

**THE INFLUENCE OF HEALTH LOCUS OF CONTROL AND
SELF-CONCEPT ON PSYCHOLOGICAL WELLBEING
AMONG UNDERGRADUATES OF UNIVERSITIES IN EKITI
STATE**

BY

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PSY/14/2031

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NOVEMBER, 2018

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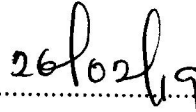
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CERTIFICATION

I certify that this study was carried out by CHUKWU LUCY UNA (PSY/14/2031) of the Department of Psychology, Faculty of Social Sciences, Federal University, Oye-Ekiti.

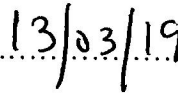




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DEDICATION

This research project is dedicated to God Almighty, Jesus Christ his begotten son, the Holy Spirit the paraclete and ultimate explanation to my existence.

ACKNOWLEDGEMENTS

My profound gratitude goes to God Almighty for giving me the privilege of being alive till today and also rendering me with the ability and assistance throughout the conduct of this project. Glory, honour and adoration are to His holy name.

I am particularly indebted to my supervisor and level advisor, Mrs. Azikiwe, Judith Chineye for her encouragement, understanding, concern, discipline towards the success of this project work, may God Almighty increase you in wealth, health and knowledge. I would like to appreciate Dr. AbiodunLawal for his advice and corrections during the course of the research, May God fulfill your heart desires.

I would also like to appreciate all my lecturers: Professor Omolayo, DrAyinde, Dr. Owoseni, DrOsuh, Dr. Olatunji, Dr. Olawa, Dr. Omole, MrsOlagundoye, Mr Israel and MrOdunjo.

Finally, I wish to show my appreciation to my relatives for their tremendous help and support throughout my stay as an undergraduate and to every other person who have in one way or the other contributed immensely to my success in life. I thank you for your love.

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ABSTRACT

Psychological wellbeing is a state of feeling good mentally and functioning healthy in one's life. For some decades psychological well-being has been central to many health studies. This study examines the influence of Health Locus of Control (HLOC) and Self-concept on Psychological well-being among undergraduates in universities in Ekiti State. An ex-post facto design was adopted to achieve the set objective of the study using 389 participants. Four hypotheses were tested in the study using independent t-test and 2 x 2 ANOVA. Result showed that students who had internal HLOC ($X = 34.01$) were not significantly different in psychological well-being from those who had external HLOC ($X = 35.79$), $t = 0.169$; $df = 387$, $p > .05$. The results imply that HLOC did not significantly influence psychological well-being among undergraduates. Also result of hypothesis two showed that students who had positive Self-concept ($X = 32.994$) was not significantly different in Psychological well-being than those who had negative self-concept ($X = 35.451$), $t = -.529$; $df = 387$, $p > .05$. This implies that self-concept did not significantly influence psychological well-being. Hypothesis three result showed that Health Locus of Control and Self-concept have no interaction influence on psychological well-being among undergraduates in Ekiti $F(1, 385) = 1.584$, $p > .05$. Finally, hypothesis four showed that male students ($X = 37.71$) were not significantly different in psychological well-being than female students ($X = 31.85$), $t = 1.27$; $df = 387$, $p = > .05$. The result implies that there is no significant gender difference in psychological well-being among undergraduates. It is recommended that further study be carried out on these variables especially among undergraduate population.

Keywords: *Psychological Well-being, Health Locus of Control, Self-Concept, Psychological distress, Ex-post facto*

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Psychological well-being is a state of feeling good mentally and functioning healthy in one's life. Psychological well-being can be considered as absence of psychological distress and can be measured by different psychological indicators like, satisfaction, depression, anxiety, self-esteem etc (Varga, Piko, and Fitzpatrick, 2014). Bar-On (1998) defined self-regard, interpersonal relationships, independence, problem solving, assertiveness, reality testing, stress tolerance, self-actualization and happiness are the integral part of psychological well-being of an individual. The key elements of psychological well-being are considered as autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance. Thus, individuals who display strength in these areas will be in a good state of psychological well-being.

Many students are faced with experiences and problems never seen before in their life. The problems that university students are faced with are different from those of non-university students. Students are frequently evaluated by their lecturers and they have continuous and active efforts to reach their own educational goals. Students are susceptible to psychological problems in different situations such as examinations, great deal of assignments, lack of leisure time, and longtime study. A student is said to have psychological well-being when he/she meets satisfaction in his/her examination, assignment, have leisure time, could cope with adjustment problems that may arise from school activities and could study at longer periods which will yield positive result in test, examinations or assignment.

One factor which controls psychological well-being is considered to be the locus of control of the person. Locus of control was considered to be associated with adolescent's psychological wellbeing and mental health; because researches show that an internal locus of control is associated with better mental health (Karbalaei, Abdollahi, Talib, Nor, and Ismail, 2013). It is also noted that individuals with better internal locus of control have been better in adjusting to daily life problems (Karbalai, Abdollahi, Momtaz, and Talib, 2014). Studies show that indicators of good psychological well-being are related to individual's lower index of stress and depression which in turn shows presence of high internal locus of control (Garber, 1980). Presence of stress indicates lower psychological well-being. Stress indicates feeling

powerless in a social situation this is linked with external locus of control (Grob, 2000). However, this study is looking at the effect health locus of control has on psychological well-being, which is how the attributions we give to our health affect our psychological well-being. Health locus of control is essential for maintaining a healthy life environment and psychological well-being. A person with a high internal locus of control may feel more empowered to convert to healthy behaviors, while on the other hand, high external locus of control is often related with unhealthy behaviour. Another factor that influences psychological well-being is self-concept which comprises of one's self-image, self-esteem and ideal self. The ways in which we think, evaluate or perceive ourselves as students and the beliefs or feelings we hold about ourselves could in turn form the outcome of our health behaviour, thereby influencing our psychological well-being, it could influence the decisions we make towards our health and cause us to live a healthy live or an unhealthy one. A student psychological well-being could be influenced by the control they have over these entire factor which in turn affect their behaviour. The decisions they make and the effort they put in attaining educational goals could affect their psychological well-being. Furthermore, the ways in which we think, evaluate or perceive ourselves as students and the beliefs or feelings we hold about ourselves could in turn form the outcome of our behaviour, thereby influencing how psychological well-being, it could influence the decisions we make and cause us to engage in riskier behaviors that will eventually tell on our psychological well-being.

According to Emmons and Diener (1989), having positive self-concept plays an important role in having positive locus of control. People with negative self-concept have a tendency to believe that the outcomes are not in their control. Different cultural factors have shown relationship between high subjective well-being and high internal locus of control. Thus, studies show that internal and external health locus of control has a unique rôle in the development of psychological well-being of an individual.

Health Locus of Control was derived from the Social Learning Theory developed by Rotter in 1966. The Social Learning Theory states that an individual learns on the basis of his or her history of reinforcement. The person will develop general and specific expectancies. Through a learning process individuals will develop the belief that certain outcomes are a result of their action (internals) or a result of other forces independent of themselves (externals). From the social learning theory Rotter developed the Locus of Control, consisting of an Internal External rating scale. Wallston, Wallston, Kaplan and Maides recognized that there was

difficulty in predicting health behavior specifically from generalized expectancy measures such as Rotter's I-E scale. Health Locus of Control (HLC) is the degree to which individuals believe that their health is controlled by internal or external Factors. Whether a person has internal or external health locus of control is based on a series of statements. The statements are scored and summed to determine whether the individual has internal or external health beliefs. This is called the unidimensional HLC Scale that was developed by Wallston, Kaplan and Maides. Dr. Hanna Levenson questioned the conceptualization of the locus of control as a unidimensional construct. She predicted that the construct could be better understood by studying fate and chance expectations separately from external control by powerful others. For this reason, Levenson developed the 3 eight item Likert scale termed the IPC Scale which was used to measure generalized locus of control beliefs.

Wallston and Wallston combined their unidimensional HLC Scale and Levenson's IPC Scale and developed the Multidimensional HLC (MHLC) Scale. The MHLC Scale consists of 3 six- item scales also using the Likert format. Internal HLC (IHLC) is the extent to which one believes that internal factors are responsible for health/illness. Thus, a student belief that if he/she treks too much he/she is likely to breakdown easily or be too stressed to listen in class after each trekking, this could lead to aggression or tiredness resulting into ill-health such as high blood pressure or malaria. Powerful Others HLC (PHLC) is the belief that one's health is determined by powerful others. That is the belief that the reason for their stress, which later results to ill-health is because the lecturer was too lengthy and so they couldn't cope. Chance HLC (CHLC) measures the extent to which one believes that health illness is a matter of fate, luck or chance. They believe that the reason why they fainted after a test was because they didn't know that there would be test that day and so didn't study to school. This aroused anxiety in them leading to high blood pressure.

Self-concept is a general term used to refer to how someone thinks about, evaluates or perceives him/herself. To be aware of oneself is to have a concept of oneself. Self-concept is viewed as the various beliefs and feelings that one holds about one's self that forms the outcome of their behavior, formed from perceptions particularly of other's reactions and directing one's behaviour, (Roy, 1976). Roy (1976) suggested that people need to feel adequate and define themselves. People want to know how they appear to others. This process occurs over a life-time as a result of social experiences. Self-concept has high degree of permanence; any change in self-concept is seen as a slow process. Self-concept could affect how we behave in the sense that the ways in which we think, evaluate or perceive

ourselves and the beliefs or feelings we hold about ourselves could in turn form the outcome of our behavior, it could influence the decisions we make, it could influence us to engage in less risky behaviors that could affect our psychological well-being. Carl Rogers (1959) believes that the self-concept has three different components:

First, is self-image, which is the view you have about yourself, those things that you see in yourself. Self-image does not necessarily have to reflect reality. Indeed, a person with anorexia who is thin may have a self-image in which the person believes they are fat. A person's self-image is affected by many factors, such as parental influences, friends, media and so on. Kuhn (1960) investigated the self-image by using The Twenty Statements Test. He asked people to answer the question 'Who am I?' in 20 different ways. He found that the responses could be divided into two major groups. These were social roles (external or objective aspects of oneself such as son, teacher, and friend) and personality traits (internal or affective aspects of oneself such as sociable, impatient, and humorous).

Typically, young people describe themselves more in terms of personal traits, whereas older people feel defined to a greater extent by their social roles. The ways in which you describe yourself or the views you have about yourself could affect ones behaviour and may have negative influence on your psychological well-being. For example, if I see myself as a sociable person, this will make me keep lots of friends in school who I would love to keep up with. I will always want to engage in more social activity to prove how social I can be, this may eventually lead to me skipping lectures, falling test because of lack of time to study. This behaviour may affect my psychological well-being negatively resulting to dissatisfaction of academic performance and low personal growth.

Second, is self-esteem, it is talking about how much value you place on yourself, the value you place on your self will determine how well you will involve in risky behavior. Self-esteem refers to the extent to which we accept or approve of ourselves or how much we value ourselves. Self-esteem always involves a degree of evaluation and we may have either a positive or a negative view of ourselves. When we have high self-esteem that means we have a positive view of ourselves. This tends to lead to Confidence in our own abilities, self-acceptance, not worrying about what others think, Optimism. Low self-esteem means we have a negative view of ourselves. This tends to lead to Lack of confidence, want to be/look like someone else, always worrying what others might think, and pessimism. Morse and Gergen (1970) showed that in uncertain or anxiety arousing situations our self-esteem may

change rapidly. For instance, even though self-esteem might fluctuate, there are times when we continue to believe good things about ourselves even when evidence to the contrary exists. This is known as the perseverance effect. Miller and Ross (1975) showed that people who believed they had socially desirable characteristics continued in this belief even when the experimenters tried to get them to believe the opposite. Does the same thing happen with bad things if we have low self-esteem? Maybe not, perhaps with very low self-esteem all we believe about ourselves might be bad.

Third, is the ideal self, what you wish you were really like. Our fantasy will prompt us to engage in certain behaviors that may affect our psychological well-being. For instance, if a person has low intelligence quota and feels that it is ideal for he/she to still perform excellently academically, instead of he or she to start taking tutorial to know more, he or she may go ahead to commit exam malpractice. The exam malpractice may be successful or unsuccessful, if it is successful then person will pass the examination and have positive psychological well-being, if not the person will fail the examination and have a negative psychological well-being.

1.2 Statement of problem

Understanding psychological well-being can define what factors can influence it. Psychological well-being is seen as an issue to be studied among undergraduate students because students who have positive psychological well-being performed better academically than students who had negative psychological well-being (Yu, Shek and Zhu, 2017). Student's psychological well-being has really been affected by the explanations they give to the outcome of their health and also by how they view themselves. Better psychological well-being will lead to better acceptance of oneself which can be affected by one self-concept. Accepting one-self as a student can help improve psychological well-being. Psychological well-being is seen as an issue when student do not have positive relationship with fellow students and lecturers, when they cannot adjust properly to their environment, when they are not free to express their thought, do not know or understand their purpose in life and cannot seek for personal growth.

Various studies have been carried out to show that health locus of control has a significant role to play if a student will report better psychological well-being or not. A study carried out by Uma and Manikandan (2017) showed that adolescents who has internal locus of control and good coping mechanism reported better psychological wellbeing. Similarly, Bada and

Gregory (2016) in their study reported that that health locus of control is a significant determinant of psychological well-being, they found out that participant who reported internal health locus of control significantly scored higher in psychological well-being. Another study by Burkhat and Rates (2004), focused on perceived health locus of control and self-concept in relations to psychological well-being; result showed that their significant relationship. Idemudia and Lawal (2016), investigated the direct influence of gender, self-esteem and health locus of control on life satisfaction among retirees in two dates in the south-western part of Nigeria. They discovered that

Self-concept has also been seen to influence psychological well-being; a person view about themselves can make them report positive or negative psychological well-being. Uma and Manikandan (2017) looked at self-esteem as a factor than can influence psychological well-being; result showed that self-esteem is significant predictor of psychological well-being. Kumari and Chamundeswari focused on investigating how self-concept can affect academic achievement among higher secondary level, they found that positive self-concept leads to better psychological well-being. Similarly, Ahman-Mahud (2016), in his research on self-concept and locus of control as determinant of academic achievement, the result gotten indicates that self-concept is major determinant of academic achievement and that there was a relationship between locus of control and academic achievement.

1.3 PURPOSE OF STUDY

The purpose of this study is to determine the influence of health locus of control and self-concept on psychological well-being of undergraduates in universities in Ekiti State.

The study also poised to:

1. Examine the influence of health locus of control on psychological well-being of undergraduates in universities in Ekiti State.
2. Determine the influence of self-concept on psychological well-being of undergraduates in universities in Ekiti State.
3. Find out whether health locus of control and self-concept will jointly influence psychological well-being of undergraduates in universities in Ekiti State.
4. Identify the influence of gender on psychological well-being of undergraduates in universities in Ekiti State.

1.4 Relevance of study

The outcome of this research is aimed at improving the body of knowledge in areas such as health locus of control, self-concept and psychological well-being.

Most studies conducted on health locus of control focused majorly on adolescents, but in this case undergraduates are used as participants. In past studies conducted on psychological well-being, other variables such as self-esteem, health behaviours, traumatic experiences and school motivation were examined to determine its influence on psychological well-being. This study seeks to concentrate on the influence health locus of control and self-concept has on psychological well-being. Most studies combined self-esteem and health locus of control with psychological well-being, while those that had self-concept combined it with school achievement to study its effect on psychological well-being.

It will add to existing literature in self-concept as researchers majorly focused on self-esteem as an aspect of self-concept. It will also add to the existing literature in health locus of control and psychological well-being.

CHAPTER TWO

2.0- LITERATURE REVIEW

2.1-THEORETICAL FRAMEWORK

2.1.1- Theories of Psychological Well-being

1. The Six-Factor Model of Psychological Well-being

The Six-factor Model of Psychological Well-being is a theory developed by Carol Ryff which explained six factors that contribute to a person's psychological well-being, satisfaction, and happiness. Psychological well-being consists of positive relationships with others, environmental mastery, autonomy, a feeling of purpose and meaning in life, and personal growth and development. Psychological well-being is attained by achieving a state of balance affected by both challenging and rewarding life events.

Ryff's model is not based on merely feeling happy, but is about living virtuously. Positive psychological well-being may emerge from numerous sources. A happy and comfortable student, who is satisfied with the course he or she is studying, and is performing fine academically and has good relationship with fellow students. When schooling includes attending class regularly, optimistic expectations from test, assignments and examinations, positive thoughts about the outcome of academic activities, and good relationship with fellow students, such student will improve significantly in psychological well-being. A propensity to unrealistic optimism and over-exaggerated self-evaluations can be useful. These positive illusions are especially important when an individual receives threatening negative feedback, as the illusions allow for adaptation in these circumstances to protect psychological well-being and self-confidence (Taylor and Brown, 1988). Optimism also can help an individual cope with stresses to their well-being.

Psychological well-being can also be affected negatively, as is the case with a degrading and unrewarding schooling environment, unfulfilling obligations and unsatisfying relationships. Social interaction has a strong effect on well-being as negative social outcomes are more strongly related to well-being than are positive social outcomes. Childhood traumatic experiences diminish psychological well-being throughout adult life, and can damage psychological resilience in children, adolescents, and adults. Perceived stigma also

diminished psychological well-being, particularly stigma in relation to obesity and other physical ailments or disabilities.

According to Seligman, positive interventions to attain positive human experience should not be at the expense of disregarding human suffering, weakness, and disorder.

2.1.2- Theories of Health Locus of Control

1. Social Learning Theory

Social Learning suggests that the expected effect or outcome of the behavior influences the motivation of people to engage in that behavior. People wish to avoid negative consequences, while desiring positive results or effects. If one expects a positive outcome from a behavior, or thinks there is a high probability of a positive outcome, then they will be more likely to engage in the behavior. The behavior is reinforced, with positive outcomes, leading a person to repeat the behavior. This social learning theory suggests that behavior is influenced by social context or environmental factors, and not psychological factors alone.

In 1966, Rotter published his famous I-E scale in the journal "Psychological Monographs", to assess internal and external locus of control. This scale has been widely used in the psychology of personality, although its use of a two-alternative forced choice technique has made it subject to criticism. Rotter himself was astounded by how much attention this scale generated, claiming that it was like lighting a cigarette and seeing a forest fire. He himself believed that the scale was an adequate measure of just two concepts, achievement motivation (which he took to be linked with internal locus of control) and outer-directedness, or tendency to conform to others (which he took to be associated with external locus of control). Critics of the scale have frequently voiced concern that locus of control is not as homogenous a concept as Rotter believed. According to him the locus of control of an individual's behavior in the case of 'propagation' lies within the individual whereas it lies outside the individual in the case of 'conversion'. (Clearly depicting how religious propagation different from that of religious conversion).

2. Locus of Control Theory

The concept of locus of control was developed by Julian Rotter (1954, 1982) as an extension of his "social learning theory." Rotter stated that a person was more likely to behave in a certain way if he or she expected that the behavior would result in a desired or positive

outcome (reinforcement) and if the reward or reinforcement had a high value to the person. In this, Rotter's theory can be related to expectancy theory.

Rotter's theory and the concept of reinforcement led him to study the development of notions of internal and external control. His theory asserts that reinforcement is contingent on whether a person learns to expect a reward for performing a specific action. For example, if a child notices that she receives dessert every time she eats all her vegetables, she will learn (to expect) that in order to receive dessert all she needs to do is finish her vegetables. This is an example of internal control: the child realizes that her actions have a direct bearing on whether or not she receives dessert.

This way of looking at what happens is different from operant conditioning, which focuses on the fact that the child may learn to eat her vegetables because she is rewarded whenever she does it correctly. Operant conditioning and similar learning theories focus on how outcomes (particularly reinforcement) affect learning (replicated behavior). Rotter's theory also should not be confused with the social learning theory (Bandura, 1977) that focuses on observation and imitation of social models or with instrumental conditioning (Miller and Dollard, 1950). Rotter focuses on the individual's learned expectations about how (or whether) his or her behavior affects outcomes. Thus, Rotter is not so concerned with how one learns as he is with whether one grows to believe that one's actions directly affect outcomes.

In another example, if a struggling artist submits painting after painting to an art company and his work is always being rejected, the artist will then take a dim view of his abilities, he may have this feeling that nobody likes my paintings, so also if his work is eventually accepted he may attribute it to outside factors or discredit it altogether. He may have this feeling that his work was accepted due to sheer luck. He does not believe that his behavior affected the outcome.

Rotter uses the term "locus of control" to describe the ways in which individuals attribute responsibility for events to factors within themselves and within their control or to factors outside their control. He proposes that the degree to which we regard an incident as a reward (or reinforcement) is influenced by whether we perceive the reinforcement as resulting directly from our own actions or whether we perceive the reinforcement as resulting from exterior forces or "fate." When a course of action produces an event that does not seem to be the direct result of that action, it is likely to be attributed to "luck" or "God's will" rather than to the person who pursued that course of action.

A person's locus of control has several antecedents, which may be **accumulative or episodic**. Accumulative antecedents are events that occur over a long period of **time and involve** continual exposure. Although relatively little research has been done concerning accumulative events, three important factors have been identified: (a) social discrimination; (b) prolonged, incapacitating disability; and (c) parental child-rearing practices. Lefcourt (1966) states that in all the reported ethnic studies, groups whose social position is one of minimal power by class or race tend to score higher in the direction of external control. Studies with the deaf have established a relationship between long-term physical disability and externalism. Evidence pertaining to the effects of parental child-rearing practices is more substantial, although it primarily is self-reported data regarding the subject's childhood experiences. Externals tend to describe their parents as higher in the use of physical punishment, affective punishment, denial of privileges, and overprotection. Internals, on the other hand, describe their parents as setting predictable standards, using more principled discipline, and being more warm and democratic. In general, internals have been exposed to parental behaviors that foster independence and a belief in being able to manage oneself in order to predictably achieve desired outcomes. There also is some evidence that sex-role stereotyping and social discrimination lead women, as a group, to be more external than men (Rotter, 1966; Feather, 1968).

Episodic antecedents are events of great importance to a person that occur over a relatively short period of time (MacDonald, 1973). Examples of such events are earthquakes or tornadoes, serious automobile accidents, the deaths of loved ones, serious economic changes, and national or international affairs.

Individual Characteristics of Health Locus of Control

Characteristics of internals and externals have been identified through both clinical reports and research. Internals are likely to describe themselves as active, striving, achieving, powerful, independent, and effective. Externals are more likely to describe themselves in opposite terms (Hersch and Scheibe, 1967).

Internality has been found to be positively associated with indices of social adjustment and personal adjustment (Hersch and Scheibe, 1967). There also is evidence that internals are more achievement oriented, less anxious, less dogmatic, more trusting, less suspicious of others, less apt to use sensitizing modes of defenses, and more self-confident and insightful. Internals, however, tend to resort to more self-blaming behavior than do externals. Because

externals do not perceive outcomes as being the result of their actions, they assume less responsibility or blame. In betting situations, internals are more cautious and conservative than externals; they are "percentage players" in risk situations.

Locus of control also indicates an individual's perception of authority figures. Internals perceive authority as more encouraging of constructive environmental manipulation, as more supportive when difficulty is encountered, as more positively reinforcing, as having more predictable standards, and as acting on and from issue-oriented reason (Ferguson and Kennelly, 1974). The fact that internals perceive authority figures more positively tends to affect their behavior as managers (as authority figures to their subordinates and as subordinates of others in the organizational hierarchy).

Rotter (1966) states that "theoretically, one would expect some relationship between internality and good adjustment in our culture but such a relationship might not hold for extreme internal scores." The extremely internalized person may be self-flagellating. Conversely, the extremely externalized person may blame outside factors as a defense against admitting personal inadequacies. Extreme externals may be passive in the face of environmental difficulties, which could result in maladjustment to society.

2.1.3- Theories of Health Self-concept

1. Humanistic Approach

Rogers' theory is based directly on the "phenomenal field" personality theory of Combs and Snygg (1949). Rogers' elaboration of his own theory is extensive. His theory as of 1953 was based on 19 propositions; All individuals (organisms) exist in a continually changing world of experience (phenomenal field) of which they are the center, the organism reacts to the field as it is experienced and perceived, this perceptual field is "reality" for the individual, the organism reacts as an organized whole to this phenomenal field, a portion of the total perceptual field gradually becomes differentiated as the self, as a result of interaction with the environment, and particularly as a result of evolutionary interaction with others. The structure of the self is formed—an organized, fluid but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me", together with values attached to these concepts, the organism has one basic tendency and striving—to actualize, maintain and enhance the experiencing organism. The best vantage point for understanding behavior is

from the internal frame of reference of the individual. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived. Emotion accompanies, and in general facilitates, such goal directed behavior, the kind of emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism. The values attached to experiences, and the values that are a part of the self-structure, in some instances, are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as if they had been experienced directly. As experiences occur in the life of the individual, they are either, a) symbolized, perceived and organized into some relation to the self, b) ignored because there is no perceived relationship to the self-structure, c) denied symbolization or given distorted symbolization because the experience is inconsistent with the structure of the self. Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of self. In some instances, behavior may be brought about by organic experiences and needs which have not been symbolized. Such behavior may be inconsistent with the structure of the self but in such instances the behavior is not "owned" by the individual. Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self. Psychological maladjustment exists when the organism denies awareness of significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension. Any experience which is inconsistent with the organization of the structure of the self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself. Under certain conditions, involving primarily complete absence of threat to the self-structure, experiences which are inconsistent with it may be perceived and examined, and the structure of self-revised to assimilate and include such experiences. When the individual perceives and accepts into one consistent and integrated system all her sensory and visceral experiences, then she is necessarily more understanding of others and is more accepting of others as separate individuals. As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system—based extensively on introjections which have been distortedly symbolized—with a continuing organismic valuing process.

Rogers is known for practicing "unconditional positive regard", which is defined as accepting a person "without negative judgment of a person's basic worth".

With regard to development, Rogers described principles rather than stages. The main issue is the development of a self-concept and the progress from an undifferentiated self to being fully differentiated.

In the development of the self-concept, he saw conditional and unconditional positive regard as key. Those raised in an environment of unconditional positive regard have the opportunity to fully actualize themselves. Those raised in an environment of conditional positive regard feel worthy only if they match conditions that have been laid down for them by others. He believed that fully functioning person optimal development, results in a certain process rather than static state. He describes this as the good life, where the organism continually aims to fulfill its full potential. He listed the characteristics of a fully functioning person (Rogers 1961):

- A growing openness to experience – they move away from defensiveness and have no need for subception (a perceptual defense that involves unconsciously applying strategies to prevent a troubling stimulus from entering consciousness).
- An increasingly existential lifestyle – living each moment fully – not distorting the moment to fit personality or self-concept but allowing personality and self-concept to emanate from the experience. This results in excitement, daring, adaptability, tolerance, spontaneity, and a lack of rigidity and suggests a foundation of trust. "To open one's spirit to what is going on now, and discover in that present process whatever structure it appears to have" (Rogers 1961).
- Increasing organismic trust – they trust their own judgment and behavior that is appropriate for each moment. They do not rely on external social norms but trust that as they are open to experiences they will find their own sense of right and wrong.
- Freedom of choice – not being shackled by the restrictions that influence the incongruent individual, they are able to make a wider range of choices more flexibly. They believe that they play a role in determining their own behavior and so feel responsible for their own behavior.

- Creativity – it follows that they will feel freer to be creative. They will also be more creative in the way they adapt to their own circumstances without feeling a need to conform.
- Reliability and constructiveness – they can be trusted to act constructively. An individual who is open to all their needs will be able to maintain a balance between them. Even aggressive needs will be matched and balanced by intrinsic goodness in congruent individuals.
- A rich full life – he describes the life of the fully functioning individual as rich, full and exciting and suggests that they experience joy and pain, love and heartbreak, fear and courage more intensely.

Rogers' description of the good life:

1. Incongruence

Rogers identified the "real self" as the aspect of one's being that is founded in the actualizing tendency, follows organismic valuing, needs and receives positive regard and self-regard. It is the "you" that, if all goes well, you will become. On the other hand, to the extent that our society is out of sync with the actualizing tendency, and we are forced to live with conditions of worth that are out of step with organismic valuing, and receive only conditional positive regard and self-regard, we develop instead an "ideal self". By ideal, Rogers is suggesting something not real, something that is always out of our reach, the standard we cannot meet. This gap between the real self and the ideal self, the "I am" and the "I should" is called incongruity.

2. Psychopathology

Rogers described the concepts of congruence and incongruence as important ideas in his theory. In proposition #6, he refers to the actualizing tendency. At the same time, he recognized the need for positive regard. In a fully congruent person realizing their potential is not at the expense of experiencing positive regard. They are able to lead lives that are authentic and genuine. Incongruent individuals, in their pursuit of positive regard, lead lives that include falseness and do not realize their potential. Conditions put on them by those around them make it necessary for them to forgo their genuine, authentic lives to meet with the approval of others. They live lives that are not true to themselves, to who they are on the inside out.

Rogers suggested that the incongruent individual, who is always on the defensive and cannot be open to all experiences, is not functioning ideally and may even be malfunctioning. They work hard at maintaining/protecting their self-concept. Because their lives are not authentic this is a difficult task and they are under constant threat. They deploy defense mechanisms to achieve this. He describes two mechanisms: distortion and denial. Distortion occurs when the individual perceives a threat to their self-concept. They distort the perception until it fits their self-concept.

This defensive behavior reduces the consciousness of the threat but not the threat itself. And so, as the threats mount, the work of protecting the self-concept becomes more difficult and the individual becomes more defensive and rigid in their self-structure. If the incongruence is immoderate this process may lead the individual to a state that would typically be described as neurotic. Their functioning becomes precarious and psychologically vulnerable. If the situation worsens it is possible that the defenses cease to function altogether and the individual becomes aware of the incongruence of their situation. Their personality becomes disorganized and bizarre; irrational behavior, associated with earlier denied aspects of self, may erupt uncontrollably.

2. Health Belief Model

The Health Belief Model (HBM) is by far the most commonly used theory in health education and health promotion (Glanz, Rimer, and Lewis, 2002; National Cancer Institute [NCI], 2003). It was developed in the 1950s as a way to explain why medical screening programs offered by the U.S. Public Health Service, particularly for tuberculosis, were not very successful (Hochbaum, 1958).

The underlying concept of the original HBM is that health behavior is a factor of our personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence (Hochbaum, 1958). Personal perception is influenced by the whole range of intrapersonal factors affecting health behavior.

This theory explains that our personal beliefs influence our health behavior. The following four perceptions serve as the main constructs of the model; perceived seriousness, perceived susceptibility, perceived benefit, and perceived barriers. Each of these perception, whether single or in combination can be used to explain health behavior. In recent times more

construct have been added to the health behavioral model which includes cues to action, motivation factors and self-efficacy.

1. Perceived Seriousness

The construct of perceived seriousness talks about an individual's belief about the seriousness or severity of a disease. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general (McCormick-Brown, 1999). For example, most of us view headaches as a relatively minor illness. We get it, rest a little by taking naps, and get better. Here headache is not perceived as a serious disease. However, if you have asthma, contracting the headache could land you in the hospital. In this case, your perception of the headache might be that it is a serious disease. Or, if you are a student, having the headache might mean a week or more of missing classes. Again, this would influence your perception of the seriousness of this illness.

2. Perceived Susceptibility

Perceived risk or susceptibility is one of the most powerful perceptions in prompting people to adopt healthier behaviors. The greater the perceived risks, the more the likely people engage in behaviors that will help them decrease the risk. This is what prompts students who stress themselves by trekking long distance to reduce how long and how often they trek against falling sick during exams periods (de Wit et al., 2005) and to eat well and healthy in an effort to decrease susceptibility to fall sick (Belcher et al., 2005). Perceived susceptibility motivates people to engage in healthier behavior (Chen et al., 2007), to use sunscreen to prevent skin cancer, and to stay away from sweet and chewing gum to prevent gum disease and tooth loss.

It is only logical that when people believe they are at risk for a disease, they will be more likely to do something to prevent it from happening. Unfortunately, the opposite also occurs. When people believe they are not at risk or have a low risk of susceptibility, they tend to engage in behaviors that are unhealthy. This is exactly what was found with older adults and HIV prevention behavior. Because older adults do not perceive themselves to be at risk for HIV infection, many do not engage in safer sex (Rose, 1995; Maes and Louis, 2003). This same scenario was found with Asian American college students. They tended to view the

HIV/AIDS epidemic as a non-Asian problem; thus, their perception of susceptibility to HIV infection was low and not associated with practicing safer sex behaviors (Yep, 1993).

What we have seen so far is that a perception of increased susceptibility or risk is linked to healthier behaviors, and decreased susceptibility to unhealthy behaviors. However, this is not always the case. In college students, perception of susceptibility is rarely linked to the adoption of healthier behaviors (Courtenay, 1998), even when the perception of risk is high. For example, although college students consider themselves at risk for HIV because of their unsafe sex behaviors, they still do not practice safer sex (Lewis and Malow, 1997), nor do they stop tanning even though they perceive themselves to be at increased risk for skin cancer (Lamanna, 2004). Perception of susceptibility explains behavior in some situations, but not all.

When we combine the perception of susceptibility with seriousness, it results in perceived threat (Stretcher and Rosen-stock, 1997). If the perception of threat is to a serious disease for which there is a real risk, behavior often changes. For instance, when eating bush meat, leaving rodents everywhere in the house and their feces in food caused a serious disease called Ebola, people reduced their intake of eating bush meat, set traps for rodents and became more conscious of the food they eat because of the risk of contracting Ebola and because Ebola was a very serious disease, this was a threat to them. The perception of threat of contracting this disease through eating bush meat was one factor related to declining bush meat consumption in Nigeria. People changed their behavior based on the perception of threat of a fatal disease.

We see the same thing when people perceive a threat of developing non-insulin-dependent diabetes mellitus (NIDDM). Among people whose parents had or have the disease, the perception of threat of developing it themselves is predictive of more health-enhancing, risk-reducing behaviors. Most important, they are more likely than others to engage in behaviors to control their weight (Forsyth, 1997), given that obesity is a known risk factor for NIDDM.

Just as perception of increased susceptibility does not always lead to behavior change, neither does a perception of increased threat. This is the scenario with older adults and safe food handling behaviors. Older adults are among the groups most vulnerable to food borne illness (Gerba, Row, and Haas, 1996) and are among those for whom it can be particularly serious. Even though they perceive a threat of illness from food borne sources, they still do not use

safe food-handling practices (Hanson and Benedict, 2002) all of the time.

3. Perceived Benefits

The construct of perceived benefits is a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. People tend to adopt healthier behaviors when they believe the new behavior will decrease their chances of developing a disease. People will not strive to eat fruits and drink water regularly if they didn't believe it was beneficial. People will not quit smoking if they didn't believe it was better for their health.

Perceived benefits play an important role in the adoption of secondary prevention behaviors, such as screenings. A good example of this is screening for breast cancer. The earlier breast cancer is found, the greater the chance of survival. When we do a breast self-exam (BSE) regularly, it can be an effective means of early detection of breast cancer. But not all women do BSE regularly. They have to believe there is a benefit in adopting this behavior, which is exactly what was found to be true among black women: those who believed breast self-exams were beneficial did them more frequently (Graham, 2002).

4. Perceived Barriers

Since change is not something that comes easily to most people, the last construct of the HBM addresses the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behavior. Of all the constructs, perceived barriers are the most significant in determining behavior change (Janz and Becker, 1984).

In order for a new behavior to be adopted, a person needs to believe the benefits of the new behavior outweigh the consequences of continuing the old behavior (Centers for Disease Control and Prevention, 2004). This enables barriers to be overcome and the new behavior to be adopted. In trying to increase breast self-examination practices in women, it would seem obvious that the threat of breast cancer would motivate adoption of this early detection practice. Certainly breast cancer is a very serious disease, one for which women are at risk and for which the perception of threat is high. Even with all of this, the barriers to performing BSE exert a greater influence over the behavior than does the threat of cancer itself

(Champion, 1993; Champion and Menon, 1997; Ellingson and Yarber, 1997; Umeh and Rogan-Gibson, 2001). Some of these barriers include difficulty with starting a new behavior or developing a new habit, fear of not being able to perform BSE correctly, having to give up things in order to do BSE, and embarrassment (Umeh and Rogan-Gibson, 2001).

5. Modifying Variables

The four major constructs of perception are modified by other variables, such as culture, education level, past experiences, skill, and motivation, to name a few. These are individual characteristics that influence personal perceptions. For example, if someone is diagnosed with basal cell skin cancer and successfully treated, he or she may have a heightened perception of susceptibility because of this past experience and be more conscious of sun exposure because of past experience. Conversely, this past experience could diminish the person's perception of seriousness because the cancer was easily treated and cured.

In personal health classes on many campuses, students are required to complete a behavior change project. They choose an unhealthy behavior and develop a plan to change it and adopt a healthier behavior. The modifying variable behind this is motivation. The motivation is a grade.

6. Cues to Action

In addition to the four beliefs or perceptions and modifying variables, the HBM suggests that behavior is also influenced by cues to action. Cues to action are events, people, or things that move people to change their behavior. Examples include illness of a family member, media reports (Graham, 2002), mass media campaigns, advice from others, reminder postcards from a health care provider (Ali, 2002), or health warning labels on a product.

Knowing a fellow church member with prostate cancer is a significant cue to action for African American men to attend prostate cancer education programs (Weinrich et al., 1998). Hearing TV or radio news stories about foodborne illness and reading the safe handling instructions on packages of raw meat and poultry are cues to action associated with safer food-handling behaviors (Hanson & Benedict, 2002). Having displays on college campuses of cars involved in fatal crashes from drunk driving is an example of a cue to action—don't drink and drive.

7. Self-efficacy

In 1988, self-efficacy was added to the original four beliefs of the HBM (Rosenstock, Strecher, and Becker, 1988). As was discussed in Chapter 2, self-efficacy is the belief in one's own ability to do something (Bandura, 1977). People generally do not try to do something new unless they think they can do it. If someone believes a new behavior is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried.

As mentioned previously, a significant factor in not performing BSE is fear of being unable to perform BSE correctly (Umeh and Rogan-Gibson, 2001). Unless a woman believes she is capable of performing BSE (that is, has BSE self-efficacy), this barrier will not be overcome and BSE will not be practiced.

When we look at osteoporosis, exercise self-efficacy and exercise barriers are the strongest predictors of whether one practices behaviors known to prevent this disease. Women who do not engage in the recommended levels of weight-bearing exercise tend to have low exercise self-efficacy, meaning they do not believe they can exercise, and perceive there to be significant barriers to exercise (Wallace, 2002). As a result, these women do not exercise.

In summary, according to the Health Belief Model, modifying variables, cues to action, and self-efficacy affect our perception of susceptibility, seriousness, benefits, and barriers and, therefore, our behavior

2.2- Literature review

Different studies have been carried out regarding what influences psychological well-being, a study was conducted on understanding the role of self-esteem, locus of control and coping in predicting the psychological wellbeing of adolescents and the study revealed that self-esteem and locus of control are the significant predictors of psychological wellbeing of adolescents also they found no significant sex difference, hence both the gender shows almost same amount of psychological wellbeing, Uma and Manikandan (2017). Moshki and Ashtarian(2010) statistical analysis revealed a negative relationship between perceived Internal HLC and self-esteem with psychological well-being, for perceived chance there was a positive correlation with psychological wellbeing. A significantly direct relationship

between low perceived Internal HLC, self-esteem and psychological problems was found among these students.

Health-related locus of control and health behavior among university students in North Rhine Westphalia, Germany was discovered that students engaged more strongly in unhealthy behavior if they believed that luck determines health. In contrast, believing in having control over one's own health was associated with healthier behavior. These findings support the need to consider health control beliefs while designing preventive strategies in this specific population (Helmer, Krämer & Mikolajczyk, 2012).

With self-concept and health locus of control, the relationship between adherence to daily peak expiratory flow rate (PEFR) monitoring, recommended for asthma self-management was studied by Burkhart and Rayens in 2014 in a sample of 42 children, ages 7 through 11. Children, who have a positive self-concept, particularly in the areas of intellect and anxiety, are more adherent to their recommended asthma regimen. Similarly, those who perceive their ability to control their health more positively adhere better to daily PEFR monitoring. These results suggest that children's adherence interventions may need to include components aimed at enhancing self-concept and health locus of control.

Wang, Wu, Chang and Chuang (2013), investigated the relationship among sociodemographic factors, neurocognitive factors, self-esteem, and health locus of control in patients diagnosed with schizophrenia. They examined the self-esteem, internal health locus of control, and external health locus of control through sociodemographic and neurocognitive factors. They found out that inhibition of attention, external health locus of control, and education contributed to self-esteem, internal health locus of control and external health locus of control. However, the overall predicted variance accounted for by these predictors was small; thus, further research is necessary to examine imperative variables related with self-esteem and health locus of control in schizophrenia.

The direct influence of gender, self-esteem and health locus of control on life satisfaction among retirees in two states in the South-western part of Nigeria was studied by Lawal and Idemudia in 2016. They found out that Self-esteem significantly influenced life satisfaction. Similarly, health locus of control significantly influenced life satisfaction. However, there was no significant influence of gender on life satisfaction. Positive self-regards or being responsible for health-related behavior helps them live a more satisfied life in retirement.

Bada, and Gregory (2016), carried out a study to examine the influence of traumatic experience and locus of control on psychological well-being of adolescents living in orphanages in Ibadan metropolis. Results showed that traumatic experience had a significant negative relationship with Psychological Well-being. This implies that increase in the level of traumatic experience will lead to decrease in the level of psychological well-being among orphans in foster homes. Also, sex, age and religion had significant joint influence on psychological wellbeing. The independent influence result indicates that only religion had significant contribution to psychological well-being among orphans at. Participants who reported internal health locus of control significantly scored higher on psychological well-being than those participants who reported external locus of control. Traumatic experience and health locus of control are significant predictors of psychological well-being among orphans in the orphanages in Ibadan metropolis. The more religious an orphan is the higher their psychological well-being.

Zhang and Jang (2017), studied on the role of internal health locus of control in relation to self-Rated health in older adults, they studied how internal health locus of control is associated with older adults' self-rated health. Multivariate analyses with older participants (aged ≥ 60) in the MIDUS II ($n = 1,533$) showed that internal health locus of control was not only directly associated with positive ratings of health but also interacted with gender and race. The positive impact of internal health locus of control on self-rated health was particularly greater in females and Whites than their counterparts. Findings showed the important role of internal health locus of control in the psychological mechanism of health and point attention to group-specific strategies for health promotion.

Self-concept, locus of control and school motivation in relation to academic achievement among Secondary School Students in Northern Nigeria was studied by Ahman-Mahmud (2016), because they noticed that the academic achievement of children and young people is an issue that concerns governments in many countries. In Nigeria, students' performance on standardized examinations has been troublingly low, especially among those from the north of the country. Previous studies on students' achievement have focused on inadequate funding, infrastructural decay, parental background factors and pedagogical issues. However, their study considered the psychological aspects of attainment, looking at the relationships between self-concept, locus of control, school motivation, academic achievement and other contextual factors (such as gender) that are likely to have an impact on students' performance in school. Their aim was to identify some of the factors contributing to low performance in

order to generate empirical evidence to inform policy and practice. Hence, they found out that high, moderate, and low levels of relationships exist between academic achievement and the conceptual variables, and that self-concept and mother's profession are the main predictors of academic achievement.

2.3- Statement of hypothesis

- Undergraduates who have internal health locus of control will significantly report better psychological well-being than those who have external health locus of control.
- Undergraduates who are have positive self-concept will significantly report better psychological well-being than those who have negative self-concept.
- There will be a significant main and interaction effect of health locus of control and self-concept on psychological well-being of undergraduate students in Ekiti state
- Male undergraduates will significantly report better psychological well-being than female undergraduates.

2.4- Operational definition of terms

Undergraduates of Universities in Ekiti state

In this study, undergraduate students of Universities in Ekiti state are students of the university that are still undergoing first degree programs in any course. This therefore excludes Pre-degree, JUPEB, Post Graduates, Masters and PhD Programs.

Psychological Well-being

Psychological wellbeing is a state of feeling good mentally and functioning healthy in one's life. In this study a student is said to have psychological well-being when he/she meets satisfaction in his/her examination, assignment, have leisure time and could study at longer period and as measured by Ryff Psychological well-being scale.

Health Locus of Control

In this study health locus of control is used to assess the kind and extent of control, a person thinks he or she has over his or her own state of health. It was measured using health locus of control scale developed by Wallston, Wallston, Kaplan, and Maides (1976). A high score

denotes belief in a high degree of external health locus of control and low score denotes belief in a high degree of internal health locus of control.

Self-concept

Self-concept in this study is used to refer to those ideas, beliefs and feelings one hold about themselves. This could be either positive or negative self-concept. The student self-concept inventory Saraswat (1984) was used to measure self-concept. A high score on this scale indicates a higher and positive self-concept, while a low score shows low and negative self-concept.

CHAPTER THREE

3.0 METHOD

3.1 Research design

This study adopted the ex-post facto research design in studying the influence of health locus of control and self-concept in psychological wellbeing in undergraduate university students of Ekiti State. Ex-post facto research design is adopted because no variable was manipulated as such the research made use of structured questions in obtaining information from respondents which was inherent in the respondents prior to the research. This research also examined the socio demographic characteristics involved in health locus of control and self-concept. The independent variables in this study are health locus of control and self-concept, while the dependent variable is psychological well-being.

3.2 Research setting

This study was conducted in two tertiary institutions in Ekiti State, which are; Federal University Oye-Ekiti (FUOYE) and Ekiti State University Ado-Ekiti (EKSU). FUOYE is a Federal university that has two campuses in Oye and Ikole, but the study was conducted using four faculties which are; faculty of art, social sciences, education and sciences. EKSU is a State University; all its faculties are situated in Ado-Ekiti. The study was conducted in the same faculties as FUOYE.

3.3 Participants

The total numbers of participants in this research was 400 undergraduate students; the researcher made use of simple random sampling and convenience sampling technique in selecting participants.

3.4 Instrument

The instrument used for the measurement of variables in this study were self-report measures pertaining to the demographic variables and the variables of interest in the study.

3.4.1. Section A

Section A consists of items measuring socio-demographic information of the participants, such as gender, age, religion, level and department.

3.4.2 Section B: health locus of control scale

The health locus of control scale was developed by Wallston, Wallston, Kaplan, and Maides (1976). It was designed to assess the kind and extent of control, a person thinks he or she has over his or her own state of health. It was developed to provide specific information about the relationship between an individual's health behavior and that person's belief about locus of health control. The instrument is made up of 11 statements that are designed to elicit information about a person's health-related beliefs. It uses a six-point likert-type scale as its response format that ranges from strongly disagree to strongly agree.

Scoring method

A numerical code of 1 to 6 is assigned to the six response category. The response to the questions 1, 2, 8, 10 and 11 must be reversed (subtracted from 7) before being added to the responses to the remaining questions. The total score for the instrument may range from 11 to 66; a high score denotes belief in a high degree of external health locus of control and low score denotes belief in a high degree of internal health locus of control.

No specific provision are necessary for the administration of the instruments and the instrument is easy to use.

Reliability

Information on the test-retest characteristics of the variable health locus of control measured by the instrument is based on a sample of 22 women who were involved in a weight reduction programme over an 8 week interval. The correlation between the test-retest HLC scores for these women was 0.71. Information on the internal consistency (reliability) characteristic of the instrument was derived from four college student groups from the community sample. Each group had approximately 100 respondents. Coefficients alpha for these varied from 0.40 to 0.72.

Validity

The correlation characteristics of HLC and the more general locus of control measure derived from Rotter's (1960) instruments varied from 0.25 (N=85) to 0.46 (N=34). The distribution characteristics of HLC are essentially the same for three groups of college students and single sample of respondents drawn from the community, that is the mean score on HLC was typically about 34.00 and the standard deviation was usually 6.00.

3.4.3 Section C: self-concept questionnaire

The student self-concept inventory was developed by Saraswat (1984), it provides six separate dimensions of self-concept; Physical (Individuals' view of their body, health, physical appearance and strength), Social (Individual's sense of worth in social interactions), Intellectual (Individuals' awareness of their intelligence and capacity of problem solving and judgments), Moral (Individual's estimation of their moral worth; right and wrong activities), Educational (Individual's view of themselves in relation to school teachers and extracurricular activities) and Temperamental (Individuals view of their prevailing emotional state or predominance of a particular kind of emotional reaction) Self-concept. It also gives a total self-concept score.

The inventory contains 48 items. Each dimension contains eight items. Each item is provided with five alternatives which are ranges from practically never to very often. There is no time limit but generally 20 minutes have been found sufficient for responding all the items.

Self-Concept Dimensions Along with their Item Numbers

Physical: 2, 3, 9, 20, 22, 27, 29 and 31

Social: 1, 8, 21, 37, 40, 43, 46 and 48

Temperamental: 4, 10, 14, 16, 19, 23, 24, and 28

Educational: 5, 13, 15, 17, 25, 26, 30, and 32

Moral: 6, 34, 35, 41, 42, 44, 45 and 47

Intellectual: 7, 11, 12, 18, 33, 36, 38 and 39

Scoring Method

The respondent is provided with five alternatives to give his responses ranging from practically never to very often his/her self-concept. The alternatives or responses are arranged in such a way that the scoring system for all the items will remain the same / e. 5, 4; 3, 2, 1 whether the items are positive or negative. If the respondent put (V) mark for first alternative the score is 5, for second alternative the score is 4, for third alternative score is 3, for the fourth it is 2 and for the fifth and last alternative the score is one. The summated score of all the forty-eight items provide the total self-concept score of an individual. A high score on this inventory indicates a higher and positive self-concept, while a low score shows low and negative self-concept. Transfer the score of each item on the front page against that item. Now add all the scores of eight items given in that column, this will give you score for that particular dimension of Self-concept.

Reliability

Reliability of the inventory was found by test-retest method, and it was found to be .91 for the total self-concept measure. Reliability coefficients of its various dimensions vary from .67 to .88. The following table shows the test-retest reliability for each dimension.

Test-Retest Reliability of the Self-concept Inventory

Code No.	Self-concept dimension	No. of items	Reliability coefficients
A	Physical	8	.77
B	Social	8	.83
C	Temperamental	8	.79
D	Educational	8	.88
E	Moral	8	.67
F	Intellectual	8	.79
	Total self-concept	48	.91

Validity

Experts' opinions were obtained to establish the validity of the inventory. 100 items were given to 25 psychologists to classify the items to the category to which it belongs. Items of highest agreement and not less 80% of agreement were selected. Thus the content and construct validity were established.

Standardization and Norms

The student Self-concept Questionnaire was standardized on 1000 students of 20 Higher Secondary schools of Delhi pertaining to Delhi Administration and Central Schools. The students were from 9th and 10th classes ranging from 14 to 18 years of both the sexes.

3.4.4 Section D: Psychological wellbeing scale

This scale was developed by Carol Ryff in 1989. Ryff multidimensional model of PWB comprises of six psychological dimensions. Each dimension deals with different challenges individuals face in an effort to function optimally (Keyes, Shmotkin, and Ryff, 2002; Ryff, 1989a; Ryff and Keyes, 1995). These dimensions include Self-Acceptance, Positive Relations with others, Environmental Mastery, Autonomy, Purpose in Life, and Personal Growth. Ryff and Keyes (1995) provided the definition of these six dimensions. Self-Acceptance refers to

feeling positive about oneself and the past, even when one is aware of his or her own shortcomings. Positive Relations with Others centers on developing and maintaining warm, satisfying and trusting interpersonal relationships. Environmental Mastery involves a sense of mastery and competence in managing the environment so as to meet personal needs, desires, and values. Autonomy is defined as a sense of self-determination and being able to resist social pressure to think and behave in certain ways. Purpose in Life refers to a sense of meaning of life and directedness. Lastly, Personal Growth centers on a sense of improvement and development in self over time, and making the most of one's talent and capacities.

Scoring method

PWB has 42 items which provides six responses which range from strongly disagree to strongly agree. Higher scores in autonomy indicates that the participant Is self-determining and independent; able to resist social pressures to think and act in certain ways; regulates behavior from within; evaluates self by personal standards, while lower scores indicate that participant Is concerned about the expectations and important decisions; conforms to social pressures to think and act based on evaluations of others; relies on judgments of others.

In environmental mastery higher scores indicates that participant Has a sense of mastery and competence in managing the environment; controls complex array of external activities; makes effective use of surrounding opportunities; able to choose or create contexts suitable to personal needs and values while lower scores shows that participant Has difficulty managing everyday affairs; feels unable to change or improve surrounding context; is unaware of surrounding opportunities; lacks sense of control over external world.

Higher scores in personal growth shows that participants Has a feeling of continued development; sees self as growing and expanding; is open to new experiences; has sense of realizing one's potential; sees improvement in self and behavior over time; is changing in ways that reflect more self-knowledge and effectiveness while lower scores indicate that participant Has few close, trusting relationships with others; finds it difficult to be warm, open, and concerned about others; is isolated and frustrated in interpersonal relationships; not willing to make compromises to sustain important ties with others.

Higher scores in purpose in lie indicates that participant Has goals in life and a sense of direction; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives for living and lower scores shows that participant Lacks a sense of meaning in life; has few goals of aims, lacks sense of direction; does not see purpose of past life; has no outlook or beliefs that give life meaning.

Lastly higher scores in self-acceptance indicates that participant Possesses a positive attitude toward the self; acknowledges and accepts multiple aspects of self, including good and bad qualities; feels positive about past life while lower scores indicate that participant Feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled about certain personal qualities; wishes to be different than what one is.

Reliability and validity

Ryff conducted the reliability and validity of the PWB scale among 321 well-educated Americans. The test-retest took place over 6-weeks with subsample respondents of 117 participants; reliability coefficient of 0.81 to 0.88 was gotten. Validity of Cronbach's α : 86 to.93. Findings in this study showed a reliability coefficient of 0.83.

3.5 Procedures

A multi-stage random sampling was used in this study.

Stage one: Four faculties were randomly chosen from the faculties in FUYOYE and EKSU.

Stage two: Two departments were randomly selected from each of the faculties. That is two from each selected faculties making it eight departments.

Stage three: Twenty-five participants were conveniently selected from each department. Seven from 1001, six from 2001, six from 3001 and six from 4001.

Stage four: Four hundred (400) copies of questionnaire were administered to those departments selected both from FUYOYE and EKSU; however, only three hundred and eighty-nine (389) were returned.

3.5 Statistical technique

Data obtained were analyzed using the Statistical Packaged for the Social Sciences (SPSS) version 20. Descriptive statistics such as frequency, mean, standard deviation and simple percentage were conducted to describe the socio demographic information of the respondents. Hypothesis one was tested using t- test for independent samples to determine the influence of health locus of control on psychological wellbeing. Hypothesis two also was tested using t. test for independent samples to determine the influence of self-concept on psychological wellbeing. Hypothesis three was tested using 2 X 2 Analysis of Variance (ANOVA). Finally, hypothesis four was tested using t. test for independent sample.

CHAPTER FOUR

RESULTS

HYPOTHESIS ONE

Hypothesis one stated that undergraduates who have internal health locus of control would significantly report better psychological well-being than those who have external health locus of control. The hypothesis was tested using t-test independent samples. The result is presented in Table 4.1.

Table 4.1: Summary t-test for independent samples showing the influence of external and internal health locus of control on psychological well-being among undergraduate.

Health locus of control		N	Mean	SD	df	T	P
Psychological well-being	External HLOC	195	35.79	46.62	387	.169	>.05
	Internal HLOC	194	34.01	44.06			

From Table 4.1, the result of the t-test shows that students who had internal HLOC ($X = 34.01$) were not significantly different in psychological well-being from those who had external HLOC ($X = 35.79$), $t = 0.169$; $df = 387$, $p > .05$. The results imply that health locus of control did not significantly influence psychological well-being among undergraduates. Therefore, hypothesis one was rejected.

HYPOTHESIS TWO

Hypothesis two states that undergraduates who have positive self-concept would significantly report better psychological well-being than those who have negative self-concept. The hypothesis was tested using t-test independent samples. The result is presented in Table 4.2.

Table 4.2: Summary t- test for independent samples showing the influence of positive and negative self-concept on psychological well-being among university students

	Self-concept	N	Mean	SD	Df	T	P
Psychological wellbeing	Positive	167	32.994	42.472	387	-.529	>.05
	Negative	222	35.451	47.385			

From Table 4.2, the result of the t-test shows that students who had positive self-concept ($X = 32.994$) was not significantly different in psychological well-being than those who had negative self-concept ($X = 35.451$), $t = -.529$; $df = 387$, $p > .05$. The result implies that self-concept did not significantly influence psychological well-being. Therefore, hypothesis three was not accepted.

HYPOTHESIS THREE

Hypothesis three stated that health locus of control and self-concept would jointly influence psychological well-being. The hypothesis was tested using 2 X 2 Analysis of Variance (ANOVA). The result is shown in Table 4.3.

Table 4.3: Summary of 2 X 2 ANOVA showing main and interaction effect of health locus of control and self-concept on psychological wellbeing

Source	Sum of Square	Df	Mean Square	F	P
HealthLocusofControl (A)	240.416	1	240.416	0.117	.733
Self-Concept (B)	573.614	1	573.614	0.279	.598
AXB	3260.331	1	3260.331	1.584	.209
Error	792355.235	385	2058.066		
Total	796247.033	388			

From Table 4.3, the result shows that health locus of control and self-concept have no interaction influence on psychological well-being among undergraduates in Ekiti $F(1, 385) = 1.584, p > .05$. Therefore, hypothesis three was not accepted.

HYPOTHESIS FOUR

Hypothesis four stated that male university students would significantly report better psychological well-being than female university students. The hypothesis was tested using t-test independent sample. The result is shown in Table 4.4.

Table 4.4: Summary of t-test for independent samples showing gender difference in psychological well-being among university students

	Sex	N	Mean	SD	Df	T	P
Psychological wellbeing	Male	169	37.71	50.72	387	1.27	>.05
	Female	220	31.85	40.59			

From Table 4.4, the result of the t-test shows that male students ($X = 37.71$) were not significantly different in psychological well-being than female students ($X = 31.85$), $t = 1.27$; $df = 387, p = >.05$. The result implies that there is no significant gender difference in psychological well-being among undergraduates. Therefore, hypothesis four was not accepted.

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION & RECOMMANDATIONS

In this chapter, the results of the study are discussed based on the data analysis made in chapter four, interpreted and inference drawn from them. Conclusions, implications and recommendations for further studies are made.

5.1 Discussion

Many variables can influence the psychological well-being of undergraduates. This study investigated the influence of health locus of control and self-concept on psychological well-being among undergraduates of universities in Ekiti state. The researcher's purpose was to explain the influence which health locus of control and self-concept tend to have on psychological well-being of undergraduates.

The hypotheses formulated were tested using t- test independent samples and 2 x 2-way analysis of variance. In this study, it was discovered that health locus of control did not influence psychological well-being which is not in line with most literatures discovered. It was discovered in most literature that people with internal health locus of control will have better psychological well-being (Moshki and Ashtanan, 2010; Bada and Gregory, 2016). This study found otherwise, discovering that health locus of control is not a variable that affect the psychological well-being of students. This implies that a student who has negative psychological well-being cannot be associated with the explanation they give about the outcome of their health.

Self-concept did not influence psychological well-being in this study. In this study, self-concept is supposed to influence psychological well-being as discovered by other studies, but surprisingly it was discovered otherwise. Although most literature did not specifically take self-concept as a whole most focused on self-esteem and studied its influence on psychological well-being. All the literature discovered reported that a positive correlation between self-esteem and psychological well-being (Moshki and Ashtanan, 2010). There are no doubts that positive psychological well-being of students will lead to better academic achievement, it was discovered in most literature that positive self-concept alongside with the right motivation can improve students' academic achievement (Alina, 2016; Ahman-Mahud, 2016).

Assessment of both health locus of control and self-concept indicated that health locus of control and self-concept did not jointly predict that undergraduates will have better psychological well-being. This has no literature support in the sense that most recent literature did not investigate health locus of control and self-concept jointly. A similar study on the relationship between health locus of control and self-esteem found out that there was a direct relationship between health locus, self-esteem and psychological well-being, that means those who have low perceived internal locus of control and self-esteem will have psychological problem (Moshki and Ashtarian,2010) A possible explanation for these findings could be that the explanation that undergraduates give to the outcome of their health and the ideas they have about themselves cannot influence their psychological well-being.

Previous studies have revealed no significance influence of sex on psychological well-being. This was in line with what was discovered in this study, there was no significance difference in the psychological well-being of males compared to that of females. Which implies that been a male or female undergraduate does not mean one will have better psychological well-being.

5.2 Conclusion

The finding of this study revealed that health locus of control and self-concept do not have any influence on psychological well-being of undergraduate student. This implies that psychological well-being of undergraduates is not jointly influenced by health locus of control and self-concept. That means other variable could cause negative psychological well-being for undergraduates. Self-concept as an independent variable had no influence on psychological well-being of undergraduate students. Health locus of control also has no independent influence on psychological well-being of undergraduate students. And lastly, there is no significant gender difference in psychological well-being among undergraduates.

5.3 Implications and recommendations

Having reflected on the study as well as the literature, it was discovered that past studies that focused on similar variable were significant but result on this study were not.

- Further study should be carried out using these variables to test influence on psychological well-being especially among undergraduate in Nigeria.
- A longitudinal design should be utilized to establish a causal relations among measures of psychological well-being, health locus of control, self-concept and age

- The contribution of other socio-demographic variables should be examined (e.g., ethnicity, socio-economic status).
- Undergraduates should be given more opportunity to discuss their personal, academic and health related problems with the school management. This will however help them in improving their psychological well-being.

5.3 limitation of the study

During the course of carrying out this study the researcher was faced with some problems which are;

First, the sample of respondents were mostly composed of first year to second year and first year to fourth year undergraduate university students attending a Federal and state, four-year university without considering private universities in the state.

Participant responses cannot be determined if it were true or false because researcher made use of self-report inventory. Self-report are subjective instruments that are based upon attitudinal and behavioural data provided by the subjects rather than objective data (e.g., actual GPA of student) or informed proxies (i.e., family members, peers, and faculty).

The volume of items in the instrument can make participants to tick options without actually reading the questions. This can confound the result of the study as participant did not read the questions before ticking. Which could bias the result of the study.

It was however not possible to conduct the study among all the universities in Ekiti and with all the undergraduates in the selected universities. Studies was only conducted in one federal university and one state university, there was no inclusion of private university.

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SECTION C

Please answer each item below by checking (√) the most appropriate blank. Options range from 1

(Practically never) – 7 (very often)

SN	QUESTIONS	1	2	3	4	5	6	7
1	Do you often think of yourself as an outstanding student?							
2	How much do you worry about whether other people will regard you as a success or a failure in your job or in school?							
3	How often are you troubled with shyness?							
4	Do you ever think that you have more ability in mathematics than most of your classmates?							
5	Do you often wish or fantasize that you were better looking?							
6	Do you ever think of yourself as more athletic than most people?							
7	Do you ever feel less capable academically than others at your grade level?							
8	Do you think of yourself as a worthwhile person?							
9	Do you often think that you are quite physically attractive?							
10	Have you ever thought that you had a greater ability to read and absorb articles and textbooks than most people?							
11	How often do you have difficulty expressing your ideas in writing for class assignments?							
12	When you think that some people you meet might have an unfavourable opinion of you, how concerned or worried do you feel about it?							
13	Most of the time, do you genuinely like yourself?							
14	Do you ever doubt that you are a worthy person?							
15	Do you often think of yourself as good at mathematical problems?							
16	Do you think of yourself as a generally competent person who can do most things well?							
17	Compared with others, how confident do you feel in your mathematical abilities?							
18	Have you ever thought that you lacked the ability to do well at recreational activities involving coordination and physical agility?							
19	Do you think of yourself as someone who can do quite well on exams and assignments in most of your classes?							
20	How often do you feel concerned about what other people think of you?							
21	Have you ever felt inferior to most other people in athletic ability?							
22	How confident are you that others see you as physically appealing?							
23	Do you usually feel comfortable and at ease meeting new people?							
24	How much do you worry about criticisms that might be made of you by others?							
25	Do you ever feel that you are less physically attractive than you would prefer to be?							
26	Do you feel comfortable and at ease when entering a conversation at a gathering where people are already talking?							
27	When involved in sports requiring physical coordination, are you usually confident that you will do well?							
28	Are you frequently concerned about your ability to do well in school?							
29	Do you ever feel especially proud of, or pleased with, your looks and							

	appearance?								
30	When trying to do well at a sport, how confident are you that your physical abilities will make it possible for you to do well?								
31	How much do you worry about how well you get along with other people?								
32	When in a group of people, do you have trouble thinking of the right things to talk about?								
33	Do you often feel nervous or self-conscious when called upon to speak in front of others?								
34	When you have to read an essay and understand it for a class assignment, how worried or concerned do you feel about it?								
35	When you have to write an essay to convincingly express your ideas, how confident do you feel that you have done a good job?								
36	How often have you felt that your mathematical ability was far below that of your classmates?								
37	How often do you feel that you have a strong sense of self-respect?								
38	Are you often concerned that your school performance is not up to par?								
39	How confident do you feel about your ability to do well on a standardized achievement test with respect to the verbal comprehension portion?								
40	How confident do you feel about your ability to do well on a standardized achievement test with respect to the mathematics portion?								
41	Have you often wished that your family would be more supportive of you?								
42	Do you often think that your family holds you in high regard?								
43	Do you sometimes feel that your family does not respect your individuality?								
44	Do you usually feel that your family sees you as capable and competent?								
45	Do you ever feel that your family does not accept you for yourself?								

SECTION D

Please indicate your degree of agreement using a score ranging from 1 (strongly disagree) – 6 (strongly agree) to the following sentences.

SN	STATEMENTS	1	2	3	4	5	6
1	I am not afraid to voice my opinions, even when they are in opposition to the opinion of most people.						
2	In general, I feel I am in charge of the situation in my life.						
3	I am not interested in activities that will expand my horizons.						
4	Most people see me as loving and affectionate.						
5	I live life one day at a time and don't really think about the future.						
6	When I look at the story of my life, I am pleased with how things have turned out.						
7	My decisions are not usually influenced by what everyone else is doing.						
8	The demands of everyday life often get me down.						
9	I think it is important to have new experiences that challenge how you think about yourself and the world.						
10	Maintaining close relationships has been difficult and frustrating for me.						

11	I have a sense of direction and purpose in life.								
12	In general, I feel confident and positive about myself.								
13	I tend to worry about what other people think of me.								
14	I do not fit very well with the people and the community around me.								
15	When I think about it, I haven't really improved much as a person over the years.								
16	I often feel lonely because I have few close friends with whom to share my concerns.								
17	My daily activities often seem trivial and unimportant to me.								
18	I feel like many of the people I know have gotten more out of life than I have.								
19	I tend to be influenced by people with strong opinions.								
20	I am quite good at managing the many responsibilities of my daily life.								
21	I have a sense that I have developed a lot as a person over time.								
22	I enjoy personal and mutual conversations with family members or friends.								
23	I don't have a good sense of what it is I'm trying to accomplish in life.								
24	I like most aspects of my personality.								
25	I have confidence in my opinions, even if they are contrary to the general consensus.								
26	I often feel overwhelmed by my responsibilities.								
27	I do not enjoy being in new situations that require me to change my old familiar ways of doing things.								
28	People would describe me as a giving person, willing to share my time with others.								
29	I enjoy making plans for the future and working to make them a reality.								
30	In many ways, I feel disappointed about my achievements in life.								
31	I have difficulty arranging my life in a way that is satisfying to me.								
32	I have difficulty arranging my life in a way that is satisfying to me.								
33	For me, life has been a continuous process of learning, changing and growth.								
34	I have not experienced many warm and trusting relationships with others.								
35	Some people wander aimlessly through life, but I am not one of them.								
36	My attitude about myself is probably not as positive as most people feel about themselves.								
37	I judge myself by what I think is important, not by the values of what others think is important.								
38	I have been able to build a home and a lifestyle for myself that is much to my liking.								
39	I gave up trying to make big improvements or changes in my life a long time ago.								
40	I know that I can trust my friends, and they know they can trust me.								
41	I sometimes feel as if I've done all there is to do in life.								
42	When I compare myself to friends and acquaintances, it makes me feel good about who I am.								

Project Results
Frequencies
Statistics

		sex	Age	level	DEPT.	NOI	RA
N	Valid	389	389	389	389	389	389
	Missing	0	0	0	0	0	0

Frequency Table
Sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	169	43.4	43.4	43.4
	Female	220	56.6	56.6	100.0
	Total	389	100.0	100.0	

Level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100 Level	128	32.9	32.9	32.9
	200 Level	110	28.3	28.3	61.2
	300 Level	73	18.8	18.8	79.9
	400 Level	78	20.1	20.1	100.0
	Total	389	100.0	100.0	

DEPT.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sociology	48	12.3	12.3	12.3
	Psychology	49	12.6	12.6	24.9
	Computer Science	49	12.6	12.6	37.5
	Industrial Chemistry	50	12.9	12.9	50.4
	ELS	46	11.8	11.8	62.2
	Linguistics	49	12.6	12.6	74.8
	LIS	52	13.4	13.4	88.2
	Agric Education	46	11.8	11.8	100.0
	Total	389	100.0	100.0	

NOI

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid FUOYE	190	48.8	48.8	48.8
EKSU	199	51.2	51.2	100.0
Total	389	100.0	100.0	

RA

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Christianity	323	83.0	83.0	83.0
Islam	59	15.2	15.2	98.2
Traditional	7	1.8	1.8	100.0
Total	389	100.0	100.0	

Descriptives**Descriptive Statistics**

	N	Minimum	Maximum	Mean	Std. Deviation
Age	389	14	29	20.73	2.724
Valid N (listwise)	389				

Reliability for HLOC scale

Scale: ALL VARIABLES

Case Processing Summary

	N	%
Valid	389	100.0
Cases Excluded ^a	0	.0
Total	389	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.201	11

Item Statistics

	Mean	Std. Deviation	N
HLCS1	1.50	1.130	389
HLCS2	3.27	2.005	389
HLCS3	4.63	1.798	389
HLCS4	3.56	2.097	389
HLCS5	4.45	1.711	389
HLCS6	3.81	1.912	389
HLCS7	4.72	1.712	389
HLCS8	3.04	1.945	389
HLCS9	4.66	1.717	389
HLCS10	3.39	1.975	389
HLCS11	3.46	1.943	389

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
HLCS1	38.98	43.835	-.001	.209
HLCS2	37.21	37.959	.126	.150
HLCS3	35.85	41.368	.021	.208
HLCS4	36.93	36.518	.165	.124
HLCS5	36.03	39.971	.101	.168
HLCS6	36.67	41.099	.014	.214
HLCS7	35.76	39.129	.142	.148
HLCS8	37.44	39.474	.075	.180
HLCS9	35.83	44.000	-.082	.255
HLCS10	37.10	41.323	-.005	.225
HLCS11	37.02	37.987	.139	.144

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
40.48	45.090	6.715	11

Reliability for Self-concept scale
Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	388	99.7
	Excluded ^a	1	.3
	Total	389	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.688	45

Item Statistics

	Mean	Std. Deviation	N
SSCI1	4.09	2.613	388
SSCI2	4.18	2.376	388
SSCI3	4.21	2.382	388
SSCI4	3.31	2.287	388
SSCI5	4.17	2.360	388
SSCI6	3.68	2.344	388
SSCI7	4.65	2.275	388
SSCI8	4.45	2.446	388
SSCI9	4.37	2.384	388
SSCI10	3.97	2.247	388
SSCI11	4.66	2.193	388
SSCI12	4.48	2.228	388
SSCI13	4.39	2.456	388
SSCI14	4.82	2.332	388
SSCI15	3.62	2.322	388
SSCI16	4.48	2.333	388
SSCI17	3.47	2.201	388
SSCI18	4.56	2.214	388
SSCI19	4.69	2.197	388
SSCI20	4.15	2.360	388
SSCI21	4.48	2.233	388

SSCI22	4.37	2.190	388
SSCI23	4.50	2.319	388
SSCI24	4.41	2.290	388
SSCI25	4.18	2.321	388
SSCI26	3.72	2.217	388
SSCI27	4.09	2.283	388
SSCI28	3.37	2.400	388
SSCI29	4.72	2.384	388
SSCI30	4.06	2.390	388
SSCI31	4.32	2.251	388
SSCI32	4.26	2.336	388
SSCI33	3.71	2.393	388
SSCI34	4.09	2.299	388
SSCI35	4.27	2.285	388
SSCI36	4.34	2.310	388
SSCI37	4.70	2.309	388
SSCI38	3.92	2.301	388
SSCI39	4.19	2.294	388
SSCI40	3.60	2.281	388
SSCI41	3.97	2.419	388
SSCI42	4.61	2.356	388
SSCI43	4.87	2.254	388
SSCI44	4.67	2.414	388
SSCI45	4.83	2.351	388

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
SSCI1	186.57	689.879	.319	.673
SSCI2	186.48	736.493	-.013	.694
SSCI3	186.44	722.769	.094	.688
SSCI4	187.34	725.585	.079	.688
SSCI5	186.48	741.429	-.051	.696
SSCI6	186.97	732.506	.020	.692
SSCI7	186.01	714.155	.174	.683
SSCI8	186.20	689.579	.350	.672
SSCI9	186.29	700.345	.273	.677
SSCI10	186.69	699.290	.304	.676
SSCI11	185.99	714.331	.182	.683
SSCI12	186.18	712.117	.197	.682
SSCI13	186.27	701.379	.254	.678

SSCI14	185.84	716.629	.148	.685
SSCI15	187.04	723.911	.090	.688
SSCI16	186.17	693.384	.339	.673
SSCI17	187.18	717.478	.154	.684
SSCI18	186.10	713.877	.184	.682
SSCI19	185.96	695.854	.344	.674
SSCI20	186.50	708.437	.211	.681
SSCI21	186.17	720.960	.121	.686
SSCI22	186.29	714.092	.185	.682
SSCI23	186.16	695.354	.325	.674
SSCI24	186.25	721.691	.110	.687
SSCI25	186.48	723.666	.092	.688
SSCI26	186.94	719.154	.138	.685
SSCI27	186.57	700.416	.289	.676
SSCI28	187.29	752.262	-.133	.701
SSCI29	185.94	695.172	.315	.674
SSCI30	186.60	697.450	.296	.676
SSCI31	186.33	730.248	.043	.690
SSCI32	186.40	717.817	.138	.685
SSCI33	186.95	713.780	.164	.684
SSCI34	186.57	721.264	.113	.687
SSCI35	186.38	715.477	.162	.684
SSCI36	186.32	715.319	.161	.684
SSCI37	185.96	702.262	.269	.677
SSCI38	186.73	731.674	.028	.691
SSCI39	186.47	701.366	.279	.677
SSCI40	187.06	705.361	.247	.679
SSCI41	186.69	747.746	-.099	.699
SSCI42	186.05	699.625	.283	.676
SSCI43	185.79	703.635	.266	.678
SSCI44	185.99	690.731	.346	.672
SSCI45	185.83	698.422	.294	.676

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
190.66	740.505	27.212	45

Reliability for Psychological Wellbeing Scale

Scale: ALL VARIABLES

Case Processing Summary

	N	%
Valid	385	99.0
Cases Excluded ^a	4	1.0
Total	389	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.836	42

Item Statistics

	Mean	Std. Deviation	N
RPWS1	3.85	2.178	385
RPWS2	4.05	1.970	385
RPWS3	4.12	1.924	385
RPWS4	4.05	1.943	385
RPWS5	4.19	1.938	385
RPWS6	3.74	1.937	385
RPWS7	4.06	1.911	385
RPWS8	3.41	1.903	385
RPWS9	4.33	1.948	385
RPWS10	3.59	2.100	385
RPWS11	4.25	2.104	385
RPWS12	4.32	1.958	385
RPWS13	3.82	1.976	385
RPWS14	4.00	1.877	385
RPWS15	4.10	1.913	385
RPWS16	3.91	2.007	385
RPWS17	4.15	1.946	385
RPWS18	3.84	1.893	385
RPWS19	3.47	2.017	385

RPWS20	4.15	1.882	385
RPWS21	4.12	1.909	385
RPWS22	4.03	1.969	385
RPWS23	4.10	1.940	385
RPWS24	4.15	1.905	385
RPWS25	4.09	1.853	385
RPWS26	3.39	1.919	385
RPWS27	3.66	1.856	385
RPWS28	3.81	1.925	385
RPWS29	4.15	1.960	385
RPWS30	3.85	1.940	385
RPWS31	4.18	1.831	385
RPWS32	3.84	1.945	385
RPWS33	4.18	1.992	385
RPWS34	3.73	1.969	385
RPWS35	4.06	2.006	385
RPWS36	3.72	1.955	385
RPWS37	4.09	1.915	385
RPWS38	3.78	1.963	385
RPWS39	4.14	1.942	385
RPWS40	3.57	1.919	385
RPWS41	4.04	1.904	385
RPWS42	3.92	1.961	385

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
RPWS1	162.18	807.333	.444	.829
RPWS2	161.98	814.408	.434	.829
RPWS3	161.91	845.088	.163	.836
RPWS4	161.98	818.606	.402	.830
RPWS5	161.84	844.648	.165	.836
RPWS6	162.30	819.626	.394	.830
RPWS7	161.97	824.757	.352	.831
RPWS8	162.63	865.953	-.023	.840
RPWS9	161.70	813.387	.449	.829
RPWS10	162.44	856.143	.053	.839
RPWS11	161.78	792.058	.596	.824
RPWS12	161.71	797.540	.594	.825
RPWS13	162.22	861.852	.011	.840
RPWS14	162.03	837.715	.237	.834

RPWS15	161.93	834.583	.260	.834
RPWS16	162.12	848.869	.121	.837
RPWS17	161.88	821.906	.371	.831
RPWS18	162.19	840.920	.205	.835
RPWS19	162.56	884.122	-.176	.845
RPWS20	161.88	809.946	.500	.828
RPWS21	161.91	812.392	.469	.828
RPWS22	162.00	809.690	.477	.828
RPWS23	161.94	816.217	.425	.829
RPWS24	161.88	805.300	.537	.827
RPWS25	161.94	815.762	.452	.829
RPWS26	162.64	883.981	-.181	.844
RPWS27	162.37	872.588	-.082	.842
RPWS28	162.22	807.598	.510	.827
RPWS29	161.88	801.817	.553	.826
RPWS30	162.18	834.307	.258	.834
RPWS31	161.85	823.040	.387	.831
RPWS32	162.19	844.902	.162	.836
RPWS33	161.85	799.880	.561	.826
RPWS34	162.30	851.410	.102	.838
RPWS35	161.97	805.254	.507	.827
RPWS36	162.31	850.559	.111	.837
RPWS37	161.94	809.916	.491	.828
RPWS38	162.25	816.349	.418	.830
RPWS39	161.89	839.103	.215	.835
RPWS40	162.46	830.327	.299	.833
RPWS41	161.99	845.214	.164	.836
RPWS42	162.11	826.058	.329	.832

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
166.03	867.041	29.446	42

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
Age	20.73	2.724	389

Level	2.26	1.120	389
HealthLocusOfControl	39.1491	6.63351	389
SelfConcept	190.7224	27.20749	389
PsychologicalWellbeing	34.3959	45.30103	389

Correlations

		age	level	HealthLocusOfControl	SelfConcept	PsychologicalWellbeing
age	Pearson Correlation	1	.484**	.005	.125*	.017
	Sig. (2-tailed)		.000	.929	.014	.744
	N	389	389	389	389	389
level	Pearson Correlation	.484**	1	-.035	.109*	.049
	Sig. (2-tailed)	.000		.495	.031	.334
	N	389	389	389	389	389
HealthLocusOfControl	Pearson Correlation	.005	-.035	1	.069	.096
	Sig. (2-tailed)	.929	.495		.173	.057
	N	389	389	389	389	389
SelfConcept	Pearson Correlation	.125*	.109*	.069	1	-.017
	Sig. (2-tailed)	.014	.031	.173		.743
	N	389	389	389	389	389
PsychologicalWellbeing	Pearson Correlation	.017	.049	.096	-.017	1
	Sig. (2-tailed)	.744	.334	.057	.743	
	N	389	389	389	389	389

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

T-Test for Hypothesis One

Group Statistics

	HealthLocusOfControl	N	Mean	Std. Deviation	Std. Error Mean
Psychological Wellbeing	ExternalHLOC	195	34.7846	46.61749	3.33835
	InternalHLOC	194	34.0052	44.05537	3.16299

Independent Samples Test

	Levene's Test for Equality of Variances	t-test for Equality of Means								
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Psychological Well-being	Equal variances assumed	.207	.649	.169	387	.866	.77946	4.59948	-8.26364	9.82256
	Equal variances not assumed			.169	385.983	.865	.77946	4.59881	-8.26240	9.82132

T-Test for Hypothesis Two

Group Statistics

	SelfConcept	N	Mean	Std. Deviation	Std. Error Mean
Psychological Wellbeing	Postive/High	167	32.9940	42.47217	3.28660
	Negative/Low	222	35.4505	47.38534	3.18030

Independent Samples Test

	Levene's Test for Equality of Variances		t-test for Equality of Means							
	F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference		
								Lower	Upper	
Psychological Well-being	Equal variances assumed	4.749	.030	-.529	387	.597	-2.45644	4.64464	11.58832	6.67544
	Equal variances not assumed			-.537	375.272	.592	-2.45644	4.57340	11.44914	6.53626

2X2 Analysis of Variance for Hypothesis Three Between-Subjects Factors

	Value Label	N
HLOCLevel	1.00 Internal HLOC	194
	2.00 ExternalHLOC	195
SelfConceptLevel	1.00 Negative/Low	222
	22.00 22.00	167

Descriptive Statistics

Dependent Variable: Psychological Wellbeing

HLOCLevel	SelfConceptLevel	Mean	Std. Deviation	N
Internal HLOC	Negative/Low	37.6000	49.67568	110
	22.00	29.2976	35.11248	84
	Total	34.0052	44.05537	194
ExternalHLOC	Negative/Low	33.3393	45.14672	112
	22.00	36.7349	48.74100	83
	Total	34.7846	46.61749	195
Total	Negative/Low	35.4505	47.38534	222
	22.00	32.9940	42.47217	167
	Total	34.3959	45.30103	389

Tests of Between-Subjects Effects

Dependent Variable: Psychological Wellbeing

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	3891.798 ^a	3	1297.266	.630	.596
Intercept	446990.652	1	446990.652	217.190	.000
HLOCLevel	240.416	1	240.416	.117	.733
SelfConceptLevel	573.614	1	573.614	.279	.598
HLOCLevel * SelfConceptLevel	3260.331	1	3260.331	1.584	.209
Error	792355.235	385	2058.066		
Total	1256464.000	389			
Corrected Total	796247.033	388			

a. R Squared = .005 (Adjusted R Squared = -.003)

T-Test for Hypothesis four (gender difference in Psychological Wellbeing)

Group Statistics

	Sex	N	Mean	Std. Deviation	Std. Error Mean
Psychological Wellbeing	Male	169	37.7101	50.72315	3.90178
	Female	220	31.8500	40.58522	2.73625

Independent Samples Test

	Levene's Test for Equality of Variances		t-test for Equality of Means							
	F	Sig.	T	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference		
								Lower	Upper	
Psychological Well-being	Equal variances assumed	8.326	.004	1.266	387	.206	5.86006	4.63011	-3.24327	14.96338
	Equal variances not assumed			1.230	315.365	.220	5.86006	4.76560	-3.51634	15.23646