FURTHER REFLECTIONS ON THE PURSUIT OF PSYCHOLOGICAL SECURITY IN DAILY LIFE

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When viewed through the lens of personal security, people’s daily lives appear to be fraught with potential challenges to their physical and psychological health. We regularly make decisions that involve financial, consumer, political, health, and interpersonal outcomes that can be uncertain and potentially adverse. Yet, typically, people navigate these challenges successfully, managing these threats in a way that maintains their sense of well-being. How does this happen? The four chapters in this section of the volume provide compelling accounts of how people’s motivation to maintain psychological security—the phrase used by Shepperd and Howell (this volume)—enables them to manage decisions that involve economic or consumer concerns (Leonardelli, Bohns, & Gu, this volume; Shepherd, Kay, & Eibach, this volume), political concerns (Shepherd et al., this volume), and health concerns (Andrews & Sweeny, this volume; Shepperd & Howell, this volume). These efforts serve an adaptive function as they enable people to maintain confidence in the financial decisions they make, the consumer products they purchase, the governmental services they rely on, and the health behaviors they perform, but they can also prove maladaptive. In some cases, they perpetuate decision-making patterns that have adverse long-term consequences for people’s financial and physical well-being as well as inhibiting efforts to pursue potential changes to the prevailing political, economic, and health systems.

In the following commentary, we consider the strategies people use to maintain their psychological security within the context of two themes that pervade the four chapters, either implicitly or explicitly. First, we examine how close others can affect the manner in which people strive to maintain their psychological security and the consequences of those efforts. Second, we examine how the implicit theories people hold about domains in their lives can affect their efforts to maintain psychological security. Although these two themes are relevant to the broad array of life domains examined in the preceding four chapters, we have grounded our discussion within the health domain. As Shepperd and Howell (this volume) note, the health area readily reveals the tension between strategies that elicit an adaptive response—maintaining one’s sense of well-being—and a maladaptive response—inhibiting or undermining physical health.

The Role of Close Others in Psychological Security

Across this set of chapters (Andrews & Sweeney; Shepherd et al.; Leonardelli et al.; Shepperd & Howell), the authors have identified a range of strategies people rely on to develop and maintain psychological security. As they make decisions, people strategically seek out, avoid, and/or
reframe information. Although examination of these decisions has focused on the individual
decision-maker, these decisions often unfold in the context of interpersonal relationships; they
involve family members, romantic partners, or friends, and the presence of these individuals can
affect the way in which people think, feel, and act. In the section below, we consider how the
presence of close others can elicit adaptive responses that promote psychological security but also
can facilitate maladaptive decisions and actions that inhibit psychological security.

How might the presence of close others promote psychological security? Several lines of
research suggest that close others can lead individuals to seek out and engage with poten-
tially threatening health information, a critical first step in the processes described by both
Andrews and Sweeney (this volume) and Shepherd and Howell (this volume) that lead indi-
viduals to manage their health. Married men tend to outlive their single, divorced, and wid-
owed counterparts, an effect that is attributed, in part, to their partners encouraging them to
address potential health threats and seek out medical expertise (Rendall, Weden, Favreault,
& Waldron, 2011; Umberson, 1992). Close others can also help people manage the unpleasant
emotions that can arise when waiting for the results of tests or treatments. Attachment theory
suggests relationship partners can serve as a secure base, a foundation individuals can depend on
as they explore and engage with the world (Bowlby, 1973). People who are securely attached
are more likely to feel they have someone to turn to if faced with a difficult problem, and
thus they may be more comfortable and confident undertaking behaviors or interactions that
could result in the receipt of threatening information.

Close others can provide support in a number of ways, from comforting the individual (emo-
tional support) to completing tasks that help him or her get through the day (instrumental support;
Cutrona & Russell, 1990). The greater the degree to which support is tailored to a person’s needs,
the more likely it will help them deal with the stress posed by threats to their psychological secu-
rity, which will, in turn, lead them to engage constructively with information about behavioral
alternatives and pursue more favorable health outcomes (Dunkel Schetter, 2011; Tanner Stapleton
et al., 2012). Furthermore, close others can assist people with adopting new patterns of behavior
that afford greater control over their health, leading to an increased sense of security (e.g., Lewis &
Butterfield, 2007; Stephens, Rook, Franks, Khan, & Iida, 2010).

However, close others can also undermine people’s ability to develop and maintain their psy-
chological security. Specifically, close others may not be comfortable or capable of dealing with
the prospect of threatening information. The presence of a partner or friend who is anxious and
has difficulty dealing with uncertainty may increase a person’s stress and undermine their ability
to deal with an issue constructively. In fact, knowing that threatening information about one’s own
heath could upset a close other might discourage people from seeking out such information, even
if they’d like to know personally. In this situation, a person may focus on managing and regulating
her or his partner’s thoughts, feelings, and behavior, which, in turn, reduces the time and energy
that can be directed toward one’s own needs (Finkel & Campbell, 2001).

Even partners who try to help may unintentionally undermine their partners’ progress. For
example, individuals who rely on negative tactics (e.g., being critical or condescending) to shape
their partners’ behavior are less likely to motivate behavior change successfully (e.g., Burns, Roth-
man, Fu, Lindgren, & Joseph, 2014; Stephens et al., 2010). On the other hand, partners who are too
supportive of a person’s health goals may unintentionally cause her or him to put less effort into
achieving these goals, a phenomenon known as self-regulation outsourcing (Fitzsimons & Finkel,
2011). When under stress, people are more likely to outsource their effort to close others, ren-
dering someone who is grappling with a threat to their personal security particularly vulnerable.
Close others may also serve as a source of comparison for setting health goals: someone might be
doing well compared to others in their situation but still feel unsatisfied with where they are in
comparison to a partner, family member, or friend (see Leonardelli et al., this volume).
A few intervention studies have attempted to address how partners can help people adjust to chronic illnesses such as cancer, arthritis, and diabetes. A recent meta-analysis indicated that couple-based interventions have small but significant effects on marital functioning, depressive symptoms, and pain (Martire, Helgeson, & Saghafi, 2010). However, the majority of these interventions have paid little attention to variability in partners’ beliefs or behaviors, factors that should determine whether engaging a close other might or might not be beneficial (Pietromonaco, Uchino, & Dunkel Schetter, 2013). Research and theory in relationship science are well positioned to help investigators determine the conditions under which engaging close others is likely to improve outcomes. Intervention strategies could also be designed to capitalize on the beneficial aspects of involving close others and blunt those aspects that undermine people’s psychological security.

However, ongoing close relationships are not the only interpersonal context that can have a major impact on the pursuit and maintenance of psychological security. The relationship between the patient and his or her doctor as well as other health professionals also has important implications for personal security (Andrews & Sweeny, this volume). There is growing evidence that the manner in which people interact with a health professional can have major effects on both patient and doctor decision-making and behavior. For example, an evaluation of interventions designed to train doctors how to communicate with patients about uncertain outcomes found that patients who saw a doctor who had completed this training were more satisfied with their consultations (Frostholm et al., 2005). Poor communication between doctors and patients has also been shown to be associated with lower rates of adherence to treatment plans (e.g., treatment adherence with diabetics; Ciechanowski et al., 2004).

Improving the quality of people’s relationships with a health professional offers the opportunity to make people feel more secure, even when faced with uncertainty and threats, but what characterizes a high-quality relationship? Given that the relationship a person has with a health professional can be construed as a type of close relationship, insights regarding this issue can come from research and theory in this area (for a broader discussion of these perspectives, see Lemay; Mikulincer & Shaver; Gillath & Karantzas, all in this volume). One key factor that has emerged in the study of close relationships is responsiveness. Relationship scientists define responsiveness as the process of attending to and reacting supportively to features of the partner (Reis, Clark, & Holmes, 2004). Responsiveness has three major facets: understanding, validation, and caring. Individuals who make an effort to understand their partners’ thoughts and feelings, to validate these thoughts and feelings, and to show caring and affection are considered high on responsiveness (Reis & Shaver, 1988). Having a highly responsive partner is associated with increased physical and emotional well-being, effective communication patterns, and greater trust (Reis et al., 2004; Shallcross & Simpson, 2012). Training health professionals to ask questions that draw out understanding from their patients, validate their concerns, and communicate that they care about their patients and their outcomes could enhance perceived responsiveness and, in turn, people’s ability to manage threatening or uncertain outcomes.

Another important aspect of responsiveness is that responsive behaviors are tailored to the needs of one’s partner (Clark & Lemay, 2010; Reis et al., 2004). In providing responsive support, one size does not and should not fit all; attempts to regulate partners in ways that are not sensitive to their individual needs are far less effective and can even backfire, making partners more defensive (Clark & Lemay, 2010; Overall & Simpson, 2013). Support can also be visible or invisible based on whether or not the recipient realizes support is being provided. Because receiving support—even support that is tailored to a person’s needs—can be taxing on individuals over time, subtle forms of support that can get in “under the radar” of the recipient can sometimes be more helpful (Howland & Simpson, 2010). Improved health outcomes may emerge if health professionals can tune their behavior to people’s needs, but this will require that health professionals be able to understand and respond to each patient’s unique needs.
to elicit information about people’s needs and motivations and know how to respond and communicate in ways that best fit those needs. Although there is evidence that these types of skills can be trained (e.g., Denton, Burleson, & Clark, 2000), whether these approaches can be integrated into the training health professionals receive remains an empirical question.

To date, research on psychological security in health settings has focused on an individual’s affective, cognitive, and behavioral tendencies. A more dyadic approach to health decision-making that captures the effect of close others on the individual should enrich our understanding of the decisions people make as they navigate the health care process (Karney et al., 2010; Pietromonaco et al., 2013). Assessing how close others feel and think about another person’s illness and observing how they interact with that person could provide valuable insights into when and why people make decisions that undermine their health or are inconsistent with their own motivations. In turn, this approach could inform the development of interventions that take into account the motivations, tendencies, and beliefs of both a person and relevant close others.

The Role of Implicit Theories in Psychological Security

A second consistent theme across the four chapters in this section is that how people construe the threats they face shapes the strategies people use to maintain their physical and psychological security. These construals may reflect people’s dispositional tendencies (e.g., regulatory focus; see Leonardelli et al., this volume) or the symbolic meaning they ascribe to social institutions (e.g., governmental services, religious institutions; Shepherd et al., this volume). In the health domain, Shepperd and Howell (this volume) and Andrews and Sweeney (this volume) highlight how people’s beliefs about a health issue (e.g., diabetes, asthma, cancer) or the health care system more broadly affect their ability to deal with uncertainty and to engage with relevant health information. Given that health issues are typically characterized by complex, ambiguous information that is potentially threatening, it is not surprising that people rely on their implicit theories regarding health to make sense of the situations they face. Yet it is less clear whether there is a set of key parameters that define these implicit theories that, if identified, could serve as targets for interventions to improve how people manage potential threats to their psychological security.

Leventhal’s Common-Sense Model of illness has provided one approach to delineating the parameters that define people’s mental representations of their diseases and medical conditions (Leventhal, Meyer, & Nerenz, 1980). These representations are thought to emerge out of prior experience with illness as well as from knowledge gained through interactions with health professionals, peers, and the broader informational and cultural environment in which one lives (Diefenbach & Leventhal, 1996). These representations capture beliefs regarding the way a disease is labeled, the causes of the disease, the timeline of the disease, the consequences of the disease, and the control one has over its development, treatment, or cure. Although this approach provides a rich depiction of how people construe a health condition, measuring each facet of the representation can be a challenge. In particular, it is unclear how to integrate people’s perceptions of the different factors thought to characterize these mental representations; thus, investigators have typically tested the influence of each factor separately. A recent meta-analysis revealed that the difficulties posed by operationalizing people’s mental representation of an illness have limited the ability of this model to predict how people react to and cope with an illness (Brandes & Mullan, 2014).

According to the Common-Sense Model of illness, how people construe their ability to control their condition is one facet of their illness representation. This perspective is consistent with findings from a separate program of research, conducted primarily outside of the health domain, which has proposed that people’s implicit theories regarding the development of an attribute (e.g., intelligence, personality, weight, and athletic ability) and their ability to alter or control that attribute shape their perception of and response to events (Ross, 1989).
Research in this area has characterized these construals as mindsets and distinguished between two types: an incremental or growth mindset and an entity or fixed mindset (Dweck & Leggett, 1988). These mindsets create a meaning system in which effort and ability are differentially weighted such that those with a growth mindset believe that human attributes are changeable and that effort is the most important factor in determining an outcome, whereas those with a fixed mindset believe that human attributes are fixed and that innate ability or genetic differences are the most important factor in determining a given outcome (Dweck, 1999; Hong, Chiu, Dweck, Lin, & Wan, 1999). Within the education domain, evidence has shown that the mindset people adopt affects how people act and what they achieve, such that people who adopt a growth mindset regarding intelligence or aspects of intellectual ability utilize strategies that afford better outcomes than do those utilized by people who adopt a fixed mindset (see Burnette, O’Boyle, VanEpps, Pollack, & Finkel, 2013). Moreover, this is particularly true in the face of threat (Aronson, Fried, & Good, 2002; Good, Aronson, & Inzlicht, 2003). People who attribute negative academic outcomes to a lack of ability utilize ineffective self-regulatory strategies and show lower rates of persistence following failure, whereas those who attribute negative academic outcomes to a lack of effort employ more effective goal-directed self-regulatory strategies and are more likely to persist in their efforts following failure.

What implications does this perspective have for health decision-making and health behavior? Shepperd and Howell (this volume) note that people who hold a fixed mindset are particularly likely to avoid important self-relevant information when they believe the information is likely to be negative, but this effect was observed in the context of negative feedback related to intelligence, not health. Within the health domain, a person who adopts a fixed mindset might construe a health condition as determined by genetics, whereas a person who adopts a growth mindset might construe the condition as determined by behavior. The latter construal may lead people to feel a greater sense of control and be more responsive to instructions that involve modifications to their behavior. To the extent that this is particularly true when the behavior involves the prospect of threatening health information (e.g., a test result), one would expect people who adopt a growth mindset to be more likely to follow guidelines regarding screening tests (e.g., colonoscopy, mammogram, or HIV test), whereas people who adopt a fixed mindset would be more likely to procrastinate or capitalize on opportunities to delay the test.

A person’s mindset may also influence how they respond to information or experience that is inconsistent with their expectations. What happens when individuals believe they can take actions to improve their health, but their health does not improve, or when their health improves even though they did not think improvement was possible? In the academic domain, Plaks and Stecher (2007) found that feedback indicating one’s performance had improved led everyone to report positive affect, regardless of their mindset, but people who held a fixed mindset also displayed anxiety. This latter finding suggests that favorable health outcomes that are unexpected may elicit stress and anxiety. Furthermore, when feedback indicated that performance did not improve despite opportunities for improvement, people with a growth mindset reported more anxiety than did those with a fixed mindset, but they also expressed greater confidence in their ability to reach their goals in the future (Plaks & Stecher, 2007). Thus, there may be reason to predict that people with a growth mindset have the self-regulatory skills to cope with adversity and maintain their behavior in the face of discouraging news about their health.

Historically, research on these two mindsets has focused primarily on decision-making and behavior in educational contexts, where the focus has been on construal of general intelligence or ability within a particular domain (Dweck, Chiu, & Hong, 1995; but see Burnette et al., 2013). In considering its implications for health decision-making and behavior, a key question is how to operationalize and measure the extent to which people hold a growth or a fixed mindset. Do people adopt a general mindset about their health in the same manner.
that they do about intelligence (Dweck, 1999), or do they adopt a distinct mindset about each health condition, similar to the perspective afforded by the Common-Sense Model (Leventhal et al., 1980)? To the extent that people’s mindsets are shaped by their dispositional tendencies, one might expect that people will adopt a relatively consistent construal across different health conditions. For example, expanding on Leonardelli et al.’s (this volume) discussion of difference in regulatory focus (Higgins, 1998), one might predict that individuals who chronically adopt a promotion focus will be more likely to adopt a growth mindset, whereas those who chronically adopt a prevention focus will be more likely to adopt a fixed mindset. On the other hand, there is reason to expect that how people construe a given health issue is shaped by their interactions with health professionals, close others, and the broader informational environment. To the extent that the narratives provided by these different sources differ in the degree to which they emphasize the behavioral or biological determinants of a condition, one would predict that there would be considerable but predictable variability in people’s mindsets. These are questions worthy of further empirical scrutiny.

Regardless of the source of a person’s mindset about a health condition, it may be important for health professionals to attend to how people construe the relevant health issue and consider its implications for how people will respond to health information, test results, and treatment plans. For example, as noted earlier, people who hold different mindsets about a health issue may react differently to test results about improvement or lack of improvement in their condition. Health professionals should also consider the degree to which they have shaped or can shape the mindsets that people adopt for a given health issue. To the extent that people’s mindset regarding a health issue is malleable, health professionals are well positioned to help people adopt a mindset that affords more adaptive approaches to maintaining psychological security. Although there is some evidence that people’s mindsets about a health issue such as weight loss can be modified (e.g., Burnette & Finkel, 2012), the durability of these changes, especially in the face of other influences within the health system, needs to be examined further.

Final Thoughts

The five chapters in this section of the volume illustrate the rich array of strategies people rely on to develop and maintain a sense of psychological security in their daily lives. In reflecting on how these efforts unfold in the health domain, we have suggested that the ways people pursue psychological security and the success of those efforts are shaped by the interpersonal context in which people find themselves and the implicit theories people hold about specific health issues. Although we have examined the implications of these two themes separately, in daily life there is reason to expect that they operate in a synergistic manner. For example, the effect that close others have on another person’s decision-making or behavior is likely to be shaped by the implicit theory the relationship partners hold about a specific health issue. A relationship partner who holds a growth mindset about a health issue should be more likely to support a person’s efforts to follow screening guidelines or adhere to a treatment plan than a partner who holds a fixed mindset about the issue. At the same time, the quality of people’s interpersonal relationships may affect the degree to which close others—including health professionals—can shape the implicit theories people adopt regarding a health issue. For example, a doctor or a nurse may work to shift how a patient construes a health issue, but the success of these efforts will likely depend on the degree to which the health professional is perceived as responsive to the patient’s needs. Although these are currently empirical questions, research programs in the area of personal security—including but not limited to those led by the authors of the four chapters in this section—are well positioned to engage with these issues and expand our understanding of how intrapersonal and interpersonal factors can both facilitate and inhibit the successful pursuit of psychological security.
References


