The aim of the present research is to find out the factorial structures of health and well-being. The search of the studies was done through Pubmed. In this regard numerous studies were conducted, but the relevant studies were selected on the basis of the tool used in the research and the key variables utilized were: health, well being, depression, self esteem, cognitive interference, subjective well being, satisfaction with life, spirituality, happiness, organized psyche. So, this chapter incorporate the relevant research work done in this context.

Larson (1978) analysed the thirty years of research among older Americans on life satisfaction, morale, and related constructs has yielded a consistent body of findings. The research shows reported well-being to be most strongly related to health, followed by socioeconomic factors and degree of social interaction, for the general population of Americans over 60. Marital status and aspects of people's living situations are also conclusively related to well-being. Age, sex, race, and employment show no consistent independent relation to well-being. In addition to indicating that negative life situation exigencies, such as poor health and low income are related to lower well-being, the results tentatively indicate that these exigencies create a greater vulnerability to the impact of other negative conditions.

Ward (1979) studied the effect of never-married in later life. The findings shows that highly-educated older women are most likely to remain single, but family background was not a predictor. Although the never-married find life more exciting than other marital statuses among younger (25 to 49) respondents, this reverses in later life. The never-married are also less happy than the married, and only slightly happier than the widowed and divorced. The characteristic that best explains their relative unhappiness is greater dissatisfaction with family life. The lower well-being of the never-married is attributable either to changes accompanying aging which lessen the viability of single life styles, or to less support of single living among current older cohorts.
Spreitzer, Snyder, & Larson (1979) studied the relative effects of health and income on life satisfaction. The relative effects of health and income on life satisfaction were analyzed using data collected in three recent national surveys. Financial situation was a slightly stronger predictor of life satisfaction for persons under age sixty-five, whereas health condition had a stronger impact on the life satisfaction of persons over age sixty-four. An attempt was made to quantify the relative impact of health and income on life satisfaction through an analysis of conjoint influence with contingency tables.

Stephens (1979) describes the data resource that will result from the Canada Health Survey. The conceptualization and measurement of well-being are discussed, and ways the data base can enhance understanding of the relationship between well-being. health, socioeconomic status, age, and activity are described. It is concluded that the Canada Health Survey should be an unusually valuable resource for psychologists interested in health and health-related behavior.

Beck (1982) studied the adjustment to and satisfaction with retirement. Logistic multiple regression and ordinary least squares regression were used in the analysis. The main findings are as follows: (a) although a negative bivariate relationship exists between retirement and happiness with life, retirement has no significant net effect; (b) health factors, recent widowhood, and income have the greatest impact on happiness with life; and (c) poor health, lower income, and earlier-than-expected retirement are the main determinants of negative evaluations of retirement.

Kozma & Stones (1983) studied the temporal stability of happiness as assessed by the Memorial University of Newfoundland Scale of Happiness (MUNSH), and the stability of the predictor/happiness relationships in three subgroups of persons over 64 years of age. Respondents were interviewed twice, 18 months apart, on the MUNSH and on nine established correlates. Separate multiple regression analyses were used to assess the predictor/happiness relationship for each phase. The stability of happiness was evaluated by the inclusion of phase 1 MUNSH scores in the phase 2 predictor array. For urban and institutional persons the main independent predictors of happiness in both phases were housing satisfaction, health, activities, and changes in life events. For rural individuals only health and marital status remained consistent predictors for both phases.
Happiness, greater in rural than in institutionalized persons, remained stable for all groups, with an average of 86% of the accounted MUNSH 2 variance due to MUNSH 1 scores. These results show that, although predictor effectiveness may differ across subgroups, happiness remains stable in later years.

Coleman, & Antonucci (1983) examined the impact of employment status on the self-esteem, psychological well-being, and physical health of 389 middle-aged (40–59 yrs old) women (206 employed outside the home and 183 homemakers). Ss completed a number of scales of psychological well-being (including the Rosenberg Self-Esteem Scale and the Lack of Depression Scale) from the national survey, The Survey of Modern Living, conducted in 1976. Results indicate that working Ss at midlife had higher self-esteem and less psychological anxiety than homemakers. Working Ss also reported being in better physical health than homemakers. Findings suggest that work may act as a stabilizing force for women during critical periods throughout the life cycle.

Okun, Stock, Haring & Witter (1984) examined the health and subjective well-being: a meta-analysis based upon studies of United States adults published prior to 1980, and the results indicate that health and subjective well-being were found to be positively and significantly related.

Linn, Yager, Cope, & Leake (1985) compared academic and clinical faculty affiliated with a major teaching hospital in terms of work characteristics, job stress, conflict between work and personal life, job and life satisfaction, and perceived health. There were no significant differences between the two physician groups on job satisfaction, total stress, anxiety, or depression scores. However, academic faculty reported working longer hours, taking less vacation time, and spending more time in research and teaching, but seeing fewer outpatients. Academic physicians experienced more conflict between work and personal life, were burdened by a variety of time pressures, and were less satisfied with their finances, but experienced fewer recent episodes of physical illness than clinical faculty. However, compared with what is known about the general population, both physician samples seemed equally or more satisfied with their health and their lives.

Muhlenkamp, & Sayles (1986) identified the relationships among perceived social support, self-esteem, and positive health practices among adults living in a south-
western metropolitan area and found a positive association among the variables, self-esteem, social support, and life-style, was determined using a simple correlation matrix. To further explicate the relationships among the variables, a theoretical causal model was developed and tested. Using path analytic techniques, both the direct and the indirect effects of various independent variables on life-style were determined; 28% of the variance, p less than .0001, was accounted for by this model. The study suggests that both self-esteem and social support are positive indicators of life-style. Further, social support was found to exert influence indirectly through its direct effect on self-esteem.

Adelmann (1987) hypothesized that higher occupational complexity, control, and personal income would be associated with higher levels of happiness and self-confidence and lower psychological vulnerability. In addition, the possibility was explored that models describing these correlations for employed women (n=330) might differ from those for employed men (n=618). Results indicate that occupational characteristics explain a small but significant proportion of variance in each measure of psychological well-being controlling for the effects of age and education. In addition, analysis of covariance reveals that separate regressions characterize employed men and women for happiness and self-confidence but not for vulnerability. Occupational characteristics also explain a significant proportion of variance in self-confidence for both men and women, and in happiness for men.

Coleman (1987) studied the dimensions of subjective well-being in the elderly: conclusions from Dutch and English studies. Result revealed that the analysis established the existence of separate but interrelated dimensions of subjective well-being as self-esteem, subjective health, contentment with ageing, satisfaction with past life, loneliness, worries and depressed feelings. It is suggested that in many research situations a multidimensional approach to the measurement of subjective well-being will have advantages over the choice of one of the existing morale, life satisfaction and depression scales which do justice only to a limited number of dimensions.

Schulz, Tompkins, & Rau (1988) investigated longitudinally the effects of a stroke on the social support systems and well-being of the patient's primary support person, both acutely and as the condition stabilized. Result shows that the prevalence of
depressive symptoms is from 2½ to 3½ times higher than rates found among representative samples of middle-aged and elderly populations. Mean level of depression did not change over time, although level of optimism declined significantly. Multiple regression analyses showed that levels of depression and perceived burden in support persons are highly related to aspects of the stroke such as its severity, and that demographic variables such as age and income play a relatively minor role in attenuating these relations in the acute adjustment phase. However, from 7 to 9 months after the stroke, well-established demographic variables such as health, income, and age were significant predictors of depression. Individuals who were older and who had good health and higher incomes were least depressed.

Ruehlman, & Wolchik (1988) examined the psychological distress and well-being as a function of the characteristics of personal projects and project-relevant social support and social hindrance provided by the three most important people in subjects' lives. Three project factors (Project Mastery, Strain, and Self-Involvement) were found to account for significant variation in both psychological distress and well-being. Project support was generally found to be significantly related to well-being, but not to distress. However, project hindrance was found to be significantly related to both distress and well-being. Additional analyses revealed that the behavior of the most important person in a subject's life is of special significance in accounting for variations in psychological distress and well-being.

Chatters (1988) studied the causal relations among social status and resource, health, and stress factors, and a single-item measure of subjective well-being (i.e., happiness) were examined among a national sample of 581 Black adults aged 55 years and over. Results indicated that although social status and resource factors had a limited impact on happiness ratings, these measures were important in predicting intermediate factors related to health status and satisfaction and stress. Happiness was directly influenced by stress and reported satisfaction with health, whereas the effect of health disability was mediated by stress and health satisfaction. The findings suggest that certain groups of older Blacks (i.e., relatively younger, widowed, and separated) may be at specific risk for diminished well-being. However, adverse health and life conditions,
which are determined by status and resources, represent circumstances that further jeopardize the well-being of older Black adults.

Antonucci, Peggs, & Marquez (1989) explored the relationship between self-esteem and physical health in a primary care setting. The findings suggest that the regression on health status was significant overall ($F = 4.12, p < .001$) with each of the predictors yielding significant coefficients. Those with high self-esteem, younger people, men, and employed people had significantly higher health status scores as assessed from the patient's chart. The regression on number of symptoms was marginally significant overall ($F = 2.28, p < .06$) with self-esteem emerging as a significant predictor ($p < .05$). Those with high self-esteem had significantly fewer symptoms as reported on the Hopkins Symptom Check List. These results support the existence of a positive relationship between self-esteem and physical health in a family practice patient population.

Chappell, & Badger (1989) examined 10 common indicators of social isolation and assessed which, if any, are related to subjective well-being among elderly individuals. The quantitative measures (no daily contact and minimal weekly contact), no children, having no children plus being unmarried, and having no children plus living alone, were unrelated to either global happiness or life satisfaction. The combined indicators of living alone and being unmarried as well as single indicators of having no companions or having no confidants were related at the bivariate level to both measures of well-being. When controlling for demographic, economic, and health factors, having no confidants and no companions were significantly and independently related to subjective well-being. These findings suggest that practitioners who seek information on living arrangements or marital status as proxy measures of lower psychological well-being are utilizing the wrong predictors.

Brett, Brief, Burke, George, & Webster (1990) studied the impact of negative affectivity (NA; i.e., neuroticism) contaminated life event items on observed life event-illness relationships. Among 330 managers and professionals, NA-contaminated items correlated significantly with 3 measures of well-being (depression, life satisfaction, and physical symptoms). In 2 of 3 cases, correlations between contaminated items and well-
being measures were significantly different from correlations between uncontaminated items and well-being indicators. Prior life event–well-being findings may be inflated considerably by the use of NA-contaminated events.

Evans, Rader, & Manninen (1990) studied the quality of life of hemodialysis recipients treated with recombinant human erythropoietin. A statistically significant improvement was established between baseline and second follow-up on most objective and subjective quality-of-life parameters, including energy and activity level, functional ability, sleep and eating behavior, disease symptoms, health status, satisfaction with health, sex life, well-being, psychological affect, life satisfaction, and happiness. No change was observed in ability to work or employment status. We conclude that, in addition to substantial improvement in hematologic parameters, recombinant human erythropoietin greatly enhances the quality of life of anemic patients who receive maintenance hemodialysis.

Burns, Doremus, & Potter (1990) studied value of health, incidence of depression, and level of self-esteem in low-income mothers of pre-school children. The findings suggest that participation in activities may increase self-esteem and lower depression. Over three-quarters (85%) of mothers placed a high value on health. Based on their high valuing of health and the potential for increasing self-esteem through activity, it can be concluded that the women in this sample will benefit from planned health activities. It is also anticipated that, because of the strong relationship between self-esteem and depression, women who participate in these activities will demonstrate lower levels of depression.

Thompson, & Heller (1990) examine the independent and interactive relationships of measures of network embeddedness and perceived social support with mental and physical health measures from responses of a sample of 271 community-dwelling elderly women. Quantitative social isolation was measured as the co-occurrence of low network embeddedness with family and with friends. The results indicate that there was a threshold effect such that quantitatively isolated participants had poorer psychological well-being and functional health than did non isolated participants. This effect was independent of perceived support levels. The pattern was different for perceived social
support. Elderly women with low perceived family support had poorer psychological well-being regardless of perceived support from friends or network embeddedness.

Fujita, Diener, & Sandvik (1991) studied the gender differences in negative affect and well-being: The case for emotional intensity. Result showed that women to be as happy as and more intense than men. Gender accounted for less than 1% of the variance in happiness but over 13% in AI. Thus, depression findings of more negative affect in women do not conflict with well-being findings of equal happiness across gender. Generally, women's more intense positive emotions balance their higher negative affect.

Winefield, Winefield, Tiggemann, & Goldney (1991) conducted a longitudinal study of school leavers, four occupational groups—satisfied employed, dissatisfied employed, unemployed, and tertiary students—were compared on a range of psychological measures. Initially, there were no group differences with respect to measures or demographic characteristics, making interpretation of later differences easier and suggesting a causal connection between employment status and psychological well-being. In longitudinal analyses, the satisfied employed and students showed higher self-esteem, less depressive affect, less externality, and less negative mood than the dissatisfied employed and unemployed. Similar cross-sectional differences were observed on social alienation, hopelessness, psychological distress, and life satisfaction. Longitudinal differences were due to improvements by the satisfied employed and/or student groups, not to deterioration by the other groups.

Tran, Wright, & Chatters (1991) examined the structural relationships among socio-demographic characteristics, health status, stress, psychological resources, and subjective well-being (SWB) among the Black elderly. The results revealed that poor subjective health status was predictive of lower levels of personal efficacy and SWB. Stressful life events tended to depress subjective assessments of health and had negative effects on self-esteem and SWB. Marital status and age had positive effects on SWB. Chronic health conditions and other demographic variables, however, had indirect effects on SWB.

Murrell, Meeks, & Walker (1991) studied the protective functions of health and self-esteem against depression in older adults facing illness or bereavement. Result
revealed that neither health nor self-esteem served as an interactive buffer. Both had direct negative effects on depression, independent of events, over 2 yrs. Neither illnesses nor bereavements had direct effects on depression; both had indirect effects through other events; illness also had indirect effects by weakening health. Health had a stronger preventive effect on illnesses but was more vulnerable to undesirable events than was self-esteem. There was little support for the specificity hypothesis that a close match between event and resource would increase resource effects.

Pillemer, & Suitor (1991) examined the effects of residence-sharing on the psychological well-being of elderly persons. 2,020 Ss (aged 65+ yrs) who share their home with one of their adult children participated in telephone or in-person interviews that included the Center for Epidemiologic Studies Depression Scale. There was no relationship between residence sharing and depression. Ss in poor health and women reported higher levels of depression. Findings counter the belief that elderly people who share a residence with an adult child are more likely than other elderly people to experience psychological distress.

Rintala, Young, Hart, Clearman, & Fuhrer (1992) studied the social support and the well-being of persons with spinal cord injury living in the community. By Result shows that amount of social support was positively related to life satisfaction and physical well-being. Satisfaction with one's support network was associated negatively with depressive symptomatology and positively with life satisfaction. There were significant differences in the correlations between life satisfaction and total social support for men and women.

Felton, & Berry (1992) studied do the sources of the urban elderly's social support determine its psychological consequences? Findings showed that, although most social provisions were valuable regardless of their source, reassurance of worth was distinctly more beneficial when provided by nonkin than by kin, and reliable alliance, or instrumental assistance, was more strongly related to well-being when provided by kin than by nonkin. Analysis of social network structure showed that "multiplexity" was negatively related to well-being, and having duplicate providers for a given social provision was uniquely important in offsetting negative affect.
yart et al. (1993) studied do depressed patients in different treatment settings different levels of well-being and functioning? Results shows that patients of mental health specialists had worse mental health and more limitations in social activities, whereas patients of medical clinicians had worse physical functioning, more pain, more physical/psychophysiologic symptoms, and worse health perceptions. Thus, each system of care had depressed patients with a similar functioning and well-being "burden," but specialty sectors had patients with slightly different functioning and well-being profiles, probably reflecting patient selection of type of provider.

Dua (1993) studied the role of negative affect and positive affect in stress, depression, self-esteem, assertiveness, Type A behaviors, psychological health, and physical health. Results showed that a preponderance of self-reported negative affect was related to higher levels of stress, depression, poor psychological well-being, poor psychological health, lower self-esteem and poor self-reported retrospective physical health. A preponderance of negative affect was associated with only one of the two measures of prospective physical health, namely, the number of visits to doctors for medical problems over a period of 4 weeks. Positive affect was not associated with either self-esteem or physical health. Assertiveness and Type A/B behaviors were not associated with either negative or positive affect. Also, of the two measures of negative affect, that caused by thoughts seemed to be a better predictor of health, well-being, and psychological problems than that caused by day-to-day experiences.

Levin, Chatters, & Taylor (1995) studied religious effects on health status and life satisfaction among black Americans. Findings reveal statistically significant effects for organizational religiosity on both health and life satisfaction, for non organizational religiosity on health, and for subjective religiosity on life satisfaction. Analyses of structural in variance reveal a good overall fit for the model across three age cohorts (< or = 30, 31-54, > or = 55) and confirm that assuming age-invariance of structural parameters does not significantly detract from overall fit. In addition, after controlling for the effects of several socio demographic correlates of religiosity, health, and well-being, organizational religiosity maintains a strong, significant effect on life satisfaction. These findings suggest that the association between religion and well-being is consistent over
the life course and not simply an artifact of the confounding of measures of organizational religiosity and health status.

Sherbourne, Hays, & Kenneth (1995) studied personal and psychosocial risk factors for physical and mental health outcomes and course of depression among depressed patients. Result showed improvements in measures of functioning and well-being associated with patients who were employed, drank less alcohol, and had active coping styles. Better clinical course of depression was associated with patients who had high levels of social support, who had more active and less avoidant coping styles, who were physically active, and who had fewer comorbid chronic conditions. Findings provide some guidance as to what can be done to improve depressed patients' levels of physical and mental health and affect the clinical course of depression.

Dunn (1996) examined the salutary effects of finding positive meaning in a disabling experience, being an optimist, and perceiving control over disability on 2 criterion variables of psychological well-being: depression and self-esteem. Result revealed that finding meaning following amputation was linked to lower levels of depressive symptomatology but not to self-esteem. Both dispositional optimism and perceived control over disability were predictive of lower scores on the Center for Epidemiological Studies Depression Scale and higher scores on the Rosenberg Self-Esteem Scale.

Schwartzberg, & Dytell (1996) studied the Dual-earner families: The importance of work stress and family stress for psychological well-being. Result suggests that working mothers and working fathers reported equivalent levels of family stress, work stress, job–family interference, and psychological well-being, although mothers did report a higher level of lack of task sharing. Self-esteem and depression of dual-earner mothers and fathers were affected by both job and family stress. Insignificance within their work role affected both self-esteem and depression. Lack of task sharing significantly predicted depression among dual-earner mothers. Lack of challenge in their work role appeared to be a positive characteristic for dual-earner fathers.

Bookwala, & Schulz (1996) studied the spousal similarity in subjective well-being: The cardiovascular health study. Results indicate that one spouse's assessments of
well-being and depression predict the other's well-being even after controlling for known predictors of these outcomes. Given the similarity of findings for affective and nonaffective domains, multiple mechanisms, including contagion, mate selection, and common environmental influences, are speculated as likely to contribute to this phenomenon.

Zorn, & Johnson (1997) studied the religious well-being in non institutionalized elderly women. Results revealed a high level of religious well-being among the participants and significant positive correlation between religious well-being and the variables of social support and hope (p < .001). Through stepwise multiple regression, hope emerged as the single significant predictor of religious well-being (p < .001), explaining 31% of the variance in the dependent variable. The majority of respondents reported regularly participating in religious activities, highly rated the value or influence of religious beliefs in their lives, and identified that religious beliefs become increasingly important with age. Conducting a comprehensive assessment and implementing focused interventions associated with religious well-being will strengthen the scope of health care practice for elderly women.

Miles, Burchinal, Holditch-Davis, & Wasilewski (1997) studied the personal, family, and health-related correlates of depressive symptoms in mothers with HIV. Result revealed that about a third of the mothers were at risk for depression, as indicated by Center for Epidemiologic Studies Depression Scale scores above the cutoff. The best predictors of depressive symptoms were feelings of stigma, self-perceptions of health, and physical symptoms, all factors associated with HIV. The findings have implications for helping HIV-infected mothers with depressive symptoms and stigma related to HIV.

Hurst, Boswell, Boogaard, & Watson (1997) studied the relationship of self-esteem to the health-related behaviors of the patients of a primary care clinic. Result suggests that self-esteem to be associated with predicted longevity, life satisfaction, social ties, overall health, personal loss, seatbelt use, age, physical activity, smoking, exposure to violence, and substance use. Multiple regression analysis of male subjects' data found self-esteem most closely related to the frequency of exposure to danger, self-perceptions of health, and tobacco use. Similar analysis of the women's data most closely
associated self-esteem to perceived social support, self-perception of health, diastolic blood pressure, and seatbelt use. The data clearly link individuals' self-esteem to predicted longevity. Those with greater self-regard were predicted to live longer, while those with poorer self-esteem achieved shorter predicted longevity. Contributing factors may have included greater emphasis on self-care.

Post, de Witte, van Asbeck, van Dijk, & Schrijvers (1998) studied predictors of health status and life satisfaction in spinal cord injury. Result showed that respondents suffered from serious limitations in physical functioning and social functioning, had only a few limitations in psychological functioning, and were satisfied with their lives in general and with most life domains. Physical functioning was accurately predicted by injury-related variables, but psychological functioning was not. Next to level and completeness of the injury, the number of secondary complications turned out to be a predictor of functional health. In a path model that had a close fit with the data, injury-related variables were related to health status but not to life satisfaction. Social functioning (-.48), marital status (-.38), psychological functioning (-.19), and age (-.16) were significant predictors of life satisfaction (total $R^2=.44$).

McBride, Arthur, Brooks, & Pilkington (1998) studied the relationship between a patient's spirituality and health experiences. Result shows significant correlation between patient health and spirituality. Significant differences were also found in both overall health and physical pain, based on the three levels of spirituality. Gender differences were only significant for overall health, not for patient pain.

Makino & Tagami (1998) studied the relationship between subjective well-being and self acceptance, and to design a happiness self-writing program to increase self acceptance and subjective well-being of adolescents. Results indicated that acceptance of self-openness, an aspect of self acceptance, was related to subjective well-being. The happiness self-writing program increased subjective well-being, but it was not found to have increased self acceptance. It was discussed why the program could promote subjective well-being, but not self acceptance.

Lachman, & Weaver (1998) studied the sense of control as a moderator of social class differences in health and well-being. Results of hierarchical multiple regression analyses showed that for all income groups, higher perceived mastery and lower
perceived constraints were related to better health, greater life satisfaction, and lower depressive symptoms. However, control beliefs played a moderating role; participants in the lowest income group with a high sense of control showed levels of health and well-being comparable with the higher income groups. The results provided some evidence that psychosocial variables such as sense of control may be useful in understanding social class differences in health.

Fryback, & Reinert (1999) studied spirituality and people with potentially fatal diagnoses. Findings suggest that spirituality is an essential component to feelings of health and well-being. Many of the subjects viewed spirituality as a bridge between hopelessness and meaningfulness in life. Those who had found meaning in their disease thought they had a better quality of life now than they had before the diagnosis.

Fitchett, Rybarczyk, DeMarco, & Nicholas (1999) studied the role of religion in medical rehabilitation outcomes: A longitudinal study. Results indicate that the protective model of the relationship between religion and health was not supported; only limited support was found for the consolation model. In regression analyses, negative religious coping accounted for significant variance in follow-up ADL (5%) over and above that accounted for by admission ADL, depression, social support, and demographic variables. Subsequent item analysis indicated that anger with God explained more variance (9%) than the full negative religious coping scale. Conclusions: Religion did not promote better recovery or adjustment.

Burnette (1999) studied the physical and emotional well-being of custodial grandparents in Latino families. Factors studied included depression, health status, life stressors, informal supports, unmet service needs, and special needs of the grandchildren. Poverty rates were found to be roughly 3 times those of grandparent caregivers nationwide and rates of self-reported poor health and depression to be twice as high. Correlates of depression included young age, poor health, greater life stress, few informal supports, and rearing grandchildren with special needs.

Staudinger, Fleeson, & Baltes, (1999) studied the predictors of subjective physical health and global well-being: Similarities and differences between the United States and Germany. Result revealed that because of cultural overlap between Western
industrialized nations, similarities in predictive patterns were expected. Differences in the
economic and social systems as well as the cultural background, however, should also
generate differences. As expected, the overall predictive power of the three sets of
predictors (sociostructural variables, personality traits, and self-regulatory characteristics)
was sizable in both countries. The strongest unique predictors were self-regulatory
indicators for subjective physical health and personality traits for global well-being. In
addition, however, theory-consistent country differences emerged in how personal and
social resources seem to be orchestrated to maximize well-being.

Meeks, Murrell, & Mehl (2000) studied the longitudinal relationships between
depressive symptoms and health in normal older and middle-aged adults. Findings
suggest that different durations of depressive symptoms have different relationships to
health. Health had an impact on short-term increases in depressive symptoms, but
depressive symptoms had a weaker impact on health. The reciprocal impact was
indistinguishable from the health influence on depression. In contrast, longer term
depressive symptoms had a clear impact on health. The results imply that physical illness
can affect depressive states; depressive traits but not states can affect illness.

Pardini, Plante, Sherman & Stump (2000) Religious faith and spirituality in
substance abuse recovery: determining the mental health benefits. The result showed that
recovering individuals tend to report high levels of religious faith and religious
affiliation, but choose to rate themselves as being more spiritual than religious. Results
also indicate that among recovering individuals, higher levels of religious faith and
spirituality were associated with a more optimistic life orientation, greater perceived
social support, higher resilience to stress, and lower levels of anxiety. This represents the
largest self-report study to date examining the relation between religious faith,
spirituality, and mental health outcomes among individuals recovering from substance
abuse.

Compton (2000) studied the meaningfulness as a mediator of subjective well-
being. Results revealed that Correlations, canonical correlations, and structural equation
modeling supported the hypothesis that meaningfulness is a significant mediator between
personality variables and subjective well-being.

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Piko (2000) studied health-related predictors of self-perceived health in a student population: the importance of physical activity. The findings suggest that psychological well-being plays a central role in determining self-perceived health. The regression analysis revealed that four health-related variables under study contributed significantly to the self-perception of health. These were the following: psychological well-being, physical activity behavior, acute illness episodes and the frequency of psychosomatic symptoms. While some differences were detected between the type and the number of contributing factors among the subgroups by sex and physical activity behavior (i.e., physical activity was far more influential among males and likewise among more active persons) psychological well-being proved to be the strongest predictor. Physical activity behavior correlated positively and the frequency of psychosomatic symptoms negatively with psychological well-being. Moreover the occurrence of harmful habits was positively related both to the frequency of symptoms and physical activity behavior.

Kim et al. (2000) studied spirituality, quality of life, and functional recovery after medical rehabilitation. Results revealed that emotional WB increased during rehabilitation, whereas life satisfaction and spiritual WB did not change, however, substantial subgroups of individuals experienced changes in life satisfaction and spiritual WB over time. Measures of spiritual WB, emotional WB, and life satisfaction were moderately correlated within and across time points. Persons making smaller functional gains during inpatient rehabilitation were least likely to experience increased emotional WB. Although African Americans as a group reported greater spiritual WB than other racial-ethnic groups on admission, they were least likely to increase in emotional WB over time.

Lee HS, Brennan PF, Daly BJ. (2001) studied the relationship between empathy and caregiving appraisal and outcomes was examined among 140 informal caregivers of older adults. Finding suggests that Caregivers with high cognitive empathy appraised the caregiving situation as less stressful and less threatening, were less depressed, and reported higher life satisfaction than did caregivers with low cognitive empathy. The caregivers' appraisal, along with educational levels and total household income, significantly predicted individual differences in caregiver depression, life satisfaction, and perceived physical health. Emotional empathy was negatively related to life
satisfaction. There appeared to be distinct roles for emotional and cognitive empathy in informal caregiving outcomes. The study supported the important role of caregiving appraisal and resources in caregiving outcomes.

Pinquart, & Sörensen (2001) studied gender differences in self-concept and psychological well-being in old age: a meta-analysis. Result shows that older women reported significantly lower SWB and less positive self-concept than men on all measures, except subjective age, although gender accounted for less than 1% of the variance in well-being and self-concept. Smaller gender differences in SWB were found in younger than in older groups. Statistically controlling for gender differences in widowhood, health, and socioeconomic status decreased gender differences in SWB. Cohort differences in SWB are reported as well.

Sahlberg, Ternestedt, & Johansson (2001) explored how a group of gravely ill patients, cared for in different care cultures, assessed their quality of life during their last month of life. The results show that despite having an assessed lower quality of life in many dimensions than people in general, several patients experienced happiness and satisfaction during their last month of life. 'Cognitive functioning' and 'emotional functioning' were the dimensions that differed least from those of the general population, and 'physical functioning', 'role functioning' and 'global health status/quality of life' differed the most. 'Fatigue' showed the highest mean for the symptom scales/items. There was a tendency for those cared for in the cure-orientated care culture to report more symptoms than those in the care-orientated care culture. An exception to this was 'pain', which was reported more often by those in the care-orientated care culture. The implications of the results are discussed from different angles. The significance of knowledge concerning how patients experience their quality of life is also discussed with respect to the care and the planning of care for dying patients.

Neto (2001) studied the personality predictor of happiness and the results showed predicted positive correlations for happiness with satisfaction with life, self-esteem, and sociability and negative correlations of happiness with embarrassability, loneliness, shyness, and social anxiety. Four predictors (satisfaction with life, shyness, loneliness, and sociability) accounted for 58% of the variance in happiness scores. These results
support previous research as well as validate the Portuguese version of the happiness inventory.

Kermode, & MacLean (2001) studied the relationship between quality of life, health and self-esteem. In this study, 757 participants reported data on quality of life (QOL), health and self-esteem. Findings indicated that older people experienced higher QOL than people in other age groups. Variables contributing to higher QOL include having good relationships with their partner, with their children, and God. Caring for others, or carrying a disability or illness diminished QOL scores. High positive self esteem scores were important in overall indices of QOL. High positive self-esteem and an absence of negative self esteem were substantial contributors to the 'happiness' dimension of QOL. Having a good sex life, or not having sex was more important than having poor sexual relationships. QOL has been an important concern for nurses in terms of the relationship between individual health and QOL, but there is a need to broaden the perspective from which QOL is viewed.

Kull (2002) measures the association between leisure time physical activity and health status, mental health and depression. The results showed that 52.8% of the sample was physically inactive. Physically active women experienced better mental health (P < 0.05), less depression (P < 0.05) and they had better general health status (P < 0.005). Differences in the emotional state (GHQ score) and depression (BDI score) between active (participating in exercise 3 or 1-2 times a week) and inactive women were significant (P < 0.05). Even a low level of physical activity (1-2 times per week) was positively related to women's mental health (P < 0.05).

Johnson (2002) explored the relationships between racial identity, self-esteem, socio demographic factors, and health-promoting lifestyles in a sample of African Americans. Result shows that the internalization racial identity stage (beta = .12; p < .001) and self-esteem (beta = .50; p < .001) contributed to the variance in health-promoting lifestyles. Self-esteem did not mediate the relationship between immersion and health-promoting lifestyle scores (beta = -.16; p = .03). The full model Beta values show that racial identity remains significant with socio demographics and interactions
controlled, but moderators do not. Racial identity, while not a strong predictor, has some impact on health-promoting lifestyles regardless of socio demographics.

Swinney (2002) described and examine the relationships among self-esteem, locus of control, and perceived health status in African Americans with cancer and to identify predictors of perceived health status. A significant positive relationship was discovered between self-esteem and powerful others health locus of control (p < .05). Participants tended to view God as the Powerful Other capable of influencing their health and well-being. Self-esteem and an internal health locus of control were found to account for 23% of the perceived variance in health status. In addition, interview data indicated that participants with normal to high levels of self-esteem and an internal health locus of control perceived their state of health and well-being positively.

Williams, Reed, Nelso, Brose (2002) examine the relationships between spiritual experience and current health status and between spiritual Relations of intrinsic spirituality with health status and symptom interference and subjective experience of symptom interference. These results suggest that the report of core spiritual experiences may be related to better current health status. These findings have implications for understanding the role of spirituality in the prevention of illness and in an individual's ability to cope with illness.

Matthews, Baker, Hann, Denniston, Smith (2002) studied health status and life satisfaction among breast cancer survivor peer support volunteers. Result shows significant correlation coefficients were shown between life satisfaction and measures of health status. SF-36 scores were significantly higher for physical functioning, emotional well-being, and vitality subscales compared to population norms. BCSs expressed greatest dissatisfaction with their sexual ability, physical strength, and bodies in general. Small age differences were found. Results suggest that incorporating multiple measures of HRQOL contribute to the understanding and measurement of the effects of cancer on perceived health status and life satisfaction.

Tsuang, Williams, Simpson, & Lyons (2002) investigate associations between empirically defined dimensions of spirituality, personality variables, and psychiatric disorders in Vietnam era veterans. Result shows that existential well-being was
significantly associated with seven of 11 dimensions of personality and was significantly
negatively associated with alcohol abuse or dependence and with two of three clusters of
personality disorder symptoms. Associations between mental health variables and
religious well-being or spiritual involvement were much more limited.

Lieberman, & Golant, (2002) tested the effects of leader behaviors on outcomes
in 269 cancer patients in professionally led support groups. Both the direct effect and a
mediation hypothesis, helpful group experiences, were examined. The leader model
specifies 5 dimensions: evoke-stimulate, executive-management, meaning attribution,
uses of self, and support-caring. Patients were drawn from The Wellness Community, a
national organization that provides services to cancer patients. Outcomes included quality
of life and depression. In a linear regressions analysis, leaders perceived as high on
meaning attribution and management-structure had lower depression, fewer physical
problems, higher well-being, and better functioning. In a test of the mediation hypothesis,
leader behaviors associated with outcomes were substantially mediated through helpful
group experiences.

Bigatti, & Cronan, (2002) compared the physical and mental health and the health
care use of spouses of patients with fibromyalgia syndrome (FS group; n=135) with that
of spouses of healthy individuals ( n=153). FS group participants reported lower health
and affective states and scored higher on depression, loneliness, and subjective stress than
comparison group participants ( p=.017). Husbands in the FS group who reported more
illness impact and whose wives reported worse sleep quality and less self-efficacy had
more psychological difficulties. No differences were found in health care costs between
groups. These findings suggest that chronic illness in a partner may negatively affect an
individual's physical and mental health.

Tate, & Forchheimer (2002) studied the quality of life, life satisfaction, and
spirituality: comparing outcomes between rehabilitation and cancer patients. Result
indicate that group differences were found across the quality of life measures used in the
study. There were also differences in life satisfaction and spiritual well-being. Spirituality
was found to be associated with both quality of life and life satisfaction, although it was
not a significant predictor in a multivariate context.
Coleman (2003) studied the spirituality and sexual orientation: relationship to mental well-being and functional health status. FINDINGS: The findings indicate that spirituality had a direct relationship with cognitive and social functioning and was inversely related to HIV symptoms. Sexual orientation had direct relationships with mental well-being, cognitive, physical, social and role functioning. t-Tests showed that heterosexual participants reported poorer mental well-being and functional health status compared with homosexual participants. Regression analysis showed that spirituality, sexual orientation, age and HIV symptoms contributed significantly to mental well-being and functional health status.

Tanyi, & Werner (2003) examined levels of and relationships between adjustment, spiritual well-being, and self-perceived health in women with ESRD. The sample included 65 women aged 24 to 82 receiving hemodialysis at five outpatient centers in a large metropolitan area. Frequencies, central tendencies, and correlations were used for analyses. Overall, these women were fairly well adjusted as measured by the Psychosocial Adjustment to Illness Scale-Self-Report. They demonstrated fairly high levels of religious, existential, and overall spiritual well-being. Self-perceived health was good. Spiritual well-being variables were all positively and significantly related to overall psychosocial adjustment and psychological distress adjustment. Self-perceived health variables were all positively and significantly related to overall psychosocial adjustment. Few significant relationships were found between spiritual well-being and other adjustment domains and between self-perceived health and other types of adjustment.

Røysamb, Tambs, Reichbor, Neale, & Harris, (2003) identify genetic and environmental influences on the covariances between subjective well-being (SWB), perceived health, and somatic illness. Result shows that heritabilities ranged from .24 to .66. SWB correlated .50 with perceived health, -.25 with musculoskeletal pain, and -.07 with allergy. Common genetic factors accounted for 45%-60% of associations. SWB and perceived health was to a high extent influenced by the same genes (rg=.72 and .82 for males and females, respectively). For SWB and musculoskeletal pain, rg =-.29 and -.42 for males and females, respectively. Effects were partly sex specific. Environmental factors shared by twins did not affect the covariances. Results support a differentiated...
view of SWB-health relations, and imply that both genes and environment play important roles in the associations between well-being and health.

Nativig, Albrektsen, & Qvamstrøm (2003) studied the association between psychosocial factors and happiness among school adolescents. Result shows an increasing degree of stress experience reduced the feeling of happiness significantly. Furthermore, increasing levels of general self-efficacy increased the odds of feeling happy, whereas the more specific measure of school self-efficacy showed no independent effect. Social support from teachers also enhanced happiness significantly. A less consistent pattern was found for support from peers, but the most happy pupils experienced significantly more support than pupils who reported being unhappy. No significant trend was found with decision control. We also explored associations between happiness and psychosomatic symptoms. Pupils feeling unhappy reported a particular symptom more often and they also had the highest mean number of reported symptoms. To evaluate whether these health indicators represent different dimensions of health, a comparison of strength of associations with common risk factors is made.

Stokes, Frederick (2003) examined the relationships between body image and happiness in adult women. Results indicated that happiness significantly and positively correlated with the three components of body esteem: sexual attractiveness, weight concern, and physical condition. There were no significant differences among the types of body satisfaction expressed by women of different ages.

Efklides, Kalaitzidou, & Chankin (2003) studied subjective quality of life in old age in Greece: The effect of demographic factors, emotional state and adaptation to aging. Result showed that the effect of demographic and health factors was mediated by affect and adaptation-to-old-age factors. Positive affect contributed to all aspects of subjective quality of life, whereas negative affect was important for the determination of happiness and SWB. Particularly important for LS proved to be good adaptation to old age and generativity toward one's children, whereas self-control and efficacy, and downward social comparison for one's health condition contributed to morale. Having children had a significant.
Chipperfield, Perry, & Weiner (2003) studied discrete emotions in later life. Result showed that certain negative emotions were associated with poor health, with a link between sadness and sickness being most prominent. Of note, poor health did not undermine positive emotions. These findings provide an optimistic view of emotions in later life, even among individuals who are poor, not well educated, and/or physically unwell.

Menec (2003) studied the relation between everyday activities and successful aging: a 6-year longitudinal study. Result indicated that greater overall activity level was related to greater happiness, better function, and reduced mortality. Different activities were related to different outcome measures; but generally, social and productive activities were positively related to happiness, function, and mortality, whereas more solitary activities (e.g., hand-work hobbies) were related only to happiness.

Pinquart, & Sörensen (2003) studied differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. Result showed differences were found with regard to depression (g = .58), stress (g = .55), self-efficacy (g = .54), and general subjective well-being (g = -.40). Differences in the levels of physical health in favor of noncaregivers were statistically significant, but small (g = .18). However, larger differences were found between dementia caregivers and noncaregivers than between heterogeneous samples of caregivers, and noncaregivers. Differences were also influenced by the quality of the study, relationship of caregiver to the care recipient, gender, and mean age of caregivers.

Szalacha, Erkut, Coll, Alarcón, Fields, & Ceder (2003) studied the discrimination and Puerto Rican children's and adolescents' mental health. Two studies of Puerto Rican youths' development on the U.S. mainland examined the consequences of perceived racial/ethnic discrimination on mental health. In Study 1, children were found to have a low likelihood of perceiving discrimination, whereas in Study 2, nearly half of the adolescent sample reported perceiving racial/ethnic discrimination. Although both groups scored high on multiple indicators of mental health, perceiving discrimination and worrying about discrimination were negatively associated with some dimensions of self-esteem and positively associated with depression and stress. Adolescents were aware of
negative stereotypes about Puerto Ricans, and nearly half of them related discriminatory instances. Results suggest that both perceiving discrimination and anxiety regarding discrimination can serve as risk factors for the mental health of this population.

Ito, Sagara, Ikeda, & Kawaura (2003) evaluated the reliability and validity of subjective well-being scale. Results indicated that for the students, college life satisfaction and self-esteem had positive correlations with SWBS score. For the adults, marital satisfaction, workplace satisfaction, and household income satisfaction had positive correlations with the score. These findings showed considerable constructive validity for SWBS. In addition, internal consistency was sufficiently high, indicating the measure's high reliability. SWBS may be a simple but reliable and valid measure, and it is useful for examining subjective well-being of both adults and college students.

Baetz, Griffin, Bowen & Koenig, (2004) studied the association between spiritual and religious involvement and depressive symptoms in a Canadian population. Result revealed that more frequent worship service attendees had significantly fewer depressive symptoms. In contrast, those who stated spiritual values or faith were important or perceived themselves to be spiritual/religious had higher levels of depressive symptoms, even after controlling for potential mediating and confounding factors. It is evident that spirituality/religion has an important effect on depressive symptoms, but this study underscores the complexity of this relationship.

Pinquart, & Sörensen (2004) studied the associations of caregiver stressors and uplifts with subjective well-being and depressive mood. The result shows that the strongest effects were domain-specific: uplifts of caregiving were associated with subjective well-being and caregiving stressors were associated with depression. In addition, weaker effects that crossed domains were present: uplifts were weakly associated with depressive symptoms. In addition, lower levels of caregivers' subjective well-being were weakly related to care receivers' physical and cognitive impairments, as well as behaviour problems, but not to the amount of caregiving. Type of care recipients' illness and the measure of well-being moderated, in part, the association between stressors/uplifts and subjective well-being.
Jesse & Reed (2004) studied effects of spirituality and psychosocial well-being on health risk behaviors in Appalachian pregnant women. Result shows that higher levels of spirituality (spiritual perspective and religiosity) were significantly correlated with greater satisfaction with social support, higher levels of self-esteem, and decreased levels of smoking. Socio-demographic, psychosocial, and spiritual variables explained 25% of the variance in frequency of smoking, and in the logistic regression analysis, psychosocial stress was the only variable that significantly predicted substance use.

Hutchinson et al. (2004) studied the social and health determinants of well being and life satisfaction in Jamaica. Result suggests that women had lower levels of psychological wellbeing and satisfaction with life. Independent predictors of lower psychological well being were having an acute illness, having a chronic illness in women and high religious behavior in men. Satisfaction with life was predicted by younger age, marital status and employment.

Cheng (2004) studied the age effect on subjective well-being was entirely mediated by goal discrepancies (GDs). Findings suggest that six GDs grouped into 3 broad categories (relationships, health, and others) were differentially related to age. Whereas GD relationships and GD others (e.g., materials) decreased with age, GD health increased with age. GD health had smaller effects on subjective well-being than GDs in relationships and other life domains. Hence, the net effect of all the GDs on well-being was positive. GD variations because of age could completely explain the age trends in life satisfaction and positive affect, and partially the age trend in negative affect.

Sedikides et al. (2004) studied that normal narcissism is correlated with good psychological health. Specifically, narcissism is (a) inversely related to daily sadness and dispositional depression, (b) inversely related to daily and dispositional loneliness, (c) positively related to daily and dispositional subjective well-being as well as couple well-being, (d) inversely related to daily anxiety, and (e) inversely related to dispositional neuroticism. More important, self-esteem fully accounted for the relation between narcissism and psychological health. Thus, narcissism is beneficial for psychological health only insofar as it is associated with high self-esteem. Explanations of the main and mediational findings in terms of response or social desirability biases (e.g., defensiveness, repression, impression management) were ruled out. Supplementary
analysis showed that the links among narcissism, self-esteem, and psychological health were preponderantly linear.

Eriksson, Tham, Fugl-Meyer (2005) identified couples' joint perception of their satisfaction with life as a whole when one of the persons in the couple had acquired brain injury between one and five years earlier. The results showed that in 16 of the 55 couples both partners were satisfied with life as a whole. The joint experience of life satisfaction was significantly related to the couple's functioning in everyday life, and specifically to perceived participation in leisure time and in their social life, and in their ability to wash clothes. Important implications from this study, showing that only one-third of the couples were satisfied, are that the partners should be included to a greater extent in the rehabilitation process and the couple's perspective of what they find difficult to deal with should serve as a guide during rehabilitation.

Lyubomirsky, King, & Diener (2005) studied the benefits of frequent positive affect: Does happiness lead to success? The results reveal that happiness is associated with and precedes numerous successful outcomes, as well as behaviors paralleling success. Furthermore, the evidence suggests that positive affect—the hallmark of well-being—may be the cause of many of the desirable characteristics, resources, and successes correlated with happiness. Limitations, empirical issues, and important future research questions are discussed.

Steger, & Frazier, (2005) studied meaning in life as a link between religiousness and psychological health. The authors tested this hypothesis in 2 studies, using multiple methods and measures of religiousness and well-being. In the studies, meaning in life mediated the relation between religiousness and life satisfaction (Study 1A), as well as self-esteem and optimism (Study 1B). In addition, using an experience sampling method, the authors found that meaning in life also mediated the relation between daily religious behaviors and well-being (Study 2). The authors discuss these findings and suggest that meaning in life may be an effective conduit through which counselors and clients can discuss "ultimate" matters, even when they do not share similar perspectives on religion.

Keyes (2005) studied mental illness and/or mental health? Investigating Axioms of the Complete State Model of Health. Result shows that measures of mental health
(i.e., emotional, psychological, and social well-being) and mental illness (i.e., major depressive episode, generalized anxiety, panic disorder, and alcohol dependence) constitute separate correlated unipolar dimensions. The categorical diagnosis yielded an estimate of 18.0% flourishing and, when cross-tabulated with the mental disorders, an estimate of 16.6% with complete mental health. Completely mentally healthy adults reported the fewest health limitations of activities of daily living, the fewest missed days of work, the fewest half-day work cutbacks, and the healthiest psychosocial functioning (low helplessness, clear life goals, high resilience, and high intimacy).

Netz, Wu, Becker, Tenenbaum, (2005) studied physical activity and psychological well-being in advanced age: a meta-analysis of intervention studies. A meta-analysis examined data from 36 studies linking physical activity to well-being in older adults without clinical disorders. The weighted mean-change effect size for treatment groups (dC. = 0.24) was almost 3 times the mean for control groups (dC. = 0.09). Aerobic training was most beneficial (dC. = 0.29), and moderate intensity activity was the most beneficial activity level (dC. = 0.34). Longer exercise duration was less beneficial for several types of well-being, though findings are inconclusive. Physical activity had the strongest effects on self-efficacy (dC. = 0.38), and improvements in cardiovascular status, strength, and functional capacity were linked to well-being improvement overall. Social-cognitive theory is used to explain the effect of physical activity on well-being.

Pierre, & Mahalik, (2005) examined African self-consciousness and black racial identity as predictors of black men's psychological well-being. Canonical correlation analysis found 2 significant roots with the 1st root indicating that Black men whose attitudes reflected Pre encounter and Immersion racial identity attitudes and who do not resist against anti-African/Black forces reported greater psychological distress and less esteem. Results from the 2nd root suggested that Black men whose attitudes reflect greater Internalization racial identity attitudes, greater resistance to anti-African/Black forces, and less identification with Blacks reported greater self-esteem.

McKee-Ryan, Song, Wanberg, & Kinicki, (2005) studied psychological and physical well-being during unemployment. Result revealed that unemployed individuals
had lower psychological and physical well-being than did their employed counterparts. Unemployment duration and sample type (school leaver vs. mature unemployed) moderated the relationship between mental health and unemployment, but the current unemployment rate and the amount of unemployment benefits did not. Within unemployed samples, work-role centrality, coping resources (personal, social, financial, and time structure), cognitive appraisals, and coping strategies displayed stronger relationships with mental health than did human capital or demographic variables.

Boero et al. (2005) studied spirituality of health workers: a descriptive study. The result shows means above the mid-point in all facets denoting reasonably good quality of life in the domain of spirituality. The most significant variables are: health conditions (p = .001*), religiousness (p < or = .0005**), personal creed (p < or = .0005**). Findings suggest that spirituality is associated with the subjective perception of people's health status.

Katoi & Snyder (2005) studied the relationship between hope and subjective well-being: reliability and validity of the dispositional Hope Scale, Japanese version. Results suggested that the Japanese version had high validity. In addition, the tendency to be hopeful had negative correlations with stress response, hopelessness, depressive tendency, and trait anxiety, and positive one with feeling of happiness. In Study 3, 175 undergraduates completed the Hope Scale and State-Trait Anxiety Inventory (STAI) immediately prior to final examinations. Results of regression analysis suggested that the tendency to be hopeful moderated examination anxiety. Taken together, results of the studies supported the hypothesis that hope had positive effects on subjective well-being.

Subramanian, Kim, & Kawachi (2005) investigated individual level determinants of self rated health and happiness, as well as the extent of community level covariation in health and happiness. Result revealed that the controlling for demographic markers, a strong income and education gradient was seen for self rated poor health and unhappiness, with the gradient being stronger for poor health. Community level correlations between self rated poor health and happiness were stronger (0.65) than the individual level correlations (0.16) between the two outcomes.
Curlin, Roach, Gorawara-Bhat, Lantos, & Chin (2005) studied how are religion and spirituality related to health? Result shows that all participants believed religion influences health, but they did not emphasize the influence of religion on outcomes. Instead, they focused on ways that religion provides a paradigm for understanding and making decisions related to illness and a community in which illness is experienced. Religion was described as beneficial when it enables patients to cope with illness but harmful when it leads to psychological conflict or conflict with medical recommendations.

Daalen, Sanders, & Willemsen (2005) studied sources of social support as predictors of health, psychological well-being and life satisfaction among Dutch male and female dual-earners. Result shows that men report better health and psychological well-being than women, whereas women report higher life satisfaction than men. Contrary to our expectations, women receive more social support from colleagues than men, while men and women equally receive support from their supervisor. As for the non work-related sources of social support, men receive more social support from their spouse, while women receive more social support from relatives and friends. No gender differences exist in the effects of social support. Although men and women differ with respect to the social support they receive from different sources, these differences cannot explain gender differences in health, psychological well-being and life satisfaction.

Subramanian, Kim, & Kawachi (2005) studied covariation in the socioeconomic determinants of self rated health and happiness: a multivariate multilevel analysis of individuals and communities in the USA. Result revealed that controlling for demographic markers, a strong income and education gradient was seen for self rated poor health and unhappiness, with the gradient being stronger for poor health. Community level correlations between self rated poor health and happiness were stronger (0.65) than the individual level correlations (0.16) between the two outcomes.

Bray, & Gunnell (2006) studied suicide rates, life satisfaction and happiness as markers for population mental health. Result shows that an inverse association exists between suicide rates and life satisfaction ($r=-0.44; 95\% \text{ CI}: -0.68, -0.11$) and happiness ($r=-0.42; 95\% \text{ CI}: -0.67, -0.08$). Similar though weaker associations were seen with hospital discharge data and MHI-5 data but not with the prevalence of mental disorders.
The association between suicide rates and life satisfaction was weaker amongst 15-44 year olds ($r=-0.31$; 95% CI: -0.59, 0.04) than amongst 45-64 year olds ($r=-0.47$; 95% CI: -0.70, -0.14). It was strongest in the 65+ age group ($r=-0.54$; 95% CI: -0.75, -0.23). A similar pattern was observed for the association with happiness. In a subgroup analysis, the association between suicide and life satisfaction in Eastern Europe was similar to that in the whole dataset ($r=-0.35$) but a positive association was seen in Western Europe ($r=0.47$).

Cheung, Loh, & Ho (2006) compared the early psychological changes of cleft lip and palate (CLP) and noncleft patients after maxillofacial corrective surgery, including maxillary distraction osteogenesis and conventional orthognathic surgery. Result revealed that the CLP patients treated with distraction osteogenesis were happier, but had a higher level of social anxiety and distress than the CLP patients receiving conventional orthognathic surgery. On the other hand, the CLP patients overall were happier, with lower social anxiety and distress, than the noncleft control group. The CLP patients showed a higher level of parental self-esteem than the noncleft patients.

Ozer, & Benet (2006) studied personality and the prediction of consequential outcomes. Using the Big Five factors as heuristics for organizing the research literature, numerous consequential relations are identified. Personality dispositions are associated with happiness, physical and psychological health, spirituality, and identity at an individual level; associated with the quality of relationships with peers, family, and romantic others at an interpersonal level; and associated with occupational choice, satisfaction, and performance, as well as community involvement, criminal activity, and political ideology at a social institutional level.

MacInnes (2006) studied self-esteem and self-acceptance: an examination into their relationship and their effect on psychological health. The results revealed that, in comparison with the general population, the sample were more likely to have lower self-acceptance and self-esteem, and higher levels of anxiety, depression and psychological ill health. The concepts of self-esteem and self-acceptance were found to be similar but not synonymous. Self-esteem was more closely associated with affect, with higher levels of self-esteem being indicative of lower levels of depression. Self-acceptance appeared to be
more closely associated with general psychological well-being and to be more helpful when undertaking clinical work for general psychological problems.

Chester, Himburg, & Weatherspoon (2006) investigated how spirituality relates to health-promoting behaviors in African-American women. Result suggests that a significant pair of canonical variables which indicated that those individuals with good nutrition (.95), physical activity (.79), and healthy eating (.42) were positively associated with stress management (.88), health responsibility (.67), spiritual growth (.66), interpersonal relations (.50), education (.49), and self-esteem (.33). This set of variables explained 56% of the variability (p < .001). Practitioners should incorporate the message of spirituality by focusing on strategies to improve health responsibility, interpersonal relations, and self-esteem, along with health-promoting behaviors.

Dogra & Baker (2006) studied physical activity and health in Canadian asthmatics. Result revealed that for all five measures of health, being physically active increased the likelihood of better health, and greater levels of PA were associated with higher values. In summary, PA was consistently associated with better health in Canadians with asthma.

Craig, Weinert, Walton, & Derwinski (2006) studied spirituality, chronic illness, and rural life. Findings suggest that spirituality, hope, depression, and social support had overlapping influence on well-being, although spirituality was not shown to have an independent effect. Participants reported unexpectedly high levels of hope and low levels of depression despite living with chronic illness. Although spirituality did not have an independent effect, the group as a whole had active spiritual and religious lives, possibly influencing the high levels of hope and low levels of depression found.

Litwinczuk, & Groh (2007) studied the relationship between spirituality, purpose in life, and well-being in HIV-positive persons. Spirituality was reported to be significantly correlated with purpose in life (r = .295, p = .049) but not with well-being (r = .261, p = .084). Additionally, the SIBS-R, PIL, and GWB had alpha coefficients greater than .83, suggesting they are reliable and valid measures for this population of HIV-positive persons. The result that spirituality and purpose in life were significantly correlated offers the potential for designing nursing interventions and care delivery
approaches that support psychological adaptation to HIV. Further studies with larger and more diverse samples are needed to better understand the role of well-being in healing.

Molzahn (2007) studied spirituality in later life: effect on quality of life. The results show spirituality was not a significant factor contributing to QOL in this sample, and that the strongest predictors of overall QOL were social support and health satisfaction. Given difficulties in measuring spirituality and homogeneity of the sample, further research is warranted.

Silva et al. (2007) evaluate the factors associated with psychological well-being among adolescents in a southern Brazilian city. Result revealed that psychological well-being was evaluated with a scale containing seven figures representing expressions varying from extreme happiness to extreme sadness. Adolescents were asked to mark the figure that best resembled the way they felt about their lives, and 72.33% reported a high level of psychological well-being. Prevalence of psychological well-being was higher in families with better economic status and higher maternal schooling. Adolescents who practiced a religion, did not smoke or consume alcohol, and wished to lose weight showed a higher level of psychological well-being, suggesting an interrelationship between health behaviors.

Winocur et al. (2007) studied cognitive rehabilitation in the elderly. an evaluation of psychosocial factors. The results, which show that the benefits of our rehabilitation program extend into the psychosocial domain, underscore the potentially important relationship between psychosocial factors and cognitive performance in older adults.

Mystakidou et al. (2007) explored the relationships between depression, hopelessness, cognitive status, pain, and spirituality in patients with advanced cancer. The result revealed that the significant associations were found between pain interference in "mood" and in "enjoyment of life" and hopelessness, as well as between worse pain and pain interference items with depression and cognitive status. Significant correlations were found between hopelessness, depression, and cognitive condition. These findings demonstrate the physical, psychological, and cognitive aspects of patients with cancer.

Swami et al. (2007) studied that general health mediates the relationship between loneliness, life satisfaction and depression. A study with Malaysian medical students.
Result shows that life satisfaction was negatively and significantly correlated with suicidal attitudes, loneliness and depression; and positively with health, which was negatively and significantly correlated with depression and loneliness. Self-concept was negatively correlated with loneliness and depression, depression was positively and significantly correlated with loneliness. Meditational analyses showed that the effects of loneliness and life dissatisfaction on depression were fully mediated by health.

Shin, Han, & Kim (2007) studied predictors of psychological well-being amongst Korean immigrants to the United States: a structured interview survey. Result shows that for happiness, lower levels of acculturative stress and recent life stress, a greater sense of mastery, and greater social support were associated with an increased level of happiness. None of the individual characteristics were significant. R(2) for the full model was .53. For negative affect, acculturative stress and recent life stress explained a significant portion (41%) of the total variance associated with depression (R(2)=.51). As with the happiness variable, individual characteristics failed to add to the predictiveness of the equation, while sense of mastery and social support functioned as significant resources in reducing depression.

Ventegodt, Flensborg, Andersen, & Merrick (2008) examined the statistical associations between Global Quality of Life (QOL) and a series of indicators representing health, ability, philosophy of life, sexuality, quality of working life and other medically relevant aspects of life. Result indicate strongest association between QOL, overall view of life (41.5% / 59.1%), relationship to self (39.3% / 56.8%), partner (32.2% / 31.7%) and friends (33.3% / 42.7%). Different aspects of physical as well as psychological health were also strongly correlated with QOL: self-perceived physical health (33.2% / 29.4%), satisfaction with own health (27.3% / 29.0%), self-perceived mental health (38.4/51.0), number of severe health problems (29.8% / 35.3%). Objective factors such as income, age, sex, weight and social group did not have any noteworthy relationship to QOL, and neither did lifestyle factors such as tobacco and alcohol consumption, drug use, exercise, and diet.

Ostir, Berges, Ottenbacher, Clow, & Ottenbacher (2008) studied associations between positive emotion and recovery of functional status following stroke. Result
revealed that discharge positive emotion score was significantly associated with higher overall functional status ($b = 0.70$, $SE = 0.21$, $p = .001$) as well as with higher motor ($b = 0.37$, $SE = 0.17$, $p = .003$) and cognitive ($b = 0.30$, $SE = 0.05$, $p = .0001$) status at 3-month follow-up after adjustment for relevant risk factors.

Banning, Hafeez, Faisal, Hassan, & Zafar (2009) studied the impact of culture and sociological and psychological issues on Muslim patients with breast cancer in Pakistan. Result reveals that the patient's experience of breast cancer focused on the range of emotions felt throughout the illness trajectory, the importance of religion and family support on coping strategies used to manage the adverse effects of chemotherapy, and also the financial concerns. This is the first study to examine Pakistani Muslim women's views on the lived experience of breast cancer. The data not only highlight the role of religion and family support as essential coping strategies but also emphasize the issues of isolation, aggression, and anger as common responses to chemotherapy. Unique features of this study are women's need to seek spiritual support for their illness and the overriding innate characteristic of maternal responsibility.

Tomy (2009) studied comparison of quality of life in multiple system atrophy and Parkinson's disease. Quality of life (QoL) in multiple system atrophy (MSA) is thought to be poorer than in Parkinson's disease (PD), primarily because of motor impairment, autonomic dysfunction and depression. The aim of the study was to investigate QoL in 10 patients with probable MSA (parkinsonian subtype) compared with 10 PD patients matched for motor disability on UPDRS III motor score. METHODS: All patients were ambulatory and non-demented. Mean durations of disease in MSA and PD patients were respectively 3.6 and 9.0 years. QoL was assessed using the SF-36 health-related questionnaire and a life satisfaction visual analogue scale. Patients were also evaluated for cognitive function (Mattis Dementia Rating Scale [Mattis DRS], Wisconsin Card Sorting Test [WCST], Stroop, Fluencies), depression (Beck Depression Inventory-II [BDI-II]), apathy (Modified Apathy Evaluation Scale) and were screened for non-motor symptoms (NMS Quest). The result shows that only difference in QoL between MSA and PD patients matched for motor disability was that the SF-36 vitality subscore was more impaired in MSA and negatively correlated with interference index on Stroop word colour testing. Depression and non-motor symptoms were associated with poorer QoL in
both groups. Among MSA patients, cognitive impairment (Stroop interference index) and apathy also had a negative impact.

Fröjd, Lampic, Larsson, von Essen (2009) investigated (i) whether specific aspects of the initial consultation (IC) and/or patients' satisfaction with doctors' care are related to health-related quality of life (HRQoL), anxiety and depression among patients with carcinoid tumours and (ii) whether patients' satisfaction with doctors' care changes over time. Result showed that patients' HRQoL, anxiety, depression and satisfaction with doctors' care were assessed longitudinally, shortly after each of the first four admissions to specialist care. Patients who met doctors showing good ability to identify their wish for information at the IC reported higher levels of cognitive function. Higher satisfaction with doctors' care was related to higher emotional and cognitive function, to higher global QoL, and to lower levels of problems with diarrhoea, financial difficulties, constipation, anxiety and depression shortly after each of the first three admissions, although not after the fourth admission to the specialist care. Although most patients with carcinoid tumours report high satisfaction with care, it is important to be aware of the fact that some patients may be less satisfied. Doctors should provide patients with information which matches the individual patients' needs and preferences as patients' satisfaction with doctors' provision of information is related to patients' HRQoL, anxiety and depression.

You et al. (2009) studied spirituality, depression, living alone, and perceived health among Korean older adults in the community and tested two hypotheses: Hypothesis 1: Korean older adults living alone would be more depressed and less healthy than older adults living with family, and Hypothesis 2: Individuals who are more religious and spiritual would report a lower level of depression and a higher level of general health even when other demographic and living status variables are controlled. Hypothesis 1 was supported as Korean older adults living alone were significantly more depressed than were older adults living with family (P<.01). However, for Hypotheses 2, only spirituality activities and Spirituality Index of Well-Being scores were significantly associated with general health and/or depression (P<.01), but there were no relationships between the variables of attendance and importance of religion with general health and depression.
Duggleby, Cooper, & Penz (2009) studied hope, self-efficacy, spiritual well-being and job satisfaction. Result shows that using linear regression, 29.9% of the variance in Herth Hope’ Index score was accounted for by scores from the General Self-Efficacy Scale and Spiritual Well-Being Scale. General Self-efficacy scores (positive relationship) and Spiritual Well-Being scores (negative relationship) accounted for a significant part of the variance. Qualitative data supported all findings, with the exception of the negative relationship between hope and spiritual well-being; participants wrote that faith, relationships, helping others and positive thinking helped them to have hope. They also wrote that hope had a positive influence on their job satisfaction and performance.

Padela, & Heisler (2010) studied the association of perceived abuse and discrimination after September 11, 2001, with psychological distress, level of happiness, and health status among Arab Americans. Result suggest that overall, 25% of the respondents reported post-September 11 personal or familial abuse, and 15% reported that they personally had a bad experience related to their ethnicity, with higher rates among Muslims than Christians. After adjustment for socioeconomic and demographic factors, perceived post-September 11 abuse was associated with higher levels of psychological distress, lower levels of happiness, and worse health status. Personal bad experiences related to ethnicity were associated with increased psychological distress and reduced happiness. Perceptions of not being respected within US society and greater reported effects of September 11 with respect to personal security and safety were associated with higher levels of psychological distress.

Lue, Chen, & Wu (2010) studied the health, financial stresses, and life satisfaction affecting late-life depression among older adults: a nationwide, longitudinal survey in Taiwan. Result revealed that women who perceived greater health or financial stress and who had greater life dissatisfaction or worsened functional condition were more likely to suffer depression. These findings imply that healthcare programs for older adults should include cognitive and behavioral interventions in order to prevent the development of depression in late life.

Kalfoss (2010) studied quality of life among Norwegian older adults. Results indicate the need for multidimensional assessments of QoL among older adults related to
health, psychological, personal competency, social, environmental, and spiritual indicators. Issues related to time use, happiness, cognitive functioning, self-concept, coping with change, social functioning, self-determination, altruistic activity, living conditions, security, and technological aids should also be considered in future assessments of QoL.

Trends and Gap:

The review of these 30+ years shows 118 studies relevant with variables and comprises of empirical studies, reviews, meta-analysis, validation of tools and criterion measurements. The review also suggests that there is no uniqueness in the study of well being and health, rather it contains different age groups from adults to old age and even those people who are at end of life, and within this most of the subjects were medically ill. There are variety of factors those contribute to health and well being like depression, psychosomatic symptoms, life satisfaction, self esteem, organized psyche, cognitive interference and happiness. The review also reveals that studies of related contributory factors in determining health and well being revolves around quality of life, depression, happiness, spirituality, living conditions, socioeconomic status and coping with change.

Well being is an umbrella term and contains variety of sub-concepts as general well being, psychological well being, emotional well being, social well being, subjective well being, spiritual well being, quality of life, health related quality of life etc. Most of the researchers tried to find out the contributing factors of well being further helps in maintaining health, and found that socioeconomic factors, degree of social interaction, marital status, financial situations are also the predictors of health (Larson, 1998., Ward, 1979., Okun, Stock, Haring & Witter, 1984., & Spreitzer, Synder & Larson, 1979). Self esteem, social support, life style and satisfaction with life also plays an important role in the study of health and well being as studied by Muhlenkamp & Sayles, (1986), Coleman, (1987) & Thompson & Hiller, (1990).

Happiness, which is a strong indicator of health and well being, has been influenced by income, housing satisfaction, healthy activities, changes in life events
There are some other factors like depression, stressful life situations, mood (negative and positive) plays important role the assessment of global well being.

Another important variable related to health and well being is spirituality and religiosity. The concept of spirituality is showing a shift. Initially it was studied as religiosity but with the change in time the concept of religiosity also changes and recently the term ‘spirituality’ is frequently used. The studies of spirituality show inconsistency. Some studies like Chester, Himberg & Weatherspoon (2006), Litwinczuk & Groh (2007), You et al. (2009), & Boero et al. (2005) found positive relation of spirituality with well being, while Craig, Weinert, Waton, & Derwinski (2006), & Molzahn (2007) did not found any kind of relation with well being, and Duggleby, Cooper & Penz (2009) found a negative impact of spirituality upon well being. But spirituality is directly or indirectly related with well being.

Cognitive interference also plays an important role in understanding health and well being. Cognitive functioning is associated with positive emotions, hopelessness, depression and apathy (Ostir et al. 2008., Torny, 2009., & Mystakidou et al. 2007). Cognitive appraisal and coping strategies have stronger impact upon mental health. However such studies reveal the importance of cognitive factors in measuring health and well being. Disorganized psyche also lack the research in relation to study the structure of well being and health.

In the end it can be concluded that well being is a global concept including various sub-concepts as mental, spiritual, social, emotional and subjective aspects. The review of the literature shows that there is no single measure of well being, rather it is multifaceted and also include self esteem, depression, happiness, organized psyche, cognitive interference, psychosomatic symptoms. After the review of the literature it was found that there is need for multivariate assessment of well being and health as suggested by Matthews, Baker, Hann, Denniston, & Smith (2002), & Kalfoos (2010), that incorporating multiple measures of well being contribute to the understanding and measurement of health and well being. So, the present study was aimed in the light of such suggestions, lacking of role of cognitive components, organized psyche, inconsistency in the study of spirituality, role of depression, self esteem, happiness,
subjective well being, satisfaction with life and psychosomatic symptoms allow us to study the factorial structure of health and well being in multivariate context.

**Problem:**

With the above theoretical perspectives, the present study was aimed at "the construct refinement of psychological well being".

The objectives set forth were:

I. To explore the structure of well being through its underlying factors; and,

II. To suggest a battery of measures of psychological well being albeit health (illness), subjective well being and general well being.