explored concerning the targeted association. The results indicated relationships between perceived control and occupational performance in the sample as a whole and in all subgroups except that representing people engaged in gainful employment or education. The latter was a surprising result, considering that the importance of perceived control was originally identified in the work science area. The results strongly supported that perceived control should be included in the clinical reasoning of occupational therapists working in mental health care.


Perceived control, a belief that outcomes in life are the consequences of one’s own actions, has attracted attention in various research fields. Originally, interest in perceived control was evoked in the work science area, because perceived control was found to be vital for satisfaction with work (Aronsson, 1989; Jackson, 1989; Karasek & Theorell, 1990). More recently, Bengtsson-Tops (2004) suggested that perceived control was an important indicator of empowerment for people with severe mental illness, and it has been shown to be important for their well-being, quality of life, and functioning (Bengtsson-Tops, 2004; Eklund, Bäckström, & Hansson, 2003; Hansson et al., 1999; Rosenfeld, 1992). A sense of control, in terms of perceived self-mastery, is an indicator of pervasive recovery, beyond reduced symptomatology (Buist-Bouwman, Ormel, de Graaf, & Vollebergh, 2004; Fava et al., 2001). Thus, perceived control has been shown to be related to health, well-being, empowerment, and recovery, all of which constitute important treatment goals in mental health care. Moreover, a recent study showed that perceived control mediated the relationship between psychopathology and self-rated health in persons with severe mental illness (Eklund & Bäckström, 2006). This finding indicates that perceived control could be one missing link in explaining why improvements on a symptomatic level often are not followed by improvements in subjective well-being. Perceived control might thereby be a potential mediator between therapeutic interventions that affect psychopathology and the subjective feeling of health and should be explored further in the context of mental health care.

Perceived control has been proposed to be an important determinant of human occupation in occupational therapy models (Kielhofner, 1985, 1995). In the struc-
ture “personal causation,” which is part of the motivational and intentional subsystem “volition” of the Model of Human Occupation (MOHO), the individual’s sense of control has been emphasized as important (Kielhofner, 1995). The model presupposes that perceived control is the main ingredient in an individual’s sense of efficacy, which, together with knowledge of capacity, forms personal causation. Thus, perceived control, regarded as a trait-like variable, is one of the determinants of occupational performance (Henry & Coster, 1997; Kielhofner, 1995). In the most recent version of the MOHO (Kielhofner, 2002), locus of control and sense of efficacy have been replaced by self-efficacy, and control is used in the sense of self-control and control over one’s emotions and actions. However, this article focuses on perceived control as introduced by Rotter (1966) and adopted in the earlier versions of the MOHO (Kielhofner, 1985, 1995), denoting the belief that outcomes in life are the consequences of one’s own actions and control (internal locus of control) as opposed to being dependent on the initiative of others, luck, faith, or other types of external control (external locus of control).

A literature search revealed few studies that had empirically investigated the role of perceived control in occupational performance. In a study of persons with schizophrenia, Bengtsson-Tops (2004) showed that perceived control, in terms of self-mastery, was negatively related to unmet needs for care and support in areas such as daytime activities. Moreover, findings from a recent study indicated that both locus of control and self-mastery were related to occupational engagement in persons with schizophrenia (Bejerholm & Eklund, 2007). Lederer, Kielhofner, and Hawkins Watts (1985) found no differences in locus of control between delinquents and nondelinquents, but this nonfinding may have been due to a small sample size.

Because perceived control is indicative of pervasive recovery (Fava et al., 2001), its role in relation to daily occupations should be explored. This proposed research may generate knowledge about how much attention should be paid to this phenomenon when devising occupational therapy interventions and methods of assessment, which are important tasks in occupational therapy practice. Treatments have been developed that specifically address perceived control, in terms of self-mastery (Gunatilake, Ananth, Parameswaran, Brown, & Silva, 2004; Starkey & Flannery, 1997), and this type of intervention might be a potential supplement to existing occupational therapy practices. Furthermore, the significance of perceived control must be investigated to validate occupational therapy models, such as the MOHO (Kielhofner, 1995). Occupational therapy models should be tested for validity in empirical research (Kielhofner, 2004; Mosey, 1986) because faulty models might mislead clinical practice. These were the reasons for the current study, further reinforced by the fact that no empirical study seems to have specifically addressed the question of how perceived control is related to occupational performance. Occupational performance may be studied from different perspectives, one of which is satisfaction with daily occupations, reflecting an experiential aspect of occupation. Another aspect is the individual’s activity level, which has to do with actual doing. Experiential aspects of occupation and actual doing have been shown to be differently associated with health and well-being in a recent study (Eklund & Leufstadius, in press), supporting the proposal that they constitute different aspects of occupation.

Thus, previous research has distinguished perceived control as a vital factor for recovery, health, and well-being among persons with mental disorders. Its role in relation to daily occupation, both subjectively perceived aspects and actual doing, should be studied to gain knowledge of its relevance for clinical practice and for occupational therapy theory. However, some factors need to be considered because they may influence the nature of these relationships. Cognitive functions tend to be affected in persons with psychosis (Green, 1996; Green, Kern, Braff, & Mintz, 2000; Palmer et al., 2002); therefore, the relationships between perceived control and occupational performance might look different in patients with psychosis compared with patients with other conditions. Whether persons have gainful employment also may be important for these relationships. Gainful employment has been shown to be related to perceived control in one sample of persons with mental illness (Eklund, Hansson, & Bejerholm, 2001) but not in another (Eklund, Hansson, & Ahlqvist, 2004).

The main aim of this study was to investigate the relationship between perceived control and occupational performance in persons with mental illness. A further aim was to elucidate these relationships with respect to subgroups—patients with psychosis versus patients with conditions other than psychosis, and patients engaged in gainful employment or education versus patients who were unemployed or on sick leave.

**Methods**

This study was based on two previously collected data sets from projects investigating the influence of daily occupation on health and well-being in persons with mental illness (Eklund et al., 2001, 2004).

**Participants**

Both projects were carried out in urban areas in southern Sweden, and both included patients of working age with...
severe mental illness. The first data set was generated from a sample selected from an outpatient unit for patients with severe mental illness (Eklund et al., 2001). Only patients with schizophrenia or related disorders were chosen for that project. Consecutive sampling was used, and 74 patients agreed to participate.

The second data set (Eklund et al., 2004) was collected in a sample from another outpatient unit for persons with severe mental illness. The study by Eklund et al. (2001) showed that having gainful employment was of some importance for satisfaction with daily occupations. Therefore, a wider diagnostic criterion, “persistent mental illness,” was used in this second sample (Eklund et al., 2004) to include a larger proportion of persons engaged in gainful employment or education. Persistent mental illness was defined in accordance with Ruggeri, Leese, Thornicroft, Bisoffi, and Tansella (2000) as 2 years of contact with the psychiatric services. A randomized procedure was used for the selection of participants. In all, 103 patients participated in this project.

Informed consent was integrated in both sampling procedures, and the local research ethics committee approved both projects. The participation rate was 62% in the 2001 sample and 60% in the 2004 sample, which is comparable to or better than other studies on similar samples (e.g., Bengtsson-Tops et al., 2005). Analyses comparing participants and nonparticipants indicated no differences in medical condition, age, or gender, except in the 2004 sample where the nonparticipants were marginally older than the participants and the proportion of women was somewhat greater among the nonparticipants.

The two samples differed in definition of diagnosis and proportion of participants engaged in gainful employment or education. However, for the purposes of this study, comparisons between the samples were not warranted, and further on they are treated as a single study group. Some characteristics of the study group as a whole can be found in Table 1, showing that patients diagnosed as having illnesses other than psychosis and engaged in gainful employment or education formed minority groups. However, the numbers in these subgroups were large enough to detect moderate effect sizes at \( p < .05 \) with 80% power (Altman, 1993).

### Table 1. Characteristics of the Participants (\( N = 177 \))

<table>
<thead>
<tr>
<th>Sociodemographic Variables</th>
<th>Descriptive Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>105</td>
</tr>
<tr>
<td>Women</td>
<td>72</td>
</tr>
<tr>
<td>Mean age</td>
<td>40.3 years</td>
</tr>
<tr>
<td>Married/cohabitating</td>
<td>58</td>
</tr>
<tr>
<td>Living with own children</td>
<td>41</td>
</tr>
<tr>
<td>Number of participants working/studying</td>
<td>52</td>
</tr>
<tr>
<td>Diagnosis of psychosis</td>
<td>134</td>
</tr>
</tbody>
</table>

Those with gainful employment—defined as paid, open-market work—represented a variety of vocations. Seventeen percent were unskilled workers or had service jobs that did not require special education, such as stockroom worker or nurse assistant, whereas 27% were skilled workers or had service jobs that required special education, such as metalworker or nurse. Nineteen percent were trained in a profession requiring a university degree, such as civil engineer or physician. For 37% of the employed participants, the type of vocation was not known.

### Instruments

Perceived control was measured using two instruments, the Locus of Control (LOC) Scale (Rotter, 1966) and the Mastery Scale (Pearlin, Menaghan, Lieberman, & Mullan, 1981). The LOC scale measures the extent to which an individual perceives reinforcement to be a function of his or her own actions (internal control) or externally determined (external control). A 4-point scale is used, in which a higher value represents more external locus of control. The present study used a short form (8 items) of the Swedish version of the instrument (Eisemann, Perris, Palm, Palm, & Perris, 1988). The LOC scale has fair internal consistency and test–retest reliability (Rotter, 1966). The Mastery Scale measures self-mastery, defined as “the extent to which people see themselves as being in control of the forces that importantly affect their lives” (Pearlin et al., 1981, p. 340). The Mastery Scale has 7 items, consisting of statements where control and influencing factors are addressed, and the respondent rates how strongly he or she disagrees with those statements. For example, the first statement says: “There is really no way I can solve some of the problems I have.” Each statement is rated on a 4-point scale, from agree completely to disagree completely, and a higher value indicates a higher level of self-mastery. The Mastery Scale has been found to have good construct, predictive validity, and internal consistency (Marshall & Lang, 1990).

Occupational performance was studied X not in its full complexity (Law et al., 1996) but from two aspects—satisfaction with daily occupations and activity level. Both aspects were generated from the pilot version of the Satisfaction with Daily Occupations (SDO) instrument (Eklund et al., 2001). The instrument comprises 7 items regarding the activity areas of work (4 items: being employed, being engaged in work during the past 2 months, participating in work rehabilitation, and participation in community-based activity centers), leisure activities (2 items: organized activities and individually enjoyed leisure), and domestic tasks (1 item). Each item consists of a two-part question. The first part queries whether the participant is performing that kind of activity at the moment. The response format is yes/no.
The second asks the participant to rate his or her satisfaction on a 7-point scale; that is, a person who performs domestic tasks rates his or her satisfaction with being involved in such activities, and a participant without involvement in domestic tasks rates that condition. Two activity indexes can be calculated from this scale. The first index reflects the level of engagement in daily activities and is based on the first part of each question. In this index a maximum of 7 points can be obtained, 1 point for each activity that is presently performed. The second index concerns satisfaction with daily activities and is expressed as a mean of the satisfaction ratings. The final SDO has satisfactory content and construct validity and good internal consistency (Eklund, 2004). The pilot version used in this study has exhibited good internal consistency (Eklund et al., 2001) and, according to an analysis made specifically for the present study, it correlates strongly, rs = .98, with the final SDO.

Procedures

Data collection was performed at the outpatient units over 6 months. Two occupational therapists were trained on the interviews, one at each unit. They administered the instruments based on self-ratings and assisted the participants if necessary by reading the questions out loud. The collection of data took between 2 hr and 4 hr, usually split on two occasions. The intrarater agreement was satisfactory concerning assessments that built on the interviewers’ ratings, but no such data were analyzed for the present study. The psychiatrists in charge diagnosed the patients. In the 2001 sample (Eklund et al., 2001), diagnoses were made according to the DSM-IV system (American Psychiatric Association, 1994), and in the 2004 sample (Eklund et al., 2004), the diagnoses were based on the ICD-10 system (World Health Organization, 1993). Different diagnostic systems were used because the clinical routines differed in this respect between the two units.

Data Analysis

Because the instruments used were based on ordinal scales, mainly nonparametric tests were used: Spearman correlations for testing for associations between perceived control and occupational performance and the Mann–Whitney U test for investigating group differences. To test whether the patients with conditions other than psychosis and those gainfully employed or studying formed separate or overlapping groups, a chi-square test was performed. To identify the group affiliation of greatest importance to perceived control, a univariate analysis of variance was also used, with the group variables as fixed factors. The software used was SPSS 11.5, and the level of significance was set at p < .05.

Results

The levels of locus of control and self-mastery in the group as a whole and in the subgroups are presented in Table 2. Group comparisons did not indicate any statistically significant differences in self-mastery, but there was a tendency toward a higher level of perceived self-mastery in the subgroup engaged in gainful employment or education. Regarding locus of control, the subgroup without psychosis had a significantly lower value than the group with psychosis, indicating more internal locus of control, and the subgroup engaged in gainful employment or education scored significantly lower than those not working or studying.

In the sample as a whole, statistically significant relationships were found between both measures of perceived control and the occupational performance estimates (see Table 3). Significant correlations between these factors also were found for the subgroups representing patients with psychosis and patients not engaged in work or education. Regarding the patient group with conditions other than psychosis, the pattern of correlations found was similar, except that a fairly strong relationship was found between self-mastery and satisfaction with daily occupations and that the association between locus of control and activity level was not significant. In the group engaged in gainful employment or education, no statistically significant relationships were found between perceived control and occupational performance.

The chi-square analysis showed an overlap between belonging to the group without psychosis and the group engaged in work or education. The expected value for this combination of groups identities was 12.6, and the observed

<table>
<thead>
<tr>
<th>Aspect of Perceived Control</th>
<th>Psychosis (n = 134)</th>
<th>Nonpsychosis (n = 43)</th>
<th>P Value</th>
<th>Working (n = 52)</th>
<th>Not Working (n = 125)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locus of control Mean (SD)</td>
<td>19.4 (4)</td>
<td>17.4 (3.7)</td>
<td>.004</td>
<td>18 (3.2)</td>
<td>19.3 (4.2)</td>
<td>.025</td>
</tr>
<tr>
<td>Self-mastery Mean (SD)</td>
<td>18.8 (4.4)</td>
<td>19.7 (4.4)</td>
<td>.353</td>
<td>19.9 (4)</td>
<td>18.7 (4.6)</td>
<td>.075</td>
</tr>
</tbody>
</table>

*Higher values indicate more external locus of control.

*Higher values indicate greater self-mastery.
value was 22 ($\chi^2 = 13$, $df = 1$, $p < .001$). A univariate analysis of variance (ANOVA) resulted in a significant model regarding locus of control ($R^2 = .064$, $p = .01$). Having a psychosis was the most important variable in explaining locus of control, and no interaction between the group variables was indicated. The corresponding analysis for self-mastery yielded nonsignificant findings.

**Discussion**

The results of this study mainly supported the idea that perceived control is important for people’s occupational performance, as suggested in the MOHO (Kielhofner, 1995, 2002). There was a difference between the working/studying subgroup and the others, indicating more external locus of control in the subgroup not working or studying. This finding also is in accordance with the results of a recent study on locus of control and sick leave in a diagnostically heterogeneous group (Hansen, Edlund, & Brännholm, 2005). The findings showed that persons who were on sick leave exhibited more external locus of control than a healthy reference sample. The study by Hansen et al. was based on the 40-item version of the locus of control instrument, but the scores obtained in the present study indicated more external control among these psychiatric patients than in the heterogeneous sample on sick leave.

No differences were found between subgroups based on medical conditions or engagement in work/education regarding self-mastery. This result is in contrast to the study by Bengtsson-Tops (2004), who found differences between subgroups of patients with schizophrenia and showed that patients diagnosed with residual schizophrenia scored lower in self-mastery than those diagnosed with a schizoaffective disorder. There were differences regarding locus of control between subgroups based on both diagnosis and engagement in work or education. However, the fact that the two measures of control yielded different findings is not surprising, because they have been shown to be only moderately related (Eklund et al., 2001).

Significant associations were found in the sample as a whole and in most of the subgroups between perceived control and occupational performance, although the correlations found were moderate or low. Strangely enough, especially when considering that the significance of perceived control was first acknowledged in studies of working life, there were no statistically significant relationships between the measures of perceived control and occupational performance in the working and studying group. This lack of significance could not be attributed to lack of statistical power, because the correlations were low per se; nor could it be the result of low variation in the perceived control variables, as indicated by the standard deviations given in Table 2.

Checking the variation in the occupational performance variables also indicated a high degree of variability. Indeed, it seems that perceived control in the working/studying group was not related to the participants’ activity level or satisfaction with daily occupations; however, the reason for this remains obscure. A tentative explanation could be inferred from results from previous studies on locus of control and sick leave, showing that people who returned to work exhibited a more external locus of control than those who remained on sick leave (Hansen, Edlund, & Henningsson, 2006; Hansen Falkdal, 2005). The explanation given was that working people have to take heed of employers and workmates, in turn being explained as an adaptive cognitive style that probably makes their locus of control develop in the external direction. Thus, participating in gainful employment leads to demands on considering the will of other people and of compromising, which might lead to some consequences that trigger the individual’s internal locus of control and some that reinforce external locus of control. This is merely a hypothesis, however, which should be tested in future research.

The studies within work science that have demonstrated the importance of control for work satisfaction and well-being have been performed on healthy, working populations, and the relationship might look different in samples of persons with a disability. That such differences may exist was the reason the associations between perceived control and occupational performance were analyzed separately in the different subgroups. However, the deviant result pattern in the working/studying group—lower correlations than in the other subgroups—was unexpected. Perhaps working

---

**Table 3. Correlations Between Estimates of Perceived Control and Occupational Performance Factors**

<table>
<thead>
<tr>
<th>Perceived Control</th>
<th>Occupational Performance Factors</th>
<th>Satisfaction With Daily Occupations</th>
<th>Activity Level</th>
<th>Self-mastery</th>
<th>Locus of control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample as a whole (N = 177)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-mastery</td>
<td></td>
<td></td>
<td></td>
<td>.33**</td>
<td>.35**</td>
</tr>
<tr>
<td>Locus of control</td>
<td></td>
<td></td>
<td></td>
<td>-.34**</td>
<td>-.28**</td>
</tr>
<tr>
<td>Patients with psychosis (n = 134)</td>
<td></td>
<td></td>
<td></td>
<td>.33**</td>
<td>.28**</td>
</tr>
<tr>
<td>Self-mastery</td>
<td></td>
<td></td>
<td></td>
<td>-.34**</td>
<td>-.22**</td>
</tr>
<tr>
<td>Locus of control</td>
<td></td>
<td></td>
<td></td>
<td>-.34**</td>
<td>-.28**</td>
</tr>
<tr>
<td>Patients without psychosis (n = 43)</td>
<td></td>
<td></td>
<td></td>
<td>.35*</td>
<td>.57**</td>
</tr>
<tr>
<td>Self-mastery</td>
<td></td>
<td></td>
<td></td>
<td>-.21</td>
<td>-.35*</td>
</tr>
<tr>
<td>Locus of control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients working/studying (n = 52)</td>
<td></td>
<td></td>
<td></td>
<td>.18</td>
<td>.28</td>
</tr>
<tr>
<td>Self-mastery</td>
<td></td>
<td></td>
<td></td>
<td>-.07</td>
<td>-.15</td>
</tr>
<tr>
<td>Locus of control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients not working/studying (n = 125)</td>
<td></td>
<td></td>
<td></td>
<td>.33**</td>
<td>.35**</td>
</tr>
<tr>
<td>Self-mastery</td>
<td></td>
<td></td>
<td></td>
<td>-.36**</td>
<td>.25**</td>
</tr>
<tr>
<td>Locus of control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05; **p < .001.*
conditions should not be too heterogeneous when studying the impact of control, because different jobs probably require varying degrees of external locus of control, depending on the degree of work autonomy. Grouping together people representing different vocations, as in this study and in the studies by Hansen and colleagues (2005, 2006), may obscure possible relationships. The unexpected results and the nonfindings of this study and previous research regarding perceived control and occupational aspects (Erlandsson & Eklund, 2003; Hansen et al., 2006) suggest that the role of perceived control should be further explored both in the occupational therapy context and in work science.

Interestingly, perceived control was related to both activity level and satisfaction with daily occupations. Otherwise, locus of control and self-mastery are variables closely related to the self (Eklund et al., 2003), and their associations to the satisfaction aspect of occupation might therefore have been more prominent. The strongest association found was between self-mastery and satisfaction with daily occupations, but the prevailing pattern among the relationships was that activity level was as consistently related to perceived control as was satisfaction with daily occupations. This finding supports the notion that perceived control seems as important for the actual doing as for how the doing is perceived, which is in contrast to studies investigating relationships between occupation and health, where findings indicate a more consistent relationship between experiential aspects of occupation and health (Aubin, Hachey, & Mercier, 1999; Eklund et al., 2001, 2004; Goldberg, Britnell, & Goldberg, 2002; Strong, 1998) than between actual doing and health (Eklund & Leufstadius, in press).

Both diagnosis and employment were of importance for the pattern of relationships that emerged between perceived control and occupational performance. The chi-square analysis indicated an overlap between belonging to the group without psychosis and being engaged in gainful work or education. To ascertain the relative importance of these influences, a univariate ANOVA was used. The result was nonsignificant for self-mastery and, therefore, could not reveal any primary influence. However, concerning locus of control, the analysis suggested that having a psychosis was more important than not being engaged in work or education for perceiving external locus of control. Considering that the majority of those with a psychosis had schizophrenia, this result is in line with Starkey and Flannery (1997), who stated that loss of control is one of the main characteristics of schizophrenia, expressed in terms of hallucinations and delusions.

Regarding diagnosis as a determinant of capacity for work and other daily occupations, previous research has yielded inconsistent results. Haglund, Thorell, and Wålinder (1998) showed that persons with schizophrenia had more difficulties in daily occupations than persons with other medical conditions. The severity of the illness may be more important than the diagnosis for people’s occupational life, however, and Brown (1998) and Nagle and associates (Nagle, Valiant Cook, & Polatajko, 2002) showed that persons with schizophrenia performed fewer meaningful occupations when their illness became worse. Thus, fluctuations in stage of illness might explain inconsistent findings regarding the significance of diagnosis for occupational performance. Moreover, the severity of the illness may be contingent on an individual’s opportunity to lead a meaningful and active life, suggesting that the relationship between participation in meaningful occupation and illness severity is dynamic (Emerson, Cook, Polatajko, & Segal, 1998).

Study Limitations

Regarding the analyses performed in this study, one could argue that nonparametric tests should have been used in all cases, and a logistic regression analysis could have been an alternative to the univariate ANOVA. However, a logistic regression analysis requires a dichotomous dependent variable, and dichotomization would have violated the variance in the variables used to assess perceived control. Thus, a univariate ANOVA was chosen.

Another methodological problem of this study is the fairly large proportion of nonparticipants. Although comparable to the average participation rate in data collection on this target group (Bengtsson-Tops et al., 2005), the validity of the findings of this study should be discussed. The nonparticipants did not differ in any important way from the participants regarding the variables considered (diagnosis, age, and gender), but they probably represented an intermediate group with respect to severity of illness. The more ill patients were probably more apt to decline participation, and the more healthy ones were not included in the 2001 sample because of the selection procedure of choosing persons who recently visited the unit. Moreover, some demographic variables of potential importance for the relationships between perceived control and occupation were not considered in this study, such as having children or not, and living single or not.

Theoretical Implications

In line with suggestions from occupational therapy theorists (Kiellhofner, 2004; Mosey, 1986) emphasizing the importance of empirical testing of occupational therapy models, this study investigated the assumption inherent in the personal causation structure of the MOHO, that perceived control is one of the determinants of people’s occupational performance. This study could not reveal the direction of
such a relationship, but the results strongly support its existence and thus validate the significance of one aspect of the personal causation structure. Although perceived control has been emphasized as an important aspect of personal causation, criticism of the construct has also been raised. In a literature review, Henry and Coster (1997) concluded that locus of control seems clearly related to occupational behavior, but they still considered measures of control to be insufficient to assess the personal causation construct. In fact, the construct of perceived control was not specifically discerned in the more recent revision of the MOHO (Kielhofner, 2002). However, the current study has shown that perceived control is one of the trait-like components that are associated with occupational performance.

**Clinical Implications**

The link between perceived control and occupation demonstrated in this study suggests that perceived control should be included in the clinical reasoning of occupational therapists working in mental health care. Results from research within other areas of the mental health field have shown that perceived control is linked to recovery (Buist-Bouwman et al., 2004; Fava et al., 2001) and perceived health and well-being (Bengtsson-Tops, 2004; Eklund et al., 2003; Hansson et al., 1999; Rosenfield, 1992). Probably as a result, interventions targeting perceived control have been developed, often denoted as mastery-oriented interventions (Gunatilake et al., 2004; Starkey & Flannery, 1997). This body of research, combined with the findings from the present study, could incite occupational therapists to develop mastery-oriented treatments. Such treatments should focus on, for example, client participation in treatment planning, client input into unit decision making, and skills development (Starkey & Flannery, 1997). This body of research, combined with the findings from the present study, could incite occupational therapists to develop mastery-oriented treatments. Such treatments should focus on, for example, client participation in treatment planning, client input into unit decision making, and skills development (Starkey & Flannery, 1997).

Further studies should be carried out to see whether the findings of this study can be replicated. The next step, if the importance of perceived control for occupational performance is to be a consistent finding, would be the development of a mastery-oriented intervention, followed by a well-controlled outcome study evaluating its effectiveness. ▲

**References**

with persistent mental illness living in the community. *Canadian Journal of Occupational Therapy.*