Multidimensional Health Locus of Control Scale

The Multidimensional Health Locus of Control (MHLC) Scales are a family of measures developed in the mid-20th century by Ken Wallston and colleagues. These scales are designed

to assess a person's beliefs regarding whether his or her health status is determined by the actions of individuals (as opposed to fate, luck, or chance) and, if so, whether the locus of that control is "internal" (i.e., residing in the person's own actions) or "external" (i.e., dependent on the actions of other people).

The predecessor of the MHLC Scales, the 11-item unidimensional Health Locus of Control (HLC) Scale developed in 1976 by Wallston, was a health-specific version of J. Rotter's 1966 I-E Scale, which was used to classify individuals as "internals" or "externals." By the time the HLC Scale was published, however, it became clear that locus of control was multidimensional; internality and externality were basically uncorrelated rather than being opposite ends of the same pole.

The initial version of the MHLC Scales, still very much in use in the early 21st century, consisted of two more or less equivalent forms (A and B), each of which contained three six-item subscales. Modeled after Levenson's (1973) I, P, & C Scales, which separated externality into two dimensions—powerful others and chance—the MHLC Scales soon became the instrument of choice for health researchers wanting to assess perceived control of health. The three MHLC subscales are IHLC (e.g., "The main thing that affects my health is what I myself do"), PHLC (e.g., "My family has a lot to do with my becoming sick or staying healthy"), and CHLC (e.g., "If it is meant to be, I will stay healthy"). In most populations, IHLC and PHLC are uncorrelated with each other, IHLC and CHLC are slightly negatively intercorrelated ($-.10$ to $-.20$), and the two external dimensions, PHLC and CHLC, are somewhat positively intercorrelated (.20 to .30). The alpha reliabilities of the six-item subscales hover around .70 (.65–.75), and the test–retest reliabilities are in the range of .70–.80.

Forms A/B of the MHLC Scales have been used in hundreds of studies since the scales were first developed. Sufficient evidence has accumulated to support a claim for the validity of the MHLC Scales, although a stronger case can be made for their association with indicators of health status (self-perceived or objective) than for their ability to predict specific health behaviors. They were never intended to be used by themselves to predict either health behavior or health status; instead, they were intended to moderate or be moderated by other theoretically relevant variables such as health value, other expectancies, or disease severity.

Form C of the MHLC Scales was designed to be a generic, medical-condition-specific assessment of locus of control beliefs. Each item of Form C contains the word "condition," which can be left intact or substituted with the name of an existing condition (e.g., "diabetes"). Form C has the same subscale structure as Forms A/B, except that PHLC consists of two three-item subscales—"doctors" and "other people"—signifying a more complex discrimination of the role that physicians play in determining the health status of those already diagnosed.

Although not formally a part of the MHLC Scales, in 1999 Wallston and colleagues developed a God Locus of Health Control (GLHC) subscale to assess the extent to which people attribute their health status to a supreme being. The GLHC subscale is more internally consistent than the traditional MHLC subscales (alpha greater than .90); however, there is no evidence that scoring high on the GLHC is associated with a better health status.

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