CHAPTER: 1

INTRODUCTION

&

REVIEW OF LITERATURE
INTRODUCTION

Perfectionism, in psychology, is a belief that perfection should be strived for. In its pathological form, it is a belief that anything less than perfect is unacceptable. This is often considered an unhealthy belief.

Definition and Measurement

Perfectionism has been defined as the setting of excessively high standards of performance accompanied by critical self evaluations (Frost, Marten, Lahart and Rosenblate; 1990). Five dimensions are hypothesized to contribute to total perfectionism. The First dimension in this conceptualization is concern over making mistakes. This has been the feature - distinguishing perfectionist from those who set high standards for themselves because they are highly competent and successful (Frost and others 1990, Hamachek 1978). The second dimension involves the setting of personal standards of performance. Most theorists in this area have described this as the central feature of perfectionism. Performance set such excessively high standards that they cannot be met satisfactorily. The third and forth dimensions measure concern for the perfections of parent attitudes. The extent to which parents are perceived as they have high expectations. Parents are perceived as being over critical from those dimensions. Each of the major contributors to this area (Burns 1980, Pacht 1984. Hamachek 1978, Hollender 1965) has described parental concession as the core of the disorder and its etiology. A fifth component of perfectionism is the tendency to doubt the quality of one's performance. This aspect of perfectionism has usually be associated with
obsessional like doubting (Reed 1985). Additional dimension which has found to be somewhat separate but which was related to some dimension is a tendency to be orderly organized. This dimension reflects and emphasizes on order and orderliness, which have often been associated with perfectionism (Hollander 1965).

Measurement of perfectionism appears to be considerably useful. Several investigators have tried to study perfectionism in relation to task importance, quality of performance, depression, complexity, efficiency and frequency of procrastination found significant perfectionism in relation to several psycho-social variables like personality limits, birth order, self-esteem, locus of control, adjustment etc.

Hamachek (cited by Parker & Adkins 1994) describes two types of perfectionism. Normal perfectionists "derive a very real sense of pleasure from the labours of a painstaking effort" while Neurotic perfectionists are "unable to feel satisfaction because in their own eyes they never seem to do things good enough to warrant that feeling". Burns (also in Parker & Adkins 1994) defines perfectionists as "people who strain compulsively and unremittingly toward impossible goals and who measure their own worth entirely in terms of productivity and accomplishment".

Hewitt and Flett (1991) devised the Perfectionistic Self-Presentation Scale (PSPS), which rates three aspects of perfectionistic self-presentation: advertising one's own perfection, avoiding situations in which one might appear to be imperfect and failing to disclose situations in which one has been imperfect.
Slaney (1996) created the Almost Perfect scale, which contains four variables: Standards and Order, Relationships, Anxiety, and Procrastination. It distinguishes between adaptive and maladaptive perfectionism. Both adaptive and maladaptive perfectionists rate high in Standards and Order, but maladaptive perfectionists also rate high in Anxiety and Procrastination.

Perfectionism is one of the 16 Personality Factors identified by Raymond Cattell. It may be related to Conscientiousness and Neuroticism in the Big Five personality traits.

Stoeber and Otto (2006) recently reviewed the various definitions and measures of perfectionism. They found that perfectionism comprised two main dimensions: perfectionist strivings and perfectionist concerns. Perfectionist strivings are associated with positive aspects and perfectionistic concerns with negative aspects. Healthy perfectionists rate high in perfectionistic strivings and low in perfectionistic concerns, whereas unhealthy perfectionists rate high in perfectionistic strivings and high in perfectionistic concerns.

**Positive aspects**

Perfectionism can drive people to accomplishments and provide the motivation to persevere in the face of discouragement and obstacles. Roedell (1984) argues that "in a positive form, perfectionism can provide the driving energy which leads to great achievement. The meticulous attention to detail necessary for scientific investigation, the commitment which pushes composers to keep working until the music realises the glorious sounds playing in the imagination, and the persistence which keeps great artists at
their easels until their creation matches their conception all result from perfectionism.

Slaney found that adaptive perfectionists had lower levels of procrastination than non-perfectionists. High-achieving athletes, scientists, and artists often show signs of perfectionism. For example, Michelangelo's perfectionism may have spurred him to create masterpieces such as the statue *David* and the Sistine Chapel. Perfectionism is associated with giftedness in children.

**Negative aspects**

In its pathological form, perfectionism can be very damaging. It can take the form of procrastination when it is used to postpone tasks ("I can't start my project until I know the 'right' way to do it."), and self-deprecation when it is used to excuse poor performance or to seek sympathy and affirmation from other people ("I can't believe I don't know how to reach my own goals. I must be stupid; how else could I not be able to do this?").

In the workplace, perfectionism is often marked by low productivity as individuals lose time and energy on small irrelevant details of larger projects or mundane daily activities. This can lead to depression, alienated colleagues, and a greater risk of accidents. Adderholt-Elliot (1989) describes five characteristics of perfectionist students and teachers which contribute to underachievement: procrastination, fear of failure, the all-or-nothing mindset, paralyzed perfectionism, and workaholics. In intimate relationships, unreal expectations can cause significant dissatisfaction in both partners. Perfectionists may sacrifice family and social activities in the quest for their goals.
Perfectionists can suffer anxiety and low self-esteem. Perfectionism is a risk factor for obsessive-compulsive disorder, eating disorders, and clinical depression.

Therapists attempt to tackle the negative thinking that surrounds perfectionism, in particular the "all-or-nothing" thinking where the client believes that an achievement is either perfect or useless. They encourage clients to set realistic goals and to face their fear of failure.

Causes

Like most personality traits, perfectionism tends to run in families and probably has a genetic component. Parents who practice an authoritarian style combined with conditional love may contribute to perfectionism in their children.

Perfectionism may be a legacy of our evolutionary past. Hominids who were motivated for prolonged, incremental improvement (perfectionism) could create better tools and this would provide significant survival advantages.

Perfectionism has been described as the tendency of individuals to set unrealistically high standards and then critically evaluate one's ability to achieve those standards (Frost, Marten, Lahart, and Rosenblate 1990). Although the concept of perfectionism has been investigated for more than four decades, it was the concurrent efforts of separate research teams in the 1990s that have led to the multidimensional perfectionism measures commonly utilized today. Hewitt and Flett (1991) developed an instrument (HMPS; Hewitt Multidimensional Perfectionism Scale) that measured perfectionism based on three subscales: Self-Oriented Perfectionism (the
setting of high expectations for oneself and the motivation to avoid failure), Other-Oriented Perfectionism (the setting of high expectations for others), and Socially Prescribed Perfectionism (the need to attain perceived high expectations of significant others). Independent research by Frost et al. (1990) led to the development of the Frost Multidimensional Perfectionism Scale (MPS). The MPS measures perfectionism in six dimensions: Concern over Mistakes (CM), Doubts about Actions (D), Personal Standards (PS), Parental Expectations (PE), Parental Criticism (PC), and Organization (O). Both the MPS and the HMPS have been used extensively in the literature (Frost, Heimburg, Holt, Mattia, and Neubauer, 1993; Frost, Trépagnier, Brown, Heimburg, Juster, Leung, and Makris, 1997; Cox, Enns, and Clara, 2002).

Much of the research involving perfectionism concerns the differentiation of positive and negative aspects of the trait. Hamachek (1978) identified individuals that set high standards and allow little leeway for mistakes as neurotic perfectionists, while those that set high standards and allow themselves some degree of latitude for not achieving those goals were labeled as normal perfectionists. Research by Enns and Cox (1999), Frost et al. (1993) and Hill, McIntire, and Bacharach (1997) isolated adaptive (healthy) and maladaptive (unhealthy) aspects of perfectionism, suggesting that some facets of perfectionism lead to higher performance and some lead to higher anxiety over performance. Frost et al. (1993) identified separate adaptive subscales in the HMPS and the MPS, specifically labeling subscales Personal Standards and Organization from the MPS as a "positive striving" characteristic of perfectionism. In the original research, Frost et al. (1990) also found that Personal Standards and Organization were negatively correlated.
with the frequency of procrastination, ascribing this to the possible planning of work strategies. Flett, Blankstein, Hewitt, and Koledin (1992) and Flett, Hewitt, and Martin (1995) determined that certain aspects of perfectionism can lead to the setting of unattainable goals and procrastination. The isolation of the impact of certain aspects of perfectionism was suggested by Frost et al. (1990), who noted that in order to understand perfectionism, it is necessary to examine its dimensions separately. The individual aspects of perfectionism as measured by the MPS have been validated by Frost et al. (1990) and Frost et al. (1997).

Given the nature of perfectionism and its bidirectional effects on performance, it is surprising that very little research has been done on the impact of perfectionism in the college classroom. One such study by Brown et al. (1999), involving female undergraduate students enrolled in an abnormal psychology course, found that the Personal Standards subscale of perfectionism was associated with improved academic performance on a subsequent exam when the individual scored higher than expected on an initial examination. Results of the study also indicated that, as a single dimension, Personal Standards was positively associated with overall academic performance as measured by GPA. Not unexpectedly, elevated levels of Personal Standards were linked with increased study time and time spent in discussion with instructors about grades. In a study of students enrolled in a second year psychology course, Bieling, Israeli, Smith, and Antony (2003) found that college students with higher levels of perfectionism set higher goals and were more likely to fall short. They also concluded that adaptive perfectionism was related modestly with performance and was
positively associated with a preparedness attribute, which is consistent with the findings of Brown et al. (1999). It appears that in the limited research involving college students, Personal Standards has been identified as a clear link of perfectionism to academic performance.

PERFECTIONISM: MYTHS AND REALITIES

Sometimes it's hard to distinguish motivation for healthy achievement from unhealthy perfectionism, and sometimes we make the distinction even harder by holding on to myths about perfectionism. This makes life a good deal more difficult than need be. Below are common myths about perfectionism.

MYTH: I wouldn't be the success I am today if I weren't such a perfectionist.

REALITY: Perfectionism does not lead to success and fulfillment. Although some perfectionists are remarkably successful, what they fail to realize is that their success has been achieved despite-not because of-their compulsive striving.

There is no evidence that perfectionists are more successful than their non-perfectionistic counterparts. There is evidence that given similar levels of talent, skill or intellect, perfectionists perform less successfully than non-perfectionists.

MYTH: Perfectionists get things done and they do things right.

REALITY: Perfectionists often have problems with procrastination, missed deadlines, and low productivity.
Psychologists find that perfectionists tend to be "all-or-nothing" thinkers. They see events and experiences as either good or bad, perfect or imperfect, with nothing in between. Such thinking often leads to procrastination, because a requirement of flawless perfection, in even the smallest of tasks, can become fearfully overwhelming. The perfectionist believes that the flawless product or superb performance must be produced every time. Perfectionists believe if it can't be done perfectly, it's not worth doing.

Such beliefs often lead to undesired results. A perfectionist student may turn in a paper weeks late (or not at all), rather than turn it in on time with less-than-perfect sentences. A perfectionist worker may spend so much time agonizing over some non-critical detail that a critical project misses its deadline.

MYTH: Perfectionists are determined to overcome all obstacles to success.

REALITY: Although perfectionists follow an "I'll-keep-trying-until-it's-perfect" credo, they are especially vulnerable to potentially serious difficulties such as depression, writer's block, and performance and social anxiety.

These internal blocks to productivity, achievement, and success result from the perfectionist's focus on end-products. Instead of concentrating on the process of accomplishing a task, perfectionists focus exclusively on the outcome of their efforts. Far from an asset, this relentless pursuit of the ultimate goal becomes the perfectionist's greatest liability; the resultant sense of overwhelming anxiety often sabotages the perfectionist's efforts.
MYTH: Perfectionists just have this enormous desire to please others and to be the very best they can.

REALITY: Perfectionistic tendencies often begin as an attempt to win love, acceptance, and approval.

Perfectionists are driven by low self-esteem, so their own needs ultimately blind them to the needs and wishes of others. Indeed, their compulsiveness may lead others to beg for a change that the perfectionist cannot or will not make. Perfectionism is more likely to complicate than enhance one's relationships.

The "perfect human" is as appealing and mythical a concept as the unicorn. Many of our greatest endeavors are indeed accomplished while striving to perfect ourselves. Great achievers, like perfectionists, want to be and do better; unlike perfectionists, they are willing to make mistakes and risk failure. Great achievers recognize mistakes, failure, and general imperfection as part of the reality of being human.

Coping Strategies

Overcoming perfectionism requires courage, for it means accepting our imperfections and humanness. Here are several strategies that will help replace perfectionist habits with healthier, more satisfying behavior patterns.

1. Make a list of the advantages and disadvantages of trying to be perfect.

When you make your own list of costs and benefits, you may find that the costs are too great. You may discover that problems with relationships, excessive work holism, eating and substance abuse problems, and other
compulsive behaviors (plus the accompanying anxiety, nervousness, feelings of inadequacy, self-criticism, and so on) actually outweigh whatever advantages perfectionism holds for you.

2. Increase your awareness of the self-critical nature of your all-or-nothing thoughts, and how they extend to other people in your life.

   Learn to substitute more realistic, reasonable thoughts for your habitually critical ones. When you find yourself berating a less-than-perfect performance, whether you're own or someone else's, force yourself to look at and acknowledge the good parts of that performance. Then ask yourself questions like these: Is it really as bad as I feel it is? How do other people see it? Is it a reasonably good performance for the person(s) and circumstances involved?

3. Be realistic about what you can do.

   By setting more realistic goals, you will gradually realize that "imperfect" results do not lead to the punitive consequences you expect and fear. Suppose you swim laps every day, not as athletic training, but for relaxation and exercise. You set yourself the goal of 20 laps, and you can barely swim 15. If you are perfectionist, you soon feel disappointed at your poor performance and anxious about improving it. You may even give up swimming because you're not "good enough." Suppose that instead you tell yourself 15 laps is good enough for now. You accept the possibility that you may never be able to swim 20 laps easily, if at all. So you continue swimming without anxiety. You don't necessarily stop trying to improve, but you swim for
fun and exercise and relaxation—for however many laps you can. Perfectionists often miss out on fun, relaxation and satisfaction.

4. Set strict time limits on each of your projects. When the time is up, move on: attend to another activity.

This technique reduces the procrastination that typically results from perfectionism. Suppose you must find references for a term paper and also study for an exam. Set time limits. For example: Decide that you will spend only 3 hours looking up references, then only 3 more hours studying for the test. If you stick to your time limits, you won’t spend the entire day searching for elusive references, nor try to study late at night when you are too tired to be effective.

5. Learn how to deal with criticism.

Perfectionists often view criticism as a personal attack, responding to it defensively. Concentrate on being more objective about the criticism, and about yourself. If someone criticizes you for making a mistake, acknowledge the mistake and assert your right to make mistakes.

Remind that person and yourself that if you stop making mistakes, you also stop learning and growing. Once you no longer buy into the fallacy that humans must be perfect to be worthwhile, you won’t feel so angry or defensive when you make a mistake. Criticism will then seem like a natural thing from which to learn, rather than something to be avoided at all costs.
The South Indian Monkey Trap: A Parable

One of the characteristics of perfectionists is their "value rigidity." They refuse to let go of particular ideas, even in the face of obvious evidence to the contrary. Here is a fable illustrating the pitfalls of value rigidity, adapted from Robert Pirsig's well-known work, Zen and the Art of Motorcycle Maintenance.

The "South Indian Monkey Trap" was developed by villagers to catch the ever-present and numerous small monkeys in that part of the world. It involves a hollowed-out coconut chained to a stake. The coconut has some rice inside which can be seen through a small hole. The hole is just big enough so that the monkey can put his hand in, but too small for his fist to come out after he has grabbed the rice.

Tempted by the rice, the monkey reaches in and is suddenly trapped. He is not able to see that it is his own fist that traps him, his own desire for the rice. He rigidly holds on to the rice, because he values it. He cannot let go and by doing so retain his freedom. So the trap works and the villagers capture him.

Perfectionists need to rethink their own values and decide whether they are going to continue to be trapped by these values or free themselves.

HISTORY OF PERFECTIONISM

Perfectionism, as a moral theory, has had a very long history and has been touched by some of the great and influential philosophers. Friedrich Nietzsche, with his view that individual human beings reach perfection when they exercise their will to power maximally, was a perfectionist.
However, the most influential perfectionist philosopher of all has to be Aristotle, who, with his conception of the good life (eudemonia), and that politics and political structures should promote the good life amongst individuals; because the polis can best promote the good life, it should be adopted over other forms of social organization.

Perfectionism vs. Happiness

Perfection, it is worthwhile noting, means more than happiness or pleasure, and is very distinct from utilitarianism in its most complex and simple forms. A society geared along perfectionist principles may not produce happy citizens, far from it. As Alfred Naquet remarked in *L'Anarchie et le Collectivisme*:

"The true role of collective existence...is to learn, to discover, to know. Eating, drinking, sleeping, living, in a word, is a mere accessory. In this respect, we are not distinguished from the brute. Knowledge is the goal. If I were condemned to choose between a humanity materially happy, glutted after the manner of a flock of sheep in a field, and a humanity existing in misery, but from which emanated, here and there, some eternal truth, it is on the latter my choice would fall."

The form upon which perfection takes shape is different for each person. For instance, one man may find further education as a form of perfection while another finds physical beauty as a form of perfection.

Each person must decide for themselves what perfection is. Perfectionism should be thought of in existential means, although there may be a perfection which yields the most successful results over a large period of time each person can decide for themselves what perfection they will strive for. There
are no set parameters of perfection, the idea of perfection changes from person to person, culture to culture.

Perfectionism & Tran humanism

Mark Alan Walker argues that rational perfectionism is or should be the ethical imperative behind Tran humanism in his essay Absolute Versus Human Perfectionism.

Perfectionism in Children and Debilitating Perfectionism

Education authors such as Miriam Adderholt and Antony and Swinson note that extreme forms of perfectionism in children and students in educational settings can take on destructive and debilitating forms such as psychosomatic symptoms (high blood pressure, tics, ulcers, etc.), drug use, eating disorders, or cause the exact opposite: fear of failure so poignant that students drop out or refuse to try new tasks they do not believe they can excel in. Educators suggest setting a distinctive line between the quest for excellence and the relentless pursuit of perfection, and offer strategies for educators, students, and parents to combat the harmful effects of extreme perfectionism.

(I-B) PERFECTIONISM: NATIONAL & INTERNATIONAL STUDIES:

Rice, Kenneth G.; Aldea, Mirela A. (2006) examined state dependency on depression, trait stability, and state-trait characteristics of perfectionism in a short-term longitudinal study of university students. Relative stability of perfectionism was assessed with test-retest correlations across 3 time points, and results showed higher rank order and relative stability for perfectionism scores compared with depression scores. Regression and path analyses to
disentangle directions of effects revealed that initial maladaptive perfectionism scores remained robust predictors of later perfectionism scores, even after the authors controlled for prior and concurrent depression and other dimensions of perfectionism. Perfectionism proved to be quite stable and was a significant predictor of later depression. Perfectionism was also not meaningfully altered by state changes in depression. The overall findings indicate that perfectionism appears to have substantial relative stability, and perfectionist discrepancy in particular is a clear vulnerability factor for depression.

Dunn, Joshua C.; Whelton, William J.; Sharpe, Donald (2006) examined the roles of hassles, avoidant and problem-focused coping, and perceived social support as mediating the relationship between maladaptive perfectionism and psychological distress in a sample of university professors. Hassles and avoidant coping both partially mediated a strong association between maladaptive perfectionism and psychological distress. These results are discussed in terms of the need to better understand how coping styles and social support are associated with the negative impact of perfectionism on the lives of university professors. The implications of these findings for counseling practice are also explored.

Correlations between the subscales of the APS-R and measures of self-esteem, self-reported grade point average (GPA), satisfaction with GPA, trait anxiety, and depression were consistent with the results of previous research. A cluster analysis was performed on the APS-R; the cluster results were similar to those found in previous studies. Finally, the limitations of the present study and the implications for future research with African Americans are discussed.

In the workplace, perfectionism is often marked by low productivity as individuals lose time and energy on small irrelevant details of larger projects or mundane daily activities. This can lead to depression, alienated colleagues, and a greater risk of accidents. [Adderholt-Elliot (1989) describes five characteristics of perfectionist students and teachers which contribute to underachievement: procrastination, fear of failure, the all-or-nothing mindset, paralyzed perfectionism, and work holism. In intimate relationships, unreal expectations can cause significant dissatisfaction in both partners.] Perfectionists may sacrifice family and social activities in the quest for their goals.

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Given the nature of perfectionism and its bidirectional effects on performance, it is surprising that very little research has been done on the impact of perfectionism in the college classroom. One such study by Brown et al. (1999), involving female undergraduate students enrolled in an abnormal psychology course, found that the Personal Standards subscale of perfectionism was associated with improved academic performance on a subsequent exam when the individual scored higher than expected on an initial examination. Results of the study also indicated that, as a single dimension, Personal Standards was positively associated with overall academic performance as measured by GPA. Not unexpectedly, elevated levels of Personal Standards were linked with increased study time and time spent in discussion with instructors about grades. In a study of students enrolled in a second year psychology course, Bieling, Israeli, Smith, and Antony (2003) found that college students with higher levels of perfectionism set higher goals and were more likely to fall short. They also concluded that adaptive perfectionism was related modestly with performance and was positively associated with a preparedness attribute, which is consistent with the findings of Brown et al. (1999). It appears that in the limited research involving college students, Personal Standards has been identified as a clear link of perfectionism to academic performance. Perfectionism is not a healthy pursuit of excellence: Perfectionism is not a healthy pursuit of excellence. There are big differences between perfectionists and healthy achievers. Perfectionists believe that mistakes must never be made and that the highest standards of performance must always be achieved.
Those who strive for excellence in a healthy way take genuine pleasure in trying to meet high standards. Perfectionists on the other hand are full of self-doubts and fears of disapproval, ridicule and rejection. The healthy striver has drive, while the perfectionist is driven.

Grzegorek, Jennifer L.; Slaney, Robert B.; Franze, Sarah; Rice, Kenneth G. (2006) Cluster analyses using the Almost Perfect Scale—Revised yielded 3 clusters that represented adaptive perfectionists, maladaptive perfectionists, and non perfectionists. Maladaptive perfectionist scores were strongly correlated with self-critical depression, but not dependent depression. Adaptive perfectionist scores were correlated with higher self-esteem and greater satisfaction with grade point average (GPA). It was hypothesized that satisfaction with GPA would moderate the relationship between cluster membership and GPA, and that participant gender would moderate the relationship between cluster membership and self-esteem. Neither hypothesis was supported. A comparison of the cluster groups from this sample with those in 2 previous samples indicated similar scores between clusters. Clinical implications and directions for future research are discussed.

Mezulis, Amy H.; Abramson, Lyn Y.; Hyde, Janet S.; Hankin, Benjamin L. (2006)suggested the presence of a self-serving attributional bias, with people making more internal, stable, and global attributions for positive events than for negative events. This study examined the magnitude, ubiquity, and adaptiveness of this bias. The authors conducted a meta-analysis of 266 studies, yielding 503 independent effect sizes. The average d was 0.96, indicating a large bias. The bias was present in nearly all samples. There were significant age differences, with children and older adults displaying the
largest biases. Asian samples displayed significantly smaller biases ($d = 0.30$) than U.S. ($d = 1.05$) or Western ($d = 0.70$) samples. Psychopathology was associated with a significantly attenuated bias ($d = 0.48$) compared with samples without psychopathology ($d = 1.28$) and community samples ($d = 1.08$). The bias was smallest for samples with depression ($0.21$), anxiety ($0.46$), and attention-deficit/hyperactivity disorder ($0.55$). Findings confirm that the self-serving attributional bias is pervasive in the general population but demonstrates significant variability across age, culture, and psychopathology.

Unreasonably high expectations of self and unhealthy or neurotic perfectionism (Schuler, 2000) may lead to problems in choosing a career path (Clark, 1992; Kelly & Hall, 1994; Novack & Novack, 1996; Silverman 1993). An unhealthy perfectionist can be immobilized because of a desire to be perfect. The pressure to make the perfect career choice, to please significant others, including percents, teachers and peers, can cause anxiety and fear of failure, which in turn may lead to indecision (Stewart, 1999), delaying decision making about careers, or frequent change of college major (Frederickson, 1986).
Locus of control is a concept in psychology that originally distinguished between two types of people - *internals*, who attribute events to their own control, and *externals*, who attribute events in their life to external circumstances. For example, college students with a strong *internal* locus of control may believe that their grades were achieved through their own abilities and efforts, whereas those with a strong *external* locus of control may believe that their grades are the result of good or bad luck, and are hence less likely to work hard for high grades. (It should not be thought however, that internality is linked exclusively with attribution to effort and externality with attribution to luck, as Weiner's work (see below) makes clear). This has obvious implications for differences between internals and externals in terms of their achievement motivation, suggesting that internal locus is linked with higher levels of N-ach. Due to their locating control outside themselves, externals tend to feel they have less control over their fate. People with an external locus of control tend to be more stressed and prone to clinical depression (Benassi, Sweeney & Dafour, 1988; cited in Maltby, Day & Macaskill, 2007).

Although popularly associated with Julian Rotter after his publication in Psychological Monographs where he outlined his now classic "locus of control" scale (1966), work on locus of control actually predates Rotter's paper, as...
Lefcourt's (1966) review of the same year clarifies. Its roots can be found in the work on typical and atypical expectancy shifts carried out by psychologists.

HISTORY OF CONCEPT

Although locus of control has frequently been viewed as a cognitive model of personality, its roots can actually be seen in behaviorism as the immediate background to this theory related to beliefs about reinforcement. Indeed, Lefcourt (1976) defined perceived locus of control as follows: "Perceived control is defined as a generalised expectancy for internal as opposed to external control of reinforcements" (Lefcourt 1976, p27). Early work on the topic of expectancies about control of reinforcement had, as Lefcourt explains, been performed in the 1950s by James and in work which Phares prepared for an unpublished doctoral dissertation at the University of Ohio. Attempts have been made to trace the genesis of the concept to the work of Alfred Adler, but its immediate background lies in the work of psychologists such as William H. James (not to be confused with William James), who studied two types of expectancy shifts:

- typical expectancy shifts, believing that a success or failure would be followed by a similar outcome; and
- atypical expectancy shifts, believing that a success or failure would be followed by a dissimilar outcome.

Work in this field led psychologists to suppose that people who were more likely to display typical expectancy shifts were those who more likely to attribute their
outcomes to ability, whereas those who displayed atypical expectancy would be more likely to attribute their outcomes to chance. This was interpreted as saying that people could be divided into those who attribute to ability (an internal cause) versus those who attribute to luck (an external cause).

A revolutionary paper in this field was published in 1966, in the journal Psychological Monographs, by Julian B. Rotter. Early history of the concept can be found in Lefcourt (1976), who, early in his treatise on the topic, relates the concept to learned helplessness.

CHARACTERISTICS OF LOCUS OF CONTROL ORIENTATIONS

Internals were believed by Rotter (1966) to exhibit two essential characteristics - high achievement motivation and low outer-directedness. This was the basis of the locus of control scale proposed by Rotter in 1966, although this was actually based on Rotter's belief that locus of control is a unidimensional construct. Since 1970, Rotter's assumption of unidimensionality has been challenged, with Levenson, for example, arguing that different dimensions of locus of control, such as belief that events in one's life are self-determined, are organized by powerful others and are due chance-based, must be separated. Weiner's early work in the 1970s, suggested that, more-or-less orthogonal to the internality-externality dimension, we should also consider differences between those who attribute to stable causes, and those who attribute to unstable causes. This meant that attributions could be to ability (an internal, stable cause), effort (an internal unstable cause), task difficulty (an external stable cause) or luck (an external, unstable cause). Such at least were how the early Weiner saw these
four causes, although he has been challenged as to whether people do see luck, for example, as an external cause, whether ability is always perceived as stable and whether effort is always seen as changing. Indeed, in more recent publications (e.g. Weiner, 1980) Weiner uses different terms for these four causes - such as "objective task characteristics" in place of task difficulty and "chance" in place of luck. It has also been notable how psychologists since Weiner have distinguished between stable effort and unstable effort - knowing that, in some circumstances, effort could be seen as a stable cause, especially given the presence of certain words such as as "industrious" in the English language.

SCALES TO MEASURE LOCUS OF CONTROL

The most famous questionnaire to measure locus of control is the 23-item forced choice scale of Rotter (1966), but this is not the only questionnaire - indeed, predating Rotter's work by five years is Bialer's (1961) 23-item scale for children. Also of relevance to locus of control scale are the Crandall Intellectual Ascription of Responsibility Scale (Crandall, 1965), and the Nowicki-Strickland Scale. One of the earliest psychometric scales to assess locus of control, using a Likert-type scale in contrast to the forced-choice alternative measure which can be found in Rotter's scale, was that devised by W.H. James, for his unpublished doctoral dissertation at the University of Ohio, although this remained an unpublished scale. Many measures of locus of control have appeared since Rotter's scale, both those, such as The Duttweiler Control Index (Duttweiler, 1984), which uses a five-point scale, and those which are related to specific
areas, such as health. These scales are reviewed by Furnham and Steele (1993), and include those related to health psychology, industrial and organizational psychology and those specifically for children, such as the Stanford Preschool Internal-External Control Index, which is used for three to six year olds. Furnham and Steele (1993) cite data which suggest that the most reliable and valid of the questionnaires for adults is the Duttweiler scale. For a review of the health questionnaires cited by these authors, see below under "Applications".

RELATED AREA: ATTRIBUTIONAL STYLE

Attributional style, or explanatory style, is a concept that was introduced by Lyn Yvonne Abramson, Martin Seligman and John D. Teasdale (Abramson, Seligman & Teasdale, 1978). Buchanan and Seligman (1995) have edited a book-length review of the topic. This concept goes a stage further than Weiner, saying that in addition to the concepts of internality-externality and stability a dimension of globality-specificity is also needed. Abramson et al. therefore believed that how people explained successes and failures in their lives related to whether they attributed these to internal or external factors, to factors that were short-term or long-term and to factors that affected all situations in their lives versus highly circumscribed situations.

This concept has had much relevance to the study of depression, with Abramson et al. believing that those who showed a characteristic way of attributing negative outcomes - to internal, stable and global causes - would be likely to suffer depression when negative events happened to them. It is important to remember this: since their model is a diathesis-stress model, they
were not arguing that this attributional style alone caused depression, nor were they arguing that this attributional style simply increases vulnerability to depression - the model stipulates that an objective, negative event must occur in conjunction with this style for clinical depression to result. Empirical research has been performed in support of this theory, as the meta-analysis of Sweeney, Anderson and Bailey (1986) (cited in Abramson, Metalksy & Abramson, 1989) of 104 empirical studies of the theory reveals. Data have, however, been ambiguous, and some researchers believe that the theory is well-supported, some believe that it has not had impressive empirical support and some believe that, at least in the early days of the theory, the theory was never adequately tested (Abramson, Metalksy & Alloy, 1989). An important consideration here, emphasised by Robbins and Hayes (1995), is that the Abramson-Seligman-Teasdale model of depression is a diathesis-stress model, implying that it is important to control for severity of actual negative event in comparisons of attributional styles of depressive and non-depressives. Indeed, one of the factors accounting for whether ambiguity in research into the model is whether empirical researchers have assessed attributions for hypothetical events or for real events. Interestingly, those studies that have looked at attributions for hypothetical events have been more supportive of the model, possibly because these studies are more likely to have controlled for event severity.

Attributional style has been assessed on questionnaires such as the Attributional Style Questionnaire or A.S.Q. (Peterson, Semmel, von Baeyer, Abramson, Metalksy & Seligman, 1982), which assesses attributions for six
negative and six positive hypothetical events, the Expanded Attributional Style Questionnaire or E.A.S.Q. (Peterson & Villanova, 1988) which assesses attributions for eighteen hypothetical negative events, and various scales that assess attributions for real events, such as the Real Events Attributional Style Questionnaire of Norman and Antaki (1988) or the Attributions Questionnaire of Gong-guy and Hammen (1980). Although these scales provide empirical methodology for study of attributional style, and considerable empirical data support the Abramson-Seligman-Teasdale model of depression, there has been dispute about whether this concept really exists. Cutrona, Russell and Jones (1987), for example, found evidence for considerable cross-situational variation and temporal change of attributional style in women suffering from post-partum depression. As Xenikou et alia (1997) note, however, Cutrona, Russell and Jones found more evidence for the cross-situational consistency of stability and globality than of internality. More data in support of long-term stability of attributional style has come from a diary study by Burns and Seligman (1989). Using a technique called Content Analysis of Verbatim Explanation (C.A.V.E) these authors found that over a long time period, people did show stable patterns of how they manifested attributional style.

The question of how specific the domain for which attributional style is being measured has to be addressed at this stage. Using the Attributional Style Assessment Test of Anderson, Anderson and his colleagues found some evidence for an attributional style for specific domains, such as work-related domains or interpersonal domains. Their position therefore fell midway between
the enthusiasm of keen believers in attributional style, and the pessimism of those skeptical of the concept (Anderson, Jennings & Arnoult, 1988).

More recently than the "learned helplessness" model which formed the theoretical basis of the original Abramson, Seligman and Teasdale (1978) statement on attributional style, Abramson, Metalsky and Alloy (1989) proposed the hopelessness theory. This theory distinguishes between hopelessness depression and circumscribed pessimism. It emphasises the dimensions of stability and globality rather than internality, holding that attributions of one's failures to stable and global causes, rather than to internal causes, is associated with hopelessness depression. Hopelessness theory also emphasises how perceived importance of a negative outcome, and perceived consequences of a negative outcome, are important as well as causal attributions in relation to clinical depression.

The important differences between locus of control and attributional style are that the latter is concerned with expectancies about the future, the former with attributions for the past, and that whereas locus of control cuts across both positive and negative outcomes, authors in the attributional style field have distinguished between a Pessimistic Explanatory Style, in which failures are attributed to internal, stable and global factors, successes to external, unstable and specific causes, and an Optimistic Explanatory Style, in which successes are attributed to internal, stable and global factors, failures to external, unstable and specific causes (Buchanan & Seligman, 1995).
Explanations as to how individual differences in attributional style originate have been considered by Eisner (1995). She notes that repeated exposure to controllable events may foster an optimistic explanatory style, whereas repeated exposure to uncontrollable events may foster a negative one, and also cites evidence from twin studies for some heredity basis to attributional style. Original with Eisner is the argument that trust in interpersonal relationships is linked with optimistic explanatory style.

Locus of control's most famous application has probably been in the area of health psychology, largely thanks to the work of Kenneth Wallston. Scales to measure locus of control in the health domain are reviewed by Furnham and Steele (1993). The most famous of these would be the Health Locus of Control Scale and the Multidimensional Health Locus of Control Scale, or MHLC (Wallston, Wallston, & DeVellis, 1976; Wallston, Wallston, Kaplan & Maldes, 1976). The latter scale is based on the idea, echoing Levenson's earlier work, that health may be attributed to three possible outcomes - internal factors, such as self-determination of a healthy lifestyle, powerful others, such as one's doctor, or luck. Some of the scales reviewed by Furnham and Steele (1993) relate to health in more specific domains, such as obesity (for example, Saltzer's ) (1982) Weight Locus of Control Scale or Stotland and Zuroff's (1990) Dieting Beliefs Scale), or mental health (such as Wood and Letak's (1982) Mental Health Locus of Control Scale or the Depression Locus of Control Scale of Whiteman, Desmond and Price, 1987) and cancer (the Cancer Locus of Control Scale of Pruyn et alia, 1988). In discussing applications of the concept to health
psychology, Furnham and Steele also refer to Claire Bradley's work, linking locus of control to management of diabetes mellitus. Empirical data on health locus of control in various fields has been reviewed by Norman and Bennett (1995). These authors note that data on whether certain health-related behaviours are related to internal health locus of control have been ambiguous. For example, they note that some studies found that internal health locus of control is linked with increased exercise, but they also cite several studies that have found only a weak or no relationship between exercise behaviours (such as jogging) and internal health locus of control. They note similar ambiguity for data on the relationship between internal health locus of control and other health-related behaviors, such as breast self-examination, weight control and preventative health behaviors. Of particular interest are the data these authors cite on the relationship between internal health locus of control and alcohol consumption. Norman and Bennett note that some studies which have compared alcoholics with non-alcoholics have suggested alcoholism is linked with increased externality for health locus of control, but other studies have found alcoholism to be linked with increased internality, and similar ambiguity has been found in studies which have looked at alcohol consumption in a more general, non-alcoholic population. Norman and Bennett appear a little more optimistic in reviewing the literature on the relationship between internal health locus of control and smoking cessation, although they also point out that there are grounds for supposing that powerful others health locus of control, as well as internal health locus of control, may be linked with smoking cessation.
Norman and Bennett argue that a stronger relationship is found when health locus of control is assessed for specific domains than when general measures of locus of control are taken. ("Overall, studies using behaviour-specific health locus scales have tended to produce more positive results (Lefcourt, 1991). Moreover, these scales have been found to be more predictive of general behaviour than more general scales, such as the MHLC scale" (Norman & Bennett, 1995, p72). Norman and Bennett cite several studies which have used health-related locus of control scales in specific domains, including smoking cessation (Georgio & Bradley, 1992), diabetes (Ferraro, Price, Desmond & Roberts, 1987), tablet-treated diabetes (Bradley, Lewis, Jennings & Ward, 1990), hypertension (Stantion, 1987), arthritis (Nicasio et al., 1985), cancer (Pruyn et al., 1988) and heart and lung disease (Allison, 1987). They also argue that health locus of control is better at predicting health-related behaviour if studied in conjunction with health value, i.e. the value people attach to their health, suggesting that health value is an important moderator variable in the health-locus of control relationship. For example, Weiss and Larsen (1990) (cited in Norman & Bennett, 1995) found increased relationship between internal health locus of control and health when health value was assessed. Despite the importance that Norman and Bennet (1995) attach to use of specific measures of locus of control, there are still some general textbooks on personality, such as Maltby, Day and Macaskill (2007), which continue to cite studies linking internal locus of control with improved physical health, mental health and quality of life in people
undergoing conditions as diverse as HIV, migraines, diabetes, kidney disease and epilepsy (Maltby, Day & Macaskill, 2007).

Other fields to which the concept has been applied include industrial and organizational psychology, sports psychology, educational psychology and the psychology of religion. Richard Kahoe has published celebrated work in the latter field, suggesting that intrinsic religious orientation correlates positively, extrinsic religious orientation correlates negatively, with internal locus of relevance to both health psychology and the psychology of religion is the work prepared by Holt, Clark, Kreuter and Rubio (2003), in preparing a questionnaire to assess spiritual health locus of control. These authors distinguished between an active spiritual health locus of control orientation, in which "God empowers the individual to take healthy actions" and a more passive spiritual health locus of control orientation, where people leave everything to God in the care of their own health. In industrial and organizational psychology, it has been found that internals are more likely to take position action to change their jobs, rather than merely to talk about occupational change, than externals (Allen, Weeks & Moffat, 2005; cited in Maltby et al., 2007).

Characteristics of locus of control orientations:

Empirical research findings have implied the following differences between internals and externals:

1. Internals are more likely to work for achievements, to tolerate delays in rewards and to plan for long-term goals, whereas externals are more likely to lower their goals. After failing a task, internals re-evaluate future performances
and lower their expectations of success, whereas externals may raise their expectations. These differences relate to differences in achievement motivation (as noted above, Rotter (1966) believed that internals tend to be higher in achievement motivation than externals). However, empirical findings have been ambiguous here. There is some evidence that sex-based differences may complicate these findings, with females being more responsive to failures, males to successes.

2. Going back to Bialer's (1961), considerable data suggest that internal locus of control is associated with increased ability to delay gratification. However, at least one study has found this effect does not apply to all samples. Walls and Miller (cited in Lefcourt, 1976) found an association between internal locus and delay of gratification in second and third grade children, but not in adults who were vocational rehabilitation clients.

3. Internals are better able to resist coercion. This relates to higher outer-directedness of externals, another factor which Rotter (1966) believed distinguished the two orientations.

4. Internals are better at tolerating ambiguous situations. There is also a lot of evidence in clinical research that internality correlates negatively with anxiety, and that internals may be less prone to depression than externals, as well as being less prone to learned helplessness. However, this does not mean that the emotional life of the internal is always more positive than that of the external, as internals are known to be more guilt-prone than externals.
5. Internals are less willing to take risks, to work on self-improvement and to better themselves through remedial work than externals.

6. Internals derive greater benefits from social supports.

7. Internals make better mental health recovery in the long-term adjustment to physical disability.

8. Internals are more likely to prefer games based on skill, while externals prefer games based on chance or luck.

Familiar origin:

The development of locus of control is associated with family style and resources, cultural stability and experiences with effort leading to reward. Many internals have grown up with families that modeled typical internal beliefs. These families emphasized effort, education, responsibility and thinking. Parents typically gave their children rewards they had promised them. In contrast, externals are typically associated with lower socioeconomic status, because poor people have less control over their lives. Societies experiencing social unrest increase the expectancy of being out-of-control, so people in such societies become more external. The research of Schneewind (1995; cited in Schultz & Schultz, 2005) suggests that "children in large single parent families headed by women are more likely to develop an external locus of control" (Schultz & Schultz, 2005, p439). Schultz and Schultz also point out that children who develop an internal locus tend to come from families where parents have been supportive and consistent in self-discipline.
As children grow older, they gain skills that give them more control over their environment. In support of this, psychological research has found that older children have more internal locus of control than younger children. Findings from early studies on the familial origins of locus of control were summarised by Lefcourt: "Warmth, supportiveness and parental encouragement seem to be essential for development of an internal locus".

**Locus of control and age**

It is sometimes assumed that as people age, they will become less internal and more external, but data here have been ambiguous. Longitudinal data collected by Gatz and Karel (cited in Johnson et al., 2004) imply that internality may increase up to middle age, and thereafter decrease. Noting the ambiguity of data in this area, Aldwin and Gilmer (2004) cite Lachman's claim that locus of control is ambiguous. Indeed, there is evidence here that changes in locus of control in later life relate more visibly to increased externality, rather than reduced internality, if the two concepts are taken to be orthogonal. Evidence cited by Schultz and Schultz (2005), for example Heckhausen and Schulz (1995) or Ryckman and Malikosi, 1975 (cited in Schultz & Schultz, 2005), suggests that locus of control increases in internality up until middle age. These authors also note that attempts to control the environment become more pronounced between the age of eight and fourteen.

**Sex-based differences in locus of control**

As Schultz and Schultz (2005) point out, significant differences in locus of control have not been found for adults in a U.S. population. However, these
authors also note that there may be specific sex-based differences for specific categories of item to assess locus of control - for example, they cite evidence that men may have a greater internal locus for questions related to academic achievement (Strickland & Haley, 1980; cited in Schultz & Schultz, 2005).

Cross-cultural issues in locus of control

The question of whether people from different cultures vary in locus of control has long been of interest to social psychologists. More on this topic can be found in Shiraev and Levy (2004).

Self-efficacy:

Self-efficacy is another related concept, introduced by Albert Bandura. Although someone may believe that how some future event turns out is under their control, they may or may not believe that they are capable of behaving in a way that will produce the desired result. For example, an athlete may believe that training eight hours a day would result in a marked improvement in ability (an internal locus of control orientation) but not believe that he or she is capable of training that hard (a low sense of self-efficacy). Self-efficacy has been measured by means of a psychometric scale and differs from locus of control in that whereas locus of control is generally a measure of cross-situational beliefs about control, self-efficacy is used as a concept to relate to more circumscribed situations and activities. Bandura has emphasised how the concept differs from self-esteem - using the example that a person may have low self-efficacy for ballroom dancing, but that if ballroom dancing is not very important to that person, this is unlikely to result in low self-esteem.
II-B: INDIAN STUDIES: LOCUS OF CONTROL

The self and the not self constitute the totality of an individual's experience. How one of these is perceived and experienced would have profound consequences for the way the other would be defined, both perceptually and experimentally. Abramson (1978) studied the relationship between internal and external attributions and self-esteem. She exposed a group of students to inescapable noise and induced in them a sense of personal helplessness by informing them that people usually learned to escape the noise. These subjects suffered both performance decrements and loss of self-esteem. Another group was informed that no one could learn to escape that noise. They were thus induced to make an external attribution for their helplessness and view it as universal helplessness. There was performance decrement under this condition but there was no loss of self-esteem.

How the noise (not-self) was perceived influenced how the self was evaluated. Therefore, de Charms' (1968) notion of personal causation of either perceiving oneself as being the origin (hence the agent) of action or as a pawn in the hands of external forces and being pushed around, and Rotter's (1966) concepts of internal and external control orientations are critical concepts for any theory of personality. Many European and American societies view internality, efficacy, and ego strength as positive values. Numerous western studies have demonstrated that internality was associated with a number of socially valued characteristics such as preferring skill-determined activities to chance-determined ones (Schneider, 1968), more effective learning and
performance (Glass & Singer, 1972), and being less dependent on external cues for succeeding at a task (Taub & Dollinger, 1975). This is a vigorous area wherein thousands of studies have been reported giving rise to many issues and several new concepts.

The broad trends however are clear. A large number of western studies emphasised the value of internality. The bulk of Indian studies have followed suit. Rao and Murthy (1984) found that externally-oriented subjects compared to internals were low achievers, more anxious, morbid, neurotic, and low on need for achievement. Sathyavathi and Thomas (1984) noted that neurotic subjects were high on externality and alienation and had low self-esteem. Externality and religiosity were positively related and females were more external than males which explained their greater religiosity (Helode & Barlinge, 1984). Those who did not manifest a clearly differentiated sex role orientation were more external. Men reported greater control over their lives (Bhogle & Murthy, 1988). A.K. Singh (1987) observed that internals were more dogmatic. Internal students regardless of gender were high academic achievers (E Sharma, 1986).

Subjects high on externality were less involved in predicting and planning their futures (Achamamba, 1987). Those who had a greater need for approval were more external (N.K.M. Tripathi, 1980). A comparison of couples revealed that wives were more external, and they were described as lacking in self-confidence. Shejwal and Palsane (1986) studied the relationship between life events stress and locus of control. The high stress group was more internal. According to
the authors, this was probably due to the internals perceiving a threat to the very control which they valued. The externals scored lower on stress as they accepted the environment without any struggle. These findings were interpreted in terms of the beliefs prevalent in the Indian culture—belief in God, karma, and predetermination.

Faroqi (1984) examined "a common stereotype of the Indian society as encouraging belief in predeterminism and attitude of resignation and passive acceptance of what is seen to be preordained" (p. 101). He estimated the median of the mean scores of American samples on Rotter's 1-E Scale on the basis of 8 studies reported between 1963 and 1972. In a similar manner he determined the median score of Indian samples on the basis of 11 studies reported between 1974 and 1984. He took into account questions "concerning comparability of the instruments and samples and concluded that this present analysis fails to support the proposition that Indian college students are more external than corresponding groups of American students" (p. 105).

Faroqi's study raised the question "Are Indians external?". This is an important question, but a number of other questions also need to be asked. A basic question concerns the very meaning of "external" and "internal". At a concrete level, skin is the dividing line between the self and the not-self; the internal and the external. But that is valid only for a mind that is still at a basic level. Even a school child is aware of the constant interchange of substances between the organism and the environment. A loaf on the table is external, an instant after ingestion it
is internal. As the mind ascends the ladder of complexity and sophistication, the dividing line between the internal and the external becomes progressively blurred. At the highest level of evolution of human consciousness, that is, the trans cognitive state of spiritual realisation, the distinction is altogether lost. The universal brotherhood of all beings which saints of all climes and creeds preach, is the spontaneous expression of the unitive experience which they attain, after transcending the cramping limitations of the ego’s boundaries.

In view of this tremendous range of human variation, is it scientifically valid to use Rotter’s scale for one and all, for those at the beginning, the middle and at the end of this dimension? Should not an effort be made to devise different kinds of instruments for people occupying varying positions on the spectrum?

It is true that this question is valid for all psychological instruments. This issue is raised here as this is an appropriate occasion as perceptions of internal and external are particularly sensitive to the level of evolution of consciousness. One possibility is to assess the clarity and definiteness with which an individual makes judgements about what is internal and external, say, a measure of perception of convergence of the internal-external dichotomy. That variable may lead to the formulation of a new theoretical model and search for correlates.

As far as Indian research is concerned, A.K. Singh and Dhawan (1984) found that only under easy task condition internals were more persistent. These findings were explained in terms of the relevance of
situational cognitions as mediators of personality and achievement behaviour. Zainuddin and Taluja (1990) observed that boys from low and middle economic classes were more external than those from high income families. Externally-oriented students of both sexes were more aggressive. Rahman and Kumar (1984) reported that absenteeism among blue collar workers was unrelated to locus of control. Gaur and Upadhyay (1988) exposed internal and external subjects to experimentally induced conditions of no-stress, mild and moderate stress. Performance of both groups on a selective attention task improved up to moderate stress and then it declined. The decline in the performance of externals under severe stress was significant. These results were interpreted in terms of Yerkes-Dodson Law.

Jahan (1989) measured the locus of control orientations of women students who either opted or did not opt for the skill training programme offered by the Career Planning Centre, Women's College, Aligarh Muslim University. Students who opted for the programme were more internal but this pattern was not observed in the case of adults.

This review would be failing in its task if it does not place on record appreciation of the excellent work done by the Career Planning Centre, which is the result of the vision and dedication of a psychologist, Dr Sultan Akhtar of Aligarh Muslim University. He succeeded in forging his psychological expertise into an effective instrument of social service. More such workers are needed if the credibility of psychology as a useful discipline is to be established in
the eyes of the Indian public. Jahan's work emanates from the activities of the Centre.

As in the case of self-concept, locus of control studies have focused on special groups. Schizophrenics and manics were more external compared to normals (Varkey & Sathyavathi, 1984), badminton players compared to non players were more internal (Kumar & Shukla, 1988). A.K. Sinha, Singh, and Shukla (1986) conducted a factor analytic study to investigate the structure of locus of control among junior and middle managers. They identified 8 factors, a theme common to many of these factors was the importance of significant others in determining the outcome. In another study sons and daughters of employed mothers were found to be more external (Rao, Parwathi, & Swaminathan, 1983).

Verma and Dubey (1982) obtained a moderate but significant correlation between PGI Locus of Control Scale and the Hindi adaptation of Health Locus of Control Scale. Another study on methodology (Begum & Shams, 1981) provided evidence for experimenter expectancy effect in all combinations of experimenter and subject control orientations.

Almost all the studies reported here, barring a few experimental investigations, are correlational studies. This is so not on account of any particular scientific merit of this method but due to the ease with which it lends itself to use. Rotter's (1966) scale or some variant of it, such as a version translated into the language of the region of the study, has been frequently used.
As stated in the section on expectancy, the concept of internal versus external control of reinforcement is a generalized problem-solving concept, reflecting the degree to which an individual perceives reinforcement as contingent upon his or her own behaviour or on some other person and/or external force. Rotter (1966) for his part defined locus of control as a generalized expectancy of perceived internal or external control or the degree to which an individual perceives events as being contingent upon his or her own behaviour or own relatively permanent characteristics, which are assumed to be more or less stable under varying conditions. Individuals who believe that they can influence outcomes though their own abilities, efforts, skills and characteristics are designated as of internal orientation (internals). Those who perceive that outcomes are contingent upon external forces such as luck, chance, fate and powerful others or are of the belief that events are unpredictable because of the many complexities in the environment are designated as of external orientation (externals). People are then classified along a spectrum of very internal to very external. It is important to note that locus of control is not about a specific reinforcement, but instead is a problem-solving (i.e cognitive process), generalized expectancy that addresses the issue of whether behaviours are perceived to be directly related to the attainment of needs, no matter what the goal or reinforcement. It should also be noted that in some particular situations or environments, individuals of
an external orientation can (and do) exhibit internal behaviour; this occurs because they have learned from earlier situations that they have control of the reinforcement.

Locus of control and working life

This section discuss locus of control and its relationship with working life behaviour, with the aim of presenting a broader view of the many areas of working life to which the construct can be applied, thus underlining its potential as a variable of considerable interest.

Locus of control and organizational behaviour

In this section the specific relations between locus of control and job satisfaction, job stress and job performance are presented. In investigating the many facets of locus of control in working life, it is argued that the assumption that an individual's locus of control can be altered is of particular importance for the use of the concept. This assumption is empirically supported by a number of studies (see e.g. Phares, 1976; Partridge & Johnston, 1989; Hansemark 1998), thus allowing empirical research not only to enquire into possible individual differences that may be found, but even to develop methods and models that are capable of enhancing workers' abilities, or indeed the ability of persons seeking to enter or re-enter the labour market to deal successfully with obstacles encountered in working life, as well as designing work environments, work tasks, and organizational learning.

Job Satisfaction

A widely used definition of job satisfaction is that presented by Lock (1976), which is conceptualised as an employee's affective response to
different facets of the job or organization, implying a personal evaluation of one's job. Another way of putting this is to say that employees experience job satisfaction if they perceive that their abilities, competence, and values are put to use in the organization and if they receive both rewards and further opportunities from the organization, based on their perceived abilities and performance. From the theory of locus of control, a logical hypothesis would be that those of internal orientation are more inclined then those of external orientation to a higher level of job satisfaction. For example, an employee with a low belief in his/her own efforts and skills having any influence upon outcomes would be unlikely to be always willing to engage with much enthusiasm and dedication in achieving goals at the workplace; while the contrary is to be expected of persons who believe that outcomes are contingent upon their own efforts and skills.

This assumption is supported by Lefcourt's (1982) statement that one can probably see locus of control as more of a diagnostic indicator of a person's likelihood to seek to accomplish their goals in life. This should to lead to internals being more active than externals in seeking ways of creating situations where their actions will be rewarded, and if not, they may be expected to pursue other forms of action. Spector (1982) suggests, for example, that internals will then leave a dissatisfying job. Further suggestions by Spector (1982) that support why internals more than externals should have a higher level of job satisfaction are that internals can be expected to perform better than externals and therefore to receive the benefits of a better
performance, such as faster promotion and better pay, thereby increasing their job satisfaction. The hypothesis put forward here is supported by the research findings presented below. Rothmann (2000), in a cross-sectional study using 624 employees from 7 different organizations in South Africa, found that job satisfaction was related to an internal locus of control orientation and a sense of coherence, which in turn was found to be related to internal control. Muhonen and Torkelson (2004), using a sample of 281 in a Swedish telecom company, reported that externals were less satisfied with their jobs than internals. Spector (1986), in a meta-analysis using 101 samples from 88 studies, found that a high perception of control was related to job satisfaction. Other studies that support this result are Petersen (1985), Garson & Stanwyck (1997), and Newton & Keenan (1990). One can even assume that the level of job satisfaction will influence other areas of working life behaviour. One example of this is in the area of organisation commitment, where a relationship between commitment and locus of control has been found to exist (Luthans et al., 1987; Spector, 1982). Another area of organizational behaviour that locus of control has been reported to influence is organizational frustration (Storms & Spector, 1987). Logically, one would expect that both commitment and frustration should have an impact on employees' job satisfaction. The conclusions drawn from the evidence is that locus of control influences employee perceptions of job satisfaction in organizations.
Job Performance

Many researchers argue that job performance can and should be judged from the point of view of the role employees see themselves as having. These roles are seen as being either of a compliant nature or of an initiatory nature, whereof the terms compliant performance and initiative performance. These two roles are the point of departure for the discussion below. There is quite a lot of empirical evidence that connects cognitive ability with job performance (Hunter & Hunter, 1984; Ree et al., 1994). The proposal here is that locus of control can be expected to play an important role in work performance. Some empirical evidence would seem to support this assumption. Lefcourt (1982) notes that externals seem to have a greater need for task structure before and during the performance of tasks; that they do not readily question the need or reason for carrying out tasks, and that as a result they may not take part in the performance of tasks with enthusiasm until they receive information on the benefits of their task. They are generally therefore more dogmatic in carrying out tasks, that is to say, give a more compliant performance. They also tend to show less interest in the entrepreneurial skills that might enable them to take greater control of situations or to produce new structures or organizations that might enable them to gain better results from their efforts (Lefcourt 1982). Internals, on the other hand, tend to show much more curiosity in the reasons for task performance and to spend more time seeking information about the various tasks they are required to perform. Here one can indeed speak about initiative performance.
(Lefcourt, 1982), for having acquired information, internals are inclined
to use that information in a more advantageous way than externals
(Lefcourt, 1982). Internals also tend to have greater interest in
entrepreneurial skills; and seem to be quicker and more willing in the
extraction of cues from information and the different situations that they
find themselves in, which makes it possible for them to produce new
structures or organizations that might enable them to gain better results
from their efforts. They even tend to show greater variability and are
more deliberate and confident when making decisions than externals.
Research shows that internals are more verbally fluent than externals
and use verbal abilities to greater advantage. The general conclusion
that can be drawn from the research into locus of control and cognitive
ability is that there is a clear tendency for internals to show a higher
level of alertness in many cognitive activities than externals. They also
seem more willing to search for and find information that they interpret
as helpful for controlling and coping with different situations and in the
performance of tasks (Phares, 1976; Lefcourt et al., 1984; Skinner,
1995, Erbin-Roesemann & Simms 1997). The proposed relationship
between locus of control and job performance has received empirical
support; for example in the results found by Broedling (1975), and
pertaining to job performance and its relation to locus of control,
concludes that there is scientific evidence that internals tend to
produce a better job performance that externals. Blau (1993), using a
sample of 146 bank employees, found support for the proposal that an
internal locus of control is related to higher initiative performance and that externals exhibited a more compliant performance. An important dimension of job performance is motivation, or as Skinner (1995) puts it, motivated action, which is defined as "intentional goal-directed behaviour" and consists of three components, behaviour, orientation, and emotion. Skinner argues that perceived control influences both motivation and volition. Spector (1982, 1986) supports this proposed relationship of locus control–motivation–job performance in organizational settings, arguing that persons of internal orientation will show more job motivation, since they are more task and goal oriented. Other empirical support can be found in studies looking into the relationship between locus of control and achievement motivation (Rotter, 1966; Lefcourt & Ladwig, 1965). In conclusion, the arguments and research finds presented here support the existence of a relationship between locus of control and job performance. Similar to the research carried out into locus of control and job satisfaction, the instruments used for investigating locus of control–job performance are both domain-specific and general; populations used are of both western and non-western origin, and all races are represented.

Measurement and psychometric problems of locus of control

Many of the studies that have investigated the locus of control construct have applied the measurement scale developed by Rotter (1966). However, in the last two decades a number of new tools of measurement have been developed with an emphasis on criterion-specific scales, thereby increasing the measurement's validity.
Lefcourt, 1984). The development of these new scales is in line with the advice given by Lefcourt and even by Rotter (1975). Today there are quite a number of scales that are either sphere-specific or multidimensional. There are, however, still a number of important questions being asked about the measurement of locus of control. Coombs & Schroeder (1988) concluded that the assumption that locus of control has strong generalized expectancy properties does not hold up when analyzing data with the use of factor analysis. They even suggest that more goal-specific scales should be used, if the locus of control is to have any great value in predicting the individual's expectancies. Rotter (1990) addressed this critique in his paper "Internal Versus External Control of Reinforcement", where he clearly points out that the construct is heuristic, an important aspect when discussing the validity of the measurement. In replying to the criticism, he presented four propositions, of which three will be taken up here, as the forth is in many respects merely an extension of the arguments in the second proposition. The first of Rotter's propositions is the importance of having a "precise definition", essential for a heuristic construct. This definition needs to be carefully worded in formulations that are precise and lead to mutual understanding. These statements should also include criteria that are both logical and generally accepted (Rotter, 1990). The second proposition emphasizes the importance of having the construct embedded in a strong and extensive theory of behaviour. In the case of the locus of control construct the theory of human learning is its principal influence. It is from this proposition that
Rotter offers explanatory arguments in his discussion of generalized expectancies. He counters by stating the following: "The theory does not specify independent traits, faculties, or types, but numerous psychologists have taken a 23-item test, subjected it to an orthogonal factor analysis, and concluded mistakenly that the concept had no generality because some specificity could be demonstrated. Generality-specificity is a matter of degree, not kind." This statement emphasizes the fact that the learning theory principle is comprised of both generalization and gradient generalization. The third proposition put forward by Rotter states that "measurement principles should be derived from psychological theory." In particular it is argued that the surety of achieving acceptable predictive value from a scale increases "if the principles of measurement are derived from the same theory as the constructs to be measured" Leone and Burns (2000) take on two other controversies concerning the measurement of locus of control. They point to the general content validity of the measurements; and also to whether or not sphere-specific scales are more reliable than multidimensional scales in predicting behaviour. To investigate these problems they carried out a study using three different measurements of locus of control, as well as applying nine scales to assess perceived behaviour-outcome contingency, interpersonal power, and self-efficacy. Their results showed construct validity problems with the three measurements and that it is possible that locus of control is confounded with interpersonal power or self-efficacy or both. At the same time, Leone and Burns caution that their results might benefit...
from more inquiry, both psychometric and theoretical, that may give better explanations and identification to the assumed relations between locus of control and other psychological phenomena. The argument that locus of control may be confounded with other constructs is rebutted by Lefcourt (1991), who points out that perception of control, personal causation, personal competence, helplessness, causal attributions, and efficacy are seen as cognates of locus of control, thus strong relations should be found between these constructs. Concerning whether sphere-specific scales are more reliable than multidimensional scales in predicting behaviour, it would seem that this question is still the subject of debate among many researchers (Furnham & Steele 1993). However, both Rotter (1975) and Lefcourt (1991) have suggested that it cannot be rejected that sphere specific scales would enhance the prediction of behaviour; an assessment that this author is in agreement with, despite the fact that the scale used in this work is not sphere-specific. This gives rise to the question of whether the relations found in the work presented here between locus of control and the various dependent variables would have appeared stronger if a sphere-specific scale had been used. Further research concerning this matter is necessary to give answers of this question.
INTRODUCTION

Our mental health can vary according to our circumstances and can change across our lifetime, in the same way as our physical health does.

Mental health problems are among the most common of all health conditions, directly affecting about a quarter of the population in any one year. Depression and anxiety are the most widespread conditions. Wellbeing, emotional welfare and psychological health are other terms often used to describe mental health.

What is good mental health?

Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against development of many such problems. Good mental health is characterized by a person's ability to fulfill a number of key functions and activities, including:

- the ability to learn
- the ability to feel, express and manage a range of positive and negative emotions
- the ability to form and maintain good relationships with others
- the ability to cope with and manage change and uncertainty
Indicators of Mental Health and Well-being - Background

Improving mental health is a national priority, as indicated in, for example, the public health white paper Towards a Healthier Scotland, 1999; and more recently the strategic framework for health improvement Improving Health in Scotland: The Challenge, 2003. In 2001, the Scottish Executive’s National Programme for Improving Mental Health and Well-Being was established. This aims to raise the profile of, and support further action in, mental health improvement, to address the stigma of mental ill-health and to prevent suicide.

To determine whether mental health and well-being are improving in Scotland, there is a need to measure and track progress. To this end, NHS Health Scotland is taking forward a project with the aim of developing a sustainable core set of public mental health (mental health and well-being) indicators for Scotland. This is a support activity to the National Programme. These indicators will provide a way of monitoring the state of mental health and well-being in Scotland, at a national level, and are vital to the development of a comprehensive health monitoring system.

- It is envisaged that these indicators will:
  - Provide a summary mental health profile for Scotland
  - Enable monitoring of changes in Scotland’s mental health and well-being over time
  - Inform decision-making about priorities for action and resource
allocation
- Maximise the contribution of data already gathered and
- Where possible enable comparability within Scotland and with other countries.

Type and Coverage of indicators

The indicators will be national level indicators for use by politicians and policy makers. They will not be designed to measure the success of specific interventions, rather they will indicate the direction of overall public mental health in Scotland. However, it is recognised that for the indicators to be useful and useable they will need to be available at local level where possible. This will be borne in mind during the development of the indicators.

Principles and Criteria

The indicators will be chosen and developed based on the following principles and criteria (as yet in no specific order of priority):
- Population health approach;
- Tied-in with existing priorities of the National programme;
- The core set to be comprehensive and balanced across mental health dimensions - positive/negative, individual/societal, key determinants as well as health outcomes, different groups in society;
- Built/based on current systems and collection methods using data routinely collected where possible (survey and administrative data) and integrated into the general health monitoring system; based on best-available data, but they should not be data-driven.
• Comparable with other countries where possible - to provide a measure of variability between countries over time;

• Agreed, clear and unambiguously defined indicators based on commonly shared definitions where possible;

• Possible to clearly interpret the value of the indicator and any direction of change;

• Sensitive to change over time;

• Characteristics of good robust indicators – feasible, measurable, acceptable, comprehensive specific (cause and effect), relevant, reliable, valid, replicable, realistic, comparable, practical, evidence-based and ethical;

• Quality of data – availability, coverage (geographical, completeness, groups), sample size (allowing statistical analysis), accuracy, frequency of collection, time to availability after gathered

• Policy relevant but not policy-dependent

• Policy responsive

• Cost effective - data collection, analysis, storage and retrieval

• May be adapted and improved upon where appropriate, whilst maintaining a degree of consistency through time.

Framework for the Development of the Mental Health Indicators

In developing these indicators it is important to outline a definition of mental health to which they will relate. Mental health, however, is a contested and still much debated concept, with no universally accepted definition. In fact, it has been argued that there can be no universally
accepted definition, due to the fact that mental health is multi-dimensional and value-laden. A wide range of meanings and definitions exist amongst individuals, reflecting, for example, differences in age, sex, social and cultural contexts, and experiences, and a lack of common language. Additionally, interpretations are dynamic and mental health is often used interchangeably with, for example, emotional, psychological and subjective well-being.

Thus, no definition is ideal or without problems and mental health is more complicated and more subjective than any definition can capture. For example, most definitions leave out more than they include, leave a number of assumptions and values unquestioned and tend to focus too much on the individual and too little on the environmental and social conditions. It is recognised that focusing on achieving a consensus on definitions of an abstract concept like mental health may not be the most beneficial use of efforts or necessary. However, the way mental health is defined and conceptualised will affect how it is measured.

Therefore, for the development of the core set of mental health indicators there is a need to outline the broad concepts and framework to which the indicators will be developed and will relate, rather than attempting to concisely define mental health and enter into the many philosophical debates. However, it is also acknowledged that as is the case for definitions of mental health, even a framework will represent a simplified version of reality and the indicators an indirect or partial measure of a complex concept. There is also a need to ensure
Within the framework mental health will be used as a broad concept reflecting both positive mental health (often used interchangeably with mental health in for example the two continua model or mental well-being) and negative mental health (mental health problems, often used interchangeably with terms like mental ill-health, mental illness and mental distress) drawing on a 'positive mental health' model. Thus, positive mental health will be considered as a separate and distinct dimension of mental health from negative mental health. This recognises that mental health is not a euphemism for mental ill-health or the absence of mental health problems and challenges the single continuum model where mental health is seen to exist at the opposite end of the same continuum as mental illness. The framework will represent a public (mental) health approach reflecting a social model of mental health. It will recognise that mental health relates to the individual but also environmental and social conditions.
Mental Health as a Broad Concept of Positive and Negative Mental Health

The framework will be developed under three broad interconnected levels of: the individual; communities; and structural (society). These are the levels at which mental health promotion works, namely

- Strengthening individuals
- strengthening communities
- Reducing structural barriers to mental health

At each of these levels, mental health improvement interventions may be designed to strengthen factors known to protect mental health.
(protective factors) or reduce factors known to increase the risk of mental health problems (risk factors).

The risk and protective factors for mental health influence the state of mental health within Scotland. Recognising this, the indicators can be developed within the framework, based on risk and protective factors, drawing from the research literature to ensure that there is a clear and robust relationship between the indicators and mental health. For some of the indicators, questions about the direction of causality will be an issue.

Mental health indicators are being/have been developed by others for example, a minimum data set of European mental health indicators has been developed by the Health Monitoring Programme of the EU, Mental Health Group. These can be accommodated in the framework.

Other Definitions

As well as defining the broad framework of mental health which will be used, it is important to clarify other terminology. The following definitions could be adopted:

Mental health indicator is defined as a measurement of the state of mental health; it is a variable that has been related to mental health and indicates a priority or problem. It may be a survey measure or a proxy for factors central to its definition or it may be a survey measure or a proxy for risk or protective factors.

Monitoring mental health is the systematic, repeated measures of factors related to the mental health of the population.
Population health approach is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.

Community For this project it is recognised that a community is a number of people who have some degree of common identity or interests. The term can mean all the people in a certain locality, particular groupings amongst them or networks not tied to locality.

Issues for the Development of the Indicators

Although much information is collected within Scotland, there are likely to be major gaps in the data required to measure mental health and well-being. This is especially the case around positive mental health as many indicators and measures of mental health are often actually indicators of mental illness. This will necessitate the incorporation of more and/or better measures of mental health and well-being into existing surveys or the development of specialist mental health and well-being surveys. It is also essential to ensure that survey samples include adequate representation from key population groups.

There are therefore many questions and issues relating to the development of these indicators that need to be debated and decided upon. These include the following
What are mental health problems?

Mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions. The majority of people who experience mental health problems can get over them or learn to live with them, especially if they get help early on.

Mental health problems are usually defined and classified to enable professionals to refer people for appropriate care and treatment. But some diagnoses are controversial and there is much concern in the mental health field that people are too often treated according to or described by their label. This can have a profound effect on their quality of life. Nevertheless, diagnoses remain the most usual way of dividing and classifying symptoms into groups.

Most mental health symptoms have traditionally been divided into groups called either 'neurotic' or 'psychotic' symptoms. 'Neurotic' covers those symptoms which can be regarded as severe forms of 'normal' emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as "neuroses" are now more frequently called "common mental health problems."

Less common are 'psychotic' symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no-one else can.
How can we help ourselves?

You can help keep yourself in good mental health by:

- talking about your feelings
- keeping active
- eating well
- drinking sensibly
- keeping in touch with friends and loved ones
- asking for help when you need it
- taking a break
- doing something you're good at and enjoy
- accepting who you are
- caring for others

Mental Health In A Public Health Perspective

Mental health is undeniably one of our most precious possessions to be nurtured, promoted and preserved as best as we can. It is the state of mind in which the individual can experience sustained joy of life while working productively, interacting with others meaningfully and facing up adversity without losing capacity to function physically, psychologically and socially. It is undoubtedly a vital resource for a nation's development and its absence represents a great burden to the economic, political and social functioning of the nation.

Understanding Mental Health

Mental health is among the more important public health issues. Defining health as physical, mental and social well being, A.V. Shah
(1982) has expressed that mental health is "the most essential and inseparable component of health.... An integrated component of public health and social welfare programmes...."

Going by the World Health Organization's definition of health, couple of words draw our attention heavily. Words like 'physical', 'mental' and 'social' force us to ponder more and more, more than the boundaries of biomedical model which addresses only physical ailments, that too not comprehensively (in the word biomedicine 'real' disease). There are number of dimensions, which contribute to positive health like, spiritual, emotional, vocational, philosophical, cultural, socio-economic, environmental, educational and nutritional besides the physical, mental and social dimension. Thus, health is multidimensional. Although these dimensions function and interact with one another, each has its own nature.

Perhaps the easiest dimension of health to understand is 'physical', which is nothing but biomedical definition of health. Mental health is not mere absence of mental illness. Good mental health is ability to respond to many varied experiences of life with flexibility and a sense of purpose. More recently mental health has been defined as "A state of balance between the individual and the surrounding world, a state of harmony between oneself and others, coexistence between the realities of the self and that of other people and that of the environment". On the other hand, social well being implies harmony and integration within the individual, between each individual and other members of society and between individuals and the world in which
they live (Park, 1995). It has been defined as the "quantity and quality of the individual's interpersonal ties and the extent of involvement with the community (Donald, 1978).

The social dimension of health includes the levels of social skills one possesses, social functioning and the ability to see oneself as a member of a larger society. Social health is rooted in "positive material environment" (focusing on financial and residential matters), and "positive human environment" which is concerned with the social network of the individual (Fillenbaum, G.G., 1984).

On the outset, these definitions and explanations of social and mental components of health look similar. But they have sharp differences, which need to be understood for a clear analysis of these dimensions.

In larger sense, mental health or mental dimension refers to the inner harmony of an individual but social component of health refers to the external harmony of an individual. The way one adjusts with his residential and financial matters. Mental dimension looks at how one solves his internal conflicts, the level of self-esteem, his needs, problems and goals and ability to strike a balance between rationality and emotionality.

A few decades ago, the mind and body were considered independent entities. Recently however, researchers have discovered that psychological factor which can induce all kinds of illnesses, not simply mental ones. They include conditions such as essential
hypertension, peptic ulcer, and bronchial asthma (WHO 1964 Technical Report Series, 275).

III-B: INDIAN RESEARCH: MENTAL HEALTH

In the past and in the present also, in the field of health, our mind has been preoccupied with communicable diseases because they are the biggest causes of death in the population. These diseases have partly been conquered. We have been looking at health in terms of physical health, while neglecting mental health. Over the years, mental illness has increased manifold. Although there has been a demographical study, psychiatrist estimates that about two percent of Indians suffer from mental illness, a staggering 20 million out of a population of 100 million. A recent survey of 500 working women in Delhi by Hamara Parivar, a family welfare programme, has found that 78% of them suffer from depression due to sociological pressures and breakdown of personal relationships.

Epidemiological surveys done in India as well as in many other parts of the world have amply confirmed that at any given time one to two percent of the population suffers from serious mental illnesses. While 10 to 15 percent suffers from so-called mental disorders like anxiety, depression, fear, obsession, somatic symptoms due to tension, alcohol and drug abuse etc. Women seem to be more prone to anxiety and depression while men to alcohol and drugs more often. One to two percent of Indians suffers from manic-depressive illness alone. Nine million people have schizophrenia in India (one out of 1000).
Bhargavi V. Davar in her book "Mental Health of Indian Women -A feminist Agenda" says that the presence of distress is estimated to be about fifteen percent of the entire population, this is only a part of the truth. Davar examines data from various studies to conclude that common mental illnesses are more common among women than in men. Even feminists have been largely silent on mental distress in women. While mental health professionals have sidestepped the issues of gender and social problems, Davar's analysis of desegregated data proves that marriage in Indian society is probably the single most important cause of distress to middle class women, as she says, "Marriage is a stressful occupation for women". She feels that mental distress may be a good indicator of social stress and justice.

The number of mental health professionals in the country is limited. The variations across state are enormous. For example, Kerala (with a population of 30 million) has over 300 psychiatrists while Madhya Pradesh (with a population of 70 million) has only 31 psychiatrists and 300 psychiatric beds. In addition, the implementation of the NMHP has had an initial spurt, with delays in expansion. The development of support materials and models at the district level facility for initiating and coordinating the large-scale expansion of the mental health programme is a serious problem.
Mental Health Policies in India

Health policies and programmes have significant role in shaping health services system and care. It is evident from the report of all committees that in the field of mental health, our achievements are not satisfactory. Although all the committee reports emphasize the need to improve the mental health services with its various recommendations, there is no serious attempt to improve mental health services in India. In this context, the National Mental Health Programme (1982) was a major development in providing mental health care through different methods as well as overall goals of health care in general.

Before Independence, there were no clear strategies for the care of mentally ill. The approach was largely to build 'asylums' which were for custodial care rather than therapeutic or rehabilitation centers. Pre Independence situation according to Bhore Committee: "Even if the proportion of mental patients are taken as two per in 1,00 crore population in India, hospital accommodation should be available for at least 2 crore mental patients, as against the existing provision of a little over 10,000 beds for the country as a whole. In India, the ratio of one bed to about 40,000 population, while in England, the corresponding ratio is approximately one bed to 300 population." (GOI 1946).

The Mudaliar Committee reviewed the progress made in mental health, subsequent to the Bhore Committee, over a period of nearly two decades, in the following words: "Reliable Statistics
regarding the incidence of mental morbidity in India is not available. It is believed that an enormous number of patients require psychiatric assistance and service... There is hardly any provision for the education of mental defectives. Provision for the treatment of psychosomatic diseases in general hospitals are inadequate."(GOI 1962)

In the curative field, the committee recommended the setting up of inpatient and outpatient departments at lay hospitals, independent psychiatric and mental health clinics, and institutions for the mentally ill.

Active thinking in the area of mental health marked the decade of the seventies. The Srivastava Committee (1974) recommended that one hour (out of the total training of 200 hours of community health workers) be devoted to mental health. In addition, one manual of the community health workers would deal with the recognition and management of mental health emergencies and problems.

In 1983, the National health policy suggested a "special well-coordinated programme should be launched to provide mental health care as well as medical care, and also the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, infirm and the aged." (GOI 1983)

The National Mental Health Programme

The national Mental Health programme (GOI 1982) is the outcome of the various initiatives taken to provide mental health care
through different methods. It aims at providing mental health care to
the population utilizing the available resources.

The Central Council of Health and Family Welfare has
recommended that mental health should form an integral part of the
total health programme, and should be included in all National policies
and programmes on health, education and social welfare.

As decided in the meeting of the Central Council of Health in
1995 and as recommended by the Workshop of all the Health
Administrators of the Country held in February, 1996, the District
Mental Health Programme was launched in 1996-97 in four Districts,
one each in Andhra Pradesh, Assam, Rajasthan and TamilNadu with a
grant assistance of Rs. 22.5 Lakhs each. A budgetary allocation of Rs.
28.00 Crores has been made during the Ninth Five Year Plan for the
National Mental Health Programme.

The training to the Trainers at the State level is being provided
regularly by the National Institute of Mental Health and Neuro
Sciences, Bangalore under the National Mental Health Programme.
The District Mental Health programme was extended to seven Districts
in 1997-1998, five Districts in 1998 and 6 Districts 1999-2000. Thus,
this programme is under implementation in 22 Districts in 20 States.

Need for Realistic Programmes

The above discussion clearly signifies that mental health is an
important component of health and development of the human society.
Despite various recommendations and policies, the development of mental health services has been uneven. Since Independence, various committees have recommended policies to conduct epidemiological survey to generate base-line epidemiological data and information system for the development of mental health services. But till date, we are dependent on estimates that vary regionally and mostly generated on the basis of hospital admissions and discharge. A similar lag has been noticed in the implementation of the Mental Health Act, in spite of the fact that it was accepted by the parliament in 1987 and became operational since April 1993.

It is necessary on the part of public health personnel to conduct research in bringing out the epidemiological basis for such programmes. Responsibilities also lie with the social scientists to influence the government and public health work in order to have a broader view and better understanding for the problems related to mental health. In the Indian context, no proper research has been done to see the ways in which culture and religion influence mental illnesses and health. It is also clear that mental illness is a significant cause of disability in India, which has been largely ignored, in health related development activities. The impact of economic structural adjustment in impoverishing people, the breakdown of traditional community and family relationships caused by urban migration, and the myriad adverse effects of newer diseases like AIDS are likely to cause a greater impact on people's psychosocial health. In addition, these programmes do not incorporate proper preventive measures, even curative and
rehabilitative services provided are inadequate in terms of the estimated needs.

The development of support materials and models at the district level facility for initiating and coordinating the large-scale expansion of the mental health problem is a serious problem. These programmes lack in-built evaluation mechanism, having no, space for continuous research and community participation at the functional level. The absence of a central organization for mental health has been a serious constraint in post Independence planning in India. Twenty out of twenty-five States have not set up The State Mental Health Authority, as in March 1996.

There have been innovative initiatives in the private sector in a number of areas of mental health. The most notables of these are crisis intervention, rehabilitation of the mentally ill, and care of the elderly and street children. However, this has mostly been at the local level, without adequate evaluation and expansion to cover the rest of the country. In this context, voluntary organizations should be given greater importance, and encouraged to participate to a greater in mental health care programme.

There are number of new issues that have come up in the country with implication for mental health. The most notable are alcohol policies, violence in society, the growing population of elderly persons, urbanization, mental health of women, disaster care, migrants and refugees, street children, and stress at the work place. These issues
have to be tackled by mental health professionals, since such cases do not reach hospitals and clinics but have impact on society, if not adequately addressed on time.

The Relationship between Mental Health and Alcoholism.

Srivastava (1984) conducted a study which was intended to determine the relationship between alcoholism and mental health. 50 gamma alcoholics, 50 delta alcoholics and 50 non alcoholic teetotalers' graduate males of Varanasi district participated in this study. Their age ranged from 30 to 45 years with a mean age of 38.62 years. Hindi version of MMHSI was administering red to these Ss. Findings indicated poor mental health for alcoholics than the non-alcoholics.

Industrialization and Mental Health

In 1984, Thakur conducted a study of the mental health scores of a sample of industrial area (Bombay) and non-industrial area (Darbhanga). MMHSI was administered on these samples. It was found that industrialization no doubt, provided help in general economic development but, at the same time, it left bad effects on the mental health of people of the area.

Mental Health of Migraine Patients

Pandey (1984) conducted a study to explore differentiated personality correlates of mental health in Migraine patients. The sample consisted of 100 migraine patients and 100 normal graduate males of Varanasi district these groups were matched on the variables of age (range 17 to 38 years) and socioeconomic status. Hindi version
of MMHSI was administered to these groups. It was found that migraine patients had poor mental health than the normal:

**Mental Health of Urban and Rural Women**

Gupta, Jam and Kumar (1985) conducted a study to ascertain variations among mental health of urban and rural women. The sample consisted of 100 urban and 100 rural women matched on the variables of age (range 25 to 40 years), education and socioeconomic status. Hindi version of MMHSI was administered to them. It was found that urban women scored significantly higher on MMHSI than the rural women which indicates poor mental health for urban women.

**Sports and Mental Health**

Kumar, Pathak and Thakur (1985) explored variations in mental health of individual, team and non-athletes. The sample consisted of 50 individual athletes, 50 team athletes and 50 non-athletes graduate males of different educational institutions of Varanasi district in India. These groups were matched on age (range 18 to 30 years with a mean age of 24.86 year) and socioeconomic status. Only skilled competitive athletes were taken in this study as individual and team athletes. Hindi version of MMHSI was administered to them. Analysis yielded significantly poorer mental health for non-athletes than the team athletes and individual athletes.
OBJECTIVES & SPECIFIC AIMS OF THE STUDY

With this above-mentioned review of literature on perfectionism, locus of control and mental health, it can be clearly be said that perfectionism plays both positive and negative roles in person’s mental health. Many of the studies have supported this very idea. In a same way, person’s attributions of their behavior (Locus of control) also influences their perceptions and these perceptions ultimately influence person’s mental health. With this line of reasoning, this very

The present study was designed to meet three main objectives-

First, to study the effects of perfectionism (High Perfectionism Group: HPG/ Low perfectionism Group: LPG) on the locus of control scores.

Second, objective of the research was to explore the effects of perfectionism (High Perfectionism Group: HPG/ Low perfectionism Group: LPG) on the mental health of subjects.

Third, objective of the research was to study Locus of Control (Internals/ Externals) effects on perfectionism scores are presented
Following hypotheses have been made in this present research:

✓ High and low perfectionism scorer would differ in locus of control.

✓ High and low perfectionism scorer would differ in mental health.

✓ Male and female Subjects would differ on perfectionism scale.

✓ Internals and externals males would be different on perfectionism scale.

✓ Internals and externals females would be different on perfectionism scale.

The Chapter, which follows, outlines the method and design of the study, development of the measures used and procedure of data collection.